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	495407	A. BUILDING _____ B. WING _____	C 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/04/2019 through 09/06/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted from 9/4/19 through 9/6/19. A complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. The census at this 90 certified bed facility was 80 at the time of the survey. The survey sample consisted of 34 current residents and six closed records.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		9/23/19

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

Electronically Signed | 09/23/2019

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F 578	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement the Advanced Directives policy to ensure periodic reviews with resident and/or responsible party, were provided to formulate Advance Directives, or, if applicable, make changes to their existing Advance Directives or maintain them as written, for seven of 40 residents in the survey sample, Residents #22, #15, #30, #20, #57, #36, and #14. The findings include:	F 578	F578 1. Advanced directives were reviewed with the following Residents and/or Responsible Party for resident #22, #15, #30, #20, #57, #36, and #14. OSM #1 and OSM#4 received education on the Advance Directives policy and periodic reviews with resident and/or responsible party. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. The Administrator or designee conducted a quality review of	

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F 578	Continued From page 2 1. Resident #22 did not have any Advance Directives, the facility staff failed to conduct a periodic review to determine if the resident or responsible party wished to develop Advance Directives later. Resident #22 was admitted to the facility on 3/8/18. Diagnoses included but are not limited to stroke, aphasia, high blood pressure, diabetes, gastrostomy, quadriplegia, dysphagia, adult failure to thrive, and contractures. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/15/19 coded the resident as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living. A review of the clinical record failed to reveal the presence of any Advance Directives. Further review revealed that the resident/responsible party were provided with information for developing Advance Directives around the time of admission, dated 3/14/18. Review of the clinical record failed to reveal any evidence that the resident's Advance Directives status was periodically reviewed with the resident/responsible party, to provide an opportunity and determine if the resident and or RP (responsible party) wished to develop an Advance Directives later. On 9/5/18 at 4:32 PM, an interview was conducted with OSM #1 (Other Staff Member) Social Services. When asked about periodic review of residents Advance Directives, OSM #1 stated that it (advanced directives) is reviewed	F 578	current residents for periodic review of Advance directives. 3. Advanced directives will be reviewed on admission and at least annually for all residents. Social Services department has been educated on advanced directive review by Administrator/Designee. 4. SW will audit new admissions and residents with care plan meetings 5x/ week for 4 weeks, then 3x/ week for 8 weeks for periodic review of advanced directives. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 2019.	

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and documented in the care plan meetings. OSM #1 was informed that only code status was noted on the care plan meeting documentation and was asked about reviews of Advanced Directives. OSM #1 stated that only the code status is reviewed, the Advance Directives are not. OSM #1 was asked if she periodically reviews Advance Directives with residents who do not have one in place to determine if they wish to develop one, or to determine if a resident with an Advance Directives, wishes to change anything. OSM #1 stated, "No, we only review code statuses." When asked , if she reviews their Advance Directives with residents that are newly admitted, OSM #1 stated she does not review them [Advanced Directives], only the code status. When asked if, Advance Directives are discussed during the first care plan meeting, OSM #1 stated only code status is discussed.

On 9/6/19 at 8:02 AM, an interview was conducted with OSM #4, the Admissions Coordinator. OSM #4 was asked if newly admitted residents are provided any information on Advance Directives. OSM #4 stated, "Yes, and I will ask them if they have one, and if so get a copy into the medical record." OSM #4 stated, "I ask them if they know what an Advance Directive is and provide them information on it, and if they want to execute one, I direct them to the Social Worker or Administrator." When asked how the facility evidence the resident was provided with information on Advance Directives, OSM #4 stated, "they are given a facility handbook which contains information on Advance Directives and they sign a receipt that they are given the handbook." She also provided pages from the resident's admission agreement that reflected that the resident was offered information and

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opportunity about developing Advance Directives. When asked about periodically reviewing the Advance Directives with residents to see if they wish to formulate one and or make any changes, OSM #4 stated, "That is done in the meetings with the social worker (care plan meetings). I don't have anything to do with that."

A review of the facility policy, "Advance Directives Protocol" documented, "Written instructions about future medical care should you become unable to make decisions...These are also called healthcare directives. Upon Admission and during Your Path Meetings, advance directives will be discussed with resident and/or resident representative to determine if any advance directives have be {sic} chosen....Advance directives will be reviewed at minimum annually according to MDS schedule...."

On 9/6/19 at 10:15 AM, ASM #1 (Administrative Staff Member), the Administrator, was notified of the concern. No further information was provided.

2. The facility staff failed to conduct a periodic review to determine if the Resident #15 or the responsible party wished to make any changes and or maintain the Advance Directives as written.

Resident #15 was admitted to the facility on 1/1/11 and was readmitted to the facility on 10/19/18, with the diagnoses of but not limited to: peripheral vascular disease, intervertebral disc disorders, ischemic heart disease, diabetes, depression, bladder dysfunction, osteoporosis, high blood pressure, and anxiety. The quarterly

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MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/13/19, coded the resident as cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for mobility, transfers, dressing, hygiene, and toileting; limited assistance for bathing; and supervision for eating.

A review of the clinical record revealed the presence of Advance Directives in the resident's chart, dated 10/20/12. Further review of the clinical record failed to reveal any evidence that the resident's Advance Directives status was periodically reviewed with the resident/responsible party, to determine if, and provide opportunity for, making any changes to the resident's existing Advance Directives.

On 9/5/18 at 4:32 PM, an interview was conducted with OSM #1 (Other Staff Member) Social Services. When asked about periodic review of residents Advance Directives, OSM #1 stated that it (advanced directives) is reviewed and documented in the care plan meetings. OSM #1 was informed that only code status was noted on the care plan meeting documentation and was asked about reviews of Advanced Directives. OSM #1 stated that only the code status is reviewed, the Advance Directives are not. OSM #1 was asked if she periodically reviews Advance Directives with residents who do not have one in place to determine if they wish to develop one, or to determine if a resident with an Advance Directives, wishes to change anything. OSM #1 stated, "No, we only review code statuses." When asked , if she reviews their Advance Directives with residents that are newly admitted, OSM #1 stated she does not review them [Advanced Directives], only the code status.

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When asked if, Advance Directives are discussed during the first care plan meeting, OSM #1 stated only code status is discussed.

On 9/6/19 at 8:02 AM, an interview was conducted with OSM #4, the Admissions Coordinator. OSM #4 was asked if newly admitted residents are provided any information on Advance Directives. OSM #4 stated, "Yes, and I will ask them if they have one, and if so get a copy into the medical record." OSM #4 stated, "I ask them if they know what an Advance Directive is and provide them information on it, and if they want to execute one, I direct them to the Social Worker or Administrator." When asked how the facility evidence the resident was provided with information on Advance Directives, OSM #4 stated, "they are given a facility handbook which contains information on Advance Directives and they sign a receipt that they are given the handbook." She also provided pages from the resident's admission agreement that reflected that the resident was offered information and opportunity about developing Advance Directives. When asked about periodically reviewing the Advance Directives with residents to see if they wish to formulate one and or make any changes, OSM #4 stated, "That is done in the meetings with the social worker (care plan meetings). I don't have anything to do with that."

A review of the facility policy, "Advance Directives Protocol" documented, "Written instructions about future medical care should you become unable to make decisions...These are also called healthcare directives. Upon Admission and during Your Path Meetings, advance directives will be discussed with resident and/or resident representative to determine if any advance

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directives have be {sic} chosen....Advance directives will be reviewed at minimum annually according to MDS schedule...."

On 9/6/19 at 10:15 AM, ASM #1 (Administrative Staff Member), the Administrator, was notified of the concern. No further information was provided.

3. Resident #30 did not have any Advance Directives, the facility staff failed to conduct a periodic review to determine if the resident or responsible party wished to develop Advance Directives later.

Resident #30 was admitted to the facility on 6/28/17, with the diagnoses including, but not limited to: high blood pressure, psychosis, anxiety disorder, diabetes, stroke, and affective mood disorder. The annual MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, mobility, dressing, toileting and hygiene; and supervision for eating.

A review of the clinical record failed to reveal the presence of any Advance Directives. Further review revealed that the resident and/or responsible party were provided with information for developing Advance Directives at the time of admission, dated 8/2/17.

Review of the clinical record failed to reveal any evidence that the resident's Advance Directives status was periodically reviewed with the

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resident/responsible party, to determine if, and provide opportunity for, the development of Advance Directives later.

On 9/5/18 at 4:32 PM, an interview was conducted with OSM #1 (Other Staff Member) Social Services. When asked about periodic review of residents Advance Directives, OSM #1 stated that it (advanced directives) is reviewed and documented in the care plan meetings. OSM #1 was informed that only code status was noted on the care plan meeting documentation and was asked about reviews of Advanced Directives. OSM #1 stated that only the code status is reviewed, the Advance Directives are not. OSM #1 was asked if she periodically reviews Advance Directives with residents who do not have one in place to determine if they wish to develop one, or to determine if a resident with an Advance Directives, wishes to change anything. OSM #1 stated, "No, we only review code statuses." When asked , if she reviews their Advance Directives with residents that are newly admitted, OSM #1 stated she does not review them [Advanced Directives], only the code status. When asked if, Advance Directives are discussed during the first care plan meeting, OSM #1 stated only code status is discussed.

On 9/6/19 at 8:02 AM, an interview was conducted with OSM #4, the Admissions Coordinator. OSM #4 was asked if newly admitted residents are provided any information on Advance Directives. OSM #4 stated, "Yes, and I will ask them if they have one, and if so get a copy into the medical record." OSM #4 stated, "I ask them if they know what an Advance Directive is and provide them information on it, and if they

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want to execute one, I direct them to the Social Worker or Administrator." When asked how the facility evidence the resident was provided with information on Advance Directives, OSM #4 stated, "they are given a facility handbook which contains information on Advance Directives and they sign a receipt that they are given the handbook." She also provided pages from the resident's admission agreement that reflected that the resident was offered information and opportunity about developing Advance Directives. When asked about periodically reviewing the Advance Directives with residents to see if they wish to formulate one and or make any changes, OSM #4 stated, "That is done in the meetings with the social worker (care plan meetings). I don't have anything to do with that."

A review of the facility policy, "Advance Directives Protocol" documented, "Written instructions about future medical care should you become unable to make decisions...These are also called healthcare directives. Upon Admission and during Your Path Meetings, advance directives will be discussed with resident and/or resident representative to determine if any advance directives have be {sic} chosen....Advance directives will be reviewed at minimum annually according to MDS schedule...."

On 9/6/19 at 10:15 AM, ASM #1 (Administrative Staff Member), the Administrator, was notified of the concern. No further information was provided.

4. The facility staff failed to conduct a periodic review to determine if the Resident #20 or the responsible party wished to change anything or

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maintain the Advance Directives as written.

Resident #20 was admitted to the facility on 6/16/14, with diagnoses that included but are not limited to, cerebrovascular disease, chronic obstructive pulmonary disease, Barrett's Esophagus, depression, and high blood pressure. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/13/19, coded the resident as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing, extensive assistance for transfers, mobility, dressing, toileting and hygiene; and supervision for eating.

A review of the clinical record revealed the presence of Advance Directives in the resident's chart, dated 3/27/14. Further review of the clinical record failed to reveal any evidence that the resident's Advance Directives status was periodically reviewed with the resident/responsible party, to determine if, and provide opportunity for, making any changes to the resident's existing Advance Directives.

On 9/5/18 at 4:32 PM, an interview was conducted with OSM #1 (Other Staff Member) Social Services. When asked about periodic review of residents Advance Directives, OSM #1 stated that it (advanced directives) is reviewed and documented in the care plan meetings. OSM #1 was informed that only code status was noted on the care plan meeting documentation and was asked about reviews of Advanced Directives. OSM #1 stated that only the code status is reviewed, the Advance Directives are not. OSM #1 was asked if she periodically

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reviews Advance Directives with residents who do not have one in place to determine if they wish to develop one, or to determine if a resident with an Advance Directives, wishes to change anything. OSM #1 stated, "No, we only review code statuses." When asked , if she reviews their Advance Directives with residents that are newly admitted, OSM #1 stated she does not review them [Advanced Directives], only the code status. When asked if, Advance Directives are discussed during the first care plan meeting, OSM #1 stated only code status is discussed.

On 9/6/19 at 8:02 AM, an interview was conducted with OSM #4, the Admissions Coordinator. OSM #4 was asked if newly admitted residents are provided any information on Advance Directives. OSM #4 stated, "Yes, and I will ask them if they have one, and if so get a copy into the medical record." OSM #4 stated, "I ask them if they know what an Advance Directive is and provide them information on it, and if they want to execute one, I direct them to the Social Worker or Administrator." When asked how the facility evidence the resident was provided with information on Advance Directives, OSM #4 stated, "they are given a facility handbook which contains information on Advance Directives and they sign a receipt that they are given the handbook." She also provided pages from the resident's admission agreement that reflected that the resident was offered information and opportunity about developing Advance Directives. When asked about periodically reviewing the Advance Directives with residents to see if they wish to formulate one and or make any changes, OSM #4 stated, "That is done in the meetings with the social worker (care plan meetings). I don't have anything to do with that."

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A review of the facility policy, "Advance Directives Protocol" documented, "Written instructions about future medical care should you become unable to make decisions...These are also called healthcare directives. Upon Admission and during Your Path Meetings, advance directives will be discussed with resident and/or resident representative to determine if any advance directives have be {sic} chosen....Advance directives will be reviewed at minimum annually according to MDS schedule...."

On 9/6/19 at 10:15 AM, ASM #1 (Administrative Staff Member), the Administrator, was notified of the concern. No further information was provided.
5. The facility staff failed to periodically review Resident #36's (or the resident's representative) decisions regarding advance directives.

Resident #36 was admitted to the facility 12/03/2010 with a readmission on 04/20/2016 with diagnoses, that included but were not limited to heart failure (1) and atrial fibrillation (2).

Resident #36's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/17/19, coded Resident #36 as scoring a 6 (six) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 6- being severely impaired for making daily decisions.

Review of Resident #36's clinical record failed to reveal documentation of periodic review regarding advance directives.

The comprehensive care plan for Resident #36

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dated 07/26/2019 documented, "Resident has chosen full code status. Date Initiated: 01/19/2018 Revision on: 01/19/2018." Under "Interventions", it documented, "Review per routine with resident and/or responsible party. Date Initiated 01/19/2018. Revision on: 01/19/2018."

On 9/5/19 at approximately 4:40 p.m., a request was made to OSM #1 for any evidence of documentation of review of Advance Directives for Resident #36.

On 9/6/19 at approximately 8:15 a.m., a request was made to OSM #4 for any evidence of documentation of review of Advance Directives for Resident #36.

On 9/6/19 at approximately 9:00 a.m., a document titled, "Acknowledgment of Receipt" for Resident #36 was provided by OSM #4. Review of the document revealed a date of 12/3/2010 with the representative for Resident #36's signature acknowledging receipt of the facility's resident handbook. It documented, "vi. Facility's Advance Directive Policy and explanation of Resident rights concerning Advance Directives ..."

On 9/6/19 at approximately 10:00 a.m., ASM (administrative staff member) #1, the administrator provided the document "Care Plan Conference Notes" dated 8/11/19 for Resident #36. The document revealed "DNR Status: Full Code" but failed to evidence periodic review of Advance Directives for Resident #36.

On 9/06/19 at approximately 10:20 a.m., ASM (administrative staff member) #1, the

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administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services, were made aware of the findings.

No further information was provided prior to exit.

References:

1. Heart failure
A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm.

2. Atrial fibrillation
A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

6. The facility staff failed to periodically review Resident #14's (or the resident's representative) decisions regarding advance directives.

Resident #14 was admitted to the facility 08/22/2017 with diagnoses, that included but were not limited to repeated falls and muscle weakness generalized.
Resident #14's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 06/08/19, coded Resident #14 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being cognitively intact for making daily decisions.

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On 9/04/19 at approximately 12:30 p.m., an interview was conducted with Resident #14. When asked if he is participates in his plan of care, Resident #14 stated that he has gone to meetings but not always. When asked if advanced directives are discussed with him at the meetings or at any other time, Resident #14 stated that he did not think so or did not remember it being discussed.

Review of Resident #14's clinical record failed to reveal documentation of periodic review regarding advance directives.

The comprehensive care plan for Resident #14 dated 07/26/2019 documented, "Resident has full code. Date Initiated: 05/15/2018." Under "Interventions", it documented, "Review annually, PRN (as needed) with resident and/or responsible party. Date Initiated: 05/15/2018."

On 9/5/19 at approximately 4:40 p.m., a request was made to OSM #1 for any evidence of documentation of review of Advance Directives for Resident #14.

On 9/6/19 at approximately 8:15 a.m., a request was made to OSM #4 for any evidence of documentation of review of Advance Directives for Resident #14.

On 9/6/19 at approximately 9:00 a.m., a document titled, "Admission Agreement Signature Page" for Resident #14 was provided by OSM #4. Review of the document revealed a date of 08/24/17 with Resident #14's signature. It documented, "13. A written summary of the FACILITY Advance Directive policy. (App. C). I

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F 578	Continued From page 16 have not executed an Advanced Directive." The documented failed to evidence periodic review of Advance Directives. On 9/6/19 at approximately 10:00 a.m., ASM (administrative staff member) #1, the administrator provided the document "Care Plan Conference Notes" dated "618" for Resident #14. The document revealed "DNR Status: Full Code" but failed to evidence periodic review of Advance Directives for Resident #14. On 9/06/19 at approximately 10:20 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services, were made aware of the findings. No further information was provided prior to exit.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		9/23/19

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F 583	Continued From page 17 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to protect confidentiality of the medical record for one of 40 residents in the survey sample, Resident #25. The findings include: Resident #25 was admitted to the facility on 12/04/2017 with a readmission on 3/22/2019. Resident #25's diagnoses included but were not limited to chronic obstructive pulmonary disease (1) and hyperlipidemia (2). Resident #25's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/01/19, coded Resident #25 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions.	F 583	F583 1. Electronic Health Record (EHR) privacy for resident #25 was immediately corrected. LPN #8 received education on providing confidentiality of the medical record. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. The DON/designee conducted a quality review of electronic health records to ensure proper privacy practices and confidentiality of electronic health record. 3. Licensed nurses have been educated on EHR confidentiality practices. 4. DON/Designee will audit four medication carts for EHR privacy 5x/ week for 4 weeks, then 3x/ week for 8 weeks for proper privacy practices and confidentiality of the medical record. Audit	

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F 583	Continued From page 18 On 9/04/19 at 4:39 p.m., LPN (licensed practical nurse) #8 was observed administering medication to Resident #25. LPN #8 pushed the medication cart to the hallway opposite the doorway to Resident #25's room. LPN #8 prepared one Omeprazole (3) 40 mg (milligram) tablet into a medication cup confirming the medication using the computer screen to view the eMAR (electronic medication administration record). LPN #8 proceeded to lock the medication cart drawers and take the prepared medication and a cup of water into Resident #25's room. The computer screen displaying Resident #25's medical record in the hallway was observed left unlocked when LPN #8 walked away from the cart to enter the resident's room. After administering the medication to Resident #25, LPN #8 exited the room and returned to the medication cart and stated, "I forgot to lock the computer screen." On 9/05/19 at 3:57 p.m., an interview was conducted with LPN #8. When asked about the process of securing resident's medical records during medication administration, LPN #8 stated that the computer screen is locked when staff leave the medication cart unattended. When asked why this is done, LPN #8 stated that this to protect privacy and protect HIPPA (4). When asked about the observation made of the computer screen in the hallway left unattended with Resident #25's information visible on 9/4/19 at 4:39 p.m., LPN #8 stated that he forgot to lock the screen when he left to go into the room to give the medication. LPN #8 stated that the computer screen should have been locked to protect Resident #25's information from potentially being viewed by anyone walking in the hallway.	F 583	results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 2019	

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The facility policy "Safeguards. Privacy Policy #HIPAA (Health Insurance Portability and Accountability Act) 6 (six). Effective Date: 11/30/2016" documented in part, " ...will maintain appropriate administrative, technical and physical safeguards to protect the confidentiality, integrity and accessibility of PHI (Protected Health Information) consistent with the requirements of these HIPAA Policies and to safeguard PHI from intentional and unintentional non-permissible uses and disclosures." Under "Procedure: A. General Safeguards." it documented "(c) [name of facility] will use reasonable safeguards so that PHI on computer screens will not be visible to unauthorized persons, including locking down computer workstations when not in use or when leaving the workstation by activating a password protected screen saver and clearing PHI from the computer screen when the PHI is not actually being used."

On 9/06/2019 at approximately 10:20 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of clinical services were notified of the findings.

No further information was provided prior to exit.

References:

1. Chronic obstructive pulmonary disease (COPD)
Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

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F 583	Continued From page 20 2. Hyperlipidemia Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm. 3. Omeprazole Indications: Frequent heartburn (?2 days/week). Not intended for immediate relief of heartburn (may take 1-4 days for full effect). This information was obtained from the website: https://www.empr.com/drug/prilosec-otc/ 4. HIPPA The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. This information was obtained from the website: https://www.hhs.gov/hipaa/for-professionals/privacy/index.html	F 583		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		9/23/19

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F 622	Continued From page 21 §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 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	F 622		

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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.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.

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F 622	Continued From page 23 (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to evidence that any of the required documentation was provided to the receiving health care institution on transfer to the hospital for one of 40 residents in the survey sample, Resident #43. The findings include: Resident #43 was admitted on 12/27/18; diagnoses included but are not limited to Alzheimer's disease, high blood pressure, dysphagia, anxiety disorder, and adult failure to thrive. The quarterly/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/25/19 coded the resident as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; and extensive care for transfers, mobility, dressing, eating, toileting and hygiene. A review of the nurse's notes dated 7/14/19 documented, "Around 4:15 a.m. resident observed with large amounts of coffee ground emesis on his clothing, mouth, and blankets. Vitals 136/92 (blood pressure), 69 (pulse rate), 97.3 (temperature), 18 (respiration rate), 85% (RA) (oxygen saturation at 85% on room air).	F 622	F622 1. Resident #43 was readmitted to the facility on 07/18/19 and discharged to Emergency Room on 09/03/19 with packet of required documentation sent to hospital in place. Resident returned to facility on 09/03/19 with no further discharges at this time. Nurse who discharged resident received education on required documentation to provide receiving health care institution on transfer to the hospital. 2. All residents who reside at Falls Run Nursing and Rehabilitation and transfer to the hospital have the potential to be affected. The Administrator or designee conducted a quality review of current residents who discharged to the hospital in the last 30 days for documentation to support information was provided to receiving health care institute on transfer. 3. Licensed nurses have been educated on required documentation for unplanned discharges by DON/Designee. 4. DON/Designee will audit discharges to hospital 5x/ week for 4 weeks, then 3x/ week for 8 weeks for required documentation to provide receiving health care institution on transfer to the hospital. Audit results will be presented monthly for three months to the Quality Assurance	

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F 622	Continued From page 24 (Medical office) on call, MD (medical doctor) notified ordered to send to ER (emergency room) for eval (evaluation). While this writer was in call to ER, CNA (certified nursing assistant) and other nurse report resident to begin projectile vomiting more coffee ground emesis. EMTx2 (two emergency medical technicians) arrived around 445am, resident out of facility via stretcher. Wife notified at 5a.m. Unit manager aware." Further review of the clinical record failed to reveal any evidence of what, if any, documentation was provided to the receiving facility upon the 7/14/19 hospital transfer. On 9/5/19 at 2:06 PM, in an interview with RN #2 (Registered Nurse), when asked what paperwork is sent to the hospital with a resident, RN #2 stated, "face sheet, med list, care plan, bed hold, recent MD notes, recent labs, Advance Directives." When asked where staff document that these forms were sent, RN #2 stated, "The eInteract transfer form." (This form was not completed for this hospital transfer). On 9/5/19 at 2:10 PM in an interview with LPN #2 (Licensed Practical Nurse) the unit manager, when asked what paperwork is sent to the hospital with a resident, LPN #2 stated, "The med [medication] list, facesheet, Advance Directives, bed hold, plan of care." When asked where staff document that these forms were sent, LPN #2 stated, "In the nurse's notes." On 9/5/19 at 2:15 PM, LPN #2 was notified of the missing documentation of what paperwork was sent to the hospital. On 9/5/19 at 2:26 PM, LPN #2 stated, "It	F 622	Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 2019.	

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[eInteract transfer form] is not in the computer." LPN #2 stated that she did not see that the eInteract transfer form was completed or a nurse's note documenting what was sent. A review of a blank eInteract form revealed that the required information would have been provided if this form had been completed. Including the resident's demographic information, functional status, where the resident was sent to, the information of the responsible party, medications and treatments, devices, risk alerts, precautions, skin and wound care needs, immunizations, behavioral issues, and rehab therapy status. However, the form did not contain any prompting for providing the comprehensive care plan goals. She also provided a folder with a paper attached titled, "E.R. Discharge Check Off List." This form documented the required transfer documents to provide to the receiving facility, including the comprehensive care plan goals. The inside of the folder included two copies of the bed hold notice. LPN #2 stated the remainder of the forms were electronic forms from the clinical record and would be printed according to the check off list and placed in the folder. However, a copy of the completed check off list for this resident's hospital transfer was not retained as evidence of that the items listed were completed and sent to the hospital.

A review of the facility policy, "Discharge/Transfer Letter Policy" did not include any criteria of what documentation is required to be sent to the hospital upon transfer. No other policy for hospital transfers were provided.

On 9/5/19 at the end of day meeting at approximately 5:00 PM, ASM #1 (Administrative Staff Member), the Administrator, was notified of

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F 622	Continued From page 26 the concern. No further information was provided.	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; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623		9/23/19

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder

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F 623	Continued From page 28 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, it was determined that the facility staff failed to evidence that written notification of a hospital transfer was provided to the resident representative upon a hospital transfer for two of 40 residents in the survey sample, Residents #43 and #22. The findings include: 1. The facility staff failed to provide Resident #43 or the resident representative with written notification of a hospital transfer on 7/14/19. Resident #43 was admitted on 12/27/18, with diagnoses including but not limited to Alzheimer's	F 623	F623 1. Resident # 43 was most recently readmitted to facility on 09/03/19 with no further discharges at this time. Resident #22 was readmitted to facility on 07/17/19 with no further discharges at this time. OSM #1 received education on providing resident and/or resident representative with written notification of a hospital transfer. 2. All residents who reside at Falls Run Nursing and Rehabilitation and are discharged have the potential to be affected. The Administrator or designee conducted a quality review of current residents who discharged to the hospital in the last 30 days for documentation to	

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disease, high blood pressure, dysphagia, anxiety disorder, and adult failure to thrive. The quarterly/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/25/19 coded the resident as severely cognitively impaired in ability to make daily life decisions.

A review of the nurse's notes dated 7/14/19 documented, "Around 4:15 a.m. resident observed with large amounts of coffee ground emesis on his clothing, mouth, and blankets. Vitals 136/92 (blood pressure), 69 (pulse rate), 97.3 (temperature), 18 (respiration rate), 85% (RA) (oxygen saturation at 85% on room air). (Name of Medical office) on call MD (medical doctor) notified ordered to send to ER (emergency room) for eval (evaluation). While this writer was in call to ER, CNA (certified nursing assistant) and other nurse report resident to begin projectile vomiting more coffee ground emesis. EMTx2 (two emergency medical technicians) arrived around 445am, resident out of facility via stretcher. Wife notified at 5a.m. Unit manager aware."

Further review of the clinical record failed to reveal any evidence that the facility provided the resident representative with written notification for the 7/14/19 hospital transfer.

On 9/5/19 at 4:28 PM in an interview with OSM #1 (Other Staff Member), Social Services, when asked about providing the resident representative with a written notice of a hospital transfer, OSM #1 stated that she does not do that.

On 9/6/19 at 8:45 AM, in an interview with ASM #1 (Administrative Staff Member) the Administrator, he stated that the facility has not

support written notification was provided to resident and/or resident representative.
3. Social Services department has been educated on required written notification for resident and/or resident representative for notification of hospital transfers by Administrator/Designee.
4. SW/Designee will audit discharges to hospital 5x/ week for 4 weeks, then 3x/ week for 8 weeks for required documentation of written notification of hospital transfers to resident and/or responsible representative. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation.
5. Date of Compliance: October 1, 2019.

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been providing the resident/family/responsible party with a written notice of the resident being transferred to the hospital.

A review of the facility policy, "Discharge/Transfer Letter Policy" documented, "The Facility will complete discharge letters appropriately and according to all federal, state, and local regulations....The following situations will result in immediate discharge / transfer from the facility as practicable and an immediate discharge/transfer letter will be issued:...4. An immediate transfer/discharge is required due to the resident's urgent medical needs....D) Discharge notices must have the following components: 1. The reason for discharge/transfer, to include appropriate verbiage...2. The effective date of transfer/discharge; 3. The location to which the resident is transferred/discharged...."

On 9/5/19 at the end of day meeting at approximately 5:00 PM, ASM #1 (Administrative Staff Member), the Administrator, was notified of the concern. No further information was provided.

2. The facility staff failed to provide Resident #22 or the resident representative with written notification of a hospital transfer on 7/15/19.

Resident #22 was admitted to the facility on 3/8/18 with the diagnoses of but not limited to stroke, aphasia, high blood pressure, diabetes, gastrostomy, quadriplegia, dysphagia, adult failure to thrive, and contractures. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/15/19 coded the resident as severely impaired in ability to

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F 623	Continued From page 31 make daily life decisions. A review of the clinical record revealed a nurse's note dated 7/15/19 documented, "Resident observed having seizure episodes around 0330 (3:30 AM), blood noted coming out of resident's mouth, possibly due to resident biting the inside of her mouth. Order received from (name of physician) to send resident to ED (emergency department) for seizures and the resident's needs can no longer be met in this Facility. RP (responsible party) has been notified." Further review of the clinical record failed to reveal any evidence that the facility provided the resident representative with written notification of the 7/15/19 hospital transfer. On 9/5/19 at 4:28 PM in an interview with OSM #1 (Other Staff Member), Social Services, when asked about providing the resident representative with a written notice of a hospital transfer, OSM #1 stated that she does not do that. On 9/6/19 at 8:45 AM, in an interview with ASM #1 (Administrative Staff Member) the Administrator, he stated that the facility has not been providing the resident/family/responsible party with a written notice of the resident being transferred to the hospital. On 9/5/19 at the end of day meeting at approximately 5:00 PM, ASM #1 (Administrative Staff Member), the Administrator, was notified of the concern. No further information was provided.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		9/23/19

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F 641	Continued From page 32 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a complete and accurate Minimum Data Set assessment for three of 40 residents in the survey sample: #73, #15, and #57. The findings include: 1. The facility staff failed to correctly document the discharge disposition on Resident #73's discharge Minimum Data Set (MDS) Assessment with an ARD (assessment reference date) of 06/27/2019. Resident #73 was admitted to the facility on 06/10/2019. Her diagnoses included anemia (low red blood cells), hypertension (high blood pressure), and diabetes. Resident #73's most recent MDS Assessment was a Discharge Assessment with an ARD (assessment reference date) of 06/27/2019. The Brief Interview for Mental Status (BIMS) scored Resident #73 at a 99, indicating that the BIMS could not be completed. Resident #73 was coded as requiring extensive assistance of one person for bed mobility and transfers, and as requiring limited assistance of one person for ambulation. A review of Resident #73's closed record revealed Resident #73 was flagged as having discharged to the Hospital by the MDS system.	F 641	F641 1. Resident #73's MDS was corrected and resubmitted to reflect the correct discharge disposition. Resident # 15's MDS section N was corrected and resubmitted to reflect the administration of insulin. Resident #57's section O was corrected and resubmitted to reflect the correct usage of oxygen. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. MDS Coordinator or designee conducted a quality review of all current residents MDS section A, N, and O for accuracy of coding. 3. MDS department staff has been educated on the completeness and accuracy of MDS by DON/Designee. 4. MDS/Designee will audit sections A, N & O for 5 MDS assessments/ week for 4 weeks, then 3x/ week for 8 weeks for accurate documentation. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 2019.	

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Upon review of the discharge nurse's note dated 06/27/2019, it was discovered that Resident #73 had not discharged to the Hospital, but rather had had a planned discharge home with family.

On 09/05/2019 at 3:26p.m., an interview was conducted with Registered Nurse (RN) #1, the MDS Coordinator. RN #1 was asked to review Resident #73's clinical record and confirm their discharge disposition. RN #1 confirmed that Resident #73 was discharged home with family. RN #1 was asked to review Resident #73's Discharge MDS and clarify whether or not it was accurate in its description of her discharge destination. RN #1 stated that the Discharge MDS was not accurate, and that she would file a correction immediately. RN #1 was asked if she followed the Resident Assessment Instrument (RAI) Manual when completing MDS Assessments, and confirmed that she did.

Administrative Staff Member (ASM) #1, the facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 09/06/2019. No further information was provided.

2. The facility staff incorrectly coded Resident #15's quarterly MDS dated 6/13/19 for the administration of insulin.

Resident #15 was admitted to the facility on 1/1/11 and readmitted on 10/19/18 with the diagnoses of but not limited to peripheral vascular disease, intervertebral disc disorders, ischemic heart disease, diabetes, depression, bladder dysfunction, osteoporosis, high blood pressure, and anxiety. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/13/19 coded the resident as cognitively intact

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

A review of the above MDS revealed in Section N "Medications" the resident was coded as having received insulin injections for seven days of the seven-day look back period. "Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days."

A review of the May 2019 and June 2019 MAR (Medication Administration Record) revealed that there were no current orders for insulin administration during the time of the above MDS.

A review of the physician's orders revealed an order dated 11/28/18 for "Insulin Regular Human Solution (1)....per sliding scale..." which was discontinued on 3/27/19. No further insulin orders had been written since that date.

On 9/5/19 at 3:18 PM, in an interview with RN #2 (Registered Nurse), the MDS coordinator. RN #2 was asked about the completion of Section N of the MDS assessment. RN #2 stated that the look back period for medications is seven days and she looks at the MAR and the nurses notes to see if they were giving any of the listed medications during the look back period. When asked about the coding of Resident #15's quarterly 6/13/19 MDS assessment for insulin, RN #2 stated that it might be miscoded but that she would check on it. When asked what the facility uses as a policy for completing the MDS assessments, RN #2 stated the RAI manual. On

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9/5/19 at 3:30 PM, RN #2 returned and stated that the 6/13/19 quarterly MDS was miscoded.

On 9/5/19 at the end of day meeting at approximately 5:00 PM, ASM #1 (Administrative Staff Member), the Administrator, was notified of the concern. No further information was provided.

A review of the RAI Manual 3.0, dated October 2017, page N-1 to N- documented, "The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident.....
1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Determine if the resident received insulin injections during the look-back period.
3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period.
4. Count the number of days insulin injections were received and/or insulin orders changed....
Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received....
Enter in Item N0350B, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable

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under state licensure laws) changed the resident's insulin orders....
For sliding scale orders:
- A sliding scale dosage schedule that is written to cover different dosages depending on lab values does not count as an order change simply because a different dose is administered based on the sliding scale guidelines.
- If the sliding scale order is new, discontinued, or is the first sliding scale order for the resident, these days can be counted and coded.
For subcutaneous insulin pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.

(1) Insulin - Insulin is a hormone produced by the pancreas to help the body use and store glucose. Glucose is a source of fuel for the body. With diabetes, the body cannot regulate the amount of glucose in the blood (called glycemia or blood sugar). Insulin therapy can help some people with diabetes maintain their blood sugar levels. Information obtained from https://medlineplus.gov/ency/patientinstructions/000965.htm

3. The facility staff failed to accurately code Resident #57's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/12/19, for oxygen use while a resident at the facility.

Resident #57 was admitted to the facility 09/15/2011 with a readmission on 01/03/2019 with diagnoses, that included but were not limited to shortness of breath and atrial fibrillation (1).

Resident #57's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/12/19, coded

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Resident #57 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section O of the MDS failed to evidence documentation of Resident #57 receiving oxygen therapy while a resident.

On 9/04/19 at 11:26 a.m., an interview was conducted with Resident #57. Resident #57 stated that she uses her oxygen frequently during the day and wears it every night in bed. When asked how long she has been using oxygen Resident #57 stated, "About a year now." Resident #57 was observed wearing a nasal cannula in her nose, that was connected to an oxygen concentrator during the interview in her room.

Additional observations of Resident #57 using oxygen were made on 9/04/19 at 1:47 p.m. and 9/5/19 at 8:18 a.m.

The physician order summary report dated 9/05/2019 documented, "O2 (oxygen) at 3L/Min (liters per minute) as needed for SOB (shortness of breath). Order Date: 05/22/2019. Start Date: 05/22/2019."

The progress note dated 07/5/2019 14:00 (2:00 p.m.) documented " ...O2 98.0%-6/28/19 14:45 Method: Oxygen via Nasal Cannula."

The progress note dated 07/12/2019 11:00 (11:00 a.m.) documented " ...O2 98.0%-6/28/19 14:45 Method: Oxygen via Nasal Cannula."

The eMAR (electronic medication administration record) dated 7/1/2019-7/31/2019, 8/1/2019-8/31/2019, and 9/1/2019-9/30/2019 for

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Resident #57 documented, "O2 at 3L/Min as needed for SOB. Start Date- 05/22/2019 1030 (10:30 a.m.)."

The comprehensive care plan "The resident has altered respiratory status/Difficulty Breathing r/t (related to) hx (history) of Pneumonia (2), CHF (congestive heart failure) (3), CAD (coronary artery disease) (4), and anxiety (5) Uses O2. Date Initiated 01/15/2018. Revision on: 07/19/2018."

On 09/05/19 at 3:26 p.m., an interview was conducted with RN (registered nurse) # 1, MDS (minimum data set) coordinator regarding the assessment process for oxygen use. RN #1 stated that she utilizes the eTAR (electronic treatment administration record), physician orders and visualizing if the resident is wearing oxygen or not to conduct her assessments. RN #1 reviewed section J of Resident #57's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/12/19, and agreed that if failed to document oxygen use for Resident #57. RN #1 stated that she had revised the MDS for a medication and had thought she had included the oxygen as well. RN #1 stated that Resident #57 has been using oxygen for over a year now and that the MDS needed to be updated.

On 9/05/19 at 3:57 p.m., an interview was conducted with LPN #8. When asked if Resident #57 wears oxygen, LPN #8 stated that she wears oxygen on a regular basis. LPN #8 stated that it is ordered as needed for shortness of breath but Resident #57 wears it frequently, especially when she is in her room.

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On 9/05/19 at 4:50 p.m., an interview was conducted with LPN #2, the unit manager. When asked if Resident #57 wears oxygen, LPN #2 stated, "Yes, she uses it when in bed."

On 09/05/19 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Atrial fibrillation
A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

2. Pneumonia
An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.

3. Congestive heart failure
A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html

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F 641	Continued From page 40 4. Coronary artery disease A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html. 5. Anxiety Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		9/23/19

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F 655	Continued From page 41 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a complete baseline care plan for two of 40 residents in the survey sample, Residents #67 and #222. The facility staff failed to develop Resident #67's baseline care plan to include the use of an incentive spirometer and staff failed to develop a baseline care plan related to the use of bed rails for Resident #222. The findings include: 1. The facility staff failed to develop Resident #67's baseline care plan to include the use of an incentive spirometer (1). Resident #67 was admitted to the facility on 8/16/19. Resident #67's diagnoses included but	F 655	F655 1. Baseline care plan was updated to include the use of incentive spirometer for Resident #67 on 09/05/19. Resident #222 was discharged on 09/11/19. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. 3. Licensed nurses have been educated on baseline care plan development and completeness by DON/Designee. The DON or designee conducted a quality review of all current residents who were admitted in the last 21 days for development and completeness of the Baseline Care Plan. 4. MDS/Designee will audit baseline care plans for development and completeness 5x/ week for 4 weeks, then 3x/ week for 8	

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F 655	Continued From page 42 were not limited to difficulty swallowing, tremor and surgical aftercare following surgery on the circulatory system. Resident #67's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 8/30/19, coded the resident as being cognitively intact. Resident #67's baseline care plan initiated on 8/16/19 failed to reveal documentation regarding an incentive spirometer. Review of Resident #67's clinical record failed to reveal a physician's order for an incentive spirometer. On 9/4/19 at 3:50 p.m., Resident #67 was observed in bed. An incentive spirometer was observed in a bag on the nightstand. On 9/5/19 at 3:18 p.m., Resident #67 was observed in bed. An incentive spirometer was observed in a bag on the nightstand. An interview was conducted with Resident #67 at this time and the resident was asked if she uses the incentive spirometer. Resident #67 stated she uses the incentive spirometer some but could not state when or how often she uses the device. On 9/5/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if a resident's care plan should include the use of an incentive spirometer. LPN #1 stated yes. When asked why, LPN #1 stated, "Because that's their personalized plan of care so you know how to take care of the patient and what's going on with them." On 9/5/19 at 5:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the	F 655	weeks. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 2019.	

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above concern.

The facility policy titled, "Care Plan" documented, "B) An 'Interim' Baseline Care plan must be developed within 48 hours of admission to insure that the resident's needs are met appropriately until the Comprehensive Care Plan is completed..."

No further information was presented prior to exit.

(1) "An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm

2. The facility staff failed to develop a baseline care plan related to the use of bed rails for Resident #222.

Resident #222 was admitted to the facility on 8/19/19 with diagnoses including, but not limited to: cancer of the esophagus and COPD (chronic obstructive pulmonary disease) (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/26/19, Resident #222 was coded as having mild cognitive impairment for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring the extensive assistance of one staff member for bed mobility and for transferring from bed to wheelchair.

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On the following dates and times, Resident #222 was observed sitting up in his bed: 9/4/19 at 1:19 p.m. and 3:59 p.m., 9/5/19 at 9:00 a.m. and 2:15 p.m., 9/6/19 at 7:40 a.m. A set of side rails (grab bars) was attached to both sides of the bed. The side rails were up during each observation.

On 9/4/19 at 1:19 p.m., Resident #222 was interviewed. When asked about the side rails, he said, "They are up all the time when I'm in the bed. I use them to help position myself. I hold on to them when I need some support."

On 9/5/19 at 2:50 p.m., LPN (licensed practical nurse) #1, the assistant director of nursing, was interviewed. When asked about the purpose of a care plan, she stated, "The care plan is how you know how to take care of a patient." LPN #1 stated, "You have to have an updated care plan so you know how to take care of a patient. The staff can access the care plans at any computer."

On 9/6/19 at 8:15 a.m., LPN #3 was interviewed. When asked about Resident #222's use of the side rails, she stated, "Yes, he uses them to help with turning and mobility in the bed."

A review of Resident #222's physician orders revealed there were no orders for use of the side rails.

A review of Resident #222's care plan dated 8/20/19 failed to reveal any information related to Resident #222's use of side rails for bed mobility or transferring.

On 9/5/19 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the

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F 655	Continued From page 45 DON (director of nursing) were informed of these concerns, and asked to present any evidence that Resident #222's baseline care plan included the use of side rails for bed mobility and transferring. On 9/6/19 at 8:54 a.m., ASM #2 stated, "I agree this is a concern. The nurses see the devices as side rails, not side rails. That is why there is not an assessment or nothing on the care plan. We are doing a 100% audit, and updating the ones that need updating. We are doing some education on it." No further information was provided prior to exit. (1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		9/23/19

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F 656	Continued From page 46 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement the plan of care for two of 40 residents in the survey sample, Residents #222 and #57. Resident #222 and Resident #57 were observed receiving oxygen at a rate that was not prescribed by the physician. The findings include:	F 656	F656 1. Comprehensive care plan for Resident #57 was updated on 09/05/19 and resident #222 was discharged on 09/11/19. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. The DON or designee conducted a quality review of all current residents who require respiratory services for staff following /	

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F 656	Continued From page 47 1. The facility staff failed to implement Resident #222's comprehensive care plan to administer oxygen at the physician-ordered rate. Resident #222 was admitted to the facility on 8/19/19 with diagnoses including, but not limited to cancer of the esophagus and COPD (chronic obstructive pulmonary disease) (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/26/19, Resident #222 was coded as having mild cognitive impairment for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). He was coded as receiving oxygen in the facility on all days of the lookback period. On the following dates and times, Resident #222 was observed sitting up in his bed. At each observation, he was wearing oxygen delivered through a nasal cannula connected to an oxygen concentrator. The dates, times, and rates of oxygen were as follows: - 9/4/19 at 1: 25 p.m. - 2.5 lpm (liters per minute) - 9/4/19 at 3:59 p.m. - 2.5 lpm - 9/5/19 at 9:00 a.m. - 3.5 lpm - 9/5/19 at 2:15 p.m. - 3.5 lpm A review of Resident #222's physicians' orders revealed the following order, written 8/19/19, "Oxygen @ (at) 3 LPM (liters per minute) via nasal cannula every shift for SOB (shortness of breath)." A review of Resident #222's comprehensive care plan dated 8/20/19 revealed, in part, the following, "The resident has COPD. Is on O2 (oxygen)...Oxygen therapy as ordered by the physician."	F 656	implementation of the care plan. 3. Licensed nurses have been educated on following / implementing the plan of care by DON/Designee. 4. MDS/Designee will audit five care plans for respiratory services implementation/ week for 4 weeks, then 3x/ week for 8 weeks for accurate documentation. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 2019.	

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On 9/5/19 at 9:00 a.m., Resident #222 was interviewed. When asked if he adjusts his own oxygen rate, he stated, "No, only the staff does that. I can't reach it, and I would not know what to do with it if I could reach it."

On 9/5/19 at 2:50 p.m., LPN (licensed practical nurse) #5 was interviewed regarding how staff ensure residents are receiving oxygen at the physician-ordered rate. LPN #5 stated, "Usually, I make my rounds first thing. I look on the computer to see my assignments. I look on the MAR (medication administration record) and TAR (treatment administration record) to see what needs to be done. This is a skilled floor. We have so many people in and out all the time." When asked if she was aware of Resident #222's physician-ordered rate, LPN #5 stated, "I would need to check on that. I am not usually working over here. I would need to check." LPN #5 then checked the order for Resident #222's oxygen, and stated, "It should be three liters." LPN #5 accompanied the surveyor to Resident #555's room. When asked what rate Resident #222's oxygen was set at, LPN #5 stated, "Three and a half. I need to turn it down." She then adjusted the oxygen to the rate of three liters per minute. LPN #5 stated, "I did check on that this morning. But he went out for therapy. When he came back, he was still on the tank. Someone must have moved him from the tank back to the concentrator. I didn't do it."

On 9/5/19 at 3:10 p.m., LPN #1, the assistant director of nursing, was interviewed. When asked about the purpose of a care plan, LPN #1 stated, "The care plan is how you know how to take care of a patient." LPN #1 stated, "The staff can

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access the care plans at any computer."

On 9/5/19 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (director of nursing) were informed of these concerns.

On 9/6/19 at approximately 10:30 a.m., ASM #2 gave the surveyor a copy of the facility's standard of practice regarding oxygen administration. The standard is from the Lippincott Manual of Nursing Practice, 10th edition, pages 239-240. A review of the standard revealed, in part, the following: "Performance phase...3. Set the flow rate at the prescribed liters per minute. Feel to determine if oxygen is flowing through the tips of the cannula."

A review of the facility policy, "Care Plan" revealed, in part, the following: "D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented..."

No further information was provided prior to exit.

(1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
2. The facility staff failed to implement the comprehensive care plan for administering oxygen as ordered for Resident #57.

Resident #57 was admitted to the facility 09/15/2011 with a readmission on 01/03/2019 with diagnoses, that included but were not limited to shortness of breath and atrial fibrillation (1).

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	495407	A. BUILDING _____ B. WING _____	C 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Resident #57's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/12/19, coded Resident #57 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section O of the MDS failed to evidence documentation of Resident #57 receiving oxygen therapy while a resident.

On 9/04/19 at 11:26 a.m., an interview was conducted with Resident #57. Resident #57 stated that she uses her oxygen frequently during the day and wears it every night in bed. When asked how long she has been using oxygen, Resident #57 stated, "About a year now." Resident #57 was observed wearing an oxygen cannula in her nose during the interview in her room. Observation of the oxygen concentrator revealed the oxygen flowrate to be set on 2 1/2 L/Min (liters/minute).

Additional observations on 09/04/19 at 1:47 p.m. and on 09/05/19 at 8:18 a.m. revealed the oxygen concentrator flow meter was set on 2 1/2 L/Min (liter/minute).

The order summary report dated 9/05/2019 documented, "O2 (oxygen) at 3L/Min (liters per minute) as needed for SOB (shortness of breath). Order Date: 05/22/2019. Start Date: 05/22/2019."

The comprehensive care plan "The resident has altered respiratory status/Difficulty Breathing r/t (related to) hx (history) of Pneumonia (2), CHF (congestive heart failure) (3), CAD (coronary artery disease) (4), and anxiety (5) Uses O2. Date Initiated 01/15/2018. Revision on: 07/19/2018." Under "Interventions/Tasks" it

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F 656	Continued From page 51	F 656		

documented, "Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Date Initiated 01/15/2018, Revision on 01/15/2018. Provide oxygen as ordered. Dated Initiated: 01/15/2018, Revision on 01/15/2018."

The eMAR (medication administration record) dated 7/1/2019-7/31/2019, 8/1/2019-8/31/2019, and 9/1/2019-9/30/2019 for Resident #57 documented, "O2 at 3L/Min as needed for SOB. Start Date- 05/22/2019 1030 (10:30 a.m.)."

On 9/05/19 at 3:57 p.m., an interview was conducted with LPN #8. When asked if Resident #57 wears oxygen, LPN #8 stated that she wears oxygen on a regular basis. LPN #8 stated that it is ordered as needed for shortness of breath, but Resident #57 wears it frequently, especially when she is in her room. When asked to describe the process for setting the flowrate of oxygen, LPN #8 stated that you must get eye level to the concentrator and then turn the knob to the correct number that is ordered. When asked to describe the location of the line defining the oxygen number and the silver ball located inside of the flow meter, LPN #8 stated that the line should be aligned in the center of the silver ball. LPN #8 observed the flowmeter on the concentrator located in Resident #57's room and agreed that it was not administering 3L/Min as ordered. LPN #57 stated that the oxygen was set on the 2 1/2 liter/minute line. LPN #8 stated that when you look at it from standing it looks like it is on three but when you are eye level the flow rate is incorrect. When asked if Resident #57 is able to change the settings on the concentrator, LPN #57 stated "No."

On 9/05/19 at 4:50 p.m., an interview was

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F 656	Continued From page 52	F 656		

conducted with LPN #2, the unit manager. When asked if Resident #57 wears oxygen, LPN #2 stated, "Yes, she uses it when in bed." LPN #2 stated that she was concerned that the resident was changing it because it was being checked frequently.

On 09/05/19 at 4:57 p.m., a request was made by written list to ASM (administrative staff member) #1, the administrator for the facility policy on oxygen administration.

On 09/06/19 at 7:39 a.m., ASM #1 stated that the facility did not have a policy on oxygen administration and provided the manufacturer instructions for use for the oxygen concentrator used for Resident #57.

The manufacturer instructions for use "Philips Respironics, EverFlo, EverFlo Q, User Manual" documented, "Chapter 2: Operating Instructions, 6. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate."

A review of the facility policy, "Care Plan" revealed, in part, the following: "D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented..."

On 09/05/19 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:

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F 656	Continued From page 53 1. Atrial fibrillation A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. 2. Pneumonia An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html. 3. Congestive heart failure A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 4. Coronary artery disease A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html. 5. Anxiety Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.	F 656		
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		9/23/19

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F 695 SS=D	Continued From page 54 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice, the comprehensive person-centered care plan, for three of 40 residents in the survey sample, Residents #222, #57, and #67. The facility staff failed to administer oxygen at the physician-ordered rate during multiple observations conducted for Resident #222 and #57, and failed to obtain a physician's order for Resident #67's use of an incentive spirometer. The findings include: 1. During multiple observations the facility staff failed to administer oxygen to Resident #222 at the physician-ordered rate. Resident #222 was admitted to the facility on 8/19/19 with diagnoses including, but not limited to cancer of the esophagus and COPD (chronic obstructive pulmonary disease) (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference	F 695	F695 1. Oxygen settings for resident #222 and #57 were immediately corrected at time of survey. Resident #67 was provided with an order by facility MD for Incentive Spirometer. 2. All residents who reside at Falls Run Nursing and Rehabilitation and receive respiratory services have the potential to be affected. The DON or designee conducted a quality review of all current residents who are provided respiratory care and services for administration of oxygen per physician order, and obtaining orders for the use of an incentive spirometer. 3. Licensed nurses have been educated on providing respiratory care and services consistent with professional standards of practice, administering oxygen at the physician-ordered rate, and obtaining orders for the use of an incentive spirometer by DON/Designee. 4. DON/Designee will audit five residents a week for provision of respiratory services consistent with professional	

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F 695	Continued From page 55 date) of 8/26/19, Resident #222 was coded as having mild cognitive impairment for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). He was coded as receiving oxygen in the facility on all days of the lookback period. On the following dates and times, Resident #222 was observed sitting up in his bed. At each observation, he was wearing oxygen delivered through short tubes in his nose. The dates, times, and rates of oxygen were as follows: - 9/4/19 at 1: 25 p.m. - 2.5 lpm (liters per minute) - 9/4/19 at 3:59 p.m. - 2.5 lpm - 9/5/19 at 9:00 a.m. - 3.5 lpm - 9/5/19 at 2:15 p.m. - 3.5 lpm A review of Resident #222's physicians' orders revealed the following order, written 8/19/19, "Oxygen @ (at) 3 LPM (liters per minute) via nasal cannula every shift for SOB (shortness of breath)" A review of Resident #222's care plan dated 8/20/19 revealed, in part, the following, "The resident has COPD. Is on O2 (oxygen)...Oxygen therapy as ordered by the physician." On 9/5/19 at 9:00 a.m., Resident #222 was interviewed. When asked if he adjusts his own oxygen rate, he stated, "No, only the staff does that. I can't reach it, and I would not know what to do with it if I could reach it." On 9/5/19 at 2:50 p.m., LPN (licensed practical nurse) #5 was interviewed. When asked about how she makes sure residents are receiving oxygen at the physician-ordered rate, LPN #5 stated, "Usually, I make my rounds first thing. I	F 695	standards and per physician orders for 12 weeks. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 2019.	

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look on the computer to see my assignments. I look on the MAR (medication administration record) and TAR (treatment administration record) to see what needs to be done. This is a skilled floor. We have so many people in and out all the time." When asked if she was aware of Resident #222's physician-ordered rate, LPN #5 stated, "I would need to check on that. I am not usually working over here. I would need to check." LPN #5 checked the order for Resident #222's oxygen, and stated, "It should be three liters." LPN #5 accompanied the surveyor to Resident #555's room and observed Resident $#22's oxygen. When asked what flowrate the oxygen was set at, LPN #5 stated, "Three and a half. I need to turn it down." She adjusted the oxygen to the rate of three liters per minute. LPN #5 stated, "I did check on that this morning. But he went out for therapy. When he came back, he was still on the tank. Someone must have moved him from the tank back to the concentrator. I didn't do it."

On 9/5/19 at 3:10 p.m., LPN #1, the assistant director of nursing, was interviewed. She stated, "Everyone in the building checks the oxygen rate on all the devices - the concentrators and portable tanks. But only the nurse can adjust the rates." She stated the nurses check all the rates at the beginning of their shift, and as often as possible throughout the day. She stated the nurses verify what the rate should be against the physician's order.

On 9/5/19 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (director of nursing) were informed of the above concern, and were asked to provide the facility policy on oxygen administration.

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On 9/6/19 at 7:35 a.m., ASM #1 stated that the facility did not have a policy on oxygen administration.

On 9/6/19 at approximately 10:30 a.m., ASM #2 provided a copy of the facility's standard of practice regarding oxygen administration. The standard is from the Lippincott Manual of Nursing Practice, 10th edition, pages 239-240. A review of the standard revealed, in part, the following: "Performance phase...3. Set the flow rate at the prescribed liters per minute. Feel to determine if oxygen is flowing through the tips of the cannula."

No further information was provided prior to exit.

(1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
2. The facility staff failed to administer oxygen at the 3 L/Min (liters per minute) flow rate prescribed by the physician for Resident #57.

Resident #57 was admitted to the facility 09/15/2011 with a readmission on 01/03/2019 with diagnoses, that included but were not limited to shortness of breath and atrial fibrillation (1).

Resident #57's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/12/19, coded Resident #57 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section O of the MDS failed to

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evidence documentation of Resident #57 receiving oxygen therapy while a resident.

On 9/04/19 at 11:26 a.m., an interview was conducted with Resident #57. Resident #57 stated that she uses her oxygen frequently during the day and wears it every night in bed. When asked how long she has been using oxygen, Resident #57 stated, "About a year now." Resident #57 was observed wearing an oxygen cannula in her nose during the interview in her room. Observation of the oxygen concentrator revealed the oxygen flowrate to be set on 2 1/2 L/Min (liters/minute).

Additional observations on 09/04/19 at 1:47 p.m. and on 09/05/19 at 8:18 a.m. revealed the oxygen concentrator flow meter was set on 2 1/2 L/Min (liter/minute).

The order summary report dated 9/05/2019 documented, "O2 (oxygen) at 3L/Min (liters per minute) as needed for SOB (shortness of breath). Order Date: 05/22/2019. Start Date: 05/22/2019."

The eMAR (medication administration record) dated 7/1/2019-7/31/2019, 8/1/2019-8/31/2019, and 9/1/2019-9/30/2019 for Resident #57 documented, "O2 at 3L/Min as needed for SOB. Start Date- 05/22/2019 1030 (10:30 a.m.)."

The comprehensive care plan "The resident has altered respiratory status/Difficulty Breathing r/t (related to) hx (history) of Pneumonia (2), CHF (congestive heart failure) (3), CAD (coronary artery disease) (4), and anxiety (5) Uses O2. Date Initiated 01/15/2018. Revision on: 07/19/2018." Under "Interventions/Tasks" it documented, "Administer medication/puffers as

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ordered. Monitor for effectiveness and side effects. Date Initiated 01/15/2018, Revision on 01/15/2018. Provide oxygen as ordered. Dated Initiated: 01/15/2018, Revision on 01/15/2018."

On 9/05/19 at 3:57 p.m., an interview was conducted with LPN #8. When asked if Resident #57 wears oxygen, LPN #8 stated that she wears oxygen on a regular basis. LPN #8 stated that it is ordered as needed for shortness of breath, but Resident #57 wears it frequently, especially when she is in her room. When asked to describe the process for setting the flowrate of oxygen, LPN #8 stated that you must get eye level to the concentrator and then turn the knob to the correct number that is ordered. When asked to describe the location of the line defining the oxygen number and the silver ball located inside of the flow meter, LPN #8 stated that the line should be aligned in the center of the silver ball. LPN #8 observed the flowmeter on the concentrator located in Resident #57's room and agreed that it was not administering 3L/Min as ordered. LPN #57 stated that the oxygen was set on the 2 1/2 liter/minute line. LPN #8 stated that when you look at it from standing it looks like it is on three but when you are eye level the flow rate is incorrect. When asked if Resident #57 is able to change the settings on the concentrator, LPN #57 stated "No."

On 9/05/19 at 4:50 p.m., an interview was conducted with LPN #2, the unit manager. When asked if Resident #57 wears oxygen, LPN #2 stated, "Yes, she uses it when in bed." When asked the process for setting the flowmeter rate for oxygen on the concentrator, LPN #2 stated that you get down to eye level with the gauge and set it to the prescribed number. LPN #2 stated

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that LPN #8 had informed her that the oxygen for Resident #57 was set at 2 1/2 L/Min and that she had set it back to the prescribed rate of 3 L/Min. LPN #2 stated that she was concerned that the resident was changing it because it was being checked frequently.

On 09/05/19 at 4:57 p.m., a request was made by written list to ASM (administrative staff member) #1, the administrator for the facility policy on oxygen administration.

On 09/06/19 at 7:39 a.m., ASM #1 stated that the facility did not have a policy on oxygen administration and provided the manufacturer instructions for use for the oxygen concentrator used for Resident #57.

The manufacturer instructions for use "Philips Respironics, EverFlo, EverFlo Q, User Manual" documented, "Chapter 2: Operating Instructions, 6. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate."

On 09/06/19 at approximately 9:30 a.m., ASM #2, the director of nursing provided a copy of "Lippincott Manual of Nursing Practice 10th Edition. Procedure Guidelines 10-12. Administering Oxygen by Nasal Cannula." ASM #2 stated that nursing used this as their standard of practice.

Lippincott Manual of Nursing Practice 10th Edition documents in "Procedure Guidelines 10-12. Administering Oxygen by Nasal Cannula. 3. Set the flow rate at the prescribed liters per minute ..."

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On 09/05/19 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Atrial fibrillation
A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

2. Pneumonia
An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html.

3. Congestive heart failure
A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html

4. Coronary artery disease
A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarte

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rydisease.html.

5. Anxiety
Fear. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.
3. The facility staff failed to obtain a physician's order for Resident #67's use of an incentive spirometer (1).

Resident #67 was admitted to the facility on 8/16/19. Resident #67's diagnoses included but were not limited to difficulty swallowing, tremor and surgical aftercare following surgery on the circulatory system. Resident #67's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 8/30/19, coded the resident as being cognitively intact.

Review of Resident #67's clinical record failed to reveal a physician's order for an incentive spirometer. Resident #67's baseline care plan initiated on 8/16/19 failed to reveal documentation regarding an incentive spirometer.

On 9/4/19 at 3:50 p.m., Resident #67 was observed in bed. An incentive spirometer was observed in a bag on the nightstand.

On 9/5/19 at 3:18 p.m., Resident #67 was observed in bed. An incentive spirometer was observed in a bag on the nightstand. Resident #67 was asked if she uses the incentive spirometer. Resident #67 stated she uses the incentive spirometer some but could not state when or how often she uses the device.

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On 9/5/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what should be done for a resident using an incentive spirometer. LPN #1 stated, "They should be taught how to use it. Educated why they are using it and make sure there is a goal attached to it." When asked if there should be a physician's order in place, LPN #1 stated, "Uh huh." When asked why, LPN #1 stated, "So the nurses are aware that needs to take place. That's our documentation proving it." When asked what information the physician's order should contain, LPN #1 stated "Frequency, the goal, the reason they are using it."

On 9/5/19 at 5:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 9/6/19 at 7:39 a.m., ASM #1 stated the facility did not have a policy for incentive spirometers. ASM #1 provided the facility standard of practice from the Lippincott Manual of Nursing Practice 10th edition. The standard of practice documented how to assist the patient using an incentive spirometer and documented, "1. Set the incentive spirometer indicator at the desired goal the patient is to reach or exceed..." but did not document specific information regarding physician's orders.

No further information was presented prior to exit.

(1) "An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths.

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F 695	Continued From page 64 Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for two of 40 residents in the survey sample, Residents #61	F 700	F700 1. Bed rail assessment for resident #61 and #222 were completed on 09/05/19. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the	9/23/19

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F 700	Continued From page 65 and #222. The facility staff failed to assess Resident #61 and Resident #222 for the use of bed rails, and staff failed to review risks and benefits for use of bed rails, and failed to obtain informed consent for the resident's use of bed rails. The findings include: 1. The facility staff failed to evidence that Resident #61 was assessed for the use of bed rails and staff failed to review the risks and benefits and obtain informed consent for the resident's use of bed rails. Resident #61 was admitted to the facility on 8/9/19. Resident #61's diagnoses included but were not limited to heart failure, seizures and history of heart attack. Resident #61's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/21/19, coded the resident's cognition as moderately impaired. Section G coded Resident #61 as requiring extensive assistance of two or more staff with bed mobility. On 9/4/19 at 11:45 a.m., and 9/5/19 at 9:43 a.m., Resident #61 was observed lying in bed. Both bed rails (assist grab bars) were in the upright position while the resident was in bed. Review of Resident #61's clinical record failed to reveal a physician's order for the bed rails. Further review failed to reveal the resident was assessed for the use of the bed rails, failed to reveal the risks and benefits were reviewed with Resident #61 (or the representative) and failed to reveal informed consent was obtained prior to the use of the bed rails. Resident #61's care plan	F 700	potential to be affected. The DON or designee conducted a quality review of all current residents who utilize bed rails for completion of bed rail assessment, and consent for usage. 3. Licensed nurses have been educated on the use of bed rails, assessment, and consent for use as outlined in the bed rail policy by DON/Designee. 4. DON/Designee will audit new admissions for side rail assessments and consent as indicated 5x/ week for 4 weeks, then 3x/ week for 8 weeks for proper documentation. Audit results will be presented monthly for three months to the Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 2019.	

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initiated on 8/8/19 failed to document information regarding the use of bed rails.

On 9/5/19 at 2:30 p.m., ASM (administrative staff member) #1 (the administrator) presented a bed rail assessment completed for Resident #61 on 9/5/19. A note attached to the assessment documented, "Used grab bars on admit for enablers. No longer using due to decline. New assessment and grab bars removed today."

On 9/5/19 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what should be completed for residents using bed rails. LPN #1 stated, "So we would identify what diagnosis they would have that may assist. Assess their diagnosis, why that would help them, what is it going to help them do; bed mobility, turning and positioning, strengthening and safe transfers." When asked if staff assess the residents need for the use of side rails, LPN #1 stated, "Yeah and make sure basically it's not going to put them at risk for any type of injury so we will assess that as well." LPN #1 was asked if the risks and benefits for using side rails are explained to the resident and if informed consent is obtained. LPN #1 stated, "Yeah. If not necessary then we remove them."

On 9/5/19 at 5:12 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern.

A review of the facility policy, "Bed Rails Policy," revealed, in part, the following: "'Bed rails' are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also, some

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bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Procedure: 1. The facility will attempt to use appropriate alternatives prior to installing a side or bed rail. 2. If a bed or side rail is used, the facility will: a. Assess the potential risks associated with the use of bed rails, including the risk of entrapment, prior to bed rail installation. b. Assess the risk versus benefits of using a bed rail and review them with the resident or if applicable, the resident's representative. c. Obtain informed consent for the installation and use of bed rails prior to the installation."

No further information was presented prior to exit.
2. The facility staff failed to assess Resident #222 for the use of bed rails, and staff failed to review risks and benefits for use of bed rails, and failed to obtain informed consent for the resident's use of bed rails.

Resident #222 was admitted to the facility on 8/19/19. Diagnoses include, but not limited to cancer of the esophagus and COPD (chronic obstructive pulmonary disease) (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/26/19, Resident #222 was coded as having mild cognitive impairment for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring the extensive assistance of one staff member for bed mobility and for transferring from bed to wheelchair.

On the following dates and times, Resident #222 was observed sitting up in his bed: 9/4/19 at 1:19 p.m. and 3:59 p.m., 9/5/19 at 9:00 a.m. and 2:15 p.m., and on 9/6/19 at 7:40 a.m. A set of grab

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bars (side rails) were attached to both sides of the bed. The side rails were up at each observation.

On 9/4/19 at 1:19 p.m., Resident #222 was interviewed. When asked about the side rails, he stated, "They are up all the time when I'm in the bed. I use them to help position myself. I hold on to them when I need some support."

A review of Resident #222's clinical record revealed no evidence that the facility attempted any alternatives prior to installing the side rails. There was no evidence of an assessment for the use of side rails, no evidence that Resident #222 was provided the risk and benefits for the use of side rails, and no evidence of informed consent by the resident or that the RR (responsible representative) for the use of side rails.

A review of the physician orders for Resident #222 failed to reveal any orders for use of the side rails.

A review of Resident #222's care plan dated 8/20/19 failed to reveal any information related to Resident #222's use of side rails for bed mobility or transferring.

On 9/5/19 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (director of nursing) were informed of the above concerns, and asked to present any documentation evidencing that alternatives had been attempted for Resident #222 prior to installing the side rails. Any documentation evidencing that Resident #222 had been assessed for the use of side rails, was informed

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F 700	Continued From page 69 of the risk and benefits of the use of the side rails, and evidence that Resident #222 or the RR (responsible party) had given informed consent for the use of side rails On 9/6/19 at 8:15 a.m., LPN (licensed practical nurse) #3 was interviewed. When asked about Resident #222's use of the side rails (grab bars), LPN #3 stated, "Yes, he uses them to help with turning and mobility in the bed." On 9/6/19 at 8:54 a.m., ASM #2 presented the surveyor with a document, "[Name of Corporation] Bed Rail Assessment dated 9/5/19. The document included the headings, Rationale, Risk Potential, and Consent. When asked why this assessment was dated 9/5/19 when the resident had been admitted on 8/19/19, ASM #2 stated, "I agree this is a concern. The nurses see the devices as grab bars, not side rails. That is why there is no assessment or anything on the care plan. We are doing a 100% audit, and updating the ones that need updating. We are doing some education on it." No further information was provided prior to exit. (1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 700		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		9/23/19

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F 812	Continued From page 70 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store food in a sanitary manner in the main kitchen freezer. In the main freezer a box of frozen green beans and lima beans were observed not closed and sealed exposing the food to the environment. The findings include: On 9/4/19 at 11:11 AM to 11:20 AM a tour of the kitchen was conducted with OSM #3 (Other Staff Member) the Assistant Dietary Manager. The following was identified: A box of frozen green beans was found in the freezer, with the lid not securely closed and the bag inside was not sealed. The food was exposed to environment of the freezer. A box of frozen lima beans was found in the	F 812	F812 1. Food storage for 2 items was immediately corrected 09/04/19. 2. All residents who reside at Falls Run Nursing and Rehabilitation have the potential to be affected. The Administrator or designee conducted a quality review of food storage area to ensure food is stored in a safe and sanitary manner. 3. Dietary staff have been educated on proper food storage by Dietary Manager/Designee. An audit was conducted of dietary/kitchen to assure all items were properly stored in a sanitary manner. 4. Dietary Manager/Designee will audit food storage area three times a week for 12 weeks for food storage in a safe and sanitary manner. Audit results will be presented monthly for three months to the	

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F 812	Continued From page 71 freezer, with the lid not securely closed and the bag inside was not sealed. The food was exposed to environment of the freezer. On 9/4/19 at approximately 11:15 AM, OSM #3 stated it should be sealed. On 9/4/19 at approximately 11:17 AM, OSM #2, the Dietary Manager, was notified of the concern. A review of the facility policy, "Storage of Frozen Foods" documented, "...11. Food stored in the freezer shall be covered, labeled and dated." On 9/5/19 at the end of day meeting at approximately 5:00 PM, ASM #1 (Administrative Staff Member), the Administrator, was notified of the concern. No further information was provided.	F 812	Quality Assurance Performance Improvement committee for review and recommendation. 5. Date of Compliance: October 1, 2019. Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	