STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495281	A. BUILDING _____ B. WING _____	C 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE REHAB CENTER	300 BLUE RIDGE STREET MARTINSVILLE, VA 24112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/21/19 through 07/24/19. Corrections are required for compliance with 42 CFR Part 483.73 Requirements for Long Term Care facilities. Three complaints were investigated during the survey.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.	E 015		9/7/19

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

Electronically Signed | 08/16/2019

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E 015	Continued From page 1 (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included policies and procedures to provide for sewage and waste disposal. The findings included: The facility staff failed to include policies and procedures to provide for sewage and waste disposal in the facility's emergency preparedness plan. On 07/23/19 at 9:30 a.m., the surveyor and the regional maintenance director reviewed the facility's emergency preparedness plan. The regional maintenance director did not provide the surveyor with any information regarding policies	E 015	E015 Emergency Preparedness plan was updated to include the policy/procedure for sewage and waste disposal. Current residents in the center have the potential to be affected. Facility staff will be educated by the Regional Director of Maintenance/designee on the facility's policy/procedure for sewage and waste disposal during an emergency. CAO/designee will update/revise the facility's Emergency Preparedness	

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E 015	Continued From page 2 and procedures to provide for sewage and waste disposal included within the facility emergency preparedness plan. On 07/23/19 at 12:35 p.m., during an interview with the administrator, the administrator verbalized to the surveyor that she had been in the process of trying to put the emergency preparedness plan back together. When asked about being cited for emergency preparedness on the last annual survey the administrator stated she had worked on it in bits and pieces. On 07/23/19 at 2:26 p.m., the director of professional services was notified that the facility had not provided the surveyor with the facility's policies and procedures regarding sewage and waste disposal. This issue was reviewed with the director of professional services, 2 regional directors of clinical services, regional director of MDS's, administrator, director of nursing, and chief executive officer on 07/24/19 at 11:30 a.m. No further information regarding the sewage and waste disposal was provided to the survey team prior to the exit conference.	E 015	periodically as needed and at least annually. The results will be reported monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Director of Maintenance will be responsible for implementation of the plan of correction.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/21/19 through 7/24/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 300 certified bed facility was	F 000		

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F 000	Continued From page 3 225 at the time of the survey. The final survey sample consisted of 35 current Resident reviews and 2 closed record reviews. Complaints were investigated during the course of the survey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		9/7/19

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F 580	Continued From page 4 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and facility document review, it was determined there was a delay in provider response to a fax that was sent to inform the provider of a fall with potential injury for one (1) of thirty-five (35) sampled current residents (Resident #168). The findings include: There was a delay in provider response to a fax notification of Resident #168 experiencing a fall which resulted in the resident complaining of pain. Resident #168 was admitted to the facility on 4/1/19. Resident #168's diagnoses include, but were not limited to: hypertension, gastroesophageal reflux disease, hyperlipidemia, and osteoporosis. Resident #168's 4/8/19 MDS	F 580	F580 No action was taken due to the timeframe had already passed. However, the provider although not timely did response back to the initial fax with new orders for an x-ray. Resident with Falls and fax communication forms from the last 30 days were reviewed to ensure notification to the provider in a timely manner with follow up if required. Licensed nurses will be educated by the Director of Nursing/designee on timely notification to the physician and timely response back from the physician when there is a change of condition of a	

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F 580	Continued From page 5 (minimum data set) assessment indicated the resident was able to express ideas and wants, was oriented to year/month/day, and was able to complete surface-to-surface transfers with staff assistance. Resident #168's clinical documentation included the following nursing notes: - On 4/9/2019 at 2:09 p.m., "was called to room by CNA (certified nursing assistant); rsd (resident) was sitting in bathroom floor with no shoes on; there was a small amount of wetness on the floor, but no puddles; initially rsd denied hitting her head or having any pain, but once her son came in he stated that she had (complained of) knee pain and swelling; rsd was given PRN (as needed) Tylenol 650mg" - On 4/9/2019 at 6:21 p.m., "RESIDENT IS RESTING IN BED QUIETLY AT THIS TIME WITH NO S/S (signs/symptoms) OF DISTRESS NOTED. NO C/O (complain of) PAIN OR SOB (shortness of breath) VOICED. RESIDENT DENIES PAIN OR DISCOMFORT R/T (related to) PREVIOUS FALL, HOWEVER STAFF STATES THAT SHE WILL NOT BARE WEIGHT OR ROLL ON INJURED SIDE OF KNEE. AWAITING RESPONSE ON MD NOTIFICATION REGARDING NEW ORDERS. CALL BELL REMAINS WITHIN REACH. WILL CONTINUE TO MONITOR." - On 4/10/19 at 1:06 a.m., "Daily Nursing Assessment Completed Resting quietly in bed with eyes closed. No complaints of previous fall. Bed at lowest position/call bell in place/will cont. to monitor." - On 4/10/19 at 6:49 a.m., "Medicated with Aleve 220 mg tab (tablet) po (by mouth) (at) 0630; c/o (complain of) pain. Rec'd fax per MD: N.O. (new	F 580	resident. In addition, education included making to call to the provider if there is not response from the fax communication from the provider within a 2-3 hours. If a significant change or injury is suspected, the provider will be notified by phone immediately. In addition, licensed nurses will be educated to place a copy of the fax communication to the provider in the Unit Managers mailbox to ensure timely follow up on fax communications. The Director of Nursing/design will monitor notifications to the physician during clinical meeting 5x weekly to ensure timeliness of notification and response back from the physician. In addition, resident with falls and/or significant changes will be reviewed in clinical meeting to ensure provider was notified in a timely manner. The results will be reported monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/Director of Nursing is responsible for implementation of the plan of correction.	

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F 580	Continued From page 6	F 580		

order) for an x-ray to left leg. Called (mobile x-ray company's name omitted); spoke with (name of employee of mobile x-ray company omitted); claim # 29624627 for 4/10/19."
- On 4/10/19 at 1:43 p.m., "son wanted his mother sent to the ED (emergency department) because he felt like "she has broken her knee"; he was advised that the doctor had already ordered a x-ray of her left knee and that it has been scheduled for today; son was ok with that and said that we could just wait on them to do it here
called (mobile x-ray company's name omitted) and spoke with (employee of mobile x-ray company name omitted) to get an ETA and she provided me with this ETA claim # 29628630"
- On 4/10/19 at 1:53 p.m., "TYLENOL 650 MG GIVEN FOR GENERALIZE PAIN EFFECTIVE."
- On 4/10/19 at 2:47 p.m., "(Resident's son's name omitted) called and wanted to know about the xray.....advised him that it has not been done at this point"
- On 4/10/19 at 2:49 p.m., "received call from (mobile x-ray company's name omitted) and he stated that he didnt [sic] have an ETA but just said later later [sic] tonight; he stated that he had just started his shift and was currently in (name of local city omitted) and it would be later some time tonight before he arrived at the facility"
- On 4/10/19 at 7:49 p.m., "RESIDENT IS RESTING IN BED QUIETLY AT THIS TIME WITH SON AT BEDSIDE. XRAY TECH IS IN ROOM TO OBTAIN XRAY OF RESIDENTS LEFT KNEE. NO C/O (compliant of) PAIN AT THIS TIME. NO S/S (signs/symptoms) OF DISTRESS NOTED. CALL BELL REMAINS WITHIN REACH. WILL CONTINUE TO MONITOR. AWAITING XRAY RESULTS."
- On 4/10/19 at 9:36 p.m., "MD MADE AWARE

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F 580	Continued From page 7	F 580		

OF XRAY RESULTS. NEW ORDER TO SEND RESIDENT TO THE ER FOR EVAL AND TREATMENT OF OBLIQUE FEMUR FX. 911 CALLED AT THIS TIME AND RESIDENT AND SON (name omitted) MADE AWARE OF NEW ORDER AND TRANSPORT TO HOSPITAL. AWAITING EMTS AT THIS TIME. RESIDENT REMAINS STABLE AND NO S/S (signs/symptoms) OF DISTRESS NOTED. CALL BELL REMAINS WITHIN REACH. STAFF REMAIN AT BEDSIDE AT THIS TIME. WILL CONTINE TO MONITOR UNTIL DEPARTURE TO HOSPITAL."
- On 4/10/19 at 9:43 p.m., Resident #168 was documented, in a facility nursing note, as leaving the facility via stretcher going to a local emergency department.

The following information was found in the facility's "FALL PROTOCOL" (this document was not dated): "A resident who has had a fall with obvious signs of an injury (or injuries) such as laceration, hematoma or goose egg to the head, found unconscious or becomes unconscious soon after being found, have altered mental status, extremity deformity, c/o of [sic] arm, leg, hip, back pain, etc., is to have vitals taken, neuro (neurological) checks per protocol and be sent to the ER (emergency room). Obvious signs of injury is the key wording here."

The following information was found in a document, provided to the survey team by the facility staff, titled "Assessing Falls and Their Cause" (with a revised date of 12/2007): "Steps in the Procedure ... After a Fall: ... Nursing staff will notify the resident's Attending Physician and family in an appropriate time frame. When a fall results in a significant injury or condition change,

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nursing staff will notify the practitioner immediately by phone. When a fall does not result in significant injury or a condition change, nursing staff will notify the practitioner routinely (e.g., by fax or by phone the next office day)."

A copy of a fax communication (of Resident #168's fall) from facility staff to Resident #168's provider was given to the survey team. This fax communication was dated 4/9/19; no time was documented in the body of the fax. The fax machine labeled the faxed page as being sent on 4/9/19 at 12:54. The provider's reply fax was not noted until 4/10/19; a time was not documented indicating when on 4/10/19 the reply fax was noted.

On 7/24/19 at 9:56 a.m., the facility's Director of Nursing (DON) was interviewed about how the provider should have been notified of Resident #168's aforementioned fall; the DON reported the provider notification "should have been a phone call".

On 7/24/19 at 11:30 a.m., the failure of the facility staff to ensure timely provider/physician notification of Resident #168's aforementioned fall was discussed for a final time during a survey team meeting with the facility's Regional Director of Clinical (RDCS), Corporate Clinical Registered Nurse, Corporate MDS (minimum data set) employee, Director of Professional Services (DPS), and Administrator.

On 7/24/19 at 1:30 p.m., the facility's DON was asked about when staff should follow-up when a provider hasn't replied to a fax notification. The DON reported the staff should follow-up on the fax notification "with-in a couple of hours or by the

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F 580	Continued From page 9 end of the shift".	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is	F 582		9/7/19

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F 582	Continued From page 10 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 interviews and facility document review, it was determined that the facility staff failed to inform residents during their stay by providing notice when discharged from a Medicare covered Part A stay with benefit days remaining for three (3) of three (3) residents sampled for beneficiary notice review (Resident #BN-1, Resident #BN-2, and Resident #BN-3). The findings include: The facility staff failed to provide Resident #BN-1, Resident #BN-2, and Resident #BN-3 with beneficiary notices when discharged from a Medicare covered Part A stay with benefit days remaining. Three (3) residents were selected for review from the "Beneficiary Notice - Residents Discharged Within the Last Six Months" form completed by the facility staff.	F 582	F582 No action taken due to the timeframe had already passed for residents #BN-1, #BN-2, and #BN-3. However, #BN-1, #BN-2, and #BN-3 SNF Beneficiary Protection Notices was presented and signed by the resident and/or responsible party. A review of the residents required to have a SNF Beneficiary Protection Notice given for the last 90 days was completed to ensure the notice was issued to the residents who was being discharged from Medicare covered Part A stay with days remaining. Social Services will be educated by the Corporate Director of Clinical Reimbursement/designee on the	

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F 582	Continued From page 11 During an interview on 07/23/19 at 9:57 a.m., the facility's Director of Professional Services (DPS) reported the three (3) aforementioned residents did not have SNF Beneficiary Protection Notifications provided. The DPS reported the employee responsible for providing the beneficiary notifications was a new hire and did not know it was something required of her. The DPS stated education has been provided to the employee responsible for issuing the beneficiary notifications. The surveyor requested evidence of the employee training and a copy of the facility's policy and procedure related to issuing the beneficiary notices. On 7/23/19 at 10:32 a.m., the facility's Regional Director of Clinical Services (RDCS) provided a copy of the requested "Inservice Training Report" to the survey team. At the same time the RDCS provided the survey team with a copy of the CMS guidance on SNF Beneficiary Protection Notification Review; the RDCS stated the facility had no written policy and procedure to guide the beneficiary notification process. On 7/24/19 at 11:30 a.m., the failure of the facility staff to provide the required aforementioned beneficiary notices was discussed for a final time during a survey team meeting with the facility's RDCS, Corporate Clinical Registered Nurse, Corporate MDS (minimum data set) employee, DPS, and Administrator.	F 582	requirements for the SNF Beneficiary Protection Notice to be signed by the resident or the responsible party when the resident is being discharged from SNF Part A Medicare stay with days remaining. Social Services will be responsible for ensuring the SNF Beneficiary Protection Notices are signed by the resident and/or responsible party. The Director of Nursing/designee will monitor discharges from Part A Medicare stays 5x weekly during clinical meeting to ensure the SNF Beneficiary Protection Notice was issued and signed by the resident or responsible party when resident is discharged from SNF part A Medicare stay with days remaining. The results will be reported monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/Director of Nursing will be responsible for implementation of the plan of correction.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		9/7/19

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comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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F 584	Continued From page 13 Based on observation, staff interview, Resident interview, and clinical record review, the facility staff failed to ensure a clean, comfortable, homelike environment for 2 of 37 residents. Resident #109 and Resident #111. The findings included: 1. For Resident #109, part of the linoleum in the resident's bathroom was missing. The clinical record review revealed that Resident #109 had been admitted to the facility 02/01/17. Diagnoses included, but were not limited to, diabetes, hypertension, glaucoma, and gastroesophageal reflux disease. Section C (cognitive patterns) of the resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/29/19 included a BIMS (brief interview for mental status) summary score of 6 out of a possible 15 points. While in the resident's room on 07/21/19 at 4:50 p.m., the surveyor observed an area inside the entrance/exit to the resident's bathroom where part of the linoleum was missing. Part of the floor where the linoleum was missing was observed to be dark brown to almost black in appearance. Upon exiting the bathroom, Resident #109 verbalized to the surveyor that the facility was supposed to of fixed the floor but they did not do a very good job. On 07/23/19 at 12:17 p.m., during an interview with CNA (certified nursing assistant) #1, CNA #1 was asked about the missing linoleum and stated she thought maybe there had been a water leak in the bathroom that might have caused the	F 584	F584 No action taken during the survey however the linoleum in resident room #109 will be replaced as well as the floor underneath repaired by 9/7/19. Resident #111 room was deep cleaned to remove any urine odors and brown substance on the floor. Environmental rounds were conducted in current resident's room to ensure rooms present in a Clean Comfortable Homelike Environment. The Director of Environmental Services and staff will be educated by the Regional Director of Maintenance/designee on daily cleaning procedures of resident rooms including the bathrooms. In addition, staff education will include areas requiring attention are logged on the maintenance repair log. The Director of Environmental Services/designee will via direct observation monitor 10 rooms 3x weekly to ensure daily cleaning of resident rooms and to ensure rooms are without pervasive odors. The results will be reported monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 584	Continued From page 14 issue. On 07/22/19 at 3:20 p.m., during a meeting with the regional director of clinical services (staff #1 and #2), chief executive officer, administrator, director of nursing, director of professional services, and the corporate director of MDS's these staff were notified of the issue with the resident's linoleum. No further information regarding the resident's linoleum was provided to the survey team prior to the exit conference. 2. For Resident #111, the resident's bathroom had a strong urine smell. The clinical record review revealed that Resident #111 had been admitted to the facility 10/02/18. Diagnoses included, but were not limited to, end stage renal disease, diabetes, hypertension, and schizophrenia. Section C (cognitive patterns) of the resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/23/19 included a BIMS (brief interview for mental status) summary score of 11 out of a possible 15 points. Section G (functional status) was coded to indicate the Resident required supervision with set up help only for toilet use and personal hygiene. Section H (bladder and bowel) was coded to indicate the Resident was occasionally incontinent in both of these areas. On 07/21/19 at 10:42 a.m., the surveyor entered the resident's bathroom and noted a pervasive odor of urine.	F 584	The CAO/Director of Environmental Services is responsible for the implementation of the plan of correction.	

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F 584	Continued From page 15 On 07/21/19 at 12:15 p.m., the surveyor again checked the resident's bathroom and again noted a pervasive odor of urine. The surveyor also observed a brown substance in the bathroom floor approximately the size of a quarter. On 07/22/19 at 8:36 a.m., the Resident was asked about his bathroom. Resident #111 stated the housekeepers cleaned every day. When asked if he noticed his bathroom had a strong odor he stated he had. Resident #111 stated even though he went to dialysis he still used the bathroom. On 07/23/19 at 12:12 p.m. LPN (licensed practical nurse) #1 and RN (registered nurse) #1 were interviewed regarding the resident's bathroom. LPN #1 and RN #1 both stated they had noticed the bathroom odor. LPN #1 stated they had a housekeeper assigned to this hall and the Resident liked to keep his room warm and maybe that magnified the odor or maybe the Resident missed the commode when urinating. The issue regarding the resident's bathroom were reviewed with the director of professional services, 2 regional directors of clinical services, regional director of MDS's, administrator, director of nursing, and chief executive officer on 07/24/19 at 11:30 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity.	F 604		9/7/19

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F 604	Continued From page 16 The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and facility, the facility staff failed to ensure that 1 of 22 residents were free from unnecessary use of a physical restraint (Resident #126). The findings included: The facility staff failed to ensure assessments	F 604	F604 An assessment was completed for resident #126 for the continued need and use of a self releasing seat belt. Residents with similar devices were reviewed to ensure the appropriate	

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F 604	Continued From page 17 were performed for Resident #126 for the continued need and use of a self-releasing seat belt. Resident #126 was admitted to the facility on 3/1/12 with the following diagnoses of, but not limited to anemia, urinary tract infection, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/28/19. The resident was coded as requiring extensive assistance of 1 staff member for dressing and being totally dependent on 1 staff member for bathing. On 7/22/19 at 2:58 pm, the surveyor observed the resident sitting up in wheelchair with a self-releasing seat belt in place. The surveyor asked the resident if she get this (surveyor pointed to seat belt) off of herself. The resident was able to self-release seat belt on request. During the clinical record review on 7/22/19, the surveyor noted there was no evidence of assessments being documented concerning the continued need of this resident's seat belt. On 7/22/19 at 3:20 pm, the surveyor notified the administrative team of the above documented findings. The DON (director of nursing) stated, "Those assessments are done on a quarterly bases." The surveyor requested copies of the assessments. At 2:17 pm on 7/23/19, the corporate MDS nurse returned to the surveyor and stated, "The resident does have the continued need for the seat belt but I cannot find complete documentation to support this."	F 604	assessments have been completed. Licensed nurses will be educated by the Regional Director of Clinical Services/designee on the required assessments to demonstrate the ongoing continued need and use of any type of self releasing seat belt. The Director of Nursing/designee will monitor required assessments 3x weekly during clinical meeting to ensure assessments are completed. The results will be reported monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Director of Nursing will be responsible for implementation of the plan of correction.	

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F 604	Continued From page 18 No further information was provided to the surveyor prior to the exit conference on 7/24/19.	F 604		
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 § 431.230 of this chapter, when a resident	F 622		9/7/19

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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 responsible for the care of the resident.

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F 622	Continued From page 20 (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to provide appropriate information that is communicated to the receiving health care provider such as comprehensive care plan goals and/or required information to ensure a safe and effective transfer of care for 5 of 35 residents (Residents #30, #201, #19, #213 and #160). The findings included: 1. For Resident #30 the facility staff failed to send a copy of the Resident's comprehensive care plan goals when the Resident was transferred to the hospital. Resident #30 was admitted to the facility on 10/03/08 and readmitted on 04/12/19. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, pneumonia, urinary tract infection, diabetes mellitus, Alzheimer's disease, depression, and psychotic disorder. The most recent MDS(minimum data set) with and ARD (assessment reference date) of 04/25/19 assigned the Resident a BIMS (brief	F 622	F622 No action taken due to time frame had already passed for residents #30, #201, #19, #213 and #160. However, moving forward when resident are transferred out to the hospital, a copy of the comprehensive care plan will be send with the resident as part of the transfer and discharge requirements. A 30 day look back was conducted for residents who was transferred/discharged from the center to the hospital to ensure the proper paperwork was send with the resident including a copy of the comprehensive care plan with documentation in the medical record. Licensed nurses will be educated by the Regional Director of Clinical Services/designee on the appropriate information to be communicated when transferring a resident out to the hospital to include the comprehensive care plan. In addition, education included the	

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F 622	Continued From page 21 interview for mental status) score of 6 out of 15 in section C, cognitive patterns. This is a significant change MDS. Resident #30's clinical record was reviewed on 07/22/19. The nurse's notes section of the clinical record contained a note, which read in part "4/9/2019 2:42:48 PM 1st Shift ...Notified Dr. ... (physician name omitted) via telephone of change in cond. T/O (telephone order) send to ER. Notified POA (power of attorney) via telephone. Called ... (name omitted) to transport. 02 stats 90. P/U (picked up) by ... (name omitted) at app. (approximately) 125 PM. Left via stretcher. Called ER gave report...". There was no documentation in the clinical record as to what information was sent with Resident at the time of transfer. Surveyor spoke with the unit manager on 07/22/19 at approximately 9:25 AM regarding Resident #30. Surveyor asked the unit manager what information was sent when a Resident was transferred to the hospital and the unit manager stated, "We send face sheet, med list, recent labs, communication sheet, progress note and bed hold information". Surveyor asked what information is on the communication sheet, and the unit manager provided the surveyor with a copy of a blank form. This form contained the facility name, address and phone number. It also contained spaces for problem to be evaluated, current diagnosis, present orders, allergies, weight, and flu and pneumonia vaccine information. Surveyor spoke with the DON (director of nursing) on 07/23/19 at approximately 2:20 PM regarding information sent with Resident when they are transferred. DON stated that the	F 622	implementation of the discharge/transfer assessment that has been developed in the electronic Medical record to be completed by licensed nurse when a resident is transferred/discharged to document the required paperwork was send with the resident. The Director of Nursing/designee will review transfers out to the hospital 5x weekly in clinical meeting to ensure the appropriate information was send with the resident when transferring out to the hospital with documentation on the discharge/ transfer summary. The results will be reported monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Director of Nursing will be responsible for implementation of the plan of correction.	

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Resident's face sheet, physician's order summary, history and physical, discharge summary, pertinent labs and x-rays and a consult sheet are to be sent with the Resident. Surveyor asked the DON if a copy of the Resident's comprehensive care plan goals is sent, and the DON stated that it is not.

The concern of not sending the comprehensive care plan goals when a Resident is transferred to the hospital was discussed with the administrative team (Administrator, CEO, Regional Director of Clinical Services, DON, Regional Director of Clinical Services, Director of Professional Services, Corporate MDS Coordinator) during a meeting on 07/22/19 at approximately 03:20.

No further information was provided prior to exit.

2. For Resident #201 the facility staff failed to send a copy of the Resident's comprehensive care plan goals when the Resident was transferred to the hospital.

Resident #201 was admitted to the facility on 11/08/06 and readmitted on 03/13/19. Diagnoses include but not limited to deep venous thrombosis, urinary tract infection, aphasia, dementia, seizure disorder, anxiety and traumatic brain injury.

The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 06/18/19 indicated the Resident has both long and short term memory loss with severely impaired cognitive skills for daily decision making.

Resident #201's clinical record was reviewed on

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07/22/19. The nurse's notes section of the clinical record contained a note, which read in part "3/9/2019 8:09 PM 2nd Shift "...new order send to ER for eval (evaluation) of seizures and vomiting. ... (name omitted) notified. ER notified spoke with ... (name omitted). Resp (responsible) party ... (name omitted) notified. 6:55 PM ... (name omitted) her and transporting to ER". There was no documentation in the clinical record as to what information was sent with Resident at the time of transfer.

Surveyor spoke with the unit manager on 07/22/19 at approximately 9:25 AM regarding Resident #201. Surveyor asked the unit manager what information was sent when a Resident was transferred to the hospital and the unit manager stated, "We send face sheet, med list, recent labs, communication sheet, progress note and bed hold information". Surveyor asked what information is on the communication sheet, and the unit manager provided the surveyor with a copy of a blank form. This form contained the facility name, address and phone number. It also contained spaces for problem to be evaluated, current diagnosis, present orders, allergies, weight, and flu and pneumonia vaccine information.

Surveyor spoke with the DON (director of nursing) on 07/23/19 at approximately 2:20 PM regarding information sent with Resident when they are transferred. DON stated that the Resident's face sheet, physician's order summary, history and physical, discharge summary, pertinent labs and x-rays and a consult sheet are to be sent with the Resident. Surveyor asked the DON if a copy of the Resident's comprehensive care plan goals is sent, and the

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DON stated that it is not.

The concern of not sending the comprehensive care plan goals when a Resident is transferred to the hospital was discussed with the administrative team (Administrator, CEO [Chief Executive Officer], Regional Director of Clinical Services, DON, Regional Director of Clinical Services, Director of Professional Services, Corporate MDS Coordinator) during a meeting on 07/22/19 at approximately 03:20.

No further information provided prior to exit.

3. The facility staff failed to ensure that a copy of the comprehensive care plan goals were sent with Resident # 19 upon transfer to the emergency room on 6/26/19.

Resident # 19 was a 66-year-old-male that was originally admitted to the facility on 9/1/12, and had a readmission date of 7/3/19. Diagnoses included but were not limited to, urinary tract infection, urinary retention, acute kidney failure, and central pain syndrome.

The clinical record for Resident # 19 was reviewed on 7/22/19 at 9:57 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/16/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 19 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 19 was cognitively intact.

On 7/22/19 at 10:11 am, the surveyor observed a nurse's note in Resident # 19's clinical record that had been documented on 6/26/19 at 12:09 pm.

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The nurse's note was documented as, "Cna (certified nursing assistant) notified this nurse that patient was clammy and stating he did not feel well, upon further assessment, VS (vital signs) obtained, BP (blood pressure) 80/50, T: (temperature) 96.6, R: (respirations) 16, P: (pulse) 74, patient has some altered mental status, hypotension, anuria, patient stated that he did not feel, stated that he was not in pain, called (Physician's name withheld) to get advising, gave t/o (telephone order) to send out to ER (emergency room) for further eval, RP (responsible party) was notified stated that she would be in the weekend and would be in to check on him, (Transportation company's name withheld) to transport, left in stable condition, will continue to monitor."

On 7/23/19 at 1:38 pm, the surveyor interviewed LPN (licensed practical nurse) unit manager # 1 and MDS coordinator # 1. The surveyor asked if a copy of the comprehensive care plan goals were sent with Resident # 19 when he was transferred to the emergency room on 6/26/19. LPN unit manager # 1 stated, "No." MDS coordinator # 1 stated, "We don't send care plan goals when we send them out."

On 7/24/19 at 12:50 pm, the regional director of clinical services # 1, Regional director of clinical services # 2, chief executive officer, corporate MDS nurse, director of professional services, director of nursing, and administrator were made aware of the findings as stated above. The surveyor asked the administrative team if it had been the practice of the facility to send a copy of the comprehensive care plan goals with a resident upon transfer. The regional director of clinical services # 2 stated, "No."

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No further information regarding this issue was provided to the survey team prior to the exit conference on 7/24/19.
4. The facility staff failed to provide the comprehensive care plan (CCP) goals to the receiving facility when Resident #213 was transferred.

Resident #213 was admitted to the facility on 6/14/19 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia and Schizophrenia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/20/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #213 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

The surveyor performed a clinical record review on 7/23/19, the surveyor noted the resident was transferred to the ER (emergency room) on 4/10/19 and again on 6/9/19. The "Consultation/Clinic Referral" form that is sent to the ER when the resident is transferred had no documentation of CCP goals documented on this form.

The surveyor notified the administrative team from the facility as well as the corporation that is receiving the facility was notified of the above documented findings on 7/24/19 at approximately 11 am.

On 7/24/19 at approximately 1:15 pm, the surveyor notified the director of nursing (DON) of

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the above documented findings. The DON stated, "We don't send the care plan goals when the resident goes to the ER (emergency room). The things we send are a face sheet, recent orders, recent labs, code status and call report to the ER or wherever the resident is transferred."

No further information was provided to the surveyor prior to the exit conference on 7/24/19.
5. For Resident #160 the facility staff failed to document what information was provided to the recipient facility (an acute care hospital) when the resident was transferred.

Resident #160 was admitted to the facility on 10/31/2018 and readmitted on 06/04/19. Diagnoses included but were not limited to cancer, anemia, Parkinson's, cirrhosis, deep vein thrombosis, and atrial fibrillation.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/09/19 noted Resident #160 had a BIMS (brief interview for mental status) score of 4 out of 15. This MDS was documented as a "significant change in status assessment."

Resident #160's electronic clinical record and hard-back chart were reviewed on 07/22/2019 and 07/23/2019. Within the electronic clinical record under the nurse's notes tab, an LPN (licensed practical nurse) documented on 06/02/19 at 3:38 p.m. that Resident #160 "WAS ON THE FLOOR [sic] WENT INTO RESIDENT ROOM, HE WAS LYING ON HIS LEFT SIDE [sic] LACERATION NOTED TO FOREHEAD, LEFT EAR AND NOSE. LEFT EAR WAS ALSO PURPLE IN COLOR [sic] RESIDENT DENIES ANY PAIN AT THIS TIME [sic] SAID HE WAS

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TRYING TO GO TO THE BATHROOM [sic] CALL BELL WAS WITHIN REACH [sic] POA NOTIFIED [sic] SAID SHE WOULD CALLED [sic] HER MOTHER [sic] 911 CALLED [sic] MD FAXED [sic] NEURO- CHECKS STARTED. 911 ARRIVED AT 3:15 TO TRANSFER RESIDENT TO ER." There was no documentation indicating what information was sent with the patient to the receiving facility when he was transferred.

Resident #160 resided in a unit referred to as "1 South." The surveyor interviewed the Unit Coordinator of 1 South, an LPN (LPN #1) on 07/23/19 at 3:00 p.m. LPN #1 stated when a resident was transferred to an acute care facility she usually sent 2 (two) face sheets, the history and physical, the most recent physician progress notes, the most recent labs, a completed consult sheet and a copy of the DNR (do not resuscitate) if indicated. LPN #1 read the electronic nurse's notes from 06/02/19 and acknowledged the notes did not document what information accompanied the resident upon transfer. LPN #1 stated that if the nurse's notes did not document what information was sent with Resident #160 when he was transferred to an acute care hospital, she was unaware of any other place that information would be documented.

The survey team met with the facility's administrative team on 07/24/19 at 11:30 a.m. The administrative team consisted of the director of professional services, both regional directors of clinical services (Regional Director #1 and Regional Director #2), the administrator, corporate director of MDS, director of nursing, and the CEO (chief executive officer). The administrative team was informed of the concern there was no documentation of information sent

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F 622	Continued From page 29 with Resident #160 when he was transferred to an acute care hospital. No further information was provided prior to exit.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; 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;	F 623		9/7/19

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F 623	Continued From page 30 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how 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	F 623		

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F 623	Continued From page 31 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review the facility staff failed to provide written notification to the resident/responsible party when a resident was transferred from the facility for 5 of 35 Residents (Residents #30, #201, #19, #213, and #160). The findings included: 1. For Resident #30 the facility staff failed to notify the Resident/responsible party in writing when the resident was transferred to the hospital. Resident #30 was admitted to the facility on 10/03/08 and readmitted on 04/12/19. Diagnoses	F 623	F623 No action taken due to timeframe had already passed for resident #30, #201, #19, #213 and #160. a 30 day look back was completed to ensure residents who was transferred/discharged from the facility was provided written notification of the transfer/discharge. Social Services department will be educated by the Regional Director of Clinical Services/designee on the	

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F 623	Continued From page 32 included but not limited to anemia, congestive heart failure, hypertension, pneumonia, urinary tract infection, diabetes mellitus, Alzheimer's disease, depression, and psychotic disorder. The most recent MDS(minimum data set) with and ARD (assessment reference date) of 04/25/19 assigned the Resident a BIMS (brief interview for mental status) score of 6 out of 15 in section C, cognitive patterns. This is a significant change MDS. Resident #30's clinical record was reviewed on 07/22/19. The nurse's notes section of the clinical record contained a note, which read in part "4/9/2019 2:42:48 PM 1st Shift ...Notified Dr. ... (physician name omitted) via telephone of change in cond. T/O (telephone order) send to ER. Notified POA (power of attorney) via telephone. Called ... (name omitted) to transport. 02 stats 90. P/U (picked up) by ... (name omitted) at app. (approximately) 125 PM. Left via stretcher. Called ER gave report...". There was no documentation in the clinical record that a written notice had been provided to the resident/responsible party. The surveyor requested and was provided with a facility policy entitled "Transfers and Discharges", which read in part "Before a facility transfers or discharges a Resident out the facility or between distinct part, the facility must notify the Resident or legal representative (and, if known, a family member of the Resident) of the transfer or discharge and the reasons. The reasons for transfer or discharge must be recorded in the Resident's medical record. The notice must include the reason for the transfer/discharge, the effective date, the location to which the Resident is to be transferred or discharged, and the right to	F 623	progress, including the Notification of Transfer/discharge form to use, for providing written notification to the resident and/or responsible party when a resident is discharged or transferred from the facility. The Director of Nursing/designee will review notifications to the resident and/or RP of the transfer/discharge from the center 5x weekly in clinical meeting to ensure the notice has been provided. The results will be reported monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis CAO/Director of Nursing will be responsible for implementation of the plan of correction.	

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appeal the action to the designated State agency." and "Exception to 30-Day Notice. Notice may be made as soon as practicable before transfer or discharge when: Safety of individuals in the facility would be endangered, Health of individuals in the facility would be endangered, Resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Resident's urgent needs or a Resident has not resided in the facility for 30 days".

The concern of not providing written notifications was discussed during a meeting with the administrative staff (Administrator, Cheif Executive Officer, Regional Director of Clinical Services, DON, Regional Director of Clinical Services, Director of Professional Services, Corporate MDS Coordinator) during a meeting on 07/22/19 at approximately 3:20 PM. The Regional Director of Clinical Services stated that the facility has not been providing written notices to the Resident/responsible party.

No further information provided prior to exit.

2. For Resident #201 the facility staff failed to provide a written notice to the Resident/responsible party when the resident was transferred to the hospital.

Resident #30 was admitted to the facility on 10/03/08 and readmitted on 04/12/19. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, pneumonia, urinary tract infection, diabetes mellitus, Alzheimer's disease, depression, and psychotic disorder.

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The most recent MDS(minimum data set) with and ARD (assessment reference date) of 04/25/19 assigned the resident a BIMS (brief interview for mental status) score of 6 out of 15 in section C, cognitive patterns. This is a significant change MDS.

Resident #30's clinical record was reviewed on 07/22/19. The nurse's notes section of the clinical record contained a note, which read in part "4/9/2019 2:42:48 PM 1st Shift ...Notified Dr. ... (physician name omitted) via telephone of change in cond. T/O (telephone order) send to ER. Notified POA (power of attorney) via telephone. Called ... (name omitted) to transport. 02 stats 90. P/U (picked up) by ... (name omitted) at app. (approximately) 125 PM. Left via stretcher. Called ER gave report...". There was no documentation in the clinical record that a written notice had been provided to the resident/responsible party.

The surveyor requested and was provided with a facility policy entitled "Transfers and Discharges", which read in part "Before a facility transfers or discharges a Resident out the facility or between distinct part, the facility must notify the Resident or legal representative (and, if known, a family member of the Resident) of the transfer or discharge and the reasons. The reasons for transfer or discharge must be recorded in the Resident's medical record. The notice must include the reason for the transfer/discharge, the effective date, the location to which the Resident is to be transferred or discharged, and the right to appeal the action to the designated State agency." and "Exception to 30-Day Notice. Notice may be made as soon as practicable before transfer or discharge when: Safety of individuals in the facility would be endangered, Health of

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individuals in the facility would be endangered, Resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Resident's urgent needs or a Resident has not resided in the facility for 30 days".

The concern of not providing written notifications was discussed during a meeting with the administrative staff (Administrator,Cheif Executive Officer, Regional Director of Clinical Services, DON, Regional Director of Clinical Services, Director of Professional Services, Corporate MDS Coordinator) during a meeting on 07/22/19 at approximately 3:20 PM. The Regional Director of Clinical Services stated that the facility has not been providing written notices to the Resident/responsible party.

No further information provided prior to exit.
3. The facility staff failed to notify Resident # 19 and Resident # 19's representative of reason for transfer to the emergency room in writing.

Resident # 19 was a 66-year-old-male that was originally admitted to the facility on 9/1/12, and had a readmission date of 7/3/19. Diagnoses included but were not limited to, urinary tract infection, urinary retention, acute kidney failure, and central pain syndrome.

The clinical record for Resident # 19 was reviewed on 7/22/19 at 9:57 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/16/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 19 had a BIMS (brief interview for mental status)

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score of 15 out of 15, which indicated that Resident # 19 was cognitively intact.

On 7/22/19 at 10:11 am, the surveyor observed a nurse's note in Resident # 19's clinical record that had been documented on 6/26/19 at 12:09 pm. The nurse's note was documented as, "Cna (certified nursing assistant) notified this nurse that patient was clammy and stating he did not feel well, upon further assessment, VS (vital signs) obtained, BP (blood pressure) 80/50, T: (temperature) 96.6, R: (respirations) 16, P: (pulse) 74, patient has some altered mental status, hypotension, anuria, patient stated that he did not feel, stated that he was not in pain, called (Physician's name withheld) to get advising, gave t/o (telephone order) to send out to ER (emergency room) for further eval, RP (responsible party) was notified stated that she would be in the weekend and would be in to check on him, (Transportation company's name withheld) to transport, left in stable condition, will continue to monitor."

On 7/23/19 at 1:38 pm, the surveyor interviewed LPN (licensed practical nurse) unit manager # 1 and MDS coordinator # 1. The surveyor asked LPN unit manager # 1 and MDS coordinator # 1 how the responsible person for Resident # 19 was made aware of him being transferred to the emergency room on 6/26/19. LPN unit manager # 1 stated, "We call her and then make a note in the chart." The surveyor asked if Resident # 19 and Resident # 19's representative was made aware in writing of the reason for transfer to the emergency room on 6/26/19. MDS coordinator # 1 stated, "No, we don't do that we just make a phone call to notify them."

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The facility policy on "Transfers and Discharges" contained documentation that included but was not limited to, ..."The facility must inform the resident in advance according to required timelines, of a transfer or discharge and the reason for the transfer or discharge, the effective date, the location, and the right to appeal. This information should be given to the resident orally and in writing. The reason, the resident's response and reaction to the notification must be documented in the medical record." ...

On 7/24/19 at 12:50 pm, the regional director of clinical services # 1, Regional director of clinical services # 2, chief executive officer, corporate MDS nurse, director of professional services, director of nursing, and administrator were made aware of the findings as stated above. The surveyor asked the administrative team if the facility had been notifying the Resident and Resident Representative in writing of reason for transfer prior to the survey. The regional director of clinical services # 2 stated, "No."

No further information regarding this issue was provided to the survey team prior to the exit conference on 7/24/19.
4. The facility staff failed to provide a written notice of transfer to the resident or resident's representative for Resident #213.

Resident #213 was admitted to the facility on 6/14/19 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia and Schizophrenia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/20/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a

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possible score of 15. Resident #213 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

The surveyor performed a clinical record review on 7/23/19, in which the resident was documented as being transferred to the ER (emergency room) on 4/10/19 and again on 6/9/19. No documentation of a written notice was sent to the resident and resident's representative when the resident was transferred to the ER (emergency room) on 4/9/19 and 6/9/19 could be found in the clinical record.

On 7/24/19 at approximately 1:15 pm, the surveyor notified the director of nursing (DON) of the above documented findings. The DON stated, "We don't send a written notice to them when the resident is transferred to the ER. We do call the resident's POA (Power of Attorney) when they go to the ER."

No further information was provided to the surveyor prior to the exit conference on 7/24/19.
5. For Resident #160 the facility staff failed to notify the resident or resident representative in writing of the resident's transfer to an acute care facility.

Resident #160 was admitted to the facility on 10/31/2018 and readmitted on 06/04/19. Diagnoses included but were not limited to cancer, anemia, Parkinson's, cirrhosis, deep vein thrombosis, and atrial fibrillation.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/09/19 noted Resident #160 had a BIMS (brief interview

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for mental status) score of 4 out of 15. This MDS was documented as a "significant change in status assessment."

Resident #160's electronic clinical record and hard-back chart were reviewed on 07/22/2019 and 07/23/2019. Within the electronic clinical record under the nurse's notes tab, an LPN (licensed practical nurse) documented on 06/02/19 at 3:38 p.m. that Resident #160 "WAS ON THE FLOOR [sic] WENT INTO RESIDENT ROOM, HE WAS LYING ON HIS LEFT SIDE [sic] LACERATION NOTED TO FOREHEAD, LEFT EAR AND NOSE. LEFT EAR WAS ALSO PURPLE IN COLOR [sic] RESIDENT DENIES ANY PAIN AT THIS TIME [sic] SAID HE WAS TRYING TO GO TO THE BATHROOM [sic] CALL BELL WAS WITHIN REACH [sic] POA NOTIFIED [sic] SAID SHE WOULD CALLED [sic] HER MOTHER [sic] 911 CALLED [sic] MD FAXED [sic] NEURO- CHECKS STARTED. 911 ARRIVED AT 3:15 TO TRANSFER RESIDENT TO ER." There was no documentation indicating the resident and/or resident representative was notified in writing of the resident's transfer to an acute care hospital.

Resident #160 resided in a unit referred to as "1 South." The surveyor interviewed the Unit Coordinator of 1 South, an LPN (LPN #1) on 07/23/19 at 3:00 p.m. LPN #1 stated when a resident was transferred to an acute care facility, the practice was usually to notify the resident verbally and notify the resident representative by phone or verbally if they were present in person. LPN #1 stated she had never given a written notification about a transfer to family.

The survey team met with the facility's

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F 623	Continued From page 40 administrative team on 07/24/19 at 11:30 a.m. The administrative team consisted of the director of professional services, both regional directors of clinical services (Regional Director #1 and Regional Director #2), the administrator, corporate director of MDS, director of nursing, and the CEO (chief executive officer). The administrative team was informed of the concern there was no evidence the facility staff had notified Resident #160 or their representative in writing of the resident's transfer to an acute care facility. On 07/24/19 at 11:37 a.m., Regional Director #1 stated the facility staff had not been notifying residents or resident representatives in writing of transfers adding that the notification had been provided "only verbally." No further information was provided prior to exit.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a	F 625		9/7/19

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F 625	Continued From page 41 resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, family interview, and facility document review the facility staff failed to provide written information to the resident of the bed hold policy before transfer for 3 of 35 residents (Residents #30, #201 and #213). The findings included: 1. For Resident #30 the facility staff failed to offer a bed hold when the Resident was transferred to the hospital. Resident #30 was admitted to the facility on 10/03/08 and readmitted on 04/12/19. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, pneumonia, urinary tract infection, diabetes mellitus, Alzheimer's disease, depression, and psychotic disorder. The most recent MDS(minimum data set) with and ARD (assessment reference date) of 04/25/19 assigned the Resident a BIMS (brief interview for mental status) score of 6 out of 15 in section C, cognitive patterns. This is a significant change MDS.	F 625	F625 No action taken during the survey due to the timeframe had already passed for resident #30, #201 and #213. However, moving forward residents who are transferred out will be made aware of the bed hold notice. A 30 day look back was conducted to ensure resident who have been transferred out of the center was provided with the bed hold notice. Social Services department will be educated by the Regional Director of Clinical Services/designee on written documentation to the resident and/or responsible party on the bed hold policy/form when residents are transferred out to the hospital. The Director of Nursing/designee will review in clinical meeting 5x weekly to ensure the bed hold form has been signed	

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F 625	Continued From page 42 Resident #30's clinical record was reviewed on 07/22/19. The nurse's notes section of the clinical record contained a note, which read in part "4/9/2019 2:42:48 PM 1st Shift ...Notified Dr. ... (physician name omitted) via telephone of change in cond. T/O (telephone order) send to ER. Notified POA (power of attorney) via telephone. Called ... (name omitted) to transport. 02 stats 90. P/U (picked up) by ... (name omitted) at app. (approximately) 125 PM. Left via stretcher. Called ER gave report..." There was no documentation in the clinical record that a bed hold was offered. Surveyor spoke with the unit manager on 07/22/19 at approximately 9:25 AM regarding Resident #30. Surveyor asked the unit manager what information was sent when a Resident was transferred to the hospital and the unit manager stated, "We send a face sheet, med list, recent labs, communication sheet, progress note and bed hold information". Surveyor spoke with the DON (director of nursing) on 07/23/19 at approximately 2:20 PM regarding bed hold information sent with Resident when they are transferred. DON stated, "The nurses are supposed to offer a bed hold at the time of transfer". Surveyor spoke with the accounts receivable on 07/23/19 at approximately 3:15 pm regarding bed hold for Resident #30. The accounts receivable staff 1 stated that they get a list of residents transferred from the facility each day, so they can call the Resident/responsible party to see if they want a bed hold. The accounts receivable staff 1stated that a bed hold was not offered to Resident #30.	F 625	by the resident and/or the responsible party. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Director of Nursing will be responsible for implementation of the plan of correction.	

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The surveyor requested and was provided with a facility policy entitled "Bedhold Policy" which read in part, "It is the policy of ... (facility name omitted) to offer Resident who have been hospitalized an opportunity to return to the nursing home and keep their room...When a Resident is admitted to the hospital, licensed nursing staff will offer the Resident and/or their responsible party the opportunity to hold the bed. Nursing staff will complete the Bedhold Offer form and give a copy to the Business Office".

The concern of not offering a bed hold when the resident was transferred to the hospital was discussed with the administrative staff (administrator, chief executive officer, DoN, regional director of clinical services, director of professional services, and regional MDS coordinator) during a meeting on 07/24/19 at approximately 11:30 AM.

No further information was provided prior to exit.

2. For Resident #201 the facility staff failed to offer a bedhold when the resident was transferred to the hospital.

Resident #201 was admitted to the facility on 11/08/06 and readmitted on 03/13/19. Diagnoses include but not limited to deep venous thrombosis, urinary tract infection, aphasia, dementia, seizure disorder, anxiety and traumatic brain injury.

The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 06/18/19 indicated the resident has both long and

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short term memory loss with severely impaired cognitive skills for daily decision making.

Surveyor spoke with Resident #201's father/responsible party (RP) on 07/21/19 at approximately 04:30 PM. Surveyor asked the Resident's RP if the Resident had been hospitalized recently and the RP stated that he had. Surveyor then asked the Resident's RP if the facility had offered the resident a bed hold, and the RP stated that they had not. RP also stated, "They have never offered me a bed hold for him, but it's never been a problem for him to come back here. They always have a bed for him".

Resident #201's clinical record was reviewed on 07/22/19. The nurse's notes section of the clinical record contained a note, which read in part "3/9/2019 8:09 PM 2nd Shift "...new order send to ER for eval (evaluation) of seizures and vomiting. ... (name omitted) notified. ER notified spoke with ... (name omitted). Resp (responsible) party ... (name omitted) notified. 6:55 PM ... (name omitted) her and transporting to ER". There was no documentation in the clinical record that a bed hold was offered.

Surveyor spoke with the unit manager on 07/22/19 at approximately 9:25 AM regarding Resident #201. Surveyor asked the unit manager what information was sent when a Resident was transferred to the hospital and the unit manager stated, "We send face sheet, med list, recent labs, communication sheet, progress note and bed hold information".

Surveyor spoke with the DON (director of nursing) on 07/23/19 at approximately 2:20 PM regarding bed hold information sent with Resident

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when they are transferred. DON stated, "The nurses are supposed to offer a bed hold at the time of transfer".

Surveyor spoke with the accounts receivable staff 1 on 07/23/19 at approximately 3:15 pm regarding bed hold for Resident #201. The accounts receivable staff 1 stated that they get a list of residents transferred from the facility each day, so they can call the resident/responsible party to see if they want a bed hold. The accounts receivable staff stated that Resident #201 was transferred to the hospital over a weekend, and they did not get the list until the business office opened on Monday. Accounts receivable staff 1 stated that by the time she contacted Resident #201's RP "they had already packed up his room" and "He (Resident #201) didn't have enough money in his account to cover the bed hold anyway".

The surveyor requested and was provided with a facility policy entitled "Bedhold Policy" which read in part, "It is the policy of ... (facility name omitted) to offer Resident who have been hospitalized an opportunity to return to the nursing home and keep their room...When a Resident is admitted to the hospital, licensed nursing staff will offer the Resident and/or their responsible party the opportunity to hold the bed. Nursing staff will complete the Bedhold Offer form and give a copy to the Business Office".

The concern of not offering a bed hold when the Resident was transferred to the hospital was discussed with the administrative staff (administrator, chief executive officer, DoN, regional director of clinical services, director of professional services, and regional MDS

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coordinator) during a meeting on 07/24/19 at approximately 11:30 AM.

No further information was provided prior to exit.
3. The facility staff failed to provide written information regarding the bed hold policy to the resident or resident's representative when Resident #213 was transferred to the ER (emergency room) on 4/9/19 and 6/9/19.

Resident #213 was admitted to the facility on 6/14/19 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia and Schizophrenia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/20/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #213 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

The surveyor performed a clinical record review on 7/23/19, the surveyor noted the resident was transferred to the ER (emergency room) on 4/10/19 and again on 6/9/19. There was no documentation located in the clinical record of the written bed hold policy being provided to the resident or resident's representative on these dates of ER visits.

On 7/24/19 at approximately 1:15 pm, the surveyor notified the director of nursing (DON) of the above documented findings. The DoN stated, "We don't do this either. We keep the bed empty and let the resident come back to the facility. We haven't had any problems with doing this."

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F 625	Continued From page 47 No further information was provided to the surveyor prior to the exit conference on 7/24/19.	F 625		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review/revise a resident centered comprehensive care plan and /or develop an initial comprehensive care plan for	F 657	F657 Resident #213 care plan was revised to include resident center interventions for	9/7/19

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F 657	Continued From page 48 2 of 22 residents in the survey sample (Resident #213 and #13). The findings included: 1. The facility staff failed to review and revise the resident centered comprehensive care plan for Resident #213 regarding the resident's weight loss. Resident #213 was admitted to the facility on 6/14/19 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia and Schizophrenia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/20/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #213 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing. During the clinical record review, the surveyor noted the resident had the following weights documented in the clinical record: 2/18/19 233.20 3/31/19 227.60 5/20/19 220.80 6/24/19 199.80 The surveyor also reviewed the resident centered comprehensive care plan dated for 6/21/19 with a target date of 9/20/19. The problem identified read in part, "_____ (name of resident) is at nutritional risk for altered status due to being on a mechanical altered diet ...Weight is trending down." The following interventions were documented on the care plan:	F 657	resident□s weight loss. Resident #13 and his responsible party had a care plan meeting on 8/15/19.. A 30 day look back was conducted for residents with weight loss to ensure their care plan had been updated with interventions addressing the weight loss. In addition, the look back also ensured residents had a care conference completed involving the IDT and the resident and/or responsible party who was scheduled to have a care conference. Interdisciplinary team will be educated by the Director of Clinical Reimbursement/designee on care plan revisions and updating for weight loss. In addition, the education included the requirements for care plan meetings with the IDT team, residents and/or resident representative. The Director of Nursing/designee will monitor weekly care plan meetings with the IDT, resident and/or resident representative are occurring as required. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis . CAO/Director of Nursing will be responsible for implementation of the plan of correction.	

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F 657	Continued From page 49 " "Diet as Ordered " Documents % (percentage) eaten Q meals/snacks " Encourage to consume at least 75% of meals " Ensure adequate daily fluid intake ...via (by) meals, snacks, med pass (medication pass), etc. " Monitor for S/S (signs and symptoms) of dehydration " Obtain and honor food preferences " Offer substitutes for uneaten items " Report weight change of +/- (plus or minus) " Supervise meals and/or assist with PO's (oral) prn (as needed) " Supplements as ordered " Vitamins and minerals as ordered " Weight as ordered." The surveyor notified the DON (director of nursing) and the corporate MDS Coordinator of the above documented findings on 7/24/19 at approximately 1:20 pm. The DON stated, "The resident did have a G tube (feeding tube) back in July last year. He would pull it out and we sent him the to ER (emergency room) to have it put back in. He did this a couple of times and he didn't want it any more. Then we put him on an altered diet." The surveyor asked if there were any care plans other than the one that the surveyor was given. The DoN remained quiet and did not answer. The corporate MDS stated, "There's not one that was updated for this. I see where he was put on mighty shakes and then super pudding." No further information was provided to the surveyor prior to the exit conference on 7/24/19. 2. For Resident #13 the facility staff failed to have an initial care plan meeting and failed to include	F 657		

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all memebers of the interdisciiplinary team in the development of the care plan.

Resident #13 was admitted to the facility on 04/08/19. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, diabetes mellitus, dementia, Parkinson's disease, and hyperlipidemia.

The admission MDS (minimum data set) with an ARD (assessment reference date) of 04/10/19 assigned the Resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns.

Surveyor spoke with Resident #13 and her son on 07/21/19 at approximately 4:40 PM. Surveyor asked the Resident if she was invited and attended her care plan meetings. Resident deferred to her son, stating, "He takes care of those things". Resident's son stated that he was not aware that any care plan meeting had been held since the Resident's admission. Resident's son stated, "They haven't told me anything about care plan meetings since she's been here".

The care plan section of Resident #13's clinical record was reviewed and the surveyor could not locate any information regarding care plan meetings.

Surveyor spoke with the unit manager on 07/23/19 at approximately 12:40 PM. Unit manager stated, "We don't have care plan meetings for the initial care plan, but try to have one within the timeframe of the first quarterly MDS/care plan. She should be having one anytime now"

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F 657	Continued From page 51 Surveyor spoke with the MDS coordinator on 07/24/19 at approximately 10:15 AM regarding Resident #13. The MDS coordinator stated the Resident should have had a care plan meeting for the first comprehensive care plan. The MDS coordinator stated that she would look for information regarding this. The concern of not having an initial care plan meeting for Resident #13 was discussed with the administrative team (administrator, chief executive officer, regional director of clinical services, director of professional services, director of nursing, regional MDS coordinator) on 07/24/19 at approximately 11:30. The regional director of clinical services informed the surveyor on 07/24/19 at approximately 1:00 PM that an initial care plan meeting for Resident #13 was not held, but should have been. Surveyor requested and was provided with a facility policy entitled "Resident/Family Participation-Assessment/Care Plans" which read in part, "Each Resident and his/her family members are encouraged to participate in the development of the Resident's comprehensive assessment and care plan." and "2. Resident assessments are begun on the first day of admission and completed no later than the fourteenth (14th) day after admission. A Comprehensive Care Plan is developed within seven (7) days of completing the Resident assessment" No further information was provided prior to exit.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		9/7/19

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F 695	Continued From page 52 § 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, clinical record review, staff interview, and facility document review, the facility staff failed to ensure that a resident who needed respiratory care received oxygen as ordered by physician for 1 of 37 residents in the survey sample, Resident # 19. The findings included The facility staff failed to ensure that Resident # 19 received 2 liters of oxygen via nasal cannula as ordered by the physician. Resident # 19 was a 66-year-old-male that was originally admitted to the facility on 9/1/12, and had a readmission date of 7/3/19. Diagnoses included but were not limited to, urinary tract infection, urinary retention, acute kidney failure, and central pain syndrome. The clinical record for Resident # 19 was reviewed on 7/22/19 at 9:57 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/16/19. Section C of the MDS assesses cognitive patterns. In Section C0500,	F 695	F695 Resident #19 is receiving oxygen therapy as ordered by the physician. A review of Current residents in the center who have physician orders for oxygen therapy was completed to ensure the residents were receiving the oxygen as ordered. Clinical staff will be educated by the Regional Director of Clinical Services/designee on following physician orders for oxygen therapy. The Director of Nursing/designee will monitor residents requiring oxygen therapy 3x weekly to ensure they are receiving the oxygen therapy as per physician order. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be	

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the facility staff documented that Resident # 19 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 19 was cognitively intact.

The current plan of care for Resident # 19 was reviewed and revised on 7/15/19. The facility staff documented a problem area for Resident # 19 as, "Risk for respiratory distress r/t (related to) Resident # 19 was admitted to the hospital with one of his diagnoses being acute hypoxic respiratory failure and MRSA (methicillin-resistant staphyloccus aureus) pneumonia and left and right pleural effusion. Has oxygen ordered continuous but resident takes off at times. Self extubated himself in the hospital." Interventions included but were not limited to, "Administer medications as ordered. Monitor for any adverse reactions and notify the MD (medical doctor) as needed."

Resident # 19 had orders that included but was not limited to, "O2 (oxygen) 2 L (liters) vian nasal cannula continuous for SOB (shortness of breath)," which was initiated by the physician on 7/4/19.

On 7/22/19 at 9:37 am, the surveyor observed Resident # 19 in his room lying in bed. The surveyor observed that Resident # 19 was not wearing oxygen. The surveyor observed an oxygen concentrator in Resident # 19 's room. The oxygen concentrator was located at the foot of Resident # 19's bed. The oxygen concentrator was on was set at 2 liters. The nasal cannula was observed hanging over the concentrator by the surveyor.

On 7/22/19 at 10:13 am, the surveyor interviewed

conducted on a random basis.

CAO/Director of Nursing will be responsible for implementation of the plan of correction.

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F 695	Continued From page 54 LPN # 2 (licensed practical nurse). The surveyor and LPN # 2 went to Resident # 19's room and observed Resident # 19 lying in bed without oxygen and observed the nasal cannula hanging over the oxygen concentrator that was at the foot of Resident # 19's bed. The surveyor asked LPN # 2 if Resident # 19 should be wearing oxygen. LPN # 2 stated, "He does take his oxygen off from time to time." The surveyor asked LPN # 2 if Resident # 19 would physically be able to remove his nasal cannula and place the nasal cannula on the oxygen concentrator himself. LPN # 2 stated, "No, there is no excuse for that." The facility policy on "Oxygen Therapy" contained documentation that included but was not limited to, ..."Policy-Oxygen therapy is administered only as ordered by a physician or as an emerge measure per standing order. The physician's order will specify the rate of flow of oxygen." ... On 7/24/19 at 12:50 pm, the regional director of clinical services # 1, Regional director of clinical services # 2, chief executive officer, coorperate MDS nurse, director of professional services, director of nursing, and administrator were made aware of the findings as stated above. The surveyor asked the administrative team to provide any additional information if to clarify the issues as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/24/19.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		9/7/19

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F 698	Continued From page 55 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure that residents who required dialysis receive such services through the coordination of care with the contracting dialysis facility in regards to ongoing communication and timely administration of medications for 2 of 37 residents (Residents #111 and #83). The findings included: 1. For Resident #111, the facility and dialysis center used a communication record for ongoing communication. However, these communication forms were not consistently completed by the contracting dialysis facility and the facility failed to ensure timely medication administration in regards to two medications not consistently being administered when the Resident returned to the facility from dialysis. The clinical record review revealed that Resident #111 had been admitted to the facility 10/02/18. Diagnoses included, but were not limited to, end stage renal disease, diabetes, hypertension, and schizophrenia. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/23/19 included a BIMS (brief interview for mental status) summary score of 11 out of a	F 698	F698 No action taken during the survey due to timeframe had already passed. However, moving forward Resident #111 dialysis communication is being completed. Resident #111 and #83 medications times were changed per provider order to ensure medications were not missed due to the resident being out to dialysis. A 30 day look back was conducted for Current residents in the center who receive dialysis services to ensure the dialysis communication form was completed and medications times did not conflict with the resident being out of the center for dialysis. Licensed nurses will be educated by the Regional Director of Clinical Services/designee on the completion of the dialysis communication form to ensure coordinator of care with the contracting dialysis facility. In addition, education will include ensuring resident□s medication times do not interfere with their dialysis times. When this occurs licensed nurses will notify the physician or time changes on medications affected. The Director of Nursing/designee will	

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F 698	Continued From page 56 possible 15 points. Section O (special treatments, procedures, programs) was coded to indicate the Resident received dialysis. The resident's comprehensive care plan included the goals will not have any adverse effects from dialysis. Approaches included, but were not limited to, communication with dialysis on dialysis days and as needed. The resident's clinical record included physician's orders for the medications hydralazine 50 mg three times daily for hypertension and furosemide 80 mg twice daily at 6:00 a.m. and 2:00 p.m. for fluid retention. On 07/22/19 at 9:13 a.m., the surveyor asked the facility for the communication forms for this resident, LPN (licensed practical nurse) #3 provided the surveyor with forms dated 06/13/19-07/16/19. When reviewing these forms with LPN #3 it was noted that only the form dated 07/04/19 had been completed by the dialysis center. The dialysis center had documented the resident's pre and post weights and vital signs. After reviewing these forms with the surveyor, LPN #3 verbalized to the surveyor that sometimes the dialysis center did not fill out the forms. During the entrance conference, the team leader requested policies regarding dialysis services. The facility provided the contracts to the survey team. This contract read in part, "...Written Protocol...Facility will provide for the interchange of information useful or necessary for the care of the Designated Resident..." A review of the resident's 07/2019 MARs	F 698	monitor dialysis forms 3x weekly to ensure they are completed to ensure coordination of care with the contracting dialysis facility. In addition, medications administration records for dialysis residents will be reviewed 3x weekly to ensure medications are administered as ordered. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Director of Nursing will be responsible for implementation of the plan of correction.	

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(medication administration records) on 07/24/19 revealed that the facility nursing staff had circled the medications furosemide and hydralazine on 07/02, 07/09, 07/11, 07/13, 07/16, 07/18, 07/20, and 07/23 at 2:00 p.m.

During an interview with RN (registered nurse) #1 on 07/24/19 at 10:29 a.m., RN #1 verbalized to the surveyor that Resident #111 typically got back from dialysis between the hours of 2-4 p.m. and if he wasn't back prior to her leaving he would not receive his 2:00 p.m. medications.

The administrative staff to include, 2 regional directors of clinical services, chief executive officer, administrator, director of nursing, director of professional services, and corporate director of MDS's were notified of the issue regarding the resident's missing information regarding communication with the dialysis center on 07/22/19 at 3:20 p.m.

The issue regarding the resident's 2:00 p.m. medications were reviewed with the director of professional services, 2 regional directors of clinical services, regional director of MDS's, administrator, director of nursing, and chief executive officer on 07/24/19 at 11:30 a.m.

Prior to the exit conference the facility provided the surveyor with a copy of a physicians telephone order that read, "Change afternoon dose Lasix 80mg to 3pm and hydralazine 50 mg 2pm to 3pm on dialysis days."

No further information regarding these issues were provided to the survey team prior to the exit conference on 07/24/19.
2. Facility staff members failed to ensure

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Resident #83's medications were scheduled in a manner that would not result in missed doses due to the resident being out of the facility for dialysis treatments.

Resident #83 was admitted on 3/8/19. Resident #83's diagnoses included, but were not limited to: anemia, heart failure, hypertension, hyperlipidemia, and diabetes mellitus. Resident #83's 5/3/19 minimum data set (MDS) assessment indicated the resident was able to express ideas and wants, had clear speech, and was oriented to year/month/day. On 7/21/19 at approximately 11:45 a.m., Resident #83 reported he received dialysis during the afternoon three times a week, on Tuesdays, Thursdays, and Saturdays. Resident #83 reported he usually leaves the facility around noon to go to the dialysis facility on his scheduled dialysis days.

Review of Resident #83's July 2019 medication administration records (MARs) indicated medication doses of cardizem and/or hydralazine were not administered on 7/2/19, 7/13/19, 7/18/19, 7/20/19, and 7/23/19 due to the resident being at dialysis.

During an interview on 7/23/19 at 2:36 p.m., LPN (licensed practical nurse) #11 was asked if the possibility of changing medication times due to the residents's dialysis treatments had been discussed; LPN #11 stated she didn't think it has been addressed but reported she will check with the physician.

A copy of the following physician order was provided to the surveyor on 7/23/19 at 2:55 p.m.: "7/23/19 Give hydralazine 25 mg one (by mouth three times a day) and Cardizem 30 mg (by

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F 698	Continued From page 59 mouth) daily (three times a day) for hypertension - give medications at 6AM, 12PM before dialysis, and 7PM". The following information was found in a facility document titled "Routine Hours for Medication Administration Policy" (dated 12/26/2017): "Medications are to be administered within sixty (60) minutes of the scheduled time except before and after meal orders, which are administered precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility." On 7/24/19 at 11:30 a.m., the failure of the facility staff to schedule Resident 83's medications to ensure medications are administered before and/or after dialysis treatments (instead of the medications not being administered) was discussed for a final time during a survey team meeting with the facility's Regional Director of Clinical (RDCS), Corporate Clinical Registered Nurse, Corporate MDS (minimum data set) employee, Director of Professional Services (DPS), and Administrator.	F 698		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		9/7/19

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F 758	Continued From page 60 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that use of psychotropic drugs are not given unless the medication is necessary for 1 of 22 residents (Resident #126). The findings included: The facility staff failed to ensure that Resident #126 was free from receiving an unnecessary psychotropic medication, Ativan, was being given to the resident for anxiety. Resident #126 was admitted to the facility on 3/1/12 with the following diagnoses of, but not limited to anemia, urinary tract infection, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/28/19. The resident was coded as requiring extensive assistance of 1 staff member for dressing and being totally dependent on 1 staff member for bathing. During the clinical record review on 7/23 and 7/24/19, the surveyor noted that the resident was being given Ativan 1 mg (milligram) at bedtime for anxiety. The resident's MAR (medication administration record) for May, June and July 2019 was also reviewed. The resident had been administrated Ativan 1 mg at bedtime for anxiety for this time period. The surveyor reviewed the behavioral monitoring sheets for May, June and July 2019. There was no evidence of a specific targeted behavior that facility staff had been monitoring for except for	F 758	F758 Resident #126 behavioral monitoring sheet has listed specific targeted behaviors for the use of the ordered Ativan. A review of Current residents on psychotropic medications was completed to ensure each resident has specific target behaviors listed on the behavioral monitoring form. Licensed nurses will be educated by the Regional Director of Nursing/designee on ensuring residents on psychotropic medications have specific targeted behaviors listed for monitoring usage of the medications. The Director of Nursing/designee will monitor new orders for psychotropic medications during clinical meeting 5x weekly to ensure the behavioral monitoring form has listed specific targeted behaviors to be monitored. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Director of Nursing will be responsible for implementation of the plan of correction.	

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F 758	Continued From page 62 "Anxiety". The surveyor notified the administrative team of the above documented findings on 7/24/19 at approximately 11:00 am in the conference room. At approximately 1:20 pm, the surveyor met with the DON (director of nursing) and the corporate MDS nurse. The surveyor asked the DON to review these behavior monitoring sheets and show the surveyor the targeted behaviors that are specific to this one resident. The DON stated, "We monitor for anxiety." The surveyor asked the DON how did the resident act or signs the staff can say the resident exhibited when she was having anxiety. The DON stated, "We don't have them listed except for monitoring anxiety." No further information was provided to the surveyor prior to the exit conference on 7/24/19.	F 758		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by:	F 773		9/7/19

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F 773	Continued From page 63 Based on staff interview and clinical record review, the facility staff failed to promptly notify the ordering physician of laboratory results that fall outside of the clinical range for 1 of 22 residents in the survey sample (Resident #126). The findings included: The facility staff failed to promptly notify the ordering physician of the urine C&S (culture and sensitivity) results that fell outside of the clinical range for Resident #126. Resident #126 was admitted to the facility on 3/1/12 with the following diagnoses of, but not limited to anemia, urinary tract infection, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/28/19. The resident was coded as requiring extensive assistance of 1 staff member for dressing and being totally dependent on 1 staff member for bathing. During the clinical record review, the surveyor noted the physician had ordered a urine C&S on 4/23/19 for Resident #126. In this review, the surveyor noted that the facility staff obtained the Resident's urine for this laboratory test on 4/23/19 at 4:15 am. The date and time in which the contracting laboratory documented as the final report being completed was 4/26/19 at 8:03 am. On 7/23/19 at 1:30 pm, the surveyor asked LPN (licensed practical nurse) #1 when these lab results were received by the facility. LPN #1 stated, "I really don't know. The C&S was completed on 4/26/19." The surveyor asked LPN #1 what the process was for the staff notifying the	F 773	F773 No action taken during survey due to the timeframe had already passed. Provider was made aware of the late notification of the Urine C & S on 5/1/19 for Resident #126. New orders for antibiotic therapy. A 30 day look back was conducted for current residents in the center to ensure ordered labs was completed with timely notification to the provider. Nursing Leadership/licensed nurses will be educated by the Regional Director of Clinical Services/designee on implementation of a lab tracking log to ensure labs are received back into the center and abnormal results reported timely to the physician. The Unit Managers/designee will monitor the lab tracking log 5x weekly during clinical meeting to ensure labs are received back into the center and reported timely to the physician. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Director of Nursing will be responsible for implementation of the plan of correction.	

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F 773	Continued From page 64	F 773		

physician of lab results that fell outside of the normal range." The surveyor asked if she could show me documentation of when the facility received these results and then when the physician had been notified. LPN #1 stated, "I can't tell when we received these results. But the doctor has ordered an antibiotic on 5/1/19. So I would guess it was that day that we notified the doctor." The surveyor asked her why the doctor had not been notified before 5/1/19 since some of the lab results on this C&S were outside the normal range for the laboratory. LPN #1 replied, "This could had been sent to another floor and we didn't get it over here until 5/1."

F773 reads in part " ... §483.50(a)(2) The facility must- ...
(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges ..."

The surveyor notified the administrative team of the above documented findings on 7/24/19 at 11 am in the conference room.

At 1:30 pm, the corporate nurse #1 stated, "I have asked staff why the doctor had not been notified of the results. They stated that the facility probably the results went to another floor and did not research which unit the resident was on." The surveyor asked corporate nurse #1 if there was a check and balance process to make sure that the laboratory tests that were ordered and obtained get back to the facility and the physician is notified in a promptly manner if the results were outside of the clinical reference range. Corporate nurse #1 stated, "There was no process in place at that time."

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F 773	Continued From page 65 No further information was provided to the surveyor prior to the exit conference on 7/24/19.	F 773		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to have sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service in the facility. The findings included: The facility staff failed to have sufficient staff to safetly and effectively carry out the functions of the food and nutrition service by not reporting to	F 802	F802 The freezer temps are now within the expected range. Echo Lab fixed the dishwasher by hooking the sanitizer thru the dishwasher's rinse cycle so the dishwasher functions as a low temp dishwasher to sanitize. A new Pest Control company was brought	9/7/19

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F 802	Continued From page 66 management the freezer temperatures that were outside of the safety range, the continued observations made by staff regarding cockroaches in the kitchen and the temperature of the dishwasher not rising to 180 degrees (F) (Fahrenheit) while the machine was rinsing. On 7/21/19 at 11:00 am, the surveyor observed the walk in temperature on the outside of the freezer being 22 degrees (F). The inside of the freezer the thermometer read -10 degrees (F). The surveyor requested and received the freezer log temperatures for the month of July 2019. There were 5 days that the freezer temperatures ranged from 21 degrees (F) to 27 degrees (F). The food service director stated to the surveyor that "the kitchen staff was instructed to take the freezer temperatures from the inside thermometer of the freezer and not to use the outside temperature because that one is broken." The surveyor then asked the food service director if the kitchen staff reported the temperatures that they documented on the log that was outside of the acceptable range for the freezer. She replied, "No, they did not and I didn't realize that they were doing this. There is a new freezer ordered but I don't know the delivery date." At 12:30 pm, the surveyor interviewed dietary aide #1 and asked if they were responsible for obtaining freezer temperatures for a day, what action would they take if the freezer temperature were outside of the acceptable range temperature. Dietary aide stated, "If they were too high, right now I wouldn't do anything because they have told us that we were getting a new freezer. I know whenever we have told someone in the past about something that was wrong in the kitchen they would tell us they don't have the	F 802	into the center. A treatment to the entire building was completed along with fogging x2 for the kitchen on two separate days. The company is currently coming into the center weekly for treatment and looking at the pest control logs for areas that might require additional attention. Current residents in the center have he potential to be affected. Dietary staff will educate by the Regional Director of Clinical Services/designee on the management of the freezer temps and dishwasher temps and to notify the Dietary Manager immediately when temps fall outside the expected range. In addition, education included reporting areas where roaches are sited and recording areas where roaches are seem in the pest control log. The Dietary Manager/designee will monitor freezer temps, dishwasher temps and the pest control log 5x weekly to ensure compliance with temps and pest control in the kitchen. Any discrepancies with the freezer or the dishwasher temps will be reported immediately to the CAO (Chief Administrative Officer). The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Dietary Manager will be responsible	

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F 802	Continued From page 67 money to get a new one." The surveyor also asked dietary aide #1 if they were running the dishwasher for the day what temperature should the dishwasher get up to during the rinse cycle for the plates, pans, etc. to be sanitized properly. The aide stated, "It's supposed to be 180 degrees but sometimes it doesn't. I just keep working trying to get my job done." The surveyor asked if this was reported to management. He replied, "I didn't. The only answer we get is we don't have the money. Sometimes it takes them 2 days longer before we are get our pay checks." The surveyor interviewed dietary aide #2 and asked the same above documented findings. Dietary aide #2 stated, " The surveyor notified the food services director of the above documented findings at 1 pm. She stated, "If they don't report things to me, I don't know about it. We are going to have to give them an in service on the expectations of reporting things to me if they are not working right." At 4:30 pm, the CEO (chief executive officer) was notified by the surveyor of the above documented findings. The CEO stated, "We will get right on this." On 7/22/19 at 9 am, regional clinical nurse #1 came to the surveyor and stated, "We in serviced all the kitchen staff that was working last night on when to report temperatures of the freezer immediately to the food service director as soon as it is noted that the freezer temperatures are higher than 0 degrees or if there are any problems with items not working properly. We will in service the rest of the staff as they come to work."	F 802	for implementation of the plan of correction.	

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F 802	Continued From page 68 No further information was provided to the surveyor prior to the exit conference on 7/24/19.	F 802		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review, the facility staff failed to ensure the Residents individual menu was followed, the Resident did not receive milk with his breakfast tray, for 1 of 37 residents,	F 803	F803 Resident #111 is currently receiving milk on his breakfast tray.	9/7/19

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F 803	Continued From page 69 Resident #111. The findings included: The facility staff failed to provide the resident with milk for breakfast on 07/23/19. The resident had rice krispies for breakfast. The clinical record included an order for milk at breakfast. The clinical record review revealed that Resident #111 had been admitted to the facility 10/02/18. Diagnoses included, but were not limited to, end stage renal disease, diabetes, hypertension, and schizophrenia. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/23/19 included a BIMS (brief interview for mental status) summary score of 11 out of a possible 15 points. Section O (special treatments, procedures, programs) was coded to indicate the Resident received dialysis. The resident's comprehensive care plan included the goals will not have any adverse effects from dialysis. Approaches included, but were not limited to, communication with dialysis on dialysis days and as needed and maintain recommended dietary and fluids restrictions if ordered. The resident's current physician orders included the diet order 1 milk at breakfast only. On 07/22/19 at 8:33 a.m., the surveyor observed Resident #111 at the breakfast meal. Resident #111's food tray included, but was not limited to, coffee, orange juice, water, and rice krispies. The Resident did not have any milk on his food tray.	F 803	A review of current residents in the center was conducted to ensure residents individual menu was being followed. Licensed staff will be educated by the Regional Director of Clinical Services/designee on the process for transcribing and communicating to the dietary department, physician orders that include new dietary orders. The Director of Nursing/designee will 5x weekly during clinical meeting review new dietary orders to ensure the communication slip was send to the dietary department. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Director of Nursing will be responsible for implementation of the plan of correction.	

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F 803	Continued From page 70 Resident #111 verbalized to the surveyor that he would have eaten his cereal if he had milk to put on his cereal. The Residents diet card that accompanied the Residents food tray revealed that Resident #111 should have been served 8 ounces of skim milk at breakfast. On 07/23/19 at 7:20 a.m., LPN (licensed practical nurse) #1 verbalized to the surveyor that Resident #111 did get milk on 07/22/19 but it was after breakfast. On 07/22/19 at 3:20 p.m., during a meeting with the regional directors of clinical services (staff #1 and #2), chief executive officer, administrator, director of nursing, director of professional services, and the corporate director of MDS's these staff were notified of the issue regarding Resident #111 not receiving his milk for breakfast. The administrator verbalized to the survey team that they did have one crate of outdated milk but they should have had milk to serve. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 803		
F 812 SS=F	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.	F 812		9/7/19

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F 812	Continued From page 71 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility staff failed to store, prepare, distribute and serve food by maintain the facility's kitchen and equipment in a sanitary manner and failed to store food properly in the walk in refrigerator. The facility staff also failed to keep the refrigerator in the pantry on 1 of 3 units free of food and liquid debris. (Unit 1 South) The findings included: 1. The facility staff failed to maintain the kitchen and equipment in a sanitary manner as evidenced by a mop bucket noted with black old dirty water in the storage room, pans nesting after they had been washed and cannot air dry appropriately, and Café food in walk in refrigerator was noted to have dates but these foods had expired and was not discarded appropriately. On 7/21/19 at 11:30 am, the surveyor was accompanied by the food services director went into the walk in refrigerator. In the refrigerator, the surveyor observed a cart of food sitting on a rolling cart in the back. The food that were on the cart had the following documented on them:	F 812	F812 The mop bucket with dirty water was immediately removed from the kitchen. The outdated food for the Café cart in the walk in refrigerator was immediately discarded. The wet pans were rewashed and stored to air dry and not nested together. The resident refrigerator in the pantry on 1 south was cleaned. Temperature of the refrigerator is now within normal range. A thermometer was placed in the freezer section of the refrigerator. Current residents in the center have the potential to be affected. The Dietary staff will be educated on maintaining the facility's kitchen and equipment in a sanitary manner, discarding of outdated food and ensuring the refrigerators in the pantry on the units are kept clean. In addition, education will	

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F 812	Continued From page 72 " Cheese with a date of 7/20 " Lettuce with a date of 7/20 " Rice with a date of 7/18 " Bacon with a date of 7/20 " Tomatoes and green peppers were dark brown in color wrapped up in clear plastic wrap with no dates on them The surveyor asked the food services director what these foods were used for. She stated, "This is the food that we serve our employees in the Café. The aide that works in there only works Monday thru Thursday. She should discard any food that she has used in the Café on Thursday so it doesn't sit in here over the weekend and goes beyond the date she has on it." At 11:35, the surveyor observed at the 3-sink compartment there was a shelving unit with pans on the shelves. There were 18 pans on the 2nd shelf and they were nested in each other where the pans could not be properly air-dried. The food services director stated, "I thought those pans were not drying properly, they have to have space between them to air dry." AT 11:40 am, the surveyor observed another shelving room outside of the dish room on the right hand side. It was noted that when the surveyor picked up 4 pans on the 2nd shelf, the pans were still wet and they were nested inside with each other. The food services director stated, "I will get the aide to rewash these and dry appropriately." At 11:50 am, the surveyor observed a mop bucket in the kitchen storage room that had water in it. The water was noted to be old black water in appearance. The food services director stated, "I don't know how long that has been in here but I	F 812	also include ensuring temperatures of the refrigerators and freezers are within normal range. The Dietary Manager/designee will monitor the sanitation of the kitchen including discarding outdated foods, and ensuring temps of the refrigerators/freezers are within normal range 5x weekly. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Dietary Manager will be responsible for implementation of the plan of correction.	

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F 812	Continued From page 73	F 812		

will get this emptied and the mop bucket cleaned."

The surveyor requested the facility's policy on the above documented findings. The food services director stated she would get these and bring them to the conference room.

On 7/23/19 at 2 pm, the surveyor informed the director of professional services of the above request of the facility's policy on 7/21/19. The surveyor did not receive the requested policies.

At 3:30 pm, the surveyor notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 7/24/19.
2. The Resident refrigerator in the pantry on 1 south was observed to have a dried brown substance in the bottom of the refrigerator. The top shelf of the refrigerator was wet and sticky with an unknown substance. Both thermometers in the refrigerator read 50 degrees. There was no thermometer in the freezer.

On 07/21/19 at 3:20 p.m., the surveyor checked the Resident refrigerator in the pantry on 1 south. This refrigerator contained 2 thermometers. Both of these thermometers read 50 degrees. LPN (licensed practical nurse) #2 verified these temperatures. The surveyor observed a brown stain on the bottom shelf of the refrigerator the top shelf was observed to be wet and sticky with an unknown substance. The freezer did not contain a thermometer and included 1 container of single serve ice cream and a Styrofoam cup with a lid and straw. LPN #1 stated housekeeping

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F 812	Continued From page 74 was supposed to clean the refrigerator but she could clean up the spills. On 07/22/19 at 3:20 p.m., during a meeting with the regional directors of clinical services (staff #1 and #2), chief executive officer, administrator, director of nursing, director of professional services, and the corporate director of MDS's these staff were notified of the issues in the Residents refrigerator in the pantry on 1 south. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 812		
F 814 SS=D	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 and staff interview, the facility staff failed to ensure that garbage and refuse was dispose of properly for the the area outside of the facility kitchen's dish room and was free of debris and foul odors. The findings included: The facility staff failed to ensure the area outside of the kitchen's dish room was free of debris and foul odors and failed to ensure sanitary conditions as to prevent the harborage and feeding of pests. The surveyor went into the kitchen to inspect it on 7/21/19 at 11:00 am. The surveyor observed dark colored water that had a foul odor standing outside of the kitchen's dish room on the floor,	F 814	F814 Area outside the kitchen's dish room was immediately cleaned as well as the dark water with the foul odor standing at the loading dock which was coming from the backed up drain in the kitchen (which was repaired). Current residents in the center have the potential to be affected. The Dietary staff will be educated by the Regional Director of Clinical Services/designee on ensuring the outside area of the loading dock is kept clean with debris picked up and discarded	9/7/19

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F 814	Continued From page 75 which is part of the loading dock. There were also clear plastic wrappers from food and cigarette butts noted in this area. The food service director was with surveyor when this observation was made. The food service director stated, "I didn't know that the water was like this out here." The surveyor asked if the plastic wrappers from food, cigarettes butts and water that was dark in color with a notable foul odor supposed to be out here like we had observed. The director stated, "No, this should be clean at all times. This is the door we use if we have to go out to the refrigerated truck to bring food back into the kitchen." The surveyor then asked who is responsible to keep this area clean and she stated, "I would think its housekeeping." The surveyor requested a copy of the facility's policy about keeping all areas of the kitchen including the loading dock clean from debris and in sanitary condition. The CEO (Cheif Executive Officer) went back into the kitchen so that the surveyor could show him what issues/concerns this surveyor had during the initial tour at 11:00 am. The CEO was shown the issues/concerns as documented above. The CEO stated, "We will get these issues corrected." On 7/22/19 at approximately 9:30 am, the regional maintenance director accompanied the surveyor to the kitchen to observe the above documented findings. The surveyor did observe the kitchen was cleaner in appearance and the clear plastic food wrappers outside the dish room had been removed. However, the dark brown water with a foul odor was still present. The regional maintenance director stated, "I will investigate to see where this water is coming	F 814	of properly. In addition, the drain in the dish room must be functional at all times and if problems occur they must be reported immediately to the CAO (Chief Administrative Officer). The Dietary Manager/designee will monitor the area outside of the dish room at the loading dock to ensure it is kept clean and debris discarded. In addition, the Dietary Manager will monitor the drain in the dish room to ensure it is functional 5x weekly. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Dietary Manager will be responsible for implementation of the plan of correction.	

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F 814	Continued From page 76 from and have it repaired." The surveyor again requested a copy of the kitchen's policy previously requested on 7/23/19 at 11:00 am. This surveyor did not receive these policies as requested. At 11:00 am, the environmental services director accompanied the surveyor and he was notified and shown the above documented concerns that the surveyor had observed on 7/22/19 during initial tour of the kitchen. The surveyor asked who was responsible for keeping the area outside the dish room clean from debris and in a sanitary manner. He stated, "I think it would be the kitchen staff, but that's just a guess. I don't feel that the housekeeping department is responsible for this area." No further information was provided to the surveyor prior to the exit conference on 7/24/19	F 814		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an	F 849		9/7/19

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LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services

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provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

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F 849	Continued From page 79 §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient.	F 849		

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F 849	Continued From page 80 (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined the facility staff failed to provide the hospice's responsibilities for determining the appropriate hospice plan of care and the services the LTC facility will continue to provide based on each resident's plan of care for 3 of 37 sampled residents (Residents # 210, 25, and 19). Findings: 1. Facility staff failed to maintain the contractually agreed upon hospice plan of care for Resident #210. The resident's clinical record was reviewed	F 849	F849 Hospice care plans for residents #210, #25, and #19 are in place in the residents medical record. Unit Managers will ensure moving forward Hospice care plans are in place on the medical record. A review of Current residents on Hospice was conducted to ensure a copy of their hospice care plan was in their medical record.	

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F 849	Continued From page 81 for hospice information on 7/22/19 at 11:37 AM. The resident was admitted to the facility on 6/28/19. Her admission diagnoses included a stroke, traumatic brain dysfunction, traumatic spinal cord dysfunction, dementia and anxiety. The latest MDS (minimum data set) dated 7/5/2019 coded the resident with slight cognitive impairment. She required the assistance of facility staff for all the ADLS (activities of daily living). Resident #210's CCP (comprehensive care plan) completed on 7/13/19 documented the resident was placed on hospice care on 7/13/19. The document did not address the division of services or communication between the facility and hospice staff. Resident #210's physician's orders document the resident was admitted to hospice services on 7/12/19. The physician signed and dated the order on 7/15/19. The clinical record had a tab for the hospice plan of care, but the section was empty. LPN I, who was the unit coordinator, reviewed the record and said she would call the hospice service and obtain one for the record. On 7/22/19 at 11:37 AM the surveyor interviewed LPN I about the division of services provided by the facility staff and the hospice staff. She said they came in three times a week did "what we need them to do". LPN described that as feeding, and bathing, etc., but didn't know what the actual division of services was because the hospice service had not provided a care plan.	F 849	Nursing Leadership will be educated by the Regional Director of Clinical Services/designee regarding ensuring the facility has a current plan of care for each resident on Hospice services in their medical record. The Director of Nursing/designee will monitor new residents on Hospice services to ensure the current plan of care is in the medical record 5x weekly. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Director of Nursing will be responsible for implementation of the plan of correction.	

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LPN I contacted the hospice service at that time to inquire about the hospice care plans. She informed the surveyor the hospice representative told her they had gotten behind, but would fax the plan to her as soon as it was completed. LPN I delivered the faxed document to the surveyor that afternoon.

On 7/22/19 at 2:32 PM RN I (the corporate MDS coordinator) was interviewed about the care plans not on the records. She stated, "They (hospice) should have that POC (plan of care) to us within 24 hours of the admission to hospice. That's on them."

The facility had a contractual agreement with the hospice service signed and dated on 5/21/15 by a representative of both parties. The agreement contained, in part ".....Hospice Plan of Care established and maintained in consultation with Facility representatives. All hospice care must be be provided in accordance with the Hospice Plan of Care.....Provision of services from the Hospice to the Facility to include: Plan of Care, election form, advance directives, certification and refortification of terminal illness, names and contact of Hospice personnel, instructions for access of Hospice 24 hour on-call system, Hospice medication information, Hospice and attending physician orders.

The facility Hospice Care and Services policy was reviewed. It contained in part: ".....The Nurse, Facility and Hospice are responsible for performing each of their respective functions that have been agreed upon and included in the plan of care. The coordinated plan of care must identify the care and services the Facility and Hospice will provide in order to be responsive to

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the unique needs of the resident....."

On 7/24/19 at 11:35 AM these findings were shared with the facility administrator and the DON. There was no additional information provided prior to exit.

2. Facility staff failed to maintain the contractually agreed upon hospice plan of care for Resident #25. The resident's clinical record was reviewed for hospice information on 7/22/19 at 11:37 AM.

Resident #25 was admitted to the facility on 2/17/13. Her diagnoses included hypertension, peripheral vascular disease, cardiovascular accident, dementia, hemiplegia, anxiety, depression, psychotic disorder and chronic obstructive pulmonary disorder.

The latest MDS assessment, dated 4/3/2019, coded the resident with significant cognitive impairment. She was fully dependent on at least on staff member for all ADLs.

Resident #25's CCP, reviewed and revised on 6/17/19, documented the resident's admission to hospice care. It did not contain information for communication or the division of services between the facility and hospice staff.

Resident #25 had a physician's order for her admission to hospice services on 6/28/19. The physician signed and dated the order on 6/29/19.

The clinical record had a tab for the hospice plan of care, but the section was empty. LPN I, who was the unit coordinator, reviewed the record and said she would call the hospice service and

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obtain one for the record.

On 7/22/19 at 11:37 AM the surveyor interviewed LPN I about the division of services provided by the facility staff and the hospice staff. She said they came in three times a week did "what we need them to do". LPN described that as feeding, and bathing, etc., but didn't know what the actual division of services was because the hospice service had not provided a care plan.

LPN I contacted the hospice service at that time to inquire about the hospice care plans. She informed the surveyor the hospice representative told her they had gotten behind, but would fax Resident #25's hospice care plan over immediately. LPN I delivered the faxed document to the surveyor on 7/22/19 at 11:57 AM.

On 7/22/19 at 2:32 PM RN I (the corporate MDS coordinator) was interviewed about the care plans not on the records. She stated, "They (hospice) should have that POC (plan of care) to us within 24 hours of the admission to hospice. That's on them."

The facility had a contractual agreement with the hospice service signed and dated on 5/21/15 by a representative of both parties. The agreement contained, in part ".....Hospice Plan of Care established and maintained in consultation with Facility representatives. All hospice care must be be provided in accordance with the Hospice Plan of Care.....Provision of services from the Hospice to the Facility to include: Plan of Care, election form, advance directives, certification and refortification of terminal illness, names and contact of Hospice personnel, instructions for access of Hospice 24 hour on-call system,

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Hospice medication information, Hospice and attending physician orders.

The facility Hospice Care and Services policy was reviewed. It contained in part: "......The Nurse, Facility and Hospice are responsible for performing each of their respective functions that have been agreed upon and included in the plan of care. The coordinated plan of care must identify the care and services the Facility and Hospice will provide in order to be responsive to the unique needs of the resident....."

On 7/24/19 at 11:35 AM these findings were shared with the facility administrator and the DON. There was no additional information provided prior to exit.

3. The facility staff failed to ensure that the hospice provider included a hospice plan of care in the clinical record for Resident # 19.

Resident # 19 was a 66-year-old-male that was originally admitted to the facility on 9/1/12, and had a readmission date of 7/3/19. Diagnoses included but were not limited to, urinary tract infection, urinary retention, acute kidney failure, and central pain syndrome.

The clinical record for Resident # 19 was reviewed on 7/22/19 at 9:57 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/16/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 19 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 19 was cognitively intact.

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Resident # 19 had current orders that included but were not limited to, "Hospice care," which was initiated by the physician on 7/4/19.

On 7/23/19 at 9:21 am, the surveyor reviewed the entire clinical record for Resident # 19 and did not locate a hospice plan of care that had been developed by the hospice provider.

On 7/23/19 at 9:27 am, the surveyor spoke with LPN (licensed practical nurse) unit manager # 1 and informed her that the hospice plan of care that was to be developed by the hospice provided for Resident # 19 was not located in Resident # 19's clinical record. LPN unit manager # 1 reviewed Resident # 19's clinical record in the presence of the surveyor and agreed that the hospice provider did not include their hospice plan of care in Resident # 19's clinical record.

The facility policy on "Hospice Care and Services," contained documentation that included but was not limited to ..."The hospice must designate a registered nurse from the hospice organization to coordinate the implementation of the plan of care." ...

On 7/24/19 at 11:31 am, the surveyor informed the administrative team which consisted of the regional director of clinical services # 1, corporate MDS consultant, regional director of clinical services # 2, chief executive officer, director of professional services, director of nursing, and administrator that Resident # 19 did not have a hospice plan of care that had been developed by the hospice provider in the clinical record. The surveyor asked the administrative team how long the hospice provider had to develop the hospice

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F 849	Continued From page 87 plan of care and include it in Resident # 19's clinical record. The regional director of clinical services # 1 stated, "We will check and see." On 7/24/19 at 12:50 pm, the director of professional services informed the surveyor that the hospice provider had been contacted, and that the hospice nurse had informed him that the hospice provider had 14 days from the date of admission to ensure the care plan was developed and in the clinical record. The director of professional services stated, "We are out of compliance because 14 days has already passed since he was admitted to hospice on July 4th." No further information regarding this issue was provided to the survey team prior to the exit conference on 7/24/19.	F 849		
F 880 SS=F	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,	F 880		9/7/19

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F 880	Continued From page 88 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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.	F 880		

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F 880	Continued From page 89 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to 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 in (1) the laundry department and in (2) the bio-hazardous containment area. Findings: 1. The facility staff failed to 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 in the laundry department. On 7/23/19 at 3:15 PM the laundry area was reviewed to determine compliance with infection control measures. On 7/23/19 at 3:15 PM the surveyor observed one of the drums containing chemicals leading to the washing machines was empty. The container label described the contents as "concentrated chlorinated bleach". The container was the only one of it's kind found in the laundry room and was designed to be hooked to the chemical washer	F 880	F880 The appropriate concentrated bleach concentrate was connected to the washer for disinfectant of laundry. Linens on the shelf was rewashed during the survey using the appropriate laundry disinfectant. Biohazard room was cleaned and the leaking box was repacked and the plastic bag leaking was placed inside a new box during the survey. The Bio-hazard room is to be kept locked. Maintenance Department will be responsible for the oversite/security of the Biohazard room. Current residents in the center have the potential to be affected. The Laundry supervisor will be educated by the Regional Director of Maintenance/designee on ensuring the laundry department has the appropriate laundry cleaning solutions. The Maintenance department will be educated by the Regional Director of	

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F 880	Continued From page 90 mix by the (name of the company) who installed it. The bleach label described the action as a "laundry disinfectant". The bleach drum was observed to be uncapped and not hooked into the chemical mix serving the row of washers. The container did contain just a small amount of liquid in the barrel when it was tipped over to visualize the contents. On 7/23/19 at 3:17 PM LW I (laundry worker I) was interviewed about the empty container. He said it had been empty for several days and he thought he had used it all on Sunday (7/21/19). He remembered they "worked a lot that day". LW I said he had not reported the empty drum because the LS (laundry supervisor) generally monitored the contents of the chemical mix running to the machines. LW I told the surveyor they were using the powdered bleach in a box across the room to disinfect the laundry. "We use 1/2 a cup of the color safe bleach per washerload." LW I had no written information on the colorfast bleach or documentation of directions for use, but assured the surveyor the laundry was being disinfected by that product. The box in the corner contained a white powder. The name on the box was Royal Brite Plus and the contents were described as a color safe bleach. There were no directions for use of this product in the industrial size washers. There was no documentation that it was a disinfectant used to sanitize infectious laundry items. On 7/23/19 at 3:19 PM LW II was asked about the empty bleach drum. Said she did not know	F 880	Maintenance/designee on ensuring the bio hazard room is secured, clean and no leakage from bio hazard boxes. The CAO/designee will monitor the laundry cleaning solution 3x weekly to ensure there is sufficient cleaning solutions in laundry. In addition, the CAO/designee will also monitor the biohazard room to ensure the room is secured and biohazard boxes are intact. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Director of Environmental Services/Director of Maintenance will be responsible for implementation of the plan of correction.	

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how long it had been empty and she never used the color safe powder in the box because she'd been told not to touch it. She told the surveyor the ED (environmental director and the LS (laundry supervisor) told her to not to touch it, and she followed their instructions.

Both LW I and II told the surveyor they had been running the washers continuously over the past few days and the biohazardous laundry was being treated the same as the regular laundry. It was all being processed without the (aforementioned company) authorized sanitizer.

This issue was reported immediately to the RDCS (Corporate regional director of clinical services). She stated, "We'll have bleach in 30 minutes".

On 7/23/19 at 3:35 PM the RDCS reported she had sent the ED out to obtain some sanitizer from another facility. She told the survey team the powdered bleach was not for use in the industrial sized machines and the staff had no idea how much to use for the larger machines.

The RDCS said they had pulled all the linens and clothing that had been washed in their laundry that day and were were going to re-wash it when the appropriate chemical were supplied. The RDCS also said she was getting in touch with the company that supplied the chemicals to determine what chemical mix was appropriate for the machines because there was no documentation in the facility pertaining to that.

On 7/24/19 at 9:18 AM the ED was interviewed. He said he had obtained a five gallon drum of bleach concentrate yesterday and had hooked it up when he brought it into the facility. He said he

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thought they had been out of liquid bleach for about three days and said a full cup of the powdered color safe bleach was supposed to be used for each of the 80 gallon industrial sized washers and he thought the laundry staff were doing that per his direction. He said he had nothing in writing from the company supplying the chemicals about using the powdered bleach but did say the company rep (representative) told him to use 1 full cup.

The ED stated, "I have a plan for the future. It's my responsibility to monitor daily and check the fluid level on Friday and I can call the company rep (Name of rep) and he'll bring it right on over. The ED said the LS usually called him and let him know when the chemicals were low so he could reorder them.

The ED further clarified the LWs did not have to concern themselves with the appropriate chemical mix going into the washers. He said it was a computerized and all they had to do was select the appropriate cycle and the computer mixed the chemicals for the laundry.

On 7/24/19 at 10:05 AM the (name of company representative) Rep was introduced to the surveyor by the facility administrator, who stayed for the interview. The Rep said he could not supply any written documentation to anyone about his products used in the machines as it was a company secret.

He told the surveyor the powdered bleach in the laundry was called Royal Brite Plus and it was to be used for heavily stained items in the smaller personal laundry machine. It was to be measured out by 8, 12 or 16 ounces in the measuring cup to

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remove stains.

He stated, "Royal Brite Plus is just for stain removal. It does not sanitize laundry". The Rep denied telling the ED or laundry staff to use the product as a disinfectant. The rep further stated, "Those industrial machines range from a 65 pound loader to a 100 pound loader. They different sizes and the chemical mix is calculated by the computer hooked up to the barrels containing detergent, softener and disinfectant. Nothing is measured by the gallons of water going into the machine."

The facility policy for infection control was reviewed. It did not have the facility name or a date of any kind for implementation or reviews. The documentation did address "Linen and Laundry". It stated, in part....."Although soiled linen may be contaminated with pathogenic organisms, the risk of disease transmission is negligible if it is handled, transported and laundered in a manner that avoids transfer of microorganisms to patients, personnel, and environments. Rather than rigid rules and regulations, hygienic and common sense storage and processing of clean and soiled linen are recommended. The methods for handling, transporting, and laundering of soiled linen are determined by hospital policy and any applicable regulations....."

This information was shared with the administrator and DON on 7/24/19 at 11:45 AM. No additional information was supplied by the facility staff.

2. The facility staff failed to help prevent the development and transmission of communicable diseases in the Bio Hazard storage area.

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The food service director accompanied this surveyor on the initial tour of the kitchen and the loading dock area on 7/21/19 at 11:00 am. The surveyor observed outside of the dish room door food wrappers and dark colored fouled smelling water. The surveyor then proceeded around the corner of the loading dock and observed a Bio Hazard room that had a bright red Bio Hazard sign, which stated, "Authorized personnel only". The surveyor was able to open the door and observed 18 Bio Hazard boxes stored in this room. In the very back of the storage room, it was noted that one of these boxes was wet with fluid leaking from the box. The surveyor asked the food service director if the door was to be locked and who was responsible for items in this room. She stated, "I really don't know but I will find out for you."

At 4:30 pm, the CEO of the receiving company accompanied the surveyor and observed the findings as documented above. The CEO stated, "I will check on who is responsible for this storage area and when the last pickup from the Bio Hazard contract company was."

On 7/23/19 at 9:30 am, the regional maintenance director, environmental services director went along with the surveyor to observe the issues/concerns of the above documented findings. The door to the Bio Hazard storage room was locked when we attempted to go in the room. The environmental services director unlocked the room and we went inside. There were 19 Bio Hazard boxes in the room today with no wetness from leakage of what a Bio Hazard box had in it. The surveyor commented on this and the environmental services director stated,

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F 880	Continued From page 95 "We came out here last night and cleaned. The box was leaking from the liquid stuff in the plastic bag that was placed in the box. So I had to repack that box and put the plastic bag into a new box." The regional maintenance director stated, "There is a better system that we use in our other buildings and we will implement that process in this building. Then you don't have to worry about a box leaking." At approximately 11 am, the surveyor asked director of professional services for a policy in regards what the facility deems as Bio Hazard waste and appropriate storage for these items. On 7/24/19 at 9:00 am, the surveyor requested the policy again from the director of professional services. No further information or requested policies were provided to the surveyor prior to the exit conference on 7/24/19.	F 880		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to maintain equipment in a safe operating condition in the facility kitchen. The findings included: The facility failed to maintain the walk in refrigerator #1 and #2, walk in freezer, free	F 908	F908 1) Refrigeration Company completed repairs on refrigerator #1. 2) Refrigeration #2 is not working-reason for the refrigerator truck (new walk in refrigerator/freezer has been ordered)-no food items at all is placed in Refrigerator	9/7/19

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F 908	Continued From page 96 standing stove, top compartment of double oven, clogged drains in the dish room that has free standing water covering 75% of the dish room floor and the garbage disposal did not work located under the 3 sink compartment. In addition, the dishwasher did not obtain a rinsing temperature of 180 degrees. All of these identified pieces of equipment concerns were in the facility's kitchen. The dietary manager accompanied the surveyor in the kitchen for the initial tour on 7/21/19 at 11:00 am. The surveyor went into the dish room and had the following observations with concerns/issues: 1. The walk in refrigerator #1 had been not working until a part was replaced in it a week ago. This information was obtain from the food services director. She also stated, "That's why we have had a refrigerator truck sitting at the loading block. We can use it for either refrigeration or freezer." The surveyor found a storage box in the back of the refrigerator, which contained Mighty Shakes for resident use. The food services director stated, "When the floors upstairs get low on these, this stock is taken to the unit refrigerators and restocked there." The surveyor asked for a temperature to be obtained from a carton of Mighty Shakes at this time. The food services director obtained a temperature from a carton of the Mighty Shakes and the temperature was noted to be 47.3 degrees (F) (Fahrenheit). She stated to the surveyor that she wanted to use a different carton of Mighty Shake and see what the temperature in that one would be. She took another carton from the same storage box in this refrigerator and that temperature was 50 degrees (F). The food services director stated, "I will discard these in	F 908	#2. 3) Walk in freezer temperature on the inside of the freezer reads -10 degrees which is accurate. 4) Ice was removed from the sprinkler head and Sprinkler Company came out to check to ensure functionality. The floor in the freezer has been repaired. The door to the freezer now shuts tightly. 5) Free standing stove and top compartment of the double ovens has been repair and are currently operational. 6) Drains in the dish room were unclogged. 7) Garbage disposal in the dish room is operational. Current residents in the center have the potential to be affected. The Dietary Manager will be educated by the Regional Director of Maintenance/designee on ensuring all areas of the kitchen are operational and when equipment breaks or requires repairs, the CAO is immediately notified so repairs can occur timely. The CAO/designee will round in the kitchen 3x weekly to ensure all areas of the kitchen are functional and operational. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 908	Continued From page 97 this storage box so no residents can get this by mistake." The surveyor asked for a cup from the food services director. This cup was obtained and the contents of the first Mighty Shake was poured into the empty cup. The shake was very thick in consistency and had chunks like cake batter that had not been mixed well. The second Mighty Shake was also poured in an empty cup and the consistency of it was like the appearance of the first carton that was opened. Both had a sour smell to them. 2. Walk in refrigerator #2 was empty and according to the food services director, "we have had to get a refrigerator/freezer truck and park it at the back loading dock to keep the rest of our refrigerator items in until the refrigerator has been fixed. 3. Walk in freezer had a thermometer reading of 27 degrees (F). This was located on the outside of the freezer. The surveyor went into the freezer and found a thermometer located inside with a temperature of -10 degrees (F). The floor in the freezer was made of aluminum and the surveyor noted areas that the floor was buckling up and had sharp edges that any employee could trip over and cause an accident. Inside this freezer on the left hand side, the sprinkler had ice covering the entire sprinkler and hung down approximately 12 inches on to the box that was under the sprinkler on the top shelf. The surveyor asked the food services director which thermometer the staff should use when they are obtaining temperatures for the freezer logbook. She stated, "They should use the inside one because everyone here knows the one on the outside of the freezer is broken and not working properly." The surveyor stepped outside of the freezer and closed the door. The door to the freezer could not be shut tight so a seal could be	F 908	CAO/Dietary Manager will be responsible for implementation of the plan of correction.	

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obtained around the freezer door. The surveyor asked how long it has been this way. The food services director stated, "I haven't been here very long and it was like that we I came to work here." The surveyor reviewed the temperature logs for the walk in freezer for the month of July 2019. It was noted that on 6 occasions the staff had documented the freezer temperatures ranging from 23 degrees to 27 degrees (F). The surveyor asked if these temperatures should had been reported to the food services director. She stated that she was not made aware of these temperatures being outside the range that the facility states it should be. She stated that the temperatures should be between -10 degrees to 0 degrees (F).

4. The freestanding stove and top compartment of the double oven were not working according to the food services. The surveyor asked how long has they been not working. She stated, "The top part of the double oven hasn't worked since I came to work here back 3-4 months ago. The surveyor asked if she had notified anyone that this piece of equipment was not working. She replied, "Yes, I reported it to the administrator because I was instructed to bring all kitchen issues or problems to her. I did that and nothing was never done to correct this or to get it fixed." The food services director stated that the freestanding stove had stopped working this morning and I notified the administrator and was told to call someone to come in and check on it. The service man came into the kitchen and started working on both the stove and oven. At 12:30 pm, the service man explained to the food services director and this surveyor that there was no electricity going to either one of these. He also notified the food services director of the breaker not working in the breaker box. He

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stated, "Have someone from maintenance come in and look at this and they will have to call an electrician if they cannot fix the problem."
5. In the dish room, the drains were clogged and this was allowing the water to be free standing in puddles in the floor. The freestanding water covered 75% of the dish room floor.
6. During this tour of the kitchen, the surveyor asked if the garbage disposal worked because there was rust noted on the outside of the garbage disposal. The surveyor asked dietary aide #1 if this worked. The aide replied, "No, it doesn't. I could turn it on for you to see but it will spray water everywhere and I don't want you to be wearing that on your clothes."
7. The dishwasher rinse temperature was only between 148 and 150 degrees (F). The surveyor asked the dietary aide #2 what temperature the rinse cycle was supposed to be and he stated 180 degrees. The surveyor notified the food services director of these documented findings about the dishwasher. She stated she would call the administrator and report this to her so she can make the call whether to use paper for supper or not.

At the end of the tour, the surveyor requested copies of kitchen policies that addresses each concern/issue that the surveyor had notified her about. The food services director stated, "I will get those and send them to you in the conference room."
At 4:30 pm, the surveyor along with the CEO (Chief Excuative Officer) of the receiving company was toured in the kitchen with each of the above documented findings shown to him. The CEO stated, "We will get to work on this kitchen as soon as possible. I know a new freezer has been ordered and we are waiting on it

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F 908	Continued From page 100 to arrive as well as another refrigerator. These other issues I will speak to the regional maintenance director to see what plan we can put in place." On 7/22/19 at 9:30 am, the surveyor and regional maintenance director toured the kitchen so the surveyor could show him the concerns/issues that were observed yesterday on initial tour. He stated, "The drains have been fixed last night and they are draining properly now." The surveyor did observe the drains were open and not clogged with water backed up in the dish room. The surveyor notified him of the above documented findings. The regional maintenance director stated, "We will address each of these issues. The man from the company that supplies the dishwasher is here this morning to check on why the rinse temperature is not getting up to 180 degrees. I will let you know what he finds out on this." No further information nor policies that were requested were provided to the surveyor prior to the exit conference on 7/24/19.	F 908		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and during the course of a complaint investigation, it was determined that the facility staff failed to maintain an effective pest control program.	F 925	F925 A new Pest Control company was brought into the center. A treatment to the entire building was completed along with fogging	9/7/19

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F 925	Continued From page 101 The findings included: 1. The facility staff failed to effectively maintain pest control, which lead to a problem with roaches in the facility. On 7/21/19 at 12:10 pm, three surveyors observed a large amount of roaches in the facility kitchen. The surveyor observed both living and dead roaches throughout the facility kitchen especially behind doors, underneath the kitchen appliances, and in the dishwashing area. On 7/22/19 at 10:31 am, the surveyor reviewed the "Maintenance/Housekeeping" logs from each facility unit. The surveyor observed that the facility staff had documented roach sightings on the following dates, 7/1/19, 7/2/19, 7/7/19, 7/8/19, 7/9/19, 7/13/19, and 7/18/19. On 7/23/19 at 10:00 am, the surveyor interviewed Cna # 1 (certified nursing assistant). The surveyor asked Cna # 1 if she had observed roaches in the facility. Cna # 1 stated, "Yes." The surveyor asked Cna # 1 if the roaches that she had seen were in an isolated area or if the roaches were seen all over the facility. On 7/23/19 at 10:07 am, the surveyor interviewed Cna # 2. The surveyor asked Cna # 2 if she had observed roaches in the facility. Cna # 2 stated, "Yes." The surveyor asked Cna # 2 if the roaches that she had seen were in an isolated area or if the roaches were seen all over the facility. Cna # 2 stated, "Everywhere, some rooms more than others." On 7/23/19 at 10:15 am, the surveyor interviewed	F 925	x2 for the kitchen on two separate days. The company is currently coming into the center weekly for treatment and looking at the pest control logs for areas that might require additional attention. Current residents in the center have the potential to be affected. Facility staff will be educated by the Regional Director of Maintenance on reporting areas where roaches are sited and recording areas where roaches are seem in the pest control log and notification to the CAO. The CAO/designee will monitor roach activity in the center via direct rounding, the pest control logs, staff interviews and information form the pest control company on a weekly basis. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. CAO/Regional Director of Maintenance will be responsible for implementation of the plan of correction.	

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Cna # 3. The surveyor asked Cna # 3 if she had observed roaches in the facility. Cna # 3 stated, "I have seen a few."

On 7/23/19 at 10:21 am, the surveyor interviewed Cna # 4. The surveyor asked Cna # 4 if she had observed roaches in the facility. Cna # 4 stated, "Yes a few." The surveyor asked Cna # 4 if the roaches that she had seen were in an isolated area or if the roaches were seen all over the facility. Cna # 4 stated, "Everywhere."

On 7/23/19 at 10:32 am, the surveyor interviewed Cna # 5. The surveyor asked Cna # 5 if she had observed roaches in the facility. Cna # 5 stated, "Yes, just a few." "It was bad but it is getting better." The surveyor asked Cna # 5 if the roaches that she had seen were in an isolated area or if the roaches were seen all over the facility. Cna # 5 stated, "All over, but third floor was the worst."

On 7/24/19 at 10:34 am, the surveyor reviewed the Resident council minutes from October 2018 through July 2019. After reviewing the Resident council minutes the surveyor observed Resident complaints of roaches in February, May, and June of 2019.

On 7/24/19 at 11:31 am, the surveyor informed the administrative team which consisted of the regional director of clinical services # 1, corporate MDS consultant, regional director of clinical services # 2, chief executive officer, director of professional services, director of nursing, and administrator were made aware of the findings as stated above. The administrative team was provided the opportunity to provide information to the survey team to clarify any statements or

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observations as stated above. The chief executive officer acknowledged that the facility did not have effective pest control and reported to the survey team that the facility has changed to a different pest control company because the previous company was ineffective with pest control.

No further information regarding this issue was presented to the survey team prior to the exit conference on 7/24/19.

This is a complaint deficiency.
2. The facility staff failed to maintain an effective pest control program so that the facility's kitchen, laundry area, and staff bathrooms on 2 north, 2 south and in the Bio Hazard room located at the loading dock of the facility.

During the initial tour of the facility's kitchen on 7/21/19 at 11:00 am, the surveyor and the food services director were together to make these observations. The surveyor observed dead golden brown large bugs, which looked like a cockroach, in the kitchen under the reach in refrigerator in the tray line area of the kitchen, the dish room in the right hand corner as the surveyor entered the room. Dead bugs were also observed behind the door and in a bucket of old water in the storage room. The Bio Hazard room located at the loading dock of facility too had dead golden brown bugs there also.

At 4:30 pm, the CEO (chief executive officer) of the receiving company accompanied the surveyor for a tour of the kitchen issues/concerns of the surveyor. The surveyor notified the CEO of the above documented findings. The CEO also observed the cockroach looking bug in the areas

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as documented above. The CEO stated, "We are going have to change pest control companies. I don't know how often this company comes into the facility to spray but we will be calling them."

At 4:50 pm, the surveyor along with the CEO asked the food services director how often the pest control company sprays the kitchen. She stated, "They were coming every week but I think they are coming once a month."

On 7/22/19 at 10 am, the surveyor notified the ADM (administrator) of the above documented findings. The surveyor requested copies of the pest control contract and any documentation that the company has given to the facility of what they observed while in the building.

At 11:00 am, the ADM brought copies of the requested documentation concerning pest control in the facility. The ADM stated, "We have had the company come in and spray every 7-10 days for a while now." The surveyor asked the ADM what was being done to prevent cockroaches. She replied, "We have been having people come in and spray more often."

The surveyor reviewed "Pest Sighting/Evidence Log" and the following was noted in this documentation:
" 5/15/19 Roaches Rooms 361, 363, 357, 354
" 5/15/19 Roaches Rooms 238, 141, 255
" 7/6/19 Roaches 2 South and Rooms (did not give the
Room numbers
The surveyor also reviewed the Pest Control "Customer Service Report" and the following documentation was noted:

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F 925	Continued From page 105 " 1/30/19 No cockroach activity noted " 2/17/19 Kitchen closed No cockroach activity noted " 2/28/19 Rooms that were serviced (164, 151, 153, 255, 171, 269, 363, 257, 267 and 272. No cockroach activity noted " 3/17/19 Kitchen closed No cockroach activity noted " 3/27/19 Rooms that were serviced (174, 218, 200 and 233) No Cockroach activity noted " 4/23/19 Kitchen closed No cockroach activity noted " 4/26/19 No cockroach activity noted " 4/29/19 No cockroach activity noted " 5/17/19 No rodent activity noted " 5/20/19 Kitchen closed No cockroach activity noted " 6/16/19 Kitchen closed No cockroach activity noted " 6/24/19 No rodent activity noted " 6/25/19 "Cockroaches noted in the dish pit area This area was Was serviced and serviced ...Will follow up service in 3-7 Days " 7/3/19 Kitchen was closed Cockroaches noted during service treated "This area was inspected and serviced. I will return for a follow-up service in 3-7 days." The area referred to was the "Kitchen Area Interior" " 7/15/19 Kitchen closed " ...Cockroaches noted during service Kitchen area-Interior ..." On 7/23/19 at 10 am, the surveyor interviewed Resident #126's representative. The surveyor asked if she had ever seen roaches in or around	F 925		

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F 925	Continued From page 106 resident's rooms. The representative stated, "I did several weeks ago. I went to use my aunt's bathroom and there were 2 in there in the corner. I told the nurses' at the desk about this." At 3:15 pm, the laundry area was reviewed by SII (Surveyor II) to determine compliance with infection control measures. SII examined a pasteboard box in the corner, which contained a white powder. The name on the box was Royal Brite Plus and the contents were described as a color safe bleach. When SII tipped the box over to determine the contents a gold colored bug, which looked like a cockroach, ran out of the box and across SII's hand. SII also found similar bugs in the staff bathrooms on 2 North and 2 South during the four-day survey. No further information was provided to the survey team prior to exit conference on 7/24/19.	F 925		