STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	C 10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/22/19 through 10/24/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No Emergency Preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/22/19 through 10/24/19. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Nine complaints were investigated during the survey. The census in this 169 certified bed facility was 156 at the time of the survey. The survey sample consisted of 63 resident reviews: 56 current residents and 7 closed record reviews.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this	F 567		12/8/19

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

Electronically Signed | 11/19/2019

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F 567	Continued From page 1 section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and facility documentation, the facility staff failed to ensure 1 of 63 residents (Resident #20) in the survey sample had a patient trust fund account. The findings included: The facility staff failed to ensure Resident #20 had a patient trust fund account. Resident #20 was originally admitted to the facility on 01/25/17. Diagnosis for Resident #20 included but not limited to: Mild Intellectual disabilities. Resident	F 567	1. Resident #20 fund account was established on 5/21/19. 2. All residents have the potential to being affected. An audit of the current resident population was conducted. All residents that had requested account, not opened were corrected. 3. Education on the protection/management of personal funds was provided to admissions coordinator,	

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F 567	Continued From page 2 #20's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/02/19 coded Resident #20's Brief Interview for Mental Status (BIMS) scored a 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. An interview was conducted with Resident #20 on 10/22/19 at approximately 11:53 p.m. She said the facility would not put money in her account until her niece got involved. She said her niece was putting money into her account every month. An interview was conducted with the Business Office Manager (BOM) on 10/23/19 at approximately 4:53 p.m. The BOM said she was not aware that Resident #20 did not have a patient fund account set-up until the resident's niece contacted her. She said the facility was not very good in requesting a Representative Payee so Resident #20 could receive her funds directly. The BOM said Resident #20 had a $0.00 liability or no income. The BOM said an application was submitted to Social Security Administration requesting a Representative Payee Application for Resident #20 on 10/04/18. She said Resident #20 did not starting receiving per personal funds until June 2019; which was $40 per month. A phone interview was conducted with the local Ombudsman on 10/24/19 at approximately 9:05 a.m., who stated, "I was not aware that Resident #20 was not receiving her funds until I was contacted by Resident #20's niece a while ago (not sure of the date). He said he spoke with the current Business of Manager (BOM) who was not here when Resident #20 was originally admitted to the nursing facility. The Ombudsman stated,	F 567	marketing liaison, and administrative assistant on 11/14/19. This training will also be provided to admissions coordinator, marketing liaison, and administrative assistant upon hire during orientation. 4. Ongoing audits by the Business Office Manager and/or Assistant Business Office Manager for review of proper execution of resident trust fund authorization. These audits will be conducted upon all new admissions going forward. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Business Office Manager is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by 12/8/19.	

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F 567	Continued From page 3 "When Resident #20 was admitted to the facility, someone should have verified her payer source right away." He said the facility should have established where her money was going the minute Resident #20 was admitted to the nursing facility." The Administrator, Director of Nursing (DON) and Nurse Consultant was informed of the finding during a briefing on 10/24/19 at approximately 4:08 p.m. The staff were asked, "When should the facility have started the process for setting up a Patient Fund Account for Resident #20?" The Administrator replied, "In January 2017, when she was admitted to the facility."	F 567		
F 577 SS=B	Complaint deficiency Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with	F 577		12/8/19

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F 577	Continued From page 4 respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility staff failed to make 3 years of survey results and corresponding plans of correction available for review, in a 169 bed facility with a census of 156. The findings include: An initial inspection of the facility on October 22, 2019 through October 24, 2019, revealed that the facility survey manual contained 2 out of the required 3 years of survey results. During an interview on October 23, 2019 at approximately 4:30 p.m. the Facility Administrator was asked how many survey results were provided for resident/public review, answered "2 years". The Administrator was informed that the requirement is 3 years of survey results and corresponding corrective action plans, responded, "I'll get right on that." The Facility Resident Handbook states, the facility is subject to visits by federal, state and other regulatory officials. These representatives may review medical records and other written information pursuant to the inspection of the facility for continued certification and licensure. The results of the most recent federal and state surveys are available for your review.	F 577	1. Additional year was immediately added to survey book on 10/24/19. 2. All residents, staff, and the public have the potential to be affected. 3. Education on the right to survey results was provided to the Administrator on 11/18/19 by the Regional Nurse Consultant. This training will also be provided to the Administrators upon hire during orientation. 4. Ongoing audits by the Administrator for observation and review of the survey binder to ensure 3 years of survey results are present. These audits will be conducted on a weekly basis for 4 weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator,	

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F 577	Continued From page 5 Administrator was informed of survey results availability on 10/24, 2019 at approximately 7:30 p.m.	F 577	Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by 12/8/19.	
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		12/8/19

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F 578	Continued From page 6 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews and facility documentation review, the facility staff failed to ensure residents were able to formulate advance directives, obtain advance directives, and/or send them upon transfer to hospital; and have these documents maintained in the clinical record, readily accessible to the direct care staff for 16 of 63 residents in the survey sample (#64, #95, #128, 78, #11, #51, #50, #15, #90, #42, #88, #61, #72, #61, #139 and #124). The findings include: 1. Resident #64 did not have an advance directive readily available for direct care staff. Upon inquiry, an advance directive was located in a file drawer in the business office, not in the clinical record. Additionally, there was no evidence the resident's advance directive was sent with her when the resident was transferred to the local hospital on 12/27/18 or 7/7/19. Resident #64 was admitted to the nursing facility	F 578	1. All identified residents have had the advance directives formulated and documents have been placed in the clinical records and are readily assessible to the front-line staff. Those identified were residents numbered 64, 95, 128, 78, 11, 51, 50, 15, 90, 42, 88, 61, 72, 61, 139, and 124. This update will be completed no later than 11/19/19. 2. To insure no other residents were affected, an audit of the current resident population was completed and updated in all records by 11/19/19. Audits will be completed on newly admitted residents. 3. Education on the advance directive policy was provided to the admissions coordinator, licensed nurses, and social services director by 11/30/19. This training will also be provided to the admission coordinator, social services director, and licensed nurses upon hire	

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F 578	Continued From page 7 on 7/29/16 with diagnoses that included generalized muscle weakness, bipolar disease and schizophrenia. Resident #64's most recent Minimum Data Set (MDS) was a significant change in status assessment. The resident scored a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was fully intact with the skills for daily decision making. On 10/23/19 at 1:48 p.m., the Unit II Nurse Manager stated, "I am not sure if (Resident #64's name) has an advance directive. I have never seen one and don't know where I would find one if she indeed had one. I do know she is a full code. There is no paperwork that we know of that says she wanted one or not." On 10/23/19 at 2:30 p.m., Resident #64 stated that she had an advance directive about some of her medical care decisions along with being a full code and hoped the facility did not lose her "important paperwork." On 10/24/19 at 10:30 a.m., the Unit II Nurse Manager, Licensed Practical Nurse (LPN) #18 and the Director of Nursing (DON) stated the document related to whether or not a resident wanted an advance directive and that it had been reviewed, should be accessible to the nurses and kept in the clinical record, as well as the advanced directive. On 10/24/19 at 1:02 p.m., upon inquiry, the Business Office Manager (BOM) stated she searched for an advance directive and found a document titled "Advance Directives/Informed Consent" form dated 8/1/16 that indicated the	F 578	during orientation. 4. Ongoing audits by the Social Services Director and Social Services Assistant to ensure the medical record contains proper documentation of the residents advance directive; including consent, physicians order, and care plan. These audits will be conducted twice a week for four weeks, weekly for 3 weeks, monthly for three months. Random audits will be conducted each month for 2 months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Social Services Director is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by 12/8/19.	

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resident "did not" want to formulate an advance directive. She stated the document was located in the file drawer in the business office. The BOM said the document should be kept on the unit where the resident resided and a copy in the business office.

On 10/24/19 at 3:30 p.m., the BOM returned to present an advance directives form for Resident #64. The BOM stated, "I dug to find this resident actually did have an advance directive dated 1/21/14 that was also in a file drawer in the business office. This should have been on the resident's chart and a copy left in the admissions or business office, as well. We will be fixing this immediately with some education because we don't want any mix-ups."

On 10/24/19 at 4:08 p.m., during the debriefing with the Administrator and DON, the aforementioned issue was readdressed. They stated the facility's policy was not followed that indicated all information about informing the resident of their rights and all rules and regulations regarding decisions concerning medical care, and if they had an advance directives be available and kept in the resident's medical record. The DON stated, "A copy of the resident's Advanced Directive should go with them to the hospital and should be documented in their clinical record." The Administrator and the DON stated they would be putting together a training plan for the staff.

2. Resident #95 did not have an advance directive readily available for direct care staff. Upon inquiry, an advance directive was located in a file drawer in the business office, not in the clinical record. The Business Office Manager

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(BOM) located a document titled "Advance Directives/Informed Consent" dated 1/17/18 that was found in a file drawer in the business office that indicated the resident had an advance directive. This advance directive was not found prior to survey exit. The facility could not provide evidence that Resident #95's advance directives were sent with her upon transfer to the local hospital on 5/11/19 or 9/3/19.

Resident #95 was admitted to the nursing facility on 1/6/18 with diagnoses that included stroke, diabetes and heart failure.

Resident #95's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment dated 9/23/19 and coded the resident on the Breif Summary for Mental Status (BIMS) with a score of 3 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for daily decision making.

On 10/23/19 at 1:48 p.m., the Unit II Nurse Manager stated she was not sure if Resident #95 had an advance directive. The Unit II Manager stated, "I have never seen one and don't know where I would find one if she indeed had one. I do know she is a DNR (do not resusitate). There is no paperwork that we know of that says she wanted one or not."

On 10/24/19 at 10:30 a.m., the Unit II Nurse Manager, Licensed Practical Nurse (LPN) #18 and the Director of Nursing (DON) stated the document related to whether or not a resident wanted an advance directive and that it had been reviewed, should be accessible to the nurses and kept in the clinical record, as well as the

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advanced directives.

On 10/24/19 at 1:02 p.m., the Business Office Manager (BOM) stated she searched for an advance directive and found a document titled "Advance Directives/Informed Consent" form dated 1/16/18 that indicated the resident formulated an advance directive dated 7/2007. She stated the Advance Directives/Informed Consent document was located in the file drawer in the business office, but she could not find the advanced directive. The BOM said the documents should be kept on the unit where the resident resided and a copy in the business office.

On 10/24/19 at 3:30 p.m., the BOM stated the facility needed to do some training immediately because she did not want any "mix-ups."

On 10/24/19 at 4:08 p.m., during the debriefing with the Administrator and DON, the aforementioned issue was readdressed. They stated the facility's policy was not followed that indicated all information about informing the resident of their rights and all rules and regulations regarding decisions concerning medical care, and if they had an advance directives be available and kept in the resident's medical record. The DON stated, "A copy of the resident's Advanced Directive should go with them to the hospital and should be documented in their clinical record." The Administrator and the DON stated they would be putting together a training plan for the staff.

3. Resident #128 did not have evidence readily accessible that the facility had offered the resident an opportunity to formulate an advance

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directive. Additionally, according to the current physician orders for October 2019 the resident was a DNR (do not resusitate), but no DNR form was located in the clinical record.

Resident #128 was admitted to the nursing facility on 5/6/09 with diagnoses that included diabetes mellitus, enlarged heart.

Resident #128's most recent Minimum Data Set (MDS) assessment was a quarterly dated 9/23/19 and coded the resident on the Breif Summary for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the skills needed for daily decision making.

On 10/24/19 at 9:20 a.m., Licensed Practical Nurse (LPN) #19 on Unit III stated she was not sure if Resident #128 had an advance directive, but she knew she was a DNR. LPN #19 stated, "I do not know where the DNR form is. It should be located in the front of the resident's chart on the unit." She could not determine if there was paperwork that addressed the resident's right to formulate or refuse advance directives.

On 10/24/19 at 10:30 a.m., the Director of Nursing (DON) stated the document related to whether or not a resident wanted an advance directive and that it had been reviewed with them should be accessible to the nurses and kept in the clinical record, as well as the advanced directives. The DON also stated even though there was a physician's order for a DNR there should be a copy of the durable DNR on the front of the resident's chart at all times, especially to give to EMTs (emerency medical team) if the resident needed to be sent out to the hospital.

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On 10/24/19 at 1:02 p.m., upon surveyor inquiry, the Business Office Manager (BOM) stated she could not locate the document titled "Advance Directives/Informed Consent" form that would indicate the wishes of the resident's representative regarding formulation of an advance directive altough there should have been one in the clinical record.

On 10/24/19 at 3:30 p.m., the BOM stated the facility needed to do some training immediately because she did not want any "mx-ups."

On 10/24/19 at 4:08 p.m., during the debriefing with the Administrator and DON, the aforementioned issue was readdressed. They stated the facility's policy was not followed that indicated all information about informing the resident of their rights and all rules and regulations regarding decisions concerning medical care, and if they had an advance directives be available and kept in the resident's medical record. The Administrator and the DON stated they would be putting together a training plan for the staff.

4. Resident #78 was originally admitted to the facility on 9/19/13 with diagnoses to include but not limited to Diabetes Mellitus and Urine Retention.

The most recent Minimum Data Set (MDS) was a Annual with an Assessment Reference Date (ARD) of 9/6/19. Resident #78's Brief Interview for Mental Status (BIMS) was a 13 out of a possible 15 which indicated the resident was cognitively intact and capable of daily decision making.

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On 10/23/19 at 10:36 AM, Resident #78's electronic and paper medical record was reviewed for the Advance Directives. Resident #78's Advance Directives were not found in the medical record. On 10/23/19 a copy of Resident #78's Advance Directives were provided from the Admissions Coordinator who stated, "There were in a file in the business office."

On 10/23/19 at approximately 11:30 A.M. an interview was conducted with the Admissions Coordinator regarding the location of the Advance Directives after being obtained from the resident or family. The Admissions Coordinator stated, "They have been being kept in the business office in their files, but the new admissions and able to sign electronically and they are being put into the EMR (Electronic Medical Record) so there are accessible to all staff. We are going to do an audit of all the charts."

On 10/24/19 at 7:30 P.M., a pre-exit debriefing was held with the Administrator, Director of Nursing and the Regulatory Care Consultant where the above information was shared. The Administrator stated, "Admissions has completed an audit last night for the Advance Directives."

Prior to exit no further information was shared.
5. The facility staff failed to ensure that Resident #11's Advanced Directive was sent upon transfer/discharge to the hospital on 09/16/19.

Resident #11 was originally admitted to the facility on 07/15/18. Diagnosis for Resident #11 included but not limited to Thromobocytopenia.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date

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(ARD) of 07/22/19 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

On 09/16/19, according to the facility's documentation, Resident #11, left the facility via ambulance service for a direct admit to the hospital, pending a surgical procedure. The clinical record did not show evidence that Resident #11's Advanced Directive was sent with her when discharged to the hospital.

Review of Resident #11's clinical record indicated that there was an Advanced Directive on the chart; however, there was no documentation the form was sent upon residents discharge to the local hospital on 09/16/19. The Health Care Instructions document included the following information: I specifically do not wish to receive the following treatments: Cardiopulmonary Resuscitation (CPR), Ventilator or Dialysis. The document was witnessed, signed and dated on 05/09/12.

An interview was conducted with the Unit Manger on who stated, "Resident #11's Advanced Directive should have been sent with her when discharged to the hospital on 09/16/19 and documented in the resident's nurses notes. The surveyor asked, "How would the hospital know Resident #11's wishes not to receive the following: CPR, Ventilator or Dialysis if her Advanced Director was not sent with her when discharged to the hospital, she replied, "They don't."

The Administrator, Director of Nursing (DON) and Nurse Consultant was informed of the finding

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during a briefing on 10/24/19 at approximately 4:08 p.m. The DON stated, "A copy of the resident's Advanced Directive should go with them to the hospital and should be documented in their clinical record."

The facility's policy titled Discharge or Transfer Summary (Last Revision date: 06/28/19). Guidelines include but not limited to:
-1. G: For the residents transferred to another provider the following will be documented and communicated to the receiver provider: Advanced Directive Information.
6. The facility staff failed to ensure that Resident #51's advance directive was on the clinical record and valid to include a date and witness signatures.

Review of Resident #51's clinical record indicated the resident was admitted to the facility on 8/5/16 with a re-admit on 2/7/17 with diagnoses that included Parkinson's disease, major depression, and unspecified dementia without behavioral disturbances.

Review of the clinical record revealed that there were no advance directive on the chart.

On 10/23/19 12:33 p.m., an interview with the Director of Social Services was conducted. She was asked where the Advance Directives could be found. She stated they are kept in the Business Office. A request was made to the Business Office Manager to provide the Advance Directive for Resident #51.

During the survey the Admission's Coordinator was able to provide a copy of the advance directive that was filed with the resident's

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admission paperwork information. This copy was not valid and it was not signed, dated and did not have two witness signatures.

7. The facility staff failed to ensure that Resident #50's advance directive was on the clinical record and valid to include two witness signatures.

Review of Resident #50's clinical record indicated the resident was admitted to the facility on 1/16/18 with diagnoses that included high blood pressure, diabetes, and vascular dementia without behavioral disturbances.

Review of the clinical record revealed that there were not an advance directive on the chart.

On 10/23/19 12:33 p.m., an interview with the Director of Social Services was conducted. She was asked where the Advance Directives could be found. She stated they are kept in the Business Office. A request was made to the Business Office Manager to provide the Advance Directive for Resident #50.

The Businees Office Manager was able to provide a copy of the advance directive that was filed with the resident's admission paperwork information. This copy was not valid as it did not have two witness signatures.

8. The facility staff failed to have an advance directive accessible in Resident #15's clinical record.

Resident #15 was originally admitted to the facility on 11/02/16. Diagnosis for Resident #15 included but not limited to Type 2 diabetes Mellitus without complications and Chronic Kidney Disease.

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The current Minimum Data Set (MDS), an annual assessment with an Assessment Reference Date (ARD) of 04/26/19 coded the resident with a BIMS summary score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

A review of the clinical record on 10/23/19 at approximately, 11:21 AM revealed there was no advanced directive in the clinical record.

On 10/23/19 at approximately 5:06 PM, an interview was conducted with the Marketing Liasion. A copy of Resident #15's advance directive was received. She stated that the advance directive was located in file cabinet in the business office. She was asked how would the staff access the advance directive. She stated, "I don't know."

On 10/24/19 at approximately, 4:17 PM, an interview was conducted with the social services worker (Other Staff #14) concerning the location of the advance directive. She stated, "It's usually in front of the chart...Physician Order Summary will state if Resident is full code or DNR."

On 10/24/19 at approximately, 5:28 PM the pre-exit interview was conducted. Present were the Administrator, the DON (Director of Nursing) and the Corporate Nurse Consultant. The DON stated that the "Advance Directive can be found in the patient's chart under the advance directive tab....The original should be in the chart."
9. The Facility failed to extend the right to formulate an Advanced Directive.

Resident # 90 was admitted to the facility on 8/9/2017 with a readmission occurring on

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11/15/2018 with the latest diagnosis including, but not limited to, spastic quadriplegic cerebral palsy, cervical spina bifida without hydrocephalus, unspecified convulsions conversion disorder with seizures or convulsions.

Resident # 90's MDS (Minimum Data Set), Quarterly Review Assessment dated 9/18/2019 coded Resident #90 with a BIM (brief interview of mental status) as 14 out of a possible 15, moderately cognitively impaired with decisions of daily living.

On 10/23/2019 at approximately 4:30 p.m., a request for any documentation regarding an Advanced Directive was given to Other Administrative Staff (OS) #6. OS #6 stated "We don't have one for him".

The facility Administrator was informed of the findings during a briefing on 10/24/2010 at approximately 7:30 p.m. The facility did not present any further information about the findings.

10. The facility failed to extend the right to formulate an Advanced Directive to Resident #42.

Resident #42 was admitted to the facility on 1/9/2019 with diagnoses including flaccid hemiplegia affecting left nondominant side, muscle weakness, cerebral infarction due to unspecified cerebral artery, difficulty walking, heart failure, and, aphasia and type 2 diabetes.

Resident # 42's MDS (Minimum Data Set), Quarterly Review Assessment with an ARD (Assessment Review Date) of 8/9/2019, indicated a BIMS (Brief Interview of Mental Status) score of 12 out of a possible 15, moderately cognitively

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impaired.

On 10/23/2019 at approximately 4:30 p.m., a request for any documentation regarding an Advanced Directive was given to Other Administrative Staff (OS) #6. OS #6 stated "We don't have one for him".

The facility Administrator was informed of the findings during a briefing on 10/24/2010 at approximately 7:30 p.m. The facility did not present any further information about the findings.
11. Resident #88 was originally admitted on 08/1/14 with a readmission date of 8/1/19. Resident #88's diagnoses included paraplegia, multiple sclerosis and anemia.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/16/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision making were intact.

Review of the clinical record didn't reveal written Advanced Directive, but the physician's order summary stated the resident was a full code.

Review of the person-centered care plan revealed a care plan dated 4/29/19 and edited 9/24/19 with a problem documenting: Advanced Directives, resident desires to be a full code. The goal read: Resident wishes to be a full code which will be followed in the event his heart has stopped through 12/23/19. The approaches included: 911 will be called for transfers to the hospital, CPR will be conducted in accordance to the resident's wishes, discuss code status during

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full life conference quarterly during care plan.

No information was included in the medical record concerning what to do if the resident becomes incapacitated, a designated health care surrogate, medical/surgical treatments, feeding restrictions, organ donation, autopsy request or other.

On 10/24/19 at approximately 10:45 a.m., the Social services Director stated the Advanced Directives are managed by the Admission/Marketing staff and if the Advanced Directive is not on the resident's chart it is in a file in the Admission's office.

An interview was conducted with the Marketing Director on 10/24/19 at approximately 1:45 p.m. The Marketing Director stated it was true if the form wasn't on the record it was likely in the Admission's Office but, currently she was conducting a 100% audit and if there wasn't a form in either place they were completing one today. The Admission's Director stated Resident #88 had no Advanced Directive form completed but it was completed today.

On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but nothing was provided.

12. Resident #61 was originally admitted on 10/21/14 with a readmission date of 5/3/17 after an acute hospital stay. Resident #61's diagnoses included stroke and asthma.

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The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/23/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision were severely impaired.

Review of the clinical record didn't reveal written Advanced Directives but the physician's order summary stated the resident was a full code.

Review of the person-centered care plan revealed a care plan dated 4/29/19 and edited 9/24/19 with a problem documenting: Advanced Directives, resident desires to be a full code. The goal read: Resident wishes to be a full code which will be followed in the event his heart has stopped through 12/23/19. The approaches included: 911 will be called for transfers to the hospital, CPR will be conducted in accordance to the resident's wishes, discuss code status during full life conference quarterly during care plan.

No information was included in the medical record concerning what to do if the resident becomes incapacitated, a designated health care surrogate, medical/surgical treatments, feeding restrictions, organ donation, autopsy request or other.

On 10/24/19 at approximately 10:45 a.m., the Social services Director stated the Advanced Directives are managed by the Admission/Marketing staff and if the Advanced Directive is not on the resident's chart it is in a file in the Admission's office.

An interview was conducted with the Marketing

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Director on 10/24/19 at approximately 1:45 p.m. The Marketing Director stated it was true if the form wasn't on the record it was likely in the Admission's Office but; currently she was conducting a 100% audit and if there wasn't a form in either place they were completing one today. The Admission's Director stated Resident #88 had no Advanced Directive form completed but it was completed today.

On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but nothing was provided.

13. Resident #72 was originally admitted on 2/28/19 and had not been discharged since admitted. Resident #72's diagnoses included stroke, hemiparesis and diabetes.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/3/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #72's cognitive abilities for daily decision making were intact.

Review of the clinical record did reveal written Advanced Directives dated 3/6/19. It stated "I do not choose to formulate or issue Advanced Directives at this time. I want efforts made to prolong my life and warrant life-sustaining treatment to be provided."

The current physician's order summary dated 10/22/19, stated the resident's code status was

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Do Not Resuscitate.

Further review of the record reveal a Do Not Resuscitate form dated 1/3/19, signed by the resident and the physician.

Review of the person-centered care plan dated 6/25/19 and edited 10/14/19, revealed no Advanced Directive care plan.

On 10/24/19 at approximately 10:45 a.m., the Social services Director stated the Advanced Directives are managed by the Admission/Marketing staff and if the Advanced Directive is not on the resident's chart it is in a file in the Admission's office.

An interview was conducted with the Marketing Director on 10/24/19 at approximately 1:45 p.m. The Marketing Director stated it was true if the form wasn't on the record it was likely in the Admission's Office but, currently she was conducting a 100% audit and if there wasn't a form in either place they were completing one today. The Admission's Director stated Resident #88 had no Advanced Directive form completed but it was completed today.

On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but nothing was provided.

14. Resident #61 was originally admitted on 10/21/14 with a readmission date of 5/3/197 after an acute care hospital stay. Resident #61's diagnoses included stroke and asthma.

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The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/23/19 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for short term memory problems as well as modified independence for decision making in new situations.

Review of the clinical record didn't reveal written Advanced Directives but the Marketing Director was able to locate it in the Admission's office. The Advanced Directives form was signed but not dated and read as follows: "I do not choose to formulate or issue Advanced Directives at this time. I want efforts made to prolong my life and warrant life-sustaining treatment to be provided."

Review of the person-centered care plan revealed a care plan dated 7/25/14 and edited 9/7/19 with a problem documenting: Resident has the following Advanced Directives on record, Full code. The goal read: Resident Advanced Directives are in effect, and their wishes and directions will be carried out in accordance with their advanced directives on an ongoing basis through the next review date 10/24/15. The approaches included: Discuss Advanced Directives with the resident and/or appointed health care representative, An Advanced Directive can be revoked or changed if the resident and/or appointed health care representative changes their mind about the medical care they want delivered, Advise resident and/or appointed health care representative to provide copies to the facility of any updated Advanced Directives.

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No information was included in the medical record concerning what to do if the resident becomes incapacitated, a designated health care surrogate, medical/surgical treatments, feeding restrictions, organ donation, autopsy request or other.

On 10/24/19 at approximately 10:45 a.m., the Social services Director stated the Advanced Directives are managed by the Admission/Marketing staff and if the Advanced Directive is not on the resident's chart it is in a file in the Admission's office.

An interview was conducted with the Marketing Director on 10/24/19 at approximately 1:45 p.m. The Marketing Director stated it was true if the form wasn't on the record it was likely in the Admission's Office but, currently she was conducting a 100% audit and if there wasn't a form in either place they were completing one today. The Admission's Director stated Resident #88 had no Advanced Directive form completed but it was completed today.

On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but nothing was provided.

15. For Resident #139, the facility staff failed to ensure Advance Directives / Informed Consent was reviewed with the resident or resident's responsible party.

Resident #139 was admitted to the facility on 09/30/2019. Diagnosis for Resident #139 included but were not limited to, Arthritis and Hip

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Fracture.

Resident #139's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 10/07/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 14, indicating no cognitive impairment.

On 10/23/2019 at approximately 5:30 p.m., an interview was conducted with the Marketing Director in Admissions. A copy of Resident #139's Advanced Directive was requested from the Marketing Director and she stated, "The Advanced Directive has not been signed by the resident as of present." The Marketing Director stated, "The resident is a new admit and every time I have went to review it with her she has been asleep. The resident's mother is her responsible party and she has not been in to review the form with me."

On 10/24/2019 at approximately 4:00 p.m., an interview was conducted with the Social Worker and she stated, "I spoke with (Resident Name) and she stated that she wanted to be a Full Code." The Social Worker provided a copy of her conversation in a progress note dated 09/30/2019.

The Administrator, Director of Nursing and Nurse Consultant was informed of the finding on 10/24/2019 at 7:30 p.m. at the pre-exit meeting. The Director of Nursing was asked, "What are your expectations regarding Advance Directives?" The Director of Nursing stated, "I expect the Admissions Department to review the Advance Directive Informed Consent with the resident or resident responsible party upon admission and

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the nurses to follow up as needed." The Director of Nursing also stated, "I expect changes to be made as needed."

The facility staff did not present any further information about the finding.

16. For Resident #124, the facility staff failed to ensure that the Advance Directives / Informed Consent reflected the resident's DNR (Do Not Resuscitate) code status.

Resident #124 was initially admitted to the facility on 08/11/2017. Resident #124 was discharged to the hospital on 01/08/2019 and readmitted to the facility on 01/13/2019. Diagnosis for Resident #124 included but are not limited to, Cerebral Infarction, Dementia and Chronic Obstructive Pulmonary Disease.

Resident #124's Quarterly Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 09/20/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment.

On 10/23/2019 a copy of Resident 124's Advance Directives and a copy of the Physician Order Summary were requested.

On 10/23/2019 at approximately 5:30 p.m., the facility provided a copy of a "Durable Do Not Resuscitate Order" for Resident #124 dated 06/11/2018 and a copy of the Physician Order Report. Review of the Physician Order Report revealed Resident #124's Code Status as DNR (Do Not Resuscitate), start date 04/25/2019.

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F 578	Continued From page 28 On 10/23/2019 at approximately 6:25 p.m., Resident #124's clinical record was reviewed and revealed that there was an Advance Directives / Informed Consent on the chart dated 08/11/2017 with the following elected statement which reads as follows: "I do not choose to formulate or issue any Advanced Directives at this time. I want efforts made to prolong my life and warrant life-sustaining treatment to be provided." The Administrator, Director of Nursing and Nurse Consultant were informed of the finding on 10/24/2019 at 7:30 p.m. at the pre-exit meeting. The Director of Nursing was asked, "What are the expectations regarding Advance Directives?" The Director of Nursing stated, "I expect the Admissions Department to review the Advance Directive Informed Consent with the resident or resident responsible party upon admission and the nurses to follow up as needed." The Director of Nursing also stated, "I expect changes to be made as needed." The facility staff did not present any further information about the finding.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		12/8/19

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F 584	Continued From page 29 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to ensure care equipment, a wheelchair and gel cushion, were maintained in a clean and sanitary condition, for 1 of 63 residents in the survey sample, Resident #51. The findings included:	F 584	1. Wheelchair cleaned and gel pad replaced for resident 51. 2. All residents have the potential to be affected. An audit of all resident wheelchairs was conducted to ensure wheelchairs and cushions are maintained in clean and sanitary condition.	

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Resident #51 was admitted to the facility on 8/5/16 with a re-admit on 2/7/17 with diagnoses that included Parkinson's disease, major depression, and unspecified dementia without behavioral disturbances.

The current MDS (Minimum Data Set) a quarterly with an assessment date of 8/16/19 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. The resident was identified as utilizing a wheelchair for mobility and was always incontinent of bowel and bladder.

On 10/22/19 at 12:03 p.m., Resident #51 was observed in bed. She stated she did not sleep well last night and was not going to get up today. A strong smell of urine was in the room. An inspection to identify the origin of the urine odor was found to be coming from the gel cushion on the resident's wheelchair. The gel cushion was observed to have approximately 50% of the top layered sheared off. This inspector with gloved hand pressed a paper towel down on the cushion and found that it was saturated with urine. The metal frame of the wheelchair had a large amount of debris that was built up.

On 10/24/19 at 5:50 p.m., Resident #51 was in bed. The gel mattress was slightly damp, the urine odor remained and the debris on the metal frame remained the same. The unit manager was asked about the cleaning schedule of resident wheelchairs. She stated, "We wipe them down when needed, I'm sure there is a schedule" and then stated she would have to ask someone. The unit manager escorted this inspector to the resident's room to see the wheelchair and the gel cushion. The staff then immediately removed the

Wheelchairs will be inspected for all newly admitted residents.

3. Education on wheelchair cleaning procedure was provided to the Maintenance Director, Maintenance assistant, licensed nurses, and certified nursing assistants by 11/30/19. Training will also be provided to Maintenance Director, Maintenance assistant, licensed nurses, and certified nursing assistants upon hire during orientation.

4. Ongoing audits by the Maintenance staff to review wheelchairs and cushions. These audits will be conducted by assessing 10 chairs/cushions weekly x 4, 5 weekly x 2 and then 5 monthly x 3. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.

5. The Administrator and Maintenance Director is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be

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F 584	Continued From page 31 gel cushion. A request for the wheelchair cleaning schedule was made at this time. On 10/24/19 the above findings was shared during the pre-exit meeting with the Administrator and the Director of Nursing. The Administrator provided a copy of the Wheelchair Cleaning Procedure. He stated this procedure was new and was initiated last week on 10/14/19. The procedure read, in part: 11-7 shift brings 4 chairs from each floor on Tuesdays and Thursdays down to Maintenance office by 05:00 for cleaning...this will average 24 chairs cleaned weekly...this will be a five or six week rotation..."	F 584	completed by 12/8/19.	
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 Facility Reported Incident, staff interview and the clinical record, facility staff failed to ensure that one of 63 residents was free from sexual abuse.	F 600	Past noncompliance: no plan of correction required.	11/21/19

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The findings include:

Resident # 90 was admitted to the facility on 8/9/2017 with a readmission occurring on 11/15/2018 with the latest diagnosis including, but not limited to, spastic quadriplegic cerebral palsy, cervical spina bifida without hydrocephalus, unspecified convulsions conversion disorder with seizures or convulsions.

Resident # 90's MDS (Minimum Data Set), Quarterly Review Assessment with an ARD (Assessment Review Date) of 9/18/2019 coded Resident #90 with a BIM (Brief Interview of Mental Status) as 14 out of a possible 15, cognitively intact with decisions of daily living.

A review of Resident #90 Care Plan indicated limitations in ease of joining other residents in activities with a long term goal to express satisfaction with activity involvement; and, limited ability to maintain grooming/personal hygiene with a long term goal to be well groomed with staff assistance on a daily basis.

Review of the FRI received on 8/8/2019 detailed a resident to resident incident where facility staff responded to repeated yelling by Resident #90 in the hallway. According to a written statement included in the facility investigation, CNA staff witnessed, "rubbing his penis on the arm of Resident # 90." Details summarized within the FRI indicated a corrective action to move Resident #105 to another floor. Additionally, FRI documentation revealed that a skin assessment was conducted on Resident # 90, with a determination of no skin issues.

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F 600	Continued From page 33 A follow-up interview with Resident #90 on 10/23/2019 at approximately 9:30 a.m. regarding this incident stating, "I was sitting in the hallway and Resident #105 walked up to me and rubbed his 'thing' on me. I started screaming for help and two CNA's moved him away from me." When asked if she saw him anymore that day, Resident #90 responded, "No, they moved him to a room on the 4th floor." When asked if she was satisfied with the facility's resolution and response, she answered, "yes, I am satisfied what they did." A review of Facility documentation verified that Resident #105 was moved to a room on the 4th floor on 8/8/2019. A review of the Facility Resident Handbook and Admission Information found that the Residents have a right to be free from verbal, physical, or mental abuse, corporal punishment and involuntary seclusion. The facility Administrator was informed of the findings during a briefing on 10/24/2010 at approximately 7:30 p.m. The facility did not present any further information about the findings.	F 600		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs	F 622		12/8/19

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cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the 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

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

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F 622	Continued From page 36 Based on clinical record reviews, staff interviews, clinical record review, facility documentation review and the facility's policy; the facility's staff failed to covey a copy of the resident's comprehensive care plan goals to the transferring facility for 10 of 63 residents (Resident #88, #112, #78, #64, #95, #128, #32, #11, #94, and #605) in the survey sample. The findings included: The facility's policy titled Discharge or Transfer Summary (Last Revision date: 06/28/19). Guidelines include but not limited to: -1. G: For the residents transferred to another provider the following will be documented and communicated to the receiver provider: Comprehensive Care Plan goals. 1. Resident #88 was originally admitted on 08/1/14 with a readmission date of 8/1/19. Resident #88's diagnoses included paraplegia, multiple sclerosis and anemia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/16/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision making are intact. Review of the clinical record reveal Resident #88 was discharged from the facility return anticipated to an acute care hospital 7/20/19 for a critical hemoglobin and hematocrit. On 10/23/19 at approximately 1:30 p.m., an interview was conducted with Licensed Practical	F 622	1. Facility unable to make corrections to the identified residents #88, #112, #78, #64, #95, #128, #32, #11, #94, and #605. Residents have now returned back to the facility. 2. All residents have the potential to be affected. Residents will have care plan goals sent upon discharge beginning 11/19/19. 3. Education on the discharge or transfer summary policy was provided to all licensed nursing staff. This education will be complete by 11/30/19. This training will also be provided to all licensed nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers will be conducted for observation and review of proper execution of notification of care plan goals upon discharge. These audits will be 15 records twice a week for four weeks, 10 records weekly for three weeks, 5 records monthly for three months, and then 5 random audits each month for two months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator,	

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F 622	Continued From page 37 Nurse (LPN) #1. LPN #1 stated there was no documentation available stating the resident's comprehensive care plan goals were sent with the resident to the hospital at the time of his 7/20/19 discharge. On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was offered to the facility's staff to present additional information but they did not. 2. Resident #112 was originally admitted on 5/9/19 with a readmission date of 7/25/19. Resident #112's diagnoses included dementia, Parkinson's disease and schizophrenia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/20/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision were severely impaired. Review of the clinical record reveal Resident #112 was discharged from the facility return anticipated to an acute care hospital 7/22/19 after a fall. On 10/23/19 at approximately 2:45 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #2. LPN #2 stated there was no documentation available stating the resident's comprehensive care plan goals were sent with the resident to the hospital at the time of his 7/22/19 discharge. On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator	F 622	Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The DON and Unit Managers is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but they did not.
3. Resident #78 was originally admitted to the facility on 9/19/13 with diagnoses to include but not limited to, Diabetes Mellitus and Urine Retention.

The most recent Minimum Data Set (MDS) was a Annual with an Assessment Reference Date (ARD) of 9/6/19. Resident #78's Brief Interview for Mental Status (BIMS) was a 13 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making.

On 10/22/19 at 11:02 A.M. Resident #78 was asked if he had been to the hospital recently. Resident #78 stated, "I went a few months ago the staff were unable to wake me up."

Resident #78's Facility Census History was reviewed and is documented in part, as follows:

03/23/2019 Discharge-Return Expected
03/27/2019 Return
05/16/2019 Discharge-Return Expected.
05/21/2019 Return.
08/06/2019 Discharge-Return Expected
08/07/2019 Return

On 10/23/19 at 1:45 P.M. the Director of Nursing was asked for documentation to show that the care plan goals were sent with Resident #78 to the hospital for the 3 discharges this year.

Resident #78's care plan was reviewed and is documented in part, as follows:
Problems: Infection Control, Restorative Nursing,

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Diabetes, Psychotropic Drug Use, Falls, Skin Integrity, Elimination, Visual Function, Tremors, Depression, Resists Care, Nutritional Status and Advance Directives.

On 10/23/19 at approximately 4:00 P.M. the Director of Nursing stated "I don't have any documentation to support that the care plan goals were sent with (Name-Resident #78) for the 3 discharges this year."

On 10/24/19 at 7:30 P.M. a Pre-exit debriefing was held with the Administrator, Director of Nursing and the Regulatory Care Consultant where the above information was shared. Prior to exit no further information was shared

4. Resident #64 was admitted to the nursing facility on 7/29/16 with diagnoses that included generalized muscle weakness, bipolar disease and schizophrenia.

Resident #64's most recent Minimum Data Set (MDS) was a significant change in status assessment. The resident scored a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was fully intact with the skills for daily decision making.

There was no evidence provided that the facility staff conveyed the summary and goals of the comprehensive plan of care upon transfer/discharge to the local hospital on 12/27/18 and 7/7/19 for Resident #64. No documentation was included in the transfer summary that indicated the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or as soon as possible to the actual

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time of transfer.

On 10/24/19 at 10:30 a.m., the Unit II Nurse Manager stated she was not aware of the process to send a care plan summary and goals when a resident is transferred to the Emergency Department (ED) or hospital.

On 10/24/19 at 11:00 a.m., the Director of Nursing (DON) stated, "We are not going far enough in the interact form or the discharge summary form that will actually generate the care plan summary goals. You might as well stop searching, we are not sending this document and education will have to take place, as well as draft a facility policy and procedure."

On 10/24/19 at 4:08 p.m., during the debriefing with the Administrator and DON, the aforementioned issue was readdressed and no further information was provided prior to survey exit.

5. Resident #95 was admitted to the nursing facility on 1/6/18 with diagnoses that included stroke, diabetes and heart failure.

Resident #95's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment dated 9/23/19 and coded the resident on the Brief Summary for Mental Status (BIMS) with a score of 3 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for daily decision making.

There was no evidence provided that the facility staff conveyed the summary and goals of the comprehensive plan of care upon

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transfer/discharge to the local hospital on 5/11/19 and 9/3/19 for Resident #95. No documentation was included in the transfer summary that indicated the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or as soon as possible to the actual time of transfer.

On 10/24/19 at 10:30 a.m., the Unit II Nurse Manager stated she was not aware of the process to send a care plan summary and goals when a resident is transferred to the Emergency Department (ED) or hospital.

On 10/24/19 at 11:00 a.m., the Director of Nursing (DON) stated, "We are not going far enough in the interact form or the discharge summary form that will actually generate the care plan summary goals. You might as well stop searching, we are not sending this document and education will have to take place, as well as draft a facility policy and procedure."

On 10/24/19 at 4:08 p.m., during the debriefing with the Administrator and DON, the aforementioned issue was readdressed and no further information was provided prior to survey exit.

6. Resident #128 was admitted to the nursing facility on 5/6/09 with diagnoses that included diabetes mellitus, enlarged heart.

Resident #128's most recent Minimum Data Set (MDS) assessment was a quarterly dated 9/23/19 and coded the resident on the Brief Summary for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the skills needed for daily decision

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making.

There was no evidence provided that the facility staff conveyed the summary and goals of the comprehensive plan of care upon transfer/discharge to the local hospital on 9/11/19 for Resident #128. No documentation was included in the transfer summary that indicated the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or as soon as possible to the actual time of transfer.

On 10/24/19 at 9:20 a.m., Licensed Practical Nurse (LPN) #19 on Unit III stated she did not know about sending a summary of the resident's care plan goals when the residents are sent to the Emergency Department (ED) or hospital.

On 10/24/19 at 11:00 a.m., the Director of Nursing (DON) stated, "We are not going far enough in the interact form or the discharge summary form that will actually generate the care plan summary goals. You might as well stop searching, we are not sending this document and education will have to take place, as well as draft a facility policy and procedure."

On 10/24/19 at 4:08 p.m., during the debriefing with the Administrator and DON, the aforementioned issue was readdressed and no further information was provided prior to survey exit

7. Resident #32 was originally admitted to the facility on 03/22/12. Diagnosis for Resident #32 included but not limited to Anemia and Altered Mental Status.

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The current Minimum Data Set (MDS), an annual assessment with an Assessment Reference Date (ARD) of 08/02/19. Staff assessment for mental status was conducted because resident was unable to complete the interview. Staff assessment for mental status coded the resident as having short-term and long-term memory problems.

The Discharge MDS assessments was dated for 04/13/19 - discharged with return anticipated.

On 04/13/19, according to the facility's documentation, Resident departed facility with local transport to the local hospital.

On 10/24/19 at approximately, 3:21 PM an interview was conducted with LPN #1, Unit Manager. She stated, "No care plan summary was sent."

A briefing was held with the Director of Nursing (DON), Administrator and with the Corporate Nurse Consultant on 10/24/19 at approximately 5:25 P.M. No further comments were made.
8. The facility staff failed to ensure that Resident #11's Plan of Care Summary to include her care plan goals was sent upon transfer/discharge to the hospital on 09/16/19. Resident #11 was originally admitted to the facility on 07/15/18. Diagnosis for Resident #11 included but not limited to Thromobocytopenia.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 07/22/19 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

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On 09/16/19, according to the facility's documentation, Resident #11, left the facility via ambulance service as a direct admit to the hospital, pending a surgical procedure. The clinical record did not show evidence that Resident #11's care plan summary to include her goals were sent upon discharge to the hospital or shortly after.

An interview was conducted with License Practical Nurse (LPN) #3 on 10/22/19 at approximately 4:10 p.m. The LPN stated, "I have never sent the resident's care plan summary when sending them out to the hospital, I was not aware we were suppose to."

A briefing was held with the Administrator, Director of Nursing and Cooperate Nurse on 10/24/19 at approximately 4:08 p.m. The facility did not present any further information about the findings.

9. Resident #94 was originally admitted to the facility on 10/22/1993 with a re-admission date of 9/3/19 with diagnoses to include chronic obstructive pulmonary disease, type II diabetes, and schizophrenia. The current Minimum Data Set an annual with an assessment reference date of 9/17/19 coded the resident as scoring a 9 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was moderately impaired.

The clinical record failed to evidence documentation that upon transfer to the hospital on 8/28/19 a copy of Resident #94's care plan was sent along with other required documents.

10/23/19 11:24 a.m., the unit manager was asked

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F 622	Continued From page 45 to locate documentation of the facility sending the care plan. The unit manager stated, "I can not locate any documentation of bed hold or care plan sent with the resident for the last transfer to the hospital." On 10/24/19 the above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting. 10. Resident #605 was admitted to the facility on 07/12/19 with diagnosis of Bipolar disorder, muscle weakness, dysphasia, abnormalities of gait and mobility, hypertension, schizophrenia, acute respiratory failure with hypoxia, reflux disease, insomnia, major depression and anemia. An admission Minimum Data Set dated 07/19/19 assessed the resident in the area of Cognitive Patterns as having a Brief Interview for Mental Status (BIMS) score of (13) indicating intact cognition. In the area of Activities of Daily Living (ADL'S) this resident was assessed as requiring total care in the areas of dressing, eating, personal hygiene and toileting. Resident #605 was transferred to the hospital from the facility on 09/22/19. There was no evidence that the facility provided a care plan regarding ongoing care needs to the receiving hospital.	F 622		
F 623 SS=B	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	F 623		12/8/19

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the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(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:

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F 623	Continued From page 47 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. 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.	F 623		

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F 623	Continued From page 48 §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 resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of hospital discharges for 1 of 63 residents in the survey sample, Resident #11. The findings included: Resident #11 was originally admitted to the facility on 07/15/18. Diagnosis for Resident #11 included but not limited to Thromobocytopenia. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 07/22/19 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. On 09/16/19, according to the facility's documentation, Resident #11, left the facility via ambulance service as a direct admit to the hospital, pending a surgical procedure. The Discharge MDS assessments was dated for 09/16/19 - discharged with return anticipated.	F 623	1. Resident #11 was added to the Ombudsman Log for discharge on 9/16/19 and sent to the Long-Term Care Ombudsman. 2. To insure no other residents were affected, an audit of the current resident population was completed and notifications were provided for those affected starting the month of October 2019. 3. Education on the written notification of discharge policy was provided to the Social Services Director. This education will be complete by 11/20/19. . This training will also be provided to all Social Services Directors upon hire during orientation. 4. Ongoing audits by the Social Services Director for observation and review of proper notification of the Long-Term Care Ombudsman of residents discharge. These audits will be conducted weekly for four weeks and monthly for three months. These audits will also include no less than	

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F 623	Continued From page 49 An interview was conducted with the Social Worker on 10/24/19 at approximately 9:30 a.m., who stated, "I will run a Discharge Summary every Monday that shows all resident's who was discharged for that time period. She said the report was ran from 09/15/19 through 09/22/19, but Resident #11 was not on the list." She said the Ombudsman was not notified of Resident #11's discharge to the hospital on 09/16/19. The facility's policy titled Discharge or Transfer Summary (Last Revision date: 06/28/19). Guidelines include but not limited to: 5. Prior to a resident transfer or discharge, the facility will do the following: B. The facility will send a copy of the notice to the representative of the Office of the state Long-term Care Ombudsman.	F 623	10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Social Services Director is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F 625		12/8/19

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SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(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 625	Continued From page 50 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, facility documentation review and the facility's policy; the facility's staff failed to provide written information to the resident and/or resident representative explaining how a resident's bed is held while the resident is absent from the facility due to hospitalization for 9 of 63 residents (Resident #88, #112, #78, #64, #95, #128, #11, #94 and #605) in the survey sample. The findings included: 1. Resident #88 was originally admitted on 08/1/14 with a readmission date of 8/1/19. Resident #88's diagnoses included paraplegia, multiple sclerosis and anemia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/16/19 coded the resident as completing the Brief Interview for Mental Status	F 625	1. Written information was provided to the resident and/or representative of resident # 88, #112, #78, #64, #95, #128, #11, #94, and #605 explaining how a resident's bed is held while the resident is absent from the facility due to hospitalization. 2. All residents had the potential to be affected. Bed hold policies will be provided to all residents discharged from the facility due to hospitalization starting the month of November 2019. 3. Education on the written notification of discharge policy was provided to the Admissions Coordinator and licensed nursing staff. This education will be complete by 11/20/19. . This training will also be provided to all Admissions Coordinators upon hire during orientation.	

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F 625	Continued From page 51 (BIMS) and scoring 15 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision making are intact. Review of the clinical record reveal Resident #88 was discharged from the facility return anticipated to an acute care hospital 7/20/19 for a critical hemoglobin and hematocrit. On 10/23/19 at approximately 1:30 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 stated there was no documentation available stating the resident was given information of the bed-hold policy at the time of his 7/20/19 discharge. On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was offered to the facility's staff to present additional information but they did not. 2. Resident #112 was originally admitted on 5/9/19 with a readmission date of 7/25/19. Resident #112's diagnoses included dementia, Parkinson's disease and schizophrenia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/20/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision were severely impaired. Review of the clinical record revealed Resident #112 was discharged from the facility return anticipated to an acute care hospital 7/22/19 after a fall.	F 625	4. Ongoing audits by the Admissions Coordinator, Administrative Assistant, and/or Unit Managers for observation and review of proper notification has been presented in writing to the resident and/or resident representative explaining how a resident□s bed is held while the resident is absent from the facility due to the hospitalization. These audits will be conducted twice a week for four weeks, weekly for three weeks, monthly for three months, and then random audits each month for two months. These audits will also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Admissions Coordinator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 625	Continued From page 52	F 625		

On 10/23/19 at approximately 2:45 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #2. LPN #2 stated there was no documentation available stating the resident was given information of the bed-hold policy at the time of his 7/22/19 discharge

On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but they did not.
3. Resident #78 was originally admitted to the facility on 9/19/13 with diagnoses to include but not limited to Diabetes Mellitus and Urine Retention.

The most recent Minimum Data Set (MDS) was a Annual with an Assessment Reference Date (ARD) of 9/6/19. Resident #78's Brief Interview for Mental Status (BIMS) was a 13 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making.

On 10/22/19 at 11:02 A.M. Resident #78 was asked if he had been to the hospital recently. Resident #78 stated, "I went a few months ago the staff were unable to wake me up."

Resident #78's Facility Census History was reviewed and is documented in part, as follows:

03/23/2019 Discharge-Return Expected
03/27/2019 Return
05/16/2019 Discharge-Return Expected.
05/21/2019 Return.
08/06/2019 Discharge-Return Expected

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F 625	Continued From page 53 08/07/2019 Return On 10/23/19 at 1:45 P.M. the Director of Nursing was asked for documentation that bedhold information was sent with Resident #78 to the hospital for the 3 discharges this year. On 10/23/19 at approximately 4:00 P.M. the Director of Nursing stated "I don't have any documentation to support that the bedholds were sent with (Name-Resident #78) for the 3 discharges this year." On 10/24/19 at 7:30 P.M. a Pre-exit debriefing was held with the Administrator, Director of Nursing and the Regulatory Care Consultant where the above information was shared. Prior to exit no further information was shared. 4. Resident #64 was admitted to the nursing facility on 7/29/16 with diagnoses that included generalized muscle weakness, bipolar disease and schizophrenia. Resident #64's most recent Minimum Data Set (MDS) was a significant change in status assessment. The resident scored a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was fully intact with the skills for daily decision making. Upon review of Resident #64's clinical record, no documentation was located that supported the resident or representative was issued a bed hold notice at the time of transfer to the local hospital on 12/27/18 and 7/7/19. On 10/24/19 at 10:30 a.m., the Unit II Nurse Manager stated she was not aware of the process to issue a bed hold notice to either the	F 625		

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resident of Resident Representative upon transfer to the Emergency Department (ED) or hospital.

On 10/24/19 at 11:00 a.m., the Director of Nursing (DON) stated the nursing staff was not issuing a bed hold notice to residents when they are transferred to the ED or hospital and that procedure and policy changes need to take place along with education to the nursing staff.

On 10/24/19 at 4:08 p.m., during the debriefing with the Administrator and DON, the aforementioned issue was readdressed and no further information was provided prior to survey exit.

5. Resident #95 was admitted to the nursing facility on 1/6/18 with diagnoses that included stroke, diabetes and heart failure.

Resident #95's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment dated 9/23/19 and coded the resident on the Brief Summary for Mental Status (BIMS) with a score of 3 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for daily decision making.

Upon review of Resident #95's clinical record, no documentation was located that supported the resident or representative were issued a bed hold notice at the time of transfer to the local hospital on 5/11/19 and 9/3/19.

On 10/24/19 at 10:30 a.m., the Unit II Nurse Manager stated she was not aware of the process to issue a bed hold notice to either the resident of Resident Representative upon transfer

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to the Emergency Department (ED) or hospital.

On 10/24/19 at 11:00 a.m., the Director of Nursing (DON) stated the nursing staff was not issuing a bed hold notice to residents when they are transferred to the ED or hospital and that procedure and policy changes need to take place along with education to the nursing staff.

On 10/24/19 at 4:08 p.m., during the debriefing with the Administrator and DON, the aforementioned issue was readdressed and no further information was provided prior to survey exit.

6. Resident #128 was admitted to the nursing facility on 5/6/09 with diagnoses that included diabetes mellitus, enlarged heart.

Resident #128's most recent Minimum Data Set (MDS) assessment was a quarterly dated 9/23/19 and coded the resident on the Brief Summary for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact in the skills needed for daily decision making.

Upon review of Resident #95's clinical record, no documentation was located that supported the resident or representative were issued a bed hold notice at the time of transfer to the local hospital on 5/11/19 and 9/3/19.

On 10/24/19 at 9:20 a.m., Licensed Practical Nurse (LPN) #19 on Unit III stated she did not know about issuing a bed hold notice with the resident or representative upon transfer to ED or hospital.

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F 625	Continued From page 56	F 625		

On 10/24/19 at 11:00 a.m., the Director of Nursing (DON) stated the nursing staff was not issuing a bed hold notice to residents when they are transferred to the ED or hospital and that procedure and policy changes need to take place along with education to the nursing staff.

On 10/24/19 at 4:08 p.m., during the debriefing with the Administrator and DON, the aforementioned issue was readdressed and no further information was provided prior to survey exit.

7. Resident #11 was originally admitted to the facility on 07/15/18. Diagnosis for Resident #11 included but not limited to Thromobocytopenia

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 07/22/19 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.

On 09/16/19, according to the facility's documentation, Resident #11, left the facility via ambulance service as a direct admit to the hospital, pending a surgical procedure. The clinical record did not show evidence that Resident #11's care plan summary to include her goals were sent upon discharge to the hospital or shortly after.

An interview was conducted with License Practical Nurse (LPN) #3 on 10/22/19 at approximately 4:10 p.m. The LPN reviewed Resident #11's clinical record then stated, "I am unable to provide evidence that Resident #11 was given the bed hold policy when transferred and admitted to the hospital on 09/16/19.

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A briefing was held with the Administrator, Director of Nursing and Cooperate Nurse on 10/24/19 at approximately 4:08 p.m. The facility did not present any further information about the findings.

8. Resident #94 was originally admitted to the facility on 10/22/1993 with a re-admission date of 9/3/19 with diagnoses to include chronic obstructive pulmonary disease, type II diabetes, and schizophrenia. The current Minimum Data Set an annual with an assessment reference date of 9/17/19 coded the resident as scoring a 9 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was moderately impaired.

Review of the clinical record nursing progress notes indicated Resident #94 was transferred to the emergency room on 8/28/19 for evaluation of a change in condition and admitted to the hospital. The resident was re-admitted back to the facility on 9/3/19. The clinical record failed to evidence documentation that upon transfer or after transfer and admission to the hospital that a copy of the bed hold policy was sent/ information provided to the resident /Responsible Party.

On 10/23/19 at 11:24 AM and interview was conducted with the Unit Manager who stated "I can not locate any documentation of bed hold or care plan sent with the resident for the last transfer to the hospital."

On 10/24/19 the above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting.

9. Resident #605 was admitted to the facility on 07/12/19 with diagnosis of Bipolar disorder,

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F 625	Continued From page 58 muscle weakness, dysphasia, abnormalities of gait and mobility, hypertension, schizophrenia, acute respiratory failure with hypoxia, reflux disease, insomnia, major depression and anemia. Resident #605 was discharged from the facility on 9/22/19. An admission Minimum Data Set dated 07/19/19 assessed this resident in the area of Cognitive Patterns as having a Brief Interview for Mental Status (BIMS) score of (13) indicating intact cognition. Resident #605 was transferred to the hospital from the facility on 09/22/19. There was no evidence in the clinical record that the facility provided a Notice of Bed Hold Policy at the time of transfer.	F 625		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review , it was determined that the facility staff failed to ensure that the assessment accurately reflected Resident #42's status, 1 of 63 resident's in the survey sample. The findings included: Resident #42 was admitted to the facility on 01/09/2019. Diagnosis included but were not limited to Anemia and Hypertension. Resident #42's Quarterly Minimum Data Set (an	F 641	1. The facility failed to accurately code the MDS reviewed for Resident #42 reviewed for physician-prescribed weight loss regimen. MDS Coordinator modified and re-submitted MDS for Residents #42 MDS Coordinator immediately educated regarding expectations for accurately coding MDS upon identification of errors. 2. All residents have the potential to be affected by this alleged deficient practice. The MDS Coordinator/designees and	12/8/19

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F 641	Continued From page 59 assessment protocol) with an Assessment Reference Date of 08/09/2019 coded Resident #42 with a BIMS (Brief Interview for Mental Status) score of 12 indicating moderate cognitive impairment. On 10/24/2019 review of Resident #42's Quarterly MDS, Section "K0300" - Weight Loss, revealed that the resident was coded as "Yes, on physician-prescribed weight loss regimen." On 10/24/2019 Resident #42's Physician Order Summary was reviewed. There was no evidence that the resident had orders to be on a physician-prescribed weight loss regimen. On 10/24/2019 at 5:50 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #5, MDS Coordinator, and she was asked, "Who enters the information into the MDS?" LPN #5 stated, "I do." LPN #5 reviewed Section "K0300" on the Quarterly MDS with an Assessment Reference Date of 08/09/2019. LPN #5 was asked, "Can you provide evidence that Resident #42 has orders to be on a physician-prescribed weight loss regimen?" LPN #5 stated, "The resident does not have an order for physician prescribed weight loss regimen. I accidentally coded the MDS incorrectly." LPN #5 was asked, "Is this an inaccurate assessment?" LPN #5 stated, "Yes. I will modify the assessment." On 10/24/2019 at approximately 7:00 p.m., LPN #5 provided a modified copy of the Quarterly MDS for 08/09/2019 with a "CMS (Centers for Medicare and Medicaid Services) Submission Report" with a submission date of 10/24/2019 at 6:33 p.m. and a processing completion date of 10/24/2019 at 6:37 p.m.	F 641	Regional MDS Consultant will complete a review of assessments for residents Section K0300 by November 30, 2019. Modifications will be completed as indicated by MDS Coordinator. 3. Education provided to MDS Coordinators on 11/11/19 on the RAI guidelines related to accurate coding of Section K weight loss- MD prescribed/not prescribed. This training will also be provided to all MDS nurses upon hire during orientation. 4. The RN MDS will complete an audit of 3 resident□s MDS Assessments weekly x 4 weeks to ensure accurate coding; then 2 resident□s MDS Assessments weekly x 2 weeks: then 1 monthly resident□s MDS Assessments x 3 months. Education will be provided as indicated. All data will be summarized and presented to the facility QAPI meeting monthly x 3 months by the MDS Coordinator. Any issues or trends identified will be addressed by the QAPI Committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and RN MDS Nurse is responsible for implementing and	

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F 641	Continued From page 60 The Administrator, Director of Nursing and Nurse Consultant was informed of the finding on 10/24/2019 at 7:30 p.m. at the pre-exit meeting. The facility staff did not present any further information about the finding.	F 641	maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		12/8/19

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F 655	Continued From page 61 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and facility document review, the facility staff failed to ensure that a Baseline Care Plan was developed for 1 of 63 resident's in the survey sample, Resident #155. The findings included: Resident #155 was a 91 year old admitted to the facility on 5/6/19 for a respite stay with diagnoses to include but not limited to Dementia and Chronic Obstructive Pulmonary Disease. Resident #155's Facility Face Sheet was reviewed and documented in part, as follows: Admit Date: 5/06/2019 Discharged: 5/20/2019 Resident #155's Electronic Medical Record was reviewed for the Baseline Care Plan and was not identified. On 10/24/19 12:06 P.M., an interview was	F 655	1. Facility unable to develop baseline care plan for resident #155 as resident discharged from the facility on 5/20/19. 2. All residents had the potential to be affected. Baseline care plans will be developed for all newly admitted residents within 48 hours of admission starting the month of November 2019. 3. Education on the baseline care plan policy was provided to the Licensed Nurses, Social Services Director, Quality of Life Director, and Dietary Manager. This education will be complete by 11/30/19. . This training will also be provided to all Licensed Nurses, Social Services Directors, Quality of Life Directors, and Dietary Managers upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure the	

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F 655	Continued From page 62 conducted with the Social Worker as to if a baseline care plan was completed. The Social Worker stated, "No I cannot find a baseline care plan, the admitting nurse should have done it on admission. I guess it wasn't done because she was a respite resident we don't normally do them for respite stays." On 10/24/19 at approximately 2:10 P.M., an interview was conducted with the Director of Nursing regarding Resident #155 not having a BaseLine Care Plan. The Director of Nursing stated. "She (Resident #155) should have had a baseline care plan complete just like all admissions do. Just because she was here for a respite stay was not a reason not to have completed it." The facility policy titled "Baseline Care Plan Process" last revised 7/19/18 was reviewed and is documented in part, as follows: Policy Statement: To ensure that care needs are met, utilizing a person centered focus, for newly admitted and/or re-admitted residents. Charge Nurse: 2. Begin initial care plan process as done in the past. This will be the start of the Baseline Care Plan. 3. Create Baseline Care Plan, High risk areas must be care planned within 24 hours. Utilize Baseline Care Plan form which incorporates the following: a. Admission nursing evaluation/ancillary evaluations (triggered areas). b. Dietary orders. c. Goals for discharge.	F 655	baseline care plan is developed for all newly admitted residents within 48 hours of admission. These audits will be conducted twice a week for four weeks, weekly for three weeks, monthly for three months, and then random audits each month for two months. These audits will also include no less than 10% of the admissions to the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 655	Continued From page 63 d. Goals based on admission orders. e. MD (Medical Doctor) orders. f. therapy. g. Social Services. h. Preadmission Screening and Resident Review (PASRR) recommendations. 4. Baseline Care Plan will be a working tool for the first 48 hours. 5. Baseline Care Plan is finalized during the first 48 hours after admit utilizing input from all disciplinary team members along with resident and/or resident's Power of Attorney/family. On 10/24/19 at 7:30 P.M. a pre-exit debriefing was held with the Administrator, Director of Nursing and the Regulatory Care Consultant where the above information was shared. Prior to exit no further information was shared.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		12/8/19

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F 656	Continued From page 64 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, resident interview and clinical record review, the facility staff failed to address Activities of Daily Living (ADLs) in the comprehensive care plan for 1 of 63 resident's in the survey sample, Resident #403. The findings included: Resident #403 was admitted to the facility on 09/30/2018. Diagnosis included but were not	F 656	1. Comprehensive care plan updated to reflect ADLs for resident #403. 2. All residents had the potential to be affected. Care plans will be reviewed for all residents with care plan meetings starting November 2019. 3. Education on the comprehensive care plan policy was provided to the MDS Nurses on 11/11/19. This training will	

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F 656	Continued From page 65 limited to, Dementia and Cerebral Infarction. Resident #403's Minimum Data Set (MDS) with an Assessment Reference Date of 09/13/2019 coded Resident #403 with short term memory problems and long term memory problems and with severely impaired cognitive skills for daily decision making. In addition, the Minimum Data Set coded Resident #403 as requiring limited assistance of 1 with transfer, extensive assistance of 1 with bed mobility, dressing and personal hygiene, and total dependence of 1 for toilet use and bathing. On 10/24/2019 at 10:45 a.m., Resident #403's comprehensive care plan was reviewed and did not include information communicating the resident's needs with ADLs as identified in the comprehensive assessment. On 10/24/2019 at 11:10 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #5 and she was asked, "Does Resident #403 have a care plan addressing ADLs?" LPN #5 stated, "No she does not. ADL did not trigger, I did not put it in the care plan." MDS Coordinator was present and stated, "The resident should have a ADL care plan." LPN #5 and the MDS Coordinator were asked, "What is the purpose of the care plan?"" LPN #5 stated, "It acknowledges the areas that the resident has problems with." MDS Coordinator stated, "It drives the care for the resident." On 10/24/2019 at 11:45 a.m., the Director of Nursing was made aware that Resident #403's needs with ADLs was not addressed in her comprehensive care plan. The Director of Nursing stated, "They are suppose to care plan	F 656	also be provided to all MDS coordinators and Licensed Nurses upon hire during orientation. 4. Ongoing audits by the MDS Coordinators for observation and review to ensure the ADLS are accurately coded on the MDS assessments for each resident. These audits will be conducted on 10 residents twice a week for four weeks, 5 residents weekly for three weeks, 5 residents monthly for three months, and then 2 random audits each month for two months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and MDS Coordinator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 656	Continued From page 66 everything. They should have care planned ADLs." The Administrator, Director of Nursing and Nurse Consultant was informed of the finding on 10/24/2019 at 7:30 p.m. at the pre-exit meeting. The facility staff did not present any further information about the finding.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		12/8/19

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F 657	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, family interview, facility documentation review and in the course of a complaint investigation, the facility staff failed to review and revise the person-centered care plan as their condition changed for 5 of 63 residents (Resident #88, #112, #11, #94 and #105) in the survey sample. The findings included: 1. Resident #88 was originally admitted on 08/1/14 with a readmission date of 8/1/19. Resident #88's diagnoses included paraplegia, multiple sclerosis and anemia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/16/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision making were intact. In section"G"(Physical functioning) the resident was coded as requiring total care with eating, personal hygiene and bathing, extensive assistance of two with bed mobility, extensive assistance of one with person with toileting and dressing. Review of a nursing progress note dated 8/2/19, at 3:25 p.m., revealed Resident #88 was readmitted to the facility 8/1/19, with a new stage 3 pressure ulcer to the left ischium and currently wound care continued to the area. Review of the physician's order summary revealed an order dated 10/17/19 which read: clean left ischium wound with Dakins 1/4 strength	F 657	1. Comprehensive care plan updated to reflect pressure ulcer for resident #88, aspiration risk for resident #112, Stage 3 pressure ulcer for resident #11, pain management for resident #94, and sexually inappropriate behavior for resident #105. 2. All residents had the potential to be affected. Care plans will be reviewed/revised during resident care plans for November 2019. 3. Education on the care plan timing and revision policy was provided to the MDS Nurses and Licensed Nurses by 11/30/19. This training will also be provided to all MDS coordinators and Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure care plans are reviewed and revised for residents person-centered care plan as their condition changed. These audits will be conducted on 10 residents twice a week for four weeks, 5 residents weekly for three weeks, 5 residents monthly for three months, and then 2 random audits each month for two months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the	

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F 657	Continued From page 68 solution, apply a nickel layer of Santyl, apply Dakins gauze and cover with a border gauze daily and as needed. Review of the active care plan dated 5/24/19 and edited 9/24/19 revealed the following problem: Resident has a pressure ulcer stage 4 of the right ischium. The goal read: Resident will not develop additional pressure ulcers through 12/23/19. Some of the approaches included Apply dressings per physician order. Conduct a systematic skin inspection weekly. Report any signs of any further skin breakdown (sore, tender, red or broken areas). A complete review of the entire care plan didn't reveal a care plan for the pressure ulcer to the left ischium therefore, an interview was conducted with the wound care nurse on 10/23/19 at approximately 2:00 p.m. The wound care nurse provided a pressure ulcer report dated 10/22/19, revealing the left ischium was currently a stage 4 pressure ulcer measuring 4.0 x 4.0 x 1.5 centimeters and presenting with 75% granulation tissue and 25% necrotic tissue. The wound care nurse also stated the resident was non-compliant with turning and positioning to relieve pressure as necessary. On 10/24/19 at approximately 1:30 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #5. LPN #5 stated the care plan we were reviewing was the resident's current and active care plan but it didn't include a care plan for Resident #88's left ischial pressure ulcer but there should have been a care plan for the site. LPN #5 stated the left ischial pressure ulcer would be added to the current person-centered plan of care.	F 657	plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was offered to the facility's staff to present additional information; no further information was presented.

2. Resident #112 was originally admitted on 5/9/19 with a readmission date of 7/25/19. Resident #112's diagnoses included dementia, Parkinson's disease and schizophrenia.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/20/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring total care with bathing, extensive assistance of one person with dressing, toileting, and personal hygiene, supervision of one person with bed mobility and transfers, and supervision after set-up with eating.

Review of the clinical record revealed Resident #112 had a modified barium swallow completed 9/4/19, which revealed the resident was a high risk for aspiration. Nothing by mouth was recommended with an alternate means of nutrition.

A physician's progress note dated 10/10/19, stated the power of attorney (POA) was notified approximately one week ago of the modified barium swallow results and of the recommendations for nothing by mouth. The

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physician's progress further stated the POA decided against a peg tube and to continue with the current diet, knowing the risk of aspiration pneumonia.

An interview was conducted with the Nurse Practitioner on 10/23/19 at approximately 11:00 a.m., she stated she is monitoring the resident's potential for aspiration by performing routine chest x-rays for changes in the lungs indicating an acute problem.

Review of Resident #112's care plan revealed a nutritional care plan dated 5/27/19 and edited 8/15/19. The problem read: at nutritional risk related to dementia. At risk for weight fluctuations related to congestive heart failure, slight weight loss exhibited. The goal read: no significant weight changes through next review and 75% intake of diet through next review 11/24/19. Some of the interventions included: diet as ordered, medication as ordered, review labs as available and weights per protocol.

On 10/23/19 at approximately 3:15 p.m., an interview was conducted with Registered Nurse MDS Coordinator, she stated the care plan we were reviewing was the resident current active care plan and it didn't address the resident's aspiration risk but the care plan would be updated to include the risk.

On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator Director of Nursing, and Corporate Consultant. An opportunity was offered to the facility staff to present additional information; no further information was provided.

3. Resident #11 was originally admitted to the

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facility on 07/15/18. Diagnosis for Resident #11 included but not limited to *Pressure ulcer of other site, unspecified stage. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 07/22/19 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #11 requiring total dependence of one with hygiene, extensive assistance of one with transfer, dressing, personal hygiene, bed mobility and toilet use.

The review of Resident #11's comprehensive person care plan with a revision date of 07/30/19 did not include the stage III sacral pressure ulcer identified on 10/09/19.

The review of the wound information pressure ulcer form noted evidence of an entry dated 10/09/19 at 6:59 a.m., indicated the following: A new sacral pressure ulcer measured 6 cm x 4.3 cm with light seropurulent (yellow or tan, cloudy and thick exudate (drainage). The tissue type observed with slough, wound edges/margins well defined and pink/normal skin surrounding wound.

The review of the Wound Information Pressure Ulcer form noted evidence of an entry dated on 10/16/19 - sacrum pressure ulcer measuring 6 cm x 4 cm with 0.1 cm depth with moderate amount of serous (clear, amber, thin and watery) exudate. The tissue bed with slough, wound edges/margins well defined with pink/normal skin surround wound.

An interview was conducted with the MDS Coordinator on 10/24/19 at approximately 9:00

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a.m., who stated, "I was unable to locate a revised skin integrity care plan to include the stage III sacral wound identified on 10/09/19." She said the nurses as well as MDS are responsible for updating/revising care plans. The MDS Coordinator said the nurse who found the wound should have revised the care plan with a new intervention, but it was not done.

On 10/24/19 at approximately 11:48 a.m., an interview was conducted with the wound nurse (Licensed Practical Nurse-LPN #7), who stated, "I found the stage III pressure ulcer to Resident #11's sacrum on 10/09/19." The surveyor asked, "Should Resident #11's care plan be revised to include the newly identified stage III sacral pressure ulcer." The LPN replied, "Absolutely, I should have made an adjustment to Resident #11's care plan to include the stage III sacral pressure ulcer."

A briefing was held with the Administrator, Director of Nursing and Cooperate Nurse on 10/24/19 at approximately 4:08 p.m. The facility did not present any further information about the findings.

The facility's policy title Pressure Ulcer Management Resources (Revised 07/24/18.) Guideline Steps include but not limited to:
-Revise the care plan to reflect the change in condition. Develop an effective plan of are consistent with resident goals and wishes. Update the care plan to reflect new treatment goals and approaches.

Definitions:
*Pressure Injury: A pressure injury is localized

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damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

*Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

4. Resident #94 was originally admitted to the facility on 10/22/1993 with a re-admission date of 9/3/19, with diagnoses to include neuralgia (severe pain occurring along the course of a nerve), neuritis (inflammation of a nerve) and right shoulder pain. The current Minimum Data Set an annual with an assessment reference date of 9/17/19 coded the resident as scoring a 9 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was moderately impaired. The resident was coded as being on a scheduled pain medication regimen.

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10/22/19 at 4:39 p.m., the resident was in bed and complained of back pain, the resident could not give a pain level number. The nurse who was outside in the hallway was informed of the resident's pain.

The physician orders dated 9/3/19 were to administer Neurontin 300 milligrams by mouth twice daily for neuralgia and neuritis and Tylenol 650 milligrams every six hours as needed for right shoulder pain.

The Comprehensive Person-Centered Plan of Care for Resident #94 was not revised to include a pain management plan of care.

The above findings was shared during the pre-exit meeting conducted on 10/24/19 with the Administrator and the Director of Nursing. No further information was provided by facility staff.

5. Resident # 105 was admitted to the facility on 7/21/2014 with a readmission occurring on 12/07/2018 with the latest diagnosis including, but not limited to, Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus, encephalopathy. Unspecified, contracture, right hand, muscle weakness (generalized, type 2 diabetes mellitus, unspecified convulsions.

Resident # 105's MDS (Minimum Data Set), Quarterly Review Assessment dated 10/07/2019 coded Resident #105 with a BIMS (brief interview of mental status) as 2 out of a possible 15, indicating severe cognitive impairment.

Review of a Facility Reported Incident (FRI)

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received at the Office of Licensure and Certification on 8/8/2019 detailed a resident to resident incident where facility staff responded to repeated yelling of a resident (Resident #90) in the hallway. According to a written statement, Certified Nursing Assistant (CNA) staff witnessed, Resident #105 "rubbing his penis on the arm of Resident #90."

A review of Resident #105's Behavior Management Care Plan dated 5/10/2019 included addressing wandering behavior with a goal to have fewer episodes of wandering, evidenced by behaviors occurring less than weekly. An additional Behavior Care Plan was initiated on 10/28/2015 with updates through 11/15/2018 and a final target date of 5/19/2019 identifying socially inappropriate behavior, walking around in the nude, and approaching visitors while undressed. The goal was to not harm himself or others and a target to a reduction in occurrences of behavior to less than 3 times per week. Identified approaches include, report to physician changes in behavioral status, reinforce positive behavior, educate the resident/responsible party on the causal factors of the behavior, address wandering behavior by walking with resident, investigate monitor need for psychological/psychiatric support, intervene as needed to protect the rights & safety of others, and, monitor resident closely for whereabouts.

There were no revisions to the Care Plan as a response to the aforementioned incident.

At 10/23/19 at approximately 1:45 PM a phone interview was conducted with Resident #105's authorized representative, regarding the aforementioned incident, stating, "Yes, there was

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F 657	Continued From page 76 an incident back in August. This was very unusual. Usually staff will give him privacy so he can take care of his nature. We talked about this in care planning." On 10/24/2019, follow-up activities to the FRI submitted on 8/8/2019, included an interview with the Director of Nursing (DON) who was asked if Resident #105 has a history of sexually inappropriate behaviors, she answered, "Yes he does, about every 2 months." The DON was subsequently asked about the facility management of identified behaviors, the DON answered, "We monitor him." The Facility Administrator was informed of the findings during a briefing on 10/24/2019 at approximately 7:30 p.m. The Facility did not present any further information about the findings.	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, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of nursing practices for 1 out of 63 residents (Resident #11) in the survey sample. The facility staff failed to obtain physician orders for a newly developed stage III sacral pressure ulcer for Resident #11. The findings included:	F 658	1. Physicians order written for Resident #11 for care of pressure wound. Treatment is on the treatment sheet. 2. All residents had the potential to be affected. Facility wounds reviewed to ensure physician□s orders have been initiated and are on the treatment sheet. This was completed by 11/22/19.	12/8/19

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F 658	Continued From page 77 Resident #11 was originally admitted to the facility on 07/15/18. Diagnosis for Resident #11 included but not limited to *Pressure ulcer of other site, unspecified stage. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 07/22/19, coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #11 requiring total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, toilet use and personal hygiene for Activities of Daily Living care. Resident #11 was coded always continent of bladder due to indwelling Foley catheter and frequently incontinent of bowel. Resident #11's person-centered comprehensive care plan last revised on 07/30/19 documented Resident #11 with multiple pressure ulcers. The goal: Resident's ulcer will heal without complications. Some of the intervention/approaches to manage goal included: to assess and record the condition of the skin surrounding the pressure ulcer, keep clean and dry as possible, provide incontinence care after each incontinent episode, treatment per physician order, use pressure reduction when resident is in the chair and bed, use moisture barrier product to perineal area, turn and reposition in bed and chair and conduct a systematic skin inspection weekly. Report any signs of further skin breakdown. The review of the wound information pressure ulcer form noted evidence of an entry dated	F 658	3. Education on the pressure ulcer management policy was provided to the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure physician□s orders have been obtained for pressure ulcers and the orders have been place on the treatment sheet. These audits will be conducted twice weekly for four weeks, weekly for four weeks, and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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10/09/19 at 6:59 a.m., indicated the following: A new sacral pressure ulcer measured 6 cm (centimeters) x 4.3 cm with light seropurulent (yellow or tan, cloudy and thick exudate (drainage). The tissue type observed with slough, wound edges/margins well defined and pink/normal skin surrounding wound.

The review of the Wound Information Pressure Ulcer form noted evidence of an entry dated on 10/16/19-sacrum pressure ulcer measuring 6 cm x 4 cm with 0.1 cm depth with moderate amount of serous (clear, amber, thin and watery) exudate. The tissue bed with slough, wound edges/margins well defined with pink/normal skin surround wound.

Review of Resident #11's October 2019, Physician Order Sheet and Treatment Administration Record did not include a treatment for Resident #11's stage III sacral pressure ulcer first identified on 10/09/19.

An interview was conducted with Unit Manager, Licensed Practical Nurse (LPN) #3 on 10/24/19 at approximately 11:23 a.m., who stated, "I reviewed Resident #11's current Physician Order Sheet and Treatment Administration Record for October 2019 and was unable to locate a treatment for the sacral pressure ulcer identified on 10/09/19."

On 10/24/19 at approximately 11:48 a.m., an interview was conducted with wound nurse (LPN #7) who identified the stage III sacral pressure ulcer on Resident #11. The LPN stated, "I found the stage III pressure ulcer to Resident #11's sacrum on 10/09/19. She said "I wrote an order for the sacral wound." The surveyor reviewed the October 2019's Physician Order Sheet and

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Treatment Administration Record with LPN #7. After she reviewed the Physician Order Sheet and Treatment Administration Record, she stated, "I remember writing a treatment for the stage III sacral wound; it should be on the physician order sheet and treatment administration record for October 2019 but I do not see an order."

An interview was conducted with LPN #3 on 10/24/19 at approximately 3:00 p.m. The LPN provided routine wound care on Resident #11 on 10/21/19. The LPN stated, "I was not aware Resident #11 had a sacral wound pressure ulcer." The surveyor asked, "Did Resident #11 have any other pressure ulcers" she replied, "Yes, but her wounds were on her feet, legs and hip/thigh area so I had no reason to look at her sacrum. The LPN stated, "I did not do wound care to a sacral wound, I did not realize she had one."

On 10/24/19 at approximately 3:05 p.m., an interview was conducted with LPN #4 who cared for Resident #11 on 10/20/19. The LPN said she was not aware Resident #11 had a sacral pressure ulcer. She stated, "I went by the treatment administration record when providing wound care and since the sacral pressure ulcer was not on the treatment record, I did not do a wound treatment to the sacrum."

A briefing was held with the Administrator, Director of Nursing and Cooperate Nurse on 10/24/19 at approximately 4:08 p.m. The facility did not present any further information about the findings.

The facility's policy titled Pressure Ulcer Management Resources (Revised 07/24/19.)
-Guideline steps to include but not limited to:

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F 658	Continued From page 80 -5. Inform the physician (and responsible party, as appropriate) of new pressure ulcer. Obtained and initiate treatment orders. Report the following to the physician to include but not limited to: -Current treatment and review of the past treatment, as appropriate. 6. Implement a preventative program to prevent additional new areas from developing. Ensure the preventative measures are listed on the care plan and flow sheets. 8. Initial ulcer care involves debridement, wound cleansing, dressing application, and possible adjunctive therapy. 11. Protect the wound with dressings. A dressing should protect the wound, be biocompatible and provide ideal hydration. The cardinal rule is to keep the ulcer tissue moist and the surrounding intact skin dry to prevent maceration. 13. All Stage 2, 3, and 4 ulcers are colonized with bacteria. Regular wound cleaning should prevent colonization from proceeding to infection.	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 process must be consistent with the discharge	F 660		12/8/19

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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 made the determination and why.

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F 660	Continued From page 82 (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 medical record review, staff interviews and facility document review, the facility staff failed to ensure that Discharge Planning was implemented for 1 of 63 resident's in the survey sample, Resident #155. The findings included: Resident #155 was a 91 year old admitted to the facility on 5/6/19 for a respite stay with diagnoses to include but not limited to, Dementia and Chronic Obstructive Pulmonary Disease.	F 660	1. Resident #155 already discharged from the facility. Unable to issue discharge plan of care. 2. All residents had the potential to be affected. Discharge plan of care to be completed on residents discharged in November 2019 and going forward. 3. Education on the discharge planning policy was provided to the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses	

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F 660	Continued From page 83 Resident #155's Facility Face Sheet was reviewed and is documented in part, as follows: Admit Date: 5/06/2019 Discharged: 5/20/2019 Resident #155's Electronic Medical Record was reviewed for Discharge Planning and there were none identified. On 10/24/19 at 12:06 P.M. an interview was conducted with the Social Worker regarding Resident #155's Discharge Planning. The Social Worker stated "There was no discharge planning completed because she was respite and we knew she would be going back home and the PACE (Program of All-Inclusive Care for the Elderly) would be in place . On 10/24/19 at approximately 2:10 P.M. an interview was conducted with the Director of Nursing regarding Resident #155 not having any documented Discharge Planning. The Director of Nursing stated. "Discharge Planning should have been started on admission with the baseline care plan. Just because she was here for a respite stay was not a reason not to have completed it." The facility policy titled "Discharge Planning Process" last revised 7/29/19 was reviewed and is documented in part, as follows: Policy Statement: The facility will ensure a discharge planning process is in place to address each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involve the resident and if applicable, the resident representative, and the interdisciplinary team in	F 660	upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure the discharge planning process is completed for discharged residents. These audits will be conducted weekly for four weeks and monthly for three months. These audits will also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 660	Continued From page 84 developing the discharge plan. GUIDELINE: 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 a preventable readmissions. 1. Discharge planning begins upon admission and is based on the resident's assessment and goals for care, desire to be discharged, and the resident's capacity for discharge. On 10/24/19 at 7:30 P.M. a Pre-exit debriefing was held with the Administrator, Director of Nursing and the Regulatory Care Consultant where the above information was shared. Prior to exit no further information was shared.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.	F 661		12/8/19

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F 661	Continued From page 85 (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and facility document review the facility staff failed to ensure that a Discharge Summary was completed at discharge for 1 of 63 resident's in the survey sample, Resident #155. The findings included: Resident #155 was a 91 year old admitted to the facility on 5/6/19 for a respite stay with diagnoses to include but not limited to, Dementia and Chronic Obstructive Pulmonary Disease. Resident #155's Facility Face Sheet was reviewed and is documented in part, as follows: Admit Date: 5/06/2019 Discharged: 5/20/2019 Resident #155's Electronic Medical Record was reviewed for the Discharge Summary but one was not identified.	F 661	1. Resident #155 already discharged from the facility. Discharge summary completed and in the medical record. 2. All residents had the potential to be affected. Discharge summaries to be completed on residents discharged in November 2019 and going forward. 3. Education on the discharge summary policy was provided to the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure the discharge summary process is completed for discharged residents. These audits will be conducted weekly for four weeks and monthly for three months. These audits will also include no less than 10% of the	

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F 661	Continued From page 86 On 10/24/19 12:06 P.M. an interview was conducted with the Social Worker regarding Resident #155's Discharge Summary. The Social Worker stated, "There is no discharge summary, we didn't do one. I guess it wasn't done because she was a respite resident." On 10/24/19 at approximately 2:10 P.M. an interview was conducted with the Director of Nursing regarding Resident #155 not having a Discharge Summary. The Director of Nursing stated. "She (Resident #155) should have had a Discharge Summary complete just like all discharges do. Just because she was here for a respite stay was not a reason not to have completed it." The facility policy titled "Discharge or Transfer Summary" last revised 6/28/18 was reviewed and is documented in part, as follows: Policy Statement: When a resident is discharged or transferred (voluntary or involuntary), a discharge summary and port-discharge plan will be developed. 3. A discharge summary will be prepared which will include, but is not limited to, the following: a. Summary of the resident's stay to include diagnoses, course of illness/treatment or therapy and pertinent lab, radiology and consultation results; b. A final summary of the resident's status; c. reconciliation of all pre-discharge medications with the resident's post-discharge medications. On 10/24/19 at 7:30 P.M. a Pre-exit debriefing was held with the Administrator, Director of Nursing and the Regulatory Care Consultant	F 661	discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 661	Continued From page 87 where the above information was shared. Prior to exit no further information was shared.	F 661		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review and review of the facility policy, the facility staff failed to ensure the necessary treatment, care and services were provided to prevent development of a pressure ulcer for 1 of 63 residents (Resident #11), resulting in harm. Resident #11's sacral pressure ulcer was not identified until it was found at a stage 3. The findings included: Resident #11 was originally admitted to the facility on 07/15/18. Diagnosis for Resident #11 included but not limited to, *Pressure ulcer of other site, unspecified stage. The current Minimum Data Set (MDS), a quarterly	F 686	1. Resident #11 has had skin assessment/ CNA skin alert sheets completed to accurately reflect the current wounds present. 2. All residents had the potential to be affected. Skin assessments completed on current resident population to identify current skin status by 11/22/19. 3. Education on the pressure ulcer management policy was provided to the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses upon hire during orientation.	12/8/19

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F 686	Continued From page 88 assessment with an Assessment Reference Date (ARD) of 07/22/19 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #11 requiring total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, toilet use and personal hygiene for Activities of Daily Living care. Resident #11 was coded as always continent of bladder due to indwelling Foley catheter and frequently incontinent of bowel. The MDS with an ARD of 07/22/19 under section "M" (Skin Condition-M0150) at risk for developing pressure ulcers was coded "yes" and under section (M1200) skin and treatments was coded for having pressure reducing device for chair and bed. Resident #11 was coded as having no mood, rejection of care or behavioral problems. Resident #11's person-centered comprehensive care plan revised on 07/30/19 documented Resident #11 with multiple pressure ulcers. The goal: Resident's ulcer will heal without complications. Some of the intervention/approaches to manage goal included to assess and record the condition of the skin surrounding the pressure ulcer, keep clean and dry as possible, provide incontinence care after each incontinent episode, treatment per physician order, use pressure reduction when resident is in the chair and bed, use moisture barrier product to perineal area, turn and reposition in bed and chair and conduct a systematic skin inspection weekly. Report any signs of further skin breakdown. A Braden Risk Assessment Report was completed on 09/28/19; the resident scored a	F 686	4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure weekly skin assessments and CNA shower sheets/skin alerts sheets are completed based on the facility schedule. These audits will be conducted daily for four weeks, twice weekly x four weeks, weekly for four weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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thirteen indicating moderate risk for the development of pressure ulcers.

Review of the Weekly Skin Integrity Evaluation completed on 10/07/19 by LPN #11 was not coded for a sacral pressure ulcer.

The review of the Wound Information Pressure Ulcer form noted evidence of an entry dated 10/09/19 at 6:59 a.m., indicated the following: A new sacrum pressure ulcer measured 6 cm x 4.3 cm with light seropurulent (yellow or tan, cloudy and thick exudate (drainage). The tissue type observed with slough, wound edges/margins well defined and pink/normal skin surrounding wound.

The review of the Wound Information Pressure Ulcer form noted evidence of an entry dated on 10/16/19-sacrum pressure ulcer measuring 6 cm x 4 cm with 0.1 cm depth with moderate amount of serous (clear, amber, thin and watery) exudate. The tissue bed with slough, wound edges/margins well defined with pink/normal skin surround wound.

Review of Resident #11's October 2019, Physician Order Sheet and Treatment Administration Record (TAR) did not include a treatment for Resident #11's stage III sacral pressure ulcer first identified on 10/09/19.

An interview was conducted with the wound nurse, Licensed Practical Nurse (LPN) #7 on 10/24/19 at approximately 10:15 a.m. The wound nurse stated, "I observed the pressure ulcer to the sacrum when I turned her over to provide wound care to her existing wounds to her hip/thigh area on 10/09/19." The wound nurse stated, "I had to do a double take because of

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what the wound looked like when I first saw it." The surveyor asked, "What did the sacral wound look like?" She replied, "The wound bed was gray in color (it was a stage III pressure ulcer). The wound nurse said "There was no prior documentation of a sacrum/sacral wound until it was first identified by me on 10/09/19."

An interview was conducted with Unit Manager, Licensed Practical Nurse (LPN) #3 on 10/24/19 at approximately 11:23 a.m., who stated, "I reviewed Resident #11's current physician order sheet and treatment administration record for October 2019 and was unable to locate a treatment for the sacral pressure ulcer identified on 10/09/19."

On 10/24/19 at approximately 11:48 a.m., an interview was conducted with wound nurse (LPN #7) who identified the stage III sacral pressure ulcer on Resident #11. The LPN stated, "I found the stage III pressure ulcer to Resident #11's sacrum on 10/09/19." She said, I wrote an order for the sacral wound. The surveyor reviewed the October 2019's Physician Order Sheet and Treatment Administration Record with LPN #7. After she reviewed the Physician Order Sheet and Treatment Administration Record, she stated, "I remember writing a treatment for the stage III sacral wound; it should be on the physician order sheet and treatment administration record for October 2019 but I do not see an order. The surveyor asked, "Resident #11 was admitted to the hospital on 10/22/19, did she still have the stage III sacral pressure ulcer prior to her discharge?" LPN #7, replied, "Yes."

Review of the Weekly Skin Integrity Evaluation completed on 10/22/19 by LPN #3 was not coded for a sacral wound pressure ulcer; even though

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Resident #11's was identified with a stage III on 10/09/19 and the Wound Information Pressure Ulcer form noted evidence of an entry dated on 10/16/19 - sacrum pressure ulcer measuring 6 cm x 4 cm with 0.1 cm depth with moderate amount of serous (clear, amber, thin and watery) exudate. The tissue bed with slough, wound edges/margins well defined with pink/normal skin surround wound.

An interview was conducted with LPN #3 on 10/24/19 at approximately 3:00 p.m. The LPN provided routine wound care on Resident #11 on 10/21/19. LPN #3 stated, "I was not aware Resident #11 had a sacral wound pressure ulcer." The surveyor asked, "Did Resident #11 have any other pressure ulcers?" She replied, "Yes, but her wounds were on her feet, legs and hip/thigh area so I had no reason to look at her sacrum. The LPN stated, "I did not do wound care to a sacral wound, I did not realize she had one."

On 10/24/19 at approximately 3:05 p.m., an interview was conducted with LPN #4 who cared for Resident #11 on 10/20/19. The LPN said she was not aware Resident #11 had a sacral pressure ulcer. She stated, "I went by the treatment administration record when providing wound care and since the sacral pressure ulcer was not on the treatment record, I did not do a wound treatment to the sacrum."

The surveyor reviewed the shower schedule and shower sheets for Resident #11. Resident #11 was scheduled for showers twice weekly on Tuesday and Friday on the 3 PM-11 PM shift. The shower sheet included the following information: the Certified Nursing Assistant (CNA) must complete on all residents shower

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days and anytime a change is noted/observed on the resident's skin, the caregiver must give skin sheet to a nurse immediately. The surveyor requested the following Certified Nursing Assistant (CNA) skin care alerts on Resident #11's shower days for the month of October 2019: 10/01/19, 10/04/19 and 10/08/19. On 10/24/19 at approximately 3:15 p.m., the Unit Manager stated, "I was unable to locate any CNA alert skin care sheets for October 2019 prior to identifying the sacral pressure ulcer to Resident #11 on 10/09/19." She explained that even if Resident #11 refused to have a shower, her skin checks should have been completed by the CNA.

A briefing was held with the Administrator, Director of Nursing (DON) and Cooperate Nurse on 10/24/19 at approximately 4:08 p.m. The surveyor asked, "At what stage do you expect for your nurses to first identify a pressure ulcer?" The DON replied, "When the skin is red, non blanchable or when the skin is reddened but not open." The surveyor asked, "If Resident #11 refused or did not receive her bi-weekly showers, should the CNA complete the skin care alert sheets?" The DON replied, "Yes, the CNA's are still required to do their skin checks."

The facility's policy titled Pressure Ulcer Management Resource (Revised 07/24/18).
-Guideline Steps to include but not limited to:
-5. Inform the physician (and responsible party, as appropriate) of new pressure ulcer. Obtained and initiate treatment orders. Report the following to the physician to include but not limited to:
-Current treatment and review of the past treatment, as appropriate.

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6. Implement a preventative program to prevent additional new areas from developing. Ensure the preventative measures are listed on the care plan and flow sheets.

8. Initial ulcer care involves debridement, wound cleansing, dressing application, and possible adjunctive therapy.

11. Protect the wound with dressings. A dressing should protect the wound, be biocompatible and provide ideal hydration. The cardinal rule is to keep the ulcer tissue moist and the surrounding intact skin dry to prevent maceration.

Definitions:
*Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

*Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an

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F 686	Continued From page 94 Unstageable Pressure Injury. (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow the physician orders to obtain weekly weights for 1 of 63 residents in the survey sample, Resident #94. The findings included: Resident #94 was originally admitted to the facility	F 692	1. Weekly weights completed as per physicians orders on resident #94. 2. All residents had the potential to be affected. Physician□s orders reviewed for residents with weekly weights. Audit completed to ensure weights have been completed and documented in the	12/8/19

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F 692	Continued From page 95 on 10/22/93 with a re-admission date of 9/3/19 with diagnoses to include chronic obstructive pulmonary disease, type II diabetes, and schizophrenia. The current Minimum Data Set an annual with an assessment reference date of 9/17/19 coded the resident as scoring a 9 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was moderately impaired. The resident's weight was 109 pounds. The physician orders dated 9/3/19 directed the staff to obtain the resident's weight on admission and then weekly for four weeks following a hospitalization. The clinical record evidenced the resident's weight was obtained on 9/4/19 at 108.6 pounds, and 9/11/19 at 108.8 pounds, there were no other weekly weights obtained. The physician orders dated 9/29/19 directed the staff to obtain the resident's weight weekly every Tuesday for abnormal weight loss. On 10/3/19 the Registered Dietitian (RD) conducted a review of the resident due to a three week 14.7% weight loss. On 10/2/19 the resident weighed 92.8 pounds. The RD documented, in part: Resident appears to have had weight fluctuations. Weights 7/1, 9/4 and 9/11 higher than usual weight range of 91-98.8# x 180 days. The RD recommended weekly weights and to continue to monitor nutrition parameters. On 10/23/19 the clinical record evidenced a weight was obtained on 10/7/19 at 97.4 pounds. There were no other weekly weights documented in the clinical record after that date.	F 692	medical record. This was completed by 11/22/19. 3. Education on the weight monitoring policy was provided to the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure weekly weights are completed per physicians orders. These audits will be conducted weekly for four weeks, and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 692	Continued From page 96 On 10/24/19 the above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to follow the physician order for the oxygen flow rate for 1 of 63 residents in the survey sample, Resident #94. The findings included: Resident #94 was originally admitted to the facility on 10/22/1993 with a re-admission date of 9/3/19 with diagnoses to include chronic obstructive pulmonary disease (COPD). The current Minimum Data Set an annual with an assessment reference date of 9/17/19 coded the resident as scoring a 9 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was moderately impaired. The resident was coded as receiving oxygen therapy. The comprehensive person-centered plan of care	F 695	1. Oxygen flow rate corrected for resident #94. 2. All residents had the potential to be affected. Physician□s orders reviewed for residents with oxygen. . Audit completed to ensure oxygen settings match the physician□s orders. This was completed by 11/22/19. Oxygen flow rates will be validated on all newly admitted residents. 3. Education on the oxygen administration policy was provided to the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure oxygen	12/8/19

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F 695	Continued From page 97 dated 9/25/19 identified as a problem, that the resident requires oxygen therapy related to COPD. The goal was that the resident will not exhibit signs of hypoxia (low levels of oxygen). One of the approaches was to administer oxygen at 2 Liters (per minute-rate) via a nasal cannula. The clinical record evidenced a physician order dated 9/25/19 that directed the staff to administer oxygen at 2 liters per minute via nasal cannula. On 10/22/19 during the initial tour of the facility, the resident was observed in bed with a nasal cannula on and oxygen infusing at 3 liters per the oxygen concentrator. On 10/23/19 and 10/24/19 when the resident was in bed, the oxygen was observed infusing at 3 liters. On 10/24/19 at 9:59 a.m., the resident's nurse (Licensed Practical Nurse-LPN #9) was asked what the liter flow was supposed to be on. LPN #9 stated, " Three liters, I'm usually on the other side." The nurse reviewed the order and noted it was for 2 liters. She was asked to check the flow rate. After noting that it was set at 3 liters, she lowered the flow rate to 2 liters. The above findings was shared with the Administrator and the Director of Nursing during the pre-exit meeting. No further information was provided. Complaint deficiency.	F 695	flow rates are administered based on the physicians orders. These audits will be conducted weekly for four weeks, and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		12/8/19

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F 698	Continued From page 98 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 observation, resident record review, staff interviews and facility document review the facility staff failed to ensure dialysis services to include ongoing communication with the dialysis center was in place for 1 of 63 residents in the survey sample, Resident #18. The findings included: Resident #18 was admitted to the facility on 3/1/17 with the diagnoses of, but not limited to, End Stage Renal Disease and Schizoaffective Disorder Resident #18 attended dialysis on Tuesday, Thursday and Saturdays. The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 8/1/19. Resident #18's Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making. Under Section O Special Treatments, Procedures, and Programs Resident #18 was coded for Dialysis while a resident. On 10/22/19 at approximately 1:00 P.M. the resident was not observed in the facility and the staff stated she was at dialysis. On 10/23/19 at 10:20 A.M. Resident #18's Dialysis Communication Book was reviewed. The last Post Dialysis Treatment documentation from the Dialysis Center was July 25, 2019. Licensed Practical Nurse (LPN) #10 was asked	F 698	1. Dialysis communication sheets obtained for resident #18. 2. Audit completed of dialysis residents to ensure evidence of ongoing communication is in place. This was completed by 11/22/19. The presence of dialysis communication sheets will be validated on all newly admitted residents receiving dialysis services. 3. Education on the Care of End Stage Renal Disease Resident Policy was provided to the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure dialysis services to include ongoing communication with the dialysis center is in place. These audits will be conducted 3 x week for four weeks, weekly for two weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee	

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F 698	Continued From page 99 where the rest of Resident #18's Post Dialysis Treatment documentation sheets were. LPN #10 stated "Name (Resident #18) usually carries the book herself and sometimes she doesn't bring it back." She stated, "The ones in the book are all we have. I can call dialysis to see if they have them." On 10/23/19 at approximately 4:30 PM the surveyor was provided a stack of Resident #18's Post Dialysis Treatment sheets from 7/25/19 to present. All presented dialysis post treatments were faxed over from the dialysis center to the facility on 10/23/19 at 13:59 and ending at 14:22 P.M. On 10/23/19 AT 5:00 P.M. an interview was conducted with the Director of Nursing and she was asked what were her expectations for communication with the dialysis center in regards to the facility residents. The Director of Nursing stated "Sometimes Name (Resident #18) does not bring her book back and if that is the case I would expect for the nurses to call over to the dialysis center and have the communication sheet sent over that day." The facility policy titled "Care of End Stage Renal Disease Resident" last revised 8/7/19 was reviewed and is documented in part, as follows: Guideline: 6. Collaborate with the Dialysis Team if you have any concerns about complications post treatment. The Dialysis Team will provide handoff communication post treatment. On 10/24/19 at 7:30 P.M. a Pre-exit debriefing was held with the Administrator, Director of Nursing and the Regulatory Care Consultant where the above information was shared. Prior to	F 698	consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 698	Continued From page 100 exit no further information was shared.	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		12/8/19

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F 732	Continued From page 101 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility document review the facility staff failed to ensure that the daily Nursing Staffing Information to include worked hours were posted daily potentially affecting all residents. The findings included: On 10/22/19 the posted Daily Staffing document was observed in the front lobby. The Daily Staffing document did not include the actual hours worked for that day. On 10/23/19 the posted Daily Staffing document was observed in the front lobby. The Daily Staffing document did not include the actual hours worked for that day. On 10/24/19 the posted Daily Staffing document was observed in the front lobby. The Daily Staffing document did not include the actual hours worked for that day. On 10/24/19 at 9:29 A.M. an interview was conducted with the Facility Scheduler regarding the posted Daily Nursing Staffing. The Facility Scheduler was informed that the Posted Nursing Staffing for past 3 days was missing nursing worked hours. The Facility Scheduler stated, "I don't ever put the hours on the posting until the next day because of callouts, so it shows the actual as worked hours and I file it. I just found out today we have a program and a different daily staffing posting sheet that put all the information in for you."	F 732	1. Posted Nurse Staffing immediately corrected. 2. All residents had the potential to be affected. Audit completed of posted nurse staffing from 10/24/19 to 11/18/19. This was completed by 11/20/19. 3. Education on the Posting of Nurse Staffing was completed with the nursing scheduler on 10/24/19. 4. Ongoing audits by the Administrator and/or Nursing Scheduler will be conducted for observation and review to ensure that the daily Nursing Staffing Information to include worked hours were posted daily. These audits will be conducted daily for two weeks, weekly for two weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should	

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F 732	Continued From page 102 On 10/24/19 at 7:30 P.M. a Pre-exit debriefing was held with the Administrator, Director of Nursing and the Regulatory Care Consultant where the above information was shared. The Administrator stated, "It was immediately fixed with the new Staffing Sheet." Prior to exit no further information was shared.	F 732	arise. 5. The Administrator and the Nursing Scheduler is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		12/8/19

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F 755	Continued From page 103 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility documentation review the facility's staff failed to ensure the medication Procrit (a red blood cell producing drug) was available to be administered as ordered to 1 of 63 residents (Resident #88) in the survey sample. The findings included: Resident #88 was originally admitted to the facility on 08/1/14 and with a readmission date of 8/1/19. Resident #88's diagnoses included anemia, paraplegia, multiple sclerosis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/16/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #88's cognitive abilities for daily decision making were intact. Review of the current physician order summary revealed Resident #88 had an order dated 9/20/19 for Procrit 10,000 units/milliliter injection once per week on Mondays between 7:15 a.m., and 11:00 a.m., for anemia. PROCRIT is indicated for the treatment of anemia due to chronic kidney disease including patients on dialysis and not on dialysis to decrease the need for red blood cell transfusion. (https://www.procrit.com/professionals/chronic_kidney.html).	F 755	1. Procrit was obtained for Resident #88 and administered as ordered. 2. All residents had the potential to be affected. Audit completed for medication availability on the current resident population to ensure medications are available to be administered as ordered. This was completed by 11/22/19. Medication availability will be verified on all newly admitted residents. 3. Education on Medication Orders (Non-Controlled Medication Orders) to include medication availability was conducted with the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers will be conducted for observation and review to ensure medications are available to be administered as ordered. These audits will be conducted daily for two weeks, weekly for two weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI	

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F 755	Continued From page 104 Review of the physician's progress note dated 10/1/19, revealed on 9/23/19 Resident #88's hemoglobin was 6.9 (low) and white blood count was 10.8, therefore the resident received one unit of packed red blood cells and tolerated it. The 10/11/19, physician's progress note stated between 7/20/19 and 8/1/19 the resident was transfused five units of blood. Resident was started on Procrit weekly. Review of the Medication manifest revealed the facility's staff received Procrit 20,000 units/milliliter in the facility for Resident #88, 9/24/19 and 10/23/19. A dose was scheduled to be administered for Monday 9/23/19 but the medication wasn't delivered until 9/24/19. The Medication Administration Record revealed the resident received a 10,000 unit/milliliter dose 9/30/19. Procrit wasn't administered 10/7/19, due to a condition. Procrit was administered late 15:07 (3:07 PM), on 10/14/19. Procrit wasn't administered 10/21/19, because it wasn't available. An interview was conducted with the Licensed Practical Nurse (LPN) #1 on 10/23/19 at approximately 12:30 p.m., regarding the Procrit for Resident #88. LPN #1 stated the staff should order the Procrit the day the last dose is used to ensure it is available for the next dose but it wasn't happening. She further stated because the dose wasn't available 10/21/19 to be administered the Nurse Practitioner changed administration to Wednesdays. LPN #1 was	F 755	committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 755	Continued From page 105 unable to state how the change in day of the week would ensure the medication was ordered and available for administration. On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator, Director of Nursing, and Corporate Consultant. The Director of Nursing stated they had identified a problem with delivery and administration of Resident #88's Procrit but they hadn't instituted a plan to correct the concern.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility documentation review the facility's staff failed to ensure 1 of 63 residents (Resident #88) in the survey sample was free from significant medication error. The findings included: Resident #88 was originally admitted on 08/1/14 with a readmission date of 8/1/19. Resident #88's diagnoses included anemia, paraplegia, multiple sclerosis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/16/19 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #88's cognitive abilities for	F 760	1. Procrit was obtained for Resident #88 and administered as ordered. 2. All residents had the potential to be affected. Audit completed for medication availability on the current resident population to ensure medications are available to be administered as ordered. This was completed by 11/22/19. Medication availability will be verified on all newly admitted residents. 3. Education on Medication Orders (Non-Controlled Medication Orders) to include medication availability was conducted with the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses upon hire during orientation.	12/8/19

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F 760	Continued From page 106 daily decision making were intact. Review of the current physician order summary revealed Resident #88 had an order dated 9/20/19 for Procrit (a red blood cell producing drug) 10,000 units/milliliter injection once per week on Mondays between 7:15 a.m., and 11:00 a.m., for anemia. PROCRIT is indicated for the treatment of anemia due to chronic kidney disease including patients on dialysis and not on dialysis to decrease the need for red blood cell transfusion. (https://www.procrit.com/professionals/chronic_kidney.html). Review of the physician's progress note dated 10/1/19, revealed on 9/23/19 Resident #88's hemoglobin was 6.9 (low) and white blood count was 10.8, therefore the resident received one unit of packed red blood cells and tolerated it. The 10/11/19, physician's progress not stated between 7/20/19 and 8/1/19 the resident was transfused five units of blood. Resident was started on Procrit weekly. Review of the Medication manifest revealed the facility's staff received Procrit 20,000 units/milliliter in the facility for Resident #88 on 9/24/19 and 10/23/19. A dose was due to be administered on Monday 9/23/19 but the medication wasn't delivered until 9/24/19. The Medication Administration record revealed the resident received a 10,000 unit/milliliter dose on 9/30/19. The Procrit wasn't administered 10/7/19, due to condition. Procrit was administered late at 15:07 (3:07 PM))	F 760	4. Ongoing audits by the Director of Nursing and/or Unit Managers will be conducted for observation and review to ensure medications are available to be administered as ordered to ensure residents are free from significant medication errors. These audits will be conducted daily for two weeks, weekly for two weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 760	Continued From page 107 on 10/14/19. Procrit wasn't administered 10/21/19, because it wasn't available. An interview was conducted with the Licensed Practical Nurse (LPN) #1 on 10/23/19 at approximately 12:30 p.m., regarding the Procrit for Resident #88. LPN #1 stated the staff should order the Procrit the day the last dose is used to ensure it is available for the next dose but it wasn't happening. She further stated because the dose wasn't available 10/21/19 to be administered the Nurse Practitioner changed administration to Wednesdays. LPN #1 was unable to state how the change in day of the week would ensure the medication was ordered and available for administration. On 10/24/19 at approximately 6:00 p.m., the above findings were shared with the Administrator, Director of Nursing, and Corporate Consultant. The Director of Nursing stated they had identified a problem with delivery and administration of Resident #88's Procrit but they hadn't instituted a plan to correct the concern.	F 760		
F 773 SS=E	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance	F 773		12/8/19

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F 773	Continued From page 108	F 773		

with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.
This REQUIREMENT is not met as evidenced by:
Based on medical record review, staff interviews, resident interview and facility document review, the facility staff failed to ensure that the physician was notified of a positive urine culture in a timely manner for 1 of 63 residents in the survey sample, Resident #78.

The findings included:

Resident #78 was a 63 year old originally admitted to the facility on 9/19/13 with diagnoses to include but not limited to Urine Retention and Diabetes Mellitus.

The most recent Minimum Data Set (MDS) was a Annual with an Assessment Reference Date (ARD) of 9/6/19. Resident #78's Brief Interview for Mental Status (BIMS) was a 13 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making.

Resident #78's Progress Notes were reviewed and are documented in part, as follows:

10/15/2019 15:46 (3:46 P.M.): urinalysis results received and placed in md (medical doctor) folder, greater than 100,000 gram negative rods, resident positive for uti (urinary tract infection), urine culture pending, np (nurse practitioner) notified, will continue to monitor.

Resident #78's Electronic Medical Record was reviewed for the urine culture results and were

1. Lab results for resident #78 was immediately call to the physician and new orders obtained.

2. All residents had the potential to be affected. Audit completed for physician notification on lab results for October 2019. This was completed by 11/26/19. Audits will be completed on newly admitted residents to ensure timely physician notification is made with abnormal lab values.

3. Education on the Laboratory Diagnostic Testing/Reporting policy was conducted with the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses upon hire during orientation.

4. Ongoing audits by the Director of Nursing and/or Unit Managers will be conducted for observation and review to ensure physician notification is made timely for abnormal lab values. These audits will be conducted daily for two weeks, weekly for two weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will

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F 773	Continued From page 109 not found. On 10/22/19 at approximately 12:30 P.M. Unit Manager LPN (Licensed Practical Nurse) #4 was asked if she could find Resident #78 urine culture results. Unit Manager LPN (Licensed Practical Nurse) #4 stated, "I have been on vacation for the past week and am just coming back I will have to go look for them." At approximately 2:00 P.M. Unit Manager LPN #4 returned to the conference room and stated, "I had to pull them off the computer today, while I was off no one pulled them. I have notified the Nurse Practitioner with the results and I am waiting for her to call back with orders." Unit Manager LPN #4 was then asked when were the urine culture results available and when should they have been reported the physician. Unit Manager LPN #4 stated, "On the 16th and we alert the physician as soon as we obtain the results" Resident #78's Progress Notes were reviewed and are documented in part, as follows: 10/22/19 15:40 (3:40 P.M.): final us (urinalysis), c&s (culture and sensitivity) results from 10/6 received. Name (NP) notified and said she will call back with orders. 3-11 nurse notified and will follow-up. 10/22/2019 18:16 (6:16 P.M.): Name (NP), in to view C&S results; >100,000 Pseudomonas Aeruginosa-new order received to change foley catheter tonight, and start Cipro 500mg every 12 hours for 10 days-orders noted-care plan updated-patient is own RP (responsible party), aware. Resident #78's Urinalysis Culture and Sensitivity Laboratory Report was reviewed and is	F 773	be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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documented in part, as follows:

Collection Date/Time: 10/13/19
Received: 10/15/19
Reported: 10/16/19

Organism 1: Urine >100,000 Pseudomonas Aeruginosa

Resident #78's current Comprehensive Care Plan was reviewed and is documented in part, as follows:

The facility's policy titled "Laboratory Diagnostic Testing/Reporting" last revised 7/10/18 was reviewed and is documented in part, as follows:

Purpose: Diagnostic tests and clinical labs will be obtained based on physician/NP orders and the results reported to the physician/NP timely.

Guideline Steps:

3. Each facility will maintain a lab/diagnostic log to identify lab/diagnostic studies and validate receipt of results and MD notification.
c. DON (Director of Nursing)/designee will monitor all orders for lab/diagnostics to ensure all entries, requisitions are entered and follow-up has occurred per log. The log book will be reviewed for completion each day during clinical meeting.

4.f. Abnormal labs will be called to the MD for follow-up at the time of receipt with information noted on the lab to include date, time, initials and orders.

On 10/24/19 at 7:30 P.M. a Pre-exit debriefing

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F 773	Continued From page 111 was held with the Administrator, Director of Nursing and the Regulatory Care Consultant where the above information was shared. The Director of Nursing was asked what would have been the expectation for reporting abnormal lab values to the physician. The Director of Nursing stated, "We should make the physician aware of the results as soon as they are available." Prior to exit no further information was shared.	F 773		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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 observations and staff interviews, the facility staff failed to handle, prepare and store food in a manner to prevent foodborne illness potentially affecting all residents.	F 812	1. Items in the refrigerator have been labeled and dated. Plastic scoop removed and store appropriately. Box food items removed from the floor. Male staff members donned beard guards.	12/8/19

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F 812	Continued From page 112 The findings included: During the Initial Kitchen Inspection at 10:31 A.M. on 10/22/19 a side salad with a use by date of 10/14/19 was observed in the two door glass refrigerator. Shredded cheese with a use by date of 10/09/19 was observed in the two door glass refrigerator. A French Silk Pie with a use by date of 10/09/19 was observed in the two door glass refrigerator. A container of Tuna with a use by date of 10/10/19 was observed in the two door glass refrigerator. A bag of cooked link sausage with a use by date of 10/19/19 was observed in the two glass refrigerator. A plastic scoop was observed in a 50 pound bag of sugar with the scoop was touching the sugar. The bag was not sealed nor in a container. Boxes of food items were stored on the floor of the dry storage room. The floor was noted to have dirt, debris, spilled food crumbs and paper. Two male staff members were observed in the kitchen handling various food items without beard guards. A Food Service Policy regarding storage, preparation and handling was requested during the survey. No Policy was provided.	F 812	2. All residents had the potential to be affected. Completed inspection of the kitchen was made by the Registered Dietician to ensure deficient areas remain corrected. This was completed by 11/22/19. 3. Education on the Food Procurement/ Storage/ Preparation policy was conducted with the Dietary Staff by 11/30/19. This training will also be provided to all Dietary Staff upon hire during orientation. 4. Ongoing audits by the Administrator, Registered Dietician and Dietary Manager will be conducted for observation and review to the facility is storing, preparing, distributing and serving food in accordance with professional standards for food service safety. These audits will be conducted daily for four weeks, weekly for two weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should	

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F 812	Continued From page 113	F 812	arise. 5. The Administrator and the Dietary Manager is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		12/8/19

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F 842	Continued From page 114 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff	F 842	1. Consultation from urologist obtained for Resident #304.	

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F 842	Continued From page 115 failed to ensure an accurate medical record for 1 of 63 residents (Resident #304) in the survey sample. The findings include: Resident #304 was a 62 year old admitted to the facility on 7/24/2018 with diagnoses to include but not limited to Adrenomyeloneurpathy, Major Depressive Disorder and Anxiety Disorder. Jewish Family Services was Resident #304's court appointed Legal Guardian. Resident #304 expired in the facility on 11/18/18. The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 9/26/18. Resident #18's Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making. Resident #304's Progress Notes were reviewed and are documented in part, as follows: 11/9/19 9:30 A.M.: Resident LOA (leave of absence) to urology appointment via stretcher. NAD (no apparent distress) noted. On 10/22/19 at approximately 4:30 P.M. the Director of Nursing was asked if there was any further documentation she could provide regarding Resident #304's urology appointment on 11/9/19. On 10/24/19 at approximately 3:00 P.M. the Director Of Nursing provided a faxed copy dated 10/24/19 of Resident #304's urology appointment encounter dated 11/9/18 which was reviewed and documented in part, as follows:	F 842	2. All residents had the potential to be affected. Audit completed of resident appointment for October 2019 to ensure consultation sheets obtained and orders carried out accordingly. This was completed by 11/30/19. 3. Education on the Resident Records process was conducted with the Licensed Nurses by 11/30/19. This training will also be provided to all Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers will be conducted for observation and review to ensure the facility maintains accurate medical records by ensuring receipt of physician consult sheets from resident appointments. These audits will be conducted daily for four weeks, weekly for two weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

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F 842	Continued From page 116 Progress Note: Please inform pt (patient) that urine culture was positive. Please send in Macrobid 100 mg (milligrams) bid (twice a day) for 7 days and will need a repeat urine culture 1 week prior to UDS (Urodynamic Study). On 10/24/19 at 3:05 P.M. the Director of Nursing was asked if the urology encounter information for Resident #304 was previously available in the resident's medical record. The Director of Nursing stated, "I was not able to locate it, so I had them fax it over to us." The Director of Nursing was also asked what was the procedure when a resident goes to an appointment to ensure if there are any new orders that the facility is aware of them. The Director of Nursing stated, "We send paperwork with them for the office to fill out with any new orders and they send it back to us. If the papers do not come back I expect for the nurses to call and ask for the documentation to be sent over." On 10/24/19 at 7:30 P.M. a Pre-exit debriefing was held with the Administrator, Director of Nursing and the Regulatory Care Consultant where the above information was shared. Prior to exit no further information was shared. Complaint Deficiency.	F 842	5. The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of	F 867		12/8/19

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F 867	Continued From page 117 action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on identified quality deficiencies determined during this survey the QAA (Quality Assessment and Assurance) committee failed to develop and implement an appropriate plan of action to correct repeat harm deficiencies in the area of Quality of Care-Pressure Injuries affecting 1 of 63 residents and potentially affecting all residents. The findings included: The facility was cited with harm in the area of Quality of Care for Pressure Injuries during the last survey ending 7/13/18. During the current survey, the facility was cited with a level 3 isolated (G) harm deficiency in the same area. The plan of correction for the last survey did not correct the deficient practice.	F 867	1. Residents in the facility have the potential to be affected by the alleged deficient practice. The facility□s Quality Assessment and Assurance committee failed to maintain procedures and monitor the interventions that the committee put in place on 7/13/18. The Quality Assurance Performance Improvement (QAPI) team notified Medical Director on October 30, 2019. and held a discussion with the QAPI team regarding the findings of the recertification survey. An Ad Hoc QAPI team meeting was held on November 14, 2019 regarding the plan of correction and the involvement of the QAPI team to ensure the identified concern is corrected and maintained in compliance. 2. Residents in the facility have the potential to be affected by the alleged deficient practice. 3. The Quality Assurance Performance Improvement Committee will ensure that Pressure Ulcer Treatments are completed regarding Treatment/Svcs to Prevent/Heal Pressure Ulcer F686 as it relates to the professional standards of practice, to prevent pressure ulcers before by November 30, 2019. 4. The QAPI Committee will review results of pressure ulcer audits during the monthly meetings. Audits will be completed on 3 residents weekly x 8 weeks to ensure appropriate treatment	

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F 867	Continued From page 118	F 867	and interventions have been initiated; then 2 residents weekly x 4 weeks: the 1 resident monthly thereafter. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to ensure quarterly QAA (Quality Assessment and Assurance) meetings were conducted as required	F 868	1. QAPI meeting held with the required members were in attendance on October 30, 2019.	12/8/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 119 and required members were in attendance. The findings included: During the QAPI (Quality Assurance and Performance Improvement) review conducted on 10/24/19 at approximately 6:30 p.m., the Administrator was asked to provide evidence of quarterly QAA meetings to include the sign in sheets. The Administrator stated that he had identified that the facility QAA committee was lacking in participation from all department heads. He stated they have QAPI every month and revamped the QAPI process. The Administrator stated he did not have all the sign in sheets to show evidence of quarterly QAA committee attendance. The third quarter July 2019 QAPI meeting signature sheet did not have the Medical Director or his/her designee in attendance. No other information was provided to the survey team about the facility's QAPI quarterly meetings prior to exit.	F 868	2. All residents have the potential to be affected. QAPI meetings will be conducted as required with the required members in attendance beginning October 2019. 3. Education on the Quality Assurance/ Performance Improvement Program by 11/30/19 with the Administrator. This training will also be provided to all Administrators upon hire during orientation. 4. Ongoing audits by the Administrator will be conducted for observation and review to ensure QAA meetings are conducted as required and the required members are in attendance. These audits will be conducted monthly x 3. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator is responsible for implementing and maintaining the	

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F 868	Continued From page 120	F 868	acceptable plan of correction. Corrective action to be completed by December 8, 2019.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		12/8/19

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F 880	Continued From page 121 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and clinical record review, the facility staff failed to follow infection control practices during wound care for 1 of 63 residents, Resident #32. The Findings included:	F 880	1. Bedside table sanitized for Resident #32. 2. All residents have the potential to be affected.	

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F 880	Continued From page 122 Resident #32 was originally admitted to the facility on 03/22/12. Diagnoses for Resident #32 included but not limited to Pressure Ulcer of unspecified buttock stage 2 and Pressure Ulcer of Sacral Region. The current Minimum Data Set (MDS), an annual assessment with an Assessment Reference Date (ARD) of 08/02/19 coded the resident with a staff assessment for mental status because resident was unable to complete the interview. Staff assessment for mental status coded the resident as having short-term and long-term memory problems. On 10/23/19 at approximately 10:46 AM wound care observation was conducted. The wound care nurse Licensed Practical Nurse (LPN) #7 sanitized the resident's bedside table, allowed it to dry, placed a drape on the table, and added wound care items. After the completion of wound care and disposal of wound care items, LPN #7 rolled the bedside table within reach of the resident and placed his personal items on the table. Once stepping outside of Resident #32's room LPN #7 was asked if she was done with her wound care procedure. She stated, "Yes." She was asked if she would normally sanitize the bedside table when wound care was completed. She stated, "Oh I forgot." She was then asked why is it important to disinfect/sanitize the Resident's bedside table? LPN #7 stated, "Infection control reasons." A Pre-exit interview was conducted on 10/24/19 at approximately, 5:30 PM. The Administrator, the Director of Nursing (DON) and the Corporate Nurse Consultant were informed of the findings.	F 880	3. Education on the Infection Prevention & Control Policy as it relates to Wound Care by 11/30/19 with the Licensed Nurses. . This training will also be provided to all Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers will be conducted for observation and review to ensure infection control practices are maintained during wound care. These audits will be conducted weekly x 4 and monthly x 3. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	

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F 880	Continued From page 123 The DON stated, "We're suppose to sanitize the table, they eat their meals from the table." No further information was provided.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to ensure privacy curtains were maintained in a sanitary condition in three resident rooms which included 6 of 169 beds. The findings included: On 10/22/19, 10/23/19 and 10/24/19 the privacy curtains in rooms 205, 206 and 208 were observed with visible stains; and food debris was noted on the curtains in room 205. On 10/24/19 at approximately 10:00 a.m., an Environmental Services Staff (other staff #12) was asked how often are privacy curtains cleaned. He stated whenever the housekeeping staff let him know. He was asked to check the three rooms with the dirty curtains, he stated they need to be changed out. The Housekeeping Staff (other staff #11) who was responsible for cleaning the rooms on that hallway was interviewed. She was asked the process on how dirty privacy curtains get changed. She stated that if she finds any privacy curtains that need to be cleaned she writes them down and forwards the information. She was asked about the dirty curtains in rooms	F 921	1. Privacy curtains have been replaced in Rooms 205, 206, and 208. 2. All residents have the potential to be affected. 3. Education on the Sanitary Environment process as it relates to privacy curtains by 11/30/19 with the Housekeeping staff. This training will also be provided to all housekeeping staff upon hire during orientation. 4. Ongoing audits by the Housekeeping Supervisor will be conducted for observation and review to ensure privacy curtains are maintained in a sanitary condition. These audits will be conducted daily x 2 weeks, weekly x 4 weeks and monthly x 3. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will	12/8/19

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F 921	Continued From page 124 205, 206 and 208. She stated her "boss" had told her a couple of days ago that the curtains needed to be taken down and cleaned, she stated, "It slipped my mind." The above findings were shared with the Administrator and Director of Nursing during the pre-exit meeting on 10/24/19.	F 921	be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Housekeeping Supervisor is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to maintain an effective pest control system/program potentially affecting all residents. The findings included: During the kitchen inspection on 10/22/19 at 10:31 A.M. house flies were observed in the kitchen area. Drain flies were observed in the mop room and dishwasher room. Fruit flies and house flies were observed in the conference room. House flies were observed in the dining	F 925	1. Facility has been treated by pest control vendor to treat houseflies in the kitchen, drain flies in dishwasher room, fruit flies in the conference room, house flies in the dining room, and flies on the units on 10/25/2019. 2. All residents have the potential to be affected. 3. Education on the Pest Control policy by 11/30/19 with the Maintenance staff. This training will also be provided to all	12/8/19

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F 925	Continued From page 125 room area. Flies were observed on all units. During an interview on 10/23/19 at 3:50 P.M. with the Maintenance Director he stated, the drain flies, fruit flies and house flies have been a concern and there is a need for pest control. The Maintenance Director stated The Pest Control company comes out to service the facility. The Maintenance Director stated the flies will be in the building like this until it turns cold out side. A review of the Pest Management policy indicated: "Mission-We shall first seek to understand the unique needs of each customer, formulate effective solutions, and implement the actions in a timely professional manner." No further information was provided by facility staff.	F 925	maintenance staff upon hire during orientation. 4. Ongoing audits by the Maintenance Supervisor will be conducted for observation and review to ensure an effective pest control system/program is maintained. These audits will be conducted weekly x 4 weeks and monthly x 3. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Maintenance Supervisor is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by December 8, 2019.	