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	495416	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY PONDS INC	21160 MAPLE BRANCH TERRACE ASHBURN, VA 20147

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/9/19 through 7/11/19. 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 survey was conducted from 7/9/19 through 7/11/19. Significant corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. Complaints were investigated during this survey. The life safety code survey/report will follow. The census at this 44 certified bed facility was 41 at the time of the survey. The survey sample consisted of 25 current residents and 6 closed records.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582		8/23/19

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

Electronically Signed | 07/24/2019

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

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F 582	Continued From page 1 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 582	1. The facility is unable to issue new Notice of Medicare Non-Coverage for	

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F 582	Continued From page 2 the facility staff failed to provide Notice of Medicare Non-Coverage and the right to appeal for one of 31 sampled residents, Resident #40. Resident #40 was admitted on 3/22/19, and discharged on 4/5/19, and had used 15 of 100 Medicare days. The facility staff failed to evidence that Resident #40 or the resident representative was provided with a Notice of Medicare Non-Coverage and their right to appeal prior to the coverage end date of 4/5/19. The findings include: Resident #40 was admitted to the facility on 3/22/19 with the diagnoses of but not limited to high blood pressure, unspecified dementia without behavioral disturbances, type 2 diabetes mellitus, and malignant neoplasm of prostate. The most recent MDS (Minimum Data Set), a significant change in status assessment, with an ARD (Assessment reference date) of 6/3/19, coded the resident as scoring a 2 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had cognitive impairment for daily decision making. The resident was coded as requiring extensive care for eating; total care for hygiene, bathing, dressing, toileting, and transfers. Resident #40 was coded as occasionally incontinent of bladder and bowel. A review of the clinical record revealed a note dated 4/5/19 at 12:06 PM, which documented, "SW (Social Worker) met with resident's wife for discharge planning, as his Medicare Part A/SNF/Rehab [skilled nursing facility/rehabilitation] stay is ending and she is planning for him to transition into long term care. NOMNC (Notice of Medicare Non-Coverage)	F 582	resident #40 because resident no longer resides in facility. 2. A 100% review all residents discharged between 6/1/19 and 6/30/19 will be completed to ensure that a Notice of Medicare non-Coverage and their right to appeal 2 days prior to coverage end date. 3. Staff Development Coordinator (SDC) or designee will educate Social Worker on process for issuing notice of Medicare Non-Coverage and detailed explanation of Non-Coverage policy. Assistant Administrator or designee will monitor (5) NOMNC□s monthly for 3 months to ensure notice is issued in compliance with policy. 4. Assistant Administrator or designee will monitor (5) NOMNC□s monthly for 3 months to ensure notice is issued in compliance with policy. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	

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reviewed for last skilled date 4/5/19; she verbalized understanding of last skilled date, appeal rights, and financial liability beginning 4/6/19. She signed form and SW gave copy of signed form to her ... ABN (Advance Beneficiary Notice) reviewed for private pay date effective 4/6/19, she verbalized understanding of date, appeal rights, private pay amount but declined to sign form. She stated that she would choose option 3 but does not want to sign any more paperwork at this time...SW notified IDT (Interdisciplinary team) that resident is being discharged from SNF (skilled nursing facility) stay and will remain in LTC (long term care)."

A review of the Notice of Medicare Non-Coverage (NOMNC) for the resident documented that "Services will end: Friday, April 5, 2019." The date portion was hand-written in. At the end of the notice, is the following statement: "Please sign below to indicate you received and understood this notice. I have been notified that coverage of my services will end on the effective date on this notice and that I may appeal this decision by contacting my QIO [quality insurance organization}." The document was signed by (name of), (Resident #40's representative, wife) and dated April 5, 2019.

A review of the "Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN)" for the resident documented that "Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee Believes that the care listed below does not meet Medicare Coverage requirements. Beginning on 'Saturday 4/6/19,' you may have to pay out of pocket for this care if

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F 582	Continued From page 4	F 582		

you do not have other insurance that may cover these costs." The date portion was hand-written in. At the end of the notice, is the following statement: "Options: Check only one box. ...Option 3. I don't want the care listed above. I understand that I'm not responsible for paying, and I can't appeal to see if Medicare would pay." The option was designated by a hand-written in "X". The document was signed by (name of), (Resident #40's representative, wife) and dated 4/28/19.

On 7/10/19 at 11:20 AM, an interview was conducted with ASM (Administrative Staff Member) #3, the Assistant Director of Nursing. ASM #3 was asked for documentation of a discussion with the resident and/or resident representative prior to the 4/5/19 date. ASM #3 stated, "The SW does not have documentation regarding speaking with family prior to 4/5/19 date. She knows the policy and did not follow it." When asked how many Medicare A days Resident #40 used and how many Medicare A days remained, ASM #3 stated, "He used 15 days and had 85 Medicare A days left. The last effective date was 4/5/19 and the resident no longer required skilled services."

On 7/10/19 at 12:14 PM, an interview was conducted with OSM (Other Staff Member) #1, the Social Worker. OSM #1 was asked when the NOMNC information should be discussed with the resident and/or resident representative. OSM #1 stated, "It should be at least 2-3 days before. I call the family and meet with them in person. I typically don't write in the notes that I left messages. We were unable to meet until Friday, 4/5/19. That is not how it is supposed to be. I don't recall if I left her messages. She lives on

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F 582	Continued From page 5 campus and visits often." On 7/10/19 at 12:51 PM, a follow up interview was conducted with OSM #1. OSM #1 stated, "Provided NOMNC and ABN paper work on 4/5/19 date but wife did not want to sign at that time. NOMNC and ABN should be completed at least 2 days prior to last day of coverage. Her daughter brought the ABN form in on 4/28/19 and that is the day the wife signed it." A review of the facility's policy "Medicare Part A Management" that documented in part, " ...3. The Social Worker issues the approved Notice of Medicare Non-Coverage letter and the Advance Beneficiary Notice (ABN) when appropriate to the resident or responsible agent notifying the resident of non-coverage and the opportunity to appeal the decision with the Fiscal Intermediary ...This notification must be given / received no less than 2 days from the proposed last day of coverage. If the responsible party is not available to receive the letter in person, Social Work ...will attempt to contact the responsible party by phone to explain the contents of the letter and then follow up by faxing, emailing using email encryption, or mailing the letter via certified mail ..." A review of the facility's policy "Process for issuing Notice of Medicare Non-Coverage & Detailed Explanation of Non-Coverage" that documented in part, " ...Policy: A Notice of Medicare Non-Coverage is issued to a member or responsible party (RP) prior to termination of covered skilled services in the Skilled Nursing Facility ...as directed by CMS (Centers for Medicaid and Medicare Services) guidelines. Medicare guidelines require the health plan	F 582		

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F 582	Continued From page 6 deliver, or instruct the provider to deliver, the Notice of Medicare Non-Coverage no later than two days prior to the last covered day of service/s. The health plan member, or responsible party, must receive a valid Notice of Medicare Non-Coverage, including the appeals process, which meets the Medicare required timeframe for delivery ..." On 7/11/19 at 4:21 PM, ASM #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 582		
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 policies for the prevention of abuse for one of 31 residents in the survey sample, Resident #2.	F 607	1. Facility is unable to report to state agency within two hour time frame as the allotted time has lapsed. Allegation of assault was reported on 5/15/19. 2. A 100% review of all resident	8/23/19

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F 607	Continued From page 7 The facility staff failed to implement and or follow the facility abuse policy for reporting Resident #2's allegation of abuse that occurred while she was out of the facility at a community movie theater on 5/14/19, to the required state agency within the required 2-hour time frame. The findings include: Resident #2 was admitted to the facility on 1/15/16, diagnoses included but are not limited to, stroke, high blood pressure, macular degeneration, and depression. The annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/29/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for dressing and toileting; and extensive care for all other areas of activities of daily living. A review of the facility policy, "Abuse Reporting and Investigation" documented, "....Skilled Nursing / Long-Term Care Facilities: Allegations 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 results in serious bodily injury...." A review of the facility policy, "Abuse Prevention" documented, "....Abuse: Any willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish....Willful: Means that the individual intended the action itself, not that the	F 607	allegations of abuse between 6/1/19 and 6/30/19 will be completed to ensure that allegations of abuse were reported within allotted 2 hour time frame. 3. SDC or designee will educate leadership team on Abuse Reporting and Investigation policy. Assistant Administrator or designee will monitor all allegation of abuse reports monthly for 3 months to ensure compliance with the policy 4. Assistant Administrator or designee will monitor all allegation of abuse reports monthly for 3 months to ensure compliance with the policy. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	

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individual must have intended to inflict injury or harm. Even though a resident may have a cognitive impairment, he/she can still commit a willful act...."

A review of the clinical record revealed a nurse's note dated 5/15/19 at 1:07pm that documented, "Skin assessment done by writer and Nurse (name of nurse) this afternoon. No bruises, redness or swelling found on her skin. Writer found her left side jaw area swollen and resident c/o (complained of) pain. Writer asked resident for ice application or pain medication. Resident refused, she stated I am fine, I don't need anything right now. Nursing will continue to monitor her."

There were no other notes regarding this issue.

On 7/10/19 at approximately 6:00 PM at an end-of-day meeting with ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) information was requested about Resident #2's swollen jaw concern and for any investigation that may have been completed.

On 7/11/19 at approximately 8:00 AM, ASM #2 provided a FRI (Facility Reported Incident) regarding this concern. The FRI documented, "(Resident #2) is a LTC (long term care) resident in skilled nursing. On 5/14/19 at approximately 8:30 pm while waiting to leave the movie theater after watching a movie, an assisted living (ALF) resident became upset that she pulled the call alert to have someone come to help him leave the theater. She reported that he struck her with his cane several times on the face and head resulting in discoloration of her left lower orbital

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area." The FRI documented that the incident occurred on 5/14/19 and the date of the report was 5/15/19. The FRI documented that the report was sent to the required state agency on 5/16/19. A review of the fax confirmation page documented the FRI was sent to the required state agency at 2:15 PM on 5/16/19.

A review of the "Investigative Tool" related to this investigation documented, "(Resident #2) was interviewed by the (county) Sherriff {sic}. She declined to press charges but has one year if she changes her mind. The Sherriff {sic}interviewed (ALF resident) and he had no memory of the event. (Resident #2) is alert and oriented and if she sees (name of ALF resident) in the theater she will leave. We will be able to provide movies for (Resident #2) in another location on the Post Acute neighborhood."

Review of the final report, undated, documented, "(Resident #2) has been a LTC [long term care] resident since 1/15/16. She is alert and oriented X [times] 3 and independently goes to the movie theater on site on a regular basis. On 5/15/19 (Resident #2) son called to notify (ASM #1) that (Resident #2) stated a resident hit her with his cane in the movie theater the evening of 5/14/19. (ASM #2) interviewed (Resident #2) and she stated the movie had ended and (ALF resident), and two other residents remained in the theater. (Resident #2) told (ALF resident) to wait for assistance before getting up and she pulled the emergency cord to get him assistance. According to (Resident #2), (ALF resident) became angry and hit her approximately 5 times on the left side of her face and shoulder with his cane then left the theater. (Resident #2) took herself to the first floor (long term care unit of the

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F 607	Continued From page 10 continuing care community) and did not report the incident to the staff. Staff reported that no one was in the theater when they responded to the emergency call. (Resident #2) notified her son of the incident on the morning of 5/15/19. She was assessed by nursing and she was found to have an area of discoloration on her left cheek and orbital area. Ice was offered but she refused. (Resident #2) was assessed by (name of Nurse Practitioner) no other injury was found and no further treatments initiated. The (county) Sherriff {sic} was notified of the incident and a Sherriff's {sic} Deputy was dispatched to interview (Resident #2 and ALF resident). (Resident #2) declined to press charges and (ALF resident) had no memory of the incident. (Resident #2) has continued with her regular activities and participation in the usual programs." On 7/11/19 at 1:18 PM, in an interview with ASM #2 and RN #4 (Registered Nurse, Clinical Manger), RN #4 stated that the incident was immediately reported to APS (Adult Protective Services). RN #4 stated that in her conversation with them, APS did not feel that the incident was considered abuse, because the incident was resident-to-resident and the ALF resident had cognitive impairments. ASM #2 stated that the facility reviewed this incident thoroughly to determine if it was abuse or not, but that based on the guidance by APS, they concluded that it was not abuse and therefore did not meet the 2-hour reportable guidelines. No further information was provided by the end of the survey.	F 607		
F 609	Reporting of Alleged Violations	F 609		8/23/19

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F 609 SS=D	Continued From page 11 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified 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 allegation of abuse to the required state agency in the required time frame for 1 of 31 residents in the survey sample; Resident #2.	F 609	1. The facility is unable to report abuse allegation for resident #2 to state agency within two hour time frame as the allotted time has lapsed. 2. A 100% review of all resident allegations of abuse between 6/1/19 and	

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ASHBY PONDS INC	21160 MAPLE BRANCH TERRACE ASHBURN, VA 20147

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F 609	Continued From page 12 On 5/15/19, Resident #2 reported an allegation of abuse to staff that occurred on 5/14/19, while she was out of the facility at a community movie theater. The facility staff failed to immediately report and or report the allegation within 2 hours to the State Agency and other officials State law through established procedures. The allegation was not reported to the State Agency until 5/17/19. The findings include: Resident #2 was admitted to the facility on 1/15/16 with the diagnoses of but not limited to stroke, high blood pressure, macular degeneration, and depression. The annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/29/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for dressing and toileting; and extensive care for all other areas of activities of daily living. A review of the clinical record revealed a nurse's note dated 5/15/19 at 1:07pm that documented, "Skin assessment done by writer and Nurse (name of nurse) this afternoon. No bruises, redness or swelling found on her skin. Writer found her left side jaw area swollen and resident c/o (complained of) pain. Writer asked resident for ice application or pain medication. Resident refused, she stated I am fine, I don't need anything right now. Nursing will continue to monitor her." There were no other notes regarding this issue. A care plan for "Safety and Exploring" initiated on	F 609	6/30/19 will be completed to ensure that allegations of abuse were reported within allotted 2 hour time frame. 3. Staff Development Coordinator or designee will educate leadership team on Abuse Reporting and Investigation policy. Assistant Administrator or designee will monitor all allegation of abuse reports monthly for 3 months to ensure compliance with the policy. 4. Assistant Administrator or designee will monitor all allegation of abuse reports monthly for 3 months to ensure compliance with the policy. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	

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4/30/19 documented, "I am able to leave the community without supervision daily." The approaches documented, "I like going OOB (out of building) with my friends and like to watch movie on second neighborhood."

On 7/10/19 at approximately 6:00 PM at an end-of-day meeting with ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) information was requested about this swollen jaw concern and for any investigation that may have been done regarding it.

On 7/11/19 at approximately 8:00 AM, ASM #2 provided a FRI (Facility Reported Incident) regarding this concern. The FRI documented, "(Resident #2) is a LTC (long term care) resident in skilled nursing. On 5/14/19 at approximately 8:30 pm while waiting to leave the movie theater after watching a movie, an assisted living (ALF) resident became upset that she pulled the call alert to have someone come to help him leave the theater. She reported that he struck her with his cane several times on the face and head resulting in discoloration of her left lower orbital area." The FRI documented that the incident occurred on 5/14/19 and the date of the report was 5/15/19, and documented that the report was sent to the required state agency on 5/16/19. A review of the fax confirmation page documented the FRI was sent to the required state agency at 2:15 PM on 5/16/19.

A review of the "Investigative Tool" related to this investigation documented, "(Resident #2) was interviewed by the (county) Sherriff {sic}. She declined to press charges but has one year if she changes her mind. The Sherriff {sic} interviewed

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(ALF resident) and he had no memory of the event. (Resident #2) is alert and oriented and if she sees (name of ALF resident) in the theater she will leave. We will be able to provide movies for (Resident #2) in another location on the Post Acute neighborhood."

Review of the final report, undated, documented, "(Resident #2) has been a LTC resident since 1/15/16. She is alert and oriented X [times] 3 and independently goes to the movie theater on site on a regular basis. On 5/15/19 (Resident #2) son called to notify (ASM #1) that (Resident #2) stated a resident hit her with his cane in the movie theater the evening of 5/14/19. (ASM #2) interviewed (Resident #2) and she stated the movie had ended and (ALF resident), and two other residents remained in the theater. (Resident #2) told (ALF resident) to wait for assistance before getting up and she pulled the emergency cord to get him assistance. According to (Resident #2), (ALF resident) became angry and hit her approximately 5 times on the left side of her face and shoulder with his cane then left the theater. (Resident #2) took herself to the first floor (long term care unit of the continuing care community) and did not report the incident to the staff. Staff reported that no one was in the theater when they responded to the emergency call. (Resident #2) notified her son of the incident on the morning of 5/15/19. She was assessed by nursing and she was found to have an area of discoloration on her left cheek and orbital area. Ice was offered but she refused. (Resident #2) was assessed by (name of Nurse Practitioner) no other injury was found and no further treatments initiated. The (county) Sherriff {sic} was notified of the incident and a Sherriff's {sic} Deputy was dispatched to interview

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(Resident #2 and ALF resident). (Resident #2) declined to press charges and (ALF resident) had no memory of the incident. (Resident #2) has continued with her regular activities and participation in the usual programs."

On 7/11/19 at 1:18 PM, in an interview with ASM #2 and RN #4 (Registered Nurse, Clinical Manger), RN #4 stated that the incident was immediately reported to APS (Adult Protective Services). RN #4 stated that in her conversation with them, APS did not feel that the incident was considered abuse, because the incident was resident-to-resident and the ALF resident had cognitive impairments. ASM #2 stated that the facility reviewed this incident thoroughly to determine if it was abuse or not, but that based on the guidance by APS, they concluded that it was not abuse and therefore did not meet the 2-hour reportable guidelines.

A review of the facility policy, "Abuse Reporting and Investigation" documented, "....Skilled Nursing / Long-Term Care Facilities: Allegations 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 results in serious bodily injury...."

A review of the facility policy, "Abuse Prevention" documented, "....Abuse: Any willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish....Willful: Means that the individual intended the action itself, not that the individual must have intended to inflict injury or

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F 609	Continued From page 16 harm. Even though a resident may have a cognitive impairment, he/she can still commit a willful act...."	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 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	F 622		8/23/19

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F 622	Continued From page 17 § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care 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	F 622		

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F 622	Continued From page 18 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, facility document review, and clinical record review, it was determined that the facility staff failed to evidence the required information was provided to the hospital staff for a facility initiated discharge for one of 31 residents in the survey sample; Resident #36. The facility staff failed to evidence what, if any, required documentation was provided to the hospital for the facility-initiated transfer of Resident #36 on 5/25/19. The findings include: Resident #36 was admitted to the facility on 2/28/18 with the diagnoses of but not limited to cellulitis, chronic obstructive pulmonary disease, fibromyalgia, dementia, embolism and thrombosis, and cognitive communication deficit. The readmission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/5/19 coded the resident as severely cognitively impaired in ability to make daily life decisions.	F 622	1. The facility is unable to provide documentation to hospital for resident #36 related to hospital transfer on 5/25/19 because resident has returned to the facility and is no longer at the hospital. 2. A 100% review of residents transferred to the hospital between 6/1/19 and 6/30/19 will be completed to ensure that required documentation was sent to the hospital. 3. SDC or designee will educate nurses on sending the required documents to hospital for transferred residents. Clinical Manger or designee will monitor compliance for all residents transferred to the hospital monthly for 3 months to ensure compliance. 4. Clinical Manger or designee will monitor compliance for all residents transferred to the hospital monthly for 3 months to ensure compliance. Any findings outside of the policy will be	

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F 622	Continued From page 19 The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, hygiene, and toileting; supervision for eating; and was incontinent of bowel and bladder. A review of the clinical record revealed a nurse's note dated 5/25/19 that documented, "Resident observed with involuntary movement, unable to arouse resident, and increase redness to bi-lateral {sic}. N/P (nurse practitioner) informed new order to send resident out for further evaluation. V/S (vital signs) 123/68 (blood pressure), 68 (pulse), 94% 2liter (94% oxygen saturation on 2 liters of oxygen), 20 respiration. Pertinent information sent with resident. R/P (responsible party) made aware. Resident transferred to (name of hospital) at 1:05pm." Further review of the clinical record revealed a physician's note dated 5/26/19 that documented, "Assessments: 1. Sepsis...2. Urinary tract infection...3. Cellulitis...." as diagnoses for the hospital admission. This physician was one of the facility physician's that also followed the resident in the hospital. Further review of the clinical record failed to reveal any evidence of what, if any, clinical record information was provided to the hospital. On 7/11/19 at 3:15 PM, an interview was conducted with RN #1 (Registered Nurse). When asked what documentation is provided to the hospital when a resident is transferred, RN #1 stated, "Med [medication] list, Advance Directives, face sheet." When asked about the comprehensive care plan goals, RN #1 stated, "Care plan goals." When asked if there is a checklist of what the facility sends, or	F 622	reported and reviewed at our monthly QAPI meeting.	

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F 622	Continued From page 20 documentation of what is sent with a resident on transfer, RN #1 stated, "Don't have a checklist. We don't document what was sent." A review of the facility policy, "Emergency Transfer to Hospital" which was most recently updated April 2019, documented, "3. Licensed nurse or designee to: a. Copy the following medical record components: i. Face Sheet; ii. Copy of note or other documentation indicating reason and residents condition at time of transfer; iii. History and Physical; iv. Current monthly orders; v. Medication records (MAR) / list of medications; vi. Copy of most recent labs, xrays or consults; vii. Provider notes if necessary; viii. Living Will; ix. State specific EMS / DNR form if applicable; x. MOLST/POLST if applicable; xi. Other state-specific or campus-specific required documents....4. Document in the Interdisciplinary Notes: a. Reason for transfer; b. Resident's condition at time of transfer; c. Mode of transportation; d. Personal belongings sent with resident i.e. Dentures, glasses, hearing aid; e. Responsible Party /Family notification, if appropriate; f. Time of transfer." The policy did not include criteria to send the comprehensive care plan goals or to retain any documentation evidencing what was provided to the hospital. On 7/11/19 at approximately 5:00 PM, ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		8/23/19

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F 623	Continued From page 21 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		

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F 623	Continued From page 22 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 23 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written notification for a facility initiated transfer to the resident, responsible party and Ombudsman for one of 31 residents in the survey sample, Resident #36. The facility staff failed to evidence that written notification was provided to the Ombudsman and responsible party (RP) when the Resident #36 was transferred to the hospital on 5/25/19. The findings include: Resident #36 was admitted to the facility on 2/28/18 with the diagnoses of but not limited to cellulitis, chronic obstructive pulmonary disease, fibromyalgia, dementia, embolism and thrombosis, and cognitive communication deficit.	F 623	1. The facility will provide the Ombudsman and responsible party with written notification of resident #36 transfer to the hospital on 5/25/19. 2. A 100% review of residents transferred to hospital between 6/1/19 and 6/30/19 will be conducted to ensure written notification was sent to Ombudsman and responsible party. 3. SDC or designee will educate admissions team on sending written notification to Ombudsman of all hospital transfers and Social Worker on sending written notification to responsible party of hospital transfers. Assistant Administrator or designee will monitor compliance with sending written notification to Ombudsman and responsible party of all hospital transfers monthly for 3 months.	

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F 623	Continued From page 24 The readmission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/5/19 coded the resident as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, hygiene, and toileting; supervision for eating; and was incontinent of bowel and bladder. A review of the clinical record revealed a nurse's note dated 5/25/19 that documented, "Resident observed with involuntary movement, unable to arouse resident, and increase redness to bi-lateral {sic}. N/P (nurse practitioner) informed new order to send resident out for further evaluation. V/S (vital signs) 123/68 (blood pressure), 68 (pulse), 94% 2liter (94% oxygen saturation on 2 liters of oxygen), 20 respiration. Pertinent information sent with resident. R/P (responsible party) made aware. Resident transferred to (name of hospital) at 1:05pm." Further review of the clinical record revealed a physician's note dated 5/26/19 that documented, "Assessments: 1. Sepsis...2. Urinary tract infection...3. Cellulitis...." as diagnoses for the hospital admission. This physician was one of the facility physician's that also followed the resident in the hospital. Further review of the clinical record failed to reveal any evidence of what, if any, written notification was provided to the Ombudsman and RP. The resident was readmitted to the facility on 5/29/19. On 7/11/19 at 3:24 PM, in an interview with OSM #1 (Other Staff Member, the social worker) she stated that she does not follow up with written	F 623	4. Assistant Administrator or designee will monitor compliance with sending written notification to Ombudsman and responsible party of all hospital transfers monthly for 3 months. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	

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F 623	Continued From page 25	F 623		

notification to family or Ombudsman. OSM #1 stated that the nurses notifies the family on the phone and Admissions handles bed hold notices.

On 7/11/19 at 3:30 PM, in an interview with RN (registered nurse) #3, Admissions, when asked about her role in hospital transfers, she stated that the facility has a nurse liaison at the hospital that provides bed hold notices. RN #3 stated that she sends the Ombudsman a monthly report but the facility does not provide a written notice to the family.

On 7/11/19 at approximately 3:45 PM, RN #3 provided the written Ombudsman notice for May 2019 and it did not include Resident #36. RN #3 stated she realized that the report that was being printed and sent to the Ombudsman each month did not include residents who went to the hospital and came back because the resident was not considered a discharge because she was expected to return. RN #3 stated she identified this when she was obtaining the information requested.

A review of the facility policy, "Emergency Transfer to Hospital" with the most recent update of April 2019, documented, "1. Obtain medical provider order for the transfer and inform resident and / or responsible party of impending transfer." The policy did not include any criteria for written notification to the responsible party and Ombudsman

On 7/11/19 at approximately 5:00 PM, ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. No further information was provided by the end of the survey.

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F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636		8/23/19

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F 636	Continued From page 27 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. 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 complete a comprehensive MDS (minimum data set) assessment for two of 31 residents in the survey sample, Residents #1 and #7. The findings include: 1. For Resident #1, the facility staff failed to complete a comprehensive significant change MDS assessment with an ARD (assessment reference date) of 3/11/19. Resident #1 was admitted to the facility on 10/19/18 with diagnoses including but not limited	F 636	1. A comprehensive significant change MDS assessment was completed for resident #1 and a comprehensive annual MDS assessment was completed for resident #7. 2. A 100% review of comprehensive MDS assessments with ARD between 6/1/19 to 6/30/19 will be completed. 3. SDC or designee will educate MDS coordinator on MDS completion and management policy for significant change and annual MDS assessments. ADON or designee will monitor completion of significant change assessments and will monitor 5 annual MDS assessments	

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F 636	Continued From page 28 to, diabetes, anxiety, insomnia, adult failure to thrive, Parkinson's disease, dysphagia, and acute kidney failure. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 1/26/19 coded the resident as being significantly impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, transfers, and toileting; limited assistance for dressing and hygiene; and was independent for eating. A review of the electronic clinical record revealed a list of the resident's MDS assessments. This list revealed that a significant change assessment was scheduled with an ARD of 3/11/19. As of the date of survey of 7/11/19, this assessment's "status" was documented as "current" and had no completion date. This assessment was never completed. There were no other completed assessments since the 1/26/19 quarterly MDS assessment. On 7/11/19 at 10:16 AM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. When ASM #2 was notified of the above concern and ASM #2 stated that the MDS coordinator had been on FMLA (Family Medical Leave Act) since May 2019. ASM #2 stated the MDS coordinator was also out on leave from November 2018 through January 2019. She stated that an MDS coordinator from another facility had been trying to fill in to help. On 7/15/19 at 11:40 AM, ASM #2 stated that she didn't have anything more to offer regarding the timely completion and/or transmission of MDS assessments that were not completed and/or transmitted timely or at all.	F 636	monthly for 3 months to ensure compliance. 4. ADON or designee will monitor completion of significant change assessments and will monitor 5 annual MDS assessments monthly for 3 months to ensure compliance. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	

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F 636	Continued From page 29 A review of the facility policy, "MDS Completion and Management" documented, "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI (Resident Assessment Instrument) MDS 3.0 User's Manual...." According to the RAI Manual, Version 1.16, dated October 2018, the table on page 2-16 documented that a comprehensive significant change assessment is due no later than the 14th day after determination that a significant change in the resident's status occurred, making the due date for this assessment on or approximately 3/24/19. 2. For Resident #7, the facility staff failed to complete a comprehensive annual MDS assessment with an ARD of 5/19/19. Resident #7 was admitted on 5/26/16, diagnoses included but are not limited to, dislocation of left hip, acute respiratory failure with hypoxia, dementia, depression, psoriasis, rhabdomyolysis, high blood pressure, and insomnia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/18/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living except eating, for which she was coded as requiring extensive assistance. A review of the electronic clinical record revealed that the above MDS was the most recent that was	F 636		

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F 636	Continued From page 30	F 636		

completed. The electronic record revealed that a comprehensive annual MDS was scheduled, with an ARD of 5/19/19. As of the date of survey of 7/11/19, this assessment's "status" was documented as "current" and had no completion date. This assessment was never completed. There were no completed assessments since the 2/18/19 quarterly assessment.

On 7/11/19 at 10:16 AM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing. When ASM #2 was notified of the above concern, ASM #2 stated that the MDS coordinator had been on FMLA (Family Medical Leave Act) since May 2019. ASM #2 stated the MDS coordinator was also out on leave from November 2018 through January 2019. She stated that an MDS coordinator from another facility had been trying to fill in to help.

On 7/15/19 at 11:40 AM, ASM #2 stated that she didn't have anything more to offer regarding the timely completion and/or transmission of MDS assessments that were not completed and/or transmitted timely or at all.

A review of the facility policy, "MDS Completion and Management" documented, "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI (Resident Assessment Instrument) MDS 3.0 User's Manual...."

According to the RAI Manual, Version 1.16, dated October 2018, the table on page 2-16 documented that a comprehensive annual assessment is due no later than the ARD date plus 14 calendar days making the due date for this assessment on or approximately 6/1/19.

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F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. 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 complete a quarterly MDS assessment within the required time frames, and/or at all, for five of 31 residents in the survey sample; Residents #2, #4, #6, #10, and #8. 1. For Resident #2 the facility staff failed to complete a quarterly MDS assessment with an ARD of 5/1/19 in the required time frame. The quarterly MDS assessment should have been completed on or approximately 5/15/19. 2. For Resident #4, the facility staff failed to complete a quarterly MDS assessment within the required time frame. The quarterly MDS assessment should have been completed on or approximately 5/10/19. 3. For Resident #6, the facility staff failed to complete a quarterly MDS assessment within the required time frame. The quarterly MDS assessment should have been completed on or approximately 5/27/19. 4. For Resident #10, the facility staff failed to complete a quarterly MDS assessment within the required time frame. The quarterly MDS assessment should have been completed on or	F 638	1. MDS quarterly assessment for resident #2, #4, #6, #10, #8 have been completed as 7/24/19 2. A 100% audit of all quarterly MDS assessment with ARD between 6/1/19 to 6/30/19 will be completed. 3. SDC or designee will educate MDS coordinator on MDS completion and management policy. ADON or designee will monitor 5 quarterly MDS assessments monthly for 3 months to ensure compliance. 4. ADON or designee will monitor 5 quarterly MDS assessments monthly for 3 months to ensure compliance. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	8/23/19

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F 638	Continued From page 32 approximately 5/15/19. 5. For Resident #8, the facility staff failed to complete a quarterly MDS assessment within the required time frame. The quarterly MDS assessment should have been completed on or approximately 6/7/19. The findings include: 1. For Resident #2 the facility staff failed to complete a quarterly MDS assessment with an ARD of 5/1/19 in the required time frame. Resident #2 was admitted to the facility on 1/15/16. Diagnoses included but are not limited to, stroke, high blood pressure, macular degeneration, and depression. The annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/29/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for dressing and toileting; and extensive care for all other areas of activities of daily living. A review of the electronic clinical record revealed a list of the resident's MDS assessments. This list revealed that a quarterly assessment was scheduled with an ARD of 5/1/19. This list further revealed that this MDS was not completed until 7/10/19. On 7/11/19 at 10:16 AM, in an interview with ASM #2 (Administrative Staff Member) the Director of Nursing, she was notified of the concern. ASM #2 stated that the MDS coordinator had been on FMLA (Family Medical Leave Act) since May 2019, and was out on leave from November 2018	F 638		

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F 638	Continued From page 33	F 638		

through January 2019. ASM #2 stated that an MDS coordinator from another facility had been trying to fill in to help.

On 7/15/19 at 11:40 AM, ASM #2 stated that she didn't have anything more to offer regarding the timely completion and/or transmission of MDS assessments that were not completed and/or transmitted timely or at all.

A review of the facility policy, "MDS Completion and Management" documented, "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI (Resident Assessment Instrument) MDS 3.0 User's Manual...."

According to the RAI Manual, Version 1.16, dated October 2018, the table on page 2-17 documented that a quarterly assessment is due no later than the ARD date plus 14 calendar days, making the due date for this assessment on or approximately 5/15/19.

2. For Resident #4, the facility staff failed to complete a quarterly MDS assessment within the required time frame. The quarterly MDS assessment should have been completed on or approximately 5/10/19.

Resident #4 was admitted to the facility on 8/4/16. Diagnoses included but are not limited to, fracture of the 1st and 2nd cervical vertebrae, high blood pressure, dementia, anxiety disorder, Bell's Palsy, peripheral vascular disease, depression, cellulitis, and dysphagia. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of

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F 638	Continued From page 34	F 638		

2/8/19. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, toileting, and transfers; extensive care for dressing and hygiene; and supervision for eating.

A review of the electronic clinical record revealed a list of the resident's MDS assessments. This list revealed that a quarterly assessment was scheduled with an ARD of 6/21/19. This assessment should have been scheduled on or approximately 5/10/19 and was late. As of the date of survey of 7/11/19, this assessment's "status" was documented as "current" and had no completion date. There were no other completed assessments since the 2/8/19 quarterly MDS.

On 7/11/19 at 10:16 AM, in an interview with ASM #2 (Administrative Staff Member) the Director of Nursing, she was notified of the concern. ASM #2 stated that the MDS coordinator had been on FMLA (Family Medical Leave Act) since May 2019, and was also out on leave from November 2018 through January 2019. ASM #2 stated that an MDS coordinator from another facility had been trying to fill in to help.

On 7/15/19 at 11:40 AM, ASM #2 stated that she didn't have anything more to offer regarding the timely completion and/or transmission of MDS assessments that were not completed and/or transmitted timely or at all.

A review of the facility policy, "MDS Completion and Management" documented, "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI (Resident Assessment Instrument)

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F 638	Continued From page 35 MDS 3.0 User's Manual...." According to the RAI (Resident Assessment Instrument) Manual, Version 1.16, dated October 2018, the table on page 2-17 documented that a quarterly assessment is due no later than the ARD date of the previous assessment plus 92 calendar days, making the due date for this assessment on or approximately 5/10/19. 3. For Resident #6, the facility staff failed to complete a quarterly MDS assessment within the required time frame. The quarterly MDS assessment should have been completed on or approximately 5/27/19. Resident #6 was admitted to the facility on 2/18/19. Diagnoses included but not limited to, degenerative disease of the nervous system, dementia, stroke, aphasia, high blood pressure, depression, anxiety, and dysphagia. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 2/25/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, toileting, dressing, and transfers; and extensive assistance for eating and hygiene. A review of the electronic clinical record revealed a list of the resident's MDS assessments. This list revealed that a quarterly assessment was scheduled with an ARD of 6/21/19. This assessment should have been scheduled on or approximately 5/27/19 and was late. As of the date of survey of 7/11/19, this assessment's	F 638		

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F 638	Continued From page 36	F 638		

"status" was documented as "current" and had no completion date. There were no other completed assessments since the 2/25/19 admission MDS.

On 7/11/19 at 10:16 AM, in an interview with ASM #2 (Administrative Staff Member) the Director of Nursing, she was notified of the concern. ASM #2 stated that the MDS coordinator had been on FMLA (Family Medical Leave Act) since May 2019, and was out on leave from November 2018 through January 2019. ASM #2 stated that an MDS coordinator from another facility had been trying to fill in to help.

On 7/15/19 at 11:40 AM, ASM #2 stated that she didn't have anything more to offer regarding the timely completion and/or transmission of MDS assessments that were not completed and/or transmitted timely or at all.

A review of the facility policy, "MDS Completion and Management" documented, "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI (Resident Assessment Instrument) MDS 3.0 User's Manual...."

According to the RAI Manual, Version 1.16, dated October 2018, the table on page 2-17 documented that a quarterly assessment is due no later than the ARD date of the previous assessment plus 92 calendar days, making the due date for this assessment on or approximately 5/27/19.

4. For Resident #10, the facility staff failed to complete a quarterly MDS assessment within the

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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
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required time frame. The quarterly MDS assessment should have been completed on or approximately 5/15/19.

Resident #10 was admitted to the facility on 1/16/19. Diagnoses included but not limited to congestive heart failure, left fibula fracture, dementia, atrial fibrillation, high blood pressure, diabetes, chronic kidney disease, irritable bowel syndrome, and cardiac pacemaker. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 2/13/19. The resident was coded as severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing, dressing, and transfers; limited assistance for toileting and hygiene; and was independent for eating.

A review of the electronic clinical record revealed a list of the resident's MDS assessments. This list revealed that a quarterly assessment was scheduled with an ARD of 6/21/19. This assessment should have been scheduled on or approximately 5/15/19 and was late. As of the date of survey of 7/11/19, this assessment's "status" was documented as "current" and had no completion date. There were no other completed assessments since the 2/13/19 significant change MDS.

On 7/11/19 at 10:16 AM, in an interview with ASM #2 (Administrative Staff Member) the Director of Nursing, she was notified of the concern. ASM #2 stated that the MDS coordinator had been on FMLA (Family Medical Leave Act) since May 2019, and was out on leave from November 2018 through January 2019. ASM #2 stated that an

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MDS coordinator from another facility had been trying to fill in to help.

On 7/15/19 at 11:40 AM, ASM #2 stated that she didn't have anything more to offer regarding the timely completion and/or transmission of MDS assessments that were not completed and/or transmitted timely or at all.

A review of the facility policy, "MDS Completion and Management" documented, "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI (Resident Assessment Instrument) MDS 3.0 User's Manual...."

According to the RAI Manual, Version 1.16, dated October 2018, the table on page 2-17 documented that a quarterly assessment is due no later than the ARD date of the previous assessment plus 92 calendar days, making the due date for this assessment on or approximately 5/15/19.

5. For Resident #8, the facility staff failed to complete a quarterly MDS assessment within the required time frame. The quarterly MDS assessment should have been completed on or approximately 6/7/19.

Resident #8 was admitted to the facility on 10/15/18 with the diagnoses of but not limited to right tibia fracture, cerebrovascular disease, dysphagia, hypothyroidism, asthma, and osteoporosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/22/19. The resident was coded as being severely

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impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, toileting, dressing, and transfers; extensive assistance for hygiene; and supervision for eating.

A review of the electronic clinical record revealed a list of the resident's MDS assessments. This list revealed that a quarterly assessment was scheduled with an ARD of 5/25/19. This list further revealed that this MDS was not completed until 6/21/19. This assessment was completed late and there were no other completed assessments since the 2/22/19 quarterly MDS.

On 7/11/19 at 10:16 AM, in an interview with ASM #2 (Administrative Staff Member) the Director of Nursing, she was notified of the concern. ASM #2 stated that the MDS coordinator had been on FMLA (Family Medical Leave Act) since May 2019, and was out on leave from November 2018 through January 2019. ASM #2 stated that an MDS coordinator from another facility had been trying to fill in to help.

On 7/15/19 at 11:40 AM, ASM #2 stated that she didn't have anything more to offer regarding the timely completion and/or transmission of MDS assessments that were not completed and/or transmitted timely or at all.

A review of the facility policy, "MDS Completion and Management" documented, "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI (Resident Assessment Instrument) MDS 3.0 User's Manual...."

According to the RAI Manual, Version 1.16, dated

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F 638	Continued From page 40 October 2018, the table on page 2-17 documented that a quarterly assessment is due no later than the ARD date plus 14 calendar days, making the due date for this assessment on or approximately 6/7/19.	F 638		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.	F 640		8/23/19

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F 640	Continued From page 41 (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to electronically submit a completed MDS (minimum data set) assessment for three of 31 residents in the survey sample; Residents #1, #7, and #8. The findings include: 1. For Resident #1, the facility staff failed to electronically submit an expired-in-the-facility MDS assessment with an ARD (assessment reference date) of 4/2/19. Resident #1 was admitted to the facility on 10/19/18 with the diagnoses of but not limited to, diabetes, anxiety, insomnia, adult failure to thrive, Parkinson's disease, dysphagia, and acute kidney failure. The quarterly MDS (Minimum Data Set)	F 640	1. Facility has submitted MDS assessments for resident # 1, #7 and # 8 as of 7/24/19. 2. A 100% review of MDS due between 6/1/19 and 6/30/19 will be conducted to ensure timely submission. 3. SDC or designee will educate MDS coordinator on MDS completion and management policy. ADON or designee will monitor 5 MDS submissions X 3 months. 4. ADON or designee will monitor 5 MDS submissions X 3 months and report any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	

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assessment with an ARD (Assessment Reference Date) of 1/26/19 coded the resident as being significantly impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, transfers, and toileting; limited assistance for dressing and hygiene; and was independent for eating.

A review of the electronic clinical record revealed a list of the resident's MDS assessments. This list revealed that a discharge/expired in facility MDS was completed on 4/2/19. As of the date of survey of 7/11/19, this assessment's "status" was documented as "current" and did not have an "accepted" date, which would indicate the assessment had been electronically submitted.

On 7/11/19 at 10:16 AM, in an interview with ASM #2 (Administrative Staff Member) the Director of Nursing, she was notified of the concern. ASM #2 stated that the MDS coordinator had been on FMLA (Family Medical Leave Act) since May 2019, and was out on leave from November 2018 through January 2019. ASM #2 stated that an MDS coordinator from another facility had been trying to fill in to help.

On 7/15/19 at 11:40 AM, ASM #2 stated that she didn't have anything more to offer regarding the timely completion and/or transmission of MDS assessments that were not completed and/or transmitted timely or at all.

A review of the facility policy, "MDS Completion and Management" documented, "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI (Resident Assessment Instrument) MDS 3.0 User's Manual....The MDS Coordinator

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F 640	Continued From page 43 or designee will transmit all MDS Assessments in compliance with State and Federal guidelines...." According to the RAI (Resident assessment Instrument) Manual, Version 1.16, dated October 2018, the table on page 2-18 documented that a death-in-facility MDS is to be electronically submitted no later than the date of death plus 14 calendar days, making the required date of electronic submission for this assessment on or approximately 4/16/19. 2. For Resident #7, the facility staff failed to electronically submit a quarterly MDS assessment with an ARD of 11/18/18. Resident #7 was admitted on 5/26/16, with diagnoses including but are not limited to, dislocation of left hip, acute respiratory failure with hypoxia, dementia, depression, psoriasis, rhabdomyolysis, high blood pressure, and insomnia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/18/19. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living except eating, for which she was coded as requiring extensive assistance. A review of the electronic clinical record revealed that a quarterly MDS assessment with an ARD of 11/18/18 was completed on 12/11/18. As of the date of survey of 7/11/19, this assessment's "status" was documented as "completed" and had no "accepted" date, which would have indicated the assessment had been electronically	F 640		

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F 640	Continued From page 44 submitted. On 7/11/19 at 10:16 AM, in an interview with ASM #2 (Administrative Staff Member) the Director of Nursing, she was notified of the concern. ASM #2 stated that the MDS coordinator had been on FMLA (Family Medical Leave Act) since May 2019, and was out on leave from November 2018 through January 2019. ASM #2 stated that an MDS coordinator from another facility had been trying to fill in to help. On 7/15/19 at 11:40 AM, ASM #2 stated that she didn't have anything more to offer regarding the timely completion and/or transmission of MDS assessments that were not completed and/or transmitted timely or at all. A review of the facility policy, "MDS Completion and Management" documented, "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI (Resident Assessment Instrument) MDS 3.0 User's Manual....The MDS Coordinator or designee will transmit all MDS Assessments in compliance with State and Federal guidelines...." According to the RAI Manual, Version 1.16, dated October 2018, the table on page 2-17 documented that a quarterly assessment is to be electronically submitted no later than the MDS completion date plus 14 calendar days, making the required date of electronic submission for this assessment on or approximately 12/25/18. 3. For Resident #8, the facility staff failed to electronically submit a significant change MDS	F 640		

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F 640	Continued From page 45 with an ARD of 11/22/18 and a quarterly MDS with an ARD of 5/25/19. Resident #8 was admitted to the facility on 10/15/18 with the diagnoses of but not limited to right tibia fracture, cerebrovascular disease, dysphagia, hypothyroidism, asthma, and osteoporosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/22/19. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, toileting, dressing, and transfers; extensive assistance for hygiene; and supervision for eating. A review of the electronic clinical record revealed that a significant change MDS assessment with an ARD of 11/22/18 was completed on 11/30/18. As of the date of survey of 7/11/19, this assessment's "status" was documented as "completed" and had no "accepted" date, which would have indicated the assessment had been electronically submitted. Further review revealed that a quarterly assessment with an ARD of 5/25/19 was completed on 6/21/19. As of the date of survey of 7/11/19, this assessment's "status" was documented as "locked" and had no "accepted" date, which would have indicated the assessment had been electronically submitted. The completion of this MDS was late, as it should have been completed by 6/7/19 (the ARD date plus 14 calendar days). The electronic submission date for this MDS, based on the actual completion date of 6/21/19 was 7/4/19.	F 640		

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F 640	Continued From page 46 On 7/11/19 at 10:16 AM, in an interview with ASM #2 (Administrative Staff Member) the Director of Nursing, she was notified of the concern. ASM #2 stated that the MDS coordinator had been on FMLA (Family Medical Leave Act) since May 2019, and was out on leave from November 2018 through January 2019. ASM #2 stated that an MDS coordinator from another facility had been trying to fill in to help. On 7/15/19 at 11:40 AM, ASM #2 stated that she didn't have anything more to offer regarding the timely completion and/or transmission of MDS assessments that were not completed and/or transmitted timely or at all. A review of the facility policy, "MDS Completion and Management" documented, "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI (Resident Assessment Instrument) MDS 3.0 User's Manual....The MDS Coordinator or designee will transmit all MDS Assessments in compliance with State and Federal guidelines...." According to the RAI Manual, Version 1.16, dated October 2018, the table on page 2-16 documented that a significant change assessment is to be electronically submitted no later than the care plan completion date plus 14 calendar days (the care plan completion date is to be no later than the completion date plus 7 calendar days), making the required date of electronic submission for the above significant change assessment on or approximately 12/19/18. On page 2-17, the table documented that a quarterly assessment is to be submitted no later than the MDS completion date plus 14 calendar days, making the required date of	F 640		

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F 640	Continued From page 47 electronic submission for the above quarterly assessment on or approximately 7/4/19.	F 640		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice for one of 31 residents in the survey sample; Resident #145. The facility staff failed to ensure a physician's order was in place for the use of an incentive spirometer (1), and failed to store an incentive spirometer in a sanitary manner for Resident #145. The findings include: Resident #145 was admitted to the facility on 7/6/19. Resident #145's diagnoses include, but are not limited to high blood pressure, and cellulitis of right lower limb. The most recent MDS (Minimum Data Set), was an admission	F 695	1. Incentive Spirometer was not ordered for resident and removed on 7/11/19 from resident #145□s room. 2. 100% review was conducted of residents with incentive spirometers to ensure a physician□s order was in place and stored in a sanitary manner. 3. SDC or designee will educate licensed nurses on physician orders policy and proper storage of incentive spirometer. Clinical manager or designee will monitor residents with incentive spirometers to ensure a physician□s order is in place and stored properly for 3 months. 4. Clinical manager or designee will monitor residents with incentive spirometers to ensure a physician□s order is in place and stored properly for 3	8/23/19

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F 695	Continued From page 48 assessment, was not due yet for completion. On 7/10/19 at 9:10 AM, 2:25 PM, and 7/11/19 at 12:00 PM, an observation of Resident #145's room revealed an incentive spirometer sitting on the bedside table, uncovered. On 7/101/9 at 9:10 AM, an interview with Resident #145 was conducted. Resident #145 resident stated she brought the incentive spirometer from the hospital. A review of the clinical record failed to reveal a physician's order for an incentive spirometer. On 7/11/19 at 1:34 PM, an interview was conducted with RN (Registered Nurse) #1. RN #1 was asked if there should be a physician's order for the use of an incentive spirometer. RN #1 stated, "Yes, of course. Since she has it. I don't know who brought it to her. It could have been therapist. I need to get rid of it." RN #1 was asked about the process for storing a resident's incentive spirometer. RN #1 stated, "It should be in a bag and washed often. We may be able to change the mouthpiece, I don't know." When asked if an uncovered incentive spirometer is an infection control issue, RN #1 stated, "Yes ma'am." When asked if there should be a physician's order for the use of an incentive spirometer, RN #1 stated, "It should have an order." A review of the facility's policy "Physician Orders" documented in part, " ...Policy: ...Diets, diagnostic tests, therapy, or any other treatments may not be administered to a resident without a written order from the provider ..."	F 695	months. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	

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F 695	Continued From page 49 On 7/11/19 at 4:21 PM, ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. (1) Incentive Spirometer: An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000451.htm	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		8/23/19

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ASHBY PONDS INC	21160 MAPLE BRANCH TERRACE ASHBURN, VA 20147

(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 700	Continued From page 50 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to obtain informed consent prior to the use of bed rails for two of 31 residents in the survey sample; Resident #145 and Resident #26. The findings include: 1. The facility staff failed to obtain informed consent prior to the use of bed rails Resident #145. Resident #145 was admitted to the facility on 7/6/19 with the diagnoses of but not limited to high blood pressure and cellulitis of right lower limb. The most recent MDS (Minimum Data Set), was an admission assessment, was not due yet for completion. On 7/10/19 at 9:10 AM, 2:25 PM, and 7/11/19 at 12:00 PM, Resident #145 was observed in her bed. Her bed was noted to have two U-shaped side rails (one on each side) and the bed rails were up at each observation. On 7/10/19 at 9:10 AM, an interview was conducted with Resident #145. Resident #145 was asked if the facility discussed the risk and	F 700	1. Informed consent for bed rails was obtained from resident #145 and #26on 7/11/19. 2. 100% review was conducted of residents with bed rails to ensure informed consent has been obtained. 3 SDC or designee will educate licensed nurses on Bed Rail policy. Clinical manager or designee will audit 5 residents with bed rails monthly for 3 months to ensure informed consent was obtained. 4 Clinical manager or designee will audit 5 residents with bed rails monthly for 3 months to ensure informed consent was obtained. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	

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benefits of using bed rails and if she had signed an informed consent, Resident #145 stated, "Yes, but I don't remember signing a consent form."

On 7/10/19 at 2:48 PM, a review of the clinical record revealed a "Bed Rails: Informed Consent" form. The blank for the signature was not completed. There was no signature by the resident or their representative, indicating that they ever reviewed the risk and benefit for the use of bedrails prior to the use and no signature of the Team Member providing education regarding "Bed Rails: Informed Consent."

A "Bed Rail Entrapment Risk Evaluation" that indicated the resident would benefit from and recommended the use of bed rails to both sides of the bed. The document was dated 7/9/19.

Resident #145's comprehensive care plan dated 7/8/19 for the use of "U-Bar right side U-Bar left side" under the section for "Bed Mobility."

On 7/11/19 at 1:34 PM, an interview was conducted with RN (Registered Nurse) #1. RN #1 was asked if a bed risk evaluation is completed when a resident is admitted. RN #1 stated, "Yes." RN #1 was asked if the bed risk evaluation recommended the use of bed rails should an informed consent also be completed. She stated, "Yes." RN #1 was informed that Resident #145 did not have a signed consent for the use of bed rails. RN #1 stated, "I can get the consent signed for her." When asked if not having a signed informed consent for the use of bed rails prior to the use of bed rails is a problem, RN #1 stated, "It is always a good idea to have a consent. I talk to the resident and family about bed rails. I personally put the side rails on the

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bed. Sometimes the resident is not aware to sign at that time. It goes with the assessment."

A review of the facility's policy "Bed Rails" documented in part, " ...Upon admission ...the licensed nurse will assess/evaluate the resident's potential need for, as well as benefits and risks of bed rail usage ...If bed rails are recommended and deemed safe and appropriate ...the Licensed Nurse or Rehab Manager will communicate with the resident and/or representative the risks and benefits of the side rail utilization using the Bed Rail Information Sheet ...The resident's medical record will reflect the staff member providing the Bed Rail Information Sheet and risk/benefit education as well as the resident or resident representative that has received the risk/benefit education. The resident or responsible party ...and staff member providing the information to the resident will sign Bed Rail Informed Consent."

On 7/11/19 at 2:15 PM, a request was made to ASM (Administrative Staff Member) #2, the Director of Nursing. for Resident #145's "Bed Rails: Informed Consent". When ASM #2, provided the requested document, the blank signature area for the resident contained the following hand written information, "7/11/19 at 2:15 PM." The consent also included Resident #145's signature.

On 7/11/19 at 4:21 PM, ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings.

No further information was provided by the end of the survey.

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2. The facility staff failed to obtain informed consent prior to the use of bed rails for Resident #26.

Resident #26 was admitted to the facility on 6/22/19 with the diagnoses of but not limited to high blood pressure, generalized anxiety disorder, type 2 diabetes mellitus, and multiple fracture of ribs. The most recent MDS (Minimum Data Set), a 14-day scheduled assessment, with an ARD (Assessment reference date) of 7/4/19, coded the resident as scoring a 9 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for daily decision making. The resident required extensive assistance for hygiene, bathing, dressing, toileting, transfers, and eating; was occasionally incontinent of bladder and frequently incontinent of bowel.

On 7/9/19 at 1:15 PM, 7/10/19 at 8:19 AM, and 4:10 PM, the resident was observed in her room, in her chair next to her bed. Her bed was noted to have two U-Bar bed rails (one on each side) and the bed rails were up at each observation. Although the resident was not seen in bed for any of the observations, the bed rails were present, in the up position, and available for potential use by the resident when she was in bed.

On 7/9/19 at 1:15 PM, an interview was conducted with Resident #26. Resident #26 was asked if the facility discussed the risk and benefits of using bed rails and if she had signed an informed consent. Resident #26 stated, "Yes, but I don't remember signing a consent form. I signed a lot of papers."

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F 700	Continued From page 54 On 7/10/19 at 3:34 PM, a review of the clinical record revealed a "Bed Rails: Informed Consent" form. The blank for the signature was not completed. There was no signature of the resident or their representative, indicating that they ever reviewed the risk and benefit for the use of bedrails prior to the use of bed rails. There was not signature of the Team Member providing education regarding "Bed Rails: Informed Consent." A "Bed Rail Entrapment Risk Evaluation" that indicated the resident would benefit from and recommended the use of bed rails to both sides of the bed. The document was dated 6/22/19. Resident #26's comprehensive care plan dated 6/22/19 for the use of "U-Bar right side U-Bar left side" under the section for "Bed Mobility." On 7/11/19 at 1:34 PM, an interview with RN (Registered Nurse #1) was conducted. RN #1 was informed that Resident #26 does not have a signed consent for the use of bed rails. RN #1 stated, "I can get the consent signed for her, but is not my assignment." RN #1 was asked if not having a signed informed consent for the use of bed rails prior to the use of bed rails is a problem. RN #1 stated, "It is always a good idea to have a consent. I talk to the resident and family about bed rails. I personally put the side rails on the bed. Sometimes the resident is not aware to sign at that time. It goes with the assessment." On 7/11/19 at 2:15 PM, a request was made to ASM (Administrative Staff Member) #2, The Director of Nursing, for Resident #26's "Bed	F 700		

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F 700	Continued From page 55 Rails: Informed Consent". When ASM #2 provided the requested document the blank signature area for the resident contained the following hand written information, "7/11/19 at 2:40 PM." The consent also included Resident #26's signature. On 7/11/19 at 4:21 PM, ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 700		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		8/23/19

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F 812	Continued From page 56 Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to prepare and serve food in a sanitary manner. The facility staff failed to keep from touching the food contact surfaces of the resident's dishes with their bare hands while serving the resident's dinner in main dining room. The findings include: On 7/10/19 between 4:47 PM and 5:59 PM, an observation of the dinner meal tray-line service in the kitchen area of the main dining room was conducted. OSM (Other Staff Member) #4, the Dining Associate, was observed as she prepared each plate for the dining room and trays for residents eating in their rooms. OSM #4 was observed wearing gloves for preparing the plates. She was noted to handle serving spoon handles, tongs, and other items potentially contaminating her gloves before handling the plates. OSM #4 was observed to lifting each plate with her gloved hand with her thumb on the food contact surface. OSM #4 was not wearing gloves, was observed picking up saucers for soup bowls with her thumb on the food-contact surface area of the saucer. OSM #2 then placed the saucers on a serving tray, during the soup service. On 7/11/19 at 11:00 AM, an interview with OSM #4 was conducted. OSM #4 was asked about the process for serving resident food. OSM #4 stated, "You hold the soup bowl on the bottom. I can't touch the inside or the rim. Everything by the	F 812	1. OSM #4 was educated on 7/11/19 on Safe Serve Food Handling Guidelines. 2. Dining Manager observed meal service on 7/12/19 to ensure no other residents were at risk from dietary staff touching food contact surfaces. 3. Dining Manager or designee will reeducate dining associates and care associates on Safe Serve Food Handling Guidelines. Dining Manager or designee will monitor meal service 5 times per month for 3 months to ensure compliance. 4. Dining Manager or designee will monitor meal service 5 times per month for 3 months to ensure compliance. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	

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bottom or handle. The plates by the bottom. You cannot put your hands or thumb inside the plate." When asked if she should touch the food-contact surface area of saucers, OSM #4 stated, "I have to put it in the dirty dishes. It is contaminated and get a new one." When informed of observations, she stated, "I have to switch out my gloves all the time. I did not change my gloves."

On 7/11/19 at 11:12 PM, an interview was conducted with OSM #2, the Dining Service Manager. OSM #2 was asked about the process staff follows for serving resident food. OSM #2 stated, "You wash your hands. Only handle tools and grab the plate, not using thumbs, put hand under plate, the thumb should not touch the rim of the plate." When asked what should happen if the top of the food contact surface area is touched, OSM #2 stated, "They have to wash their hands and put on new gloves."

A review of the facility's policy "Food Handling Sanitation" documented in part, "Purpose ...To ensure the prevention of food borne illness ....Policy: High standards of sanitation will be maintained and practiced in all community food preparation and service areas ...Procedure: Continuing care staff will practice proper sanitation at all times when handling food."

A review of the facility's "ServSafe Food Handler Guide" documented in part, "Preventing Cross-Contamination When Serving Food ...Surfaces that touch food are called food-contact surfaces ....Plates, glasses, forks, and tongs are examples. You can contaminate these surfaces if you are not careful when handling them ...Do NOT touch the parts of dishes or glassware that come in contact with

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F 812	Continued From page 58 food ..." On 7/11/19 at 4:21 PM, ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 812		
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to maintain the dumpster area in a clean and sanitary manner to prevent pests. A pile of debris was observed on the ground approximately 2 - 3 inches from the small dumpster. The findings include: On 7/9/19 at 12:24 PM, an inspection of the facility dumpster area was conducted with OSM (Other Staff Member) #2, the Dining Service Manager. A pile of debris was observed on the ground approximately 2 - 3 inches from the small dumpster. The pile contained two used white gloves, plastic wrap, string, paper, and a paper box. A pile of debris was observed on the ground approximately 2 - 3 inches from the large dumpster. The pile contained plastic wrapper,	F 814	1. Debris was removed from the ground and housekeeping and dining staff were educated on Sanitation and Waste Handling Policy on 7/9/19. 2. Observation of dumpster area was conducted on 7/12/19 to ensure Sanitation and Waste Handling policy was followed. 3. Senior Facilities Manager completed reeducation with housekeeping and dining staff on 7/9/18. Housekeeping supervisor will monitor dumpster area 5 times per month for 3 months to ensure area to ensure compliance with policy. 4. Housekeeping supervisor will monitor dumpster area 5 times per month for 3 months to ensure area to ensure compliance with policy. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	8/23/19

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tape, and a used blue glove. In addition, two kittens were observed under the large dumpster.

On 7/9/19 at 12:41 PM, an interview was conducted with OSM #2. OSM #2 was asked if the pile of debris should be on the ground. OSM #2 stated, "First of all, cardboard does not belong there. It could bring rats, bugs, moisture and cats." When asked who is responsible for keeping the dumpster area clean, OSM #2 stated, "Housekeeping maintains the dumpster area. It's a team."

On 7/9/19 at 12:48 PM, an interview was conducted with OSM #3, the Housekeeping Supervisor. When asked if the pile of debris should be on the ground, OSM #3 stated, "No. Well, sometimes the dumpster overflows." When OSM #3 was asked if the pile on the ground would cause a problem, she stated, "Infection, rats." When OSM #3 was asked who is responsible for keeping the dumpster area clean, she stated, "Housekeeping."

On 7/9/19 at 1:40 PM, a follow up observation of the dumpster area was made. The larger dumpster was observed with trash bags in the smaller, lower section with no lid. The smaller, lower section was attached to a middle, higher section that was attached to the larger compactor. The middle, higher section was observed with trash bags and no lid.

On 7/9/19 at 1:40 PM, a follow up interview with OSM #2 was conducted. When OSM #2 was asked how often the trash is compacted into the compactor, he stated, "It is done periodically. Housekeeping has the key and pushes the button."

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F 814	Continued From page 60 On 7/9/19 at 1:51 PM, a follow up interview with OSM #3 was conducted. When OSM #3 was asked how often the trash is compacted into the compactor, she stated, "Twice in the AM and twice in the PM. It all depends if it gets full before then." When asked who compacts the trash, OSM #3 stated, "Anyone in housekeeping knows where the key is and can push it." We empty the container one time a month or when full, but not weekly. We have to check it more often." When asked if the dumpster should have a lid, OSM #3 stated, "Yes. Cause now we have this problem with them open." OSM #3 was asked for the facility policy regarding the dumpster. She stated she did not know if there was a policy. On 7/9/19 at 2:10 PM, ASM (Administrative Staff Member) #1, the Administrator was made aware of the dumpster area concerns. ASM #1 stated he would check the dumpster area, see about relocating the cats, and get the requested policies. On 7/9/19 at 2:39 PM, ASM #1 stated the dining and housekeeping staff are being educated about the dumpster area upkeep and (name of) pest control was called regarding the cats. A review of the facility policy "Sanitation and Waste Handling Policy" documented in part, " ...Departments generating waste are responsible for: The proper handling, storage and removal of all waste ...Ensuring waste storage areas are clean and orderly at all times ...External Waste and Recycled Material ...Keep the lids on all outside waste containers closed at all times using, locking lids shall be supplied where needed. Waste shall not extend above the top of	F 814		

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F 814	Continued From page 61 the container thus preventing the lid from closing completely ...Keep the area around waste containers (within 10 feet) clean of all refuse at all times ..." On 7/11/19 at 4:21 PM, ASM #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 814		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		8/23/19

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F 880	Continued From page 62 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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	495416	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 880	Continued From page 63 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow infection control practices for one of 6 residents in the medication administration observation, Resident #18; and for one of 31 residents in the survey sample, Resident #145. The findings include: 1. The facility staff failed to prepare Resident #18 medications in a sanitary manner to prevent infection. Resident #18 was admitted to the facility on 9/28/18. Diagnoses include but not limited to, left femur fracture, high blood pressure, chronic kidney disease, dysphagia, and malnutrition. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 4/7/19 coded the resident as mildly impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing and toileting; limited assistance for transfers, dressing and hygiene; supervision for eating; and was coded as occasionally incontinent of bowel and bladder. On 7/10/19 at 9:03 AM, LPN #1 (Licensed Practical Nurse) was observed preparing and administering medications to Resident #18. She prepared the following medications: " Thera M (1) 9mg (milligrams) 400mcg (micrograms), 1 tablet " D3 (2) 2000 units, 1 tablet	F 880	1. LPN# 1 cleaned medication cabinet on 7/10/19 and the incentive spirometer was removed from resident #145□s room on 7/11/19. 2. All medication cabinets were cleaned on 7/10/19. A 100% room audit was completed for any resident with incentive spirometers to ensure storage in a sanitary manner. 3. SDC or designee will educate licensed nurses on maintaining medication cabinets in a sanitary manner and proper storage of incentive spirometers. Clinical Manager or designee with monitor 5 medication cabinets monthly and all residents with incentive spirometers for 3 months. 4. Clinical Manager or designee with monitor 5 medication cabinets monthly and all residents with incentive spirometers for 3 months. Any findings outside of the policy will be reported and reviewed at our monthly QAPI meeting.	

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F 880	Continued From page 64 " Lexapro (3) 15 mg, 1.5 tablets The medications were prepared in the resident's room. Each room had its own medication cabinet, with a door that hinged on the bottom, and when unlocked, could be opened downward, allowing the inside of the door to be used as a flat tabletop surface to work on. The inside of the medicine cabinet door, when opened into the tabletop position, was noted to be covered with multiple dried "drips" of a liquid substance, which were tacky to the touch. LPN #1 was observed preparing Resident #18's medications on this surface without attempting to clean the surface. In addition, the inside of the medication cabinet was observed with dried "drips" of a liquid substance that had dripped down the back wall. Rings of liquid substance drips were observed on the shelf from the base of a liquid medication bottle, and a line of liquid medication was observed along the seam where the back of the horizontal shelf contacted the bottom of the vertical back wall of the cabinet. On 7/10/19 at 9:35 AM, in an interview with LPN #1, she stated that the nurses are responsible to keep the inside of the medication cabinets clean, as housekeeping does not have access to them. LPN #1 stated that the medications for Resident #18 were not stored and prepared in a clean and sanitary manner. A review of the facility policy, "Medication Storage in Resident's Room" did not include criteria for the medication cabinets to be maintained in a clean and sanitary manner. A review of the facility policy, "Medication Administration, Receipt, Storage & Disposal" did not include criteria for the	F 880		

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F 880	Continued From page 65 medication cabinets to be maintained in a clean and sanitary manner. On 7/10/19 at approximately 6:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member, the Administrator) and ASM #2 (the Director of Nursing) were made aware of the findings. 1. Thera M - A multivitamin, used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy. Vitamins are important building blocks of the body and help keep you in good health. Information obtained from https://www.webmd.com/drugs/2/drug-18820-9038/multivitamin-oral/multivitamins-includes-prenatal-vitamins-oral/details 2. D3 - Vitamin D is a nutrient found in some foods that is needed for health and to maintain strong bones. It does so by helping the body absorb calcium (one of bone's main building blocks) from food and supplements. People who get too little vitamin D may develop soft, thin, and brittle bones, a condition known as rickets in children and osteomalacia in adults. Vitamin D is important to the body in many other ways as well. Muscles need it to move, for example, nerves need it to carry messages between the brain and every body part, and the immune system needs vitamin D to fight off invading bacteria and viruses. Together with calcium, vitamin D also helps protect older adults from osteoporosis. Vitamin D is found in cells throughout the body. Information obtained from https://ods.od.nih.gov/factsheets/VitaminD-Consumer/	F 880		

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F 880	Continued From page 66 3. Lexapro - is an antidepressant. It is used to treat depression and generalized anxiety disorder. Information obtained from https://medlineplus.gov/druginfo/meds/a603005.html 2. The facility staff failed to follow infection control practices for the use and storage of an incentive spirometer (1) for Resident #145. Resident #145's incentive spirometer was observed sitting on the bedside table, uncovered. Resident #145 was admitted to the facility on 7/6/19. Diagnoses include but are not limited to, high blood pressure and cellulitis of right lower limb. The most recent MDS (Minimum Data Set), was an admission assessment had not yet been completed. On 7/10/19 at 9:10 AM, 2:25 PM, and 7/11/19 at 12:00 PM, during an observation of Resident #145's room an incentive spirometer was observed sitting on the bedside table, uncovered. On 7/101/9 at 9:10 AM, an interview with Resident #145 was conducted and the resident stated she brought the incentive spirometer from the hospital. A review of the clinical record failed to reveal a physician's order for Resident #145's incentive spirometer. On 7/11/19 at 1:34 PM, an interview with RN (Registered Nurse) #1 was conducted. When was asked about the facility process for storing a resident's incentive spirometer, RN #1 stated, "It	F 880		

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F 880	Continued From page 67 should be in a bag and washed often. We may be able to change the mouthpiece, I don't know." When asked if an uncovered incentive spirometer is an infection control issue, RN #1 stated, "Yes ma'am." A request for the facility's policy for the use of incentive spirometer and infection control practices was made. However, the facility did not provide the requested policies. On 7/11/19 at 4:21 PM, ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. (1) Incentive Spirometer: An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000451.htm	F 880		