State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON COURT REHABILITATION & HEALTH C	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 10/1/19 through 10/3/19. The facility was in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 190 certified bed facility was 158 at the time of the survey. The survey sample consisted of 59 current resident reviews and 4 closed record reviews.	F 000	Lexington Rehabilitation and Healthcare shares the state focus on the health, safety, and wellbeing of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, it has implemented this plan of correction to demonstrate its continuing efforts to provide quality care to its residents. Any area cited by the survey team is placed into our Quality Assurance and Process Improvement process and monitored through this system to assure compliance.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-140. Policies and Procedures Cross references to F623, F758 12VAC5-371-150. Resident Rights. Cross reference to F623 12VAC5-371-220. Nursing Services. Cross reference to F758 12VAC5-371-240. Physician Services. Cross reference to F758 12VAC5-371-250. Resident Assessment and Care Planning. Cross reference to F758 12VAC5-371-300. Pharmaceutical Services. Cross reference to F758 Staff Development and Inservice Training 12vac-371-260F cross reference F730	F 001	**F 001 STATE REGULATION FOR USE OF CRIMINAL BACKGROUND DATABASE** **12VAC5-371-210. Nurse Staffing cross reference to F725.** **12VAC5-371-250. Resident Assessment and Care Planning cross reference to F641.** **12VAC5-371-300. Pharmaceutical Services cross reference F761.** **12VAC5-371-250. Resident Assessment and Care Planning cross reference to F656.** **12VAC5-371-250. Resident Assessment and Care Planning cross reference to F657.** **12VAC5-371-250. Nursing Services cross reference to F686.** **12VAC5-371-220. Nursing Services cross reference to F688.** **12VAC5-371-140. Policies and Procedures cross reference to F689.** **12VAC5-371-220. Nursing Services cross reference to F695.** **12VAC5-371-220. Nursing Services cross reference to F698.** **12VAC5-371-180. Infection Control cross reference to F880** **12VAC5-371-140 (E)(3)(B)**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Administrator | (X6) DATE: 10/31/19

STATE FORM 021199 ZY4V11

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State of Virginia

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F 001 Continued From Page 1

F 001

12VAC5-371-210. Nurse Staffing
cross reference to F725.

12VAC5-371-250. Resident Assessment and Care Planning
cross reference to F641.

12VAC5-371-300. Pharmaceutical Services
cross reference to F761.

12VAC5-371-250. Resident Assesment and Care Planning
Cross reference to F656.

12VAC5-371-250. Resident Assesment and Care Planning
Cross reference to F657

12VAC5-371-220. Nursing Services
Cross reference to F686

12VAC5-371-220. Nursing Services
Cross reference to F688

12VAC5-371-140. Policies and Procedures
Cross reference to F689

12VAC5-371-220. Nursing Services
Cross reference to F695

12VAC5-371-220. Nursing Services
Cross reference to F698

12VAC5-371-180. Infection Control
Cross reference to F880

12 VAC 5-371-140(E)(3)(B)

Based on facility documentation review and staff

1) The criminal background check for Employee #6 could not be located. Employee #6 is no longer employed by the facility.
2) Potentially all employees could be affected by this practice.
3) A 100% audit of employee files will be audited for the presence of criminal background checks. A request for a current background check will be made for any employee whose hire background check is not located.
4) The Human Resources Director will audit new hire files monthly for completion of criminal background check. Any instance of non-compliance will be reported to the Administrator.
5) Compliance Date: 11/01/2019

State of Virginia

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F 001	Continued From Page 2	F 001		

interview, facility staff failed to maintain a complete employee file for one of 25 employee records reviewed, that of Certified Nurse Aide (CNA) #6.

The facility Staff failed to evidence a criminal background check was conducted prior to hire for CNA #6.

The findings included:

A review of employee records was conducted beginning on 10/02/2019. During this review, it was noted that the file for CNA #6 did not contain a background check. Other Staff Member (OSM) #5, the Human Resources Manager, was asked to locate CNA #6's background check.

On the afternoon of 10/03/2019, OSM #5 stated that they were unable to locate the background check for CNA #6.

Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 10/03/2019. No further documentation was provided.

PRINTED: 10/15/2019
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/01/2019 through 10/03/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	Lexington Rehabilitation and Healthcare shares the state focus on the health, safety, and wellbeing of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, it has implemented this plan of correction to demonstrate its continuing efforts to provide quality care to its residents.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/1/19 through 10/3/19. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 190 certified bed facility was 158 at the time of the survey. The survey sample consisted of 59 current resident reviews and 4 closed record reviews.	F 000	Any area cited by the survey team is placed into our Quality Assurance and Process Improvement process and monitored through this system to assure compliance.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make	F 561	**F561 RESIDENT PREFERENCES** 1) Resident #8's shower schedule has been adjusted to reflect her preference for 2 showers per week 2) All residents with specific bathing or shower preferences could be affected. A brief interview to determine preferences will be completed for all residents currently in house. 3) A) Shower schedules will be adjusted to reflect resident preferences and noted in the resident care plan. B) Showers given will be recorded on Shower/Skin Observation forms C) CNAs will be educated on honoring resident preference, shower schedules and documentation of completed showers 4) A) Unit Managers will review the documentation of showers daily to ensure preferences are met B) Compliance with the completion of showers and preferences will be reviewed at the weekly facility skin/wound meeting 5) Compliance Date: 11/01/2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 10/31/19

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

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F 561	Continued From page 1 choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to honor the preference for showers twice a week for one sampled resident, (Resident #8), coded as being dependent upon staff for bathing, in the survey sample of 63 residents. Resident #8, who was coded as dependent for bathing with one staff assistance required stated she preferred two showers a week and that staff only provided her one shower a week. Resident #8's bathing documentation evidenced she was only provided three showers during the month of September 2019. The findings include: Resident #8 was admitted to the facility on 03/22/2019. Resident #8's diagnoses included but were not limited to cerebral infarction (1) and schizoaffective disorder (2). Resident #8 was admitted to the facility on 03/22/2019. Resident #8's diagnoses included but were not limited to	F 561		

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F 561	Continued From page 2 cerebral infarction (1) and schizoaffective disorder (2). Resident #8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/25/19, coded Resident #8 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. Resident #8 was coded as being totally dependent on one person for physical assistance with bathing. The admission MDS dated 03/29/19 documented under preferences for customary routine and activities that Resident #8 felt it was very important that she choose between a tub bath, shower, bed bath or sponge bath. The comprehensive care plan for Resident #8 documented "Resident requires staff assistance with (eating, personal hygiene, grooming, dressing, toileting, bathing) secondary to: cognitive impairments, impaired mobility. Start Date: 03/22/2019, Edited: 07/16/2019." Under "Approach" it documented, "Resident requires the assistance of one person for all adls (activities of daily living). Created: 03/22/2019." On 10/1/19 at approximately 4:00 p.m., an interview was conducted with Resident #8. When asked if staff assist with showers, Resident #8 stated that she gets showers once a week. Resident #8 stated, "I am supposed to get them twice a week but they never do it." She stated it was her preference to take showers twice a week but she felt that staff just could not get it done. She stated staff did give her sponge baths. When asked how not getting showers as scheduled made her feel Resident #8 stated that it upsets her sometimes that staff is so busy.	F 561		

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F 561	Continued From page 3 Review of Resident #8's electronic ADL (activities of daily living) flowsheet for 9/1/19 to 9/30/19 revealed documentation of a shower received on 9/18/19 and 9/25/19. On 10/3/19 at 11:20 a.m., an interview was conducted with CNA (certified nursing assistant) #2. When asked how showers are scheduled for residents CNA #2 stated that all residents are showered twice a week and are split among the day, evening and night shift. When asked if showers are documented when they are given CNA #2 stated that they are documented on the kiosk (computer) and then put into the book at the nurse's station. CNA #2 stated that skin assessments are also completed during shower days. When asked if refusals are documented, CNA #2 stated that refusals are documented in the book, in the computer and the charge nurse is notified. CNA #2 stated that if showers are not completed on the scheduled shift the next shift is notified to complete them. When asked specifically about Resident #8's shower schedule, CNA #2 stated that she was pretty sure Resident #8 was on the 11-7 (11pm - 7am) shift schedule for Tuesday and Thursdays. When asked to review the shower records for Resident #8, CNA #2 reviewed several binders at the nurse's station and was unable to locate any records for Resident #8. Review of the binder titled [11-7 [Name of Facility unit] Shower Book] failed to evidence documentation of showers for Resident #8. CNA #2 stated that the shower logs should be in the book. On 10/3/19 at 11:45 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked how showers are scheduled, LPN #6 stated that all residents are showered twice a	F 561		

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F 561	Continued From page 4 week. LPN #6 stated that the night shift has the least amount of aides, right now they only have two aides on the night shift and it is hard to do the showers that are scheduled for the residents during those times. LPN #6 stated that they are in the process of changing the schedule for showers to accommodate the residents. When asked how showers are documented, LPN #6 stated that showers are documented in the computer and also on paper in a book kept at the nurse's station. LPN #6 stated that if a shower is refused it is documented on the computer and in the book. LPN #6 stated that if the aides do not get the showers from night shift completed they report to the day shift so that the shower can be given then. On 10/3/19 at approximately 12:30 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing, for the shower records for September 2019 for Resident #8. On 10/3/19 at approximately 3:45 p.m., a document titled "[Name of Facility] CNA Skin Observations]" dated for the month of September for Resident #8 was provided. Review of the document revealed documentation of a shower for Resident #8 on 9/11/19, 9/18/19 and 9/25/19. Further review of the document revealed an area for documentation of bathing dated 9/4/19 with a CNA signature but did not contain documentation in the area. The document failed to evidence Resident #8 receiving showers twice a week as scheduled and per the resident's preference. The facility document "Resident Rights" documented in part, "The resident has the right to be informed of, and participate in, his or her	F 561		

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F 561	Continued From page 5	F 561		

treatment, including: The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency and the duration of care, and any other factors related to the effectiveness of the plan of care ..."

The facility policy "Shower Skin Sheets Protocol/Competency" documented the process for completing the shower sheet form and provided a staff competency tool. The document did not provide any guidance on following the shower schedule.

"Fundamentals of Nursing" 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 863, documented, " Providing hygiene is a very basic part of a client's care. Caring practices help to alleviate the client's anxiety and promote comfort and relaxation while performing each hygiene measure."

On 10/3/19 at 4:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

References:

1. Cerebral infarction
A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:
https://medlineplus.gov/ency/article/000726.htm

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F 561	Continued From page 6 2. Schizoaffective disorder A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.	F 561		
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 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	F 578	**F 578 PERIODIC REVIEW OF ADVANCED DIRECTIVES** 1) The Social Workers have scheduled meetings with Resident #'s 65, 106, 112, 21, 159, 8, 85, 60, 57, 148, 18, 73, 12, 99, 78, 150, 110, 45 and/or their representatives to review advanced directives. 2) All residents are potentially affected by this practice. 3) A) Information regarding Advance Directives will be posted in the November 2019 resident newsletter. B) A mailing will be sent to current and/or their responsible representative with information regarding Advanced Directives and a request for any updates to emergency contact, responsible representative and Advanced Directives. C) Advanced Directives will be discussed with residents and/or their representative during care plan meetings. The discussion will be documented on the Care Plan Signature form. 4) The MDS Director or designee will audit care plan signature forms and/or care conference notes for documentation of Advance Directives review. Audits will be completed on 100% of residents scheduled for care plans weekly for 4 weeks, then 25% of residents scheduled for care plans monthly for 3 months. Results of the audit will be presented to the monthly Quality Assurance and Performance Improvement Committee for review and recommendations. 5) Compliance Date: 11/01/2019	

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information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

This REQUIREMENT is not met as evidenced by:

Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to meet the advance directive* requirements for eighteen of 63 residents in the survey sample, Residents #65, #106, #112, #21, #159, #8, #85, #60, #57, #148, #18, #73, #12, #99, #78, #150, #110 and #45.

*"What kind of medical care would you want if you were too ill or hurt to express your wishes? Advance directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. They give you a way to tell your wishes to family, friends, and health care professionals and to avoid confusion later on.

A living will tells which treatments you want if you are dying or permanently unconscious. You can accept or refuse medical care. You might want to include instructions on

- The use of dialysis and breathing machines
- If you want to be resuscitated if your breathing or heartbeat stops
- Tube feeding
- Organ or tissue donation

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A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions for you if you are unable to do so." This information was obtained from the website: https://medlineplus.gov/advancedirectives.html

The findings include:

1. The facility staff failed to implement the advanced directive policies and procedures to review periodically Resident #65's (or the representative's) decisions regarding all advance directives.

The facility policy titled, "Advance Directives and Code Status" documented, "5. Periodically, the resident and/or resident representative will be asked to confirm their decision regarding code status (the decision whether or not to implement cardiopulmonary resuscitation in the event the heart stops beating) and advance directives to insure the resident's right to accept or refuse medical treatment is upheld..."

Resident #65 was admitted to the facility on 9/16/16. Resident #65's diagnoses included but were not limited to heart failure, diabetes and high cholesterol. Resident #65's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/22/19, coded the resident's cognition as moderately impaired.

Review of Resident #65's clinical record failed to reveal a periodic review regarding all advance directives (except code status) since admission.

A social services note dated 7/22/19 documented

F 578 Continued From page 9 F 578

Resident #65's do not resuscitate code status order but failed to document further information regarding the resident's advance directives.

On 10/3/19 at 10:19 a.m., an interview was conducted with OSM (other staff member) #1 (the social services director), OSM #3 (the admissions liaison) and OSM #4 (the admissions director). OSM #4 stated the admission department's responsibility was to review advance directives with residents/representatives upon admission but not periodically. OSM #1 stated she periodically reviews code status with residents/representatives at care plan meetings and as needed but does not periodically review all advance directives in their entirety. OSM #1 was not aware the facility policy documented the facility will periodically review advance directives with residents/representatives.

On 10/3/19 at 10:37 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality nurse) were made aware of the above concern.

No further information was presented prior to exit.

2. The facility staff failed to implement the advanced directive policies and procedures to review periodically Resident #106's (or the representative's) decisions regarding all advance directives.

The facility policy titled, "Advance Directives and Code Status" documented, "5. Periodically, the resident and/or resident representative will be asked to confirm their decision regarding code status (the decision whether or not to implement cardiopulmonary resuscitation in the event the

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heart stops beating) and advance directives to insure the resident's right to accept or refuse medical treatment is upheld..."

Resident #106 was admitted to the facility on 2/8/18. Resident #106's diagnoses included but were not limited to quadriplegia (paralysis of all four limbs), anxiety disorder and difficulty swallowing. Resident #106's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/15/19, coded the resident's cognition as moderately impaired.

Review of Resident #106's clinical record failed to reveal a periodic review regarding all advance directives (except code status) since admission.

A social services note dated 8/15/19 documented Resident #106's full code status order but failed to document further information regarding the resident's advance directives.

On 10/3/19 at 10:19 a.m., an interview was conducted with OSM (other staff member) #1 (the social services director), OSM #3 (the admissions liaison) and OSM #4 (the admissions director). OSM #4 stated the admission department's responsibility was to review advance directives with residents/representatives upon admission but not periodically. OSM #1 stated she periodically reviews code status with residents/representatives at care plan meetings and as needed but does not periodically review all advance directives in their entirety. OSM #1 was not aware the facility policy documented the facility will periodically review advance directives with residents/representatives.

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F 578	Continued From page 11 On 10/3/19 at 10:37 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality nurse) were made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to implement the advanced directive policies and procedures to review periodically Resident #112's (or the representative's) decisions regarding all advance directives. The facility policy titled, "Advance Directives and Code Status" documented, "5. Periodically, the resident and/or resident representative will be asked to confirm their decision regarding code status (the decision whether or not to implement cardiopulmonary resuscitation in the event the heart stops beating) and advance directives to insure the resident's right to accept or refuse medical treatment is upheld..." Resident #112 was admitted to the facility on 8/11/12. Resident #112's diagnoses included but were not limited to diabetes, convulsions and functional urinary incontinence. Resident #112's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/24/19, coded the resident's cognition as moderately impaired. Review of Resident #112's clinical record failed to reveal a periodic review regarding all advance directives (except code status) since admission. A social services note dated 8/23/19 documented Resident #112's do not resuscitate code status	F 578		

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F 578	Continued From page 12 order but failed to document further information regarding the resident's advance directives. On 10/3/19 at 10:19 a.m., an interview was conducted with OSM (other staff member) #1 (the social services director), OSM #3 (the admissions liaison) and OSM #4 (the admissions director). OSM #4 stated the admission department's responsibility was to review advance directives with residents/representatives upon admission but not periodically. OSM #1 stated she periodically reviews code status with residents/representatives at care plan meetings and as needed but does not periodically review all advance directives in their entirety. OSM #1 was not aware the facility policy documented the facility will periodically review advance directives with residents/representatives. On 10/3/19 at 10:37 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality nurse) were made aware of the above concern. No further information was presented prior to exit. 4. The facility staff failed to implement the advanced directive policies and procedures to review periodically Resident #21's (or the representative's) decisions regarding all advance directives. The facility policy titled, "Advance Directives and Code Status" documented, "5. Periodically, the resident and/or resident representative will be asked to confirm their decision regarding code status (the decision whether or not to implement cardiopulmonary resuscitation in the event the heart stops beating) and advance directives to insure the resident's right to accept or refuse	F 578		

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F 578	Continued From page 13 medical treatment is upheld..." Resident #21 was admitted to the facility on 9/29/17 and most recently readmitted on 6/19/19 with diagnoses including, but not limited to cerebral palsy (1) and diabetes mellitus (2). On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 7/1/19, Resident #21 was coded as being severely impaired for making daily decisions. Review of Resident #21's clinical record failed to reveal a periodic review regarding all advance directives (except code status) since admission. A social services note dated 7/23/19 documented Resident #21's do not resuscitate code status order but failed to document further information regarding the resident's advance directives. On 10/3/19 at 10:19 a.m., an interview was conducted with OSM (other staff member) #1 (the social services director), OSM #3 (the admissions liaison) and OSM #4 (the admissions director). OSM #4 stated the admission department's responsibility was to review advance directives with residents/representatives upon admission but not periodically. OSM #1 stated she periodically reviews code status with residents/representatives at care plan meetings and as needed but does not periodically review all advance directives in their entirety. OSM #1 was not aware the facility policy documented the facility will periodically review advance directives with residents/representatives. On 10/3/19 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the	F 578		

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F 578	Continued From page 14 director of nursing, and ASM #3, the corporate quality nurse, were informed of these concerns. No further information was provided prior to exit. (1) "Cerebral palsy is a group of disorders that affect a person's ability to move and to maintain balance and posture." This information is taken from the website https://medlineplus.gov/cerebralpalsy.html. (2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html. 5. The facility staff failed to implement the advanced directive policies and procedures to review periodically Resident #159's (or the resident's representative) decisions regarding advance directives. Resident #159 was admitted to the facility on 04/15/2019. Resident #159's diagnoses included but were not limited to cerebral infarction (1) and atrial fibrillation (2). Resident #159's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/16/19, coded Resident #159 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. Review of Resident #159's clinical record revealed the status of full code (full life-saving interventions) but failed to reveal documentation of periodic review regarding advance directives. The comprehensive care plan for Resident #159	F 578		

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F 578	Continued From page 15 dated 09/19/2019 failed to document a care plan addressing advanced directives. On 10/1/19 at approximately 4:30 p.m., an interview was conducted with Resident #159. When asked if staff periodically review advance directives, Resident #159 stated, "No, not that I know of." On 10/2/19 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for the evidence that advance directives were discussed upon admission and periodic reviews were conducted for Resident #159. On 10/2/19 at approximately 7:30 a.m., OSM (other staff member) #1, the director of social services provided a document titled "Care Conference Report" for Resident #159. It documented the following: - "7/30/2019 Quarterly Care Plan meeting held 7/30/19. Resident and her daughters were invited and both daughters attended. Resident has a Full Code status and she is prescribed a psychotropic medication (3) ...Care Plan will be reviewed and updated appropriately." - "9/3/2019 Quarterly Care Plan meeting held today. Resident and her daughters were invited and both daughters attended. Resident is Full Code status and is prescribed psychotropic medication ...Care Plan will be reviewed and updated appropriately." - "9/19/2019 Significant Change Care Plan meeting held 09/19/19. Resident and her daughters were invited and her daughters attended. Resident remains a Full Code status and she is prescribed a psychotropic medication for her dementia (4) ...Care Plan will be reviewed	F 578		

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and updated appropriately."

On 10/03/2019 at 10:20 a.m., an interview was conducted with OSM #1. When asked about the process for periodic review of advance directives at the facility, OSM #1 stated that code status is discussed at care plan meetings and periodically, to see if the resident or the resident's representative has changed the status. OSM #1 stated that the entire advance directive is not brought up unless there is a question about it but the code status is always reviewed. The facility policy "Advance Directives and Code Status" that documented "Periodically, the resident and/or resident representative will be asked to confirm their decision regarding code status and advance directives to insure the resident's right to accept or refuse medical treatment is upheld. (Examples of periodic confirmation include but are not limited to discussions of code status and advance directives at each resident care plan conference)" was reviewed with OSM #1. OSM #1 stated that she was not aware of that part of the policy and that only the code status was being reviewed in care plan meetings.

On 10/3/19 at approximately 10:30 a.m., a request was made to OSM #1 for any additional documentation for Resident #159 regarding periodic review of advance directives.

On 10/3/19 at approximately 11:30 a.m., OSM #1 provided a copy of page 8 from the admission agreement documenting "Advance Directive Acknowledgement" and page 10 documenting the signature of Resident #159's responsible party dated April 15, 2019.

On 10/3/19 at 3:35 p.m., an interview was

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conducted with OSM #1 regarding the admission agreement document provided for Resident #159. When asked if the document provided evidence of periodic review of advance directives OSM #1 stated, "No." OSM #1 stated that the admission agreement document provided shows that they were discussed on admission only. OSM #1 stated that staff have been good about reviewing code status but have not been reviewing the advance directives.

The facility policy "Advance Directives and Code Status, December 12, 2016" documented, "5. Periodically, the resident and/or resident representative will be asked to confirm their decision regarding code status and advance directives to insure the resident's right to accept or refuse medical treatment is upheld. (Examples of periodic confirmation include but are not limited to discussions of code status and advance directives at each resident care plan conference.)"

On 10/3/19 at 4:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

References:

1. Cerebral infarction
A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:

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F 578	Continued From page 18 https://medlineplus.gov/ency/article/000726.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 3. Psychotropic Acting on the mind: psychotropic drugs. This information was obtained from the website: https://www.merriam-webster.com/dictionary/psychotropic 4. Dementia A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm 6. The facility staff failed to implement the advanced directive policies and procedures to review periodically Resident #8's (or the resident's representative) decisions regarding advance directives. Resident #8 was admitted to the facility on 03/22/2019. Resident #8's diagnoses included but were not limited to cerebral infarction (1) and schizoaffective disorder (2). Resident #8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/25/19, coded Resident #8 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 578		

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F 578	Continued From page 19 Review of Resident #8's clinical record revealed the status of full code (full life-saving interventions) but failed to reveal documentation of periodic review regarding advance directives. The comprehensive care plan for Resident #8 dated 07/16/2019 failed to document a care plan addressing advanced directives. On 10/1/19 at approximately 4:00 p.m., an interview was conducted with Resident #8. When asked if staff periodically review advance directives, Resident #8 stated, "I don't think so." On 10/2/19 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for the evidence that advance directives were discussed upon admission and periodic reviews were conducted for Resident #8. On 10/2/19 at approximately 7:30 a.m., OSM (other staff member) #1, the director of social services provided a document titled "Care Conference Report" for Resident #8. It documented the following: - "7/16/2019 Quarterly Care Plan Note: Resident and RP (responsible party) were invited to care plan meeting, but did not attend ... She (Resident #8) is Full Code and prescribed psychotropic medication for schizoaffective disorder and seizures (3) ...Care plan will be reviewed and updated appropriately." On 10/03/2019 at 10:20 a.m., an interview was conducted with OSM #1. When asked the process for periodic review of advance directives at the facility OSM #1 stated that code status is discussed at care plan meetings and periodically,	F 578		

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F 578	Continued From page 20 to see if the resident or the resident's representative have changed the status. OSM #1 stated that the entire advance directive is not brought up unless there is a question about it but the code status is always reviewed. The facility policy "Advance Directives and Code Status" that documented "Periodically, the resident and/or resident representative will be asked to confirm their decision regarding code status and advance directives to insure the resident's right to accept or refuse medical treatment is upheld. (Examples of periodic confirmation include but are not limited to discussions of code status and advance directives at each resident care plan conference)" was reviewed with OSM #1. OSM #1 stated that she was not aware of that part of the policy and that only the code status was being reviewed in care plan meetings. On 10/3/19 at approximately 10:30 a.m., a request was made to OSM #1 for any additional documentation for Resident #8 regarding periodic review of advance directives. On 10/3/19 at approximately 11:30 a.m., OSM #1 provided a copy of page 8 from the admission agreement documenting "Advance Directive Acknowledgement" and page 10 documenting the signature of Resident #8 dated March 26, 2019. On 10/3/19 at 3:35 p.m., an interview was conducted with OSM #1 regarding the admission agreement document provided for Resident #8. When asked if the document provided evidence of periodic review of advance directives OSM #1 stated, "No." OSM #1 stated that the admission agreement document provided shows that they were discussed on admission only. OSM #1 stated that staff have been good about reviewing	F 578		

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F 578	Continued From page 21 code status but have not been reviewing the advance directives. On 10/3/19 at 4:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. References: 1. Cerebral infarction A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm 2. Schizoaffective disorder A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm. 3. Seizure Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html. 7. The facility staff failed to implement the advanced directive policies and procedures to	F 578		

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F 578	Continued From page 22 review periodically Resident #85's (or the resident's representative) decisions regarding advance directives. Resident #85 was admitted to the facility on 01/28/2016 with a readmission on 01/08/2018. Resident #85's diagnoses included but were not limited to anoxic brain damage (1) and seizures (2). Resident #85's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/06/19, coded Resident #85 as being severely impaired for making daily decisions. Review of Resident #85's clinical record revealed the status of full code (full life-saving interventions) but failed to reveal documentation of periodic review regarding advance directives. The comprehensive care plan for Resident #85 dated 08/27/2019 failed to document a care plan addressing advanced directives. On 10/2/19 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for the evidence that advance directives were discussed upon admission and periodic reviews were conducted for Resident #85. On 10/2/19 at approximately 7:30 a.m., OSM (other staff member) #1, the director of social services provided a document titled "Care Conference Report" for Resident #85. It documented the following: - "12/18/2018 Annual Care Plan meeting held today. Resident and his family were invited, but did not attend. Resident is Full Code status, prescribed psychotropic medication (3) for	F 578		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 23 convulsions (seizures), and resides on the [Name of Facility Unit] for LTC (long term care) ... Care Plan will be reviewed and updated appropriately." - "3/19/2019 Quarterly Care Plan meeting held 3/19/19. Resident and his family were invited, with resident's mother being in attendance. Resident is Full Code status and is prescribed psychotropic medication for convulsions ... Care Plan will be reviewed and updated appropriately." - "6/18/2019 Quarterly Care Plan meeting held 6/18/19. Resident and his spouse were invited but were not in attendance. Resident remains a Full Code status and he is prescribed psychotropic medication for seizures ... Care Plan will be reviewed and updated appropriately." - "8/27/2019 Quarterly Care Plan meeting held today. Resident and his spouse were invited and both attended the meeting. Resident remains Full Code status and prescribed psychotropic medication for seizures ... Care Plan will be reviewed and updated appropriately." On 10/03/2019 at 10:20 a.m., an interview was conducted with OSM #1. When asked the process for periodic review of advance directives at the facility OSM #1 stated that code status is discussed at care plan meetings and periodically, to see if the resident or the resident's representative have changed the status. OSM #1 stated that the entire advance directive is not brought up unless there is a question about it but the code status is always reviewed. The facility policy "Advance Directives and Code Status" that documented "Periodically, the resident and/or resident representative will be asked to confirm their decision regarding code status and advance directives to insure the resident's right to accept or refuse medical treatment is upheld. (Examples of periodic confirmation include but are not limited	F 578		

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F 578	Continued From page 24 to discussions of code status and advance directives at each resident care plan conference)" was reviewed with OSM #1. OSM #1 stated that she was not aware of that part of the policy and that only the code status was being reviewed in care plan meetings. On 10/3/19 at approximately 10:30 a.m., a request was made to OSM #1 for any additional documentation for Resident #85 regarding periodic review of advance directives. On 10/3/19 at approximately 11:30 a.m., OSM #1 provided a copy of page 5 from the admission agreement documenting "Advance Directive Acknowledgement" and page 6 documenting the signature of Resident #85's responsible party dated 1/28/2016. On 10/3/19 at 3:35 p.m., an interview was conducted with OSM #1 regarding the admission agreement document provided for Resident #8. When asked if the document provided evidence of periodic review of advance directives OSM #1 stated, "No." OSM #1 stated that the admission agreement document provided shows that they were discussed on admission only. OSM #1 stated that staff have been good about reviewing code status but have not been reviewing the advance directives. On 10/3/19 at 4:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. References:	F 578		

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F 578	Continued From page 25	F 578		

1. Anoxic brain damage
Not enough oxygen getting to the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001435.htm

2. Seizure
Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

3. Psychotropic
Acting on the mind: psychotropic drugs. This information was obtained from the website: https://www.merriam-webster.com/dictionary/psychotropic

8. The facility staff failed to implement the advanced directive policies and procedures to review periodically Resident #60's (or the resident's representative) decisions regarding advance directives.

Resident #60 was admitted to the facility on 02/06/2019 with a readmission on 06/10/2019. Resident #60's diagnoses included but were not limited to chronic obstructive pulmonary disease (1) and diabetes (2). Resident #60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/18/19, coded Resident #60 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.

Review of Resident #60's clinical record revealed

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F 578	Continued From page 26 the status of full code (full life-saving interventions) but failed to reveal documentation of periodic review regarding advance directives. The comprehensive care plan "Adjusting to a new facility due to recent admission for LTC (long term care). Start Date: 02/06/2019. Edited: 08/07/2019" for Resident #60 dated 02/06/2019 documented "Provide information on advanced directives, medications, ordered treatments. Created: 02/06/2019." On 10/2/19 at approximately 5:00 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for the evidence that advance directives were discussed upon admission and periodic reviews were conducted for Resident #60. On 10/2/19 at approximately 7:30 a.m., OSM (other staff member) #1, the director of social services provided a document titled "Care Conference Report" for Resident #60. It documented the following: - "4/9/2019 Quarterly Care Plan meeting held today. Resident and her RP (responsible party) were invited to the meeting and both attended. Resident is full code and prescribed psychotropic medication (3) for paranoid schizophrenia (4) ... her care plan will be updated as is necessary." - "6/4/2019 Quarterly Care Plan meeting held 6/4/19. Resident and family were invited though neither attended. Resident resides in the [Name of Facility unit] under LTC (long term care) and is Full Code Status ... her care plan will be updated as is necessary." - "8/6/2019 Quarterly Care Plan meeting held today. Resident and her RP were invited to meeting but did not attend. Resident is full code	F 578		

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F 578	Continued From page 27 and prescribed psychotropic meds for paranoid schizophrenia ... Care Plan will be reviewed and appropriately updated." On 10/03/2019 at 10:20 a.m., an interview was conducted with OSM #1. When asked the process for periodic review of advance directives at the facility OSM #1 stated that code status is discussed at care plan meetings and periodically, to see if the resident or the resident's representative have changed the status. OSM #1 stated that the entire advance directive is not brought up unless there is a question about it but the code status is always reviewed. The facility policy "Advance Directives and Code Status" that documented "Periodically, the resident and/or resident representative will be asked to confirm their decision regarding code status and advance directives to insure the resident's right to accept or refuse medical treatment is upheld. (Examples of periodic confirmation include but are not limited to discussions of code status and advance directives at each resident care plan conference)" was reviewed with OSM #1. OSM #1 stated that she was not aware of that part of the policy and that only the code status was being reviewed in care plan meetings. On 10/3/19 at approximately 10:30 a.m., a request was made to OSM #1 for any additional documentation for Resident #60 regarding periodic review of advance directives. On 10/3/19 at approximately 11:30 a.m., OSM #1 provided a copy of page 8 from the admission agreement documenting "Advance Directive Acknowledgement" and page 10 documenting the signature of Resident #60's responsible party dated 2/6/2019.	F 578		

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On 10/3/19 at 3:35 p.m., an interview was conducted with OSM #1 regarding the admission agreement document provided for Resident #60. When asked if the document provided evidence of periodic review of advance directives OSM #1 stated, "No." OSM #1 stated that the admission agreement document provided shows that they were discussed on admission only. OSM #1 stated that staff have been good about reviewing code status but have not been reviewing the advance directives.

On 10/3/19 at 4:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

References:

1. Chronic obstructive pulmonary disease
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.

2. Diabetes
A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

3. Psychotropic
Acting on the mind: psychotropic drugs. This information was obtained from the website: https://www.merriam-webster.com/dictionary/psychotropic

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4. Paranoid schizophrenia
The paranoid type of schizophrenia is dominated by delusions and/or auditory hallucinations. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/17236.htm.

9. The facility staff failed to evidence that the policies and procedures advanced directives were implemented for review periodically of the residents advance directive status with Resident #57 and/or his responsible party (RP) to ascertain if they wanted to change anything or maintain the advance directives as written.

Resident #57 was admitted on 1/29/13 with the diagnoses of but not limited to dementia with behaviors, rheumatoid arthritis, high blood pressure, dysphagia, diabetes, psychosis, depression, anxiety, glaucoma, pressure ulcer, and insomnia. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) coded the resident as being severely impaired in ability to make daily life decisions.

A review of the clinical record revealed a signed acknowledgement dated 1/29/13, that the resident and/or responsible party were provided with Advance Directive information. The acknowledgement documented, "By signing this agreement, You agree that You have received an oral and written explanation of Your right to make an advance decision "Advance Directive" about life-sustaining or life-prolonging measures in cases where You are acutely and terminally ill and not conscious or otherwise competent to make decisions. (Facility) will not withhold or withdraw life-sustaining or life-prolonging measures from

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F 578	Continued From page 30 You without an Advance Directive and a Physician Order. You understand that You are not required to execute an Advance Directive. The terms of any Advance Directive that You have executed will be followed by (facility) to the extent permitted by law." The resident was checked as having provided Advance Directives. Further review of the clinical record failed to reveal any evidence that the resident's Advance Directives were reviewed periodically with the resident's responsible party to ascertain if they wanted to change anything or maintain the Advance Directives as written. On 10/3/19 at 10:17 AM, in an interview with OSM #1 (Other Staff Member, Director of Social Services), OSM #1 stated, when asked about a periodic review of Advance Directives, " We always discuss code status at care plan meetings and periodically. The entire advance directives is not brought up at the care plan meetings in its entirety but code status always is." When asked if there is anytime, the Advance Directives are reviewed entirely, OSM #1 stated, "No, I have not been involved in that unless they have a question about it. I was not aware of the policy that the Advance Directive should be reviewed periodically with the resident or responsible party." On 10/3/19 at 5:15 PM, ASM #1 and #2 (Administrative Staff Member - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey. 10. The facility staff failed to evidence that the	F 578		

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F 578	Continued From page 31 policies and procedures advanced directives were implemented for review periodically of the residents advance directive status with Resident #148 and/or his responsible party (RP) to ascertain if they wanted to change anything or maintain the advance directives as written Resident #148 was admitted to the facility on 11/10/17 with the diagnoses of but not limited to dementia with behaviors, anxiety, hypothyroidism, psychosis, insomnia, high blood pressure, delusional disorders, pressure ulcers, and blindness. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/4/19 coded the resident as being severely impaired in ability to make daily life decisions. A review of the clinical record revealed a signed acknowledgement, undated, that the resident and/or responsible party were provided with Advance Directive information. The acknowledgement documented, "By signing this agreement, You agree that You have received an oral and written explanation of Your right to make an advance decision "Advance Directive" about life-sustaining or life-prolonging measures in cases where You are acutely and terminally ill and not conscious or otherwise competent to make decisions. (Facility) will not withhold or withdraw life-sustaining or life-prolonging measures from You without an Advance Directive and a Physician Order. You understand that You are not required to execute an Advance Directive. The terms of any Advance Directive that You have executed will be followed by (facility) to the extent permitted by law." The resident was checked as having provided Advance Directives.	F 578		

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F 578	Continued From page 32 Further review of the clinical record failed to reveal any evidence that the resident's Advance Directives were reviewed periodically with the resident's responsible party to ascertain if they wanted to change anything or maintain the Advance Directives as written. On 10/3/19 at 10:17 AM, in an interview with OSM #1 (Other Staff Member, Director of Social Services), OSM #1 stated, when asked about a periodic review of Advance Directives, " We always discuss code status at care plan meetings and periodically. The entire advance directives is not brought up at the care plan meetings in its entirety but code status always is." When asked if there is anytime, the Advance Directives are reviewed entirely, OSM #1 stated, "No, I have not been involved in that unless they have a question about it. I was not aware of the policy that the Advance Directive should be reviewed periodically with the resident or responsible party." On 10/3/19 at 5:15 PM, ASM #1 and #2 (Administrative Staff Member - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey. 11. The facility staff failed to evidence that the policies and procedures advanced directives were implemented for review periodically of the residents advance directive status with Resident #18 and/or his responsible party (RP) to ascertain if they wanted to develop any. Resident #18 was admitted to the facility on 6/7/16 with the diagnoses of but not limited to	F 578		

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F 578	Continued From page 33 stroke, dysphagia, acute kidney failure, diabetes, morbid obesity, benign prostatic hyperplasia, depression, sleep apnea, brain cancer, high blood pressure, pressure ulcers, dementia with behaviors, and nasopharynx cancer. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/1/19 coded the resident as being moderately impaired in ability to make daily life decisions. A review of the clinical record revealed a signed acknowledgement dated 6/7/16 that the resident and/or responsible party were provided with Advance Directive information. The acknowledgement documented, "By signing this agreement, You agree that You have received an oral and written explanation of Your right to make an advance decision "Advance Directive" about life-sustaining or life-prolonging measures in cases where You are acutely and terminally ill and not conscious or otherwise competent to make decisions. (Facility) will not withhold or withdraw life-sustaining or life-prolonging measures from You without an Advance Directive and a Physician Order. You understand that You are not required to execute an Advance Directive. The terms of any Advance Directive that You have executed will be followed by (facility) to the extent permitted by law." The resident was not checked as having provided Advance Directives. Further review of the clinical record failed to reveal any evidence that the resident's Advance Directive status was periodically reviewed with the resident and/or responsible party to ascertain if they wanted to develop any Advance Directives later. On 10/3/19 at 10:17 AM, in an interview with	F 578		

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F 578	Continued From page 34 OSM #1 (Other Staff Member, Director of Social Services), OSM #1 stated, when asked about a periodic review of Advance Directives, " We always discuss code status at care plan meetings and periodically. The entire advance directives is not brought up at the care plan meetings in its entirety but code status always is." When asked if there is anytime, the Advance Directives are reviewed entirely, OSM #1 stated, "No, I have not been involved in that unless they have a question about it. I was not aware of the policy that the Advance Directive should be reviewed periodically with the resident or responsible party." On 10/3/19 at 5:15 PM, ASM #1 and #2 (Administrative Staff Member - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey. 12. The facility staff failed to evidence that the policies and procedures advanced directives were implemented for review periodically of the residents advance directive status with Resident #73 and/or his responsible party (RP) to ascertain if they wanted to change anything or maintain the advance directives as written Resident #73 was admitted to the facility on 4/27/18 with the diagnoses of but not limited to leg wound, chronic obstructive pulmonary disease, diabetes, dysphagia, giant cell arteritis, dementia, anxiety disorder, degenerative disease of the nervous system, atrial fibrillation, congestive heart failure, stenosis of the larynx, trach stoma malfunction, abnormal weight loss, and congenital malformations of the heart. The significant change MDS (Minimum Data Set) with	F 578		

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an ARD (Assessment Reference Date) of 8/1/19 coded the resident as moderately impaired in ability to make daily life decisions.

A review of the clinical record revealed a signed acknowledgement dated 4/23/18 that the resident and/or responsible party were provided with Advance Directive information. The acknowledgement documented, "By signing this agreement, You agree that You have received an oral and written explanation of Your right to make an advance decision ("Advance Directive") about life-sustaining or life-prolonging measures in cases where You are acutely and terminally ill and not conscious or otherwise competent to make decisions. (Facility) will not withhold or withdraw life-sustaining or life-prolonging measures from You without an Advance Directive and a Physician Order. You understand that You are not required to execute an Advance Directive, but that (facility) is available to assist You if You wish to make an Advance Directive. The terms of any Advance Directive that You have executed will be followed by (facility) to the extent permitted by law." The resident was checked as having provided Advance Directives.

Further review of the clinical record failed to reveal any evidence that the resident's Advance Directives were periodically reviewed with the resident's responsible party to ascertain if they wanted to change anything or maintain the Advance Directives as written.

On 10/3/19 at 10:17 AM, in an interview with OSM #1 (Other Staff Member, Director of Social Services), OSM #1 stated, when asked about a periodic review of Advance Directives, " We always discuss code status at care plan meetings

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F 578	Continued From page 36 and periodically. The entire advance directives is not brought up at the care plan meetings in its entirety but code status always is." When asked if there is anytime, the Advance Directives are reviewed entirely, OSM #1 stated, "No, I have not been involved in that unless they have a question about it. I was not aware of the policy that the Advance Directive should be reviewed periodically with the resident or responsible party." On 10/3/19 at 5:15 PM, ASM #1 and #2 (Administrative Staff Member - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey. 13. The facility staff failed to implement the advanced directive policies and procedures to review periodically the Resident #12's wishes regarding Advanced Directives. Resident #12 was admitted to the facility on 09/19/2018. His diagnoses included muscle weakness, arthritis, and generalized anxiety disorder. Resident #12's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 06/30/2019. The Brief Interview for Mental Status (BIMS) scored Resident #12 at a 15, indicating no impairment. During initial review of the clinical record, it was noted that Resident #12 had a documented Advanced Directive. However, a review of the Progress Notes by the Social Services department did not reveal documentation of a review periodically of the Advanced Directive, only a review of the Resident's code status.	F 578		

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F 578	Continued From page 37 On 10/03/2019 at 10:21a.m. an interview was conducted with Other Staff Member (OSM) #1, the Director of Social Services. During the interview, OSM #1 was asked what role Social Services played in the Advanced Directive process. OSM #1 stated that Social Services reviews the resident's code status at the quarterly care plan meetings, but not the Advanced Directive as a whole. OSM #1 offered an example: a resident might have changed their code status during a recent hospitalization and the facility did not receive a copy. Social Services would follow up on that and make sure the correct status is documented in the medical record. When asked if she was aware of the facility policy on Advanced Directives specifying that the full Advanced Directive was to be reviewed periodically by Social Services, OSM #1 stated that she was not. As part of the same interview, OSM #4, the Admissions Director, was also interviewed. OSM #4 was asked what role the Admissions department played in documenting the resident's Advanced Directive. OSM #4 stated that upon admission, as part of the admissions agreement, the staff request copies of any existing Advanced Directives from the resident or their representative. The resident or representative then signs a document that they have been made aware of their right to formulate an Advanced Directive if they wish. OSM #4 provided surveyors with copies of these signed agreements for Resident #12. Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 10/03/2019. No further	F 578		

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F 578	Continued From page 38 documentation was provided. 14. The facility staff failed to implement the advanced directive policies and procedures to review periodically the Resident 99's wishes regarding Advanced Directives. Resident #99 was admitted to the facility on 11/21/2018. His diagnoses included quadriplegia (weakness and paralysis of all 4 limbs), diabetes, and hypertension (high blood pressure). Resident #99's most recent MDS Assessment was a Quarterly Assessment with an ARD of 08/13/2019. The BIMS scored Resident #99 at a 15, indicating no impairment. Review of the clinical record, revealed that Resident #12 had a documented Advanced Directive. However, a review of the Progress Notes by the Social Services department did not reveal documentation of a review of the Advanced Directive, only a review of the Resident's code status. On 10/03/2019 at 10:21a.m., an interview was conducted with Other Staff Member (OSM) #1, the Director of Social Services. During the interview, OSM #1 was asked what role Social Services played in the Advanced Directive process. OSM #1 stated that Social Services reviews the resident's code status at the quarterly care plan meetings, but not the Advanced Directive as a whole. OSM #1 offered an example: a resident might have changed their code status during a recent hospitalization and the facility did not receive a copy. Social Services would follow up on that and make sure the correct	F 578		

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status is documented in the medical record. When asked if she was aware of the facility policy on Advanced Directives specifying that the full Advanced Directive was to be reviewed periodically by Social Services, OSM #1 stated that she was not.

As part of the same interview, OSM #4, the Admissions Director, was also interviewed. OSM #4 was asked what role the Admissions department played in documenting the resident's Advanced Directive. OSM #4 stated that upon admission, as part of the admissions agreement, the staff request copies of any existing Advanced Directives from the resident or their representative. The resident or representative then signs a document that they have been made aware of their right to formulate an Advanced Directive if they wish. OSM #4 provided surveyors with copies of these signed agreements for Resident #99.

Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 10/03/2019. No further documentation was provided.

15. The facility staff failed to the evidence the advanced directives policy was implemented to complete periodic reviews of Resident # 78's advance directive.

Resident # 78 was admitted to the facility on 01/02/17 with diagnoses that included but were not limited to Wernicke's encephalopathy [1], ataxia [2] and apraxia [3].

Resident # 78's most recent MDS (minimum data

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F 578	Continued From page 40 set), an annual assessment with an ARD (assessment reference date) of 08/02/19, coded Resident # 78 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. The "[Name of Facility] Comprehensive Admission Agreement" for Resident # 78 documented in part, "6. ADVANCE DIRECTIVE ACKNOWLEDGEMENT. C. You would wish to execute an Advance Directive." The clinical record and the EHR (electronic health record) for Resident # 78 failed to evidence a copy of an advance directive and failed to evidence of periodic reviews of advanced directives were completed. On 10/03/19 at 10:15 a.m., an interview was conducted with OSM [other staff member] # 1, director of social services. When asked to describe her role regarding a resident's advance directive, OSM # 1 stated that the resident's code status is reviewed at the care plan meetings. When asked about conducting periodic reviews of advance directives, OSM # 1 stated, "It is not brought up during the care plan meetings." When asked if she conducted any periodic reviews of resident's advance directive, OSM # 1 stated, "No." On 10/04/19 at approximately 4:00 p.m., an interview and review of Resident # 78's EHR and clinical record was conducted with OSM # 1. When asked to explain the statement, "You would wish to execute an Advance Directive" as documented under the heading "ADVANCE DIRECTIVE ACKNOWLEDGEMENT" on the	F 578		

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"[Name of Facility] Comprehensive Admission Agreement", OSM # 1 stated, "It means they have an advance directive." OSM # 1 confirmed that Resident # 78's EHR and clinical record did not contain a copy of an advanced directive and stated, "They should have an advance directive."

On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

References:
[1] An acute neurological condition characterized by a clinical triad of ophthalmoparesis with nystagmus, ataxia, and confusion. This is a life-threatening illness caused by thiamine deficiency, which primarily affects the peripheral and central nervous systems. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/books/NBK470344/.

[2] A sudden, uncoordinated muscle movement due to disease or injury to the cerebellum in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/001397.htm.

[3] A disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked, even though: the request or command is understood, they are willing to perform the task, the muscles needed to perform the task work properly, the task may have already been learned. This information was obtained from the website: https://medlineplus.gov/ency/article/007472.htm.

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16. The facility staff failed to evidence the facility policy for advanced directives was implemented to complete periodic reviews of Resident # 150's advance directive.

Resident # 150 was admitted to the facility on 08/21/18 with diagnoses that included but were not limited to difficulty swallowing, muscle weakness and low iron.

Resident # 150's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 09/04/19, coded Resident # 150 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six - being severely impaired of cognition for making daily decisions.

The clinical record and the EHR (electronic health record) for Resident # 150 evidenced a copy of an advance directive. Further review failed to evidence periodic reviews of the advance directive.

On 10/03/19 at 10:15 a.m., an interview was conducted with OSM [other staff member] # 1, director of social services. When asked to describe her role regarding a resident's advance directive OSM # 1 stated that the resident's code status is reviewed at the care plan meetings. When asked about conducting periodic reviews of advance directives OSM # 1 stated, "It is not brought up during the care plan meetings." When asked if she conducted any periodic reviews of resident's advance directive OSM # 1 stated, "No."

On 10/04/19 at approximately 4:00 p.m., an interview an review of Resident # 150's EHR and

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clinical record was conducted with OSM # 1. When asked to explain the statement, "You would wish to execute an Advance Directive" as documented under the heading "ADVANCE DIRECTIVE ACKNOWLEDGEMENT" on the "[Name of Facility] Comprehensive Admission Agreement", OSM # 1 stated, "It means they have an advance directive." OSM # 1 confirmed that there were no reviews of Resident # 150's advance directive.

On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

17. The facility staff failed to evidence the facility advanced directives policy was implemented to complete periodic reviews of Resident # 110's advance directive.

Resident # 110 was admitted to the facility on 01/30/14 with diagnoses that included but were not limited to muscle weakness, difficulty swallowing and shortness of breath.

Resident # 110's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/28/19, coded Resident # 110 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions.

The "[Name of Facility] Comprehensive Admission Agreement" for Resident # 78 documented in part, "6. ADVANCE DIRECTIVE ACKNOWLEDGEMENT. C. You would wish to

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F 578	Continued From page 44 execute an Advance Directive." The clinical record and the EHR (electronic health record) for Resident # 110 failed to evidence a copy of an advance directive and failed to evidence of periodic reviews of advanced directives. On 10/03/19 at 10:15 a.m., an interview was conducted with OSM [other staff member] # 1, director of social services. When asked to describe her role regarding a resident's advance directive OSM # 1 stated that the resident's code status is reviewed at the care plan meetings. When asked about conducting periodic reviews of advance directives OSM # 1 stated, "It is not brought up during the care plan meetings." When asked if she conducted any periodic reviews of resident's advance directive OSM # 1 stated, "No." On 10/04/19 at approximately 4:00 p.m., an interview and review of Resident # 110's EHR and clinical record was conducted with OSM # 1. When asked to explain the statement, "You would wish to execute an Advance Directive" as documented under the heading "ADVANCE DIRECTIVE ACKNOWLEDGEMENT" on the "[Name of Facility] Comprehensive Admission Agreement", OSM # 1 stated, "It means they have an advance directive." OSM # 1 confirmed that Resident # 110's EHR and clinical record did not contain a copy of an advanced directive and stated, "They should have an advance directive." On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings.	F 578		

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F 578	Continued From page 45 No further information was provided prior to exit. 18. The facility staff failed to evidence the facility policy for advanced directives was implemented to complete periodic reviews of Resident # 45's advance directive. Resident # 45 was admitted to the facility on 07/10/19 with diagnoses that included but were not limited to high blood pressure, high cholesterol and heart failure. Resident # 45's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/28/19, coded Resident # 45 as scoring a four on the brief interview for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions. The "[Name of Facility] Comprehensive Admission Agreement" for Resident # 45 documented in part, "6. ADVANCE DIRECTIVE ACKNOWLEDGEMENT. C. You would wish to execute an Advance Directive." The clinical record and the EHR (electronic health record) for Resident # 110 failed to evidence a copy of an advance directive and evidence of periodic reviews of advanced directives. On 10/03/19 at 10:15 a.m., an interview was conducted with OSM [other staff member] # 1, director of social services. When asked to describe her role regarding a resident's advance directive OSM # 1 stated that the resident's code status is reviewed at the care plan meetings. When asked about conducting periodic reviews of advance directives OSM # 1 stated, "It is not	F 578		

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F 578	Continued From page 46 brought up during the care plan meetings." When asked if she conducted any periodic reviews of resident's advance directive OSM # 1 stated, "No." On 10/04/19 at approximately 4:00 p.m., an interview and review of Resident # 45's EHR and clinical record was conducted with OSM # 1. When asked to explain the statement, "You would wish to execute an Advance Directive" as documented under the heading "ADVANCE DIRECTIVE ACKNOWLEDGEMENT" on the "[Name of Facility] Comprehensive Admission Agreement" OSM # 1 stated, "It means they have an advance directive." OSM # 1 confirmed that Resident # 45's EHR and clinical record did not contain a copy of an advanced directive and stated, "They should have an advance directive." On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings. No further information was provided prior to exit.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those	F 582	**F582 MEDICAID/MEDICARE COVERAGE LIABILITY NOTICE** 1) Resident # 68 was provided a notice of financial liability on 10/08/19. 2) Residents who complete a Medicare skilled stay and remain in facility once skilled services have ended have the potential to be affected by the deficient practice. 3) A) An audit of residents, who, in the past six months, have remained in facility and experienced a change in payor source will be completed by the Business Office Manager to ensure receipt of financial liability notice. B) The Social Worker has been educated on the process for issuing Notices of Medicare Non-Coverage and Advanced Beneficiary Notices. 4) The Business Office Manager will complete a monthly audit for proper notice given to residents whose payor source has changed with report of non-compliance to the Administrator for corrective action 5) Compliance Date: 11/1/2019	

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services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

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

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F 582	Continued From page 48 these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide notice of Medicare non-coverage for one of three beneficiary protection notification resident reviews, Resident #68. Resident #68's last covered day of Medicare part A services was 8/29/19. The facility staff failed to notify Resident #68 (and/or the resident's representative) of the last covered day and the right to appeal. The findings include: Resident #68 was admitted to the facility on 7/3/19. Resident #68's diagnoses included but were not limited to paralysis, difficulty swallowing and constipation. Resident #68's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 7/31/19, coded the resident's cognitive skills for daily decision-making as severely impaired. On 10/2/19 at 3:07 p.m., an interview was conducted with OSM (other staff member) #1 (the director of social services). OSM #1 confirmed Resident #68 should have been issued a Medicare notice of non-coverage form (a form that documents the last covered day of Medicare part A services and the right to appeal) and was not. OSM #1 stated she had been preoccupied because she was working on a 30-day discharge notice (for a discharge from the facility) that Resident #68's family had appealed. Resident #68 remained in the facility at the time of the survey.	F 582		

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F 582	Continued From page 49 On 10/3/19 at 10:37 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality nurse) were made aware of the above concern. On 10/3/19 at 4:03 p.m., ASM #1 stated the facility did not have a policy regarding the Medicare notice of non-coverage but the federal regulations should be followed. On 10/3/19 at 4:37 p.m., another interview was conducted with OSM #1 regarding the facility policy for Medicare notices of non-coverage. OSM #1 stated, "When somebody is being discharged from traditional Medicare part A and they are coming off the skilled nursing facility coverage before the time, when we stop billing Medicare, they need to be informed since they no longer qualify and what the cost of room and board will be for the potential expenses that may incur will be." No further information was presented prior to exit.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583	**F583 RESIDENTS RIGHTS: PRIVACY** 1) The privacy curtain for resident #85 is closed around the resident to ensure privacy during care. LPN #5 and LPN #6 have been observed during wound treatment. Treatment observation competency included taking steps to ensure resident privacy. 2) Residents receiving wound treatments may have been impacted by this practice. 3) Nurses providing treatments have been re-educated on the importance of providing privacy during treatments.	

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F 583	Continued From page 50 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined that the facility staff failed to promote privacy during a dressing change for one of 63 residents in the survey sample. During Resident #85's dressing change on 10/3/19 at 11:00 a.m., the facility staff failed to pull the privacy curtain and failed to close Resident #85's door, staff were visible in the hallway from the residents room during the dressing change. The findings include: Resident #85 was admitted to the facility on 01/28/2016 with a readmission on 01/08/2018.	F 583	4) A) The DON or designee will complete treatment observations of licensed nurses on the identified unit who provide treatments for adherence to residents' right to privacy. B) Any non-compliance found during audits will be addressed with education and training as needed. C) A summary of the observations will be presented to the QA Committee for additional oversight and/or recommendations. 5) Compliance Date: 11/01/2019	

F 583 Continued From page 51 | F 583

Resident #85's diagnoses included but were not limited to anoxic brain damage (1) and seizures (2). Resident #85's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/06/19, coded Resident #85 as being severely impaired for making daily decisions.

The comprehensive care plan for Resident #85 documented "Pressure ulcer, actual left top of his foot. Start Date: 02/19/2019, Edited: 10/02/2019."

On 10/3/19 at approximately 11:00 a.m., LPN (licensed practical nurse) #5 was observed performing a dressing change to Resident #85's pressure ulcer on the top of the residents left foot. Resident #85 was observed lying in the bed in his room. LPN #5 prepared the supplies to perform the dressing change and entered the room. LPN #5 proceeded to perform the dressing change to the pressure ulcer to the top of left foot with LPN #6 assisting. The door to Resident #85's room was observed open and the privacy curtain was not pulled during the dressing change. Staff members were observed in the hallway outside of Resident #85's room during the dressing change for Resident #85.

On 10/3/19 at 11:45 a.m., an interview was conducted with LPN #5. When asked how privacy is ensured when performing dressing changes, LPN #5 stated, "I should have pulled the curtain." LPN #5 stated that Resident #85's room is at the end of the hallway but the door should still have been closed or the curtain pulled. When asked why, LPN #5 stated to give privacy during the dressing change.

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F 583	Continued From page 52 On 10/3/19 at 11:45 a.m., an interview was conducted with LPN #6. When asked how privacy is ensured when performing dressing changes LPN #6 stated the door is closed or the privacy curtain is pulled. LPN #6 stated, "We should have pulled the curtain." The facility document "Resident Rights" documented in part, "The resident has a right to personal privacy ..." The facility policy "Wound Treatment Protocol/Competency 3/19/2018" documented, "Provides full privacy including closing privacy curtains fully around resident, closing window blinds fully, and closing doors." On 10/3/19 at 4:30 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. References: 1. Anoxic brain damage Not enough oxygen getting to the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001435.htm 2. Seizure Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.	F 583		

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F 609	Continued From page 53	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility documentation review and staff interview, it was determined that the facility staff failed to immediately report an allegation of abuse to the State Survey Agency and other officials for one of 63 residents in the survey sample, Resident #61.	F 609	F 609 REPORTING OF ALLEGED VIOLATIONS 1) The reporting window for an allegation of abuse made by resident #61 on 2/19/2019 cannot be corrected. The individual responsible for the late report is no longer employed by facility. 2) Any resident making an allegation of abuse, neglect, misappropriation of funds or injury of unknown origin could be affected by this practice. 3) A) Facility staff have been re-educated on the facility abuse reporting policy. B) A protocol for reporting abuse allegations during off-shifts and weekends has been made available with education to Department Managers and key supervisory staff 4) The Facility Abuse Reporting Coordinator or designee will review each reported allegation for regulatory compliance. In cases of non-compliance, identified personnel will be re-educated. 5) Compliance date: 11/01/2019	

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The facility staff failed to notify the Office of Licensure and Certification of a credible allegation of abuse involving Resident #61 within 2 hours of discovering it.

The findings included:

Resident #61 was admitted to the facility on 07/19/2017. Her diagnoses included chronic obstructive pulmonary disease (1), muscle weakness, and arthritis. Resident #61's most recent Minimum Data Set (MDS) Assessment was a Significant Change Assessment with an Assessment Reference Date (ARD) of 07/18/2019. The Brief Interview for Mental Status (BIMS) scored Resident #61 at a 12, indicating mild to moderate impairment. Resident #61 was coded as requiring extensive assistance of one person for bed mobility and dressing, and as totally dependent on one person for toileting.

On 10/01/2019, a review of Resident #61's medical record was conducted as part of an investigation into a complaint of an abuse allegation involving Resident #61. On 02/19/2019, Resident #61 alleged that a CNA at the facility sexually abused her "about a week ago" (a week prior to reporting the allegation to staff). A review of the Facility Reported Incident (FRI) and its accompanying investigation evidenced the allegation was unsubstantiated. The FRI report indicated that facility staff became aware of the allegation on 02/19/2019 at approximately 11:00 a.m., but did not submit their initial reporting of the incident to the Office of Licensure and Certification (OLC) until 02/19/2019 at 4:51 p.m.., as evidenced by the timestamp Fax confirmation sheet.

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F 609	Continued From page 55 The facility policy on abuse reads in part: "PROCEDURE: Reporting Actual or Suspected Resident Abuse... 3. Report to VDOH (Virginia Department of Health) and Adult Protective Services an Injury of Unknown Source and an allegation of Abuse (including neglect, mistreatment, or misappropriation of resident property) within 2 hours of becoming aware of the allegation if the events that caused the allegation involve abuse or result in serious bodily injury." Administrative Staff Member (ASM) #1, the Administrator, was asked about the reporting of the allegation during the end of day meeting on 10/03/2019. ASM #1 stated that the incident occurred prior to his becoming the Administrator, but that the incident should have been reported more quickly. ASM #1 and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 10/03/2019. No further documentation was provided. 1. COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. - https://medlineplus.gov/copd.html	F 609		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622	See Next Page	

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§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

F622 TRANSFER AND DISCHARGE REQUIREMENTS

1) Resident #76 experienced a life threatening emergency at the time of hospital transfer. Resident #76 has been readmitted to facility. The failure to provide care plan goals at the time of the 8/11/19 transfer cannot be corrected.
2) All residents who are transferred to a hospital may potentially be affected.
3) A) Transfer/Discharge packets have been developed which includes direction on providing the CCD document which includes care plan goals to the receiving hospital at the time of transfer.
B) Licensed nurses have been educated on transfer and discharge requirements
C) The DON or designee will review unplanned discharges to hospital for compliance with regulatory requirements for notification. Report of findings will be made during Morning Management Meeting.
D) In the case of transfers for life threatening emergency where the provision of required notification may not be practical, the facility admissions liaison will deliver required documentation to the hospital
4) Tracking of unplanned hospitalization is done monthly by the facility Quality Assurance and Performance Improvement committee. Compliance with Transfer and Discharge requirements will be included in the monthly report.
5) Compliance date: 11/01/19

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F 622	Continued From page 57 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.	F 622		

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(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 review of facility documentation the facility staff failed to ensure all required documentation was provided to the receiving provide upon transfer for one of 63 residents in the survey sample, Resident #76. The facility staff failed to ensure that the comprehensive care plan goals were sent with Resident #76 to the hospital at the time of transfer on 8/11/19.

The findings included:

Resident #76 was admitted to the facility on 07/27/2018. Her diagnoses included urinary tract infection, chronic obstructive pulmonary disease (1), and major depression. Resident #76's most recent Minimum Data Set (MDS) Assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 08/01/2019. The Brief Interview for Mental Status (BIMS) scored Resident #76 at 11, indicating moderate impairment. Resident #76 was coded as requiring extensive assistance of 2 or more people for bed mobility and transfers, and as requiring extensive assistance of one person for dressing.

A review of Resident #76's clinical record was conducted starting on 10/01/2019. Upon review, it was noted that Resident #76 was hospitalized on 08/11/2019 due to suspicion of sepsis (2). A

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review of the facility documentation including progress notes related to the transfer failed to evidence that the comprehensive care plan goals were sent with the resident to the hospital at the time of her transfer. On the afternoon of 10/01/2019, facility staff were asked to provide evidence Resident #76's comprehensive care plan goals were sent and provided to the receiving hospital.

On 10/02/2019, an interview was conducted with Administrative Staff Member (ASM) #3, the Corporate Quality Nurse. ASM #3 stated that they had been unable to locate any documentation related to Resident #76's transfer to the hospital. ASM #3 stated that typically the facility process is to complete a transfer checklist, which documents what is sent with the resident or provided to the RP (responsible party). ASM #3 stated that in this case, it appeared that this was not done.

A review of the facility policy entitled "Transfer and Discharge" revealed the following: "3. When the facility transfers or discharges a resident the facility will ensure that the transfer or discharge is documented in the medical record/EMR and appropriate information is communicated to the receiving health care institution or provider.
c. The facility provides the following information to the receiving provider: v. Comprehensive care plan goals."

ASM #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 10/03/2019. No further documentation was provided.

References:

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F 622	Continued From page 60 1. COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. - https://medlineplus.gov/copd.html 2. Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This leads to blood clots and leaky blood vessels. They cause poor blood flow, which deprives your body's organs of nutrients and oxygen. In severe cases, one or more organs fail. In the worst cases, blood pressure drops and the heart weakens, leading to septic shock. - https://medlineplus.gov/sepsis.html	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	F 623	**F623 NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE** 1) Resident #76's family member was present at the time of transport to the hospital. Resident #148's representative was notified via telephone of hospitalization on 8/12/19. Resident # 21's responsible representative requested transport to the emergency department on 6/11/19. Late written notice of hospital transfer for these three residents has been provided to the responsible representatives and to the ombudsman on 10/22/19, 2) All residents who are transferred to a hospital may potentially be affected.	

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F 623	Continued From page 61 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F 623	3) A) Licensed nurses and the Social Workers have been educated on the purpose and use of the facility Discharge/Transfer Notice. B) The DON or designee will review unplanned discharges to hospital for compliance with written notice requirement. Report of findings will be made during Morning Management Meeting. C) In the case of transfers for life threatening emergency where the provision of required notification may not be practical, the facility admissions liaison will deliver required documentation to the hospital D) The Social Worker will fax Discharge/Transfer Notices to the Ombudsman weekly 4) A) Tracking of unplanned hospitalization is done monthly by the facility Quality Assurance and Performance Improvement committee. Compliance with Transfer and Discharge Notice requirements will be included in the monthly report. B) The Social Worker will provide a report of Ombudsman notification monthly to the QAPI committee. 5) Compliance Date: 11/01/19	

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F 623	Continued From page 62 completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §	F 623		

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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 the Ombudsman and/or Resident Representative was notified in writing of a hospital transfer for three of 63 residents in the survey sample, Residents #148, #76, and #21.

The findings include:

1. Resident #148 was admitted to the hospital on 8/11/19. The facility staff failed to evidence that the resident representative (RP) and Ombudsman were provided with written notification of the hospital transfer.

Resident #148 was admitted to the facility on 11/10/17 with diagnoses that include but not limited to dementia with behaviors, anxiety, hypothyroidism, psychosis, insomnia, high blood pressure, delusional disorders, pressure ulcers, and blindness. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/4/19 coded the resident as being severely impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 8/12/19 at 1:02 AM which documented, "Resident vitals: 100.5% (sic) (temperature), 108 (pulse), 14 (respirations), 88% (oxygen saturation) on 4L (four liters) O2 (oxygen) via NC (nasal cannula), face appear flushed red, resident gurgling down the throat, PACE (Program of All-Inclusive Care for the

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Elderly) was called and instructed that resident go to the hospital for further evaluation, 911 called, resident transported to (name of hospital) by 4 paramedics, (name of hospital) ER (emergency room) called and was given report before resident's arrival, RP (responsible party) called and a voice message was left to call the facility back per facility protocol, emergency contact (name) was also called and was notified of resident condition, resident is now at (name of hospital)."

Further review failed to reveal any evidence of written notification of the hospital transfer to the resident representative or Ombudsman.

On 10/03/19 at 10:55 AM, an interview was conducted with LPN #4 (Licensed Practical Nurse). When asked about notifying the Ombudsman and resident representative in writing of the hospital transfer, LPN #4 stated, "Nursing does not notify ombudsman. Nursing does not do written family notification."

On 10/03/19 at 11:46 AM, an interview was conducted with OSM #1 (Other Staff Member, the director of social services). OSM #1 stated, "I do a monthly list I fax to the Ombudsman. I do not provide a written notification to the family. I'm not positive what families get. It is a nursing procedure.

On 10/03/19 at 2:37 PM, OSM #1 stated that she was not able to locate any Ombudsman notification for August 2019.

A review of the facility policy, "Transfer and Discharge" documented, "7. Emergency Transfers: When a resident is temporarily

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transferred on an emergency basis to an acute care facility, notice of the transfer is provided to the resident and resident representative as soon as practicable....a. copies of notices for emergency transfers are sent to the ombudsman, but they are sent when practicable, such as a list of residents on a monthly basis."

On 10/3/19 at 5:15 PM, ASM #1 and #2 (Administrative Staff Member - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey.
2. The facility staff failed to provide written notification to the Resident #76 and or the resident representative (RR) for the residents transfer to the hospital on 08/11/2019.

Resident #76 was admitted to the facility on 07/27/2018. Her diagnoses included urinary tract infection, chronic obstructive pulmonary disease (1), and major depression. Resident #76's most recent Minimum Data Set (MDS) Assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 08/01/2019. The Brief Interview for Mental Status (BIMS) scored Resident #76 at 11, indicating moderate impairment of cognition.

A review of Resident #76's clinical record revealed Resident #76 was hospitalized on 08/11/2019 due to suspicion of sepsis (2). A review of the facility documentation including progress notes related to the transfer failed to evidence that a written notice of transfer was provided to the resident or their responsible party (RP) at the time of her transfer to the hospital on 8/11/19. On the afternoon of 10/01/2019, facility staff were asked to provide evidence of a written

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F 623	Continued From page 66 notice being provided. On 10/02/2019, an interview was conducted with Administrative Staff Member (ASM) #3, the Corporate Quality Nurse. ASM #3 stated that they had been unable to locate any documentation related to Resident #76's transfer to the hospital. ASM #3 stated that typically the facility process is to complete a transfer checklist, which documents what is sent with the resident or provided to the RR. ASM #3 stated that in this case, it appeared that this was not done. ASM #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 10/03/2019. No further documentation was provided. 3. The facility staff failed to provide written notification to the Resident #21 and or the resident's responsible party (RP) for the residents transfer to the hospital on 08/11/2019. Resident #21 was admitted to the facility on 9/29/17, and was most recently readmitted on 6/19/19 with diagnoses including, but not limited to cerebral palsy (1) and diabetes mellitus (2). On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 7/1/19, Resident #21 was coded as being severely impaired for making daily decisions. A review of Resident #21's clinical record revealed the following nurse's note dated 6/11/19: "Critical lab values called to [name of managed care company] NP (nurse practitioner)...RP (responsible party) requested resident be sent to ER (emergency room) per MD (medical doctor). Resident pickup by [name of ambulance service]	F 623		

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F 623	Continued From page 67 enroute to [name of hospital] via stretcher...RP made aware." Further review of the clinical record revealed evidence that Resident #21 was admitted to the hospital on 6/11/19, and was readmitted to the facility on 6/19/19. Further review failed to reveal any evidence that written notification was provided to the resident representative. On 10/3/19 at 8:25 a.m., ASM (administrative staff member) #2, the DON (director of nursing) was interviewed. ASM #2 stated, "We have a packet that we send to the hospital. It has all the information about the resident, including care plan goals and things like that." When asked if this packet includes written notification to the RP of the transfer, ASM #2 stated, "No. It doesn't have that." On 10/03/19 at 10:55 a.m., in an interview with LPN #4 (Licensed Practical Nurse), when asked about notifying the Ombudsman and resident representative in writing of the hospital transfer, LPN #4 stated, "Nursing does not notify ombudsman. Nursing does not do written family notification." On 10/03/19 at 11:46 AM, in an interview with OSM #1 (Other Staff Member, the director of social services), OSM #1 stated, "I do a monthly list I fax to the Ombudsman. I do not provide a written notification to the family. I'm not positive what families get. It is a nursing procedure." On 10/3/19 at 2:55 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the corporate quality nurse, were informed of these concerns.	F 623		

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F 623	Continued From page 68 No further information was provided prior to exit. (1) "Cerebral palsy is a group of disorders that affect a person's ability to move and to maintain balance and posture." This information is taken from the website https://medlineplus.gov/cerebralpalsy.html. (2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625	F625 WRITTEN BED HOLD NOTICE 1) Resident #76 experienced a life threatening emergency at the time of hospital transfer. Resident #76 has been readmitted to facility. The failure to provide written bed hold notice at the time of the 8/11/19 transfer cannot be corrected. 2) All residents who are transferred to a hospital may potentially be affected. 3) A) Transfer/Discharge packets have been developed which includes a copy of the written bed hold notice. B) Licensed nurses have been educated on transfer and discharge requirements C) The DON or designee will review unplanned discharges to hospital for compliance with regulatory requirements for written bed hold notice. Report of findings will be made during Morning Management Meeting. D) In the case of transfers for life threatening emergency where the provision of required notification may not be practical, or the responsible representative may not be available, the facility admissions liaison will place a follow up phone call to explain the bed hold policy and will deliver required written notice to the resident in the hospital. 4) Tracking of unplanned hospitalization is done monthly by the facility Quality Assurance and Performance Improvement committee. Compliance with Written Bed Hold notice requirements will be included in the monthly report. 5) Compliance date: 11/01/19	

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F 625	Continued From page 69 the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on facility documentation review and staff interview, facility staff failed to ensure all required documentation was sent with a resident to the hospital at the time of transfer for 1 of 63 residents, Resident #76. Facility staff failed to ensure that the bed hold notice was sent with Resident #76 to the hospital at the time of transfer. The findings included: Resident #76 was admitted to the facility on 07/27/2018. Her diagnoses included urinary tract infection, chronic obstructive pulmonary disease(1), and major depression. Resident #76's most recent Minimum Data Set (MDS) Assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 08/01/2019. The Brief Interview for Mental Status (BIMS) scored Resident #76 at 11, indicating moderate impairment. Resident #76 was coded as requiring extensive assistance of 2 or more people for bed mobility and transfers, and requiring extensive assistance of 1 person for dressing. A review of Resident #76's clinical record was conducted starting on 10/01/2019. Upon review, it was noted that Resident #76 was hospitalized on 08/11/2019 due to suspicion of sepsis(2). A	F 625		

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review of the facility documentation including progress notes related to the transfer failed to evidence that the bed hold notice was sent with the resident to the hospital at the time of her transfer. On the afternoon of 10/01/2019, facility staff were asked to provide evidence of the bed hold notice being sent.

On 10/02/2019, an interview was conducted with Administrative Staff Member (ASM) #3, the Corporate Quality Nurse. ASM #3 stated that they had been unable to locate any documentation related to Resident #76's transfer to the hospital. ASM #3 stated that typically the facility process is to complete a transfer checklist, which documents what is sent with the resident or provided to the RP. ASM #3 stated that in this case, it appeared that this was not done.

A review of the facility policy entitled "Transfer and Discharge" revealed the following:

"13. The facility provides the following written information to the residents and or resident representatives at the time of trasfer to a hospital or when the resident goes on a theraputic leave:
a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility.
b. The reserve bed payment policy in the state plan.
c. The nursing facility policies regarding bed-hold periods."

ASM #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 10/03/2019. No further documentation was provided.

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F 625	Continued From page 71 References: 1. COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. - https://medlineplus.gov/copd.html 2. Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This leads to blood clots and leaky blood vessels. They cause poor blood flow, which deprives your body's organs of nutrients and oxygen. In severe cases, one or more organs fail. In the worst cases, blood pressure drops and the heart weakens, leading to septic shock. - https://medlineplus.gov/sepsis.html	F 625		
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	F 656	F 656 IMPLEMENTATION OF COMPREHENSIVE CARE PLAN 1) The orders for palm protectors and knee splints for resident #518 have been rewritten to include the wearing schedule. Resident #518's care team has been re-educated on the current plan of care. A request for re-evaluation of the continued appropriateness of these devices has been made to OT. An interdisciplinary team meeting to revise the comprehensive plan of care will be scheduled. 2) All residents who have orders for palm protectors and knee splints have the potential to be affected by the deficient practice.	

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F 656	Continued From page 72 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for one of 63 residents in the survey sample, Resident #518. The facility staff failed to apply palm protectors and knee splints to Resident #518 per the comprehensive care plan.	F 656	3) A) The DON or designee will audit all residents with orders for palm protectors and knee splints for implementation of the resident care plan. B) Communication of the use of palm protectors and knee splints and their associated wearing schedule to the care team will be accomplished via the resident profile. C) Nursing staff will be educated on how to access the resident profile. 4) The DON or designee will perform observation audit on 10% of residents who use palm protectors and knee splints according to the individual resident care plan weekly for 4 weeks. Results will be reported to the QAPI Committee. 5) Compliance Date: 11/01/2019	

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The findings include:

Resident #518 was admitted to the facility on 6/11/18 and most recently readmitted on 9/25/19 with diagnoses including, but not limited to: history of cardiac arrest (heart stopping), anoxic brain injury (brain not getting enough oxygen), COPD (chronic obstructive pulmonary disease) (1), and contractures (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 9/11/19, Resident #518 was coded as being severely cognitively impaired for making daily decisions. She was coded as being completely dependent on staff members for all activities of daily living. She was coded as being functionally limited in range of motion in both her upper and lower extremities. She was coded as receiving oxygen and tracheostomy (3) care during the look back period.

On the following dates and times, Resident #518 was observed lying in her bed. She was observed at all of these times without palm protectors in each hand, and without knee splints on each knee: 10/1/19 at 3:54 p.m., 10/2/19 at 8:57 a.m., and 10/2/19 at 12:05 p.m.

On 10/2/19 at 12:05 p.m., LPN (licensed practical nurse) #6, the unit manager, and LPN #5, the unit manager, were observed turning Resident #518. Once they had completed this, LPN #5 was asked whether Resident #518 was wearing palm protectors and knee splints. LPN #5 stated, "I will have to check on those orders. I'm not sure they are even ordered for her." She returned to the surveyor at 12:09 p.m. and stated, "She is supposed to have them. I will get them for her."

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F 656	Continued From page 74 A review of Resident #518's POS (physician order sheet) revealed the following orders dated 9/25/19: "Palm protectors at all times/remove for hygiene QS (every shift). Resident to wear BLE (bilateral lower extremity) (left and right) knee extension splints to manage abnormal posture and reduce contracture risk - to be worn at all times - remove for personal care/ADL (activities of daily living) and monitor for redness." A review of Resident #518's comprehensive care plan dated 6/11/18, updated 2/8/19 revealed, in part, the following: "Palm guards and knee brace to be worn as ordered. Check skin condition upon removal of devices and report signs of irritation or increased difficulty applying or removing devices." On 10/3/19 at 10:35 a.m., CNA (certified nursing assistant) #3 was interviewed. When asked how she knows what devices a totally dependent resident should be wearing, CNA #3 stated, "A lot of it was gone over during the orientation period. It is just through experience, learning different residents and their needs, during orientation." When asked how she becomes aware of the device needs of new residents, CNA #3 stated, "Those things are listed for us in the computer. They are listed for us there." When asked how often she checks the computer for information regarding devices, CNA #3 stated, "Usually every shift. But not always." On 10/3/19 at 10:44 a.m., LPN #8 was interviewed. When asked who is responsible for making sure dependent residents are wearing devices per the comprehensive care plan, LPN #8 stated, "The devices should be in the orders. The care plan, too. The nurses are supposed to know what the residents need. The CNAs can	F 656		

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help, but the nurses are responsible."

On 10/3/19 at 11:10 a.m., LPN #5 was interviewed. When asked the purpose of palm protectors, she stated, "Her hands are contracted. Those palm protectors keep her from getting a pressure area on her hands." When asked the purpose of knee splints, she stated, "They are a positioning device. They are supposed to help keep her from getting more contracted in her legs."

On 10/2/19 at 11:39 a.m., LPN #6 was asked the purpose of the care plan, he stated, "It tells us what we are doing with the resident. We need to know what we are doing."

On 10/3/19 at 2:55 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the corporate quality nurse, were informed of these concerns.

A review of the facility policy, "Care Planning," revealed, in part, the following: "The Comprehensive Care Plan will describe: the services furnished to the resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including trauma related care needs (as applicable)." Further review of the policy revealed no information specific to the facility's procedure for following the comprehensive care plan.

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

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F 656	Continued From page 76 for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657	**F 657 CARE PLAN TIMING AND REVISION** 1) Care plans for residents #40, #21, and #518 were revised on 10/23/18 to reflect current wound and/or isolation status 2) All residents with a change in condition following the initial implementation of the care plan could be affected 3) A) The 24 Hour report will be used to identify residents who may require care plan revisions B) Changes in resident condition will be discussed in daily clinical stand up meeting during which care plan revisions will be determined and documented 4) The MDS Director will review the 24 Hour report and select a 10% sample of residents with condition changes. The identified sample will be provided to the DON for audit of timeliness of care plan revisions. Results of audits will be provided to the QAPI Committee and will be ongoing until the committee determines the need for monitoring has been met. 5) Compliance Date: 11/01/2019	

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F 657	Continued From page 77 comprehensive and quarterly review assessments. 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 review and revise the comprehensive care plan for three of 63 residents in the survey sample, Residents #40, #21, and #518. The facility staff failed to revise comprehensive care plan for Resident #40's when the resident developed a pressure ulcer in August 2019, and when Resident #21 developed a pressure sore in March 2019. The staff failed to revise Resident #518's comprehensive care plan to include isolation precautions in September 2019. The findings include: 1. The facility staff failed to revise Resident #40's comprehensive care plan when the resident developed a pressure ulcer in August 2019. Resident #40 was admitted to the facility on 9/20/18, and was most recently readmitted on 9/30/19 with diagnoses including but not limited to ESRD (end stage renal disease) (1) and diabetes (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 7/11/19, Resident #40 was coded as being moderately cognitively impaired for making daily decisions, having scored 11 out of 15 on the BIMS (Brief Interview for Mental Status). She was coded as having no unhealed pressure ulcers, and as being at risk for developing a pressure ulcer. A review of Resident #40's clinical record	F 657		

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revealed the following nurse's note dated 8/22/19: "Area noted sacrum/open red with yellow center. Wound nurse and PA (physician assistant) made aware. Treatment in place. Self RP (responsible party). Sister...made aware."

Further review of the clinical record revealed the following physician order dated 8/22/19: "Collagen sheet (3) with silver. Apply once daily for 30 days. Foam with border apply once daily for 30 days."

A review of Resident #40's comprehensive care plan dated 7/11/18 revealed, in part, the following: "Category: Pressure Ulcer. [Resident #40] will develop no further pressure injuries through next review." The care plan review failed to evidence the pressure ulcer documented on 8/22/19, and failed to evidence new interventions to treat the pressure ulcer.

On 10/3/19 at 10:44 a.m., LPN (licensed practical nurse) #8 was interviewed regarding the documentation of a new pressure ulcer. LPN #8 stated, "Once I assess it and put whatever treatment the doctor wants in the orders, I write a progress note. Usually the wound nurse will see it within the next week." When asked if the care plan should be updated, LPN #8 stated, "Of course. The unit manager updates the care plan. Not me."

On 10/3/19 at 11:10 a.m., LPN #5, the unit manager, was interviewed regarding the process for documenting pressure ulcers. LPN #5 stated, "The nurse looks at it, assesses it, and determines if the doctor needs to be notified for a treatment." When asked if the resident's care plan should be updated to reflect the presence of

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a pressure ulcer, LPN #5 stated, "Absolutely." When asked if floor nurses can update care plans, LPN #5 stated, "Well, that's a little bit iffy. We are working through that." When asked if she had updated Resident #40's care plan regarding the pressure ulcer discovered on 8/22/19, LPN #5 stated, "I wasn't working over here at that time, so no. I did not. It doesn't look like it was done when it should have been."

On 10/3/19 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality nurse, were informed of these concerns.

A review of the facility policy, "Care Planning," revealed, in part, the following: "The plan of care for each resident is person-centered and updated when needed with episodic change of conditions and reviewed/revised periodically."

No further information was provided prior to exit.

(1) "End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD)." This information is taken from the website https://medlineplus.gov/ency/article/000500.htm.

(2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(3) "Collagen dressings are dressings that are derived from animal sources, such as bovine (cattle), equine (horse) or porcine (pig) sources.

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The collagen helps to promote the growth of new collagen at the wound site, prompting an often speedier recovery period." This information is taken from the website https://advancedtissue.com/2013/12/collagen-dressing-basics/.

2. The facility staff failed to revise Resident #21's comprehensive care plan when the resident developed a pressure ulcer in March 2019.

Resident #21was admitted to the facility on 9/29/17 and most recently readmitted on 6/19/19 with diagnoses including, but not limited to cerebral palsy (1) and diabetes mellitus (2). On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 7/1/19, Resident #21 was coded as being severely impaired for making daily decisions. He was coded as having one unhealed pressure ulcer, and as being at risk for developing pressure ulcers.

A review of Resident #21's clinical record revealed the following nurse's note dated 3/29/19: "Resident has new open area on right buttock. Resident seen for right buttock area. New orders are in place and MD (medical doctor) and RP (responsible party) are aware."

Further review of the record revealed the following order, dated 3/29/19: "Cleanse right buttock with NS (normal saline) and apply Santyl, calcium alginate, and foam dressing QD."

A review of Resident #21's comprehensive care plan with revisions, dated 2/12/18, most recently updated 9/17/19, revealed, in part, the following: "[Resident #21]...is at risk for skin breakdown. He

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will demonstrate no further pressure injury development through next review." The comprehensive care plan review failed to evidence documentation of the pressure ulcer documented on 3/29/19, or any new interventions to treat the pressure ulcer.

On 10/3/19 at 10:44 a.m., LPN (licensed practical nurse) #8 was interviewed regarding the documentation of a new pressure ulcer. LPN #8 stated, "Once I assess it and put whatever treatment the doctor wants in the orders, I write a progress note. Usually the wound nurse will see it within the next week." When asked if the care plan should be updated, LPN #8 stated, "Of course. The unit manager updates the care plan. Not me."

On 10/3/19 at 11:10 a.m., LPN #5, the unit manager, was interviewed regarding the process for documenting pressure ulcers. LPN #5,"The nurse looks at it, assesses it, and determines if the doctor needs to be notified for a treatment." When asked if the resident's care plan should be updated to reflect the presence of the pressure ulcer, she stated, "Absolutely." When asked if floor nurses can update care plans, LPN #5,"Well, that's a little bit iffy. We are working through that." When asked if she had updated Resident #21's care plan regarding the pressure ulcer discovered on 3/29/19, LPN #5, "I wasn't working over here at that time, so no. I did not. It doesn't look like it was done when it should have been."

On 10/3/19 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality nurse, were informed of these concerns.

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No further information was provided prior to exit.

(1) "Cerebral palsy is a group of disorders that affect a person's ability to move and to maintain balance and posture." This information is taken from the website https://medlineplus.gov/cerebralpalsy.html.

(2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(3) "SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal." This information is taken from the manufacturer's website https://www.santyl.com/.

(4) "Alginate dressings are absorbent wound care products that contain sodium and calcium fibers derived from seaweed. They come in the form of flat dressings that can be placed over open ulcers and rope dressings that are used for packing the wound, which absorb fluids and promote healing with pressure ulcers, diabetic foot ulcers, or venous ulcers. An individual dressing is able to absorb up to 20 times its own weight. These dressings, which are easy to use, mold themselves to the shape of the wound, which helps ensure that they absorb wound drainage properly. This also makes these dressings ideal for using on ulcers in areas that are difficult to dress, such as heels and sacral areas." This information is taken from the website https://advancedtissue.com/2015/09/treating-wounds-with-absorbent-alginate-dressings/.

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3. The facility staff failed to revise Resident #518's comprehensive care plan to include isolation precautions in September 2019.

Resident #518 was admitted to the facility on 6/11/18 and most recently readmitted on 9/25/19 with diagnoses including, but not limited to: history of cardiac arrest (heart stopping), anoxic brain injury (brain not getting enough oxygen), COPD (chronic obstructive pulmonary disease) (1), and contractures (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 9/11/19, Resident #518 was coded as being severely cognitively impaired for making daily decisions. She was coded as being completely dependent on staff members for all activities of daily living. She was coded as having received antibiotics during the look back period.

On the following dates and times, Resident #518 was observed lying in her bed. At each observation, an isolation cart was positioned just outside Resident #518's door: 10/1/19 at 3:54 p.m., 10/2/19 at 8:57 a.m., and 10/2/19 at 12:05 p.m.

A review of Resident #518's clinical record revealed the following physician orders dated 9/25/19: "Contact Precautions for MDRO (multi-drug resistant organism) (3)."

A review of Resident #518's comprehensive care plan dated 6/11/18, updated on 2/8/19 revealed, in part, the following: "Resident will not exhibit signs of new infection." The care plan review failed to evidence the isolation precautions put in place 9/25/19.

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F 657	Continued From page 84 On 10/3/19 at 10:35 a.m., CNA (certified nursing assistant) #3 was interviewed. When asked how she is informed if a resident should be on isolation, she stated, "Usually we know from working with them before. Or the nurse will tell us." On 10/3/19 at 10:44 a.m., LPN (licensed practical nurse) #8 was interviewed regarding the process to be followed when a resident is placed on isolation. She stated that there must be a physician's order, and that a cart with PPE (personal protection equipment) is placed outside the resident's door. When asked if the resident's care plan should be updated to include the isolation precautions, LPN #8 stated, "Yes. Of course." When asked if she updates any care plans, she stated, "No. The unit manager updates the care plan. Not me." On 10/3/19 at 11:10 a.m., LPN #5, the unit manager, was interviewed regarding the process for documenting when a resident is placed on isolation, LPN #5 stated, "There should be a doctor's order and we may write a nurses' note. When asked if the isolation status should be a part of the resident's care plan, she stated, "Absolutely." When asked if floor nurses can update care plans, LPN #5 stated, "Well, that's a little bit iffy. We are working through that." When asked if she had updated Resident #518's care plan regarding the isolation status on 9/25/19, LPN #5 stated, "I need to look at it." After reviewing Resident #518's care plan, LPN #5 stated, "It doesn't look like it was done when it should have been." On 10/3/19 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the	F 657		

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F 657	Continued From page 85 director of nursing, and ASM #3, the corporate quality nurse, were informed of these concerns. 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) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm. (3) "For epidemiologic purposes, MDROs are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents (1). Although the names of certain MDROs describe resistance to only one agent (e.g., MRSA, VRE), these pathogens are frequently resistant to most available antimicrobial agents." This information is taken from the website https://www.cdc.gov/infectioncontrol/guidelines/mdro/background.html.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686	**F 686 SERVICES TO PREVENT PRESSURE ULCERS** 1) The orders for palm protectors for resident #518 have been rewritten to include the wearing schedule. Resident #518's care team has been re-educated on the current plan of care. A request for re-evaluation of the continued appropriateness of these devices has been made to OT. An interdisciplinary team meeting to revise the comprehensive plan of care will be scheduled.	

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F 686	Continued From page 86 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide services for the prevention of a pressure injury for one of 63 residents in the survey sample, Resident #518. The facility staff failed to apply palm protectors to Resident #518's hands per the physician's order. The findings include: Resident #518 was admitted to the facility on 6/11/18 and was most recently readmitted on 9/25/19 with diagnoses including, but not limited to: history of cardiac arrest (heart stopping), anoxic brain injury (brain not getting enough oxygen), COPD (chronic obstructive pulmonary disease) (1), and contractures (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 9/11/19, Resident #518 was coded as being severely cognitively impaired for making daily decisions. She was coded as being completely dependent on staff members for all activities of daily living. She was coded as being functionally limited in range of motion in both her upper and lower extremities. She was coded at risk of	F 686	2) All residents who have orders for palm protectors have the potential to be affected by the deficient practice. 3) A) The DON or designee will audit all residents with orders for palm protectors for implementation of the resident care plan. B) Communication of the use of palm protectors and their associated wearing schedule will be accomplished to the care team via the resident profile. C) Nursing staff will be educated on how to access the resident profile. 4) The DON or designee will perform observation audit of 10% of residents who use palm protectors according to the individual resident care plan weekly for 4 weeks. Results will be reported to the QAPI Committee. 5) Compliance Date: 11/01/2019	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 87 developing a pressure ulcer, and as having two unhealed pressure ulcers. On the following dates and times, Resident #518 was observed lying in her bed. She was observed at all of these times without palm protectors in each hand: 10/1/19 at 3:54 p.m., 10/2/19 at 8:57 a.m., and 10/2/19 at 12:05 p.m. On 10/2/19 at 12:05 p.m., LPN (licensed practical nurse) #6, the unit manager, and LPN #5, the unit manager, were observed turning Resident #518. Once they had completed this, LPN #5 was asked if Resident #518 was wearing palm protectors. LPN #5 stated, "I will have to check on those orders. I'm not sure they are even ordered for her." She returned at 12:09 p.m. and stated, "She is supposed to have them. I will get them for her." A review of Resident #518's POS (physician order sheet) revealed the following orders dated 9/25/19: "Palm protectors at all times/remove for hygiene QS (every shift)." A review of Resident #518's comprehensive care plan dated 6/11/18 and updated 2/8/19 revealed, in part, the following: "Palm guards...to be worn as ordered. Check skin condition upon removal of devices and report signs of irritation or increased difficulty applying or removing devices." On 10/3/19 at 10:35 a.m., CNA (certified nursing assistant) #3 was interviewed. When asked how she knows what devices a totally dependent resident should be wearing, CNS #3 stated, "A lot of it was gone over during the orientation period. It is just through experience, learning different residents and their needs, during orientation."	F 686		

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F 686	Continued From page 88	F 686		

When asked how she becomes aware of the device needs of new residents, CNA #3 stated, "Those things are listed for us in the computer. They are listed for us there." When asked how often she checks the computer for information regarding devices, CNA #3 stated, "Usually every shift. But not always."

On 10/3/19 at 10:44 a.m., LPN #8 was interviewed. When asked who is responsible for making sure dependent residents are wearing devices per the comprehensive care plan, LPN #8 stated, "The devices should be in the orders. The care plan, too. The nurses are supposed to know what the residents need. The CNAs can help, but the nurses are responsible."

On 10/3/19 at 11:10 a.m., LPN #5 was interviewed. When asked the purpose of palm protectors, LPN #5 stated, "Her hands are contracted. Those palm protectors keep her from getting a pressure area on her hands." When asked why Resident #518 was not wearing the palm protectors as ordered on 10/1/19 and 10/2/19, LPN #5 stated, "I really don't know. But she has them now."

On 10/2/19 at 11:39 a.m., LPN #6 was asked the purpose of the care plan, he stated, "It tells us what we are doing with the resident. We need to know what we are doing."

On 10/3/19 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality nurse, were informed of these concerns.

A review of the facility policy, "Pressure Ulcer Prevention," revealed, in part, the following:

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F 686	Continued From page 89 "Pressure ulcers can occur quickly in a person with compromising health conditions...Any resident who resides in the facility will receive services to decrease the risk of development of pressure ulcers...Residents who require mobility assistance are turned and repositioned frequently to prevent skin breakdown in bed...Positioning devices are used with the resident as needed." 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) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688	**F 688 SERVICES TO PREVENT DECLINE IN RANGE OF MOTION** 1), The orders for knee splints for resident #518 have been rewritten to include the wearing schedule. Resident #518's care team has been re-educated on the current plan of care. A request for re-evaluation of the continued appropriateness of these devices has been made to OT. An interdisciplinary team meeting to revise the comprehensive plan of care will be scheduled.	

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F 688	Continued From page 90 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. 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 provide services to prevent a decrease in range of motion for one of 63 residents in the survey sample, Resident #518. The staff failed to ensure Resident #518's knee splints were applied and in place as ordered by the physician. The findings include: Resident #518 was admitted to the facility on 6/11/18 and was most recently readmitted on 9/25/19 with diagnoses including, but not limited to: history of cardiac arrest (heart stopping), anoxic brain injury (brain not getting enough oxygen), COPD (chronic obstructive pulmonary disease) (1), and contractures (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 9/11/19, Resident #518 was coded as being severely cognitively impaired for making daily decisions. She was coded as being completely dependent on staff members for all activities of daily living. She was coded as being functionally limited in range of motion in both her upper and lower extremities. On the following dates and times, Resident #518	F 688	2) All residents who have orders for knee splints have the potential to be affected by the deficient practice. 3) A) The DON or designee will audit all residents with orders for knee splints for implementation of the resident care plan. B) Communication of the use of knee splints and their associated wearing schedule will be accomplished to the care team via the resident profile. C) Nursing staff will be educated on how to access the resident profile. 4) The DON or designee will perform observation audit 10% of residents who use knee splints according to the individual resident care plan weekly for 4 weeks. Results will be reported to the QAPI Committee. 5) Compliance Date: 11/01/2019	

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F 688	Continued From page 91	F 688		

was observed lying in her bed. She was observed at all of these times without knee splints on either knee: 10/1/19 at 3:54 p.m., 10/2/19 at 8:57 a.m., and 10/2/19 at 12:05 p.m.

On 10/2/19 at 12:05 p.m., LPN (licensed practical nurse) #6, the unit manager, and LPN #5, the unit manager, were observed turning Resident #518. Once they had completed this, LPN #5 was asked if Resident #518 was wearing knee splints. LPN #5 stated, "I will have to check on those orders. I'm not sure they are even ordered for her." She returned at 12:09 p.m. and stated, "She is supposed to have them. I will get them for her."

A review of Resident #518's POS (physician order sheet) revealed the following orders dated 9/25/19: "Resident to wear BLE (bilateral lower extremity) (left and right) knee extension splints to manage abnormal posture and reduce contracture risk - to be worn at all times - remove for personal care/ADL (activities of daily living) and monitor for redness."

A review of Resident #518's comprehensive care plan dated 6/11/18 and updated 2/8/19 revealed, in part, the following: "Palm guards and knee brace to be worn as ordered. Check skin condition upon removal of devices and report signs of irritation or increased difficulty applying or removing devices."

On 10/3/19 at 10:35 a.m., CNA (certified nursing assistant) #3 was interviewed. When asked how she knows what devices a totally dependent resident should be wearing, CNA #3 stated, "A lot of it was gone over during the orientation period. It is just through experience, learning different residents and their needs, during orientation."

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F 688	Continued From page 92 When asked how she becomes aware of the device needs of new residents, CNA #3 stated, "Those things are listed for us in the computer. They are listed for us there." When asked how often she checks the computer for information regarding devices, CNA #3 stated, "Usually every shift. But not always." On 10/3/19 at 10:44 a.m., LPN (licensed practical nurse) #8 was interviewed. When asked who is responsible for making sure dependent residents are wearing devices per the comprehensive care plan, LPN #8 stated, "The devices should be in the orders. The care plan, too. The nurses are supposed to know what the residents need. The CNAs can help, but the nurses are responsible." On 10/3/19 at 11:10 a.m., LPN #5 was interviewed. When asked the purpose of knee splints, LPN #5 stated, "They are a positioning device. They are supposed to help keep her from getting more contracted in her legs." When asked why Resident #518 was not wearing the knee splints as ordered on 10/1/19 and 10/2/19, LPN #5 stated, "I really don't know. But she has them now." On 10/2/19 at 11:39 a.m., LPN #6 was asked the purpose of the care plan, he stated, "It tells us what we are doing with the resident. We need to know what we are doing." On 10/3/19 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality nurse, were informed of these concerns. The surveyor requested a copy of the facility policy regarding range of motion/positioning devices.	F 688		

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F 688	Continued From page 93 On 10/3/19 at 4:12 p.m., ASM #3 stated the facility did not have a policy on range of motion/positioning devices. 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) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. 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 provide ensure the environment remains free	F 689	F689 FREE OF ACCIDENT HAZARDS 1) Resident #518 has been reassessed for fall risk. Resident #518's fall history is remote (greater than 1 year). The fall mats have been discontinued. 2) All residents with ordered fall mats have the potential to be affected. Continued Next Page	

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F 689	Continued From page 94	F 689		

from accident hazards to prevent injury from a fall for one of 63 residents in the survey sample, Resident #518. The facility staff failed to provide fall mats beside Resident #518's bed as ordered by the physician.

The findings include:

Resident #518 was admitted to the facility on 6/11/18 and most recently readmitted on 9/25/19 with diagnoses including, but not limited to: history of cardiac arrest (heart stopping), anoxic brain injury (brain not getting enough oxygen), COPD (chronic obstructive pulmonary disease) (1), and contractures (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 9/11/19, Resident #518 was coded as being severely cognitively impaired for making daily decisions. She was coded as being completely dependent on staff members for all activities of daily living.

On the following dates and times, Resident #518 was observed lying in her bed. She was observed at all of these times to be without fall mats on either side of her bed: 10/1/19 at 3:54 p.m., 10/2/19 at 8:57 a.m., and 10/2/19 at 12:05 p.m.

On 10/2/19 at 12:05 p.m., LPN (licensed practical nurse) #6, the unit manager, and LPN #5, the unit manager, were observed turning Resident #518. Once they had completed this, LPN #5 was asked if Resident #518 had fall mats in place. LPN #5 stated, "I thought we had discontinued those orders. I'm not sure they are even ordered for her." She returned to at 12:09 p.m. and stated, "We are getting that order changed right now."

A review of Resident #518's POS (physician order

3) A) An audit of all residents with orders for fall mats will be completed to determine continued need and compliance with care plan approaches.
B) Resident care plans will be revised based on audit findings
C) Use of fall mats will be communicated to the care team via the resident profile.
D) Residents who fall will be discussed in daily clinical stand up and in weekly interdisciplinary risk meeting.

4) Falls are tracked monthly by the facility Quality Assurance and Performance Improvement Committee. Audit results of the use of fall mats will be reported at the next scheduled meeting.

5) Compliance Date: 11/01/2019

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F 689	Continued From page 95	F 689		

sheet) revealed the following order dated 9/25/19: "Fall mats beside bed. Check placement qs (every shift)."

A review of Resident #518's comprehensive care plan dated 6/11/18 revealed, in part, the following: "Resident is at risk for falls related to: impaired mobility, inability to move or reposition herself, muscle spasms...Fall mats beside bed. Check placement qs."

On 10/3/19 at 10:35 a.m., CNA (certified nursing assistant) #3 was interviewed. When asked how she knows what fall injury prevention interventions should be in place, CNA #3 stated, "A lot of it was gone over during the orientation period. It is just through experience, learning different residents and their needs, during orientation." When asked how she becomes aware of the needs of new residents, CNA #3 stated, "Those things are listed for us in the computer. They are listed for us there." When asked how often she checks the computer for information regarding devices, CNA #3 stated, "Usually every shift. But not always."

On 10/3/19 at 10:44 a.m., LPN (licensed practical nurse) #8 was interviewed. When asked who is responsible for making sure fall mats are in place for residents. LPN #8 stated, "The physician's orders tell us. The care plan, too. The nurses are supposed to know what the residents need. The CNAs can help, but the nurses are responsible."

On 10/3/19 at 11:10 a.m., LPN #5 was interviewed. When asked the purpose of fall mats, LPN #5 stated, "They help prevent a resident from getting hurt if they would fall out of the bed." When asked why Resident #518 did not

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F 689	Continued From page 96	F 689		

have fall mat beside her bed on 10/1/19 and 10/2/19, LPN #5 stated, "We had meant to discontinue that order. I don't really think she needs them. She really is not moving around at all now."

On 10/2/19 at 11:39 a.m., LPN #6 was asked the purpose of the care plan, he stated, "It tells us what we are doing with the resident. We need to know what we are doing."

On 10/3/19 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality nurse, were informed of these concerns.

A review of the facility policy, "Falling Star," revealed, in part, the following: "Many residents residing in the facility are at risk for falls due to existing physical conditions, medications, or change in environment. Facility staff should be aware of any resident who is at risk so there can be frequent observation in an attempt to minimize falls...Fall Reduction Initiatives: Each facility must maintain a fall reduction initiative. This initiative will be an ongoing program...assessment of the resident's environment with identification of environmental needs)."

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) "A contracture develops when the normally

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F 689	Continued From page 97 stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide respiratory care and services according to professional standards of practice for one of 63 residents in the survey sample, Resident #518. The facility staff administered oxygen to Resident #518 without a provider's order for rate or percentage of oxygen to be delivered. The findings include: Resident #518 was admitted to the facility on 6/11/18 and most recently readmitted on 9/25/19 with diagnoses including, but not limited to: history of cardiac arrest (heart stopping), anoxic brain injury (brain not getting enough oxygen), COPD (chronic obstructive pulmonary disease)	F 695	**F695 RESPIRATORY/ TRACHEOSTOMY CARE AND SUCTIONING** 1) The physician's order for 28% humidified air via trach mask for resident # 518 was rewritten on 10/3/19. 2) There are no other residents with tracheostomy in facility. 3) A) A respiratory therapist has been consulted to review Resident #518's tracheostomy management with the care team and for ongoing care as needed. B) The DON or designee will review consult documentation and ensure implementation of recommendations in the resident care plan. C) The DON or designee will reconcile admission and readmission orders for humidified air/ oxygen with hospital discharge orders. D)The Director of Admissions will track admission referral requests for individuals with tracheostomies for purposes of future planning. 4) Implementation of ordered oxygen devices is to be monitored through daily and weekly rounds by Unit Managers, ADON and DON. Weekly checks will be conducted on residents who have respiratory needs to include tubing, flow rate, condition of equipment, and settings for Humidified Air on residents with Trach by 11-7 supervisor. A report of findings and corrective action will be provided to the Administrator. 5) Compliance Date: 11/01/2019	

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(1), and contractures (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 9/11/19, Resident #518 was coded as being severely cognitively impaired for making daily decisions. She was coded as being completely dependent on staff members for all activities of daily living. She was coded as having received oxygen and as receiving tracheostomy (3) care during the look back period.

On the following dates and times, Resident #518 was observed lying in her bed. She was observed at all of these times with a tracheostomy mask connected to a device delivering humidified air via the trach (tracheostomy) mask. The settings on the device were 5L (liters) and 28% (oxygen): 10/1/19 at 3:54 p.m., 10/2/19 at 8:57 a.m., and 10/2/19 at 12:05 p.m.

A review of Resident #518's clinical record revealed the following physician orders dated 9/25/19: "Continuous humidified Air via Trach mask." The review revealed no orders related to the rate or percentage of oxygen to be delivered.

A review of Resident #518's comprehensive care plan dated 6/11/18 and updated 6/18/19 revealed, in part, the following: "[Resident #518] is at risk for further respiratory and cardiac complications...she has a tracheostomy with continued (sic) humidified air...Administer oxygen as ordered."

On 10/3/19 at 10:44 a.m., LPN (licensed practical nurse) #8 was interviewed. When asked if oxygen required a physician's order for administration, LPN #8 stated, "Yes. We need an order for everything." When asked if oxygen is considered

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a medication, LPN #8 stated, "Yes it is." LPN #8 accompanied the surveyor to Resident #518's bedside. When shown the device settings for the humidified air being delivered to Resident #518, and when asked what the rates mean, LPN #8 stated, "I really don't know. That's what it's always been set at. I'm just agency. I'm not here a lot. I'll have to go ask someone."

On 10/3/19 at 11:10 a.m., LPN #5, the unit manager, was interviewed about the device settings for the humidified air being delivered to Resident #518. LPN #5 stated, "It's a certain percentage (of oxygen). It's supposed to be set at 28%." When asked how she knew the percentage, LPN #5 stated, "I think the respiratory therapist at the hospital told us in report. He said that is equal to three liters of oxygen." When asked if there should be an order for the device settings, LPN #5 stated, "Yes. I'm sure there's an order." After reviewing the physician's orders for Resident #518, LPN #5 stated, "It should have a rate order, but it doesn't. We can fix that."

On 10/3/19 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality nurse, were informed of these concerns.

A review of the facility policy, "Oxygen, Administration of," revealed, in part, the following: "Check the physician's order for liter flow rate and method of administration...Oxygen is a medication and therefore the order for oxygen administration is charted on the EMAR (electronic medication administration record) by the licensed nurse."

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F 695	Continued From page 100 (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) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm. (3) "A tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube." This information is taken from the website https://medlineplus.gov/ency/article/002955.htm.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide dialysis care and services for one of 63 residents	F 698	**F 698 DIALYSIS** 1) Resident #40's dialysis communication book was set up with dividers for each day resident goes to dialysis (Tuesday, Thursday, Saturday). Communication forms were placed behind each divider. 2) Residents receiving outpatient dialysis may be affected by this practice. Continued Next Page	

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in the survey sample, Resident #40. The facility staff failed to utilize and maintain consistent communication with the dialysis center by way of the dialysis communication book in September 2019, for Resident #40.

The findings include:

Resident #40 was admitted to the facility on 9/20/18 and most recently readmitted on 9/30/19 with diagnoses including but not limited to ESRD (end stage renal disease) (1) and diabetes (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 7/11/19, Resident #40 was coded as being moderately cognitively impaired for making daily decisions, having scored 11 out of 15 on the BIMS (Brief Interview for Mental Status). She was coded as receiving dialysis (3) services during the look back period.

A review of Resident #40's clinical record revealed the following physician's order dated 9/30/19: "Hemodialysis X3 weekly (3 X a week) at [name of dialysis center]."

A review of Resident #40's comprehensive care plan dated 7/25/18 and updated 5/16/19 revealed, in part, the following: "Resident has diagnosis of ESRD and is at risk for complications due to her kidney failure...Dialysis as ordered. Resident will be assisted with dialysis transportation arrangements."

Further review of Resident #40's clinical record revealed the presence of a dialysis communication book. The book contained papers with resident's name and columns for vital signs,

F 698 (Plan of Correction)

3) A) Residents who go to outpatient dialysis will have their dialysis communication books set up in a manner consistent with resident # 40
B) The charge nurse will review the communication book when the resident returns from dialysis. If no information is provided by the dialysis center, the charge nurse will contact the center and request verbal report. Verbal report will be documented in the communication book.
C) Licensed nursing staff will be educated on revised process.

4) An audit of 100% of dialysis communication books will be completed weekly by the unit managers for 4 weeks, then monthly. Results of audit to be reported to Quality Assurance and Performance Improvement Committee.

5) Compliance Date: 11/01/2019

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F 698	Continued From page 102 weight, facility comments, and dialysis center comments. For September 2019, the book contained entries for only the following dates: 9/5/19, 9/19/19, and 9/24/19. The book contained no other entries for September 2019. A review of September 2019 nurses' notes for Resident #40 revealed no mention of communication with the dialysis center. On 10/3/19 at 10:35 a.m., CNA (certified nursing assistant) #3 was interviewed regarding the use of the dialysis communication book. She stated, "The only experience I have had with residents going to dialysis is making sure they are up and dressed." On 10/3/19 at 10:44 a.m., LPN (licensed practical nurse) #8 was interviewed. When asked about the process that is to be followed when residents leave for and return from dialysis, LPN #8 stated, "We get a set of vital signs that morning before they leave, then when they come back, we check and see if there are any new orders." When asked where she looks to determine if there are new orders, LPN #8 stated, "I look in the book." When asked the purpose of the dialysis communication book, LPN W#8 stated, "So dialysis can know what's going on with the resident before they get there. And so we can know what happened at dialysis when they get back to us." When asked if the dialysis communication book should be utilized every day in which the resident received dialysis, LPN #8 stated, "Yes. Every day they go, a sheet should be filled out." When asked the process to be followed if a resident returns without a communication sheet for that day, LPN W#8 stated, "If there is no sheet, I would call dialysis	F 698		

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F 698	Continued From page 103 and get a report." On 10/3/19 at 11:10 a.m., LPN #5, the unit manager was interviewed. When asked the purpose of the dialysis communication book, LPN #5 stated, "So you can communicated with the dialysis center about vital signs, labs. If we are concerned about something, we can look in the book, and vice versa. Also, the dietician can use it." When asked if a sheet should be filled out in the dialysis communication book for each day the resident receives dialysis, LPN #8 stated, "Yes. It should be filled out every time they go." When asked what could be determined from the lack of sheets in the communication book for the days a resident received dialysis, LPN #8 stated, "You would have to say there wasn't any communication. You would have to say there should have been, but wasn't." On 10/3/19 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality nurse, were informed of these concerns. A review of the facility policy, "Hemodialysis, care of resident receiving treatment," revealed, in part, the following: "Purpose: To provide services to the resident to aid in maintaining optimal benefit from hemodialysis...Documentation...Document communication with the dialysis center." No further information was provided prior to exit. (1) "End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD)." This	F 698		

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F 698	Continued From page 104 information is taken from the website https://medlineplus.gov/ency/article/000500.htm. (2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html. (3) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was taken from the website https://medlineplus.gov/dialysis.html.	F 698		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725	**F 725 INSUFFICIENT STAFFING** 1) Sufficient staffing has been provided to meet the needs of resident #112 since her complaint on 9/22/2019. The issue of taking leave from work has been addressed with CNA#1. 2) Potentially all residents could be adversely affected by insufficient staffing. 3) A) Procedures for reporting to work on time, leaving work during the shift and unscheduled absences have been reviewed with facility staff. B) The facility has a plan in place to meet staffing requirements through recruitment of new staff, increasing the work hours of current staff and utilizing agency staff as needed. C) Education completed with supervisory and management staff to ensure off shift and weekend staffing procedures for unit coverage is accomplished.	

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F 725	Continued From page 105 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to maintain sufficient nursing staff for one of 63 residents in the survey sample, Resident #112. On 9/22/19, the facility staff failed to assist Resident #112 out of bed in a timely manner due to insufficient CNA (certified nursing assistant) staffing. The findings include: Resident #112 was admitted to the facility on 8/11/12. Resident #112's diagnoses included but were not limited to diabetes, convulsions and functional urinary incontinence. Resident #112's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/24/19, coded the resident's cognition as moderately impaired. Section G coded Resident #112 as requiring extensive assistance of one staff with bed mobility/dressing/toilet use and personal	F 725	4) Concerns related to insufficient staffing are tracked through the facility grievance process. A report of resident grievances is reviewed monthly by the Quality Assurance and Performance Improvement Committee 5) Compliance Date: 11/01/2019	

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hygiene, required extensive assistance of two or more staff with transfers and was totally dependent on one staff with bathing.

Resident #112's comprehensive care plan dated 12/3/14 and edited on 9/17/19 documented, "Recent decline in ADL (activities of daily living) self performance with further losses anticipated due to her advanced age and end stage disease processes related to impaired mobility due to debility, arthritis, dm (diabetes mellitus) with neuropathy (affecting the nervous system) as well as her age and dx (diagnosis) of dementia...Assist resident with turning and repositioning every 2-3 hours as needed. Assist to bathroom as needed/requested. Provide assistance as needed with dressing and hygiene tasks. Provide assistance with bed mobility, transfers, grooming, toileting and bathing as necessary. Attempt in include resident in planning schedule for daily routine. Know that she often prefers to spend most of her time out of bed..."

On 9/27/19 the Virginia Department of Health, Office of Licensure and Certification received a complaint regarding Resident #112. The complaint documented that on 9/22/19 around 1:45 p.m., Resident #112's family member arrived to the facility and heard the resident hollering, with no response from the staff. The complaint further documented Resident #112 was in bed and wanting to get out of bed and the family member was informed by a nurse that the facility was short staffed. The complaint alleged there were only two CNAs (certified nursing assistants) to care for the residents on the unit where Resident #112 resided. Resident #112 was reportedly, assisted with a bath, then was

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assisted out of bed only after the family member complained to facility staff.

Review of Resident #112's September 2019 ADL documentation failed to reveal documentation of care provided during the day shift on 9/22/19. Review of September 2019 nurse's notes failed to reveal any notes dated 9/22/19.

The daily staffing form for the unit Resident #112 resided on documented the following for Sunday 9/22/19 during the day shift:
-Three nurses were scheduled.
-Six CNAs were scheduled; however, one CNA was in the hospital, one CNA was late and one CNA was no call- no show (did not come to work).

Review of September 2019 assignment sheets for the unit Resident #112 resided on failed to reveal an assignment sheet for the day shift on 9/22/19.

On 10/2/19 at 1:50 p.m., an interview was conducted with OSM (other staff member) #2 (the staffing coordinator). OSM #2 was asked the facility process for ensuring enough nursing staff to care for residents. OSM #2 stated she reviews the census (amount of residents) on each unit then utilizes multiple tools including a per patient ratio guide and the staffing form to determine how many nurses and how many CNAs to staff on each unit. OSM #2 was asked what should be done if scheduled nursing staff do not show up for work. OSM #2 stated, "It could go different ways. Someone here may stay or someone come in. Sometimes if a CNA calls off, we still have enough because I have a couple more than really needed. It depends on the numbers (census) for the day. We are also using agency to fill." OSM

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#2 confirmed the 9/22/19 resident census for Resident #112's unit on 9/22/19 was 64. OSM #2 was made aware that according to the 9/22/19 daily staffing form for the day shift on Resident #112's unit documented only three CNAs were present and one other CNA arrived late. OSM #2 stated a CNA from another unit could have been pulled to work on Resident #112's unit. OSM #2 stated the daily staffing form does not always reflect changes and who actually worked and which unit, especially on weekends and nights.

On 10/2/19 at 2:18 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #2, an agency nurse who worked on Resident #112's unit during the day shift on 9/22/19. LPN #2 stated staffing was definitely an issue on the unit where Resident #112 resided. LPN #2 was asked if Resident #112's family voiced any concerns on 9/22/19. LPN #2 stated, "Yes. She (Resident #112) wanted to get up. Her original aide had left to go pick up his daughter and never came back. Her family wanted her to get out of bed. She was still in bed at 1:30 (p.m.) or 2:00 (p.m.). I have worked other days since, and she has been up. I don't know if it was a bad day because of staffing. We started with three aides and he (a CNA) left at 8:30 (a.m.) or 9:00 (a.m.). We told the managers on call (not able to recall names). He (the CNA) never returned and management did not send any other CNAs." LPN #2 stated someone from management did assist Resident #112 out of bed after the family member complained. LPN #2 stated it was tough to provide good care when the facility is "short staffed." LPN #2 stated at times, residents would stay in bed because it is almost impossible for two people to assist 62 or 63 residents out of bed.

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F 725	Continued From page 109 On 10/2/19 at 4:26 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing) (who was on-call but not present in the facility on 9/22/19). ASM #2 was asked if she had received any complaints from Resident #112's family. ASM #2 stated she had a conversation with the resident's family member a week or two ago because the family member had some issues with staffing. ASM #2 was asked to elaborate. ASM #2 stated the family member believed the facility was short staffed. ASM #2 stated the family member reported she came in late on a Saturday afternoon, Resident #112 was in bed and it appeared no care had been rendered to her. ASM #2 stated the facility was staffed with agency staff on that day and Resident #112 told the staff she did not want to get out of bed. When asked to confirm that this occurred on a Saturday, ASM #2 stated she could not remember what day it was. ASM #2 stated the family member was concerned about agency staff caring for residents stating they did not know how to care for the residents but she (ASM #2) assured the family member that agency staff are provided orientation and given reports regarding resident care information. ASM #2 stated she and the family member discussed the industry and how it was a problem to get staff to work in this environment. ASM #2 stated she was in the process of developing "cheat sheets" with resident care information. ASM #2 stated Resident #112's family member seemed pleased at the end of the conversation. ASM #2 was asked how many CNAs should be staffed to meet residents' needs during the day shift on Resident #112's unit if the census is 64. ASM #2 stated there should be five CNAs and a CNA to provide baths/showers. ASM #2 was asked if it was	F 725		

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possible for two or three CNAs to meet the care needs for 64 residents. ASM #2 stated, "It's difficult. Indeed. It's difficult. We don't like that to happen. We like the nurses to help out to get it done. It other situations, we do it together."

On 10/3/19 at 7:50 a.m., an interview was conducted with LPN #3 (the manager on duty, present in the facility on 9/22/19). LPN #3 stated she is present in the facility for four hours when she is manager on duty and thought she was in the facility during the morning on 9/22/19. LPN #3 was asked if any staffing concerns were reported to her regarding Resident #112's unit on 9/22/19. LPN #3 stated, "Not that I'm aware of." LPN #3 was asked how many staff was present on the unit during the day shift on 9/22/19. LPN #3 stated, "I would have to go look. I want to say that it was okay." LPN #3 was asked if any concerns regarding, Resident #112 were reported to her by staff or family on 9/22/19 and stated, "No."

On 10/3/19 at 7:58 a.m., LPN #3 returned and stated she remembered more information. LPN #3 stated Resident #112's unit started off, "okay" with staff during the day shift on 7/22/19 but one of the CNAs had to leave to be with his daughter. LPN #3 stated when she went over to the unit, the CNA was gone and Resident #112's family member was upset because Resident #112 was not out of bed. LPN #3 stated she thought the resident had previously refused to get out of bed but she offered again, and she and another nurse assisted the resident out of bed. LPN #3 stated the family member was very upset and wanted to talk to someone in charge so she provided ASM #3's phone number. LPN #3 was asked what time this occurred. LPN #3 stated she did not

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F 725	Continued From page 111 remember the exact time. When asked if this occurred after lunch, LPN #3 stated it did. LPN #3 stated the CNA who left (CNA #1) did return. LPN #3 was asked if arrangements were made to cover the unit and care for residents when CNA #1 left. LPN #3 stated, "Well they all just pitch in." LPN #3 stated someone called CNA #1 to see if he was going to return then she got a message that he was on his way back. LPN #3 could not state when CNA #1 returned but stated it was before the end of the day shift. When asked what time CNA #1 left, LPN #3 stated, "I have no idea." LPN #3 stated there was also a supervisor in the facility that day and she made that person aware of the situation before she (LPN #3) left the facility. LPN #3 apologized multiple times because she did not remember this information during the previous interview on 10/3/19 at 7:58 a.m. NOTE: There was no documentation in Resident #112's clinical record to evidence the resident refused to get out of bed on 9/22/19. Furthermore, interviews with a nurse and a CNA who worked on Resident #112's unit on 9/22/19 failed to reveal reports that Resident #112 refused to get out of bed. On 10/3/19 at 9:19 a.m., a telephone interview was conducted with CNA #1 (the CNA who left the facility during the day shift on 9/22/19). CNA #1 stated he reported to work on 9/22/19 but left because he had to get his kids. CNA #1 was asked what time he left the facility. CNA #1 stated he left two hours after his arrival (approximately 9:00 a.m.) and returned at 2:00 p.m. When asked who he made aware that he needed to leave, CNA #1 stated he told the agency nurse and another CNA. CNA #1 was	F 725		

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asked if the facility staff did anything to provide resident care coverage since he had to leave. CNA #1 stated, "We were three CNAs then went down to two. They did the best they could to care for people and I finished up when I returned. Two CNAs- they cannot get 66 people up and cared for." CNA #1 stated lack of CNA coverage on the weekends is nothing new. CNA #1 sometimes there are four CNAs but usually there are only three CNAs and sometimes only one or two. CNA #1 stated, "It's just bad." When asked if the lack of CNAs affected resident care, CNA #1 stated, "Oh yeah. Very much. That's why I got another job." CNA #1 stated it is even difficult when four CNAs are responsible for 64 residents' care because each CNA is assigned 16 residents. CNA #1 stated each resident typically needs one hour of care and CNAs have to assist residents out of bed with Hoyer (mechanical) lifts, provide showers and assist with meals in between caring for each resident. CNA #1 stated, "How are you going to get all those people done in that short period of time. By the time lunch comes, you don't have time to get everyone done. It's not good for staff or residents." When asked to clarify what he meant by getting residents done, CNA #1 stated getting all am care provided and residents out of bed.

On 10/3/19 at 11:04 a.m., an attempt to contact the supervisor LPN #3 referred to was made. The supervisor was not available.

Multiple attempts to contact other nursing staff members listed on the schedule for Resident #112's unit during the day shift on 9/22/19 were made during the survey. The staff members were not available.

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F 725	Continued From page 113 On 10/3/19 at 10:37 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality nurse) were made aware of the above concern. On 10/3/19 at 2:50 p.m., ASM #1 presented time clock sheets for the staff documented on the daily staffing form as working on Resident #112's unit during the day shift on 9/22/19. ASM #1 was made aware OSM #1 had stated during an interview that the daily staffing forms do not always reflect who actually worked on the unit. ASM #1 was made was aware that a nurse and a CNA who worked on Resident #112's unit during the day shift confirmed there were only two CNAs on the unit for most of the shift. ASM #1 was made aware that attempts were made to contact the other staff documented on the daily staffing form for that unit on that day. ASM #1 was made aware this surveyor was willing to speak with those staff if he could reach them. On 10/3/19 at 4:12 p.m., ASM #3 stated the facility did not have a policy regarding staffing. On 10/3/19 at 4:47 p.m., ASM #1 stated he had no further information regarding the 9/22/19 nursing staff concern. No further information was presented prior to exit.	F 725		
F 727 SS=F	COMPLAINT DEFICIENCY RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility	F 727	**F 727 RN 8 HOURS/7 DAYS; FULL TIME DON** 1) No correction for RN hours can be made for September 2019. 2) Potentially all residents could be adversely affected by	

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F 727	Continued From page 114 must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to RN [registered nurse] coverage for a 24-hour period from 09/01/19 through 09/30/19. The findings include: On 10/031//19 at approximately 9:00 a.m., a review of the facility "As worked schedule" dated 09/01/19 through 09/30/19 was conducted by this surveyor. The review revealed that on 09/07/19, 09/08/19, 09/14/19, 09/15/19, 09/22/19, 09/28/19 and 09/19/19, seven, out of thirty days, the facility failed to maintain registered nurse coverage for each 24-hour period. On 10/03/19 at 10:10 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing and ASM # 3, corporate quality assurance, nurse consultant. After reviewing the facility "As worked schedule" dated 09/01/19 through 09/30/19. ASM # 2 and # 3 confirmed that there was no registered nurse coverage for the 24-hour periods on above dates. ASM # 2, stated, "We have had a vacancy and we have been recruiting. Going forward will have	F 727	gaps in RN scheduling. 3) A) Schedules for Part time and Per Diem RNs, as well as RN Supervisors, have been adjusted to ensure compliance with RN coverage requirements. B) The facility has a plan in place to meet staffing requirements through recruitment of new staff, increasing the work hours of current staff and utilizing agency staff as needed. C) The DON or designee will review staffing schedules daily; any gaps in RN coverage will be reported to the Administrator. 4) Compliance with RN coverage requirements will be reviewed during the monthly Quality Assurance and Performance Improvement Committee. 5) Compliance Date: 11/01/2019	

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an RN [registered nurse] supervisor from 7:00 a.m. to 7:00 p.m. on Saturdays and Sundays." When asked why it was important to have an RN on duty in a 24-hour period ASM # 2 stated, "For clinical oversight and supervising of the staff."

On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

F 730 SS=D Nurse Aide Peform Review-12 hr/yr In-Service
CFR(s): 483.35(d)(7)

§483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and employee record review it was determined that the facility staff failed to ensure that two of ten CNA (certified nursing assistant) records reviewed received the required 12 hours of annual training's, CNA # 4, and #5.

The findings include:

On 10/03/19 at 8:15 a.m. a review of the facility's CNA [certified nursing assistant] annual training was conducted. Review of ten CNA training transcripts revealed two of ten CNAs selected for review did not meet the required 12-hours of annual training.

F 730

F 730 CNA PERFORMANCE REVIEW – 12 HOUR INSERVICE

1) CNA #4's surveyed in-service record was from 2018 and cannot be corrected. CNA #5's surveyed in-service record was from 2017 and cannot be corrected. CNA #4 and CNA #5 will receive education on 12-hour in-service requirement.
2) Currently employed CNAs are at risk for not meeting 12-hour yearly in-service requirements.
3) A) The facility provides computer carrels for CNAs to complete their 12- hour training requirement.
B) RELIAS Learning Modules are assigned to each CNA annually. These modules meet the 12-hour yearly requirement.
C) The DON or designee will review compliance reports related to completion of assigned RELIAS Learning Modules monthly.
4) The DON will provide a report on compliance with the 12-hour in-service requirement quarterly. Identified non-compliance will be addressed with CNA coaching and counseling.
5) Compliance Date: 11/01/2019

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F 730	Continued From page 116 Review of CNA # 4's training transcript documented a hire date of 12/11/2012. Further review of the training transcript dated 03/09/18 through 04/10/18 documented, "Total Hours: 7.00." Review of CNA # 5's training transcript documented a hire date of 11/21/2017. Further review of the training transcript dated 11/24/17 through 05/11/18 documented, "Total Hours: 8.00." On 10/03/19 at 10:00 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing and ASM # 3, corporate quality assurance, nurse consultant regarding the CNA's annual training. ASM # 3 stated, "They [CNAs] should have a minimum of 12-hours of annual training." When asked who was responsible for coordinating the training and ensuring the CNAs meet the minimum 12-hours annually, ASM # 3 stated, "Currently we don't have a staff development person but we have someone from corporate who is currently overseeing it." On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings. No further information was provided prior to exit.	F 730		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758	See Next Page	

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F 758	Continued From page 117 processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758	F758 FREE FROM UNNECESSARY MEDICATIONS 1) Resident #73 has been taking a very low dose of Seroquel for anxiety disorder since admission to facility April 2018. According to consultant pharmacist, Seroquel for anxiety is an accepted "off label" use of the medication due to its mechanism of blocking dopamine and serotonin receptors, having the effect of calming the mind. Documentation indicates Seroquel has been effective in reducing anxiety symptoms in resident #73. Will discuss with resident # 73's physician the possibility of attempting gradual dose reduction since mood has been stable. 2) Residents taking Seroquel have the potential for unnecessary use of the medication. Consultant pharmacist has completed an audit of residents receiving Seroquel to determine the presence of acceptable diagnosis. 3) A) Monthly pharmacy review for potential unnecessary Seroquel use. B) For residents who are receiving Seroquel for anxiety, request physicians to document rationale for its selection over other anxiolytics. C) Gradual dose reduction of residents receiving as determined appropriate by ordering physician. 4) Psychoactive medication use is tracked monthly through the Quality Assurance and Performance Improvement Committee. The consultant pharmacist will report "off label" use or unnecessary use of Seroquel to the committee quarterly. 5) Compliance Date: 11/01/2019	

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F 758	Continued From page 118 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure that one of 63 residents in the survey sample was free of unnecessary medication, Resident #73. Resident #73 was prescribed an antipsychotic medication, Seroquel, for anxiety, which is not an approved use for the medication. The clinical record did not reflect the presence of any approved diagnoses or any documented behaviors for the use of this medication. The findings include: Seroquel (1) is an antipsychotic medication used to treat the symptoms of schizophrenia; used alone or with other medications to treat or prevent episodes of mania or depression in patients with bipolar disorder; used along with other medications to treat depression. Seroquel information also includes the following: Important warning for older adults with dementia: Studies have shown that older adults with dementia who take antipsychotics such as Seroquel have an increased risk of death during treatment. The Food and Drug Administration (FDA) do not approve Seroquel for the treatment of behavioral problems in older adults with dementia. Resident #73 was admitted to the facility on	F 758		

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4/27/18 with the diagnoses of but not limited to leg wound, chronic obstructive pulmonary disease, diabetes, dysphagia, giant cell arteritis, dementia, anxiety disorder, degenerative disease of the nervous system, atrial fibrillation, congestive heart failure, stenosis of the larynx, trach stoma malfunction, abnormal weight loss, and congenital malformations of the heart. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/1/19 coded the resident as moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for all areas of activities of daily living and was incontinent of bowel and bladder.

A review of the clinical record revealed the physician's order; dated 1/13/19, for Seroquel, 25 mg (milligrams) tablet, take 12.5 mg (half tablet) daily for "other specified anxiety disorders."

A review of the Medication Administration Record for September 2019 revealed documentation evidencing that this medication was being administered as ordered.

Review of the clinical record failed to reveal any evidence that the resident had any of the approved diagnoses justifying the use of Seroquel, or any documented evidence of the resident having any signs/symptoms requiring this medication. (Note in the medication description above, that anxiety disorders was not identified as an approved use of this medication.)

Further review of the nurse's notes and clinical record from January 2019 through the survey revealed no evidence of the resident exhibiting behaviors other than occasional refusal of

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personal care needs. There was no evidence of the resident exhibiting psychotic or delusional behaviors, or aggressive behaviors towards others. Refusal of personal care was the resident's choice and right and did not warrant the use of an antipsychotic medication.

A review of the comprehensive care plan revealed one dated 5/15/18 for the use of psychotropic drugs, which documented, "Res. (resident) is at risk for possible complications d/t (due to) res. receiving antidepressant & (and) antipsychotic during lookback. Res. has dx (diagnoses) of Other specified depressive episodes & Other specified anxiety disorders." The care plan contained three interventions. These interventions were "Administer medication as ordered" dated 5/15/18, "Assess/record effectiveness of drug treatment. Observe for and report signs of sedation, hypotension, or anticholinergic symptoms" dated 5/15/18, and "Pharmacist review of record to recommend gradual dose reduction to the physician" dated 5/15/18.

The care plan also included one for Behavioral Symptoms dated 5/9/18 which documented, "Resident refuses at times to permit wound tx (treatment), adl (activities of daily living) care, wear his palm protector and gauze between right fingers and palm r/t (related/to) personal choice. He also may curse at staff, refuses treatments and care via (wound care physician services) wound doctor at times." This care plan contained 3 interventions which were "education given on the importance of accepting care and treatment changes " dated 2/25/19, "Cue/redirect, as needed" dated 5/9/18, and "May need to leave and re-approach at a later time to comply with

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care" dated 5/9/18.

The care plan revealed no evidence that the resident exhibited behaviors or diagnoses warranting the use of an antipsychotic medication.

On 10/03/19 at 11:17 AM, in an interview with LPN #4 (Licensed Practical Nurse), she stated, "Seroquel is an antipsychotic and given for behaviors related to psychosis. He has not shown any evidence of it as long as I have been working with him, which has been for about a year. Physicians at PACE (Program of All-Inclusive Care for the Elderly) prescribe it (Seroquel). We get the orders from PACE. They fax us an update in medication or treatment orders. We only document if he has behaviors. He does not have much behavior. He is pretty well controlled. Every now and then, he might resist care. Anxiety is not a diagnosis for Seroquel."

On 10/3/19 at 4:16 PM, in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing), she stated, "Seroquel is an antipsychotic used to help with behaviors. It should not be used for anxiety. Since I started here, I have been trying to get on top of these things coming from PACE. It has taken a lot of work to get them (PACE) to communicate with me and work with me on these things."

A review of the facility policy, "Unnecessary Use of Antipsychotic/Psychotropic Medications System" documented,

On 10/3/19 at 5:15 PM, ASM #1 and #2 (Administrative Staff Member - the Administrator

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F 758	Continued From page 122 and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey. (1) Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility	F 761	**F 761 LABEL AND STORE BIOLOGICALS** 1) The expired vial of Novolog insulin was discarded per facility policy. 2) Residents with orders for insulin have the potential to be affected by this practice as insulin vials have the potential to be stored improperly. 3) A) Licensed Nurses have been educated on proper labelling and storage of insulin vials. B) Unit Managers will weekly inspect medication carts for expired medication. C) A report of weekly medication cart inspection will be submitted to the DON. 4) DON will provide a report of medication cart inspection results to the Quality Assurance and Performance Improvement Committee monthly. 5) Compliance Date: 11/01/2019	

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F 761	Continued From page 123	F 761		

document review, it was determined that the facility staff failed to store medication per manufacturer's instructions for one of five observed medication carts, a medication cart on the Grove unit. One expired vial of Novolog (1) insulin with an open date of 7/9/19 was observed in a medication cart on the Grove unit. According to the manufacturer's instructions, the insulin should be discarded 28 days after opening the vial.

The findings include:

On 10/2/19 at 1:30 p.m., observation of a medication cart on the Grove unit was conducted. A vial of opened Novolog insulin was observed labeled with an open date of 7/9/19. Another label on the vial documented to discard the vial 28 days after opening. At this time, an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked how long Novolog insulin should be kept in the medication cart after being opened. LPN #1 stated Novolog should be kept in the cart for only 28 days after being opened. LPN #1 confirmed the vial of Novolog was opened in July 2019 and was older than 28 days. LPN #1 stated she would discard the vial.

The Novolog manufacturer's instructions documented, "Throw away open vials and pens 28 days after first use, even if there is insulin left inside." This information was obtained from the website: https://www.rapidactinginsulin.com/novolog/using-novolog/storage-and-handling.html

On 10/3/19 at 10:37 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate quality nurse) were made aware of

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F 761	Continued From page 124 the above concern. The facility pharmacy policy titled, "INSULIN ADMINISTRATION" documented, "Insulin is a high risk drug and warrants additional precautions for the safe and effective administration...6. Follow the manufacturer's instruction for storage and expiration..." No further information was presented prior to exit. (1) Novolog is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605013.html	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812	F 812 FOOD PROCURE/STORE/SERVE SANITARY 1) The bowls and cups were immediately cleaned, dried and stored properly on 10/1/19. The food processor and mixer were immediately cleaned 10/1/19. The storage of the dry goods scoop was corrected. The dietary director was re-educated on policies to store equipment in a sanitary manner. The fan was removed from the dish room on 10/22/2019. 2) All residents have the potential to be affected by this practice. A 100% audit of shelving units within the dietary area was accomplished with no similar issues found. 3) A) The dietary department staff were educated on: 1. Storing cups and bowls in a manner that prevents wet nesting. A new shelving unit was ordered for proper storing. 2. Policy for handling clean equipment and utensils, and that clean equipment and utensils will be stored in a clean location that protects them from contamination and dust and free from food debris. 3. Proper storage and placement of scoops. Continued Next Page	

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by:
Based on observation, staff interview, and facility document review it was determined facility staff failed to store and prepare food in a sanitary manner.

1. The facility staff failed to ensure cups and vegetable bowls were clean and not wet nesting.

2. The facility staff failed to ensure a mixer and food processor that were ready for use, were clean and free from food debris.

3. The facility staff failed to maintain a 30-inch fan blowing on clean dishes and cups, located in the clean dish area of the kitchen was clean and free of grease and dust.

4. The facility staff failed to ensure a flour scoop was not stored inside the sugar bin.

The findings include:

On 10/01/19 at approximately 2:25 p.m., an observation of the facility's kitchen was conducted with OSM [other staff member] # 8, dietary manager with the following concerns:

1. The facility staff failed to ensure cups and vegetable bowls were clean and not wet nesting.

On 10/01/19 at approximately 2:25 p.m., an observation of the facility's kitchen was conducted with OSM [other staff member] # 8, dietary manager. Observation of the drying rack located in the dishwashing room revealed seven "Kendal Cups" with handles stacked inside each other on the top shelf of the drying rack. Further observation of the cups revealed they were

F 812

B) The Director of Dietary, Registered Dietician and or designee will perform infection control rounds twice a week for a month in the kitchen. Then once a month there after. All findings will be immediately corrected.

4) Results of kitchen infection control rounds will be reported to the Quality Assurance and Performance Improvement Committee for review and recommendations monthly.

5) Compliance Date: 11/01/2019

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stacked wet resulting in wet nesting. When shown the cups to OSM # 8, he verbally confirmed that the cups were stacked wet and immediately removed them from the drying rack. Observation of the second shelf of the drying revealed 64 vegetable bowls stacked inside each other. When asked if the vegetable bowls were cleaned and ready for use, OSM # 8 stated yes. Further observation of the vegetable bowls revealed eleven were wet nesting and sixteen were found with food debris on the inside of the bowls. When shown the bowls OSM # 8 he agreed the eleven bowls were stored wet nested and sixteen of the bowls were not clean.

2. The facility staff failed to ensure a mixer and food processor that were ready for use, were clean and free from food debris.

Observation of the food processor located in the facility's kitchen was conducted with OSM # 8. When asked if the food processor was cleaned and ready for use OSM # 8 stated, "Yes." Observation of the inside of the food processor bowl revealed water in the bottom of the bowl. After observing the food processor bowl OSM # 8 stated that it contained approximately one to two tablespoons of water. OSM # 8 immediately removed the food processor bowl and sent it to the dishwasher to be cleaned. Observation of the floor-standing mixer revealed it was covered with a plastic bag. When asked if the mixer was cleaned and ready for use, OSM # 8 stated yes. After OSM # 8 removed, the plastic bag from the mixer an observation of the mixer revealed food debris splattered on the neck of mixer, on the spindle, and on support bracket for the mixing bowl. When asked if the mixer was clean OSM # 8 stated no.

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3. The facility staff failed to maintain a 30 inch fan blowing on clean dishes and cups, located in the clean dish area of the kitchen was clean and free of grease and dust.

Observation of the dishwashing room in the facility's s kitchen area revealed a 30-inch fan mounted on the wall across from the dishwasher. Observation of the fan revealed it was oscillating right to left and back again and blowing toward a stack of clean dinner plates and a drying rack containing clean bowls, cups and glasses. OSM # 8 was asked to turn the fan off. Observation of the fan's front and rear fan cages and the fan blades revealed dust. When fan cages and the fan blades were touched it left a greasy film on this surveyors fingers. OSM # 8 was then asked to visually inspect and touch the fan cages and the fan blades. OSM # 8 agreed that there was dust on the fan parts and that the fan cages and fan blades felt greasy.

4. The facility staff failed to ensure a flour scoop was not stored inside the sugar bin.

Observation of the sugar storage bin located under a food preparation table in the facility's kitchen revealed a scoop lying in the sugar. When it was shown to OSM # 8, he stated that the scoop should not be lying in the sugar and he immediately removed the scoop from the bin.

On 10/02/19 at 4:22 p.m., an interview was conducted with OSM # 8. When asked about the cups and bowls wet nesting and the observation of the bowls with food debris, OSM # 8 stated, "They should be air dried before they are stored and they should be visually checked when they

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F 812	Continued From page 128 come through the dish machine and spot checked to make sure they are clean." When asked about the scoop lying in the sugar inside the sugar bin OSM # 8 stated, "The scoop should be stored in the holster above the pre [preparation table] not in the bin." When asked about the food processor OSM # 8 stated, "The parts should be left on the rack to air dry before they are assembled." When asked about the floor mixer OSM # 8 stated, "It should be wiped down properly and they [staff] should be visually inspecting before it is covered." When asked about the process for cleaning the fan OSM # 8 stated, "It is cleaned by maintenance monthly. We [kitchen staff] cleans it twice a week on Tuesdays & Fridays." When asked why it would be important to keep the fan clean OSM # 8 stated, "So we don't blow debris and dust on the clean dishes." The facility's policy "Cleaning Dishes. Manual Dishwashing" documented, "Policy: Dishes and cookware will be washed after each meal to assure all dishes are clean and sanitary. 7. Allow dishes to dry on racks. Do not dry with towels." The facility's policy "Cleaning Instructions: Food Preparation Appliances" documented, "Small appliances (such as mixers and food processors) will be cleaned and sanitized after each use." Under "Procedure", it documented in part, "3. Scrape solid food from the parts into the garbage container, 4. Rinse the parts with warm water and place in the dishwasher or sink. Clean, sanitize and rinse following the guidelines for automatic or hand washing, 5. Air dry, 6. Clean the outer surface of the appliance with a clean cloth that has been moistened with hot soapy	F 812		

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F 812	Continued From page 129 water. Follow with a hot water rinse. Do no immerse bases of electrical appliance in water, 7. Allow air dry, 8. Reassemble the equipment." On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings. No further information was provided prior to exit.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880	F880 INFECTION CONTROL & PREVENTION 1) A) Signage indicating Contact Precautions was placed on the door of resident #518's room on 10/4/19. B) The laundry room and dryer vent were immediately cleaned of lint 10/02/2019. Clean laundry and linen was covered on 10/2/2019 2) A) There are no other residents on isolation precautions currently in facility. B) All residents have the potential to be adversely affected by this practice in the laundry room. 3) A) The Infection Preventionist will ensure that ordered isolation precautions are set up properly with available personal protective equipment and appropriate signage placed on resident's door. B) Laundry Room staff will be educated on laundry room and dryer cleaning procedures and on procedures for handling and covering clean linen for infection control. C) The Infection Preventionist will conduct weekly rounds of the laundry room and isolation rooms to ensure infection control procedures are in place. D) Maintenance Director or designee will perform cleaning behind the dryers at least monthly or more frequently as indicated. 4) Results of infection control rounds will be reported monthly to the facility Safety Committee. 5) Compliance Date: 11/01/2019	

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F 880	Continued From page 130 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow infection control procedures for one of 63 residents in the survey sample, Resident #518; and the facility staff failed to store laundry in a sanitary manner. The facility staff failed to display prominently notice that Resident #518 was on isolation precautions on 10/1/19 and 10/2/19, and staff failed to keep air vent free of dust when storing clean linens and maintain the floor behind the clothes dryers free of lint.

The findings include:

1. Resident #518 was admitted to the facility on 6/11/18 and most recently readmitted on 9/25/19 with diagnoses including, but not limited to: history of cardiac arrest (heart stopping), anoxic brain injury (brain not getting enough oxygen), COPD (chronic obstructive pulmonary disease) (1), and contractures (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 9/11/19, Resident #518 was coded as being severely cognitively impaired for making daily decisions. She was coded as being completely dependent on staff members for all activities of daily living. She was coded as having received antibiotics during the look back period.

On the following dates and times, Resident #518 was observed lying in her bed. At each observation, an isolation cart was positioned just outside Resident #518's door: 10/1/19 at 3:54 p.m., 10/2/19 at 8:57 a.m., and 10/2/19 at 12:05 p.m.

A review of Resident #518's clinical record

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F 880	Continued From page 132 revealed the following physician orders dated 9/25/19: "Contact Precautions (4) for MDRO (multi-drug resistant organism) (5)." A review of Resident #518's comprehensive care plan dated 6/11/18 and updated 2/8/19 revealed, in part, the following: "Resident will not exhibit signs of new infection." On 10/3/19 at 10:35 a.m., CNA (certified nursing assistant) #3 was interviewed. When asked how she is informed if a resident should be on isolation, CNA #3 stated, "Usually we know from working with them before. Or the nurse will tell us." On 10/3/19 at 10:44 a.m., LPN (licensed practical nurse) #8 was interviewed regarding the process to be followed when a resident is placed on isolation. She stated that there must be a physician's order, and that a cart with PPE (personal protection equipment) is placed outside the resident's door. When asked how a visitor knows that a resident is on isolation, LPN #8 stated, "There should be a sign posted on the door." When asked why it is important for a visitor to know that a resident has been placed on isolation, LPN #8 stated, "For their own safety. So they don't go in the room and catch something." LPN #8 accompanied the surveyor to Resident #518's door. When asked if she saw a sign indicating that Resident #518 was on isolation, LPN #8 stated, "No, I do not. There should be one." On 10/3/19 at 11:10 a.m., LPN #5, the unit manager, was interviewed regarding the process for documenting when a resident is placed on isolation, LPN #5 stated, "There should be a	F 880		

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doctor's order and we may write a nurses' note." When asked how a visitor knows that a resident is on isolation, LPN #5 stated, "A visitor sees the cart outside. The cart is the giveaway." When asked how a visitor with no medical knowledge would know what the isolation cart means, LPN #5 stated, "They should know what they are supposed to do by the cart being there."

On 10/3/19 at 2:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate quality nurse, were informed of these concerns.

A review of the facility policy, "Infection Control - Use of Isolation," revealed, in part, the following: "Transmission-Based precaution (isolation) rooms are prepared to identify residents who require transmission-based isolation and supply caregivers with the elements required to provide care. Rooms are prepared as follows: Precautions and PPE requirements are posted for caregivers, staff, visitors/families to utilize when entering room and providing care."

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) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken

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from the website https://medlineplus.gov/ency/article/003185.htm.

(3) "A tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube." This information is taken from the website https://medlineplus.gov/ency/article/002955.htm.

(4) "Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment...Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination." This information is taken from the website https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html.

(5) "For epidemiologic purposes, MDROs are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent (e.g., MRSA, VRE), these pathogens are frequently resistant to most available antimicrobial agents." This information is taken

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from the website
https://www.cdc.gov/infectioncontrol/guidelines/mdro/background.html.
2. The facility staff failed to keep air vent free of dust when storing clean linens and maintain the floor behind the clothes dryers free of lint.

On 01/03/19 at approximately 11:10 a.m., an observation of the facility's laundry room was conducted. Observation of the clean part of the facility's laundry room revealed a three tier shelving rack approximately twenty-five feet long and five-and-a-half feet tall on the left side of the hall and a three tier clean laundry cart on the right side of the hall as you enter the door of the "Clean Laundry" room. Further observation of the shelving revealed clean linens folded and stacked on the shelving uncovered. Further observation of the clean laundry cart revealed folded clean linen on all three tiers with the front of the cart uncovered. An observation of the ceiling approximately half way down the clean laundry hallway revealed a ceiling heating/cooling air vent. Further observation of the vent revealed cool air blowing out of the vent toward the clean laundry cart and the open shelving and the vent baffles coated with grey lint/dust. Observation of the area behind the three commercial size clothes dryers, approximately nine feet long and two-and-a-half-feet wide, revealed the black flooring covered with lint. The amount of lint covering the floor made the flooring appear grey in color.

On 10/03/19 at 11:15 a.m., an interview was conducted with OSM [other staff member] # 10, laundry aide. When asked who was responsible for cleaning the ceiling vents and behind the clothes dryers, OSM # 10 stated, "It's

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F 880	Continued From page 136 maintenance. We don't clean behind the dryers because the fire Marshall told us we shouldn't because of the wiring and stuff behind there and that maintenance should do it." On 01/03/19 at approximately 11:25 a.m., an observation of the area behind the clothes dryers and the ceiling vent and interview was conducted with OSM # 7, director of maintenance and OSM # 6, director of housekeeping and laundry. When asked about cleaning behind the clothes dryers, OSM # 7 stated his department should clean behind the dryers. OSM # 7 further stated, "It should be cleaned behind the dryers monthly and I've been here for a month-and-a-half and it hasn't been done." When asked if the build-up of lint could pose a potential hazard OSM # 7 stated yes. OSM # 7 was then asked to visually, inspect, and wipe the ceiling vent in the clean laundry hallway. OSM # 7 obtained a ladder and accessed the ceiling vent. OSM # 7 agreed the vent was coated with vent/dust. When it was pointed out to OSM # 6 that the vent was dirty and blowing on the clean linen OSM # 6 removed the linen from the cart to be rewashed and stated that the shelving should probably be covered to keep the linen clean. On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings. No further information was provided prior to exit.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883	See Next Page	

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§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative

F883 INFLUENZA IMMUNIZATIONS

1) The missing consent/ education for residents identified during survey were for 2018-19 influenza season. No corrective action can be taken
2) Potentially all residents who receive the influenza vaccine in facility could be affected by this practice
3) A) The influenza consent form has been revised to require yearly consent.
   B) Education and consent will be reviewed with residents who are their own responsible party and retained in the resident medical record.
   C) For residents requiring consent by a responsible representative, letters containing a consent form and written education will be mailed to the last known address with the request they be completed and returned to facility.
   D) A resident log will be maintained for the 2019-2020 influenza season.
4) 10% random monthly audit of resident records for compliance with consent and education will be conducted for as long as flu shots are administered. Results to be reported to the Quality Assurance and Performance Improvement Committee.
5) Compliance Date: 10/11/2019

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has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to obtain consent and/or provide education regarding the influenza vaccine for three of five residents in the survey sample, Residents # 150, # 45 and # 110. The facility staff failed to obtain consent and provide education regarding the 2018 influenza vaccine for Resident # 150. Staff failed to obtain consent regarding the 2018 influenza vaccine for Resident # 45 and staff failed to obtain consent and provide education regarding the 2018 influenza vaccine for Resident # 110.

The findings include:

1. The facility staff failed to obtain consent and provide education regarding the 2018 influenza vaccine for Resident # 150.

Resident # 150 was admitted to the facility on 08/21/18 with diagnoses that included but were not limited to difficulty swallowing, muscle weakness and low iron.

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F 883	Continued From page 139 Resident # 150's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 09/04/19, coded Resident # 150 as scoring a six on the brief interview for mental status (BIMS) of a score of 0 - 15, six - being severely impaired of cognition for making daily decisions. A review of the Resident # 150's clinical record and EHR [electronic health record] failed to evidence a consent and education for the 2018 influenza vaccine. On 10/02/19 at 4:45 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked to describe the process for obtaining consents and providing education for the influenza vaccine, ASM # 2 stated, "We set aside a time to send out the consents and education to the residents and/or the resident's responsible party. When we get them back we start administering the vaccines one unit at a time." When asked about the missing education and consents, ASM # 2 stated, "This was done before I was here, I don't know what happened." ASM # 2 confirmed that Resident # 150 did not have a consent and education for the 2018 influenza vaccine. The facility's policy "Infection Control - Influenza Immunization" documented in part, "3. Facility staff obtain consent for administration of the influenza vaccine from the resident or the resident's representative. The completed consent is evidence of education to the resident or resident representative regarding the current year's vaccine and potential side effects. 4. Signed consent will be files in the resident's clinical record. 5. Facility nursing staff provide	F 883		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 883	Continued From page 140 education to the resident and/or resident's representative regarding the benefits and potential side effects of the immunization prior to offering the immunization. 7. A copy of the educational materials, as provided to the resident and/or resident representatives will be maintained on file in the office of the Director of Nursing and/or in the office of the Infection Preventionist (infection control nurse." On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to obtain consent regarding the 2018 influenza vaccine for Resident # 45. Resident # 45 was admitted to the facility on 07/10/19 with diagnoses that included but were not limited to high blood pressure, high cholesterol and heart failure. Resident # 45's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/28/19, coded Resident # 45 as scoring a four on the brief interview for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions. A review of the Resident # 150's clinical record and EHR [electronic health record] failed to evidence a consent and education for the 2018 influenza vaccine. On 10/02/19 at 4:45 p.m., an interview was	F 883		

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conducted with ASM [administrative staff member] # 2, director of nursing. When asked to describe the process for obtaining consents and providing education for the influenza vaccine, ASM # 2 stated, "We set aside a time to send out the consents and education to the residents and/or the resident's responsible party. When we get them back we start administering the vaccines one unit at a time." When asked about Resident # 45's missing consent, ASM # 2 stated, "This was done before I was here, I don't know what happened." ASM # 2 confirmed that Resident # 45 did not have a consent for the 2018 influenza vaccine.

On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to obtain consent and provide education regarding the 2018 influenza vaccine for Resident # 110.

Resident # 110 was admitted to the facility on 01/30/14 with diagnoses that included but were not limited to muscle weakness, difficulty swallowing and shortness of breath.

Resident # 110's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/28/19, coded Resident # 110 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions.

A review of the Resident # 110's clinical record

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F 883	Continued From page 142 and EHR [electronic health record] failed to evidence a consent and education for the 2018 influenza vaccine. On 10/02/19 at 4:45 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. When asked to describe the process for obtaining consents and providing education for the influenza vaccine, ASM # 2 stated, "We set aside a time to send out the consents and education to the residents and/or the resident's responsible party. When we get them back we start administering the vaccines one unit at a time." When asked about the missing education and consents, ASM # 2 stated, "This was done before I was here, I don't know what happened." ASM # 2 confirmed that Resident # 110 did not have a consent and education for the 2018 influenza vaccine. On 10/04/19 at approximately 4:30 p.m., ASM [administrative staff member] #1, the administrator was made aware of the findings. No further information was provided prior to exit.	F 883		

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