STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME CORRECTED COPY	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/24/2019 through 06/27/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/24/19 through 6/27/19. A complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 53 certified bed facility was 40 at the time of the survey. The survey sample consisted of 21 current Resident reviews and 5 closed record reviews.	F 000	F 000 This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Covenant Woods is committed to sustaining compliance with regulations.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys,	F 577		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Davis LNHA | TITLE: Administrator | (X6) DATE: 7-25-19

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

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F 577	Continued From page 1 certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure survey results were readily available on one of two separate wings (the A wing) and failed to post notice of survey results on two of two wings (the A wing and the C wing). The findings include: On 6/25/19 at 12:21 p.m. and 6/26/19 at 1:50 p.m., observation of the survey results was conducted. The facility contained two wings (wing A and wing C). Each wing contained separate entrances due to construction. Survey results were observed on wing C but there was no posted notice regarding the survey results. No survey results or posting regarding the survey results was observed on wing A. On 6/26/19 at 3:19 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated the survey results are usually contained in a binder that is placed near the main entrance that residents use the most but recently there was two entrances so the survey results were duplicated	F 577	F 577 1. New signage posted at c-wing location to identify survey results. New copy and signage of survey results placed at A-wing location. 2. Residents and families unfamiliar with location of survey results may have been affected. 3. Staff will check placement of results and signage daily. Documents will be replaced as needed and reported to Administrator. 4. Policy updated to reflect required posting of notice.	26-Jun-19 11-Aug-19 19-Jul-19

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F 577	Continued From page 2 and placed at both entrances. ASM #1 was made aware there was no survey results located on wing A. ASM #1 stated the facility staff tries to make sure the survey results are placed on the wing but unfortunately, they "walk off" from time to time. ASM #1 was also made aware there was no posted notice regarding the survey results on wing A or wing C. ASM #1 confirmed there should be a posted notice. On 6/26/19 at 3:36 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "EXAMINATION OF SURVEY RESULTS" documented, "The resident has the right to examine the facility's most recent survey results. The facility makes the results available to residents in an easily accessible location..." The policy failed to document information about the posting of a notice regarding the survey results. No further information was presented prior to exit.	F 577		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		

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F 578	Continued From page 3 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to evidence that a periodic review was conducted with the resident and/or resident's responsible party if they wish to make changes to their existing advance directives or maintain them as written for one of 26 residents in the survey sample; Residents #14	F 578	F 578 1. Resident #14's advanced medical directive and code status was reviewed with resident. Resident does not wish to make any changes to current advanced medical directive and code status. 2. All residents could be affected. 3. Advanced medical directives and code status will be reviewed with residents and their resident representative, if applicable, upon admission, readmission, quarterly, and with any significant change. 4. The resource nurse or designee will monitor 50% of documentation for residents' advanced medical directives review for 3 months. All results will be tracked and trended and presented at QAPI for further recommendations.	16-Jul-19 11-Aug-19 11-Aug-19

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F 578	Continued From page 4	F 578		

The facility staff failed to evidence Resident #14's Advance Directive was reviewed periodically with the resident and/or her responsible party (RP) to ascertain if the resident's wishes and preferences had changed or remained the same.

The findings include:

Resident #14 was admitted to the facility on 7/1/11 with the diagnoses of but not limited to dysphagia, parastomal hernia with obstruction, kidney calculus, osteoarthritis, ischemic heart disease, diverticulitis, depression, macular degeneration, and dementia. The significant change MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 4/3/19 coded the resident as being moderately impaired in ability to make daily life decisions.

On 6/26/19 at 8:55 AM, an interview was attempted with Resident #14. She was not able to recall anything about a review of her Advance Directives.

A review of the clinical record revealed an "Advance Medical Directive Health Care Instructions" form dated 1/20/1997. Further review of the clinical record failed to reveal any evidence that the contents of this form was discussed with the resident and/or RP periodically to ascertain if the information contained within continued to be the resident's wishes or did she wish to make any changes.

On 6/25/19 at 4:31 PM, in an interview with OSM #1 (Other Staff Member) the social worker. OSM #1 stated that for periodic review, "if a resident has questions, we review it, briefly go over it in

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F 578	Continued From page 5	F 578		

care plan meetings, and ask if they want to make any changes to it." When asked how staff evidenced that the Advanced Directive was reviewed with the resident, OSM #1 stated, "There is a general note from the care plan meeting and what happened in the meeting."

On 6/26/19 at 11:40 AM, OSM #1 provided a copy of the most recent Care Plan meeting invitation provided to the resident. The Care Plan meeting invitation documented, "You and your responsible party (RP) are invited to a Care Plan meeting on the morning of Thursday, April 4th....we will discuss care and services unique to you....If you cannot meet on April 4th, you can call to schedule an alternate meeting date...."

On 6/26/19 at 11:40 AM, OSM #1 stated that the resident and RP did not attend the above meeting and therefore a review of the Advance Directives were not discussed with her. She stated that she could go to the resident and discuss them at an alternate time but had not.

A review of the care plan revealed one, undated, for "(Resident #14) has elected an Advance Directive and has defined preferences including: Living Will-Do Not Resuscitate-Do Not." This care plan included the goal of, "(Resident #14) and/or responsible party requests will be honored regarding Advance Directives and directions related to care and code status." The interventions, undated, included, "The staff will respect (Resident #14) and/or responsible party wishes and preferences and will make all reasonable efforts to carry out their wishes."

A review of the facility document, "Advance Directives" documented, "A resident's choice

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F 578	Continued From page 6 about Advance Directives will be respected....1. Prior to or upon admission of a resident, the Admissions Representative will ask the resident, and/or their family member(s), about the existence of any Advance Directives, and provide information to the resident or their legal representative regarding their right to formulate an Advance Directive if they do not have one and wish to do so. 2. Should the resident indicate that he or she has issued Advanced Directives about his or her care and treatment; the facility will require that a copy of such directives be included in the medical record. 3. Each resident will also be informed that our facility's policies do not condition the provision of care or discriminate against an individual based upon whether or not that person has executed an Advance Directive. 4. Our facility has defined Advance Directives as preferences regarding treatment options which include, but are not limited to: Living Will...Do Not Resuscitate...Do Not Hospitalize....Organ Donation....Autopsy Request....Feeding Restrictions....Medication Restrictions....Other Treatment Restrictions....5. The Social Services department will review a resident's Advance Directives annually, upon request and/or as needed and incorporate advance decision-making into the interdisciplinary care plan. In (facility unit) changes in Advance Directives will be submitted in writing by the resident or their legal representative to the Nursing department and communicated promptly to the attending physician so that appropriate changes in orders may be obtained....6. Inquiries concerning Advance Directives should be referred to the Social Services personnel, the Administrator, and/or the Director of Nursing services."	F 578		

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F 578	Continued From page 7 On 6/26/19 at 4:00 PM, ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (Director of Nursing) was made aware of the findings. No further information was provided by the end of the survey.	F 578		
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 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	F 580		

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F 580	Continued From page 8 (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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician of a possible need to alter treatment for one of 26 residents in the survey sample, Resident #149. The facility staff failed to notify Resident #149's physician when some of the resident's medications were not available for administration on 6/19/19. The findings include: Resident #149 was admitted to the facility on 6/18/19. Resident #149's diagnoses included but were not limited to urinary tract infection, shortness of breath and hearing loss. Resident #149's MDS (minimum data set) assessment was not complete. An admission nursing assessment dated 6/18/19 documented the resident was alert and oriented times three (person, place and	F 580	F 580 1. R#149's physician was notified of meds not administered as ordered on June 26 by the DON. R#149 is no longer a current resident at Covenant Woods. 2. LPN #1 and nurses working 7-3 and 3-11 on June 26, 2019, were educated by the DON on the process for obtaining meds and notifying physician if meds not available. All resident could be affected 3. Nurses will be re-educated on the process for obtaining meds on admissions, including notifying physician for meds not available per Remedi policy/procedure by Remedi Pharmacy representative. 4. DON or designee will audit 100% of all new admission MARS for 1 month and then 50% of all new admission MARs for 2 months to confirm meds are available and administered as ordered. Education will be provided for any discrepancies noted. Results will be tracked and trended and presented at QAPI for further recommendations	1. 26-Jun-19 2. 26-Jun-19 3. 11-Aug-19 4. 11-Aug-19

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F 580	Continued From page 9 time). Review of Resident #149's clinical record revealed the following physician's orders: 6/18/19 Aspercreme (1) 4% topical patch- apply one patch to left chest daily. 6/18/19 albuterol sulfate (2) 90 micrograms/actuation aerosol inhaler- two puffs two times a day. 6/18/19 diclofenac (3) 1% topical gel- two grams four times daily. Review of the June 2019 MAR (medication administration record) for Resident #149 revealed the above medications were not administered during the morning medication pass on 6/19/19 because the facility staff was awaiting arrival of the medications from the pharmacy. In addition, the diclofenac was not administered during the lunch medication pass on 6/19/19 because the facility staff was awaiting arrival of the medication from the pharmacy. A nurse's note dated 6/19/19 at 12:00 p.m. documented, "Medications given this am awaiting a few from pharmacy due to arrive today..." Further review of Resident #149's clinical record (including the June 2019 MAR and nurses' notes) failed to reveal documentation that Resident #149's physician was notified and made aware that the above medications were not administered on 6/19/19. Resident #149's baseline care plan dated 6/18/19 documented, "MEDICATION/TREATMENT ORDERS. See MAR/TAR (treatment administration record)..."	F 580		

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F 580	Continued From page 10 On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse caring for Resident #149 during the 6/19/19 morning and lunch medication passes). LPN #1 confirmed Resident #149's Aspercreme, albuterol sulfate and diclofenac did not arrive during her shift on 6/19/19 so the medications were not administered to the resident. When asked if she notified Resident #149's physician and made him aware the medications were not administered, LPN #1 stated, "I don't recall." LPN #1 stated she would notify the physician if the resident went the entire day without the medications or if the medications were not going to arrive but in this case, she (LPN #1) had contacted the pharmacy and knew the medications were going to arrive. On 6/26/19 at 3:11 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was asked if the physician should be notified if a resident misses a dose of medication. ASM #2 stated, "Yes." When asked why, ASM #2 stated, "It's a missed medication and could be a medication error." On 6/26/19 at 3:36 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "CHANGES IN CONDITION" documented, "(Name of facility) will immediately inform the resident and consult with the resident's physician, if appropriate, when changes occur..." No further information was presented prior to exit.	F 580		

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F 580	Continued From page 11 (1) Aspercreme is used to treat arthritis pain. This information was obtained from the website: https://www.mayoclinic.org/diseases-conditions/osteoarthritis/in-depth/pain-medications/ART-20045899?p=1 (2) Albuterol sulfate is used to treat shortness of breath. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682145.html (3) Diclofenac is used to relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a611002.html	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the abuse policy for one of 26 residents in the survey sample, Resident #22.	F 607		

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COVENANT WOODS NURSING HOME CORRECTED COPY	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 12 Resident #22 sustained an injury of unknown origin on 8/11/18. The facility staff failed to implement the abuse policy for reporting the injury of unknown origin to the SA (state agency); the injury was not reported until 8/13/18. The findings include: Resident #22 was admitted to the facility on 9/25/17. Resident #22's diagnoses included but were not limited to muscle weakness, high blood pressure and repeated falls. Resident #22's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/22/19, coded the resident's cognitive skills for daily decision-making as moderately impaired. Review of Resident #22's clinical record revealed a nurse's note dated 8/11/18 that documented, "Resident noted to have facial drooping to left eye. Nurse assessed resident and bruise noted to lower left chin. Swelling noted to left high cheek bone and when touched, resident stated 'that it hurts'..." The note further documented the resident's physician and representative was notified, but failed to document a cause of the injury. A FRI (facility reported incident) submitted to the SA by ASM (administrative staff member) #1 (the administrator) on 8/13/18 documented, "Report date: 8-13-18. Incident date: 8-11-18. Residents involved: (name of Resident #22). Injuries: (an X beside Yes). If yes, describe: Discoloration to left side of face. Incident type: (an X beside Injury of unknown origin)..." The final report dated 8/17/28 documented no abuse was founded.	F 607	F 607 1. R#22 is no longer a current resident at Covenant Woods. 2. All residents at Covenant Woods could potentially be affected 3. Staff was educated on the abuse policy including timely reporting of injuries of unknown origin was conducted on 11-Jul-19. Additional training sessions will be provided to ensure staff completion. 4. Administrator or designee will audit 100% of all Facility Reported Incidents for 3 months to ensure timely reporting per facility abuse policy. Education will be provided to team members for any discrepancies noted. All results will be tracked and trended and presented at QAPI for further recommendations	19-Jul-19 11-Aug-19 11-Aug-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 607	Continued From page 13 On 6/26/19 at 3:19 p.m., an interview was conducted with ASM (administrative staff member) #1. ASM #1 was asked if a bruise of unknown origin should be reported to the SA. ASM #1 stated, "If there is bruising that appears and nobody knows how it got there then yes." ASM #1 was asked about the timeframe for reporting an injury of unknown origin to the SA. ASM #1 stated, "Usually immediate. As soon as you can get it all together to report." On 6/26/19 at 3:36 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled "ABUSE" documented, "Reporting- a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures..." No further information was presented prior to exit.	F 607		
F 608 SS=C	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii)	F 608		

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F 608	Continued From page 14 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post notice of employee rights regarding the reporting of suspicious crimes. The findings include:	F 608	F 608 1. Posting of employee rights under the Elder Justice Act placed in each care base and break room. 2. Staff may have been affected. 3. Bulletin board in care bases and breakroom will be checked weekly x 8 weeks for placement of posting. Posting will be replaced as needed and reported to the DON. 4. Staffing Coordinator will monitor bulletin boards for continued postings ongoing.	26-Jun-19 11-Aug-19

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F 608	Continued From page 15 On 6/25/19 at 12:25 p.m. and 6/26/19 at 1:55 p.m., a tour of the facility was conducted to locate a posted notice of employee rights regarding the reporting of suspicious crimes. No notice could be located. On 6/26/19 at 3:19 p.m., ASM (administrative staff member) #1 (the administrator) was made aware a posted notice of employee rights regarding the reporting of suspicious crimes could not be located. ASM #1 stated she would double check the employee break room. On 6/27/19 at 9:07 a.m., ASM #1 confirmed the notice was not posted on the previous date. ASM #1 stated the notice was now posted in the nursing care bases. The facility policy titled, "REPORTING SUSPECTED CRIMES UNDER THE FEDERAL ELDER JUSTICE ACT POLICY" documented, "2. The facility must post a sign in a conspicuous area for employees and other covered individuals a notice specifying the employees' rights..." No further information was presented prior to exit.	F 608		
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,	F 609		

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F 609	Continued From page 16 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report an injury of unknown origin within the required timeframe for one of 26 residents in the survey sample, Resident #22. Resident #22 sustained an injury of unknown origin on 8/11/18. The facility staff failed to report the injury of unknown origin to the SA (state agency) within 24 hours. The injury was not reported until 8/13/18. The findings include: Resident #22 was admitted to the facility on 9/25/17. Resident #22's diagnoses included but	F 609	F 609 1. R#22 is no longer a current resident at Covenant Woods. 2. All residents at Covenant Woods could potentially be affected. 3. Education on the abuse policy including timely reporting of injuries of unknown origin was conducted on 11-Jul-19. Additional training sessions will be provided to ensure staff completion. 4. Administrator or designee will audit 100% of all Facility Reported Incidents for 3 months to ensure timely reporting per facility abuse policy. Education will be provided to team members for any discrepancies noted. All results will be tracked and trended and presented at QAPI for further recommendations	19-Jul-19 11-Aug-19 11-Aug-19

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F 609	Continued From page 17	F 609		

were not limited to muscle weakness, high blood pressure and repeated falls. Resident #22's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/22/19, coded the resident's cognitive skills for daily decision-making as moderately impaired.

Review of Resident #22's clinical record revealed a nurse's note dated 8/11/18 that documented, "Resident noted to have facial drooping to left eye. Nurse assessed resident and bruise noted to lower left chin. Swelling noted to left high cheek bone and when touched, resident stated 'that it hurts'..." The note further documented the resident's physician and representative was notified but failed to document a cause of the injury.

A FRI (facility reported incident) submitted to the SA by ASM (administrative staff member) #1 (the administrator) on 8/13/18 documented, "Report date: 8-13-18. Incident date: 8-11-18. Residents involved: (name of Resident #22). Injuries: (an X beside Yes). If yes, describe: Discoloration to left side of face. Incident type: (an X beside Injury of unknown origin)..." The final report dated 8/17/28 documented no abuse was founded.

On 6/26/19 at 3:19 p.m., an interview was conducted with ASM (administrative staff member) #1. ASM #1 was asked if a bruise of unknown origin should be reported to the SA. ASM #1 stated, "If there is bruising that appears and nobody knows how it got there then yes." ASM #1 was asked what timeframe should an injury of unknown origin be reported to the SA. ASM #1 stated, "Usually immediate. As soon as you can get it all together to report."

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F 609	Continued From page 18 On 6/26/19 at 3:36 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled "ABUSE" documented, "Reporting- a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures..." No further information was presented prior to exit.	F 609		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved	F 622		

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F 622	Continued From page 19 sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health 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	F 622	F 622 1. The facility was not able to validate documents sent to hospital for residents # 12, #14 and #41 during transfer to the hospital ER 2. All residents transferred to the hospital ER maybe at risk for validating information sent to the hospital at the time of transfer. 3. A process to validate all required information; contact information for the practitioner, resident representative contact information, advance directive, current physician orders and comprehensive care plan goals sent to the hospital ER upon transfer of any resident was implemented on 6/27/2019. This process also included documentation of the reason for the transfer to the hospital ER in the resident's medical record. 4. Education on the Facility Initiated Transfer /Discharge policy was provided to nursing staff on 27-Jun-19. Continued education of nursing staff on the Facility Initiated Transfer/Discharge policy will be provided to ensure compliance with the policy.	19-Jul-19 27-Jun-19 11-Aug-19

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F 622	Continued From page 20 communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure the required	F 622	F 622 5. Unit Manager or designee will audit 50% of residents transferred to hospital ER for compliance with the facility initialed transfer/discharge policy for 3 months. Education will be provided to team members for any discrepancies noted. All results will be tracked and trended and presented at QAPI for further recommendations	11-Aug-19

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F 622	Continued From page 21 physician documentation was completed and/or that the required transfer documentation was provided to the receiving facility upon hospital transfers for three of 26 residents in the survey sample; Resident #14, #12, and #41. 1. The facility staff failed to evidence what, if any, required documentation was provided to the receiving facility when Resident #14 was transferred to the hospital on 2/28/19. 2. The facility staff failed to evidence what, if any, required documentation was provided to the receiving facility when Resident #12 was transferred to the hospital on 5/18/19. 3. The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #41 was transferred to the hospital on 5/21/19. The findings include: 1. The facility staff failed to evidence what, if any, required documentation was provided to the receiving facility when Resident #14 was transferred to the hospital on 2/28/19. Resident #14 was admitted to the facility on 7/1/11, with the diagnoses of but not limited to, dysphagia, parastomal hernia with obstruction, kidney calculus, osteoarthritis, insomnia, abnormal weight loss, colostomy, and dementia. The significant change MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 4/3/19 coded the resident as being moderately impaired in ability to make daily life decisions.	F 622		

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F 622	Continued From page 22 A review of the clinical record revealed a nurse's note dated 2/28/19 that documented in part, "At approx. 1700 (5:00PM) Per on-call to send resident out since the emesis was continuing and the Zofran has not helped at this time. At 1715 (5:15PM) family notified of request to send out resident and verbal acknowledgement per family. Management notified of request to send out resident and verbal acknowledgement per family...." There was no evidence in the clinical record regarding what, if any, documentation was provided to the hospital upon this transfer. On 6/26/19 at 10:20 AM, in an interview with LPN #3 (Licensed Practical Nurse), she stated that, "Typically we send a MAR (medication administration record), POS (physician's order sheet), a note showing what transpired to send them out, a facesheet, their DNR (Do Not Resuscitate), Advance Directives." When asked about sending the comprehensive care plan goals, LPN #3 stated, "We do not send the care plan goals." When asked about documentation evidence regarding what was sent, LPN #3 stated, "We do not have it documented exactly what was sent." When asked if it was a fair statement, that the facility cannot evidence what if anything was sent, she stated it was a fair statement. On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information that is provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated she sends the resident's face sheet, list of	F 622		

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F 622	Continued From page 23 medications, current vital signs, a description of what's going on, any recent changes and advance directives. When asked if she sends the resident's comprehensive care plan goals, LPN #1 stated, "I'm not sure about that. I will have to look into that." LPN #1 was asked how nurses evidence the information provided to hospital staff. LPN #1 stated she documents specific information in the nurses' notes. On 6/26/19 at 4:00 PM, ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (Director of Nursing) was made aware of the findings. On 6/27/19 at 7:30 AM, ASM #2 provided a policy titled, "Facility Initiated Transfer and Discharge." This policy was documented as being developed "6/19" (June of 2019), and ASM #2 stated that this was a "new policy going into service today." The facility provided no evidence of having a previous policy regarding transfers and discharges to the hospital that were in effect prior to being notified of the above concerns. (1) Zofran - used to prevent nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a601209.html 2. The facility staff failed to evidence what, if any, required documentation was provided to the receiving facility when Resident #12 was transferred to the hospital on 5/18/19. Resident #12 was admitted to the facility on	F 622		

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4/3/19 with the diagnoses of but not limited to Parkinson's disease, insomnia, depression, tremors, asthma, and overactive bladder. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) coded the resident as being cognitively intact for daily decision-making.

A review of the clinical record revealed a nurse's note dated 5/17/19, which documented in part the following: "Because this residents condition was so far from her baseline, I requested that she go to the ER (emergency room) for evaluation and she agreed. Resident was tachycardic 138. Pupils 6mm (millimeters) dilated. EMS (emergency medical services) was called, verbal report and necessary paperwork given and resident left the facility by stretcher around 4:10pm. Spouse was called for notification and to discuss the additional, non prescribed medication that was given to resident. He mentioned that he did give her some migraine medication that was from her home bottles, because she asked for it. He was educated on not providing resident with non prescribed medications while she lives in (facility). Communicated with MD (medical doctor), DON (director of nursing), and administrator."

There was no evidence in the clinical record regarding what, if any, documentation was provided to the hospital upon this transfer.

On 6/26/19 at 10:20 AM, in an interview with LPN #3 (Licensed Practical Nurse), she stated that, "Typically we send a MAR (medication administration record), POS (physician's order sheet), a note showing what transpired to send them out, a facesheet, their DNR (Do Not

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Resuscitate), Advance Directives." When asked about sending the comprehensive care plan goals, LPN #3 stated, "We do not send the care plan goals." When asked about documentation evidence regarding what was sent, LPN #3 stated, "We do not have it documented exactly what was sent." When asked if it was a fair statement, that the facility cannot evidence what if anything was sent, she stated it was a fair statement.

On 6/26/19 at 4:00 PM, ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (Director of Nursing) was made aware of the findings.

3. The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #41 was transferred to the hospital on 5/21/19.

Resident #41 was admitted to the facility on 1/16/18. Resident #41's diagnoses included but were not limited to high blood pressure, asthma and urinary tract infection. Resident #41's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/5/19, coded the resident's cognitive skills for daily decision making as independent.

Review of Resident #41's clinical record revealed the resident was transferred to the hospital on 5/21/19 for a gray appearance and a low oxygen saturation level.

Further review of Resident #41's clinical record failed to reveal documentation to evidence the information that was provided to the hospital staff when the resident was transferred on 5/21/19.

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F 622	Continued From page 26 On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information that is provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated she sends the resident's face sheet, list of medications, current vital signs, a description of what's going on, any recent changes and advance directives. When asked if she sends the resident's comprehensive care plan goals, LPN #1 stated, "I'm not sure about that. I will have to look into that." LPN #1 was asked how nurses evidence the information provided to hospital staff. LPN #1 stated she documents specific information in the nurses' notes. On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		

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F 623	Continued From page 27 and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (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	F 623	F 623 1. Notice of transfer to emergency room for residents #14, 12, and 41 was sent to the Office of the State Long-Term Care Ombudsman by the social worker. Facility not able to validate written notification provided to resident or resident representative at time of transfer to hospital ER for residents #14, 12, and 41. 2. All facility initiated transfers for the month of June have been sent to the Office of the State Long-Term Care Ombudsman by the social worker. All residents transferred to the hospital ER are at risk for not receiving written notification of transfer. 3. Notification of all facility initiated discharges will be sent to the Office of the State Long-Term Care Ombudsman by Social Worker on a monthly basis. Written notification of all facility initiated discharges will be given to resident or resident's representative at time of transfer to hospital ER.	16-Jul-19 16-Jul-19 19-Jul-19

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F 623	Continued From page 28 to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §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	F 623	F 623 4. Director of Resident Services or designee will audit Ombudsman notifications monthly. All results will be tracked and trended and presented at QAPI for further recommendations. Unit Manager or designee will audit 50% of residents transferred to hospital ER for compliance with the facility initialed transfer/discharge policy for 3 months. Education will be provided to team members for any discrepancies noted. All results will be tracked and trended and presented at QAPI for further recommendations	11-Aug-19

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F 623	Continued From page 29 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide written notification to the resident/representative and/or ombudsman for hospital transfers for 3 of 26 Residents in the survey sample; Residents #14, #12, and #41. 1. The facility staff failed to evidence that written notification was provided to Resident #14 or the resident representative and Ombudsman when the resident was transferred to the hospital on 2/28/19. 2. The facility staff failed to evidence that written notification was provided to Resident #12 or the resident representative and Ombudsman when the resident was transferred to the hospital on 5/17/19. 3. Resident #41 was transferred to the hospital on 5/21/19. The facility staff failed to evidence that written notification regarding the transfer was provided to the resident, resident representative and/or the ombudsman. The findings include: 1. The facility staff failed to evidence that written notification was provided to Resident #14 or the resident representative and Ombudsman when the resident was transferred to the hospital on 2/28/19. Resident #14 was admitted to the facility on	F 623		

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7/1/11, with the diagnoses of but not limited to, dysphagia, parastomal hernia with obstruction, kidney calculus, osteoarthritis, insomnia, abnormal weight loss, colostomy, and dementia. The significant change MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 4/3/19 coded the resident as being moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 2/28/19, that documented in part the following, "1700 (5:00PM) Per on-call to send resident out since the emesis was continuing and the Zofran has not helped at this time. At 1715 (5:15PM) family notified of request to send out resident and verbal acknowledgement per family. Management notified of request to send out resident and verbal acknowledgement per family. Management notified of resident status. Residents VS: BP (blood pressure) 189/119, t (temperature) 99.3, r (respirations) 24, p (pulse) 106 and SpO2 @ 92 (oxygen saturation at 92%) on 2 L [liter] via NC [nasal cannula]. Residents ostomy cleaned and changed, cool wash clothe {sic} placed on forehead, and resident cleaned up from projectile emesis that happened when this staff was in room. 911 called and this staff printed paperwork and awaited ambulance. Ambulance arrived at approx.[approximately] 1845 (6:45PM), report given to EMT (emergency medical technician) and paramedic. Resident was placed on stretcher, 2 L of O2 via NC [oxygen via nasal cannula], out room door via stretcher, to elevator to main door."

A review of the most recent physician note after this hospitalization documented, "...recently admitted.....after ventral hernia surgery as she

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F 623	Continued From page 31 had intestinal obstruction. She has a history of chronic colostomy from diverticulitis. Recently she was having abdominal pain and vomiting and she was sent to the hospital where she was diagnosed with obstruction, and she is status post ventral hernia repair...." There was no evidence in the clinical record about written notification provided to Resident #14 and or the resident representative and ombudsman for this hospitalization. On 6/26/19 at 10:13 AM, in an interview with OSM #1 (Other Staff Member) the social worker, she stated that she provides the resident/resident representative with written notice for planned discharges but not for hospital transfers. OSM #1 stated, "We identified that we have not been doing it and are developing a checklist. We are developing a packet to be sent to the emergency room and adding that letter since we identified that was not being done." OSM #1 stated that the letter was not implemented "until 2 or 3 weeks ago." OSM #1 was asked about notification to the Ombudsman. OSM #1 stated letters were mailed to the Ombudsman but that that they were addressed as "To whom it may concern" and did not specifically identify the Ombudsman by name, that the letters were not mailed by certified mail, and that she did not retain evidence of who the letters she sent were about. OSM #1 was asked to contact the ombudsman and ask the ombudsman to verify the above notification with the survey team. On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses provide written notification regarding hospital transfers to	F 623		

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F 623	Continued From page 32 residents and/or their representatives. LPN #1 stated she thought nurses only provide verbal notification. On 6/26/19 at 1:56 p.m., OSM #1 stated she left messages for the ombudsman but had not heard back. On 6/26/19 at 4:00 PM, ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (Director of Nursing) was made aware of the findings. On 6/27/19 at 7:30 AM, ASM #2 provided a policy titled, "Facility Initiated Transfer and Discharge." This policy was documented as being developed "6/19" (June of 2019), and ASM #2 stated that this was a "new policy going into service today." The facility provided no evidence of having a previous policy regarding transfers and discharges to the hospital that were in effect prior to being notified of the above concerns. (1) Zofran - used to prevent nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a601209.html 2. The facility staff failed to evidence that written notification was provided to Resident #12 or the resident representative and Ombudsman when the resident was transferred to the hospital on 5/17/19. Resident #12 was admitted to the facility on 4/3/19 with the diagnoses of but not limited to	F 623		

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Parkinson's disease, insomnia, depression, tremors, asthma, and overactive bladder. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) coded the resident as being cognitively intact for daily decision-making.

A review of the clinical record revealed a nurse's note dated 5/17/19, which documented in part the following: "Because this residents condition was so far from her baseline, I requested that she go to the ER (emergency room) for evaluation and she agreed. Resident was tachycardic 138. Pupils 6mm (millimeters) dilated. EMS (emergency medical services) was called, verbal report and necessary paperwork given and resident left the facility by stretcher around 4:10pm. Spouse was called for notification and to discuss the additional, non prescribed medication that was given to resident. He mentioned that he did give her some migraine medication that was from her home bottles, because she asked for it. He was educated on not providing resident with non prescribed medications while she lives in (facility). Communicated with MD (medical doctor), DON (director of nursing), and administrator."

There was no evidence in the clinical record about written notification provided to Resident #12, or the resident representative and ombudsman for the hospitalization.

On 6/26/19 at 10:13 AM, in an interview with OSM #1 (Other Staff Member) the social worker, she stated that she provides the resident/resident representative with written notice for planned discharges but not for hospital transfers. OSM #1 stated, "We identified that we have not been

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doing it and are developing a checklist. We are developing a packet to be sent to the emergency room and adding that letter since we identified that was not being done." OSM #1 stated that the letter was not implemented "until 2 or 3 weeks ago." OSM #1 was asked about notification to the Ombudsman. OSM #1 stated letters were mailed to the Ombudsman but that that they were addressed as "To whom it may concern" and did not specifically identify the Ombudsman by name, that the letters were not mailed by certified mail, and that she did not retain evidence of who the letters she sent were about. OSM #1 was asked to contact the ombudsman and ask the ombudsman to verify the above notification with the survey team.

On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses provide written notification regarding hospital transfers to residents and/or their representatives. LPN #1 stated she thought nurses only provide verbal notification.

On 6/26/19 at 1:56 p.m., OSM #1 stated she left messages for the ombudsman but had not heard back.

On 6/26/19 at 4:00 PM, ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (Director of Nursing) was made aware of the findings.

On 6/27/19 at 7:30 AM, ASM #2 provided a policy titled, "Facility Initiated Transfer and Discharge." This policy was documented as being developed "6/19" (June of 2019), and ASM #2 stated that this was a "new policy going into service today."

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The facility provided no evidence of having a previous policy regarding transfers and discharges to the hospital that were in effect prior to being notified of the above concerns.
3. Resident #41 was transferred to the hospital on 5/21/19. The facility staff failed to evidence that written notification regarding the transfer was provided to the resident, resident representative and/or the ombudsman.

Resident #41 was admitted to the facility on 1/16/18. Resident #41's diagnoses included but were not limited to high blood pressure, asthma and urinary tract infection. Resident #41's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/5/19, coded the resident's cognitive skills for daily decision making as independent.

Review of Resident #41's clinical record revealed the resident was transferred to the hospital on 5/21/19 for a gray appearance and a low oxygen saturation level.

Further review of Resident #41's clinical record failed to reveal documentation to evidence the resident, resident representative and/or the ombudsman was provided written notification regarding the transfer.

A letter dated 6/4/19 documented, "To Whom It May Concern: During the month of May 2019, (name of facility) had five emergency transfers to the hospital from our Health Care facility. Please see the details below: (name of Resident #41 was transferred to (name of hospital) on May 21st due to pneumonia..."

On 6/26/19 at 10:10 a.m., an interview was

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F 623	Continued From page 36 conducted with OSM (other staff member) #1 (the social worker). OSM #1 was asked if she provides written notification regarding resident hospital transfers to the ombudsman. OSM #1 stated she mails the notifications and could not provide evidence that the notifications were actually sent to the ombudsman. OSM #1 was asked to contact the ombudsman and ask the ombudsman to verify the above notification with the survey team. On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses provide written notification regarding hospital transfers to residents and/or their representatives. LPN #1 stated she thought nurses only provide verbal notification. On 6/26/19 at 1:56 p.m., OSM #1 stated she left messages for the ombudsman but had not heard back. On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 623		
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	F 656		

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F 656	Continued From page 37 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate 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 observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop	F 656	F 656 1. R#46 care plan was updated to include the use of quarter-length grab bar per physician's order. 2. 100% review of residents with grab bars will be completed to ensure care plans are updated and current per physician's order by MDS nurse or designee. 3. Education will be provided to nurses by the MDS coordinator or designee on the development of comprehensive care plans to include use of grab bars. 4. DON or designee will audit 100% of care plans x 1 month and 50% x 2 months for residents with grab bars to ensure care plans are current per physician's grab bar order. Education will be provided to team members for any discrepancies noted. All results will be tracked and trended and presented at QAPI for further recommendations.	16-Jul-19 01-Aug-19 11-Aug-19 11-Aug-19

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F 656	Continued From page 38	F 656		

a comprehensive care plan for the use of side rails for one of 26 residents in the survey sample, Residents #46.

The findings include:

1. Resident #46 was admitted to the facility on 5/30/19 with the diagnoses of but not limited to Parkinson's disease, spinal stenosis, diabetes, high blood pressure, osteoarthritis, and chronic lower back pain. The Admission MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) coded Resident #46 as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing, hygiene, toileting, dressing, and transfers; limited assistance for eating; and was frequently incontinent of bowel and bladder.

On 6/25/19 at 1:45 PM and 6/26/19 at 8:55 AM, observations were made of Resident #46's room. The resident was not in the room. The bed was noted with approximate quarter-length sized side rails on the bed in the up position.

Review of the clinical record revealed a physician's order, dated 5/30/19, for "1/2 siderails up when in bed to assist with repositioning and independence."

A review of the comprehensive care plan with an "Effective Date" of 6/11/19, revealed one, undated, for "Turning/positioning in bed (bed mobility). (Resident #46) requires extensive assistance." This care plan included the intervention, undated, "While in bed, assist (Resident #46) to turn/reposition self. Use pillows and foam wedges to maintain position." This

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F 656	Continued From page 39	F 656		

care plan did not include and or document that the use of bedrails was appropriate for this resident. A second care plan, undated, for "Impaired Bed Mobility" also did not include and or document the use of bedrails was appropriate for this resident.

The resident was not care planned for the use of side rails.

On 6/26/19 at 10:37 AM, in an interview with LPN #3 (Licensed Practical Nurse), when asked if the side rails should be care planned, LPN #3 stated that they should be.

On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if the side rails should be care planned, she stated that they should be.

A review of the facility policy, "Care Planning" documented, "....An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident....Each resident's comprehensive care plan is designed to: a) Incorporate identified problem areas; b) Incorporate risk factors associated with identified problems; c) Build on the resident's strengths; d) Reflect the resident's expressed wishes regarding care and treatment goals; e) Reflect treatment goals, timetables and objectives in measurable outcomes; f) Identify the professional services that are responsible for each element of care; g) Aid in preventing or reducing declines in the resident's functional status and/or functional levels; h) Enhance the optimal functioning of the resident by focusing on a rehabilitative program;

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F 656	Continued From page 40 and i) Reflect currently recognized standards of practice for problem areas and conditions...." On 6/28/19 at 4:00 PM, ASM #1 (Administrative Staff Member - the Administrator) and ASM #2 (the Director of Nursing) made aware of the findings. No further information was provided by the end of the survey.	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 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.	F 657		

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F 657	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation resident interview, staff interview facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for six of 26 residents in the survey sample, Residents #10, #35, #22, #17, #41 and Resident #14. The findings include: 1. The facility staff failed to review and revise Resident #10's comprehensive care plan to include the use of side rails. Resident #10 was admitted to the facility on 6/12/18. Resident #10's diagnoses included but were not limited to muscle weakness, arthritis (inflammation of joints) and high blood pressure. Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/20/19, coded Resident #10 with no cognitive impairment. Section G coded Resident #10 as requiring extensive assistance of one staff member with bed mobility. Review of Resident #10's clinical record revealed a physician order dated 06/20/18 which documented, "Side rails to be on both sides of bed at all times" and a facility document titled, "Side Rail & Entrapment Risk Evaluation," completed 5/06/19. Further review of Resident #10's clinical record failed to reveal a review and revision of the comprehensive care plan to include the use of	F 657	F 657 1. Grab bars were removed for R#35. Care plans were updated for R#10, #14, #17, #41. R#22 is no longer a resident of Covenant Woods. Care Plan for R#17 for antidepressant use was updated. 2. All residents that use grab bars, antidepressant medications, or experience falls may be affected 3. 100% review of residents using grab bars will be completed to ensure care plan accuracy per physician order by MDS coordinator or designee. 100% review of residents using antidepressant medications will be completed to ensure care plan accuracy per physician order by MDS coordinator or designee. 100% review of residents who have experienced falls in the past 30 days will be completed to ensure care plan accuracy per physician order by the MDS coordinator or designee. Any discrepancies noted in care plan review will be immediately updated by MDS Coordinator or designee.	28-Jun-19 19-Jul-19 01-Aug-19

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F 657	Continued From page 42 side rails for Resident #10. On 6/25/19 at 11:45 a.m., Resident #10 was observed sitting in her wheelchair watching television. Both quarter rails were in a raised position. Resident #10 was asked if she used the half rails at any time. Resident #10 stated, "I use them to move around sometimes." On 6/26/19 at 12:30 p.m., an interview was conducted with LPN #6. LPN #6 was asked about the process staff follow for ensuring interventions are added to the care plan. LPN #6 stated, "You add interventions to the care plan after reviewing physician orders or during the care plan meeting while the interdisciplinary team is reviewing them." LPN #6 was asked if side rails should be care planned. LPN #6 stated, "Yes, they should be." On 6/28/19 at 12:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. A review of the facility policy, "Care Planning", documented, "8) The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a) When there has been a significant change in resident's condition; b) When the desired outcome is not met; c) When the resident has been readmitted to the facility from a hospital stay; and i) At least quarterly. No further information was presented prior to the end of the survey.	F 657	F 657 4. Education will be provided to nurses by the MDS coordinator or designee regarding timely review and update of the comprehensive care plan. 5. Residents who experience falls will be reviewed during clinical meeting and risk meeting to ensure care plans have be updated timely. Residents who have new orders for grab bars will be reviewed at weekly standards of care meeting to ensure care plans have be updated timely. Residents who have new orders for antidepressants will be reviewed at weekly standards of care meeting to ensure care plans have be updated timely. 6. Unit Manager or designee will audit 50% of care plans for residents with grab bars x 3 months to ensure that the comprehensive care plan is current. Unit Manager or designee will audit 50% of care plans for residents with orders for antidepressant medications x 3 months to ensure that the comprehensive care plan is current. Unit Manage or designee will audit 50% of care plans for residents with falls x 3 months to ensure that the comprehensive care plan is current.	11-Aug-19 01-Jul-19 22-Jul-19

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F 657	Continued From page 43 2. The facility staff failed to review and revise Resident #35's comprehensive care plan to include the use of side rails. Resident #35 was admitted to the facility on 5/10/18. Resident #35's diagnoses included but were not limited to high blood pressure, blindness and osteoporosis (a bone disease). Resident #35's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/17/19, coded Resident #35 with no cognitive impairment. Section G coded Resident #35 as requiring limited assistance of one staff member with bed mobility. Review of Resident #35's clinical record revealed a facility document titled, "Side Rail & Entrapment Risk Evaluation", completed 5/06/19. Further review of Resident #35's clinical record failed to reveal a review and revision of the comprehensive care plan to include the use of side rails for Resident #35. On 6/25/19 at 11:50 a.m., Resident #35 was observed sitting on her bed in the room. Both quarter rails were in a raised position. Resident #35 was asked if she used the half rails at any time. Resident #35 stated, "I use the rails sometimes because I am blind. My bed remote hangs from it." On 6/26/19 at 12:30 p.m., an interview was conducted with LPN #6. LPN #6 was asked what the process is for ensuring interventions are added to the care plan. LPN #6 stated, "You add interventions to the care plan after reviewing physician orders or during the care plan meeting while the interdisciplinary team is reviewing	F 657	F 657 7. Education will be provided to team members for any discrepancies noted. All results will be tracked and trended and presented at QAPI for further recommendations.	11-Aug-19

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F 657	Continued From page 44 them." LPN #6 was asked if side rails should be care planned. LPN #6 stated, "Yes, they should be." On 6/28/19 at 12:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to the end of the survey. 3. a. The facility staff failed to review and revise Resident #22's comprehensive care plan after the resident fell on 1/28/19, 2/1/19, 2/11/19 and 2/17/19. Resident #22 was admitted to the facility on 9/25/17. Resident #22's diagnoses included but were not limited to muscle weakness, high blood pressure and repeated falls. Resident #22's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/22/19, coded the resident's cognitive skills for daily decision-making as moderately impaired. Section G coded Resident #22 as requiring extensive assistance of one staff with bed mobility and transfers. Section J coded the resident as sustaining two or more falls with no injury. Review of Resident #22's clinical record and fall investigations revealed the following falls: 1/28/19- Resident #22 was observed on the floor beside the bed. 2/1/19- Resident #22 was observed on the floor beside the bed. 2/11/19- Resident #22 was observed on the floor	F 657		

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F 657	Continued From page 45 in the living room area. 2/17/19- Resident #22 sustained a fall from the bed. Review of fall investigations dated 1/28/19, 2/1/19, 2/11/19 and 2/17/19, and Resident #22's comprehensive care plan dated 10/6/17 failed to reveal evidence that the resident's comprehensive care plan was reviewed and/or revised after each fall. On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the facility process regarding resident falls. LPN #1 stated a different intervention is implemented after each fall and the type of intervention depends on the cause of the fall; what has occurred with the fall and what facility staff can do to prevent future falls. LPN #1 stated the fall and interventions are then discussed with the resident and/or family and the resident's care plan is updated. On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. b. The facility staff failed to review and revise Resident #22's comprehensive care plan for the use of bed rails. A side rail (bed rail) evaluation dated 1/7/19 documented Resident #22 used side rails for positioning and support. The evaluation further documented no risk to the resident if side rails are used.	F 657		

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F 657	Continued From page 46 Review of Resident #22's clinical record failed to reveal a physician's order for bed rails. Resident #22's comprehensive care plans dated 10/6/17 and 6/3/19 failed to document information regarding bed rails. On 6/26/19 at 2:55 p.m., Resident #22 was observed lying in bed. Both quarter bed rails were up. On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if residents' comprehensive care plans should be reviewed and revised to include the use of bed rails. LPN #1 stated, "Yes." LPN #1 stated residents' care plans should be updated every so often to see if the resident is still using bed rails and if continued use is safe. On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 4. a. The facility staff failed to review and revise Resident #17's comprehensive care plan for the use of bed rails. Resident #17 was admitted to the facility on 6/10/17. Resident #17's diagnoses included but were not limited to urinary tract infection, muscle weakness and heart failure. Resident #17's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 4/11/19, coded the resident's	F 657		

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cognition as severely impaired. Section G coded Resident #17 as requiring extensive assistance of one staff with bed mobility and as requiring extensive assistance of two or more staff with transfers.

Review of Resident #17's clinical record revealed a side rail (bed rail) evaluation dated 6/10/17. The evaluation documented there was no risk to the resident if side rails are used.

A physician's order dated 7/5/18 documented an order for 1/2 side rails (bed rails) up when in bed to assist with repositioning and independence. Resident #17's comprehensive care plan with an effective date of 5/16/19 failed to document information regarding bed rails.

On 6/25/19 at 9:38 a.m., the bed rails on Resident #17's bed were observed in an upright position.

On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if residents' comprehensive care plans should be reviewed and revised to include the use of bed rails. LPN #1 stated, "Yes." LPN #1 stated residents' care plans should be updated every so often to see if the resident is still using bed rails and if continued use is safe.

On 6/26/19 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if Resident #17 uses his bed rails. LPN #2 stated the resident uses his bed rails for turning and positioning.

On 6/26/19 at 3:36 p.m., ASM (administrative

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 48 staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 4. b. The facility staff failed to review and revise Resident #17's comprehensive care plan for the use of antidepressant medication. Resident #17 was admitted to the facility on 6/10/17. Resident #17's diagnoses included but were not limited to urinary tract infection, muscle weakness and heart failure. Resident #17's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 4/11/19, coded the resident's cognition as severely impaired. Section N coded Resident #17 as having received antidepressant medication seven out of the last seven days. Review of Resident #17's clinical record revealed a physician's order dated 11/2/18 for Lexapro (1) 10 milligrams one time daily for major depressive disorder. Resident #17's comprehensive care plan with an effective date of 5/16/19 failed to document information regarding antidepressant medication. The MDS coordinator was not available for interview during the survey. On 6/26/19 at 2:47 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the MDS nurse was responsible for reviewing and revising care plans for psychotropic medications but that responsibility was now transitioning to all of the nurses. LPN #3 was asked if a resident's care plan should be	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	C 06/27/2019

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reviewed and revised to include antidepressant medication use. LPN #3 stated, "Yes." When asked why, LPN #3 stated, "Because for any psychotropic meds you want to do reductions, and also well, because we need to know what they are on, look for side effects and things like that and what our goal is for it."

On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Lexapro is used to treat depression. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a603005.html

5. The facility staff failed to review and revise Resident #41's comprehensive care plan for the use of bed rails.

Resident #41 was admitted to the facility on 1/16/18. Resident #41's diagnoses included but were not limited to high blood pressure, asthma and urinary tract infection. Resident #41's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/5/19, coded the resident's cognitive skills for daily decision making as independent. Section G coded Resident #41 as requiring extensive assistance of two or more staff with bed mobility and transfers.

Review of Resident #41's clinical record revealed a side rail (bed rail) evaluation dated 9/12/18 that

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	495419	A. BUILDING _____ B. WING _____	C 06/27/2019

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documented the resident was not at risk if side rails are used. A physician's order dated 5/29/19 documented an order for 1/2 side rails (bed rails) up when in bed to assist with repositioning and independence. Resident #41's comprehensive care plan with an effective date of 6/1/19 failed to document information regarding bed rails.

On 6/26/19 at 7:54 a.m., Resident #41's quarter bed rails were observed in an upright position.

On 6/26/19 at 11:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if residents' comprehensive care plans should be reviewed and revised to include the use of bed rails. LPN #1 stated, "Yes." LPN #1 stated residents' care plans should be updated every so often to see if the resident is still using bed rails and if continued use is safe.

On 6/26/19 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked if Resident #41 uses her bed rails. LPN #2 stated the resident uses her bed rails for turning and positioning.

On 6/26/19 at 3:36 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.
6. The facility staff failed to review and revise the Resident #14's comprehensive care plan to address the residents use of be rails.

Resident #14 was admitted to the facility on 7/1/11 with the diagnoses of but not limited to

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dysphagia, parastomal hernia with obstruction, kidney calculus, osteoarthritis, ischemic heart disease, diverticulitis, depression, macular degeneration, high blood pressure, insomnia, abnormal weight loss, colostomy, and dementia. The significant change MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 4/3/19 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and transfers; extensive assistance for dressing, toileting, and hygiene; supervision for eating; and was incontinent of bladder and had an ostomy for bowel.

Observations conducted on 6/25/19 at 10:47 AM, and 6/26/19 at 8:55 AM revealed the resident in her room in her wheelchair. The bed was noted to have approximate quarter-length sized side rails on in the up position.

Review of the clinical record revealed a physician's order, dated 8/18/16 that documented, "1/2 side rails up when in bed to assist with repositioning and independence."

A review of the comprehensive care plan, with an "Effective Date" of 5/16/19, revealed one, undated, for "Turning/positioning in bed (bed mobility) - (Resident #14) requires extensive assistance." This care plan included the goal, undated, for "While in bed, assist (Resident #14) to turn/reposition self. Use pillows and foam wedges to maintain position." The care plan did not address or include any interventions for the use of side rails.

On 6/26/19 at 10:37 AM, in an interview with LPN