STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495279	A. BUILDING _____ B. WING _____	C 11/05/2019

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CULPEPER HEALTH & REHABILITATION CENTER	602 MADISON ROAD CULPEPER, VA 22701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/03/2019 through 11/05/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/3/19 through 11/5/19. 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 180 certified bed facility was 160 at the time of the survey. The survey sample consisted of 45 current resident reviews and seven closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		11/27/19

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

Electronically Signed | 11/22/2019

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F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician of a need to alter treatment for one of 52 residents in the survey sample, Resident #38. The facility staff	F 580	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited	

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F 580	Continued From page 2 failed to notify Resident #38's physician when administered, as needed Tylenol did not relieve the resident's pain. The findings include: Resident #38 was admitted to the facility on 10/28/18. Resident #38's diagnoses included but were not limited to urinary tract infection, major depressive disorder and difficulty swallowing. Resident #38's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/26/19, coded the resident's cognition as severely impaired. Section J documented Resident #38 reported no pain. Review of Resident #38's clinical record revealed a nurse's note dated 7/7/19 at 7:27 p.m. that documented the resident was administered two tablets of as needed Tylenol 325 milligrams per physician's order for head and nose pain rated as a five (on a scale from zero to ten). A nurse's note dated 7/7/19 at 8:09 p.m. documented the Tylenol was ineffective and failed to document the physician was notified. A pain level assessment dated 7/7/19 at 8:09 p.m. documented Resident #38's pain as an eight. A nurse's note dated 7/8/19 at 3:04 a.m. documented Resident #38 was administered two tablets of as needed Tylenol 325 milligrams per physician's order for pain. A pain level assessment dated 7/8/19 at 3:04 a.m. documented Resident #38's pain as a ten. A nurse's note dated 7/8/19 at 3:45 a.m. documented the Tylenol was ineffective and the resident continued with intermittent moaning. The note failed to document the physician was notified. (Note- a pain assessment dated 7/8/19 at 10:26 a.m. documented the resident's pain	F 580	in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F580 1. Resident #38 has received adequate pain management/relief since 11/05/2019. The staff member who failed to notify physician for unrelieved pain no longer works for facility. 2. The DON/ADON completed a three-day audit (11/05/2019-11/07/2019) of documentation for administration and follow-up on unrelieved pain experienced by applicable patients. No resident was found to have reported ineffective pain management regimen without adequate follow-up. 3. Staff Development Coordinator/Nursing Leadership to provide an in-service to all CNAs and Charge nurses on the following topics: a) CNA to report complaints of pain to charge nurse for follow-up b) Management of unrelieved pain with an existing pharmacological pain management regime. 4. DON/ADON or designee to complete pain management audit weekly x1 month and monthly x3 months to ascertain that residents are receiving effective pain	

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F 580	Continued From page 3 level as a one). Resident #38's comprehensive care plan dated 10/29/18 documented, "PAIN: (Resident #38) is at risk for pain. Notify MD (medical doctor) for pain not relieved with medication..." On 11/4/19 at 5:07 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse who administered Tylenol to Resident #38 on 7/7/19 at 7:27 p.m.). LPN #1 was asked what should be done if a resident is given Tylenol for pain and the Tylenol is not effective. LPN #1 stated, "Contact the doctor and see if he wants to administer something stronger." LPN #1 was made aware of the above concern. LPN #1 stated, "It looks like the night nurse that took over my cart didn't do anything with her pain rating being an eight as a follow up." The nurse who documented the Tylenol was ineffective on 7/7/19 at 8:09 p.m., administered Tylenol on 7/8/19 at 3:04 a.m. and documented the Tylenol was ineffective on 7/8/19 at 3:45 a.m. was not available for interview. On 11/5/19 at 9:59 a.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern. On 11/5/19 at 2:19 p.m., ASM #1 (the administrator) and ASM #3 (the corporate nurse consultant) were made aware of the above concern. The facility pain management policy documented, "3. Administration of pain medication and effectiveness will be documented...5. If pain is not relieved, notify physician..."	F 580	management regimen with appropriate follow-up and notification of MD when not relieved. Any noncompliance to the above-stated standard will be rectified immediately and further forwarded to the QAPI committee for review and recommendation. 5. Date of compliance: 11/27/2019	

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F 580	Continued From page 4 No further information was presented prior to exit.	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure five of 52 residents in the survey sample, were free from abuse, Residents #193, #8, #100, #17, #544. On 4/27/19, Resident #17 hit Resident #193 and the resident sustained small laceration above right eye and small abrasion to right forehead. On 1/28/19, Resident # 20 struck Resident #8 in the face. On 8/12/19, Resident #20 struck Resident #100. On 10/12/19, Resident # 16 struck Resident #17 on the back. On 1/17/19, Resident #142 struck Resident #544 arm with his fist, with no injury noted.	F 600	1. Resident #193 deceased on October 07, 2019. Resident # 17 has note engaged in any new episode of altercation at the Center since 4/27/2019. Resident #8 discharged on 11/11/2019 and Resident #20 have not been in new episode of altercation since 1/28/2019. Resident #100 has not experienced any new physical struck from resident # 20 since last episode on 8/12/2019. Resident #17 has not been struck by Resident #16 since last episode on 10/12/2019. Resident #544 discharged on 1/25/2019. Resident #142 has not strike any other patient since last episode on 1/17/2019. Residents # 17, #20, and #142 are	11/27/19

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F 600	Continued From page 5 The findings include: 1. The facility failed to ensure Resident #193 was free from abuse. On 4/27/19, Resident #17 hit Resident #193 and the resident sustained small laceration above right eye and small abrasion to right forehead. The FRI (facility reported incident) dated, 4/27/19, documented Resident #193 and Resident #17 were in a "Resident to resident altercation. Immediately separated, assessed for injury, notification of MD/RP (medical doctor/responsible party), investigation initiated." The "Final Investigation of Resident-to-Resident Altercation" dated 5/1/19, documented in part, "On 04/27/19 at approximately 3:15 p.m., (Resident #193) entered the room of (Resident #17), who was seated at the side of bed in his wheelchair, stating that was his room and attempted to get into (Resident #17)'s bed. The entry and attempts of (Resident #193) to make himself comfortable in (Resident #17)'s room prompted agitation causing (Resident #17) to strike (Resident #193). Staff immediately separated residents and proceeded to complete a head-to-toe assessment to rule out injury. At time of initial assessment, no injuries were noted to (Resident #17), however, (Resident #193) had an abrasion to scalp and laceration to right eyebrow, first aid was provided and MD/RP (medical doctor/resident representative) of both parties notified accordingly. (Resident #193) and (Resident #17) are followed by psych (psychiatry) services. Neither (Resident #193) nor (Resident #17) have displayed any further behaviors since incident."	F 600	followed by a psychiatrist, behavior monitored by the staff and intervention provided as applicable, and have been engaged in daily activities as tolerable/as per preference. 2. All patients with behavior will be reviewed to determine any presentation of their tendency to engage in physical altercation and/or strike another patient. Any patient identified with such a tendency will be evaluated/assessed and necessary behavioral management intervention(s) initiated as applicable/tolerated by the affected patient. Facility will also continue to implement its developed 2019 Performance Improvement Plan (PIP) on behavior management accordingly. 3. Staff Development Coordinator (SDC)/DON/ADON/Designee will complete in-service/remediation session on the following: a) Preventing patient-to-patient altercation b) Deescalating patient behavior c) Protocol for managing patient-to-patient altercation d) 2019 Performance Improvement Plan on behavior management 4. DON/ADON/UMs will conduct a 10% weekly review of all patients with behavior x4 weeks and then monthly x3 months to determine the effectiveness of behavioral management being implemented. Any anomaly identified will be immediately rectified and forwarded to weekly risk meeting/QAPI committee for further review and recommendation 5. Date of compliance: 11/27/2019	

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Resident #193 was admitted to the facility on 6/15/18 with diagnoses that included but were not limited to: dementia, diabetes, depression and anxiety disorder. The most recent MDS (minimum data set) assessment, around the time of the incident, a quarterly assessment, with an assessment reference date of 3/21/19, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as capable of walking in his room and corridor; as able to get in and out of bed, and as able to move on the unit, with supervision set up assistance only. In Section E - Behaviors, the resident was not coded as having any behaviors including wandering.

The nurse's note dated, 4/27/19 at 3:56 p.m. documented in part, "Resident in physical/verbal altercation this afternoon. Assessed for injuries. Small laceration above right eye. Small abrasion to right forehead. C/O (complained of) pain to right out thigh, no discoloration or bruising noted at this time, small lump felt under skin. Laceration above eye cleansed with NS (normal saline). OTA (other the counter antibiotic). Vitals obtained, WNL (within normal limits), Escorted to nurse's station to sit with staff until calm."

This resident was no longer in the facility and unavailable for interview. The witness statement dated 4/27/19 stated Resident #193 could not recall the incident.

Review of the comprehensive care plan dated, 8/2/17 and revised on 8/31/19, documented a review of the care plan at the time of the incident.

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Resident #17 was admitted to the facility on 5/27/12 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), lung cancer, metastatic cancer (cancer that has spread to other organisms), depression, dementia, and anxiety disorder.

The most recent MDS around the time of the incident, a quarterly assessment, with an assessment reference date of 4/11/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section E - Behaviors, the resident was coded as resisting care during 1-3 days of the lookback period.

The nurse's note dated 4/27/19 at 4:33 p.m. documented in part, "Resident with physical aggression this afternoon. Spoke to and redirected by staff. Hx (history) of dementia and aggressive behaviors. Skin assessed after episode occurred, no skin issues or injuries noted. Currently lying in bed with call light within reach. Resident is his own RP (responsible party) and is aware."

An interview was conducted with Resident #17 on 11/4/19 at 2:00 p.m. When asked if he could recall the incident of Resident #193 crawling in his bed, Resident #17 stated he had no recollection of that.

Review of the comprehensive care plan dated 3/3/16, revealed the care plan, had been reviewed and revised by staff on 4/27/19.

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An interview was conducted with RN (registered nurse) # 4 on 11/5/19 at 7:46 a.m. When asked, what abuse is, RN #4 stated, "It can be physically hitting someone, sexual, verbal or neglect" When if a resident hitting another resident is abuse, RN #4 stated, "Yes." When asked what staff do when if they see resident-to-resident abuse, RN #4 stated, "Immediately separate residents, try to calm them down and console them, inform manager; the manager fills out paperwork for reporting, we write our statements and write notes in the chart". RN #4 stated, "Managers update care plans and make sure reporting is filed". RN #4 stated, "Sometimes they (the residents) may be moved to other beds or units; that is up to the managers."

An interview was conducted with CNA (certified nursing assistant) # 8 on 11/5/19 at 10:30 a.m. When asked, what abuse is, CNA #8 stated, "Physical, verbal, involuntary seclusion, sexual, emotional that causes direct or indirect harm." When asked if it is abuse when a resident hits another resident, CNA #8 is stated, "Yes it is." CNA #8 stated, "I would separate them (residents) immediately, document event and notify nurse, charge nurse, manager. I would make sure the resident wasn't hurt."

The facility policy, "Abuse/Neglect/Misappropriation/Crime: Policy Name: Patient Protection." documented in part, "Policy: There is a zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center. Procedure: 1. Patients of the Center have the legal right to be free from verbal, sexual, mental and physical

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abu7se, corpora; punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology."

Administrative staff member (ASM) #1, the administrator, ASM #3, the corporate nurse consultant, and ASM #4, the assistant administrator, were made aware of the above concern on 11/5/19 at 5:00 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

2. The facility staff failed to ensure Resident #8 was free from abuse. On 1/28/19, Resident # 20 struck Resident #8 in the face.

The FRI dated, 1/28/19, documented Resident #8 and Resident #20 were in a "Resident -to Resident altercation, Residents separated and assessed for injury. MD (medical doctor) and RPs (responsible party) aware of incident. Investigation initiated."

The "Final Investigation of resident-to-resident altercation" dated 2/1/19, documented in part, "On 1/28/19 at approximately 8:30 a.m., (Resident #8) reported to staff that she had a physical altercation with (Resident #20). (Resident #8) stated that she and (Resident #20) were in the dining room and without provocation; (Resident #20) struck her in the face. A head-to-toe assessment was completed on (Resident #8) and (Resident #20) to rule out any

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injury. (Resident #8) sustained an abrasion to her lip and (Resident #20) had an abrasion to the third knuckle on his left hand. Investigation of the incident was initiated, which included interviewing the involved residents, the charge nurse assigned to the residents and other nursing assistants who worked on the Unit on the date of the incident. Upon initial interview, (Resident #20) was unable to recall the incident. (Resident #8) reported that the altercation emanated from a verbal disagreement that escalated into a physical altercation. (Resident #8) is her own responsible party and requested that the facility call the police. The police department investigation is in progress with their finding still pending. (Resident #20)'s responsible party was made aware of the incident and updated on the investigation accordingly. The NP (nurse practitioner) was also made aware at the time of the incident and both resident were seen by psych (psychiatric) services. No psychosocial stress was noted at this time."

Resident #8 was admitted to the facility on 8/3/16 with diagnoses that included but were not limited to: diabetes, depression, obesity, anxiety disorder, high blood pressure, and COPD. The MDS (minimum data set) assessment, closest to the incident was an quarterly assessment, with an assessment reference date of 12/18/19, and coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score indicating the resident was capable of making daily cognitive decisions. In Section E - Behaviors, the resident was not coded as having any behaviors. Resident #8 was coded as requiring supervision to extensive assistance for her activities of daily living. Her locomotion on and off the unit she required supervision.

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The nurse's note dated, 1/28/19 at 9:53 a.m. documented, "Pt (patient) noted crying in room, this nurse went into room and per pt (patient [Resident #8]) another pt [Resident #20] struck her in the face while in the dining room. Small abrasion noted to inside of bottom lip. Ice applied for swelling. Denies any c/o (complaint of) pain at this time. NP aware and pt (Resident #8) is her own RP and is aware."

Review of the comprehensive care plan dated, 11/3/17, documented it was reviewed on 1/28/19.

An interview was conducted with Resident #8 on 11/4/19 at 2:22 p.m. When asked what happened when (Resident #20) struck her in the face, Resident #8 stated, "He was always a nice guy. I don't know what happened that day. I was sitting in the dining room and he walked towards me and threw his fist in my face. I was shocked. I've never been hit by a man before; he asked me if I wanted him to do it again." When asked if she had any injuries, Resident #8 stated her teeth hurt for a couple of days and she had a cut inside her lip. When asked if she had any effects from that day, Resident #8 stated she cried about it but was okay after that. She stated the nurses had given her Tylenol and that helped. When asked if she if afraid or scared at this time, Resident #8 stated that she was fine now.

Resident #20 was admitted to the facility on 5/28/19 with diagnoses that included but were not limited to: depression, bipolar disorder (a mental disorder characterized by episodes of mania and depression) (1), dementia with behaviors, pseudobulbar affect (is characterized by frequent, uncontrollable outbursts of crying or laughing.)

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(2), diabetes, and stroke. The most recent MDS around the time of the incident, a quarterly assessment, with an assessment reference date of 12/6/18, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating he was moderately impaired to make daily cognitive decisions. The resident was coded as requiring supervision with set up assistance for walking, moving on and off the unit and required supervision with one staff member assist for the rest of his activities of daily living. In Section E - Behaviors, the resident was coded as not having any behaviors during the look back period.

The nurse's note dated, 1/28/19 at 11:51 a.m. documented, "Another resident [Resident #8] Reported (Sic.) to this nurse that this resident [Resident #20] struck her in the face while in the dining room. Per resident [Resident #20], 'I did not hit her in the face.' Upon assessment resident, noted small skin tear to 3rd (Sic.) left knuckle. Resident states, 'I hit it on dresser in room.' Area cleansed and treatment order obtained, see TAR (treatment administration record). RP (responsible party) aware and NP (nurse practitioner) aware."

Review of the comprehensive care plan dated, 8/2/17, revealed it was reviewed and revised by staff on 1/28/19.

An attempt to interview Resident #20 on 11/4/19 at approximately 2:30 p.m. was unsuccessful. He did not recall the incident.

Administrative staff member (ASM) #1, the administrator, ASM #3, the corporate nurse consultant, and ASM #4, the assistant

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administrator, were made aware of the above concern on 11/5/19 at 5:00 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72. .
(2) This information was obtained from the following website: https://www.parkinson.org/Understanding-Parkinsons/What-is-Parkinsons/Conditions-Related-to-Parkinsons

3. The facility staff failed to ensure Resident #100 was free from abuse. On 8/12/19, Resident #20 struck Resident #100.

The FRI dated, 8/12/19, documented "Residents [Resident #100 and Resident #20] involved in verbal altercation, leading to physical altercation in courtyard. Residents separated no injury. MD/RP notification, investigation initiated."

The "Final Investigation of resident-to- resident altercation." dated 8/13/19, documented in part, "On 8/12/19 at approximately 12:30 p.m. staff reported that (Resident #20) and (Resident #100) were involved in a verbal altercation while in the courtyard. Investigation of the incident was initiated, which revealed that a physical altercation ensued from the verbal altercation. Upon interviewing (Resident #100), reported that (Resident #20) entered the courtyard and went towards the areas he was seated using his telephone and began yelling obscenities and racial slurs at him. (Resident #100) further reported that (Resident #20) grabbed his arm as

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he passed by his wheelchair. Consequently, (Resident #100) threw an item he took from the table at (Resident #20). When (Resident #20) was interviewed, he denied having provoked (Resident #100) and denied having any involvement of physical altercation with (Resident #100). The staff immediately separated the two residents and completed a head to toe assessment on both of them - none was noted with injury. The MD and RP of both parties were notified accordingly. Both resident are followed by psych [psychiatric] services."

Resident #100 was admitted to the facility on 11/20/18. Diagnoses include but are not limited to: stroke, diabetes, high blood pressure and GERD (backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn) (1). The most recent MDS assessment, around the time of the incident was a quarterly assessment, with an assessment reference date of 8/28/19, coded the resident as scoring "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section E - Behaviors, the resident was coded as rejecting care on one to three days of the look back period. The resident was coded as requiring extensive assistance for most of his activities of daily living except locomotion on the unit in which he required supervision.

The nurse's note dated, 8/12/19 at 3:26 p.m. documented, "Pt was involved in verbal altercation with another resident. Patients were separated. No injuries noted. No c/o (complaints

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of) pain. MD and RP (Resident #100) aware."

Review of the comprehensive care plan dated11/21/18 revealed staff reviewed it on 8/12/19.

An interview was conducted with Resident #100 on 11/5/19 at 3:38 p.m. When asked to describe the incident in the courtyard on 8/12/19, Resident #100 stated, "I was scared at that moment but it hasn't bothered me since." When asked who started it, Resident #100 stated he couldn't recall that. When asked if he had any injuries from it, he stated he did not. When asked if he was afraid or scared now, Resident #100 stated he was not scare or fearful now.

Resident #20 was admitted to the facility on 5/28/19 with diagnoses that included but were not limited to: depression, bipolar disorder (a mental disorder characterized by episodes of mania and depression) (1), dementia with behaviors, pseudobulbar affect (is characterized by frequent, uncontrollable outbursts of crying or laughing.) (2), diabetes, and stroke. The most recent MDS around the time of the incident, a quarterly assessment, with an assessment re3fernce date of 12/6/18, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating he was moderately impaired to make daily cognitive decisions. The resident was coded as requiring supervision with set up assistance for walking, moving on and off the unit and required supervision with one staff member assist for the rest of his activities of daily living. In Section E - Behaviors, the resident was coded as not having any behaviors during the look back period.

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The nurse's note dated, 8/12/19 at 2:31 p.m. documented, "Staff reported resident initiating verbal altercation with another resident outside in courtyard. Resident began cursing at the other resident. Staff intervened and transported resident to unit and into room. Advised resident to stay separate from other resident. Resident denies incident. NP made aware, assessed resident. No new orders. RP made aware."

The review of the comprehensive care plan dated 8/2/17; revealed staff reviewed it on 8/12/19.

An attempt to interview Resident #20 on 11/4/19 at approximately 2:30 p.m. was unsuccessful. He did not recall the incident.

An interview was conducted with other staff member (OSM) #9, the physical therapist that witnessed the altercation, on 11/5/19 at 9:14 a.m. When asked what happened, OSM #9 stated she heard a noise outside the window; she turned to look and saw (Resident #100) moving backwards throwing his fist. (Resident #20) was also in his wheelchair advancing forward throwing his fist. When asked if she actually saw (Resident #20) strike (Resident #100), OSM #9 stated that she actually saw (Resident #20) strike (Resident #100). OSM #9 stated she yelled to another therapy employee (OSM #10) and stated, "Oh my- gosh, they are fighting in the courtyard." (OSM #10) and OSM #9 ran outside. I ran to (Resident #100) and (OSM #10) ran to (Resident #20). OSM #9 stated she had backed up (Resident #100) as far as we could. (OSM #10) went to (Resident #20). We kept them separated and brought them into the building. When asked what the noise she heard was, OSM #9 stated the noise that alerted her was unusual, like

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something hitting the ground. She stated that when she got outside there was pieces of a broken flowerpot on the ground and in (Resident #20)'s wheelchair and there was dirt on (Resident #20)'s lap. OSM #9 stated, as she got closer to the residents she could see the flowerpot that must have come from the resident's tabletop garden. It had succulents in it. OSM #9 stated that we brought both of the men inside and the unit managers were there to take them. When asked if (Resident #100) said anything to her, OSM #9 stated she had asked him if he was, hurting anywhere, he told me no but (Resident #20) called him a nigger and he had to defend himself.

An interview was conducted with OSM #10 on 11/5/19 at 9:40 a.m. When asked her knowledge of the above incident, OSM #10 stated she heard (OSM #9) yell, "They are fighting in the courtyard." We both ran out. They were both in each other's faces. There was a broken flowerpot between the two of them. (Resident #20) was covered in dirt. OSM #9 took (Resident #100) and I took (Resident #20) inside. OSM #10 stated, "(Resident #100) told me that (Resident #20) was in his face and calling me a nigger. I had to defend myself." When we got inside, we gave the men over to the unit managers.

Administrative staff member (ASM) #1, the administrator, ASM #3, the corporate nurse consultant, and ASM #4, the assistant administrator, were made aware of the above concern on 11/5/19 at 5:00 p.m.

No further information was provided prior to exit.

References:

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.

4. The facility staff failed to ensure Resident #17 was free from abuse. On 10/12/19, Resident # 16 struck Resident #17 on the back.

The FRI dated 10/12/19, documented Resident #17 and Resident #16 were in a "Resident -to Resident altercation, Residents separated and assessed for injury. MD (medical doctor) and RPs (responsible party) aware of incident. Investigation initiated."

The "Final investigation of resident-to resident altercation" documented in part, "On 1012/19, at approximately 06:50 a.m. staff overheard yelling coming from resident room, upon responding to the distress call in the residents 'room, (Resident #16) was observed yelling and striking (Resident #17) on his back. Per (Resident #17), he was getting dressed to exit the room when (Resident #16) became upset. (Resident #16) reported that he was frustrated because of the noise from (Resident #17) and staff coming in throughout the night to assist (Resident #17); which he purported inhibited him from sleeping longer into the morning. This he continued to state caused him to yell and strike the roommate. Staff immediately separated and proceeded to complete a head-to-toe assessment to rule out injury - none noted. The two residents are no longer roommates, and have been relocated to new rooms with respective compatible new roommates. (Resident #16) and (Resident #17) are followed by psych services. Neither (Resident #16) nor (Resident #17) have displayed any further behaviors since incident."

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Resident #17 was admitted to the facility on 5/27/12 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), lung cancer, metastatic cancer (cancer that has spread to other organisms), depression, dementia, and anxiety disorder. The most recent MDS around the time of the incident, a quarterly assessment, with an assessment reference date of 4/11/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section E - Behaviors, the resident was coded as resisting care during 1-3 days of the look back period.

The nurse's note in Resident #17's clinical record dated, 10/12/19 at 8:33 a.m. documented, "Resident (Resident #17) involved in an altercation with another resident. Full skin assessment completed."

An interview was conducted with Resident #17 on 11/4/19 at 2:00 p.m. When asked if he could recall the incident of Resident #16 yelling and hitting him, Resident #17 stated he remembered that morning. He stated (Resident #16) thought he was God and could tell me to keep the door shut. It's my door too and I wanted it opened. He just went crazy and started hitting me on my back. The nurse got me out of here but while getting me out the man shoved the door on us, hitting us with the door. When asked if he was fearful or afraid of anyone, Resident #17 stated he was not.

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Review of the comprehensive care plan dated, 3/3/16, was reviewed on revised on 10/12/19.

Resident #16 was admitted to the facility on 11/18/18 with diagnoses that included but were not limited to: Alzheimer's disease (a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability.) (1), repeated falls, low back pain, and GERD (backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn) (2)

The most recent MDS, around the time of the incident, a quarterly assessment, with an assessment reference date of 8/13/19, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as not having any behaviors during the look back period. In Section G - Functional Status, the resident was coded as requiring only supervision with set up assistance for all of his activities of daily living.

The nurse's note dated, 10/12/19 at 8:16 a.m. documented, "Resident (Resident #16) involved in an altercation with another resident. Resident assessed for injuries, none found." The next nurse's note documented, "Resident was moved from room (XX) to room (XX) for clinical needs. His RP (responsible party) was made aware. MD (medical doctor) made aware."

Review of the comprehensive care plan dated 11/19/19 was documented as reviewed on

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10/21/19.

An interview was conducted with Resident #16 on 11/5/19 at 11:15 a.m. When asked about the incident with Resident #17, Resident #16 stated, "I was wrong. I had just woken up from a sound sleep and wanted the door closed. When asked if he hit Resident #17, Resident #16 stated, "I didn't strike him, I just slapped him. I knew better not to hit people, it was just a slight push, and he didn't fall."

An interview was conducted on 11/5/19 at 2:00 p.m. with administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the corporate nurse consultant. When asked what they have in place for the residents that keep striking other residents, ASM #3 stated the facility identified in January 2019 that they had a problem with an increase in resident-to-resident incidents. They put in place an action plan. They just renewed the action plan in September 2019 and it is ongoing. They have behavior monitoring in place on the MAR (medication administration record) and each of the residents mentioned have psychiatric services in place.

An interview was conducted with LPN (licensed practical nurse) #11 on 11/5/19 at 3:42 p.m. When asked her recollection of the incident between Resident #17 and Resident #16, LPN #11 stated she had just come on the unit when they called me to the room. LPN # 11 stated when she walked in (Resident #16) was hitting (Resident #17) on the back. She immediately removed (Resident #17) out of the room. She stated she went back to talk to (Resident #16) and he hit her on the shoulder; LPN #11 stated he

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(Resident #16) had been aiming for her chest. She notified administration and she then moved (Resident #16) to another room. LPN #11 stated they (the staff) wanted the door to the residents room open as (Resident #17) had news that his cancer had spread and they wanted to keep an eye on him. When asked where (Resident #16) struck (Resident #17), LPN #1 stated he struck him several time to get him out of the way and only hit her (LPN #11) once.

Administrative staff member (ASM) #1, the administrator, ASM #3, the corporate nurse consultant, and ASM #4, the assistant administrator, were made aware of the above concern on 11/5/19 at 5:00 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.
5. The facility staff failed to ensure Resident #544 was free from abuse. On 1/17/19, Resident #142 struck Resident #544 arm with his fist, with no injury noted.

The "Facility Reported Incident" dated, 1/17/19, documented in part, "Incident date: 1/17/19. Resident's involved (Resident #544) and (Resident #142). Injuries: (A check mark was documented next to)"No." Describe Incident: Resident to resident altercation between (Resident #544) and (Resident #142). Resident #544 wandered into Resident #142's room and received physical aggression from Resident

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#142.

The "Final Report" dated, 1/22/19, documented in part, Subject 'Final investigation of resident-to-resident altercation.' "Upon initial interview, Resident #544 was unable to recall the incident, but Resident #142 reported that the altercation emanated from Resident #544's confusion and wandering into his room. The RP (responsible party) and NP (nurse practitioner) were made aware at the time of the incident and both residents are followed by psychiatric services. No psychosocial stress was noted at this time. In light of the above investigative outcome of the incident based on the review of available information and the interview of staff present with the involved residents, the facility was able to substantiate that Resident #142's actions were intentional in the spirit of spontaneous defense to an assumed intruder. In effect, the facility assessed the altercation to have been a natural response by Resident #142 to the invasion of his personal space by Resident #544. Resident #544 was assessed to have been principally driven by his current disease process and not an intentional act. Facility will continue to engage and support the stay of Resident #142 and Resident #544 in an environment that guarantees their safety and wellbeing."

Resident #544 was admitted to the facility on 8/23/18 with diagnoses that included but were not limited to: dementia (progressive state of mental decline) (1), atrial fibrillation (rapid and random contraction of atria of heart) (2), and intracerebral hemorrhage (bleeding within the brain) (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/30/18,

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coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating the resident had moderately impaired cognition. The resident was coded as requiring supervision from the staff for bed mobility, transfer, walking in room and corridor, dressing, toilet use and personal hygiene.

The nurse's progress note in Resident #544's clinical record dated, 1/17/19 at 7:18 PM, documented in part, "Resident with dementia and confusion noted to be anxious. Actively exit seeking and wandering in facility. Resident redirected multiple times wandered into another patient's room and received physical aggression from the resident in that room. The resident [Resident #544], was struck on the arm by another resident [Resident #142], both were immediately separated and educated. Skin checks completed and no injury, bruising noted. Vital signs stable. RP (Resident #544's wife) and physician were made aware."

The care plan dated 8/23/18, documented in part, Problem: "Behaviors: Resident #544 has the potential to display the following behaviors: agitation, aggression, threatening, elopement, and crawling on floor." The Goal: dated 8/23/18, documented, "Resident will be free of behaviors through next review date." The Approaches: dated 8/23/18, documented, "1:1 redirection as applicable. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him as passing by. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable."

An interview was conducted on 11/05/19 at 07:46 AM with RN (registered nurse) #4 regarding

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abuse. RN #4 stated, "It can be physically hitting someone, sexual, verbal or neglect." When asked if it is abuse if a resident hits another resident, RN #4 stated, "It certainly is." RN #4 stated, "I immediately separate the residents, try to calm them down and console them, inform manager. The manager fills out paperwork for reporting; we write our statements and write notes in the chart. The manager updates the care plan and makes sure report is filed." What asked if the residents are moved, RN #4 stated, "Sometimes they may be moved to other beds or units-that is up to the manager."

An interview was conducted on 11/05/19 at 10:30 AM with CNA (certified nursing assistant) #8. When asked to describe abuse, CNA #8 stated "Physical, verbal, involuntary seclusion, sexual, or emotional interactions that causes direct or indirect harm." When asked if a resident striking another resident is abuse, CNA #8 stated, "Yes it is." CNA #8 stated, "I would separate them immediately, document event and notify nurse, charge nurse, manager. I would make sure the resident wasn't hurt."

An interview was conducted on 11/4/19 at 2:13 PM with Resident #142. When asked if he remembered any physical altercation or striking another resident, Resident #142 stated, "No I don't."

Administrative staff members (ASM) #1, the administrator, (ASM) #2, the director of nursing, and ASM #3 were made aware of the above concerns on 11/5/19 at 5:11 PM.
No further information was provided prior to exit.

References:

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F 600	Continued From page 26 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 54. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 304.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to develop and implement the facility abuse policy for screening requirements. The facility staff failed to obtain criminal background checks for volunteers working with residents in the facility. The findings include: The facility policy regarding abuse prevention and screening documented, "The Administrator	F 607	1. Medical Facilities of America, the corporate body of Culpeper Health & Rehab Center, will update its policies and procedures on volunteer services to include the provision for a criminal background check for all volunteers working at its Centers. 2. Criminal background check will be completed on all current volunteers to ascertain that they do not have any criminal history that could have the potential to compromise the safety of the	11/27/19

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F 607	Continued From page 27 promotes the prevention of abuse and neglect and misappropriation of property by performing background checks on all employees and by advocating and enforcing patient rights and providing patients, families, and staff information on how and to whom they may report concerns, incidents, and grievances without fear of retribution." The facility policies regarding volunteer services failed to document information regarding criminal background checks. On 11/4/19 at 10:10 a.m., the names of five volunteers were selected from a facility list of volunteers and OSM (other staff member) #1 (the human resources manager) was asked to provide criminal background checks for the selected volunteers. OSM #1 stated the activities director coordinates the volunteers. On 11/4/19 at 11:24 a.m., an interview was conducted with OSM #2 (the activities director). OSM #2 provided volunteer orientation guides and acknowledgements for the five requested volunteers and stated the facility policy does not contain information regarding the completion of background checks on volunteers. OSM #2 confirmed she did not have background checks for the five selected volunteers but stated the orientation guide orients volunteers to workplace violence, conduct and behavior. OSM #2 provided the following information regarding the five selected volunteers: -Volunteer #1 is in the facility on a weekly basis and completes tasks such as passing mail, assisting residents to activities, manicures and room visits. -Volunteer #2 is in the facility on a weekly basis and completes room visits and church service every Sunday morning.	F 607	patients 3. Administrator in consultation with the Human Resource Manager to complete an in-service with the Activities Department on criminal background check protocol for all potential volunteers wanting to provide services at the Center. 4. Administrator/Human Resource Manager/Designee to review the records of all new volunteers weekly x4weeks and monthly x3 months to ensure compliance with the Center requirement for a criminal background check. Any missing one will be rectified and then forwarded to the QAPI Committee for further review and guidance. 5. Date of compliance: 11/27/2019	

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F 607	Continued From page 28 -Volunteer #3 is in the facility on a weekly basis and completes room visits and bible study on Monday afternoons. -Volunteer #4 is in the facility on a monthly basis and completes room visits and assists with communion. -Volunteer #5 is in the facility on a monthly basis and completes room visits and pet therapy. On 11/4/19 at 6:31 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the corporate nurse consultant) and ASM #4 (the assistant administrator) were made aware of the above concern. No further information was presented prior to exit.	F 607		
F 608 SS=C	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.	F 608		11/27/19

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F 608	Continued From page 29 (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post notice of employee rights for the reporting of suspicious crimes. The findings include: On 11/4/19 at 4:00 p.m., observation of the lobby, a time clock area and the employee break room was conducted. No posted notice of employee rights regarding the reporting of suspicious crimes was observed. On 11/4/19 at 4:05 p.m., observation of the lobby, employee break room, time clock areas and other facility common areas was conducted with ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate nurse consultant). No posted notice of employee rights regarding the reporting of suspicious crimes was observed. ASM #1 stated the posting should be posted in a visible, high traffic area at eye level. On 11/4/19 at 5:00 p.m., ASM #1 stated that according to the company, the elder justice act information (that contains information regarding employee rights for reporting suspicious crimes) and posting is included in the resident rights and abuse	F 608	1. Facility will post at common areas of the Center notice of employee rights for the reporting of suspicious crime. 2. The Administrator/Designee will review all posted notices at the Center to ascertain that they have met State requirements accordingly. 3. Vice President of Operation/Designee to provide re-education to the Administrator and Assistant Administrator on State requirement for the posting of notice of employee rights for the reporting of suspicious crime. The Administrator/Assistant Administrator will in turn conduct an information sharing session with current staff on designated areas of posted notice of employee rights for the reporting of suspicious crime. 4. Administrator to audit posted notices at the Center weekly x1 month and monthly x3 months to ascertain that posted notice of employee rights for the reporting of suspicious crime is accessible by the staff. Any noted anomaly will be rectified immediately and forward to the QAPI committee for further guidance as	

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F 608	Continued From page 30 trainings/postings. ASM #1 was asked to provide the postings that he was referencing. On 11/4/19 at 5:21 p.m., OSM (other staff member) #1 (the human resources manager) presented a poster that was posted in the lobby and other common areas. The poster-documented information regarding residents' rights, how to resolve a problem, and contact information for various state agencies. The poster failed to document notice of employee rights regarding the reporting of suspicious crimes. On 11/4/19 at 6:31 p.m., ASM #1, ASM #2 (the director of nursing), ASM #3 and ASM #4 (the assistant administrator) were made aware of the above concern. The facility policy regarding abuse prevention and screening documented, "2. All employees are trained in orientation and are routinely in-serviced regarding mandated reporting requirements as well as reporting requirements under the Elder Justice Act for reporting any reasonable suspicion of a crime that has occurred against any individual who is a patient or any individual who is receiving care from the Center. The Center notifies covered individuals annually of their duty to report suspected crimes. 3. An employee poster detailing the reporting requirements and established time limits as well as the rights of employees to be free from retaliation for filing a complaint or a report of a crime to a law enforcement agency of jurisdiction and the State Survey Agency." No further information was presented prior to exit.	F 608	applicable. 5. Date of compliance: 11/27/2019	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		11/27/19

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F 622	Continued From page 31 §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	F 622		

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or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for

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F 622	Continued From page 33 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, agency interview, clinical record review and facility document review and in the course of complaint investigation it was determined that the facility staff failed to evidence that requirements were met for a facility-initiated discharge for one of 52 residents in the survey sample, Resident #67. The facility staff discharged Resident #67 on 8/5/2019, while Medicaid was pending. The findings include: Resident #67 was admitted to the facility on 06/13/2019 with diagnoses that included but were not limited to dementia (1), rheumatoid arthritis (2), major depressive disorder (3), and macular degeneration (4). Resident #67's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/20/19, coded Resident #67 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired for making daily decisions. Review of the clinical record revealed "Discharge planning progress notes; Effective Date 8/20/2019 14:35 (2:35 p.m.)." The note documented the following "late entry: Discharge	F 622	1. Resident #67 was returned to the Center by Discharge Planning staff on the same date of attempted discharge on 8/5/2019. Post return assessment on 8/5/2019 revealed no presentation of change in patient condition from the baseline. Resident #67 continue to safely reside at the Center. 2. Discharge Planning Department to review all discharged patients in the last 30 days (starting 10/21/2019 to 11/21/2019) to be certain that requirement were met for Facility-initiated discharges, particularly for patients with pending Medicaid application. Any anomaly noted will be used as a learning experience for a similarly patient□s discharge situation in the future. 3. Administrator/Designee will provide in-service to the Discharge Planning staff on the requirements for completing a facility-initiated patient discharge. 4. Director of Discharge Planning to audit all facility-initiated discharges weekly x1 month, and monthly x3 months to ensure that all necessary requirements were fulfilled accordingly. Any anomaly will be forwarded to the weekly risk meeting/QAPI committee for further review and recommendation.	

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F 622	Continued From page 34 Meeting held with family on July 18, 2019. Present: [Name of granddaughter], granddaughter; [Name of grandson] and wife, grandson and granddaughter-in-law; [Name of discharge planner]; [Name of occupational therapist], therapy and [Name of physical therapist], therapy. Meeting was held to discuss therapy progress and upcoming discharge due to a plateau in therapy progress being made. Although there is no discharge date at this time, the facility wanted to make the family is aware that patient is not progressing as much as previously so they can prepare to bring her back to live with the grandson. During that point in the conversation the grandson and his wife stated that they have been taking care of the patient in their home for seven years and were no longer able to do so as the wife was starting a new job. DDP (Director of discharge planning) asked the family what the plan was and the family all responded that they will keep the patient here [at the facility]. I [DDP] explained that the patient does not have a payor (Sic.) source and will need to apply for Medicaid asap (as soon as possible). DDP also explained that the Medicaid decision can take up to 45 days and that they (the family) would have to make arrangements for the patient during the decision making process as we [facility] do not accept Medicaid pending as a payment. The family became visibly upset and the grandson's wife started yelling at DDP stating that the patient is taking too much of a toll on the grandson and they were just not going to pick her up. The DDP then asked the family, "Are you saying that you are refusing to pick [First Name of Resident #67] up?" The family responded yes. The DDP explained that they must come together to make a safe decision for the patient. The DDP did explain that the patient can stay here after	F 622	5. Date of compliance: 11/27/2019	

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therapy discharge as a private pay resident of $245/day. The family stated that she did not have the money to pay privately and that she had bills to pay. After the meeting, the DDP assisted the family with the Medicaid application and faxed it to [Name of County Department of Social Services]. The fax did not go through that day and was faxed again on July 19, 2019."

The "Notice of Transfer/Discharge" in the clinical record documented in part "Date of Notice 7/18/19; Patient Name: [Name of Resident]; The reason for this notice of your transfer/discharge is: you have failed to pay for a stay at the center." The field on the notice "Date of Transfer/Discharge:" was empty, as well as the field "Location of transfer/discharge: and Address:" The form documented "This information was completed by [Name of Director of Discharge Planning] and contained the signature of OSM (other staff member) #12, the director of discharge planning dated 7/18/19 and ASM (administrative staff member) #1, the administrator dated 7/18/19. The Notice of Transfer/Discharge failed to evidence notification of a planned date of discharge.

The nurses' "Progress Notes," dated "8/5/2019 09:05" (9:05 a.m.) for Resident #67 documented, "Pt (patient) discharged, skin clean, dry and intact. let [sic] facility via wheelchair. No complain of pain. She was provided with medications and discharged instructions."

On 11/4/19 at approximately 4:40 p.m., an interview was conducted with OSM (other staff member) #3, the ombudsman. When asked about Resident #67's discharge on 8/5/19, OSM #3 stated that the family contacted her after the

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discharge because Resident #67's Medicare skilled days had run out and the facility told the family that they did not accept Medicaid pending. OSM #3 stated that they also contacted her regarding Resident #67 being sent home on 8/5/19 without thirty-day notice after the family had expressed concerns for providing care for her at the home. OSM #3 stated that the family was applying for Medicaid for Resident #67 and needed to supply additional documentation. OSM #3 stated that Resident #67's grandson provided her with two invoices from the facility. OSM #3 stated that the invoices appeared to display the private pay rate for the month and the following month requested payment up front. OSM #3 stated that she explained to the facility staff that Resident #67 had applied for Medicaid and that there were no concerns that it would not be approved. OSM #3 stated that she explained to the facility staff that after the Medicaid was approved the facility would be paid for the care of Resident #67 retrospectively. OSM #3 stated that she voiced concerns on behalf of the family in addition to the family voicing their concerns that Resident #67 should not be discharged due to the family being unable to care for her. OSM #3 stated that her concerns were that Resident #67 and Resident #67's responsible party were not given proper notice of discharge, that Resident #67 was sent home with a Medicaid pending status and that Resident #67 was discharged home without the ability to get in her home.

On 11/5/19 at approximately 9:25 a.m., an interview was conducted with OSM #12, the director of discharge planning and OSM #11, the discharge-planning assistant regarding the discharge of Resident #67 on 8/5/19. OSM #12 stated that a discharge meeting was held with

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Resident #67's family members on 7/18/19 to discuss the end of therapy and plan to discharge her to her grandson's home soon. OSM #12 stated that the family voiced concerns about not being able to take Resident #67 at the home and wanting her to remain in the facility. OSM #12 stated that immediately after the discharge meeting she assisted the family to apply for Medicaid. OSM #12 stated that they do not take Medicaid pending residents at the facility, those residents have to set up a payment plan. OSM #12 stated a payment plan was offered to Resident #67's family and they refused. OSM #12 stated she has heard of other facilities that are Medicaid pending. OSM #12 stated that residents could be discharged if they are Medicaid pending and not paying but if they make an attempt to pay, they will not discharge them. OSM #12 stated this is because there is no guarantee that Medicaid will be approved. When asked if there were concerns or issues with Resident #67's Medicaid application submitted on 7/17/19, OSM #12 stated that the facility was worried about her income and that she owned property. OSM #12 stated that she had not received notice from social services that there were any issues with the Medicaid process or that additional verification was needed. OSM #12 stated she is new to the skilled nursing world and still learning.

On 11/5/19 at approximately 11:00 a.m., an interview was conducted with OSM #17, the business office manager regarding the discharge of Resident #67. OSM #17 stated that Resident #67's discharge date was 8/5/19, that the Medicare benefits ended on 8/4/19. OSM #17 stated that Resident #67 needed to have a payer source by the 31st day or she would have to have

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a $174/day coinsurance. OSM #17 stated that Resident #67 was her own responsible party at the time. OSM #17 stated that Resident #67's grandson came into her office on 7/11/19 and she discussed payment options and how to sign up for Medicaid. OSM #17 stated that Resident #67's grandson stated that his grandmother did not have any money to pay the facility when she asked him about setting up a payment plan. When asked how decisions are made for discharge, OSM #17 stated when there are financial issues they talk as a team and the administrator makes the final decision whether or not to give the discharge notice. OSM #17 stated that they have daily meetings. When asked if residents are allowed to remain in the facility when Medicaid is pending, OSM #17 stated, "We don't take Medicaid pending here, there is no guarantee that they are going to get it; it is not one-hundred percent." OSM #17 stated, "If it (Medicaid) falls through and they go home, they do not care. We have had that happen before."

On 11/5/19 at 4:25 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator regarding the discharge of Resident #67 on 8/5/19. When asked if Medicaid pending residents are allowed to stay in the facility, ASM #1 stated that Resident #67 had a large amount of money coming in and her family told them that the money was needed to pay the bills in the home. When asked if the beds at the facility are all dually certified (skilled nursing and nursing facility, can admit Medicare or Medicaid patients to either) ASM #1 stated that they were.

On 11/5/19 at approximately 2:00 p.m., ASM (administrative staff member) #3, the corporate

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nurse consultant provided the document "Business Contract" dated "6/13/2019." It documented in part, "The [Name of Facility] shall provide room, board, rehabilitation, and nursing care as directed by the Resident's physician and as required by law for the health, welfare and benefit of the Resident." Section III "Termination" documented in part, "B. In the event that the fees and charges payable to the [Name of facility] hereunder remain unpaid or in any other event that discharge may be necessary, the care and services rendered pursuant to their Business Contract may be terminated by the [Name of facility] upon thirty (30) days written notice to Resident and Responsible Party ..." which was signed by Resident #67, OSM #13, the admissions coordinator and ASM #1, the administrator dated June 27, 2019. The document contained "Resident Rights" which documented in part, "4. To be transferred or discharge only for medical reasons, or for his/her welfare or that of other Residents, or for non-payment for his/her stay except as prohibited by Titles XVIII or XIX of the United States Social Security Act, and to be given proper notice as outlined in federal and state law so as to ensure orderly transfer or discharge, and all such actions are documented in his/her medical record;" The agreement was signed by Resident #67 and OSM #13 dated July 11, 2019.

On 11/5/19 at approximately 11:15 a.m., OSM #17 provided the document "Activity Report" for Resident #67. It documented the following in part:
- "7/11/2019 11:52 General Notes, Family came in at some point to fill out a Medicaid application. Grandson who was taking care of her came in and I went over benefits again, he said they were

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applying for Medicaid, couldn't take care of her anymore did not really seem interested in what I was trying to explain to him, as he did not want to take her home but said she could not afford copay and was not offering up any suggestions. Went over payment options for the Part A coinsurance but explained we do not take pending Medicaid ltc (long term care) residents, and that they would have to take her home during that time and she could return once approved." -"8/5/2019 15:53 (3:53 p.m.) General Notes, on day of DC (discharge) family flat refused to come pick her up sayin [sic] they no longer want to take care of her, we are looking for another facility to take her."

On 11/5/19 at approximately 10:30 a.m., OSM #12 provided the following documents:
-"Notice of Medicare Non-Coverage" which documented "The effective date coverage of your current skilled nursing facility services will end 8/4/19." Page 2 documented in part "Beginning on 8/5/19 Mond., (Monday), you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. Care: Inpatient Skilled Nursing Care. You no longer require skilled care on a daily basis. Medicare will not pay for your stay at this facility unless you require daily skilled care for your medical condition. Estimated Cost: $20,000." Under Options on the form, it documented a mark in Option 3, which documented "I don't want the care listed above. I understand that I'm responsible for paying, and I can't appeal to see if Medicare would pay." An "X" was in the area designated "Signature of Patient or Authorized Representative" with the documentation "*Patient sign. Can't see well, Date 8-1-19."
- Fax confirmation of receipt from the department

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of social services for the application for Medicaid dated 7/18/2019, stamped as received by social services on 7/22/19 for Resident #67.
- A faxed document dated "November 4, 2019." It documented the following, "On July 18, 2019, [Name of OSM (other staff member) #12, the director of discharge planning] contacted APS (Adult Protective Services) in [Name of County] regarding [Name of Resident #67] and spoke with [Name of OSM #16, APS]. We talked about the discharge for [Name of Resident #67] along with filing for Medicaid." The fax was signed by OSM #16 and OSM #12.

The facility policy "Notice of Transfer/Discharge, Effective Date 08/27/19" documented in part, "Procedure: 1. Verify the reason for the initiation of the [Name of Facility] Notice of Transfer/Discharge. Under federal and state law, a Notice of Transfer/Discharge can be initiated for the following reasons:
a. The patient's welfare and needs cannot be met in the Center;
b. The patient's health has improved and they no longer require the services provided by the Center;
c. The safety of individuals in the Center is endangered due to the clinical and/or behavioral status of the patient.
d. The health of individuals in the Center would be endangered;
e. The patient has failed, after reasonable and appropriate notice, to pay for their stay at the Center; or
f. The Center ceases to operate."

The facility document "Resident Handbook" documented on page 13, "Resident Rights- 7. To be transferred or discharged only for medical

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reasons, or for his/her welfare or that of other residents, or for non-payment for his/her stay except as prohibited by Titles XVIII or XISX of the United States Social Security Act, and to be given proper notice as outlined in federal and state law so as to ensure orderly transfer or discharge, and all such actions are documented in his/her medical record."

On 11/5/19 at approximately 5:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #3, the corporate nurse consultant and ASM #4, the assistant administrator were notified of the concerns.

No further information was presented prior to exit.

Complaint deficiency

References:

1. 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.

2. Rheumatoid arthritis- A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

3. Major depressive disorder
Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body

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F 622	Continued From page 43 works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm. 4. Macular degeneration- A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. This information was obtained from the website: https://medlineplus.gov/maculardegeneration.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 (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	F 623		11/27/19

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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 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

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F 623	Continued From page 45 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 § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, agency interview, clinical record review and facility document review and in the course of complaint investigation it was determined that the facility staff failed to evidence that thirty day notice was given for a facility-initiated discharge or transfer for one of 52 residents in the survey sample, Resident #67. The facility staff failed to provide a thirty day	F 623	1. Resident #67 was returned to the Center by the Discharge Planning staff on the same date of attempted discharge on 8/5/2019. Post return assessment on 8/5/2019 revealed no presentation of change in patient condition from the baseline. Resident #67 continue to safely reside at the Center.	

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F 623	Continued From page 46 notice prior to the facility-initiated discharge of Resident #67 on 8/5/19. The findings include: Resident #67 was admitted to the facility on 06/13/2019 with diagnoses that included but were not limited to dementia (1), rheumatoid arthritis (2), major depressive disorder (3), and macular degeneration (4). Resident #67's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/20/19, coded Resident #67 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired for making daily decisions. Review of the clinical record revealed "Discharge planning progress notes; Effective Date 8/20/2019 14:35 (2:35 p.m.)." The note documented the following "late entry: Discharge Meeting held with family on July 18, 2019. Present: [Name of granddaughter], granddaughter; [Name of grandson] and wife, grandson and granddaughter-in-law; [Name of discharge planner]; [Name of occupational therapist], therapy and [Name of physical therapist], therapy. Meeting was held to discuss therapy progress and upcoming discharge due to a plateau in therapy progress being made. Although there is no discharge date at this time, the facility wanted to make the family is aware that patient is not progressing as much as previously so they can prepare to bring her back to live with the grandson ...After the meeting, the DDP (Director of discharge planning) assisted the family with the Medicaid application and faxed it	F 623	2. Discharge Planning Department to review all discharged patients in the last 30 days (starting 10/21/2019 to 11/21/2019) to be certain that all discharge notification requirements were met for facility-initiated discharges. Any anomaly noted will be used as a learning experience for a similarly patient□s discharge situation in the future. 3. Administrator/Designee will provide in-service to Discharge Planning staff on the following topic: a) Patient/Responsible Party notification requirements for facility-initiated patient discharge 6. Discharge Planning Director/Designee to audit completed written notification on discharged patients weekly x1 month and monthly x3 months to ensure compliance with facility-initiated discharge notification requirements. Any anomaly will be forwarded to the weekly risk meeting/QAPI committee for further review and recommendation. 4. Date of compliance: 11/27/2019	

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to [Name of County Department of Social Services]. The fax did not go through that day and was faxed again on July 19, 2019."

The nurses' "Progress Notes," dated "8/5/2019 09:05" (9:05 a.m.) for Resident #67 documented, "Pt (patient) discharged, skin clean, dry and intact. let [sic] facility via wheelchair. No complain of pain. She was provided with medications and discharged instructions."

On 11/4/19 at approximately 4:40 p.m., an interview was conducted with OSM (other staff member) #3, the ombudsman. OSM #3 stated that Resident #67's family had contacted her office after the discharge on 8/5/19, for several reasons, one of them being that they were not given thirty days' notice. OSM #3 stated that the family met with the discharge planner at the facility on 7/18/19 and expressed concerns for providing care for her at the home. OSM #3 stated that the family was applying for Medicaid for Resident #67 and had requested that Resident #67 stay at the facility because they were unable to care for her in their home. OSM #3 stated that her concerns were that Resident #67 and Resident #67's responsible party were not given proper notice of discharge, that Resident #67 was sent home with a Medicaid pending status and that Resident #67 was discharged home without the ability to get in her home.

On 11/5/19 at approximately 9:25 a.m., an interview was conducted with OSM #12, the director of discharge planning and OSM #11, the discharge planning assistant regarding the discharge of Resident #67 on 8/5/19. OSM #12 stated that a discharge meeting was held with

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Resident #67's family members on 7/18/19 to discuss the end of therapy and plan to discharge her to her grandson's home soon. OSM #12 stated that the family voiced concerns about not being able to take Resident #67 at the home and wanting her to remain in the facility. OSM #12 stated that immediately after the discharge meeting she assisted the family to apply for Medicaid. OSM #12 stated that she had discussed what was mentioned in the discharge meeting regarding leaving her in the facility with Resident #67 and she stated that she still wanted to go back to her grandson's home where she was living prior to coming to the facility. OSM #12 stated that she then arranged for discharge and transportation for Resident #67 to the grandson's home. OSM #12 stated that attempts were made to contact Resident #67's grandson but they were not answering calls from the facility. OSM #12 stated that written notice of the discharge date was sent to the family members by the business office.

On 11/5/19 at approximately 11:00 a.m., an interview was conducted with OSM #17, the business office manager regarding the discharge of Resident #67. OSM #17 stated that Resident #67's discharge date was 8/5/19, that the Medicare benefits ended on 8/4/19. OSM #17 stated that Resident #67 needed to have a payer source by the 31st day or she would have to have a $174/day coinsurance. When asked for evidence of the notification of discharge with the 8/5/19 date that was sent to the family, OSM #17 stated that she does not notify families or residents of discharge. OSM #17 stated that all of that is completed by the discharge planners.

On 11/5/19 at approximately 10:30 a.m., OSM

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#12, the director of discharge planning, provided the following documents:
- "Notice of Transfer/Discharge" which documented in part "Date of Notice 7/18/19; Patient Name: [Name of Resident]; The reason for this notice of your transfer/discharge is: you have failed to pay for a stay at the center." [Note at this time the resident was currently covered under Medicare services and had applied for Medicaid] The field on the notice "Date of Transfer/Discharge:" was blank, as well as the field "Location of transfer/discharge: and Address:" The form documented "This information was completed by [Name of Director of Discharge Planning] and contained the signature of OSM (other staff member) #12, the director of discharge planning dated 7/18/19 and ASM (administrative staff member) #1, the administrator dated 7/18/19. The Notice of Transfer/Discharge failed to evidence a planned date of discharge or notification of Resident #67 or Resident #67's family of the planned discharge date.
- "Notice of Medicare Non-Coverage" which documented "The effective date coverage of your current skilled nursing facility services will end 8/4/19." Page 2 documented in part "Beginning on 8/5/19 Mond., (Monday), you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. Care: Inpatient Skilled Nursing Care. You no longer require skilled care on a daily basis. Medicare will not pay for your stay at this facility unless you require daily skilled care for your medical condition. Estimated Cost: $20,000." Under Options on the form it documented a mark in Option 3 which documented "I don't want the care listed above. I understand that I'm responsible for paying, and I can't appeal to see if Medicare

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would pay." An "X" was in the area designated "Signature of Patient or Authorized Representative" with the documentation "*Patient sign. Can't see well, Date 8-1-19."

On 11/5/19 at 11:00 a.m., OSM #12 stated that she did not have anything to provide that would evidence written notification documenting the planned discharge date of 8/5/19 that was provided to Resident #67 or the family of Resident #67 for the discharge on 8/5/19.

On 11/5/19 at approximately 2:00 p.m., ASM (administrative staff member) #3, the corporate nurse consultant provided the document "Business Contract" dated "6/13/2019." It documented in part, "The [Name of Facility] shall provide room, board, rehabilitation, and nursing care as directed by the Resident's physician and as required by law for the health, welfare and benefit of the Resident." Section III "Termination" documented in part, "B. In the event that the fees and charges payable to the [Name of facility] hereunder remain unpaid or in any other event that discharge may be necessary, the care and services rendered pursuant to their Business Contract may be terminated by the [Name of facility] upon thirty (30) days written notice to Resident and Responsible Party ..." which was signed by Resident #67, OSM #13, the admissions coordinator and ASM #1, the administrator dated June 27, 2019.

On 11/5/19 at 4:25 p.m., an interview was conducted with ASM #1, the administrator regarding the discharge of Resident #67 on 8/5/19. When asked if notice of discharge is provided to residents at discharge ASM #1 stated, "Yes, there are two types of notice." When asked

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about the time frame for notification of discharge to residents or the responsible party, ASM #1 stated that long term residents are different from short term residents. ASM #1 stated that long term residents get thirty day notices in most cases unless it is an emergency situation. ASM #1 stated that short term residents are different and most of them get about five to eight days' notice. When asked if notice was given for Resident #67's discharge on 8/5/19, ASM #1 stated that Resident #67 was a short term resident and she did not come in for long term care. [*Note Resident #67 had been a resident at the facility for more than 30 days].

The facility policy "Notice of Transfer/Discharge, Effective Date 08/27/19" documented in part, "Procedure: 1. Verify the reason for the initiation of the [Name of Facility] Notice of Transfer/Discharge. Under federal and state law, a Notice of Transfer/Discharge can be initiated for the following reasons:
a. The patient's welfare and needs cannot be met in the Center;
b. The patient's health has improved and they no longer require the services provided by the Center;
c. The safety of individuals in the Center is endangered due to the clinical and/or behavioral status of the patient.
d. The health of individuals in the Center would be endangered;
e. The patient has failed, after reasonable and appropriate notice, to pay for their stay at the Center; or
f. The Center ceases to operate."

The facility document "Resident Handbook" documented on page 13, "Resident Rights- 7. To

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be transferred or discharged only for medical reasons, or for his/her welfare or that of other residents, or for non-payment for his/her stay except as prohibited by Titles XVIII or XISX of the United States Social Security Act, and to be given proper notice as outlined in federal and state law so as to ensure orderly transfer or discharge, and all such actions are documented in his/her medical record."

On 11/5/19 at approximately 5:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #3, the corporate nurse consultant and ASM #4, the assistant administrator were notified of the concerns.

No further information was presented prior to exit.

Complaint deficiency

References:

1. 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.

2. Rheumatoid arthritis
A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm.

3. Major depressive disorder
Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or

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F 623	Continued From page 53 frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm. 4. Macular degeneration A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. This information was obtained from the website: https://medlineplus.gov/maculardegeneration.html.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		11/27/19

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F 656	Continued From page 54 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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for two of 52 residents in the survey sample, Residents #38 and #57. The facility staff failed to implement Resident #38's comprehensive care plan for pain management. The facility staff failed to develop a comprehensive care plan for the use of assist rails for Resident #57. The findings include: 1. Resident #38 was admitted to the facility on 10/28/18. Resident #38's diagnoses included but were not limited to urinary tract infection, major depressive disorder and difficulty swallowing. Resident #38's most recent MDS (minimum data set), a quarterly assessment with an ARD	F 656	1. Resident #38 care plan and progress notes were reviewed on 11/20/2019 to reflect implementation of care plan interventions associated with pain management in regards to notification of the MD for unrelieved pain. Resident #57 care plan was reviewed and updated on 11/20/2019 to reflect the use of assist bars. 2. DON/ADON/Unit Mangers will review all current patients with assist bars to ascertain its reflection on their comprehensive care plans. Also, the progress notes of current residents will be reviewed to determine any occurrence of failure to implement care plan interventions on pain management. Any abnormal findings will be corrected accordingly.	

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F 656	Continued From page 55 (assessment reference date) of 8/26/19, coded the resident's cognition as severely impaired. Section J documented Resident #38 reported no pain. Resident #38's comprehensive care plan dated 10/29/18 documented, "PAIN: (Resident #38) is at risk for pain. Notify MD (medical doctor) for pain not relieved with medication..." Review of Resident #38's clinical record revealed a nurse's note dated 7/7/19 at 7:27 p.m. that documented the resident was administered two tablets of as needed Tylenol 325 milligrams per physician's order for head and nose pain rated as a five (on a scale from zero to ten). A nurse's note dated 7/7/19 at 8:09 p.m. documented the Tylenol was ineffective and failed to document the physician was notified. A pain level assessment dated 7/7/19 at 8:09 p.m. documented Resident #38's pain as an eight. A nurse's note dated 7/8/19 at 3:04 a.m. documented Resident #38 was administered two tablets of as needed Tylenol 325 milligrams per physician's order for pain. A pain level assessment dated 7/8/19 at 3:04 a.m. documented Resident #38's pain as a ten. A nurse's note dated 7/8/19 at 3:45 a.m. documented the Tylenol was ineffective and the resident continued with intermittent moaning. The note failed to document the physician was notified. (Note- a pain assessment dated 7/8/19 at 10:26 a.m. documented the resident's pain level as a one). On 11/4/19 at 5:07 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse who administered Tylenol to Resident #38 on 7/7/19 at 7:27 p.m.). LPN #1 was asked what should be done if a resident is given Tylenol	F 656	3. SDC/Designee to in-service the charge nurses on care plan initiation, revision/updating, and implementation. 4. DON/ADON/Unit Managers to audit progress notes and quarterly device assessments weekly x4 weeks and monthly x3 months to ascertain the updating of care plan to reflect use of assist bars and enforcement of care plan interventions on pain management. Any identified deficient practice will be rectified accordingly. 5. Date of compliance: 11/27/2019	

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for pain and the Tylenol is not effective. LPN #1 stated, "Contact the doctor and see if he wants to administer something stronger." LPN #1 was made aware of the above concern. LPN #1 stated, "It looks like the night nurse that took over my cart didn't do anything with her pain rating being an eight as a follow up."

The nurse who documented the Tylenol was ineffective on 7/7/19 at 8:09 p.m., administered Tylenol on 7/8/19 at 3:04 a.m. and documented the Tylenol was ineffective on 7/8/19 at 3:45 a.m. was not available for interview.

On 11/5/19 at 2:15 p.m., an interview was conducted with LPN #2 regarding the purpose of the care plan. LPN #2 stated, "It's their goal of care. Their plan of care. As things change, we adjust it accordingly, based on their needs so everybody knows what is going on completely with the patient." LPN #2 was asked how nurses ensure they implement residents' care plans. LPN #2 stated she references and reviews residents' care plans.

On 11/5/19 at 2:19 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the corporate nurse consultant) were made aware of the above concern.

The facility policy regarding care planning documented, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient."

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No further information was presented prior to exit.
2. Resident #57 was admitted to the facility on 2/5/19 with diagnoses that include but are not limited to: Alzheimer's (a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability) (1), depression (dejected state of mind) (2), and high blood pressure.

The MDS (minimum data set) assessment, a quarterly day Medicare assessment, with an ARD (assessment reference date) of 8/14/19, coded the resident as scoring a 99 on the BIMS (brief interview for mental status) score, indicating she was incapable of completing the interview. Resident #57 was coded as requiring extensive assistance from one or more persons' physical assistance for bed mobility, transfers, toileting, and dressing.

A review of the clinical record noted that the physician ordered, "Assist rails for turning and repositioning in bed to begin 2/5/19.

A review of the comprehensive care plan dated 2/6/19, failed to address and document Resident #57's assist bars which was ordered on 2/5/19.

The resident was observed in wheelchair on 11/3/19 at 3:00 PM. When asked about if she uses the assist bars, Resident #57 stated, "I use them when I'm in bed."

An interview was conducted on 11/05/19 at 10:51 AM with RN (registered nurse) #8. When asked to identify where the assist bars were located on Resident # 57's care plan, RN #8 stated, "It is usually under the fall goal, under interventions."

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F 656	Continued From page 58 When asked to locate this intervention on Resident #57's comprehensive care plan, RN #8 stated, "I can't find it there, I don't go into the care plan as much as the unit manager, let me ask her. It should be here under falls." When asked the purpose of care plan, RN #8 stated, "The care plan is to identify goals and interventions for the resident." When asked the purpose of assist bars, RN #8 stated, "They are used to help the resident with turning and positioning." Administrative staff members (ASM) #1, the administrator, (ASM) #2, the director of nursing, ASM #3, the regional clinical coordinator and RN #6, the assistant director of nursing, were made aware of the above concerns on 11/4/19 at 6:25 PM. No further information was provided prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 25. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 157.	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	F 657		11/27/19

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F 657	Continued From page 59 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to review or revise the comprehensive care plan for one of 52 residents in the survey sample, Resident # 86. The facility staff failed to address storage of the cigarettes and a lighter on the care plan for Resident #86. The findings include: Resident #86 was admitted to the facility on 12/11/2015 with a readmission on 10/01/2019, with diagnoses that included but were not limited to diabetes mellitus (1) and end stage renal disease (2). Resident #86's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/07/19, coded Resident #86 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section J of the significant	F 657	1. Resident #86 care plan was reviewed and updated on 11/21/2019 to reflect storage of cigarettes and lighter. Facility is a non-smoking Center and will therefore work with Resident #86 within such a framework in ensuring his safety and the safety of other residents. 2. DON/ADON/Unit Managers to audit the care plan of all residents currently smoking at facility to ascertain that their care plans addresses the storage of smoking materials. Any anomalies identified will be corrected accordingly. 3. SDC/Designee will complete an in-service with facility staff on the following topics: a) Facility non-smoking status and the management of current grandfathered active smokers at the Center within the non-smoking framework. b) Ongoing monitoring, documentation	

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F 657	Continued From page 60 change MDS assessment with an ARD of 6/28/19 documented no current tobacco use. On 11/3/19 at approximately 2:15 p.m., an interview was conducted with Resident #86. Resident #86 was observed in a wheelchair self propelling in the room. The outline of a small rectangular box was observed in the front pocket of the shirt he was wearing. When asked what was in his pocket Resident #86 stated, "Those are my cigarettes" and proceeded to take out his lighter and a pack of [Brand Name] cigarettes. When asked if he smokes at the facility, Resident #86 stated, "They don't like smoking on the property, I go outside on the side walk." When asked where his cigarettes and lighter are stored, Resident #86 stated that he keeps them with him. When asked if he smokes in the facility, Resident #86 stated that he does not because they do not allow it so he has to go out to the sidewalk. When asked if the staff know that he goes out to smoke, Resident #86 stated, "Yes, I don't go out at night, just during the day." When asked if the staff are aware that he keeps his cigarettes and lighter in his room with him, Resident #86 stated, "Yes, they know I am safe with them so I can keep them. I don't start any fires or anything." When asked how often he smokes, Resident #86 stated that he only smokes one or two cigarettes a day. Resident #86 stated that he has PTSD (post-traumatic stress disorder) and the cigarettes help to calm him down. Resident #86 stated that he knows they are bad for him and he has cut down since being at the facility. The POS (physicians order sheet) dated "11/05/2019" for Resident #86 documented, "Behaviors- Monitor for the following: Argumentative, restlessness (Agitation), increase	F 657	and notification of non-compliance with adherence to facility smoking policies. 4. DON/ADON/Unit Managers will audit all residents currently smoking at facility weekly x1 month and monthly x3 months to ascertain compliance with care plan revision in respect to storage of smoking materials. Any anomaly noted will be rectified accordingly and then forwarded to the QAPI committee for further review and recommendation 5. Date of compliance: 11/27/2019	

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in complaints, cussing, aggression and refusing care, impulsive, verbally/physically aggressive, yelling, refusing care, refusing medications, refusing wound care and blood glucose monitoring, smoking, refusing assessments ...See Nurses Notes and progress note findings every shift. Order Date 10/01/2019. Start Date 10/01/2019."

Review of the Nurses notes and progress notes dated 10/1/19 through 11/5/19 did not evidence documentation of Resident #86 displaying any smoking behaviors in the facility.

Review of Resident #86's medical record revealed the document "Smoking-Safety Screen" dated "04/25/2019." It documented the following in part, "How many cigarettes does the resident smoke (per day)? 1-2; Does resident need facility to store lighter and cigarettes? Yes; Plan of care is used to assure resident is safe while smoking? Yes; Notes on Safety ...IDT (Interdisciplinary team) team met and discussed this behavior with the resident, he is aware that he can not smoke at the facility; Team Decision: Safe to smoke without supervision; Rationale/conditions: Resident is appropriate to smoke without supervision, but has been advised that he is not allowed to smoke at the facility."

The comprehensive care plan for Resident #86 dated 03/16/2018 documented, "Smoking: Non-Smoking Center: [Name of Resident] is a smoker and not grand-fathered to smoke at center. Created on: 03/16/2018. Revision on: 09/26/2019." Under "Interventions", it documented, "Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Created on 03/16/2018. Revision

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on: 09/26/2019." The care plan failed to evidence documentation addressing storage of smoking supplies for Resident #86 if he chose to smoke offsite.

On 11/4/19 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #7, unit manager. When asked about smoking at the facility, LPN #7 stated there is a no smoking policy. LPN #7 stated that some residents are grand-fathered in and allowed to smoke in the smoking area of the courtyard. LPN #7 stated that the cigarettes and lighters are stored in the medication rooms. LPN #7 stated that she is aware that there are residents who refuse to give up their cigarettes and lighters but she is not sure what is done about that because they are on other units. LPN #7 stated that if the resident is their own responsible party they can sign themselves out and go smoke. LPN #7 stated that if they do this they have a smoking assessment done initially and quarterly and it is in their care plan also. LPN #7 stated that nicotine alternatives are attempted for newly admitted residents who smoke.

On 11/5/19 at 8:30 a.m., an interview was conducted with RN (registered nurse) #4, charge nurse. When asked about residents smoking in the facility, RN #4 stated that she was unsure, the policy may have changed and but residents who have been in the facility for more than 25 years used to be grand-fathered in and allowed to smoke. RN #4 stated that some residents are allowed to smoke and a smoking assessment is completed to determine if it is safe for resident to carry their cigarettes and lighter on their person. When asked how she would know if a resident is allowed to carry their cigarettes and lighter, RN

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#4 stated that she would ask the unit manager to see. When asked if it would be addressed on the care plan, RN #4 stated that she was not sure. When asked where residents smoke at the facility, RN #4 stated that there is a courtyard by the dining room where they are allowed to smoke. RN #4 stated that the area is open during the day. When asked about Resident #86's ability to smoke at the facility, RN #4 stated that he is his own responsible party and can sign himself out and leave the facility to smoke. When asked if he carries his cigarettes and lighter with him, RN #4 stated that she had seen him with them but he does not smoke on the property. When asked where Resident #86 would sign out of the facility, RN #4 stated in the book at the nurses station. When asked if the care plan for Resident #86 addressed the storage of his smoking supplies for smoking offsite, RN #4 stated she was not sure. RN #4 stated that she was not sure what care plans should address regarding smoking because it is all done by the unit manager. When asked what she does if there are questions regarding resident care, RN #4 stated she would go to the unit manager.

On 11/5/19 at 8:50 a.m., an interview was conducted with LPN #10, unit manager. LPN #10 stated that the facility is now smoke free but some residents are grand-fathered in and are allowed to smoke. LPN #10 stated that those residents have to have a smoking assessment and their smoking supplies are kept in the medication room with set times and locations for them to smoke in the courtyard. LPN #10 stated that the smoking assessment is completed to determine if the resident is allowed to smoke unsupervised and if the resident is allowed to carry their smoking supplies on them. LPN #10

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stated that Resident #86 is not grand-fathered in to be allowed to smoke and that he goes offsite to smoke. LPN #10 stated that she was told that Resident #86 signs himself out and goes to [Name of Pharmacy] to smoke but he has not gone off the premises that she knows of since June of this year. LPN #10 stated that Resident #86 is not care planned to carry his cigarettes and lighter and that she has not seen them on him personally. LPN #10 stated that it had not been reported to her that Resident #86 was carrying his cigarettes and lighter on him or storing them in his room. When asked if the care plan for Resident #86 addressed the storage of the smoking supplies for smoking offsite, LPN #10 stated that she did not know for sure. After reviewing Resident #86's care plan, LPN #10 stated that she would have to check and see if it needed to be revised to include the storage of the smoking supplies.

On 11/5/19 at 2:30 p.m., an interview was conducted with CNA (certified nursing assistant) #8. CNA #8 stated that Resident #86 has asked staff for cigarettes but they do not give them to him. CNA #8 stated that she has smelled smoke on him before when he comes back to the unit after meals or after dialysis. CNA #8 stated that Resident #86 is independent and goes off of the unit a lot. CNA #8 stated that she knows some residents are grand-fathered in and allowed to smoke at the facility. CNA #8 stated that they cannot see the care plans but if she had questions about a resident's ability to smoke that she would ask the nurse or the unit manager for clarification.

The facility document "Release of Responsibility for Leave of Absence" from the unit sign out book

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for Resident #86 revealed a sign out date and time of "3/30 at 11:17", the document failed to evidence a sign in date and time. No further sign out or sign in dates were documented on the leave of absence form provided.

On 11/5/19 at 2:15 p.m., an interview was conducted with LPN #10. LPN #10 stated that Resident #86's care plan should be updated to reflect the storage of cigarettes and lighter if he is going offsite to smoke. LPN #10 stated that the care plan should also be updated to reflect Resident #86 signing out when going off site to smoke including if he is refusing to sign in and out. LPN #10 stated that she has never observed him go out to smoke and that he always tells the staff that he is visiting another resident on unit two.

On 11/5/19 at approximately 12:00 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility's policy regarding smoking and storage of smoking supplies.

On 11/5/19 at approximately 4:00 p.m., ASM #1, the administrator provided the facility policy "Smoke-Free Environment; Effective date 06/20/16." ASM #1 stated that he was told that Resident #86 has cigarettes that he will not allow the staff to take away and he is not allowed to smoke on the property. ASM #1 was made aware that Resident #86's care plan failed to evidence documentation addressing storage of the cigarettes and lighter that he was carrying and using when he was smoking offsite.

The facility's policy "Smoke-Free Environment, Effective Date 06/20/16" failed to evidence

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F 657	Continued From page 66 guidance on the storage of smoking materials by residents. The facility's policy "Care Planning, Effective Date 11/01/19" documented in part, "Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur ..." On 11/5/19 at approximately 5:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #3, the corporate nurse consultant and ASM #4, the assistant administrator were made aware of the findings. No further information was provided prior to exit. Reference: 1. 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. 2. End stage renal disease The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		11/27/19

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F 658	Continued From page 67 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and review of facility documentation it was determined that the facility staff failed to provide professional standards of quality for as needed pain medication orders for one of residents in the survey sample, Resident #17. The facility staff failed to clarify the physician orders for three different pain as needed pain medications for Resident #17, to determine, when and which as needed pain medication to administer based on pain level parameters. The findings include: Resident #17 was admitted to the facility on 5/27/12 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), lung cancer, metastatic cancer (cancer that has spread to other organisms), depression, dementia, and anxiety disorder. The most recent MDS, a quarterly assessment, with an assessment reference date of 8/114/19, coded the resident as having short-term memory difficulties, but long-term memory as intact. The resident was coded as being moderately impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring supervision only for all of his activities of daily living. In Section J - Health Conditions, the resident was coded as stating he had no pain at the time of the assessment.	F 658	1. Resident #17 three PRN pain medications will be clarified to further direct nurses as to when they can administer any one of the medications to the patient. Review of Resident #17 medication record did not indicate patient pain not well managed as a consequent of the three pain medications not having parameters for administration. 2. DON/ADON/UMs to audit all current patients with more than one PRN pain medications to ascertain that they have appropriate parameter to further direct nurses as to when they can be administered. Any anomaly noted will be rectified accordingly in consultation with the attending physician/Nurse Practitioner. 3. SDC/Designee will provide in-service to all current charge nurses on the following topics: a) Taking and scheduling two or more PRN pain medication orders b) Assigning parameters to patients on two or more PRN pain medications c) Managing multiple PRN pain medications ordered for a patient. 4. DON/ADON/UMs will audit all patients on multiple PRN pain medications weekly x1 month and monthly x3 months to ensure that they have adequate clarification to direct administration by the staff. Any anomaly identified will be rectified immediately as appropriate and then forwarded to the QAPI committee for further review and recommendation	

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F 658	Continued From page 68 The physician orders documented, "Acetaminophen (Tylenol) [used to treat mild to moderate pain (2)], 500 mg (milligrams) Give 2 tablet by mouth every 6 hours as needed for pain. Ibuprofen Tablet [used to treat mild to moderate pain (3)] 400 mg by mouth every 6 hours as needed for pain. Oxycodone [used to relieve moderate to severe pain (4)] tablet 5 mg give 1 tablet by mouth every 4 hours as needed for pain." The September 2019 MAR (mediation administration record) documented the above physicians orders for the three medications. In September, Resident #17 received Acetaminophen twice, once on 9/23/19 for a pain level of "5" and on 9/27/19 for a pain level of "4." The Ibuprofen was not administered in September. The Oxycodone was documented as administered on 9/16/19 for a pain level of "5" and on 9/24/19 for a pain level of "6." The October 2019 MAR documented the above medications. In October Resident #17 did not receive any Acetaminophen nor Ibuprofen. Resident #17 did receive Oxycodone on 10/1/19 for a pain level of "8" and then again on 10/31/19 for a pain level of "2." The November 2019 MAR documented the above physicians orders for the three medications. In November, Resident #17 did not receive any Acetaminophen or Ibuprofen. Resident #17 did receive Oxycodone on 11/1/19 at 7:59 a.m. for a pain level of "8" and then again at 6:42 p.m. for a pain level of "8." He also received the Oxycodone on 11/4/19 for a pain level of "8."	F 658	5. Date of compliance: 11/27/2019	

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The comprehensive care plan dated 2/24/14 and revised on 10/2/19, documented in part, "Focus: (Resident #17) has potential for pain r/t (related to) generalized weakness and decreased mobility." The "Interventions" documented in part, "Administer analgesia per order."

An interview was conducted with LPN (licensed practical nurse) #12 on 11/4/19 at 11:07 a.m. When asked how staff know which medication to administer if a resident has three different pain medications ordered, LPN #12 stated, "Well I ask the resident their pain level. I actually was going to ask (LPN #4) about discontinue it." When asked if it is her professional scope of practice to decide which medication to give, LPN #12 stated, "No."

An interview was conducted with LPN #4 on 11/4/19 at 3:28 p.m. LPN #4 was asked to review the physician orders for the three pain medication ordered for Resident #17. When asked how staff know which as needed pain medication to administer, LPN #4 stated, "You ask the resident the pain level but these orders do not give the nurse the right to decide which one to give. But this patient is very particular, it depends on his mood. LPN #4 stated she would consult with the nurse practitioner, they (the as needed pain medication orders) need clarification.

The facility policy, "Documentation and Notification" documented, "Notification of the MD/RP (medical doctor/responsible party) is not limited to the above list. The list may be considered a sample of triggers that would prompt the Charge Nurse to notify the MD/RP."

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F 658	Continued From page 70 Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse consultant, ASM #4, the assistant administrator and RN (registered nurse) #6 were made aware of the above concern on 11/4/19 at 6:25 p.m. No further information was provided prior to exit. References (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682159.html (4) This information was obtained from the website:https://medlineplus.gov/druginfo/meds/a682132.html	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning	F 660		11/27/19

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process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who

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F 660	Continued From page 72 made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, agency interviews, clinical record review and facility document review and in the course of complaint investigation it was determined that the facility staff failed to evidence that complete and safe discharge planning was provided for a facility-initiated discharge for one of 52 residents in the survey sample. The facility staff discharged Resident #67 on 8/5/2019, while Medicaid was pending, failed to ensure a proper discharge notice was provided to the resident and family, failed to ensure a caregiver was available	F 660	1. Resident #67 was returned to the Center by the Discharge Planning staff on the same date of the attempted discharge on 8/5/2019. Post return assessment on 8/5/2019 revealed no presentation of change in patient condition from the baseline. Resident #67 continue to safely reside at the Center. 2. Discharge Planning Department to review all discharges in the last 30 days (starting 10/21/2019 to 11/21/2019) to be certain that discharged patients were	

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F 660	Continued From page 73 to provide the 24-hour care that the facility documented the resident required, and failed to arrange home health services for the resident. Resident #67 subsequently returned to the facility several hours later due to not having a caregiver to accept her in the home. The findings include: Resident #67 was admitted to the facility on 06/13/2019 with diagnoses that included but were not limited to dementia (1), rheumatoid arthritis (2), major depressive disorder (3), and macular degeneration (4). Resident #67's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/20/19, coded Resident #67 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired for making daily decisions. On 11/4/19 at approximately 10:15 a.m., an interview was conducted with Resident #67 regarding the discharge home on 8/5/19. When asked about the discharge Resident #67 stated, "I don't really remember, I never went to my house. My grandson should have come to pick me up." When asked if she remember riding in a van in her wheelchair to her grandson's home and then back to the facility, Resident #67 stated, "I don't remember." Review of the clinical record revealed the care plan "Discharge planning: [Name of Resident] preference for discharge is: to d/c (discharge) home with grandson. Created on: 06/21/2019. Revision on 06/21/2019."	F 660	adequately notified, that there were no pending Medicaid applications, and there were provisions for home health services/care givers as applicable. Any anomaly noted will be forwarded to the weekly risk meeting for guidance and also used as a learning experience for future discharges. 3. Administrator/Designee will complete an in-service to all Discharge Planning staff on the following topics c) Patient discharge notification d) Managing pending medication application for patients who are due to be discharged e) Managing patient discharge needing home health services/care giver 4. Discharge Planning Director/Designee will audit all pending facility-initiated discharges weekly x1 month and monthly x3 months to ascertain that proper notification were given, result of pending Medicaid applications were established, and applicable home health services/care giver provision were catered. Any anomaly noted will be rectified accordingly and then forwarded to the QAPI committee for further review and recommendation 5. Date of compliance: 11/27/2019	

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The nurses' progress notes documented the following:
- "8/5/2019 09:05 (9:05 a.m.), Pt (patient) discharged, skin clean, dry and intact. let [sic] facility via wheelchair. No complain of pain. She was provided with medications and discharged instructions."
- "8/5/2019 14:41 (2:41 p.m.), an admission assessment has been completed. See the assessment for details. The Resident arrived from Own Home. The reason for the admission per the resident/POA (power of attorney) is family is unable to provide care for resident at this time."

Further review of the clinical record revealed "Discharge planning progress notes; Effective Date 8/20/2019 14:35 (2:35 p.m.)." The note documented the following "late entry: Discharge Meeting held with family on July 18, 2019. Present: [Name of granddaughter], granddaughter; [Name of grandson] and wife, grandson and granddaughter-in-law; [Name of discharge planner]; [Name of occupational therapist], therapy and [Name of physical therapist], therapy. Meeting was held to discuss therapy progress and upcoming discharge due to a plateau in therapy progress being made. Although there is no discharge date at this time, the facility wanted to make the family is aware that patient is not progressing as much as previously so they can prepare to bring her back to live with the grandson. During that point in the conversation, the grandson and his wife stated that they have been taking care of the patient in their home for seven years and were no longer able to do so as the wife was starting a new job. DDP (Director of discharge planning) asked the family what the plan was and the family all

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responded that they will keep the patient here. I explained that the patient does not have a payor (Sic.) source and will need to apply for Medicaid asap (as soon as possible). DDP also explained that the Medicaid decision can take up to 45 days and that they (the family) would have to make arrangements for the patient during the decision making process as we [facility] do not accept Medicaid pending as a payment. The family became visibly upset and the grandson's wife started yelling at DDP stating that the patient is taking too much of a toll on the grandson and they were just not going to pick her up. The DDP then asked the family, "Are you saying that you are refusing to pick [First Name of Resident #67] up?" The family responded yes. The DDP explained that they must come together to make a safe decision for the patient. The DDP did explain that the patient can stay here after therapy discharge as a private pay resident of $245/day. The family stated that she did not have the money to pay privately and that she had bills to pay. After the meeting, the DDP assisted the family with the Medicaid application and faxed it to [Name of County Department of Social Services]. The fax did not go through that day and was faxed again on July 19, 2019."

The document "Physical Therapy Discharge Summary" dated "8/2/2019 06:00:44 PM EST (6:00 p.m.)" documented in part, "Patient was seen for 10 day(s) during the 7/19/2019-7/30/2019 progress period"; "Discharge Recommendations: Home health services, Remove throw rugs, Remove environmental barriers, Assistive device for safe functional mobility, Elevated toilet seat/3 in 1 commode (a bedside commode), grab bars (devices used to assist in getting up and down

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and balance), assistance with IADLs (Instrumental activities of daily living, examples include laundry, shopping, using the telephone), 24 hour care, gel cushion and Walker basket/tray/bag, wheelchair for community mobility, HEP (Home exercise program)."

The document "Occupational Therapy Discharge Summary" dated "8/9/2019 06:43:29 PM EST (6:43 p.m.)" documented in part, "Patient was seen for 4 day(s) during the 7/30/219-8/4/2019 progress period."; "Discharge Recommendations: 24 hour supervision, assistance with ADLs (Activities of daily living) as needed related to SOB (shortness of breath) or c/o (complaints of) knee pain, RW (Rolling walker), w/c (wheelchair) for long distances or community. BSC (bedside commode) during the night, hand rails and grabbers (device used to pick up items).

On 11/4/19 at 9:10 a.m., a telephone interview was conducted with OSM (other staff member) #8, driver for [Name of transportation service]. When asked about the discharge of Resident #67 on 8/5/19, OSM #8 stated that she remembered it well. OSM #8 stated that Resident #67 was scheduled to be picked up by transportation for discharge home at 8:00 a.m. on 8/5/19. OSM #8 stated that one of the discharge planners at the facility arranged the transportation. OSM #8 stated that when Resident #67 was brought into the main lobby in her wheelchair the morning of 8/5/19 she resisted the staff and was asking where she was going. OSM #8 stated that they were delayed in the lobby for approximately 30 to 45 minutes due to Resident #67 being hesitant about leaving and not knowing what was happening. OSM #8 stated that OSM #11, the discharge planning assistant was in the lobby with

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her, two CNA's (certified nursing assistants) that she did not know and Resident #67. OSM #8 stated that OSM #11 went into her office to call Resident #67's grandson, returned and stated that he did not answer but stated that Resident #67's grandson was going to be waiting for her at the home. OSM #11 stated that the CNA's boarded Resident #67 into the van and she drove her to the address provided by OSM #11, the discharge planner. OSM #11 stated that when they arrived to the location there were no cars in the driveway and it appeared that no one was home. OSM #8 stated that Resident #67 provided her with a phone number for her grandson, which she called. OSM #8 stated that Resident #67's grandson was very upset when he found out that she was being discharged and told OSM #8 not to take her from the facility. OSM #8 stated that she was afraid because he was so angry and threatening. OSM #8 stated that she felt as if she had been caught in the middle of something between the facility and the family that she did not know about. OSM #8 stated that the cell phone reception was very spotty, GPS (global positioning system) would not pick up any signal in the area and that some calls would not go through in the area. OSM #8 stated that she attempted to call the facility 12 to 13 times without success. OSM #8 stated that she left the home with Resident #67 in the van and started driving back to get phone service. OSM #8 contacted the facility when she was able to get her location and phone service and it was arranged to meet at [Name of Hospital]. When asked to describe Resident #67 during this time OSM #8 stated that Resident #67 was very upset and distressed. OSM #8 stated that Resident #67 was emotional and tearful, saying that she just wanted to go home. OSM #8 stated that she arrived at [Name

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of Hospital] at approximately 11:45 a.m. on 8/5/19. OSM #8 stated that she assisted Resident #67 out of the van and into the emergency room lobby to wait for facility staff and to use the restroom. OSM #8 stated that when she brought Resident #67 out of the restroom OSM #11 and OSM #12, the director of discharge planning were waiting for them. OSM #8 stated that OSM #12 asked her if she could take Resident #67 to [Name of another City] to another facility while OSM #11 was on her phone attempting to set up placement at the other facility for Resident #67. OSM #8 stated that she respectfully declined to transport Resident #67 to [Name of another City] after the hours she had spent in the van that morning and anxiety Resident #67 had encountered. OSM #8 stated that Resident #67 did not have access to a restroom during the transport from approximately 8:30 a.m. until 11:45 a.m.

On 11/4/19 at 2:00 p.m., a telephone interview was conducted with RN (registered nurse) #2. When asked about the discharge of Resident #67 on 8/5/19, RN #2 stated he was in orientation that week, but remembers the resident being discharged home around 9:15 a.m. but that the family would not accept her. RN #2 stated that Resident #67 was provided with medication instructions and discharge instructions the morning of discharge. RN #2 stated that Resident #67 knew that she was going home and that the facility had set up transportation for her to go home. RN #2 stated that he knew that she returned to the facility the same day but he did not interact with her when she returned. When asked who at the facility ensures a caregiver is notified of discharge and is aware when a resident is on the way home, RN #2 stated that

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the discharge planners would do that.

On 11/4/19 at approximately 5:20 p.m., an interview was conducted with OSM #7, occupational therapist. When asked if she was present during the discharge meeting for Resident #67 on 7/18/19, OSM #7 stated that she was present. OSM #7 stated that Resident #67's grandson, granddaughter and grandson's wife were at the meeting as well. OSM #7 was asked if Resident #67's family discussed not feeling that discharge was safe. OSM #7 stated that the family got upset when discharge was discussed. OSM #7 stated, "They did get upset, but more along the lines that they did not want to provide the care. Not that they weren't already doing it before and couldn't continue doing it, just didn't appear to want to." OSM #7 stated that the facility discharge planner reviewed the discharge process with the family and what would be required but she did not remember the specifics. OSM #7 stated that the family questioned what would happen if they did not pick the resident up for discharge and leave her at the facility. OSM #7 stated that she did not remember exactly what was discussed with the family but she remembered that the discharge planner mentioned discussing a referral to APS (adult protective services).

On 11/4/19 at approximately 4:40 p.m., an interview was conducted with OSM #3, the ombudsman. When asked about Resident #67's discharge on 8/5/19, OSM #3 stated that the family contacted her after the discharge because Resident #67's Medicare skilled days had run out and the facility told the family that they did not accept Medicaid pending. OSM #3 stated that they also contacted her regarding Resident #67

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being sent home on 8/5/19 without thirty-day notice after the family had expressed concerns for providing care for her at the home. OSM #3 stated that the family was applying for Medicaid for Resident #67 and needed to supply additional documentation. OSM #3 stated that Resident #67's grandson provided her with two invoices from the facility. OSM #3 stated that the invoices appeared to display the private pay rate for the month and the following month requested payment up front. OSM #3 stated that she explained to the facility staff that Resident #67 had applied for Medicaid and that there were no concerns that it would not be approved. OSM #3 stated that she explained to the facility staff that after the Medicaid was approved the facility would be paid for the care of Resident #67 retrospectively. OSM #3 stated that she voiced concerns on behalf of the family in addition to the family voicing their concerns that Resident #67 should not be discharged due to the family being unable to care for her. OSM #3 stated that her concerns were that Resident #67 and Resident #67's responsible party were not given proper notice of discharge, that Resident #67 was sent home with a Medicaid pending status and that Resident #67 was discharged home without the ability to get in her home. OSM #3 stated that Resident #67 was out of the facility for hours with unknown access to water, food and restroom causing undue anxiety and stress.

On 11/5/19 at approximately 9:25 a.m., an interview was conducted with OSM #12, the director of discharge planning and OSM #11, the discharge planning assistant regarding the discharge of Resident #67 on 8/5/19. OSM #12 stated that a discharge meeting was held with Resident #67's family members on 7/18/19 to

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discuss the end of therapy and plan to discharge her to her grandson's home soon. OSM #12 stated that Resident #67 was admitted to the facility for short-term therapy, she was her own responsible party and the plan was always to go back to her grandson's home after therapy. OSM #12 was asked to provide documented evidence that Resident #67 was her own responsible party. OSM #12 stated that Resident #67's face sheet currently listed her grandson as the responsible party and she was not sure if she could find evidence that on admission Resident #67 was her own responsible party since it had been updated. OSM #12 stated that she knew Resident #67 had signed her admission agreement. OSM #12 stated that she would look for something. When asked if Resident #67 was her own responsible party if she was invited to her discharge-planning meeting on 7/18/19, OSM #12 stated that Resident #67 was not invited to the discharge planning meeting because the family had requested that she not attend. OSM #12 stated that when discharging Resident #67 was discussed with the family members in the meeting the family mentioned on multiple occasions, "What if we don't pick her up? What if we just leave her here?" OSM #12 stated that immediately after the discharge meeting she assisted the family to apply for Medicaid. OSM #12 stated that she had discussed what was mentioned in the discharge meeting regarding leaving her in the facility with Resident #67 and she stated that she still wanted to go back to her grandson's home where she was living prior to coming to the facility. OSM #12 stated that she then arranged for discharge and transportation for Resident #67 to the grandson's home. OSM #12 stated that attempts were made to contact Resident #67's grandson but they were

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not answering calls from the facility. OSM #12 stated that written notice of the discharge date was sent to the family members by the business office.

OSM #11 stated that Resident #67 was discharged with a walker and a wheelchair and she set up delivery for a bedside commode as directed on the recommendations from the occupational and physical therapy discharge recommendations. When asked if home health was set up as directed on the occupational and physical therapy discharge recommendations, OSM #11 stated that it was not. When asked if it is a safe discharge if the facility did not confirming a caregiver was at the home to receive the resident and provide 24 hour care as directed on the occupational and physical therapy discharge recommendations. OSM #11 stated that on the morning of 8/5/19 prior to Resident #67 leaving the facility, she left a message for the family of Resident #67 to let them know that she was being discharged and on the way home. OSM #11 stated that Resident #67 was made aware that she had not talked with anyone at the home. OSM #11 stated that Resident #67 stated that she had a key to the house and that it was fine. OSM #11 stated that she did not ask to see the key. OSM #12 stated that on 8/5/19 when Resident #67 was discharged, she was taken to her grandson's home where she had lived prior to the facility but no one would answer the door to let her in so the van driver contacted them [facility]. When asked why Resident #67 did not use her key to get in, OSM #12 stated the van driver did not feel comfortable leaving her there. OSM #12 stated that they set up a central meeting location at [Name of Hospital] to meet the van and Resident #67. OSM #12 stated that

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Resident #67 was upset at the hospital when they arrived. OSM #12 stated that she called Resident #67's grandson who spoke with Resident #67 on speakerphone and "told her that she was no longer welcome at the house." OSM #12 stated that Resident #67 was visibly upset and stated "you get my money checks" and "he hung up on her." OSM #12 stated that at that point they set up another transport service to return Resident #67 to the facility.

OSM #12 stated that she did not ask transportation to take the resident to [Name of another City]; that they came to the hospital to take her back to the facility. When asked if staff made sure someone was going to be home when Resident #67 was discharged on 8/5/19, OSM #12 stated, "No, I did not make sure that someone was home, because the resident was ok going home by herself." OSM #11 stated, "I talked to [First Name of Resident #67] and she said she was ok she had a key." When asked why transportation did not let her use the key OSM #12 stated that they didn't feel comfortable with that. When asked if they told transportation the situation that the family had voiced concerns regarding having Resident #67 return to the home but she [Resident #67] still wanted to be discharged, OSM #12 and OSM #11 stated that they did not.

On 11/5/19 at approximately 10:30 a.m., OSM #12, the director of discharge planning, provided the following documents:
- "Notice of Transfer/Discharge" which documented in part "Date of Notice 7/18/19; Patient Name: [Name of Resident]; The reason for this notice of your transfer/discharge is: you have failed to pay for a stay at the center." The

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field on the notice "Date of Transfer/Discharge:" was blank, as well as the field "Location of transfer/discharge: and Address:" The form documented "This information was completed by [Name of Director of Discharge Planning] and contained the signature of OSM (other staff member) #12, the director of discharge planning dated 7/18/19 and ASM (administrative staff member) #1, the administrator dated 7/18/19. The Notice of Transfer/Discharge failed to evidence a planned date of discharge or notification of Resident #67 or Resident #67's family of the planned discharge date.
- "Notice of Medicare Non-Coverage" which documented "The effective date coverage of your current skilled nursing facility services will end 8/4/19." Page 2 documented in part "Beginning on 8/5/19 Mond., (Monday), you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. Care: Inpatient Skilled Nursing Care. You no longer require skilled care on a daily basis. Medicare will not pay for your stay at this facility unless you require daily skilled care for your medical condition. Estimated Cost: $20,000." Under Options on the form, it documented a mark in Option 3, which documented "I don't want the care listed above. I understand that I'm responsible for paying, and I can't appeal to see if Medicare would pay." An "X" was in the area designated "Signature of Patient or Authorized Representative" with the documentation "*Patient sign. Can't see well, Date 8-1-19."

On 11/5/19 at 11:00 a.m., OSM #12 stated that she did not have documentation to evidence written notification documenting the planned discharge date of 8/5/19 that was provided to Resident #67 or the family of Resident #67 for the

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discharge on 8/5/19.

On 11/5/19 at approximately 10:35 a.m., an interview was conducted with Resident #67. Resident #67 was observed sitting in the wheelchair at the left side of the bed near the window. Upon greeting Resident #67 she stated, "I remember you [First name of Surveyor], you were in here yesterday talking to me." When asked if she has or has ever had a key to her grandson's home Resident #67 stated, "No, I don't think I have ever had one."

On 11/5/19 at approximately 11:00 a.m., an interview was conducted with OSM #17, the business office manager regarding the discharge of Resident #67. OSM #17 stated that Resident #67's discharge date was 8/5/19, that the Medicare benefits ended on 8/4/19. OSM #17 stated that Resident #67 needed to have a payer source by the 31st day or she would have to have a $174/day coinsurance. OSM #17 stated that Resident #67's grandson stated that they were trying to set up Medicaid and that she had reviewed how to apply with him on 7/11/19. OSM #17 stated that on 7/11/19 Resident #67's grandson stated that he could not take care of her [Resident #67] anymore and did not want to take her home.

On 11/5/19 at approximately 11:15 a.m., OSM #17 provided the document "Activity Report" for Resident #67. It documented in part, "7/11/2019 11:52 General Notes, Family came in at some point to fill out a Medicaid application. Grandson who was taking care of her came in and I went over benefits again, he said they were applying for Medicaid, couldn't take care of her anymore did not really seem interested in what I was trying

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to explain to him, as he did not want to take her home but said she could not afford copay and was not offering up any suggestions. Went over payment options for the Part A coinsurance but explained we do not take pending Medicaid ltc (long term care) residents, and that they would have to take her home during that time and she could return once approved."

On 11/5/19 at 4:25 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator regarding the discharge of Resident #67 on 8/5/19. ASM #1 stated that her family member handled Resident #67's finances and when the business office met with them, they stated that they did not know if they wanted to take her home. ASM #1 stated that if there were no guardianship in place the facility has to respect her wishes to go back to her prior living arrangements with her family in their home. ASM #1 stated that he was informed that during the discharge meeting with the family the family had discussed not wanting Resident #67 to come home and that the discharge planner had contacted adult protective services to assess the situation.

ASM #1 stated that when Resident #67 was discharged on 8/5/19 he was notified that the transport had arrived at the family's home and no one would answer the door. ASM #1 stated that he immediately had the discharge planners go to [Name of Hospital] to meet the transportation service to pick up the resident to bring her back to the facility safely. ASM #1 stated that he called the hospital to alert them what was happening and that the discharge planners were coming to meet Resident #67 to bring her back to the facility. ASM #1 stated that he contacted DMAS

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(Department of Medical Assistance Services) to forgo any further discharges and contacted the ombudsman. ASM #1 stated that Resident #67's family has continued to handle her funds and her account is two months behind currently. ASM #1 was asked if the discharge of Resident #67 on 8/5/19 to her family's home was safe when proper notice and confirmation that a caregiver would be at home when she arrived, since the resident required 24-hour care per therapy documentation, and the concerns voiced previously from the family regarding not wanting the resident to come home. ASM #1 stated that they sent her home because she wanted to go there. ASM #1 stated that the transport service would never leave anyone there alone. ASM #1 stated that Resident #67 stated that he understood that she had a key and knew the address of where she wanted to go. ASM #1 stated that he sees a lot of elderly people in their nineties living independently. ASM #1 stated that Resident #67 was out of the facility for probably less than two hours. ASM #1 stated that they have never had a situation like this before.

On 11/5/19 at 12:00 p.m., a telephone interview was conducted with OSM #16, APS (adult protective services). OSM #16 stated that OSM #12, the director of discharge planning had contacted him regarding applying for Medicaid on 7/18/19 and for a referral to set up discharge planning. OSM #16 stated that the family was directed to benefit staff to set up discharge planning or apply for Medicaid. When asked if the facility voiced any concerns for safe discharge for Resident #67, OSM #16 stated that it was his understanding that a discharge home was not an option but he did not remember specifically why. OSM #16 stated that resident screenings for safe discharge to home by APS are performed by the

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local department of social services offices and those assessments are initiated by the facility calling their APS office in the county they are located in. OSM #16 stated he was not located in the same county as the facility. OSM #16 stated that someone from the county that the facility is located in would have come to the facility to assess Resident #67 prior to the discharge date upon request. OSM #16 stated that the local ombudsman and benefits worker worked closely with the family to set up Medicaid for Resident #67.

On 11/5/19 at 2:00 p.m., OSM #12 stated that she spoke to APS in [Name of County] but she did not speak with anyone at the local social service office to discuss assessment of Resident #67 for safe discharge while she was still in the facility prior to the discharge on 8/5/19.

The facility policy "Notice of Transfer/Discharge, Effective Date 08/27/19" documented the following:
- "Policy: When the Center initiates a notice of transfer/discharge to a patient and/or responsible party the discharge planning staff will pursue timely and appropriate transfer/discharge notifications as well as discharge planning initiatives to ensure a safe and orderly discharge from the Center."

The facility document "Job Description and Performance Appraisal Discharge Planning Director, Date Revised: May 2011" documented in part, "Directs and supervises the discharge planning department within the framework of [Name of Facility]'s standards for best practices and in accordance with state and federal regulations. Coordinates and expedites patient

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discharge planning initiatives from the day of admission through the day of discharge. Provides all other comprehensive medically related social services identified and needed by the patients of the Center." Pages 2-4 documented in part, "Job Specific Duties- Initiates discharge planning upon admission and coordinates with the patient, the family and the interdisciplinary team, timely and effective plans for transitioning home or to an optimal care environment ...Assesses the patient's support systems and home situation to assist in decision-making regarding the patient's discharge plan and discharge needs ...Identifies and assists in the securing of the patient's medically related social service needs"

On 11/5/19 at 11:00 a.m., OSM #12 stated that she did not have anything to provide that would evidence written notification documenting the planned discharge date of 8/5/19 that was provided to Resident #67 or the family of Resident #67 for the discharge on 8/5/19.

On 11/5/19 at 10:45 a.m., an interview was conducted with OSM #12. When asked if she would consider the discharge of Resident #67 on 8/5/19 a safe discharge, OSM #12 stated that she did not think it was the smoothest discharge. OSM #12 stated that looking back now she would like to have included Resident #67 in the discharge meeting.

On 11/5/19 at approximately 5:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #3, the corporate nurse consultant and ASM #4, the assistant administrator were notified of the concerns.

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F 660	Continued From page 90 No further information was presented prior to exit. Complaint deficiency References: 1. 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. 2. Rheumatoid arthritis A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm. 3. Major depressive disorder Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm. 4. Macular degeneration A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. This information was obtained from the website: https://medlineplus.gov/maculardegeneration.html.	F 660		
F 684 SS=G	Quality of Care CFR(s): 483.25	F 684		11/22/19

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F 684	Continued From page 91 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to ensure that one of 52 sampled residents, (Resident #33) received timely treatment for a change in condition and injuries sustained from a fall. Resident #33 fell out of bed on 3/9/19 at approximately 7:30 p.m. A mobile right wrist x-ray was obtained and the results were reported to the facility staff on 3/10/19 at 12:35 a.m. The results of the x-ray concluded a fracture through the distal end of the radius and ulna (both lower arm bones). The facility staff failed to send Resident #33 immediately to the hospital for evaluation and treatment when the resident asked to see a physician and the physician on call failed to respond to calls regarding the x-ray results and the resident's pain management. Resident #33's injuries were not evaluated by a physician at the hospital, until 7:40 a.m., on 3/10/19, at which time, the resident was diagnosed with a fractured right fourth finger, a right wrist fracture that required closed reduction under procedural sedation, and a right knee abrasion measuring three centimeters that required four sutures.	F 684	Past noncompliance: no plan of correction required.	

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The findings include:

Resident #33 was admitted to the facility on 1/28/18. Resident #33's diagnoses included but were not limited to muscle weakness, chronic kidney disease and low back pain. Resident #33's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/27/19, coded the resident as being cognitively intact. Section G coded Resident #33 as requiring supervision with bed mobility and transfers. Section J coded the resident as not having sustained any falls since the prior assessment.

Resident #33's comprehensive care plan dated 1/29/18 and revised on 3/11/19 documented, "FALL: (Resident #33) has an actual fall and is at risk for falls r/t (related to) Deconditioning, episodes of incontinence." The care plan documented multiple interventions including but not limited to:
- Assistive Devices
-Anticipate and meet the resident's needs
-Assist with toileting as needed
-Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.
Staff reviewed and revised Resident #33's care plan, revealed after the fall on 3/9/19.

A nurse's note dated 3/9/19 documented, "Resident noted on the floor between her bed and the wall lying on her left side at about 19:30 (7:30 p.m.) this shift. On assessment, resident is alert and oriented x (times) 3. Resident stated she rolled out of bed while sleep. she (sic) c/o (complained of) pain to her right wrist and stated

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she thinks it is broken. Resident also noted to have a laceration on the back of her left hand, hematoma on her right wrist, swollen area on the back of her head, and an open area on her lip. resident (sic) assisted to bed by four staff. MD (Medical doctor) (name) notified who gave orders for treatment to left hand, Stat (immediate) X-ray and pain management with Tylenol. Treatment to left hand done as ordered. X-ray called in and resident medicated for pain. Resident's RP (responsible party) (name) always made aware of fall and injuries. Resident is resting in bed at moment."

Review of Resident #33's March 2019 MAR (medication administration record) revealed the resident was administered 500 milligrams of as needed Tylenol per physician's order on 3/9/19 at 7:46 p.m. for a pain level of ten and the medication was effective.

Further review of the resident's clinical record revealed physician's orders dated 3/9/19 for a stat [immediate] right wrist x-ray and to cleanse the left wrist skin tear and apply steri strips (medical tape used to close wounds).

A wrist x-ray result with an examination date of 3/9/19 at 7:57 p.m. and a reported date of 3/10/19 at 12:35 a.m. documented a slightly displaced angulated fracture through the distal end of the radius and ulna (both lower arm bones) with soft tissue swelling.

A nurse's note documented as a late entry, signed by RN (registered nurse) #1, dated 3/10/19, documented, "Patient had a fall on Saturday 03/092019 on 3-11 shift. An X-ray was ordered and performed between 11:00 pm

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(03/09/2019) and 00:00 am (12:00 a.m.) (03/10/2019) at about 0030 (12:30 a.m.), imaging faxed results indicating that patient had a right wrist and right ulnar fracture on (sic). Notified MD (medical doctor), (name of ASM [administrative staff member] #5) and patient about the results at 00:50 (12:50 a.m.) Around midnight, as I always do checked with patient about the need for stronger pain medication (she is on Tylenol prn [as needed]) as I gave Tylenol to her roommate. Patient declined Tylenol and said she would wait for a stronger pain medication. She did ask if she could be seen by a doctor and I told her that I will find out about what the doctor will says (sic) and a possibility to see a podiatrist as well and that she will get adback (sic). I notified MD about the need for a review of the pain management plan as the patient wanted a stronger pain medication. I rechecked her for pain when I notified her about the order for ER (emergency room) visit in the morning when I received the order to send her to the hospital and patient denied the need for Tylenol. At that time there was no new order for pain medication. When I came back for the 11-7 shift, the medication was supplied and as soon as I got it, I gave it to her crushed in apple sauce per her preference. This patient has a chronic back pain and I always check on her at midnight. about 3:00 am in the middle of the shift and in the morning to make sure her pain is controlled and she is aware of this."

Review of Resident #33's pain assessments revealed the following:
-3/9/19 at 7:44 p.m.: pain level 10
-3/9/19 at 8:10 p.m.: pain level 9
-3/9/19 at 9:25 p.m.: pain level 5
There were no further documented pain level assessments until after the resident's return from

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the hospital.

A nurse's note dated 7/10/19 at 10:46 a.m. documented Resident #33 had been sent to the ER (emergency room) but failed to document the specific time of the transfer.

A hospital history and physical dated 3/10/19 documented Resident #33 was received at the hospital on 3/10/19 at 7:36 a.m. The form documented, "98-year-old female with PMHx (past medical history) of arrives via EMS (emergency medical services) and presents with concerns of a fractured right wrist after falling out of bed last night around 8 or 9pm. Associated sx (symptoms) of right knee pain that is secondary to her fall. Her pain is described as constant and rated 10/10 in severity... 0841 (8:41 a.m.): Per nursing home, the patient fell last night around 8:40 pm. The nurses state they wanted to send the patient to ED (emergency department) but could not send the patient without the doctor's approval..."
The hospital documentation further documented Resident #33 presented with steri strips on a bruised left hand, a fractured right fourth finger, a right wrist fracture that required closed reduction under procedural sedation, and a right knee abrasion measuring three centimeters that required four sutures. Resident #33 was administered two milligrams of morphine via IV (intravenous) line while at the hospital and discharged back to the facility on 3/10/19.
(Note: review of Resident #33's nursing facility clinical record failed to reveal any documentation regarding an injury to the resident's right knee).

On 11/4/19 at 8:58 a.m., an interview was conducted with Resident #33. The resident was

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sitting in a wheelchair in her room. The resident's right wrist bone was observed as being deformed (bulging out from the wrist area) and the resident reported she cannot write as good as she used to. Resident #33 was asked to describe what she could remember about the night she fell out of bed on 3/9/19. Resident #33 stated she thought she fell out of bed between 10:00 p.m. and 12:00 a.m. and an x-ray was obtained but she did not go to the hospital until the next morning. Resident #33 was asked to describe her pain after she fell and stated, "It was pretty bad. I was crying and bleeding from my head and face." Resident #33 was asked what the facility staff did to assist her and stated, "I don't remember but they let me lie there; a lot of nurses standing over me. After a while, they picked me up and put me back to bed. I'm sure they gave me pain pills 'cause I was hollering because I was hurting." Resident #33 stated she begged staff to take her to the hospital and the staff said help was on the way. Resident #33 stated the pain pill did help her pain and she fell asleep. When asked to rate her pain, Resident #33 stated her pain was a seven or eight when she fell and probably a five or six shortly before she was transferred to the hospital.

On 11/4/19 at 10:19 a.m., a phone interview was attempted with the CNA (certified nursing assistant) who cared for Resident #33 during the evening on 3/9/19. The CNA did not answer the phone.

On 11/4/19 at 10:51 a.m., a phone interview was conducted with CNA #1 (the CNA who cared for Resident #33 during the night of 3/9/19 into 3/10/19). CNA #1 was asked to describe Resident #33's condition after she fell on 3/9/19.

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CNA #1 stated she could not recall much information but she had to assist Resident #33 with the bed pan and put briefs on the resident during the night on 3/9/19 into 3/10/19 because the resident was too weak to walk to the bathroom. CNA #1 stated she also remembered the resident's arm being very swollen and on a pillow throughout the night.

On 11/4/29 at 11:04 a.m., a phone interview was conducted with LPN (licensed practical nurse) #3 (the nurse who cared for Resident #33 when she fell on 3/9/19). LPN #3 stated she recalled the fall but did not recall any further details.

On 11/4/19 at 11:15 a.m., a phone interview was attempted with RN (registered nurse) #1 (the nurse who cared for Resident #33 during the night of 3/9/19 into 3/10/19). RN #1 did not answer the phone.

On 11/4/19 at 2:30 p.m., an interview was conducted with LPN #4 (unit manager). LPN #4 stated she was not in the facility the day Resident #33 fell or the next day. LPN #4 stated she reviewed Resident #33's chart and from what she read, Resident #33 was assessed after she fell and complained of pain to her right wrist. The nurse gave her as needed Tylenol, the doctor was notified, and ordered a stat [immediate] x-ray and the x-ray was completed between 11:00 p.m. and 12:00 a.m. then the doctor was notified of a positive fracture around 12:30 a.m. and the nurses received orders to send Resident #33 to the emergency room in the morning. LPN #4 was asked why Resident #33 was not sent to the hospital until the following morning on 3/10/19 when she had requested to be sent. LPN #4 stated Resident #33 denied Tylenol during the

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night and when Resident #33 was sent to the hospital, she did not require surgery. LPN #4 stated the resident was later evaluated by an orthopedist and she did not require surgery, only splint management, repositioning and stronger pain medication. When asked again, why Resident #33 was not sent to the hospital until the morning of 3/10/19, LPN #4 stated she could not fully speak to the situation but staff monitored Resident #33 during the night, managed her pain, the resident's representative was made aware of the situation and the resident slept during the night. When was asked what time Resident #33 was sent to the hospital, LPN #4 stated she thought the resident was transferred around 6:05 a.m. on 3/10/19.

On 11/4/19 at 5:00 p.m., a phone interview was conducted with ASM (administrative staff member) #5 (Resident #33's physician and the on-call physician for the night of 3/9/19 into 3/10/19). ASM #5 stated he did not remember details but most likely, the nurse called and left him a voicemail at 1:00 a.m. or 1:30 a.m. on 3/10/19. ASM #5 stated he received the voicemail around 6:00 a.m. and said to send Resident #33 to the hospital. ASM #5 stated there was no reason for him to keep the resident sitting around for several hours, especially with a fracture. When asked what the nurses should do if he does not answer his phone, ASM #5 stated this rarely happens and he usually answers his phone. When asked if staff are allowed to obtain medical treatment if he cannot be reached, ASM #5 stated, "Yeah." When asked if nurses can send a resident to the hospital if a resident requests to go, ASM #5 stated, "Yes." ASM #5 stated the goal is to do what is best for the patient.

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On 11/4/19 at 5:43 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated she was made aware of Resident #3's fracture after the resident had been sent to the hospital.

On 11/4/19 at 6:31 p.m., ASM #1 (the administrator), ASM #2, ASM #3 (the corporate nurse consultant) and ASM #4 (the assistant administrator) were made aware of the above concern and the concern for harm. ASM #2 stated she had further information to present.

On 11/5/19 at 7:44 a.m., a phone interview was conducted with RN #1 (the nurse caring for Resident #33 during the night of 3/9/19 into 3/10/19). RN #1 stated he arrived at the facility at 11:00 p.m. on 3/9/19. RN #1 stated he obtained shift report and then went straight to Resident #33's room because he had received information that the resident had sustained a fall. RN #1 stated he completed an assessment and Resident #33's mental status was intact. RN #1 stated the resident was due for Tylenol at midnight and the resident said she was not in extreme pain and did not want to take Tylenol. RN #1 stated Resident #33 was in bed and rated her pain between a three and a four. RN #1 was read the portion of his note that documented, "Patient declined Tylenol and said she would wait for a stronger pain medication." RN #1 stated if he could correctly remember, the physician put in an order for oxycodone but the strength was not available and the pharmacy had not delivered the medication. RN #1 was made aware that per the clinical record review, the only pain medication ordered on the night of 3/9/19 into 3/10/19 was

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Tylenol and oxycodone was not ordered until the resident's return from the hospital. RN #1 stated he asked Resident #33 if she was used to narcotics and the resident was not showing any overt signs of pain. RN #1 stated he completed rounds and assessed Resident #33 for pain every two hours. RN #1 stated during his rounds, the resident was asleep and that was a sign that the pain was not excruciating. RN #1 was asked what was done when the right wrist x-ray results were reported to him. RN #1 stated he called ASM #5 and received no response so he left a voicemail. RN #1 stated he applied his critical judgement so he continued to assess Resident #33 and make sure she was comfortable. RN #1 stated he did not see any critical signs or changes that would urge him to do anything besides continuing to assess and making sure the resident was comfortable. RN #1 stated he assessed Resident #33's mental status, breathing, pain and circulation. RN #1 stated the resident did not present with any numbness, tingling or bleeding. RN #1 stated he saw a skin tear covered with a dressing on one of the resident's arms. RN #1 was asked if Resident #33 presented with any injury to her right knee. RN #1 stated he did not recall any injury to the knee. RN #1 stated he assessed all of Resident #33's extremities and there was no swelling, or bleeding. Nothing that would warrant any clinical change to demonstrate the need to send the resident to the hospital. RN #1 was asked if a resident request to see a doctor and a fractured arm warranted a transfer to the hospital. RN #1 stated this depended on the effect of the fracture. RN #1 stated that as a nurse, he knows that a fracture can warrant a hospital transfer but in some other situations does not warrant a hospital transfer. RN #1 stated if the fracture was open

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then this could cause a blood clot and would warrant a hospital transfer. RN #1 stated Resident #33 did not have an open fracture and he made sure the resident did not have chest pain, tingling or numbness. RN #1 stated if he had seen those kind of signs then he would have called 911 right away. RN #1 stated that from his clinical judgement, there was no clinical change and Resident #33's pain was controlled so he did not send the resident to the hospital. RN #1 was asked if he explained to Resident #33 that he called the physician and the physician did not answer the phone. RN #1 stated he updated the resident about the progress of her care and let her know that a doctor would be able to see her some time. RN #1 stated Resident #33 was okay and very happy that the doctor would be able to see her some time. RN #1 was read the portion of his note that documented, "I notified MD about the need for a review of the pain management plan as the patient wanted a stronger pain medication" and asked was asked to explain. RN #1 stated sometime in the middle of the night, he called the doctor as soon as Resident #33 verbalized pain. RN #1 stated the doctor did not answer the phone so he continued to monitor the resident's pain. RN #1 was asked if he notified anyone else besides the physician about Resident #33's right wrist x-ray. RN #1 stated he does not necessarily call the director of nursing or manager regarding x-ray results but he would have called if he had found a clinical change. RN #1 could not recall if he called anyone else. RN #1 was asked what prompted Resident #33's transfer to the hospital during the morning on 3/10/19. RN #1 stated he thought the physician called back around 6:00 a.m. RN #1 was asked what the physician stated when he called. RN #1 stated, "I don't remember his message but he did

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invite to send her for a further exam." When asked to clarify if that meant to send the resident to the hospital, RN #1 stated, "Yeah. For further exam. I did all arrangements." When asked what Resident #33's pain level was when the resident was transferred to the hospital, RN #1 stated the resident did not complain of pain or ask for pain medication. RN #1 stated he did his best to offer his care in the conditions he was working in.

On 11/5/19 at 8:21 a.m., an interview was conducted with LPN #5. LPN #5 was asked what should be done if a resident falls and an x-ray confirms a fracture. LPN #5 stated, "Notify the doctor first, make sure non-pharmacological interventions should be in place and they are comfortable and manage their pain." LPN #5 was asked what should be done if the nurse calls the doctor and he doesn't answer the phone. LPN #5 stated, "We are going to send the patient out, notify the responsible party and get the patient over to the hospital." LPN #5 was asked if the resident should be transferred to the hospital if the nurse can't reach the doctor and the resident does not present with any other significant clinical changes besides the x-ray. LPN #5 stated, "Yes. I feel that is an emergent situation and something where a fracture is confirmed by x-ray. If we can't get ahold of the doctor, we should send them out to make sure more measures are taken and so they are not in pain. I still feel like they need to be sent out whether they are showing changes or not; that it needs to be followed up by a physician; the best possible situation for the patient. We still need to follow up with a physician and not wait until the morning. I would communicate with the managers. We have a manager on call, and make sure the rp (responsible party) is aware."

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F 684	Continued From page 103 On 11/5/19 at 9:59 a.m., another interview was conducted with ASM #2. ASM #2 confirmed residents who present with a positive fracture from an x-ray should be transferred to the hospital if the physician does not answer the phone. ASM #2 stated staff had been education regarding this matter and she had further information to provide. On 11/5/19 at 10:20 a.m., ASM #2 presented an action plan that documented, In addition to the performance improvement plan on fall, there is the need to further strengthened (sic) staff intervention during off-shift for falls with injury requiring medical intervention within or outside of the facility. An example of the above was noted on 3/9/2019 for a patient with a fracture during an off-shift, who was subsequently transferred out to the ER the next day shift for further evaluation. Consequent to the above, there appears to have been staff rigidity in the interpretation of them requiring doctor's order for patient transfer to the ER. As a result of the above, the following action will be implemented. 1. Review post-fall intervention process with the staff, particularly when there is a potential presentation of an injury. 2. Review ER transfer with the nursing staff s/p (status post) fall during off-shift to include; action taken when unable to reach the MD/NP (nurse practitioner), and management of post fall positive radiology for a fracture. 3. Review with staff pain management for patient with fall related injury to include both pharmacological and non-pharmacological interventions. 4. Review all subsequent post fall interventions during the fall committee meeting to ensure	F 684		

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F 684	Continued From page 104 adequate management of fall related change of condition. 5. Date of compliance 3/15/2019." An in-services completed with the facility nurses on 3/11/19 documented, If a patient/resident falls and diagnostic testing indicates a fracture is present, notify MD or NP immediately. If you do not get a response from the MD or NP on call, send the patient/resident to the hospital as soon as possible. When MD or NP returns your call make them aware of transfer to the hospital for fall with fracture. Use pharmalogical and non-pharmalogical interventions to make patient/resident comfortable until transport to hospital arrives. Notify responsible party if applicable." The action plan was verified onsite. The survey team conducted interviews with random nurses, a total of eight, on all three shifts. All staff interviewed were able to state the above information. Review of all documentation of the in-services including staff signatures was completed. Review of documentation weekly monitoring by facility staff was completed and confirmed. Review of all other residents failed to reveal any residents that were not provided timely treatment for injuries. No further information was presented prior to exit. COMPLAINT DEFICENCY PAST NON-COMPLIANCE	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		11/27/19

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F 690	Continued From page 105 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to	F 690	1. Resident #47 foley catheter tubing and drainage bag was changed on 11/03/2019. Resident care plan updated	

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F 690	Continued From page 106 provide appropriate treatment and services to prevent urinary tract infections with the use of a Foley catheter for one of 52 residents in the survey sample; Resident #47. During multiple observations on 11/3/19, Resident #47's Foley catheter tubing was observed in direct contact with the floor. The findings include: Resident #47 was admitted to the facility on 5/17/19. Diagnoses include but are not limited to, chronic kidney disease, obstructive uropathy, renal cyst, edema, high blood pressure, congestive heart failure, and benign prostatic hyperplasia. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/4/19 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, dressing, toileting and transfers; limited assistance for hygiene; supervision for eating; and was incontinent of bowel and had an indwelling catheter for bladder (1). A review of the clinical record revealed an order dated 10/31/19 for Bactrim DS (2) 800/160 mg (milligrams) twice daily for 10 days for a UTI (urinary tract infection). Further review revealed a nurse's note dated 11/3/19 at 4:02 PM that documented the resident was having complaints of abdominal pain with a blood pressure of 208/94, a pulse of 115, a respiratory rate of 18, and a temperature of 97.6. A nurse's note dated 11/3/19 at 8:08 PM documented that the resident was having	F 690	on 11/21/2019 to reflect intervention to maintain foley drainage bag and catheter tubing from direct contact with floor. 2. DON/ADON/Unit Managers to audit all current residents with foley catheters to ensure catheter bag/tubing is not touching the floor and interventions included in care plan to maintain drainage bag and tubing from coming in direct contact with floor are active. Any noted variances will be corrected immediately through changing of catheter system, notification of MD and instantaneous update to care plan. 3. SDC/Designee will complete an in-service with the nurses/CNA on the following topics: a) Foley catheter tubing and drainage bag maintenance to include ensuring catheter system remains off floor and interventions available. b) Adequate follow-up and timely response required when determination of contamination to catheter system has occurred. 4. DON/ADON/Unit Managers will complete an audit of all foley catheters weekly x1 month and monthly x3 months to assure that catheter systems remain without contamination from direct contact with floor. Any anomaly noted will be rectified immediately as per MD order and forwarded to the QAPI committee for further review and recommendation. 5. Date of compliance: 11/27/2019	

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hematuria (blood in the urine), a blood pressure of 208/90 and a temperature of 97.9. In addition, the note also documented that the resident's "temp [temperature] spiked" but the temperature was not documented. The note documented that the physician and family were called and the resident was to be sent to the hospital.

A nurse's note dated 11/3/19 at 10:33 PM documented that the resident was admitted to the hospital for sepsis (3).

On 11/03/19 at 1:58 PM, an observation was made of Resident #47. He was up in his wheel chair with the Foley catheter observed in place. The Foley catheter tubing was observed directly on the floor and blood was noted in the tubing. Resident #47 was observed wheeling himself to the doorway of his room, and positioning his wheel chair in the doorway. At this time, the following was observed:

On 11/03/19 at 2:04 PM, CNA #2 (Certified Nursing Assistant) spoke with resident, and did not address the Foley catheter tubing on the floor.

On 11/03/19 at 2:07 PM, ASM #4 (Administrative Staff Member, the Assistant Administrator) was noted speaking to the resident.

On 11/03/19 at 2:09 PM, CNA #3 went around Resident #47 into his room, and quickly left the room after obtaining a water pitcher. She did not address the Foley catheter tubing on the floor.

On 11/03/19 at 2:10 PM, CNA #2 was again speaking to the resident. The conversation was about the catheter potentially leaking. CNA #2 did not address the Foley Catheter tubing on the

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floor.

On 11/03/19 at 2:10 PM, LPN #6 (Licensed Practical Nurse) was observed stopping and speaking to the resident. The catheter was discussed, regarding if it was potentially leaking. LPN #6 did not address the Foley catheter tubing on the floor. LPN #6 then went into another room.

On 11/3/19 at 2:17 PM, CNA #3 returned with the water pitcher, went around Resident #47 into his room put the pitcher in his room and then came out of the room. CNA #3 did not address the Foley catheter tubing on the floor.

On 11/4/19 at various times, Resident #47's room was observed and the resident was not in the room. At 4:49 PM, after not having been able to observe the resident all day, LPN #7, the unit manager, was asked about the location of Resident #47. LPN #7 stated that Resident #47 was discharged to the hospital on 11/3/19 at about 6:30-7:00 PM, (approximately 5 hours after the above observations) and admitted to hospital for urosepsis (4). She stated that his blood pressure went up, he had some blood in catheter, the catheter was changed, and flushed, and there was no improvement, and the resident spiked a temperature.

On 11/5/19 at 8:45 AM, an interview was conducted with CNA #6, regarding how to maintain a Foley catheter tubing. CNA #6 stated that it (Foley catheter tubing) should be off the floor. CNA #6 stated that there are Velcro straps used to hold the tubing up in place to the wheel chair so it does not drag the floor. When asked, what staff should do if they see Foley catheter

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tubing dragging on the floor, CNA #6 stated clean it with Sani-wipes and pull it up off the floor.

On 11/5/19 at 9:35 AM in an interview with LPN (licensed practical nurse) #2, regarding how Foley catheter tubing is maintained. LPN #2 stated that it is to be maintain off the floor. She stated that if it is on the floor, clean it and reposition it off the floor.

On 11/5/19 at 9:37 AM in an interview with LPN #7. When informed of the above observations and asked how a Foley catheter tubing should be maintained, LPN #7 stated off the floor. When asked if Foley catheter tubing directly on the floor could contribute to a UTI. LPN #7, yes it can and stated the staff needs re-education. LPN #7 stated Resident #47 was already under treatment for a UTI (urinary tract infection) at the time of the above observations and was admitted to the hospital for urosepsis.

A review of the comprehensive care plan revealed one for the use of the Foley catheter dated 5/17/19 but it did not include any interventions for maintaining the catheter tubing off the floor.

A review of the facility policy that was provided, "Urinary/Catheter Care" did not include any criteria for maintaining any part of the catheter system off of the floor.

According to Lippincott Manual of Nursing Practice, Eighth Edition 2006, chapter 21, Renal and Urinary Disorders, page 757, "Maintaining a Closed Urinary Drainage System: Many UTI's are due to extrinsically acquired organisms transmitted by cross-contamination. 2. c. Keep

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the drainage bag off the floor to prevent bacterial contamination".

On 11/5/19 at 3:00 PM, ASM #1 the Administrator, #4 the Assistant Administrator, and #3 the corporate nurse consultant, were made aware of the findings. No further information was provided by the end of the survey.

References

(1) Foley catheter - According to Mosby's Dictionary of Medicine, Nursing & Health Professions 7TH Edition, 2006; Mosby Inc; Page 754. A Foley catheter is "a rubber catheter with a balloon tip to be filled with a sterile liquid after it has been placed in the bladder. This kind of catheter is used when continuous drainage of the bladder is desired ..."

(2) Bactrim - is used to treat certain bacterial infections.
Information obtained from https://medlineplus.gov/druginfo/meds/a684026.html

(3) Sepsis - 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.
Information obtained from https://medlineplus.gov/sepsis.html

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F 690	Continued From page 111 (4) Urosepsis - sepsis in the urinary tract. Information obtained from https://medlineplus.gov/ency/article/000666.htm	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 ensure a complete pain management program for one of 52 residents in the survey sample, Residents #38. The facility staff failed to provide further intervention and treatment for Resident #38 when the resident's pain was not relieved by as needed Tylenol. The findings include: Resident #38 was admitted to the facility on 10/28/18. Resident #38's diagnoses included but were not limited to urinary tract infection, major depressive disorder and difficulty swallowing. Resident #38's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/26/19, coded the resident's cognition as severely impaired. Section J documented Resident #38 reported no pain. Review of Resident #38's clinical record revealed	F 697	1. Review of Resident #38 progress notes show no additional occurrences of ineffective pain management as Resident #38 has demonstrated adequate pain management/relief since 11/05/2019 2. The DON/ADON completed a three-day audit (11/05/2019-11/07/2019) of documentation for administration and follow-up on ineffective pain management regimen. No resident was found to have reported an ineffective pain management without adequate intervention 3. Staff Development Coordinator/Nursing Leadership to provide an in-service to all CNAs and Charge nurses on the following topics: c) CNA to report complaints of pain to charge nurse for follow-up d) Management of pain not relieved by current pharmacological pain intervention. 4. DON/ADON or designee to complete pain management audit weekly x1 month and monthly x3 months to ascertain that	11/27/19

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F 697	Continued From page 112 a nurse's note dated 7/7/19 at 7:27 p.m. that documented the resident was administered two tablets of as needed Tylenol 325 milligrams per physician's order for head and nose pain rated as a five (on a scale from zero to ten). A nurse's note dated 7/7/19 at 8:09 p.m. documented the Tylenol was ineffective and failed to document the physician was notified or the ineffectiveness of the Tylenol was addressed. A pain level assessment dated 7/7/19 at 8:09 p.m. documented Resident #38's pain as an eight. A nurse's note dated 7/8/19 at 3:04 a.m. documented Resident #38 was administered two tablets of as needed Tylenol 325 milligrams per physician's order for pain. A pain level assessment dated 7/8/19 at 3:04 a.m. documented Resident #38's pain as a ten. A nurse's note dated 7/8/19 at 3:45 a.m. documented the Tylenol was ineffective and the resident continued with intermittent moaning. The note failed to document the physician was notified or the ineffectiveness of the Tylenol was addressed. (Note- a pain assessment dated 7/8/19 at 10:26 a.m. documented the resident's pain level as a one). Resident #38's comprehensive care plan dated 10/29/18 documented, "PAIN: (Resident #38) is at risk for pain. Notify MD (medical doctor) for pain not relieved with medication or with new complaints of pain..." On 11/4/19 at 5:07 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the nurse who administered Tylenol to Resident #38 on 7/7/19 at 7:27 p.m.). LPN #1 was asked what should be done if a resident is given Tylenol for pain and the Tylenol is not effective. LPN #1 stated, "Contact the doctor and see if he wants to administer something stronger." LPN #1 was	F 697	residents are receiving effective pain management regimen with appropriate follow-up and interventions when not effective accordingly. Any noncompliance to the above-stated standard will be rectified immediately and further forwarded to the QAPI committee for review and recommendation. 5. Date of compliance: 11/27/2019	

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F 697	Continued From page 113 informed of the above concern. LPN #1 stated, "It looks like the night nurse that took over my cart didn't do anything with her pain rating being an eight as a follow up." The nurse who documented the Tylenol was ineffective on 7/7/19 at 8:09 p.m., administered Tylenol on 7/8/19 at 3:04 a.m. and documented the Tylenol was ineffective on 7/8/19 at 3:45 a.m. was not available for interview. On 11/5/19 at 9:59 a.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above concern. On 11/5/19 at 2:19 p.m., ASM #1 (the administrator) and ASM #3 (the corporate nurse consultant) were made aware of the above concern. The facility, pain management policy documented, "3. Administration of pain medication and effectiveness will be documented...5. If pain is not relieved, notify physician. Any unusual findings and follow-up interventions are to be documented on the Progress Notes including notification of physician and responsible party..." No further information was presented prior to exit.	F 697		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 745		11/27/19

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F 745	Continued From page 114 Based on resident interview, staff interview, agency interviews, clinical record review and facility document review and in the course of complaint investigation it was determined that the facility staff failed to provide medically-related social services related to discharge planning for a safe facility initiated discharge for one of 52 residents in the survey sample, Resident #67 on 8/5/2019. The facility staff discharged Resident #67 while the residents Medicaid was pending to her grandson's home on 8/5/19, despite the grandson informing the facility he could not care for Resident #67 anymore. Without notification of the 8/5/19 discharge, to the resident, or residents family, without obtaining home health services and without ensuring a caregiver would be present to provide 24 hour care as documented and recommended by physical and occupational therapy. The findings include: Resident #67 was admitted to the facility on 06/13/2019 with diagnoses that included but were not limited to dementia (1), rheumatoid arthritis (2), major depressive disorder (3), and macular degeneration (4). Resident #67's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/20/19, coded Resident #67 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired for making daily decisions. Review of the clinical record revealed the care plan "Discharge planning: [Name of Resident] preference for discharge is: to d/c (discharge)	F 745	1. Resident #67 was returned to the Center by Discharge Planning on the same date of attempted discharge on 8/5/2019. Post return assessment on 8/5/2019 revealed no presentation of change in patient condition from the baseline. Resident #67 continue to safely reside at the Center. 2. Discharge Planning Department staff to review all discharged patients in the last 30 days (starting 10/21/2019 to 11/21/2019) to be certain that all discharge patients were adequately notified, that there were no pending Medicaid applications at time of discharge, and that there were provisions made for home health services/care givers as applicable. Any anomaly noted will be used as a learning experience for future discharges. 3. Administrator/Designee will complete an in-service to all Discharge Planning staff on the following topics f) Patient discharge notification g) Managing pending medication application for patients who are due to be discharged h) Managing patient discharge needing home health services/care giver i) Inter-departmental team care coordination on pending patient discharge 4. Discharge Planning Director/Designee will audit all pending facility-initiated discharges weekly x1 month and monthly x3 months to ascertain that proper notification were given, result of pending Medicaid applications were established, and applicable home health services/care givers provision were catered. Any	

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F 745	Continued From page 115 home with grandson. Created on: 06/21/2019. Revision on 06/21/2019." The nurses' progress notes documented the following: - "8/5/2019 09:05 (9:05 a.m.), Pt (patient) discharged, skin clean, dry and intact. let [sic] facility via wheelchair. No, complain of pain. She was provided with medications and discharged instructions." - "8/5/2019 14:41 (2:41 p.m.), an admission assessment has been completed. See the assessment for details. The Resident arrived from Own Home. The reason for the admission per the resident/POA (power of attorney) is family is unable to provide care for resident at this time." Further review of the clinical record revealed "Discharge planning progress notes; Effective Date 8/20/2019 14:35 (2:35 p.m.)." The note documented the following "late entry: Discharge Meeting held with family on July 18, 2019. Present: [Name of granddaughter], granddaughter; [Name of grandson] and wife, grandson and granddaughter-in-law; [Name of discharge planner]; [Name of occupational therapist], therapy and [Name of physical therapist], therapy. Meeting was held to discuss therapy progress and upcoming discharge due to a plateau in therapy progress being made. Although there is no discharge date at this time, the facility wanted to make the family is aware that patient is not progressing as much as previously so they can prepare to bring her back to live with the grandson. During that point in the conversation the grandson and his wife stated that they have been taking care of the patient in their home for seven years and were no longer able to do so as the wife was starting a new job.	F 745	anomaly noted will be rectified accordingly and then forwarded to the QAPI committee for further review and recommendation 5. Date of compliance: 11/27/2019	

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DDP (Director of discharge planning) asked the family what the plan was and the family all responded that they will keep the patient here. I explained that the patient does not have a payor source and will need to apply for Medicaid asap (as soon as possible). DDP also explained that the Medicaid decision can take up to 45 days and that they (the family) would have to make arrangements for the patient during the decision making process as we do not accept Medicaid pending as a payment. The family became visibly upset and the grandson's wife started yelling at DDP stating that the patient is taking too much of a toll on the grandson and they were just not going to pick her up. The DDP then asked the family, "Are you saying that you are refusing to pick [First Name of Resident #67] up?" The family responded yes. The DDP explained that they must come together to make a safe decision for the patient. The DDP did explain that the patient can stay here after therapy discharge as a private pay resident of $245/day. The family stated that she did not have the money to pay privately and that she had bills to pay. After the meeting, the DDP assisted the family with the Medicaid application and faxed it to [Name of County Department of Social Services]. The fax did not go through that day and was faxed again on July 19, 2019."

The document "Physical Therapy Discharge Summary" dated "8/2/2019 06:00:44 PM EST (6:00 p.m.)" documented in part, "Patient was seen for 10 day(s) during the 7/19/2019-7/30/2019 progress period"; "Discharge Recommendations: Home health services, Remove throw rugs, Remove environmental barriers, Assistive device for safe functional mobility, Elevated toilet seat/3 in 1

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commode (a bedside commode), grab bars (devices used to assist in getting up and down and balance), assistance with IADLs (Instrumental activities of daily living, examples include laundry, shopping, using the telephone), 24 hour care, gel cushion and Walker basket/tray/bag, wheelchair for community mobility, HEP (Home exercise program)."

The document "Occupational Therapy Discharge Summary" dated "8/9/2019 06:43:29 PM EST (6:43 p.m.)" documented in part, "Patient was seen for 4 day(s) during the 7/30/219-8/4/2019 progress period."; "Discharge Recommendations: 24 hour supervision, assistance with ADLs (Activities of daily living) as needed related to SOB (shortness of breath) or c/o (complaints of) knee pain, RW (Rolling walker), w/c (wheelchair) for long distances or community. BSC (bedside commode) during the night, hand rails and grabbers (device used to pick up items)."

On 11/4/19 at 9:10 a.m., a telephone interview was conducted with OSM (other staff member) #8, driver for [Name of transportation service]. When asked about the discharge of Resident #67 on 8/5/19 OSM #8 stated that she remembered it well. OSM #8 stated that Resident #67 was scheduled to be picked up by transportation for discharge home at 8:00 a.m. on 8/5/19. OSM #8 stated that one of the discharge planners at the facility arranged the transportation. OSM #8 stated that when Resident #67 was brought into the main lobby in her wheelchair the morning of 8/5/19 she resisted the staff and was asking where she was going. OSM #8 stated that they were delayed in the lobby for approximately 30 to 45 minutes due to Resident #67 being hesitant about leaving and not knowing what was

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happening. OSM #8 stated that OSM #11, the discharge-planning assistant was in the lobby with her, two CNA's (certified nursing assistants) that she did not know and Resident #67. OSM #8 stated that OSM #11 went into her office to call Resident #67's grandson, returned and stated that he did not answer but stated that Resident #67's grandson was going to be waiting for her at the home. OSM #11 stated that the CNA's boarded Resident #67 into the van and she drove her to the address provided by OSM #11, the discharge planner. OSM #11 stated that when they arrived to the location there were no cars in the driveway and it appeared that no one was home. OSM #8 stated that Resident #67 provided her with a phone number for her grandson, which she called. OSM #8 stated that Resident #67's grandson was very upset when he found out that she was being discharged and told OSM #8 not to take her from the facility. OSM #8 stated that she was afraid because he was so angry and threatening. OSM #8 stated that she felt as if she had been caught in the middle of something between the facility and the family that she did not know about. OSM #8 stated that the cell phone reception was very spotty, GPS (global positioning system) would not pick up any signal in the area and that some calls would not go through in the area. OSM #8 stated that she attempted to call the facility 12 to 13 times without success. OSM #8 stated that she left the home with Resident #67 in the van and started driving back to get phone service. OSM #8 contacted the facility when she was able to get her location and phone service and it was arranged to meet at [Name of Hospital]. When asked to describe Resident #67 during this time OSM #8 stated that Resident #67 was very upset. OSM #8 stated that Resident #67 was emotional and tearful,

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saying that she just wanted to go home. OSM #8 stated that she arrived at [Name of Hospital] at approximately 11:45 a.m. on 8/5/19. OSM #8 stated that she assisted Resident #67 out of the van and into the emergency room lobby to wait for facility staff and to use the restroom. OSM #8 stated that when she brought Resident #67 out of the restroom OSM #11 and OSM #12, the director of discharge planning were waiting for them. OSM #8 stated that OSM #12 asked her if she could take Resident #67 to [Name of another City] to another facility while OSM #11 was on her phone attempting to set up placement at the other facility for Resident #67. OSM #8 stated that she respectfully declined to transport Resident #67 to [Name of another City] after the hours she had spent in the van that morning and anxiety Resident #67 had encountered.

On 11/4/19 at approximately 5:20 p.m., an interview was conducted with OSM #7, occupational therapist. When asked if she was present during the discharge meeting for Resident #67 on 7/18/19 OSM #7 stated that she was present. OSM #7 stated that Resident #67's grandson, granddaughter and grandson's wife were at the meeting as well. When asked if Resident #67's family discussed not feeling that discharge was safe. OSM #7 stated that the family got upset when discharge was discussed. OSM #7 stated, "They did get upset, but more along the lines that they did not want to provide the care. Not that they weren't already doing it before and couldn't continue doing it, just didn't appear to want to." OSM #7 stated that the facility discharge planner reviewed the discharge process with the family and what would be required but she did not remember the specifics. OSM #7 stated that the family questioned what

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would happen if they did not pick the resident up for discharge and leave her at the facility. OSM #7 stated that she did not remember exactly what was discussed with the family but she remembered that the discharge planner mentioned discussing a referral to APS (adult protective services).

On 11/4/19 at approximately 4:40 p.m., an interview was conducted with OSM #3, the ombudsman. When asked about Resident #67's discharge on 8/5/19 OSM #3 stated that the family contacted her after the discharge because Resident #67's Medicare skilled days had run out and the facility told the family that they did not accept Medicaid pending. OSM #3 stated that they also contacted her regarding Resident #67 being sent home on 8/5/19 without thirty-day notice after the family had expressed concerns for providing care for her at the home. OSM #3 stated that the family was applying for Medicaid for Resident #67 and needed to supply additional documentation. OSM #3 stated that Resident #67's grandson provided her with two invoices from the facility. OSM #3 stated that the invoices appeared to display the private pay rate for the month and the following month requested payment up front. OSM #3 stated that she explained to the facility staff that Resident #67 had applied for Medicaid and that there were no concerns that it would not be approved. OSM #3 stated that she explained to the facility staff that after the Medicaid was approved the facility would be paid for the care of Resident #67 retrospectively. OSM #3 stated that she voiced concerns on behalf of the family in addition to the family voicing their concerns that Resident #67 should not be discharged due to the family being unable to care for her. OSM #3 stated that her

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concerns were that Resident #67 and Resident #67's responsible party were not given proper notice of discharge, that Resident #67 was sent home with a Medicaid pending status and that Resident #67 was discharged home without the ability to get in her home. OSM #3 stated that Resident #67 was out of the facility for hours with unknown access to water, food and restroom causing undue anxiety and stress.

On 11/5/19 at approximately 9:25 a.m., an interview was conducted with OSM #12, the director of discharge planning and OSM #11, the discharge-planning assistant regarding the discharge of Resident #67 on 8/5/19. OSM #12 stated that a discharge meeting was held with Resident #67's family members on 7/18/19 to discuss the end of therapy and plan to discharge her to her grandson's home soon. When asked if Resident #67 was invited to her discharge-planning meeting on 7/18/19, OSM #12 stated that Resident #67 was not invited to the discharge-planning meeting because the family had requested that she not attend. OSM #12 stated that when discharging Resident #67 was discussed with the family members in the meeting the family mentioned on multiple occasions, "What if we don't pick her up? What if we just leave her here?" OSM #12 stated that immediately after the discharge meeting she assisted the family to apply for Medicaid.

OSM #12 stated that she had discussed what was mentioned in the discharge meeting regarding leaving her in the facility with Resident #67 and she stated that she still wanted to go back to her grandson's home where she was living prior to coming to the facility. OSM #12 stated that she then arranged for discharge and

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transportation for Resident #67 to the grandson's home. OSM #12 stated that attempts were made to contact Resident #67's grandson but they were not answering calls from the facility. OSM #12 stated that written notice of the discharge date was sent to the family members by the business office.

OSM #11, discharge-planning assistant stated that Resident #67 was discharged with a walker and a wheelchair on 8/5/19 and she set up home delivery for a bedside commode as directed on the recommendations from the occupational and physical therapy discharge recommendations. When asked if home health was set up as directed on the occupational and physical therapy discharge recommendations, OSM #11 stated that it was not. When asked if Resident #67's discharge was safe, if they failed to confirm a caregiver is at home to receive the resident and provide 24 hour care as directed on the occupational and physical therapy discharge recommendations, OSM #11 stated that on the morning of 8/5/19 prior to Resident #67 leaving the facility, she left a message for the family of Resident #67 to let them know that she was being discharged and on the way home. OSM #11 stated that Resident #67 was made aware that she had not talked with anyone at the home. OSM #11 stated that Resident #67 stated that she had a key to the house and that it was fine. OSM #11 stated that she did not ask to see the key. OSM #12 stated that on 8/5/19 when Resident #67 was discharged, she was taken to her grandson's home where she had lived prior to the facility but no one would answer the door to let her in so the van driver contacted them [the facility]. When asked why Resident #67 did not use her key to get in, OSM #12 stated the van

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driver did not feel comfortable leaving her there. OSM #12 stated that they set up a central meeting location at [Name of Hospital] to meet the van and Resident #67. OSM #12 stated that Resident #67 was upset at the hospital when they arrived. OSM #12 stated that she called Resident #67's grandson who spoke with Resident #67 on speakerphone and "told her that she was no longer welcome at the house." OSM #12 stated that Resident #67 was visibly upset and stated "you get my money checks" and "he hung up on her." OSM #12 stated that at that point they set up another transport service to return Resident #67 to the facility.
OSM #12 stated that she did not ask transportation to take the resident to [Name of another City]; that they came to the hospital to take her back to the facility. When asked if staff made sure someone was going to be home when Resident #67 was discharged on 8/5/19, OSM #12 stated, "No, I did not make sure that someone was home, because the resident was ok going home by herself [note it was documented the resident required 24 hour care]."
OSM #11 stated, "I talked to [First Name of Resident #67] and she said she was ok she had a key." When asked why transportation did not let her use the key, OSM #12 stated that they didn't feel comfortable with that. When asked if they told transportation the situation that there was no confirmed caregiver at the house for Resident #67 and that the family had voiced concerns regarding having her return to the home, OSM #12 and OSM #11 stated that they did not.

On 11/5/19 at approximately 10:35 a.m., an interview was conducted with Resident #67. Resident #67 was observed sitting in the wheelchair at the left side of the bed near the

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window. Upon greeting Resident #67 she stated, "I remember you [First name of Surveyor], you were in here yesterday talking to me." When asked if she has or has ever had a key to her grandson's home Resident #67 stated, "No, I don't think I have ever had one."

On 11/5/19 at approximately 11:00 a.m., an interview was conducted with OSM #17, the business office manager regarding the discharge of Resident #67. OSM #17 stated that Resident #67's discharge date was 8/5/19, that the Medicare benefits ended on 8/4/19. OSM #17 stated that Resident #67 needed to have a payer source by the 31st day or she would have to have a $174/day coinsurance. OSM #17 stated that Resident #67's grandson stated that they were trying to set up Medicaid and that she had reviewed how to apply with him on 7/11/19. OSM #17 stated that on 7/11/19, Resident #67's grandson stated that he could not take care of her anymore and did not want to take her home. When asked for evidence of the discharge notification for the 8/5/19 date that was sent to the family, OSM #17 stated that she does not notify families or residents of discharge. OSM #17 stated the discharge planners complete all of that.

On 11/5/19 at approximately 11:15 a.m., OSM #17 provided the document "Activity Report" for Resident #67. It documented in part, "7/11/2019 11:52 General Notes, Family came in at some point to fill out a Medicaid application. Grandson who was taking care of her came in and I went over benefits again, he said they were applying for Medicaid, couldn't take care of her anymore did not really seem interested in what I was trying to explain to him, as he did not want to take her

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home but said she could not afford copay and was not offering up any suggestions. Went over payment options for the Part A coinsurance but explained we do not take pending Medicaid ltc (long term care) residents, and that they would have to take her home during that time and she could return once approved."

On 11/5/19 at 4:25 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator regarding the discharge of Resident #67 on 8/5/19. When asked if notice was given for Resident #67's discharge on 8/5/19 ASM #1 stated that Resident #67 was a short term resident and she did not come in for long-term care [note the resident had resided at the facility for more than 30 days]. ASM #1 stated that Resident #67 wanted to go home after her therapy was completed and that she was her own responsible party. ASM #1 stated that her family member handled Resident #67's finances and when the business office met with them, they stated that they did not know if they wanted to take her home. ASM #1 stated that if there were no guardianship in place the facility had to respect her wishes to go back to her prior living arrangements with her family in their home. ASM #1 stated that he was informed that during the discharge meeting with the family the family had discussed not wanting Resident #67 to come home and that the discharge planner had contacted adult protective services to assess the situation. ASM #1 stated that when Resident #67 was discharged on 8/5/19 he was notified that the transport had arrived at the family's home and no one would answer the door. ASM #1 stated that he immediately had the discharge planners go to [Name of Hospital] to meet the transportation service to pick up the

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resident to bring her back to the facility safely. ASM #1 stated that he called the hospital to alert them what was happening and that the discharge planners were coming to meet Resident #67 to bring her back to the facility. ASM #1 stated that he contacted DMAS (Department of Medical Assistance Services) to forgo any further discharges and contacted the ombudsman.

ASM #1 was asked if the discharge of Resident #67 on 8/5/19, to her family's home without notification to the resident, and family, without home health services as recommended, and without confirmation that a caregiver would be at home to provide 24-hour care was a safe and effective discharge. ASM #1 stated that they sent her home because she wanted to go there. ASM #1 stated that the transport service would never leave anyone there alone. ASM #1 stated that Resident #67 stated that he understood that she had a key and knew the address of where she wanted to go. ASM #1 stated that he sees a lot of elderly people in their nineties living independently. ASM #1 stated that Resident #67 was out of the facility for probably less than two hours. ASM #1 stated that they have never had a situation like this before.

On 11/5/19 at 12:00 p.m., a telephone interview was conducted with OSM #16, [Name of County] APS (adult protective services). OSM #16 stated that OSM #12, the director of discharge planning had contacted him regarding applying for Medicaid on 7/18/19 and for a referral to set up discharge planning. OSM #16 stated that the family was directed to benefit staff to set up discharge planning or apply for Medicaid. When asked if the facility voiced any concerns for safe discharge for Resident #67, OSM #16 stated that

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it was his understanding that a discharge home was not an option but he did not remember specifically why. OSM #16 stated that resident screenings for safe discharge to home by APS are performed by the local department of social services offices and those assessments are initiated by the facility calling their APS office in the county they are located in. OSM #16 stated he was not located in the same county that the facility was located. OSM #16 stated that someone from the county that the facility is located in would have come to the facility to assess Resident #67 prior to the discharge date upon request. OSM #16 stated that the local ombudsman and benefits worker worked closely with the family to set up Medicaid for Resident #67.

On 11/5/19 at 2:00 p.m., OSM #12 stated that she spoke to APS in [Name of County] but she did not speak with anyone at the local social service office to discuss assessment of Resident #67 for safe discharge while she was still in the facility prior to the discharge on 8/5/19.

On 11/5/19 at 10:45 a.m., an interview was conducted with OSM #12. When asked if she would consider the discharge of Resident #67 on 8/5/19 a safe discharge, OSM #12 stated that she did not think it was the smoothest discharge. OSM #12 stated that looking back now she would like to have included Resident #67 in the discharge meeting. OSM #12 stated that she is learning and anytime she feels uncomfortable she calls APS (adult protective services) like she did about the concerns of the family saying that they were not sure whether they would take her at home and assist in completing the Medicaid application.

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On 11/5/19 at 11:00 a.m., OSM #12 stated that she did not have documentation to evidence written notification documenting the planned discharge date of 8/5/19 that was provided to Resident #67 or the family of Resident #67 for the discharge on 8/5/19.

The facility policy "Notice of Transfer/Discharge, Effective Date 08/27/19" documented the following:
- "Policy: When the Center initiates a notice of transfer/discharge to a patient and/or responsible party the discharge planning staff will pursue timely and appropriate transfer/discharge notifications as well as discharge planning initiatives to ensure a safe and orderly discharge from the Center."

The facility document "Job Description and Performance Appraisal Discharge Planning Assistant, Date Revised: May 2011" documented in part, "Operates within the framework of [Name of Facility]'s standards of best practices as well as state and federal regulations. Coordinates and expedites all discharge planning initiatives for the assigned caseload, from the day of admission, through the day of discharge. Provides comprehensive medically related social services identified and needed by the patients of the Center." Page 3 documented "Job Specific Duties- Initiates discharge planning upon admission and coordinates with the patient, the family and the interdisciplinary team, timely and effective plans for transitioning home or to an optimal care environment ...Assesses the patient's support systems and home situation to assist in decision-making regarding the patient's discharge plan and discharge needs ... Identifies

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and assists in the securing of the patient's medically related social service needs"

The facility document "Job Description and Performance Appraisal Discharge Planning Director, Date Revised: May 2011" documented in part, "Directs and supervises the discharge planning department within the framework of [Name of Facility]'s standards for best practices and in accordance with state and federal regulations. Coordinates and expedites patient discharge planning initiatives from the day of admission through the day of discharge. Provides all other comprehensive medically related social services identified and needed by the patients of the Center." Pages 2-4 documented in part, "Job Specific Duties- Initiates discharge planning upon admission and coordinates with the patient, the family and the interdisciplinary team, timely and effective plans for transitioning home or to an optimal care environment ...Assesses the patient's support systems and home situation to assist in decision-making regarding the patient's discharge plan and discharge needs ...Identifies and assists in the securing of the patient's medically related social service needs"

On 11/5/19 at approximately 5:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #3, the corporate nurse consultant and ASM #4, the assistant administrator were notified of the concerns.

No further information was presented prior to exit.

Complaint deficiency

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F 745	Continued From page 130 1. 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. 2. Rheumatoid arthritis A long-term disease. It leads to inflammation of the joints and surrounding tissues. It can also affect other organs. This information was obtained from the website: https://medlineplus.gov/ency/article/000431.htm. 3. Major depressive disorder Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm. 4. Macular degeneration A disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. This information was obtained from the website: https://medlineplus.gov/maculardegeneration.html.	F 745		
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	F 812		11/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495279	A. BUILDING _____ B. WING _____	C 11/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULPEPER HEALTH & REHABILITATION CENTER	602 MADISON ROAD CULPEPER, VA 22701

(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 812	Continued From page 131 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to store and prepare food in a sanitary manner. The findings include: On 11/03/19 at 1:35 p.m., an observation of the facility's kitchen was conducted with OSM [other staff member] # 5, dietary manager. Observation of walk-in refrigerator # 1 revealed a ladder rack against the sidewall. The left side of the ladder rack [when facing it] revealed six sheet pans. The second and third sheet pans from the top were observed to contain approximately twenty strips of bacon in each pan thawing. The fourth sheet pan, under the bacon was observed to contain twelve raw biscuits. When asked about the biscuits, OSM # 5 stated, "They should have been place below the bacon." OSM # 5 immediately removed the biscuits from the walk-in refrigerator.	F 812	1. The approximately twelve strips of bacon in the sheet pans were moved to the bottom of the ladder rack and the 12 raw biscuits in the fourth sheet pan was moved on the upper rack above the raw bacons on 11/03/2019. 2. Kitchen staff audited the entire kitchen walk-in refrigerator to ascertain that food items were appropriately stored. No additional improper food storage was noted. 3. Corporate Dietitian/Designee to in-service all of the kitchen staff on the proper storage of food items in the kitchen walk-in refrigerator. 4. Kitchen Manager/Designee will complete a routine audit of the kitchen walk-in refrigerator weekly x1 month and monthly x3 months to ascertain adherence to food storage standard. Any deficient practice will be remediated immediately and forwarded to the QAPI	

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F 812	Continued From page 132 The facility's policy "Food Storage" documented in part, "3. Place foods in the following order on shelves in the refrigerator: Top shelf to Bottom shelf- Prepared or ready-to-eat foods, Fish and seafood items, Whole cuts of raw beef, Whole cuts of raw pork, Ground or processed meats, Raw poultry/Eggs." On 11/04/19 at 6:25 p.m., ASM # 1, administrator, ASM # 2, director of nursing, and RN [registered nurse] # 6, assistant a director of nursing were made aware of the above findings. No further information was provided prior to exit.	F 812	committee for further review and recommendation. 5. Date of compliance: 11/27/2019	