LV

PRINTED: 03/18/2020
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL VIRGINIA BEACH LLC	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/2/20 through 3/5/20. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by:	E 007		

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

Helena Molnar 3.27.2020

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

Helena Molnar 3.27.20

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E 007	Continued From page 1 Based on record review, and staff interview, the facility staff failed to have documentation of the facility's identified population at risk during an emergency. The findings included: During an interview on 03/03/20 at 10:47 A.M. with the Administrator and Maintenance Director, they were asked for documentation of the facility's identified population at risk during an emergency and delegation of authority during an emergency. The Administrator stated the facility had not conducted a risk assessment of it's resident population at risk during an emergency, nor did the facility have documentation of delegation of authority during an emergency.	E 007		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following:	E 015		

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E 015	Continued From page 2 (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation that the emergency preparedness plan included policies and procedures for emergency lighting, fire detection, extinguishing, alarm system, sewage and waste disposal. The findings included:	E 015		

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E 015	Continued From page 3 During an interview conducted on 3/3/20 at approximately 10:40 a.m. the Administrator stated, they did not have documentation of the facility having policy and procedures in place to address emergency lighting, fire detection, extinguishing, alarm system and alternate energy source to maintain temperatures.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE]	E 018		

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E 018	Continued From page 4 must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis	E 018		

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E 018	Continued From page 5 facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to provide documentation for identifying the location of residents at alternate sites. The facility failed to provide documentation that staff have been trained on the system to track the location of on-duty staff and sheltered patients who may be relocated during an emergency. The findings included: During a review of the facility's emergency preparedness plan on 03/03/20 at 10:50 A.M. with the Administrator and Maintenance Director, the Administrator was asked to provide documentation that facility staff had been trained on the facility's system to track the location of on-duty staff and sheltered residents who are relocated during an emergency. The Administrator stated, "We have not trained our staff nor do we have a tracking system."	E 018		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:]	E 020		

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E 020	Continued From page 6 [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation that the	E 020		

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E 020	Continued From page 7 emergency preparedness plan included policy and procedures for the safe evacuation from the facility. The findings included: During an interview on 03/03/20 at 11:05 A.M. with the Administrator and the Maintenance Director, they were asked for documentation for the safe evacuation from the facility including care for the residents, transportation, identification of evacuation location and alternate means of communication with external resources and staff responsibilities. The Administrator stated she did not have documentation for the safe evacuation from the facility which included care for residents, transportation needs, communication with external resources and staff responsibilities.	E 020		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.	E 023		

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E 023	Continued From page 8 *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have verification for preserving patient information in the event of an emergency. The findings included: During an interview on 03/03/20 at 11:10 A.M. with the Administrator and Maintenance Director, they were asked for documentation for preserving patient information and protecting confidentiality of patient information and maintain the availability of resident records. The Administrator stated, she did not have documentation to ensure patient records were secure and readily available to support the continuity of care for residents during an emergency.	E 023		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness	E 026		

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E 026	Continued From page 9 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation describing the facility's role in providing care at an alternate care site. The findings included: During an interview with the Administrator and the Maintenance Director at 11:12 A.M. on 03/03/20, the Administrator was asked for documentation describing the facility's role in providing care at an alternate care site. The Administrator stated the she did not have documentation describing the facility's role or the care that would be provided at an alternate care site.	E 026		

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E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs.	E 030		

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E 030	Continued From page 11 (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff.	E 030		

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E 030	Continued From page 12 (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have all facility contact information in the communication plan. The findings included: During an interview on 03/03/20 at 11:14 A.M. with the Administrator and the Maintenance Director, the Administrator was asked for names and contact information for all facility staff, as well as entities providing services under agreement during an emergency. A review of the communication plan did not include the name of all staff and their contact information, nor did the plan include vendors providing services to the facility during an emergency.	E 030		
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local	E 032		

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E 032	Continued From page 13 emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to develop an emergency preparedness communication plan which included alternate means of communication in an emergency. The findings included: During an interview with the administrator on 03/03/20 at 11:16 A.M. the administrator was asked to see the facility's alternate communication equipment. The administrator stated, the facility had not purchased alternate communication devices. The facility staff failed to have alternate communication equipment.	E 032		
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's]	E 033		

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E 033	Continued From page 14 care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation that the communication plan included a method for sharing information and medical documentation to maintain continuity of care. The findings included: During an interview on 03/03/20 at 11:18 A.M. with the Administrator and the Maintenance	E 033		

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E 033	Continued From page 15 Director they were asked for evidence that the facility had a method for sharing information and medical care for residents with other health care providers to maintain continuity of care. The Administrator stated, she did not have documentation for sharing information and medical care needs for residents at an alternate care site. The facility staff failed to have documentation that the communication plan included methods for sharing information and medical care with other health care providers.	E 033		
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its	E 034		

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E 034	Continued From page 16 ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation about the facility's occupancy needs and its ability to provide assistance. The findings included: During an interview on 03/03/20 at 11:21 A.M. with the Administrator and the Maintenance Director, they were asked for documentation for identifying the needs of the facility, as well as the facility's ability to provide assistance to the Incident Command Center. The Administrator stated, the facility had not identified the needs of the residents nor had the facility identified how the facility could provide assistance.	E 034		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and	E 036		

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E 036	Continued From page 17 the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph	E 036		

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E 036	Continued From page 18 (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have evidence of emergency preparedness training and testing program review. The findings included: On 3/3/20 at 10:40 a.m. review of the Emergency Preparedness (EP) plan was initiated. The facility had EP policies and procedures (P&P's) however due to a change of ownership occurring July 1, 2019, the EP P&P's were still titled as the former owner's name. During an interview on 03/03/20 at 11:25 A.M. with the Administrator, she was asked for documentation of the facility's training and testing program and review. The Administrator stated, the facility had not developed a training and testing program.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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E 037	Continued From page 19 arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training	E 037		

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E 037	Continued From page 20 program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers,	E 037		

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E 037	Continued From page 21 consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 22 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to maintain documentation of emergency preparedness training. The findings included: On 3/3/20 at 10:40 a.m. review of the Emergency Preparedness (EP) plan was initiated. The facility had EP policies and procedures (P&P's) however due to a change of ownership occurring July 1, 2019, the EP P&P's were still titled as the former owner's name. During an interview on 03/03/20 at 11:28 A.M. with the Administrator, she was asked for documentation for training of emergency preparedness policies and procedures for all new and existing staff. The Administrator stated, the facility had not conducted an initial training program for emergency preparedness and did not produce documentation from the previous owners.	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2)	E 039		

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E 039	Continued From page 23 *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 24 (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 25 (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]	E 039		

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E 039	Continued From page 26 (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL VIRGINIA BEACH LLC	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 27 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises	E 039		

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E 039	Continued From page 28 to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise	E 039		

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E 039	Continued From page 29 is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation of the facility's emergency preparedness exercise, analysis and response if needed. The findings include: On 3/3/20 at 10:40 a.m. review of the Emergency Preparedness (EP) plan was initiated. The facility had EP policies and procedures (P&P's) however due to a change of ownership occurring July 1, 2019, the EP P&P's were still titled as the former owner's name. During an interview on 03/03/20 at 11:31 A.M. with the Administrator, she was asked for documentation of the facility's table top exercise analysis and the revised emergency plan if necessary. The Administrator stated the facility staff did not conduct a table top exercise (since the change of ownership) and did not provide documentation of any exercises.	E 039		

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F 000	Continued From page 30	F 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/2/20 through 3/5/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five complaints were investigated during the survey. The census in this 150 certified bed facility was 118 at the time of the survey. The survey sample consisted of 57 residents.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to 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.	F 578		

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F 578	Continued From page 31 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and review of facility documentation, the facility staff failed to implement the advance directive policy by not sending a resident's advance directive to the receiving hospital, and/or provide acknowledgement that allowed an opportunity to formulate an advance directive for 3 of 57 residents (#82, #63 and #109) in the survey sample. The findings included: 1. Resident #82 was admitted to the nursing facility on 2/5/18 with diagnoses that included Alzheimer's disease, bipolar disorder and paranoid schizophrenia. The most recent Minimum Data Set (MDS) assessment was an annual dated 1/15/20 and coded the resident with short and long term	F 578		

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F 578	Continued From page 32 memory and moderately impaired in the cognitive skills for daily decision making. A copy of the resident's Advance Directive was not sent with the resident when he was transferred to the local hospital on 6/2/19, 12/26/19 and 1/5/20. The Acute Care Transfer Document form for each of the resident's aforementioned transfers indicated the advance directives (durable power of attorney for health care, living will) to be sent at the time of transfer in addition to advance care orders (POLST, MOLST, POST, others), but they were not checked off as sent. On 3/3/19 at 11:05 a.m., an interview was conducted with a Licensed Practical Nurse (LPN) #7. She stated when a resident is transferred to the hospital the following discharge documents are sent with the resident: -Physician's order sheet (POS) with medication list -Face Sheet -Bedhold policy given to 911 or medical transport, not the resident or resident representative -Laboratory reports -The SBAR report -Copy of the DNR form (as indicated) The LPN stated the DNR form was the resident's advance directive and she had not been made aware of any other documents that were considered advance directives or where they were located. On 3/5/20 at 1:45 p.m., the Medical Records Director located Resident #82's advance directives on the unit where the resident resided in his hard chart at the nurse's station.	F 578		

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F 578	Continued From page 33 On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. They shared they were not aware of the mandate to send a copy of the Advance Directive other than the DNR form upon transfer to the hospital. No further information was provided prior to survey exit. The facility's policy and procedure dated 12/2016 indicated the Nurse Supervisor will be required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made. 2. The facility staff failed to provide Resident #63 with an opportunity to formulate an Advance Directive. A review of the clinical records indicated that Resident #63 was admitted to the facility on 03/24/14. Diagnoses for this resident included cancer, A-fib, heart failure, hypertension, diabetes mellitus, depression, psychotic disorder and asthma. A review of the annual Minimum Data Set (MDS) dated 01/07/20 assessed this resident as having a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. A review of the clinical records did not indicate Resident #63 was provided an opportunity to formulate an Advance Directive. During an interview with the Social Worker on 03/03/20 at 2:30 P.M. the Social Worker stated Resident #63 was not provided the opportunity to formulate an	F 578		

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F 578	Continued From page 34 Advance Directive. 3. The facility staff failed provide Resident #109 with an opportunity to formulate an Advance Directive. A review of the clinical record indicated that Resident #109 was admitted to the facility on 06/27/18. Diagnoses for this resident included diabetes mellitus, hyperlipidemia, and dementia. A review of the Significant Change MDS dated 02/05/20 assessed this resident as having a BIMS score of 01 which indicated severe cognitive impairment. A review of the clinical records did not indicate this resident was provided an opportunity to formulate an Advance directive. During an interview with the Social Worker on 03/03/20 at 2:30 P.M. the social worker stated Resident #109 was not provided the opportunity to formulate an Advance Directive.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F 582		

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F 582	Continued From page 35 changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 582		

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F 582	Continued From page 36 Based on staff interview, clinical record review and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 2 of 3 residents (Resident #3 and #87) in the survey sample. The findings included: 1. The facility staff failed to issue a Notice of Medicare Non-Coverage (NOMNC) letter to Resident #3 who was discharged from skilled services with Medicare days remaining. Resident #3 was admitted to the nursing facility on 11/11/19. Diagnoses for Resident #3 included but not limited to Muscle Weakness. Resident #3's Minimum Data Set (MDS) a significant change assessment with an Assessment Reference Date (ARD) date of 11/18/19 coded Resident #3 with an 02 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognitive skills for daily decision-making. On review of the Beneficiary Notification Checklists provided by the facility to surveyor, it was noted that Resident #3 was not listed for having been issued the Notice of Medicare Non-Coverage (NOMNC) letter. The resident had received the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) however, no copies of the (NOMNC) was provided. Resident #3 started a Medicare Part A stay on 10/04/19 and the last covered day of this stay was 12/04/19. Resident #3 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-10055) and an NOMNC	F 582		

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F 582	Continued From page 37 (CMS-10123). Resident #3 had only used 31 days of her Medicare Part A services. Only a SNF ABN letter was issued. An interview was conducted with the Social Services Director (SSD) on 03/03/20 at approximately 2:00 p.m. The SSD stated, "I did not realize they could receive both; an ABN and NOMNC letter." The SSD said she only gave Resident #3 an ABN letter. A briefing was held with the Administrator and Director of Nursing on 03/03/20 at approximately 4:00 p.m. The facility did not present any further information about the findings. 2. The facility staff failed to issue a Notice of Medicare Non-Coverage (NOMNC) letter to Resident #87 who was discharged from skilled services with Medicare days remaining. Resident #87 was admitted to the nursing facility on 01/19/20. Diagnoses for Resident #87 included but not limited to Muscle Weakness. Resident #87's Minimum Data Set (MDS) a 5-day PPS with an (ARD) date of 01/23/20 coded Resident #87 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. On review of the Beneficiary Notification Checklists provided by the facility to surveyors, it was noted that Resident #87 was not listed for having been issued the Notice of Medicare Non-Coverage (NOMNC) letter. The resident had received the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) however, no copies of the (NOMNC) was provided.	F 582		

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F 582	Continued From page 38 Resident #87 started a Medicare Part A stay on 01/19/20, and the last covered day of this stay was 02/11/20. Resident #87 was discharged from Medicare Part A services when benefit days were not exhausted and should have been issued a SNF ABN (CMS-10055) and an NOMNC (CMS-10123). Resident #87 only used 37 days of her Medicare Part A services. Only an NOMNC was issued. An interview was conducted with the Social Services Director (SSD) on 03/03/20 at approximately 2:00 p.m. The SSD stated, "I did not realize they could receive both; an ABN and NOMNC letter." The SSD said she only gave Resident #87 an ABN letter. A briefing was held with the Administrator and Director of Nursing on 03/03/20 at approximately 4:00 p.m. The facility did not present any further information about the findings.	F 582		
F 584 SS=E	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 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		

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F 584	Continued From page 39 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 observations and staff interviews, the facility staff failed to ensure a homelike environment on 3 units. The findings included: During the survey, the baseboard on Units III, IV and V were observed to be missing. The base boards were missing throughout the entire units. During an interview with the Maintenance Director on 03/04/20 at 11:00 a.m. he stated, the facility	F 584		

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F 584	Continued From page 40 staff had removed the baseboard last year and had not replaced it. The Administrator was made aware of the findings on 03/04/20 at 3:15 P.M. The Administrator stated the new owners were going to renovate the facility. When asked for a capital improvement plan she was not able to provide one, nor was she able to give a date and time for the improvements. No further information was provided by the facility staff.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review, the facility staff failed to implement their Abuse Investigation and Reporting Policy after a witnessed allegation of abuse/mistreatment for 1 of 57 Residents in the survey sample, Resident #64. The findings included: Resident #64 was admitted to the facility on	F 607		

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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 607	Continued From page 41 3/16/2015 with diagnoses to include but not limited to Schizophrenia, Major Depressive Disorder, Bipolar Disorder and Dementia. Resident #64's most recent comprehensive Minimum Data Set (MDS) was an annual assessment with an Assessment Reference Date (ARD) of 1/7/2020. The Brief Interview for Mental Status (BIMS) for Resident #64 was coded as having short and long term memory recall problems and severely impaired for cognition and daily decision making. On 3/3/20 at approximately 12:15 P.M. a test tray food cart was followed onto Unit 5, the secured unit. At the first doorway of the dining area of the secure unit CNA (Certified Nursing Assistant) #2 was observed behind Resident #64's wheelchair pushing him with full force under the table and yelling at him "Put your legs down." When Resident #64 resisted being pushed up to the table, CNA #2 went to the other side of the table and pushed the table into him. Resident #64 yelled, "Stop." CNA #2 then said, "Don't you yell at me." There was no other resident at the table and there was also no other staff members in the room at the time of this incident. The Dietary Manager was standing on my left side in the hallway and did hear the incident when asked about it. The Dietary Manager stated, "I couldn't see what was happening I just heard her loud tone I thought she was redirecting him." CNA #3 and LPN (Licensed Practical Nurse) #5 were down near the entrance of the secured unit when the incident occurred, the dining area is at the back of the unit. On 3/3/20 at 12:40 P.M. the Administrator was made aware of the above witnessed interaction	F 607		

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F 607	Continued From page 42 by the surveyor between CNA #2 and Resident #64 with physical demonstration. The Administrator was told to please provide any documentation to the surveyor of the facility's response to the incident. Prior to leaving the facility on 3/3/20 at 5:00 P.M. no facility documentation was provided to the surveyor. On 3/4/20 at 9:40 A.M. the Administrator was asked for the Facility Reportable Incident (FRI) Form that was sent to the State Agency regarding the incident between Resident #64 and CNA #2 on 3/2/20 witnessed by this surveyor. The Administrator stated, "Give us a minute." On 3/4/20 at approximately 11:00 A.M. the Administrator provided an Investigational Summary which was reviewed and is documented in part, as follows: Investigation Regarding: Abuse allegation Date Prepared: 3/2/20 Prepared By: Name (Administrator) I. Cause to Initiate Investigation: Survey team member (Name) informed Administration that she witnessed (Name) CNA #2 pushing (Name) Resident #64 up to the dining room table in an aggressive manner. Surveyor states that the CNA was yelling at the resident to "put down your legs:. She states that she overheard the resident say "stop" and (Name) CNA #2 allegedly stated "don't you yell at me". The CNA was placed on administrative suspension pending investigation.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 607	Continued From page 43 II. Investigation: Statements were taken from other staff members who were witness to the event including (Name) Dietary Manager and (Name) CNA #3. Both statements indicate that they did not observe anything that could be considered abuse and did not feel that (Name) CNA #2 was inappropriate with (Name) Resident #64. Family members for two other residents who reside on the unit were contacted to determine if they have had any issues with the care provided by the CNA's on the unit. Both stated that they do not have any care issues or concerns about how staff treat the residents. Staff member (Name) LPN #5 was not a witness to the incident but works with (Name) CNA #2 on the unit. She states that she has never witnessed (Name) CNA #2 being inappropriate or abusive with residents. (Name) CNA #2 was interviewed regarding the incident. She states that (Name) Resident #64 attempted to kick the table with his feet and she was concerned that the table was going to fall on the legs of another resident. She pulled (Name) Resident #64 back and steadied the table and told the resident to put his legs down so that he could be positioned under the table in preparation for the meal. (Name) CNA #2 was asked if she felt that she was inappropriate with the resident and she responded by stating that she knows that she is very loud and sometimes people misinterpret that but that she would never be abusive towards a resident. (Name) CNA #2's personnel record was reviewed and she does not have and disciplinary actions or violations of policy in her file. III. Summary of Investigation:	F 607		

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F 607	Continued From page 44	F 607		

After speaking with the CNA involved in the incident, the staff on the unit, family members and colleagues who work with (NAME) CNA #2, we were unable to substantiate that the survey team member witnessed an abuse situation. Staff members report that (NAME) CNA #2 is an excellent CNA and she is very respectful and affectionate with her residents.

IV. Recommendations:

Even though the facility was unable to substantiate abuse in this incident the facility will continue to provide regular staff training on the abuse policy and report allegations of abuse per regulatory guidelines.

No FRI was presented at the time the Investigational Summary was given to this surveyor.

On 3/4/20 at approximately 5:45 P.M. the Administrator was asked if she had submitted a FRI to the State Office regarding the abuse/mistreatment allegation for Resident #64. The Administrator stated, "No, we didn't, I thought (NAME) Regional Director of Operations told you that we didn't."

The facility policy titled "Abuse Prevention Program" revised December 2016 was reviewed and is documented in part, as follows:

Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or

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F 607	Continued From page 45 chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. The facility policy titled "Abuse Investigation and Reporting" revised July 2017 was reviewed and is documented in part, as follows: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. Role of the Investigator: e. Interview the resident (as medical appropriate). i. Interview other residents to whom the accused employee provides care or services. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of	F 607		

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F 607	Continued From page 46 an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services; e. Law enforcement officials; f. The resident's Attending Physician; g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		

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F 609	Continued From page 47 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review the facility staff failed to report an allegation of abuse/mistreatment to the State Survey Agency and Adult Protective Services within the required time frame for 1 of 57 Residents in the survey sample, Resident #64. The findings included: Resident #64 was admitted to the facility on 3/16/2015 with diagnoses to include but mot limited to Schizophrenia, Major Depressive	F 609		

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Disorder, Bipolar Disorder and Dementia.

Resident #64's most recent comprehensive Minimum Data Set (MDS) is an annual assessment with an Assessment Reference Date (ARD) of 1/7/2020. The Brief Interview for Mental Status (BIMS) for Resident #64 was coded as having short and long term memory recall problems and severely impaired for cognition and daily decision making.

On 3/3/20 at approximately 12:15 P.M. a test tray food cart was followed onto Unit 5 the secured unit. At the first doorway of the dining area of the secure unit CNA (Certified Nursing Assistant) #2 was observed behind Resident #64's wheelchair pushing him with full force under the table and yelling at him "Put your legs down." When the Resident #64 resisted being pushed up to the table, CNA #2 went to the other side of the table and pushed the table into him. Resident #64 yelled, "Stop." CNA #2 then said, "Don't you yell at me." There was no other resident at the table and there was also no other staff members in the room at the time of this incident. The Dietary Manager was standing on my left side in the hallway and did hear the incident when asked about it. The Dietary Manager stated, "I couldn't see what was happening I just heard her loud tone I thought she was redirecting him." CNA #3 and LPN (Licensed Practical Nurse) #5 were down near the entrance of the secured unit when the incident occurred, the dining area is at the back of the unit.

On 3/3/20 at 12:40 P.M. the Administrator was made aware of the above witnessed interaction by the surveyor between CNA #2 and Resident #64 with physical demonstration. The

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Administrator was told to please provide any documentation to the surveyor of the facilities response to the incident.

Prior to leaving the facility on 3/3/20 at 5:00 P.M. no facility documentation was provided to the surveyor.

On 3/4/20 at 9:40 A.M. the Administrator was asked for the Facility Reportable Incident (FRI) Form that was sent to the State Agency regarding the incident between Resident #64 and CNA #2 on 3/2/20 witnessed by this surveyor. The Administrator stated, "Give us a minute."

On 3/4/20 at approximately 11:00 A.M. the Administrator provided an Investigational Summary which was reviewed and is documented in part, as follows:

Investigation Regarding: Abuse allegation
Date Prepared: 3/2/20
Prepared By: Name (Administrator)

I. Cause to Initiate Investigation:

Survey team member (Name) informed Administration that she witnessed (Name) CNA #2 pushing (Name) Resident #64 up to the dining room table in an aggressive manner. Surveyor states that the CNA was yelling at the resident to "put down your legs:. She states that she overheard the resident say "stop" and (Name) CNA #2 allegedly stated "don't you yell at me". The CNA was placed on administrative suspension pending investigation.

II. Investigation:

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F 609	Continued From page 50	F 609		

Statements were taken from other staff members who were witness to the event including (Name) Dietary Manager and (Name) CNA #3. Both statements indicate that they did not observe anything that could be considered abuse and did not feel that (Name) CNA #2 was inappropriate with (Name) Resident #64. Family members for two other residents who reside on the unit were contacted to determine if they have had any issues with the care provided by the CNA's on the unit. Both stated that they do not have any care issues or concerns about how staff treat the residents. Staff member (Name) LPN #5 was not a witness to the incident but works with (Name) CNA #2 on the unit. She states that she has never witnessed (Name) CNA #2 being inappropriate or abusive with residents. (Name) CNA #2 was interviewed regarding the incident. She states that (Name) Resident #64 attempted to kick the table with his feet and she was concerned that the table was going to fall on the legs of another resident. She pulled (Name) Resident #64 back and steadied the table and told the resident to put his legs down so that he could be positioned under the table in preparation for the meal. (Name) CNA #2 was asked if she felt that she was inappropriate with the resident and she responded by stating that she knows that she is very loud and sometimes people misinterpret that but that she would never be abusive towards a resident. (Name) CNA #2's personnel record was reviewed and she does not have and disciplinary actions or violations of policy in her file.

III. Summary of Investigation:

After speaking with the CNA involved in the incident, the staff on the unit, family members

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F 609	Continued From page 51	F 609		

and colleagues who work with (NAME) CNA #2, we were unable to substantiate that the survey team member witnessed an abuse situation. Staff members report that (NAME) CNA #2 is an excellent CNA and she is very respectful and affectionate with her residents.

IV. Recommendations:

Even though the facility was unable to substantiate abuse in this incident the facility will continue to provide regular staff training on the abuse policy and report allegations of abuse per regulatory guidelines.

No FRI was presented at the time the Investigational Summary was given to this surveyor.

On 3/4/20 at approximately 5:45 P.M. the Administrator was asked if she had submitted a FRI to the State Office regarding the abuse/mistreatment allegation for Resident #64. The Administrator stated, "No, we didn't, I thought (NAME) Regional Director of Operations told you that we didn't"

The facility policy titled "Abuse Prevention Program" revised December 2016 was reviewed and is documented in part, as follows:

Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the resident's symptoms.

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F 609	Continued From page 52 Policy Interpretation and Implementation: 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. The facility policy titled "Abuse Investigation and Reporting" revised July 2017 was reviewed and is documented in part, as follows: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of	F 609		

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F 609	Continued From page 53 Record; d. Adult Protective Services; e. Law enforcement officials; f. The resident's Attending Physician; g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		

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F 610	Continued From page 54	F 610		

investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews and facility document review the facility staff failed to thoroughly investigate a witnessed allegation of abuse/mistreatment for 1 of 57 Residents in the survey sample, Resident #64.

The findings included:

Resident #64 was admitted to the facility on 3/16/2015 with diagnoses to include but mot limited to Schizophrenia, Major Depressive Disorder, Bipolar Disorder and Dementia.

Resident #64's most recent comprehensive Minimum Data Set (MDS) is an Annual Assessment with an Assessment Reference Date (ARD) of 1/7/2020. The Brief Interview for Mental Status (BIMS) for Resident #64 was coded as having short and long term memory recall problems and severely impaired for cognition and daily decision making.

On 3/3/20 at approximately 12:15 P.M. a test tray food cart was followed onto Unit 5 the secured unit. At the first doorway of the dining area of the secure unit CNA (Certified Nursing Assistant) #2 was observed behind Resident #64's wheelchair pushing him with full force under the table and yelling at him "Put your legs down". When the Resident #64 resisted being pushed up to the table, CNA #2 went to the other side of the table

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and pushed the table into him. Resident #64 yelled, "Stop." CNA #2 then said, "Don't you yell at me." There was no other resident at the table and there was also no other staff members in the room at the time of this incident. The Dietary Manager was standing on my left side in the hallway and did hear the incident when asked about it. The Dietary Manager stated, "I couldn't see what was happening I just heard her loud tone I thought she was redirecting him." CNA #3 and LPN (Licensed Practical Nurse) #5 were down near the entrance of the secured unit when the incident occurred, the dining area is at the back of the unit.

On 3/3/20 at 12:40 P.M. the Administrator was made aware of the above witnessed interaction by the surveyor between CNA #2 and Resident #64 with physical demonstration. The Administrator was told to please provide any documentation to the surveyor of the facilities response to the incident.

Prior to leaving the facility on 3/3/20 at 5:00 P.M. no facility documentation was provided to the surveyor.

On 3/4/20 at 9:40 A.M. the Administrator was asked for the Facility Reportable Incident (FRI) Form that was sent to the State Agency regarding the incident between Resident #64 and CNA #2 on 3/2/20 witnessed by this surveyor. The Administrator stated, "Give us a minute."

On 3/4/20 at approximately 10:30 A.M. an interview was conducted with Resident #64. Resident #64 was asked if anything happen when he was in the dining room for lunch yesterday. Resident stated, "She banged my knee, I don't

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like to be yelled at." Resident #64 was able to verbalize his name, the correct year and who the current President was.

On 3/4/20 at approximately 10:45 A.M. an interview was conducted with the Dietary Manager regarding what he witnessed with Resident #64 in the dining area on 3/3/20 around 12:15 P.M. The Dietary Manager stated, "I did not see anything, I was outside of the room.. I heard the CNA being loud I thought she was redirecting the resident. I did not hear the actual verbage. I was concentrating on you and focused on getting the temperatures of the test trays. I didn't process the verbage of what I heard."

On 3/4/20 at approximately 10:50 A.M. an interview was conducted with CNA #3 regarding what he witnessed with Resident #64 in the dining area on 3/3/20 around 12:15 P.M. CNA #3 stated, "I didn't see anything prior to passing trays. I was probably gathering other residents. When I was asked about it I thought they were talking about when we were passing trays, I wasn't in the room prior to passing trays."

On 3/4/20 at approximately 11:00 A.M. the Administrator provided an Investigational Summary which was reviewed and is documented in part, as follows:

Investigation Regarding: Abuse allegation
Date Prepared: 3/2/20
Prepared By: Name (Administrator)

I. Cause to Initiate Investigation:

Survey team member (Name)) informed Administration that she witnessed (Name) CNA

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F 610	Continued From page 57 #2 pushing (Name) Resident #64 up to the dining room table in an aggressive manner. Surveyor states that the CNA was yelling at the resident to "put down your legs:. She states that she overheard the resident say "stop" and (Name) CNA #2 allegedly stated "don't you yell at me". The CNA was placed on administrative suspension pending investigation. II. Investigation: Statements were taken from other staff members who were witness to the event including (Name) Dietary Manager and (Name) CNA #3. Both statements indicate that they did not observe anything that could be considered abuse and did not feel that (Name) CNA #2 was inappropriate with (Name) Resident #64. Family members for two other residents who reside on the unit were contacted to determine if they have had any issues with the care provided by the CNA's on the unit. Both stated that they do not have any care issues or concerns about how staff treat the residents. Staff member (Name) LPN #5 was not a witness to the incident but works with (Name) CNA #2 on the unit. She states that she has never witnessed (Name) CNA #2 being inappropriate or abusive with residents. (Name) CNA #2 was interviewed regarding the incident. She states that (Name) Resident #64 attempted to kick the table with his feet and she was concerned that the table was going to fall on the legs of another resident. She pulled (Name) Resident #64 back and steadied the table and told the resident to put his legs down so that he could be positioned under the table in preparation for the meal. (Name) CNA #2 was asked if she felt that she was inappropriate with the resident and she responded by stating that she knows that	F 610		

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F 610	Continued From page 58 she is very loud and sometimes people misinterpret that but that she would never be abusive towards a resident. (Name) CNA #2's personnel record was reviewed and she does not have and disciplinary actions or violations of policy in her file. III. Summary of Investigation: After speaking with the CNA involved in the incident, the staff on the unit, family members and colleagues who work with (NAME) CNA #2, we were unable to substantiate that the survey team member witnessed an abuse situation. Staff members report that (NAME) CNA #2 is an excellent CNA and she is very respectful and affectionate with her residents. IV. Recommendations: Even though the facility was unable to substantiate abuse in this incident the facility will continue to provide regular staff training on the abuse policy and report allegations of abuse per regulatory guidelines. No FRI was presented at the time the Investigational Summary was given to this surveyor. On 3/4/20 at approximately 11:20 A.M. an interview was conducted with Resident # 20 whom also resides on the secure unit regarding what he witnessed with Resident #64 in the dining area on 3/3/20 around 12:15 P.M. Resident #20's most recent MDS was reviewed which was an Annual Assessment with an ARD of 2/20/20. The BIMS for Resident #20 was a 15 out of a possible 15 indicating that the resident is cognitively intact	F 610		

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and capable of daily decision making. Resident #20 stated, "I saw (Name) CNA #2 pushing (Name) Resident #64 legs under the table. She was yelling and rough with him. I see that often and it's not good. Resident #20 was asked how seeing that makes him feel. Resident #20 stated, "Makes me feel bad because they can't speak for themselves. I was sitting right there I saw it." Resident #20 was asked if any staff had been rough with him or other residents. Resident #20 stated, "Yes, a lot of people, but not me I won't let them." Resident #20 was asked if he had ever reported want he has seen. Resident #20 stated, "No, I'm to scared to report it." Resident #20 was asked if any staff member has interviewed him yesterday regarding CNA #2 or if he witnessed in the dining area during lunch on 3/3/20. Resident #20 stated, "No".

On 3/4/20 at approximately 5:45 P.M. the Administrator was asked if she had submitted a FRI to the State Office regarding the abuse/mistreatment allegation for Resident #64. The Administrator stated, "No, we didn't, I thought (NAME) Regional Director of Operations told you that we didn't"

The facility policy titled "Abuse Prevention Program" revised December 2016 was reviewed and is documented in part, as follows:

Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the resident's symptoms.

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F 610	Continued From page 60 Policy Interpretation and Implementation: 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. The facility policy titled "Abuse Investigation and Reporting" revised July 2017 was reviewed and is documented in part, as follows: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. Role of the Investigator: e. Interview the resident (as medical appropriate). i. Interview other residents to whom the accused employee provides care or services. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility	F 610		

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F 610	Continued From page 61 Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services; e. Law enforcement officials; f. The resident's Attending Physician; g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. I asked if anyone had interviewed Resident #64 or any other residents on the unit during the investigation. The Regional Director of Operations stated, " No, because (Name) Resident #64 has a low BIMS score and is not interviewable as well as the other residents on the locked unit." The Regional Director of Operations was made aware that Resident #20 on the secure unit had a BIMS score of 15 and was cognitively intact. Prior to exit no further information was	F 610		

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F 610	Continued From page 62 provided.	F 610		
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 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	F 622		

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F 622	Continued From page 63 discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including	F 622		

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F 622	Continued From page 64 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to send the comprehensive care plan goals upon transfer to the hospital for 4 out of 57 residents in the survey sample, Residents #119, #53, #82, and #21. The findings included: 1. Resident #119 was admitted to the facility on 1/16/20 with diagnoses that included but were not limited to cognitive communication deficit, unspecified mood disorder, and dementia with other diseases with behavioral disturbance. Resident #119's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 1/27/20. Resident #119 was coded as being severely impaired in cognitive function on the staff interview for mental status exam. Review of Resident #119's clinical record revealed that he was transferred to the hospital on 2/1/2020 for behaviors. The following was documented: "Resident extremely agitated this shift, as exhibited by constantly walking in and out of other resident's room urinating, on their beds,	F 622		

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F 622	Continued From page 65 pushing over furniture in the dining room and not responding at all to redirection. This activity culminated in resident becoming physically aggressive, kicking a nursing aide in the stomach when she tried to intervene resident physically threatening another resident. At this point, a nursing manager called 911 and resident was taken by stretcher to (name of hospital) (medical record) were notified of incident." There was no evidence that care plan goals were sent with Resident #119 upon transfer to the hospital. Further review of the clinical record revealed that Resident #119 was not admitted back to the facility due to being a danger to staff and residents. On 3/4/20 at 3:05 p.m. the nurse who transferred Resident #119 out to the hospital on 2/1/20 was attempted for an interview. She could not be reached. On 3/4/20 at 4:22 p.m., an interview was conducted with the former DON (Director of Nursing) ASM (administrative staff member) #3. When asked when a resident is sent to the hospital what documents were sent upon transfer, ASM #3 stated that she expected staff to send the e-interact transfer form and the bed hold policy. When asked if she expected her nurses to document what items were sent with the resident upon transfer to the hospital, ASM #3 stated that she did. When asked if the e-interact form included the care plan goals, ASM #3 stated, "I don't know." When asked if staff were expected to send the care plan or care plan goals upon transfer to the hospital, ASM #3 "Not that I am aware of."	F 622		

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F 622	Continued From page 66 On 3/4/20 at 4:33 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #7. When asked what documents were sent with residents upon transfer to the hospital, LPN #7 stated that she would send the face sheet, advanced directive, any pertinent laboratory tests, bed hold policy and the e-interact form. When asked if she would send care plan goals or the care plan with the resident upon transfer to the hospital, LPN #7 stated, "I have never heard of that." LPN #7 stated that she also never heard of documenting what items were sent with the resident upon transfer to the hospital. Review of Resident #119's e-interact form dated 2/1/2020 did not address care plan goals. On 3/4/20 at 5:00 p.m., ASM (administrative staff member) #1, the Administrator, was made aware of the above concerns. ASM #1 stated that her admission/transfer/discharge policy did not address care plan goals. No further information was provided prior to exit. 2. Resident #53 was initially admitted to the facility on 12/30/2019 with diagnoses including, but not limited to, dysphagia, repeated falls, other Escherichia coli, urinary tract infection and metabolic encephalopathy. Resident #53's most recent MDS (Minimum Data Set) assessment was a Quarterly Review Assessment with an ARD (Assessment Review Date) of 12/30/2019. Resident #53's BIMS (Brief Interview for Mental Status) score was recorded as unobtainable. A review of Resident #53's clinical record revealed, there was no evidence that a Comprehensive Care Plan was sent to the	F 622		

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F 622	Continued From page 67 receiving provider during a transfer to the hospital that occurred on, or about, 12/22/2019. An interview with the facility Administrator on 3/5/2020 at approximately 11:00 a.m. regarding procedures to submit the Comprehensive Care Plan to receiving providers upon discharge, responded, "No, we don't do that." An interview with the Corporate Staff #2 regarding facility policy on submitting comprehensive care plans upon discharge produced the following response, "There is no policy for submitting the care plan upon discharge." These findings were reviewed with the facility Administrator, Director of Nursing, and Corporate Staff during a briefing held on 3/5/2020 at approximately 5:00 p.m. There was no additional information provided. 3. Resident #82 was admitted to the nursing facility on 2/5/18 with diagnoses that included Alzheimer's disease, bipolar disorder and paranoid schizophrenia. The most recent Minimum Data Set (MDS) assessment was an annual dated 1/15/20 and coded the resident with short and long term memory and moderately impaired in the cognitive skills for daily decision making. A copy of the resident's comprehensive care plan goals was not sent with the resident when he was transferred to the local hospital on 6/2/19, 12/26/19 and 1/5/20. On 3/3/20 at 11:05 a.m., an interview was conducted with a Licensed Practical Nurse (LPN) #7. She stated when a resident is transferred to	F 622		

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F 622	Continued From page 68 the hospital the following discharge documents are sent with the resident: -Physician's order sheet (POS) with medication list -Face Sheet -Bedhold policy given to 911 or medical transport, not the resident or resident representative -Laboratory reports -The SBAR report -Copy of the DNR form (as indicated) LPN #7 stated she was never told to send anything with the patient or forward to the provider other that the aforementioned documents and never heard of a care plan summary and what it entails. On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. They shared they were not aware of the mandate to send or fax a summary of the care plan goals to the transferring entity when residents are transferred from the facility. They stated they did not have a policy or procedure that outlined the directive. No further information was provided prior to survey exit. 4. Resident #21 was re-admitted to the facility on 11/28/19. Diagnoses for this resident included seizures, depression, and multiple sclerosis. Resident #21 was admitted to the hospital on 11/24/19. A review of the Re-admit Minimum Data Set (MDS) dated 12/05/19 assessed this resident in the area of Cognitive Patterns - Brief Interview for Mental Status (BIMS) as a 15 which indicated intact cognition.	F 622		

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F 622	Continued From page 69 A review of the clinical records did not indicate a Care Plan Summary was sent to the hospital with Resident #21. During an interview on 03/05/20 at 11:00 A.M. with the Administrator, she stated care plans were not sent to the hospital with Resident #21 during his admission (to the hospital) on 11/24/19.	F 622		
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; (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.	F 625		

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F 625	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to issue a bedhold notice to the resident or resident representative at time of transfer to the hospital for 3 of 57 Residents (#89, #82 and #21) in the survey sample. The findings include: 1. The facility staff failed to ensure Resident #89 or Resident Representative (RR) was issued a written notice of the bed hold reserve policy upon transfer to the local hospital on 1/14/20. Resident #89 was admitted to the nursing facility on 7/12/18 with diagnoses that included non-Alzheimer's disease dementia and generalized muscle weakness. The resident was readmitted on 1/19/20 with diagnoses that included dysphagia, meniere's disease and urinary tract infection (UTI). The most recent Minimum Data Set (MDS) assessment dated 1/23/20 was a significant change is status and coded the resident with moderate difficulty in hearing, usually has the ability to express ideas and wants and usually comprehends most conversation. Resident #89 was coded on this assessment as having short and long term memory and never/rarely made decisions. The nurse's notes dated 1/14/20 indicated the resident was sent to the local hospital and admitted with a diagnosis of Altered Mental Status (AMS), Urinary Tract Infection (UTI) and elevated cardiac enzymes. The resident was	F 625		

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F 625	Continued From page 71 readmitted to the nursing facility on 1/19/20. There was no documentation that a written notice of the bed hold reserve policy was issued to the RR upon transfer to the local hospital. On 3/3/20 at 11:05 a.m., an interview was conducted with a Licensed Practical Nurse (LPN) #7. She stated when a resident is transferred to the hospital the following discharge documents are sent with the resident: -Physician's order sheet (POS) with medication list -Face Sheet -Bedhold policy given to 911 or medical transport, not the resident or resident representative -Laboratory reports -The SBAR report -Copy of the DNR form (as indicated) LPN #7 stated she does not issue the bedhold policy to the resident or their families, but gave the bedhold notice to 911 or regular transportation. She stated, "Maybe they give the bedhold notice to the resident and/or family." The facility's policy and procedures titled Bed-Holds and Returns dated 3/2017 indicated prior to transfer, written information will be given to the residents and the resident's representatives that explains in detail the rights and limitation of the resident regarding bed-holds, reserve bed payment, perdiem rate and details of the transfer. On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and	F 625		

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F 625	Continued From page 72 discussed. No further information was provided prior to survey exit. 2. The facility staff failed to ensure Resident #82 or Resident Representative (RR) was issued a written notice of the bed hold reserve policy upon transfer to the local hospital on 6/2/19, 12/26/19 and 1/5/20. Resident #82 was admitted to the nursing facility on 2/5/18 with diagnoses that included Alzheimer's disease, bipolar disorder and paranoid schizophrenia. The most recent Minimum Data Set (MDS) assessment was an annual dated 1/15/20 and coded the resident with short and long term memory and moderately impaired in the cognitive skills for daily decision making. The nurse's notes dated 6/2/19 with readmission to the facility on 6/3/19; the nurse's notes dated 12/26/19 with readmission on 12/26/19, and nurse's notes dated 1/5/20 with readmission on 1/6/20 did not reference documentation that a written notice of the bed hold reserve policy was issued to the RR upon transfer to the local hospital. On 3/3/20 at 11:05 a.m., an interview was conducted with a Licensed Practical Nurse (LPN) #7. She stated when a resident is transferred to the hospital the following discharge documents are sent with the resident: -Physician's order sheet (POS) with medication list -Face Sheet -Bedhold policy given to 911 or medical transport, not the resident or resident representative	F 625		

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F 625	Continued From page 73 -Laboratory reports -The SBAR report -Copy of the DNR form (as indicated) LPN #7 stated she does not issue the bedhold policy to the resident or their families, but gave the bedhold notice to 911 or regular transportation. She stated, "Maybe they give the bedhold notice to the resident and/or family." On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. No further information was provided prior to survey exit. 3. The facility staff failed to provide Resident #21 with a bed hold notice upon discharge to the hospital. Resident #21 was discharged to the hospital on 11/24/19. Diagnoses for this resident included seizures, depression, and multiple sclerosis. Resident #21 was admitted to the hospital on 11/24/19. A review of the re-admission Minimum Data Set (MDS) dated 12/05/19 assessed this resident in the area of Cognitive Patterns - Brief Interview for Mental Status (BIMS) as a 15 which indicated intact cognition. A review of the clinical records did not indicate a bed hold notice was provided to Resident #21 upon his discharge to the hospital on 11/24/19. During an interview on 03/05/20 at 11:00 A.M. with the Administrator she stated, Resident #21 was not provided a bed hold notice upon discharge to the hospital on 11/24/19.	F 625		

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F 640	Continued From page 74	F 640		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment.	F 640		

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F 640	Continued From page 75 (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a discharge assessment (MDS) was submitted for 2 of 57 residents (Residents #91 and Resident #1), in the survey sample. The findings included: 1. The facility staff failed to complete a discharge MDS assessment for Resident #91. Resident #91 was admitted to the nursing facility on 01/22/20. Resident #91 was discharged from the facility to home on 02/07/20. Diagnoses for Resident #91 included but not limited to Muscle Weakness. Resident #91's last Minimum Data Set (MDS), an Admission Assessment with an Assessment Reference Date of 01/27/20 coded Resident #91's Brief Interview for Mental Status (BIMS) scoring a 09 out of a possible 15 indicating moderately impaired cognitive skills for daily decision-making. Review of Resident #91's clinical note dated	F 640		

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F 640	Continued From page 76 02/07/20 read in part: Resident discharged from facility at 3:00 p.m. An interview was conducted with Licensed Practical Nurse (LPN) #2 (Assistant MDS Coordinator) on 03/03/20 at approximately 3:25 p.m. She reviewed Resident #91's clinical record then stated, "Resident #91 was discharged home on 02/07/20." She said a discharge MDS was not completed." The MDS Coordinator said a discharge MDS should have been completed within 14 days after Resident #91's discharge from the facility. A briefing was held with the Administrator and Director of Nursing on 03/03/20 at approximately 4:00 p.m. The facility did not present any further information about the findings. CMS' RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI). -Discharge Assessment-return not anticipated: Must be completed when the resident is discharge from the facility and the resident is not expected to return to the facility within 30 days. -Must be completed (Item Z0500B) within 14 days after the discharge date (A200 + 14 calendar days). -Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). 2. Resident #1 was admitted to the facility 6/25/18, and was discharged from the facility to the hospital 10/21/19. The last assessment accepted into the MDS databank was a quarterly assessment dated 9/20/19. Review of the clinical record revealed a nurse's note dated 10/21/19 which stated the resident was sent to a local emergency room for	F 640		

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F 640	Continued From page 77 evaluation. An interview was conducted with the MDS Coordinator on 3/4/20, at approximately 11:30 a.m. The MDS Coordinator stated the resident's discharge MDS assessment wasn't completed and transmitted to CMS. The MDS Coordinator present a completed discharge MDS assessment on 3/4/20 at approximately 2:15 p.m., along with a validation report indicating the MDS assessment was transmitted to the CMS data bank. On 3/5/19, at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing and the Regional Director of Operations. The Administrator stated no addition information would be provided.	F 640		
F 641 SS=D	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 clinical record review and staff interviews, the facility staff failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 57 residents (Resident #76), in the survey sample. The findings included; Resident #76 was originally admitted to the facility 11/7/19 and has never been discharged from the facility. The current diagnoses included dementia and coronary artery disease.	F 641		

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F 641	Continued From page 78	F 641		

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/19/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 6 out of 15. This indicated the resident was with severely impaired daily decision making abilities.

In section "O0100k2"of the 12/12/18 MDS assessment, the resident was coded for hospice care while a resident.

Review of the physician order summary revealed no physician's order for hospice care, nor did the active care plan revel hospice services.

On 3/2/20 at approximately 11:00 a.m., Licensed Practical Nurse (LPN) #3 was asked which days the hospice staff visited Resident #76. LPN #3 stated she wasn't aware the resident received hospice services but she would review the record for information. LPN #3 stated there was no orders or information in Resident #76's record indicating hospice services.

An interview was conducted with the Social Service Director (SSD) on 3/4/20 at approximately 1:35 p.m., the SSD stated upon admission to the facility the resident's daughter stated the resident was admitted to hospice services and would resume the services but later the hospice agency stated Resident #76 didn't qualify at the time for hospice services but they would periodically re-evaluate the resident to determine if she qualified.

An interview was conducted with the MDS Coordinator on 3/4/19 at approximately 11:30 a.m., the MDS Coordinator stated the 11/7/18,

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F 641	Continued From page 79 MDS assessment should not have been coded for hospice care because the hospice agency didn't pick the resident up for hospice services. At approximately 4:35 p.m., the MDS Coordinator stated a modification was made to the 11/7/19, MDS assessment and presented a copy of the modified assessment. On 3/5/20, at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing and Regional Director of Operations. The Administrator stated she understood the concern and had no additional information the offer.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		

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F 656	Continued From page 80 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 staff interview, clinical record review and facility documentation review, the facility staff failed to develop a person centered care plan to include depression and anxiety for 1 of 57 residents in the survey sample, Resident #100. The findings included: Resident #100 was admitted to the facility on 03/12/2015. Diagnoses for Resident #100 included but are were limited to, Major Depressive Disorder and Anxiety Disorder Due to Known Physiological Condition. Resident #100's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/04/2020 coded Resident #100 with short-term memory problems, long-term memory problems, and with severely impaired cognitive skills for daily	F 656		

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F 656	Continued From page 81 decision making. Review of Resident #100's clinical record on 03/04/2020 revealed the following: The Medication Administration Record (MAR) for the period of 03/01/2020 - 03/31/2020 revealed the following: "Paroxetine (used for the treatment of depression) Tab 40 MG (Milligram) Give 1 tablet orally one time a day related to Anxiety Disorder Due To Known Physiological Condition. Start Date: 08/28/2019" and "Xanax (used for the treatment of anxiety) Tablet 0.5 MG (Alprazolam) Give 1 tablet by mouth as needed for anxiety 3 times a day Q (every) 8 H (hours) Start Date: 02/11/2020." The MAR also included the following: "Behavior Monitoring - Anxiolytic: Alternative Used Before Administering PRN; 1=Music; 2=low stern activity; 3=Relaxation every 8 hours as needed for Behavior Monitoring. Start Date: 01/08/2020." Review of Order Summary Report Dated with Active Orders As Of: 3/04/2020 revealed the following: "Document on behaviors, how long it last, any intervention pharmical (sic) or non pharmical (sic) and was it effective. Notify MD every shift.." Order Date: 02/12/2020 Start Date: 02/12/2020 "(Name Psychological Services) May Provide Psychological Services / Med Management Associates to Provide Psychiatric Services" Order Date: 02/21/2020 Review of Nurse Practitioner Notes dated 02/24/2020 revealed and is documented in part,	F 656		

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F 656	Continued From page 82 as follows: "He had significant anxiety during today's exam and was holding his breath during auscultation. Staff stated he does often as a coping mechanism for his anxiety., but it is interfering with his ADL's (Activities of Daily Living). He is on Xanax and Risperdal as well as Paxil for depression. A referral to the psych nurse to manage his anxiety was ordered. Review of Resident #100's comprehensive care plan on 03/04/2020 did not include a care plan for depression or anxiety. On 03/05/2020 at 11:15 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #2, the MDS Coordinator, when asked if Resident #100 had a diagnosis of depression and anxiety, LPN #2 stated, "Yes." When asked if the diagnosis of depression and anxiety was addressed in the residents care plan, LPN #2 stated, "No, it probably should have been. May have been left off, we have been changing things over." When asked if the care plan had been reviewed since change over, LPN #2 stated, "Yes." LPN #2 stated, "I will add it to the care plan." When asked what is the purpose of the care plan, LPN #2 stated, "It's to help us take care of the resident." On 03/05/2020 at 2:30 p.m., during briefing the Director of Nursing was made aware of finding. When asked what her expectations were, Director of Nursing stated, "Yes, depression and anxiety should have been addressed individually in the care plan." No further information was presented about the finding. The facility policy titled Care Planning, Care Plan Updated - InterdisciplinaryTeam	F 656		

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F 656	Continued From page 83 Policy Statement: Our facility's Updating Care Plan/Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan/Updating for each resident.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review staff interview	F 657		

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and review of facility documentation, the facility staff failed to revise the care plan for 1 of 57 residents (Resident #96) in the survey sample.

The findings include:

Resident #96 was admitted to the nursing facility on 7/12/18 with diagnoses that included non-Alzheimer's disease dementia and generalized muscle weakness. The resident was readmitted on 1/19/20 with diagnoses that included *dysphagia, *meniere's disease and urinary tract infection (UTI).

The most recent Minimum Data Set (MDS) assessment dated 1/23/20 was a significant change is status and coded Resident #96 was coded on this assessment as having short and long term memory and never/rarely made decisions. Resident #96 was coded to need assistance with personal care. This assessment indicated the resident had no significant weight loss or gain. Significant weight loss is a loss of 5% or more in the last month or a loss of 10% in the last 6 months. Significant weight gain is a gain of 5% or more in the last month or 10% or more in the last 6 months. The height of the resident was coded as 49 inches (4 feet and 1 inch) and weight 120 lb (pounds). The resident was coded to be on a mechanically altered therapeutic diet.

The Care Area Assessment (CAA) dated 2/5/20 identified nutritional status as a care area that was triggered with a decision to care plan the area.

The aforementioned care plan was not revised to reflect the physician prescribed diet order change

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dated 2/14/20 of NAS (no added salt) diet pureed texture, regular/thin consistency liquids.

On 3/4/20 at 10:00 a.m., and interview was conducted with the Minimum Data Set (MDS) coordinator. She stated although it is an interdisciplinary approach, the MDS Coordinator usually enters updates to the care plan, as she should have to reflect any changes in the resident's diet and just missed it.

On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. No further information was provided prior to survey exit.

The facility's policy and procedures titled Care planning, Care Plan Updated-Interdisciplinary Team dated 9/2013 indicated the facility's updating care plan/care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan/updating for each resident.

The policy and procedure titled Resident Nutrition Services dated 7/2017 indicated that the multidisciplinary staff, including the nursing staff, the attending physician and the dietician will assess each resident's nutritional need, food likes, dislikes and eating habits. They will develop and revise a resident care plan based on this assessment.

*People with dysphagia have difficulty swallowing and may even experience pain while swallowing (odynophagia). Some people may be completely

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F 657	Continued From page 86 unable to swallow or may have trouble safely swallowing liquids, foods, or saliva(https://www.nidcd.nih.gov/health/dysphagia #1). *Meniere's disease is a disorder of the inner ear that can lead to dizzy spells (vertigo) and hearing loss. In most cases, Meniere's disease affects only one ear (https://www.mayoclinic.org/diseases-conditions/meniere's-disease/symptoms-causes/syc-20374910).	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to provide supervision for one resident (Resident #167) in the survey sample of 57 to prevent an elopement. The findings included: Resident #167 was admitted to the facility on 07/25/19 with diagnoses of diabetes mellitus, Alzheimer's Disease, cardiovascular accident (CVA), dementia, Asthma, violent behavior, and dysphagia. Resident #167 eloped from the facility on 12/23/19.	F 689		

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F 689	Continued From page 87 A Quarterly Minimum Data Set (MDS) dated 12/11/19 assessed this resident in the area of Cognitive Patterns -Brief Interview for Mental Status as a 7 which indicated severe cognitive impairment. In the area of Behaviors this resident was assessed as having behaviors for rejecting care. As well as other behavioral symptoms including pacing. In the area of Activities of Daily Living (ADL) this resident was assessed as requiring limited assistance with one person physical assist with transfer, dressing, and eating. A care plan revision dated 12/21/19 indicated: Focus- The resident has a behavior problem. Resident was chasing and yelling at nurses stating "I'M going to kill you ___". Goal- The resident will have no evidence of behavior problems. Interventions- Assist the resident to develop more appropriate methods of coping and interacting. Observe behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. A wandering assessment dated 10/09/2019 indicated: Family requested a wander assessment. The assessment indicated- Significant Change in Condition. Mental Status- Can follow instructions. Mobility- Is ambulatory. History of Wandering -Has a history of wandering (past hospitalization or history from resident/family). Comments/Notes - Resident stated to RP (Responsible Party) that once he got the strength he was going to leave and wasn't staying on the unit. Scoring (7) Low Risk.	F 689		

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A 12/21/19 Nursing note indicated: "Resident was very combative with the nursing staff chasing the nurses around the unit say (sic) I am going to kill you "____ " it had gotten so bad the police was call (sic), he calm down when he saw the police and took all med, now resting in his room. Resident RP was call (sic) left a message to call back when she get the message. MD was notify (sic)."

A 12/23/19 (08:45) Nursing note indicated: "Resident wandered outside of facility this shift and picked up by (Name of Ambulance Service) accompanied by an unknown woman, resident taken to local hospital for evaluation and treatment."

An Investigation Summary For Resident #167 included:

Event: Elopement 12/23/2019
Date- Monday, December 23, 2019
approximately 0530.

"Resident was noted not to be in his room around 5:30 A.M. on 12/23/19 when CNA (certified nursing assistant) entered to provide care. Facility activated missing resident protocol and began to search the grounds. Facility staff called (DON) Director of Nursing and Administrator regarding the incident. Upon calling 911, the facility staff were informed another call had just come in and the description matched that provided for resident and stated, local EMS was in route to location. Local EMS called facility at 6:45 A.M. and asked which hospital to take resident to for evaluation and then transported to local hospital. DON spoke to hospital staff who reported that resident was doing fine just a little cold, and that they were running some tests to make sure nothing was

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F 689	Continued From page 89 bothering him. Resident returned to facility in early afternoon at his baseline with no noted injury and was placed on secured unit. DON and Administrator met with resident RP to discuss incident, facility investigation in progress, and previous elopement assessment. Resident left the facility without knowledge of the staff, and the MD and RP were notified of the elopement. The resident was not on the low stem secured unit and not wearing a wander guard as resident had an elopement assessment on 10/09/19 at family request that produced 7.0 low risk. Resident had no changes in status since last 10/09/2019 (name) wandering assessment was completed. The facility elopement policy was re-educated to staff along with staff education to lock front doors. Facility maintenance staff ensured door bell was in place and functioning. maintenance further assessed the locks on the front doors and they were found to be functioning correctly." During an Interview with the Administrator on 03/05/20 at 10:30 A.M. she stated, Resident #167 eloped from the facility. He did not have a wander guard at the time. All doors to the facility were to be locked at night. The Administrator stated, all staff were re-educated on residents who wander and possibly elope. Interviews were attempted with that staff on duty the night of the occurrence however the on duty certified nursing assistant and LPN were called several times but did not answer or return the call.	F 689		
F 727	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse	F 727		

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F 727	Continued From page 90 §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and information obtained during the Sufficient and Competent Nurse Staffing task, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week potentially affecting all residents in the facility. The findings included: During the nursing staff review for July 4, 2019 through March 1, 2020 the facility staff was unable to provide nurse staffing documentation for July 4, 2019 through October 6, 2019. Nurse staffing for October 12, 2019 through March 1, 2010 revealed there were not RN presence in the facility for at least 8 consecutive hours on 10/5/19, 10/19/19, 10/20/19, 10/31/19, 11/3/19, 11/9/19, 11/10/19, 11/16/19, 11/17/19, 11/28/19, 11/29/19, 11/30/19, 12/1/19, 12/7/19, 12/8/19, 12/15/19, 12/21/19, 12/22/19, 12/23/19, 12/24/19, 12/25/19, 12/26/19, 12/28/19, 12/31/19, 1/1//20, 1/11/20, 1/18/20, 1/19/20, 1/25/20, 1/26/20, 2/1/20, 2/2/20, 2/8/20, and 2/28/20.	F 727		

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F 727	Continued From page 91 On 3/5/20 at approximately 3:50 p.m., the Staffing Coordinator was interviewed. The staffing coordinator stated she wasn't employed by the facility for all the requested dates and the staffing system was managed differently therefore; she couldn't verify the requested staffing. On 3/5/20, at approximately 3:50 p.m., the above findings were shared with the Administrator, Director of Nursing and Regional Director of Operations. The Administrator stated she understood the concern and had no additional information the offer.	F 727		
F 755 SS=E	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.	F 755		

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F 755	Continued From page 92 §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 §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 observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide an accurate record of controlled medications for 4 of 57 residents (Residents #22, #37, #168 and #418), in a survey sample. The findings included: 1. The facility staff failed to ensure an accurate account of controlled medication for Resident #22. Resident #22 was admitted to the nursing facility on 05/23/19. Diagnoses for Resident #22 included but not limited to Cognitive Decline. On 3/02/20 at approximately 11:52 a.m., an inventory of controlled medication was conducted on the medication cart on Unit 1 with Licensed Practical Nurse (LPN) #2. The Medication Monitoring/Control Record was compared to the actual medication count with the following discrepancy: Resident #22's, Ativan 1 mg count per record=23, actual count=22. On 03/02/20 at approximately 11:55 a.m., an interview was conducted with LPN #2 who stated, "I did not give Resident #22 her morning Ativan."	F 755		

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F 755	Continued From page 93 She (LPN) said "I retrieved the medication cart keys from Registered Nurse (RN)#1 this morning but we never did not do a narcotic count; that was my mistake; we should have counted." An interview was conducted with RN #1 on 03/02/20 at approximately 1:15 p.m. The RN said "I should have counted with LPN #2 but it actually slipped my mind." Review of Resident #22's February 2020 Physician Order Sheet revealed the following order: -10/23/19 - Ativan 1 mg - give 1 tablet by mouth two times a day for cognitive decline. On 03/02/20, an interview was conducted with Director of Nursing (DON) at approximately 3:03 p.m. The DON stated, "The nurse should not have taken possession of the medication cart keys until the narcotic count has been counted and was correct." 2. The facility staff failed to ensure an accurate account of controlled medications for Resident #37. Resident #37 was originally admitted to the nursing facility on 05/05/16. Diagnoses for Resident #37 included but not limited Anxiety disorder. On 3/02/20 at approximately 12:45 p.m., an inventory of controlled medication was conducted on the medication cart on Unit 3 with Licensed Practical Nurse (LPN) #4. The Medication Monitoring/Control Record was compared to the actual medication count with the following discrepancy: Resident #37's, Xanax 0.5 mg count per record=27, actual count=26.	F 755		

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F 755	Continued From page 94 On 03/02/20 at approximately 12:45 p.m., an interview was conducted with LPN #4. LPN #4 said "I gave Resident #37 her morning Xanax." She said she should have signed the narcotic count sheet right away but was still getting used to the residents here. The LPN stated, "I know the correct way to sign off narcotics but I'm still trying to get it together." Review of Resident #37's February 2020 Physician Order Sheet revealed the following order: -12/30/19 - Give Xanax 0.5 mg by mouth two times a day for agitation. On 03/02/20, an interview was conducted with Director of Nursing (DON) at approximately 3:03 p.m. The DON stated, "The nurse should not have taken possession of the medication cart keys until the narcotic count has been counted and was correct." 3. The facility staff failed to ensure an accurate account of controlled medications for Resident #168. Resident #168 was admitted to the nursing facility on 02/24/20. Diagnoses for Resident #168 included but not limited to Anxiety disorder. On 3/02/20 at approximately 1:05 p.m., an inventory of controlled medication was conducted on the medication cart on Unit 5 with Licensed Practical Nurse (LPN) #5. The Medication Monitoring/Control Record was compared to the actual medication count with the following discrepancy: Resident #168's, Clonazepam 0.5 mg count per record=11, actual count=10.	F 755		

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F 755	Continued From page 95 On 03/02/20 at approximately 1:05 p.m., an interview was conducted with LPN #5. LPN stated, "I forgot to sign off on Resident #168's 9:00 a.m., Clonazepam." She said "I should have signed off once I removed the medication from the card." Review of Resident #22's February 2020 Physician Order Sheet revealed the following order: -02/25/20 - Give Clonazepam 0.25 mg by mouth two times a day for Generalized Anxiety Disorder. An interview was conducted with Director of Nursing (DON) on 03/02/20 at approximately 3:03 p.m. The DON stated, "I expect for all nurses to sign off their controlled medication at the time the medication is administered." 4. The facility staff failed to ensure an accurate account of controlled medications for Resident #418. Resident #418 was admitted to the nursing facility on 02/17/20. Diagnoses for Resident #418 included but not limited to Pain. On 3/02/20 at approximately 11:55 p.m., an inventory of controlled medication was conducted on the medication cart on Unit 1 with Licensed Practical Nurse (LPN) #2. The Medication Monitoring/Control Record was compared to the actual medication count with the following discrepancy: Resident #418, Gabapentin 300 mg count per record=4, actual count=3. On 03/02/20 at approximately 11:55 a.m., an interview was conducted with LPN #2 who stated, "I did not give Resident #418 his morning Gabapentin, which was given by RN #1." She	F 755		

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(LPN) said "I retrieved the medication cart keys from RN #1 this morning but we never did a narcotic count; that was my mistake; we should have counted."

An interview was conducted with RN #1 on 03/02/20 at approximately 1:15 p.m. The RN stated, "I should have followed the 5 right for administering medication." He said "I should have signed off on Resident #418's 9:00 a.m., Gabapentin at the time it was administered." He said "I should have counted with LPN #2 but it actually slipped my mind."

Review of Resident #418's February 2020 Physician Order Sheet revealed the following order:
-02/17/20 - Gabapentin 300 mg - give 1 capsule by mouth two times a day for pain.

On 03/02/20, an interview was conducted with Director of Nursing (DON) at approximately 3:03 p.m. The DON stated, "The nurse should not have taken possession of the medication cart keys until the narcotic count has been counted and was correct."

A briefing was held with the Administrator and Director of Nursing on 03/03/20 at approximately 4:00 p.m. The facility did not present any further information about the findings.

The facility policy titled Controlled Substances (Revised December 2012).
-Policy statement: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Scheduled II and other controlled substances.

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F 755	Continued From page 97 Definitions: 1) Ativan is used to relieve anxiety (www.nlm.nih.gov/medlineplus/drug). 2) Xanax is used to treat anxiety disorders. 3) Clonazepam is used alone or in combination with other medications to control certain types of seizures. It is also used to relieve panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks) (https://medlineplus.gov). 4) Gabapentin is used to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles) (https://medlineplus.gov).	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756		

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drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review and facility documentation review the facility staff failed to ensure monthly medication reviews were readily available for review for 3 residents (Residents #21, #61, #71) and to ensure the physician reviewed pharmacy recommendations for 1 resident (Resident #112) of 57 residents in the survey sample.

The findings included:

On 03/05/2020 the following policy was reviewed regarding medication reviews:

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F 756	Continued From page 99 "ORGANIZATIONAL ASPECTS IA2: CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS "POLICIES AND PROCEDURES-Pharmacy Services for Nursing Facilities" 2006 American Society of Consultant Pharmacists and MED-PAS, INC (Revised January 2018) (Pharmacy Name) RX August 2019 Policy-Regular and Reliable consultant pharmacist services are provided to residents. A written agreement with a consultant pharmacist stipulates financial arrangements, at fair market price, and the terms of the services provided." Review of the procedures revealed and is documented in part, as follows: "F. Specific activities that the consultant pharmacist performs includes, but is not limited to: 1) Reviewing the medication regimen (medication regimen review) of each resident at least monthly, or more frequently under certain conditions (e.g., upon admission or with a significant change in condition), incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review (See IIIA1:MEDICATION REGIMEN REVIEW), and documenting the review and findings in the resident's medical record or in a readily retrievable format if utilizing electronic documentation. 2) Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues [at least monthly]." 1. Resident #21 was originally admitted to the facility on 09/08/2011. Diagnoses included but	F 756		

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F 756	Continued From page 100 were not limited to, Multiple Sclerosis and Depression. Resident #21's Minimum Date Set (MDS-an assessment protocol) with an Assessment Reference Date of 12/05/2019 coded Resident #21 with a BIMS (Brief Interview for Mental Status) score of 11 indicating moderate cognitive impairment. On 03/04/2020 at approximately 10:00 a.m., requested copies of Medication Regiment Reviews of Resident #21 for the past 12 months from the Administrator and Corporate Nurse Consultant. The Administrator stated, "We acquired the facility in July 2019. We can provide Medication Regimen Reviews completed after August 2019." The Administrator also stated that they were part owners of the pharmacy, (Name). On 03/04/2020, the facility provided copies of Medication Regimen Reviews for the period of July 2019 through February 2020. On 03/05/2020 at approximately 9:00 a.m., requested copies of Medication Regimen Reviews for April, May and June 2019. The facility was unable to provide Medication Regimen Reviews for April and June 2019. On 03/05/2020 at 2:30 p.m., during a briefing, the Director of Nursing was made aware of the finding. No further information was presented about the finding. 2. Resident #61 was originally admitted to the facility on 06/30/2018. Diagnoses included but were not limited to, Nontraumatic Subarachnoid Hemorrhage, unspecified and Vascular Dementia Without Behavioral Disturbance. Resident #61's Minimum Data Set (MDS-an assessment	F 756		

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F 756	Continued From page 101 protocol) with an Assessment Reference Date of 01/04/2020 coded Resident #61 with a BIMS (Brief Interview for Mental Status) score of 01 indicating severe cognitive impairment. On 03/04/2020 at approximately 10:00 a.m., requested copies of Medication Regiment Reviews of Resident #61 for the past 12 months from the Administrator and Corporate Nurse Consultant. The Administrator stated, "We acquired the facility in July 2019. We can provide Medication Regimen Reviews completed after August 2019." The Administrator also stated that they were part owners of the pharmacy, (Name). On 03/04/2020, the facility provided copies of Medication Regimen Reviews for the period of July 2019 through February 2020. On 03/05/2020 at approximately 4:00 p.m., the facility reported they were unable to provide evidence of Medication Regimen Reviews for April, May and June 2019. On 03/05/2020 at 2:30 p.m., during briefing the Director of Nursing was made aware of finding. No further information was presented about the finding. 3. Resident #71 was originally admitted to the facility on 01/23/2018. Diagnoses included but were not limited to, Cerebral Infarction and Unspecified Dementia. Resident #71's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 01/09/2020 coded Resident #71 with short-term memory problems and long-term memory problems with severely impaired cognitive skills for daily	F 756		

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F 756	Continued From page 102 decision making. On 03/04/2020 at approximately 10:00 a.m., requested copies of Medication Regiment Reviews for Resident #71 for the past 12 months from the Administrator and Corporate Nurse Consultant. The Administrator stated, "We acquired the facility in July 2019. We can provide Medication Regimen Reviews completed after August 2019." The Administrator also stated that they were part owners of the pharmacy, (Name). On 03/04/2020, the facility provided copies of Medication Regimen Reviews for the period of July 2019 through February 2020. On 03/05/2020 at approximately 9:00 a.m., requested copies of Medication Regimen Reviews for April, May and June 2019. Medication Regimen review for April 2019 was received however they were unable to provide evidence of Medication Regimen Reviews for May and June 2019. On 03/05/2020 at 2:30 p.m., during briefing the Director of Nursing was made aware of finding. No further information was presented about the finding. 4. Resident #112, the facility staff failed to ensure that the physician reviewed pharmacy recommendation. Resident #112 was originally admitted to the facility on 03/31/2017. Diagnosis included but were not limited to, Unspecified Dementia Without Behavioral Disturbance and Depression. Resident #112's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 02/13/2020 coded Resident #112 with a BIMS (Brief Interview	F 756		

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F 756	Continued From page 103 for Mental Status) score of 12 indicating moderate cognitive impairment. On 03/04/2020 at approximately 10:00 a.m., requested copies of Medication Regiment Reviews of Resident #112 for the past 12 months from the Administrator and Corporate Nurse Consultant. The Administrator stated, "We acquired the facility in July 2019. We can provide Medication Regimen Reviews completed after August 2019." The Administrator also stated that they were part owners of the pharmacy, (Name). On 03/04/2020 at approximately 12:00 p.m., Resident #112's Consultant Pharmacist Medication Regimen Review was reviewed and revealed and is documented in part, as follows: "Recommendations: Please consider a dose reduction to Zolpidem 5 mg (Milligram) at bedtime, while concurrently monitoring for reemergence of depressive and/or withdrawal symptoms." Date: 02/12/2020. On 03/04/2020 at approximately 12:15 p.m., review of Resident #112's Medication Administration Record for the period of 02/01/2020 through 02/29/2020 revealed the following order: "Ambien Tablet 10 MG (Zolpidem Tartrate) Give 1 tablet by mouth at bedtime for Insomnia. Start Date: 09/24/2019" On 03/04/2020 at approximately 12:20 p.m., review of Resident #112's Medication Administration Record for the period of 03/01/2020 through 03/31/2020 revealed the following order: "Ambien Tablet 10MG (Zolpidem Tartrate) Give 1 tablet by mouth at bedtime for insomnia. Start Date: 09/24/2019."	F 756		

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F 756	Continued From page 104 An interview was conducted with Corporate Staff #3 on 03/05/2020 at 12:30 p.m.. Reviewed Consultant Pharmacist Medication Regiment Review with recommendations with Corporate #3. There was no evidence that the physician responded to the pharmacist recommendation. Reviewed Medication Administration records for months of February 2020 and March 2020 with Corporate #3. Corporate #3 stated, "The process should be that the recommendation is posted to Polaris and then it goes to the DON (Director of Nursing) then the DON delegates to nursing or the Unit Manager then it is sent to the attending physician. The physician should document on the form, it should be documented and addressed on the pharmacist recommendation." Corporate #3 stated that he would check on it. On 03/05/2020 facility policy and procedure on Medication Regimen Reviews was received and included: "ORGANIZATIONAL ASPECTS IA2: CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS "POLICIES AND PROCEDURES-Pharmacy Services for Nursing Facilities" 2006 American Society of Consultant Pharmacists and MED-PAS, INC (Revised January 2018)...Specific activities that the consultant pharmacist performs includes, but is not limited to: 1) Reviewing the medication regimen (medication regimen review) of each resident at least monthly, or more frequently under certain conditions (e.g., upon admission or with a significant change in condition), incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review..., and documenting the review and findings in the resident's medical	F 756		

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F 756	Continued From page 105 record or in a readily retrievable format if utilizing electronic documentation. 2) Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues [at least monthly]." "G. The consultant pharmacist documents activities performed and services provided on behalf of the residents and the facility. 1) A written or electronic report of the findings and recommendations resulting from the activities as described above is given to the, attending physician, director of nursing, medical director and others as may be appropriate (e.g. administrator, regional manager, etc.) [at least monthly]. The facility has a process to ensure that the findings are acted upon. On 03/05/2020 at 2:30 p.m., during a briefing the Director of Nursing was made aware of finding. The Director of Nursing stated, " It should have been addressed within 7 days. As soon as we get the recommendation we should go ahead and get them out to the doctor." No further information was presented about the finding.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		

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F 757	Continued From page 106 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on family interview, medical record review, staff interviews and facility document review the facility staff failed to ensure 1 of 57 Residents in the survey sample, Resident #77, was free from unnecessary medications. The findings included: Resident #77 was admitted to the facility on 2/8/18 with diagnoses to include but not limited to Dementia, History of Falling and Schizoaffective Disorder. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 1/14/20. The Brief Interview for Mental Status (BIMS) was a 9 out of a possible 15 indicating the resident has moderate cognitive impairment. Under Section O Special Treatments, Procedures and Programs 00250 Influenza Vaccine A. Did the resident receive the influenza vaccine in the facility Resident #77 was coded as 1-Yes.	F 757		

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F 757	Continued From page 107 On 3/3/20 at 12:20 P.M. a phone interview was conducted with Resident #77's daughter who was also the Resident's Responsible Party (RP) and Power of Attorney (POA). During the interview the POA stated, "They gave her the flu shot after I told them I refused for her to have it." Resident #77's Informed Consent for Influenza Vaccine was reviewed and is documented in part, as follows: Under Informed Consent the following box was checked and Resident #77's POA's name was written in: I hereby DO NOT GIVE the facility permission to administer an influenza vaccination. Document was signed by LPN (Licensed Practical Nurse) #6. Resident #77's Electronic Medical Record was reviewed under the Immunization tab which indicated the following information: Update Immunization: Immunization: Influenza Given: Refused Reason Refused: POA Refused Consent Confirmed By: (Name) RN (Registered Nurse) #2 Consent Confirmed Date: 11/25/19 Resident #77's Physician Orders were reviewed and are documented in part, as follows: Order Date: 12/09/2019 Order Status: Completed Order Summary: Afluria Quadrivalent Suspension Prefilled Syringe 0.5 ML (milliliters) (Influenza Vac Split Quad) Inject 0.5 ml intramuscularly one time only for Routine	F 757		

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F 757	Continued From page 108 Immunization for 1 Day. Resident #77's Medication Administration Record dated 12/1/2019-12/31/2019 was reviewed and is documented in part, as follows: Date 12//9/2019 Afluria Quadrivalent Suspension Prefilled Syringe 0.5 ML (milliliters) (Influenza Vac Split Quad) Inject 0.5 ml intramuscularly one time only for Routine Immunization for 1 Day. -Start Date- 12/09/2019 Temp: 98.7 One Time: Nurse's Initials Time: 21:19 P.M. On 3/5/20 at 2:00 P.M. an interview was conducted with Registered Nurse (RN) #2 who is also the Staff Development Coordinator regarding Resident #77's Informed Consent for the Influenza Vaccine. RN #2 stated, "I called the daughter on the phone and explained what the shot was for and the precautions and she said "No, I don't want her to have the flu shot because she got it last year and no one asked me if she could have it". I said ok. Once I had the refusal I went into the computer and marked her as refusing under the immunization tab. The nurse that gives the shot should check for allergies and the consent in the computer before giving the medication. The nurse that gave her the flu shot doesn't work here anymore." On 3/5/20 at 2:40 P.M. an interview was conducted with Licensed Practical Nurse (LPN) #6 regarding Resident #77's Influenza Vaccine. LPN #6 stated, "Before I wrote the order I went into the immunizations tab but I didn't open it all the way so I didn't see the consent was refused. I	F 757		

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F 757	Continued From page 109 tried to stop the order but the nurse already gave it." On 3/5/20 at 2:35 P.M. an interview was conducted with the Director of Nursing regarding what were her expectations of the staff with influenza vaccines. The Director of Nursing stated, "I expect for them to follow the consent that is received." The Director of Nursing was also asked if it would be considered an unnecessary medication. The Director of Nursing stated, "Absolutely, because it was by the daughter, we should not have given it." The facility policy titled "Influenza Vaccine" revised August 2016 was reviewed and is documented in part, as follows: 6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record. A facility "Unnecessary Medication" policy was not received from the facility prior to exit. On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		

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F 758	Continued From page 110 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F 758		

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F 758	Continued From page 111 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review the facility staff failed to indicate the duration for an as needed psychotropic medication for 1 resident (Resident #100) and failed to perform a gradual dose reduction for 1 resident (Resident #20) of 57 residents in the survey sample. The findings included: Resident #100 was admitted to the facility on 03/12/2015. Diagnosis for Resident #100 included but are not limited to, Major Depressive Disorder and Anxiety Disorder Due to Known Physiological Condition. Resident #100's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/04/2020 coded Resident #100 with short - term memory problems, long - term memory problems, and with severely impaired cognitive skills for daily decision making. On 03/04/2020 at approximately 10:00 a.m., review of Consultant Pharmacist recommendation revealed the following: "The resident is on a PRN psychotropic drug: ALPRAZOLAM Tablet 0.5 MG (Milligram) Give 1 tablet by mouth every 8 hours as needed for Anxiety PRN (As Needed) TID (Three Times A Day). Per federal regulations, PRN orders for psychotropic drugs are limited to 14 days. For extension of PRN orders for psychotropic medications beyond 14 days or renewal of PRN	F 758		

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therapy, the attending physician or prescribing practitioner must evaluate to determine appropriateness of therapy. Recommendations: Please consider either (1) discontinuing the PRN order, or (2) provide rational for extended time period and indicate a specific duration." Printed: 01/14/20. Review of recommendation did not evidence Physician response.

On 03/04/2020 at approximately 11:00 a.m., review of Medication Administration Record for the period of 02/01/2020 - 02/29/2020 revealed the following: "Alprazolam Tablet 0.5 MG Give 1 tablet by mouth every 8 hours as needed for Anxiety PRN TID Start Date: 11/29/2019 D/C (Discontinue) Date: 02/07/2020."

On 03/04/2020 at approximately 11:10 a.m., review of Medication Administration Record For the period of 03/01/2020 - 03/31/2020 revealed the following: "Xanax Tablet 0.5 MG (Alprazolam) Give 1 tablet by mouth as needed for anxiety 3 times a day Q (every) 8 H (hours) Start Date: 02/11/2020"

On 03/04/2020 at approximately 11:20 a.m., review of Nurse Practitioner's Referrals/Response Letter dated 02/24/2020 revealed and is documented in part, as follows: "Resident is currently receiving PAROXETINE TAB 40MG PO (By Mouth) daily & RISPERIDONE TAB 0.5MG PO TID. The resident has an HX (History) of Panic & anxiety disorder Resident PRN medication was d/c'd. His Xanax was reordered and the patient improved."

On 03/05/2020 at 2:30 p.m., during briefing the Director of Nursing was made aware of finding. The Director of Nursing stated, "I expect the

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nurses to call the doctor and ask him what he wants, ask him do you want to discontinue the order or schedule it?" Director of Nursing stated, "PRN order should be scheduled for 14 days." No further information was presented about the finding.

The facility policy titled - Antipsychotic Medication Use
Policy Statement: Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed.
Policy included the following: 14. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order.
2. The facility staff failed to attempt a gradual dose reduction (GDR) for a psychotropic medication for Resident #20.

Resident #20 was admitted to the facility on 02/15/19. Diagnoses for this individual included hyperlipidemia, dementia, depression, and insomnia. A Quarterly Minimum Data Set (MDS) dated 12/03/19 assessed this resident in the area of Cognitive Patterns for Brief Interview for Mental Status (BIMS) was a 15 indicating no cognitive impairment.

A Consultant Pharmacist's Medication Regimen Review signed and dated 02/12/20 indicated: "Recommendations:

Routing MD - Note written to physician

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F 758	Continued From page 114 Resident is currently on Citalopram 10 Milligrams (mg) daily. Please consider a dose reduction to Citalopram 5 (mg) daily, while concurrently monitoring for reemergence of depressive and/or withdrawal symptoms." A review of a physician's order dated 02/15/20 included: Citalopram Tab 10 mg give 1 tablet orally one time a day related to other specified depressive episodes. A review of the Medication Administration Record (MAR) for the month of March 2020 included: Citalopram tab 10 mg give one tablet orally one time a day related to other specified depressive episodes. A Consultant Pharmacist's Medication Regimen Review signed and dated 1/14/20 indicated: " Resident is currently on Trazodone 50 mg daily. Recommendations: Please consider a dose reduction to Trazodone 25 mg daily, while concurrently monitoring for reemergence of depressive and/or withdrawal symptoms." A Physician order dated 02/15/20 indicated: Trazodone tab 50 mg give 1 tablet orally at bedtime related to Insomnia, unspecified. A review of the MAR for the month of March 2020 included: Trazodone 50 mg give one tablet orally at bedtime related to Insomnia. A revised care plan dated 01/10/20 indicated: Focus-Resident #20 uses antidepressant medications r/t Depression, and Insomnia. Goal-The resident will be free from discomfort or adverse reactions related to antidepressant	F 758		

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F 758	Continued From page 115 therapy. Interventions-Administer Antidepressant medications as ordered by physician. Observe/document side effects and effectiveness Q (every) shift. Educate the resident about risks, benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given. Observe/document/report PRN adverse reactions to Antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea, gait change, rigid muscles, balance probes, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia, appetite loss, wt loss, n/v dry mouth, and dry eyes. During an interview on 03/04/20 at 2:30 P.M. with the Cooperate Director of Nursing she stated, the physician was given notice of the pharmacist recommendation, but there is no indication that the GDR had been attempted.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		

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F 761	Continued From page 116 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on general observations of the nursing facility and staff interview, the facility failed to ensure medications were labeled in accordance with currently accepted professional principles and stored according to manufacture guidelines in 3 out of 5 medication carts The findings included: 1. The facility staff failed to ensure one Lantus (insulin) vial was dated once open for Resident #109. Resident #109 was originally admitted to the nursing facility on 04/20/15. Diagnosis for Resident #109 included but not limited to Type 2 Diabetes. On 3/02/20 at approximately 11:37 a.m., the medication cart on Unit 4 was inspected with Licensed Practical Nurse (LPN) #1. During the inspection of the insulins stored inside the medication cart, one Lantus vial was open with no open date. An interview was conducted with LPN #1 who stated, "The Lantus insulin vial belongs to	F 761		

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F 761	Continued From page 117 Resident #109 but does not have an open date; the insulin should have been dated once open." The Lantus insulin was removed from the medication cart by the nurse. Review of Resident #109's February 2020 Physician Order Sheet revealed the following order: -08/28/19 - Lantus - inject 35 units subcutaneously at bedtime for diabetes. An interview was conducted with Director of Nursing (DON) on 03/02/20 at approximately 3:03 p.m. The DON stated, "All insulins must be labeled and dated once opened." 2. The facility staff failed to ensure medication label (Ativan) was legible for Resident #75. Resident #75 was originally admitted to the nursing facility on 02/04/11. Diagnoses for Resident #75 included but not limited to Anxiety. On 3/02/20 at approximately 11:37 a.m., the medication cart on Unit 4 was inspected with Licensed Practical Nurse (LPN) #1. During the inspection of the controlled medications stored inside the medication cart, a bottle of liquid Ativan was observed but the resident's name was not legible (most of the name was missing). An interview was conducted with LPN #1 who stated, "The medication belongs to (Resident #75)." The LPN was asked, "How do you know who the Ativan belong to if most of the name on the bottle is missing" she replied, "I just know who the medication belong." The LPN stated, "By looking at the Ativan bottle, I am unable to identify who this medication belong too; I am unable to ready the label."	F 761		

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F 761	Continued From page 118 An interview was conducted with Director of Nursing (DON) on 03/02/20 at approximately 3:03 p.m. The DON stated, "If a label is not legible; the medication is not to be administered but a new label must be ordered from pharmacy first." The DON said "Once the new label arrives, the nurse can administer the medication." A briefing was held with the Administrator and Director of Nursing on 03/03/20 at approximately 4:00 p.m. The facility did not present any further information about the findings. The facility policy titled Labeling of Medication Containers (Revised 2007). Policy statement: All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. -Policy Interpretation and Implementation include but not limited to: Medication labels must be legible at all times. 3. The facility staff failed to ensure multi dose vials of liquid Ativan was stored according to manufacture guidelines on 3 of 5 medication carts. During the inspection of the controlled medications stored inside the medication cart, liquid Ativan bottles were observed. The label contain the following information: Store at cold temperature - refrigerate between 36-46 degrees. The following Residents multi dose vials of liquid Ativan (2 mg per ml) was observed on the medication carts: -Resident #75's (Unit 4). -Resident #83's (Unit 1). -Resident #43's (Unit 2).	F 761		

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F 761	Continued From page 119 On 03/20/20 at approximately 11:37 a.m., an inventory of controlled medication was conducted on the medication cart located on Unit 4, assigned to Licensed Practical Nurse (LPN) #1. The LPN stated, "The liquid Ativan for Resident #75 should be stored in the medication refrigerator and not on the medication cart." On 03/20/20 at approximately 11:52 a.m., an inventory of controlled medication was conducted on the medication cart located on Unit 1, assigned to LPN #2. The LPN stated, "The liquid Ativan should be stored in the refrigerator." The LPN was asked, "What is the purpose for storing liquid Ativan in the refrigerator" she replied, "So the medication will not lose it potency." On 03/20/20 at approximately 12:30 p.m., an inventory of controlled medication was conducted on the medication cart located on Unit 2, assigned to LPN #3. The LPN stated, "The liquid Ativan for Resident #43 should be stored in the refrigerator after reviewing the label on the liquid Ativan." An interview was conducted with Director of Nursing (DON) on 03/02/20 at approximately 3:03 p.m. The DON stated, "Liquid (name of medication) should be stored in the refrigerator according to manufactures guidelines." -Manufacture Guidelines: How should I store Ativan. Store Ativan at a cold temperature. Refrigerate at 36 degrees to 46 degrees and protect from light. Definition: -Lantus is used to treat type 1 diabetes (condition	F 761		

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F 761	Continued From page 120 in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood). It is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes) (https://medlineplus.gov/ency/article/007365.htm). -Ativan is used to relieve anxiety (www.nlm.nih.gov/medlineplus/drug).	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and review of facility documentation, the facility staff failed to prepare food by methods that conserves nutritive value and provide and present food that is palatable and attractive for 1 of 57 residents (Resident #89) in the survey sample. The findings include: Resident #89 was admitted to the nursing facility on 7/12/18 with diagnoses that included non-Alzheimer's disease dementia and	F 804		

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F 804	Continued From page 121 generalized muscle weakness. The resident was readmitted on 1/19/20 with diagnoses that included *dysphagia (difficulty swallowing), *meniere's disease and urinary tract infection (UTI). The most recent Minimum Data Set (MDS) assessment dated 1/23/20 was a significant change is status and coded the resident with moderate difficulty in hearing, usually has the ability to express ideas and wants and usually comprehends most conversation. Resident #89 was coded on this assessment as having short and long term memory and never/rarely made decisions. She was not coded to have mood or behavioral problems to have rejected care to include medications, treatments and or assistance with daily activities. The resident was coded to require limited assistance with one person for eating which indicated assistance to lift, hold or support trunk or arms less than half of the time. Resident #89 was coded to need assistance with personal care. This assessment indicated the resident had no significant weight loss or gain. Significant weight loss is a loss of 5% or more in the last month or a loss of 10% in the last 6 months. Significant weight gain is a gain of 5% or more in the last month or 10% or more in the last 6 months. The height of the resident was coded as 49 inches (4 feet and 1 inch) and weight 120 lb (pounds). The resident was coded to be on a mechanically altered therapeutic diet. The Care Area Assessment (CAA) dated 2/5/20 identified nutritional status as a care area that was triggered with a decision to care plan the area.	F 804		

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F 804	Continued From page 122 The care plan dated 2/14/20 identified ADL (Activities of Daily Living) deficits and was at risk for dehydration. The goal the staff set for the resident was that she would be free of symptoms of dehydration and would receive the assistance she needed for ADL. One of the approaches to accomplish this goal included staff assistance to support the resident to eat and drink. The care plan dated 12/3/19 identified Resident #89 at risk for a nutritional problem and was on a low sodium, mechanical soft thin liquid diet. The goal the staff set for the resident was that she would tolerate the physician prescribed diet and have no significant weight loss through review date of 1/8/20. The aforementioned care plan was not revised to reflect the physician prescribed diet order change dated 2/14/20 of NAS (no added salt) diet pureed texture, regular/thin consistency liquids. The rehabilitation screen dated 1/14/20 indicated the resident had a score of 9 out of a possible score of 15 which indicated Resident #96 was moderately impaired in the necessary cognitive skills for daily decision making. The screen noted that the nursing staff stated the resident suffered a decline in function following the death of her husband and was totally dependent for all ADLs. The resident had not been identified with weight loss at the time of this screen. The following observations were conducted of Resident #89 during meals: On 3/2/20 at 12:15 p.m., during tour of Unit 1, Resident #89 was observed in her room in a recliner. The lunch tray was sitting on the over bed table in front of the resident. Three pureed	F 804		

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F 804	Continued From page 123 items (based on color) were noted on one plate. All three pureed items merged into each other that created one large multi-colored item. Individual sides included pureed bread and pureed cake. Un-opened ice cream, house shake and ice tea was also observed on the resident's tray. There was no soup on the resident's tray. When asked by this surveyor if she was hungry, she took her left hand and slightly lifted the side of the plate and said, "I can't eat this slop." On 3/2/20 at 1:00 p.m. the lunch tray was removed. No portions or liquids had been consumed. The Certified Nursing Assistant (CNA) #5 said the resident required set up only and no help to eat and that she apparently was not hungry. CNA #5 recorded in the ADL record for the lunch meal on 3/2/20-0,0 (independent with no help or staff oversight at any time and no setup or physical help from staff). The CNA recorded the resident consumed 0 % of her meal. On 3/2/20 at 5:15 p.m., the evening meal plate had three items on the one plate in the same configuration as the lunch meal. Side items included house shake, applesauce, the broth of the soup of the day, ice cream and ice tea. The resident was not assisted to eat any portions of the dinner meal. CNA #6 stated that the resident could independently eat her meal. The tray was picked up at approximately 6:00 p.m. CNA #6 recorded the resident's meal as 0,0. On 3/3/20 at approximately 12:20 p.m., the Resident Representative (RR) stated, "The nurses leave the tray with no assistance. No alternatives offered because she does not like the meals, but will eat soup if they puree it. I was told by the current nutritionist in the kitchen that they do not puree soups. My Mom is losing too much weight now." The resident's tray had two main	F 804		

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F 804	Continued From page 124 items on one plate merged into one with pureed bread, chocolate pudding, house shake and ice tea. The resident looked up at this surveyor, flicked the side of her plate and said, "It looks like this everyday. They sit it in front of me day after day and walk off." The RR confirmed what the resident said. The RR stated when she asked how much weight the resident lost, they told her she was not losing weight, but she could tell based on how she looked in her clothes. The RR asked the resident if she would like thickened soup, to which the resident stated, "I think I would accept that." On 3/3/20 at 1:00 p.m., one of the cooks of the kitchen was asked if soup could be pureed to which he responded that the Dietary Manager told him, "No soups could be pureed." On 3/3/20, at approximately 1:22 p.m., the RR was at the bedside feeding the resident soup she brought in that was in a pureed consistency. The resident was observed to consume 75% of the soup and 100 % of ice tea. She stated the resident loved soup and would eat it if it was offered to her. She continued to say that she had a meeting with the "nutritionist" from the kitchen which was identified as the Dietary Manager and was told that he was unable to puree soup, but could strain the broth off the "soup of the day" and she felt that she had to accept his conditions. The RR stated, while crying, "Her husband was also a resident here and they used to eat their meals together. He died two months ago. I am exhausted trying to keep my Mom going and I can only come every other day mostly. Things are different now she needs their help and without it she will keep losing more weight." She stated she was happy with everything and she did not expect	F 804		

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F 804	Continued From page 125	F 804		

miracles, but just help with her meals. The RR said she was told to consider Hospice, which she did, but stated she did not want the staff to "write off" Resident #89. Hospice services was implemented on 2/26/20 under diagnosis of senile degeneration. The resident has received ongoing psychological counseling to address stabilization/reduction of affective and/or cognitive symptoms from 6/26/19 to as recent as 2/13/20. The psychological counseling dated 12/17/19 to 2/13/20 continued to address the resident's grief from the loss of her husband.

There was no physician's order for "strained broth". The current physician's order dated was 2/14/20 of NAS (no added salt) diet pureed texture, regular/thin consistency liquids.

On 3/3/20 at approximately 3:15 p.m., the Dietary Manager was asked what items could not be pureed to which he responded, "Everything can be pureed, but lettuce."

An interview was conducted with the Physician's Assistant (PA) on 3/4/20 at 11:45 a.m. She stated there was a speech consult based on the resident having swallowing difficulties after her last hospitalization on January 2020. She stated she was out of the building in January and returned in the first week of February and did not know the resident was losing weight. The PA stated she expected if the resident was no longer eating, the staff would set up her tray accordingly and assist her to eat, offer alternatives and consult the RD. She stated she was with the attending physician's office and was playing catch up with seeing all of the facility residents, but possibly the attending was providing oversight for the resident's care when she was out.

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F 804	Continued From page 126 On 3/4/20 at 12:40 p.m., CNA #1 was observed feeding the resident "strained broth." The CNA stated that the resident loved soup, but she had to go to the kitchen and get it for the current meal and consistently have to send for it, stating that it was supposed to be on every tray because they knew she would eat it. She said she was not aware of any conversations that may have taken place about "strained broth verses pureed soup," she just knew it was supposed to be on the tray every day for lunch and dinner. The CNA stated, "As soon as she sees the pureed plate of food, she shakes her head. She won't touch it. The residents tell me they hate it." CNA #1 stated that she will sit and try and feed her all of the broth and hopefully she would eat the ice cream and mighty shake. The CNA stated for breakfast the resident had oatmeal and yogurt, but ate very little of it so she recorded 4,2 (total dependence-full staff assistance) with 0-25% meal consumption. CNA #1 stated she offered Resident #89 in between snacks to include yogurt, pudding and ice cream, but there was no where in their charting system to record intake of the between meal snacks. On 3/5/20 at 10:15 a.m., and interview was conducted with the Rehabilitation Director (Rehab Director). The Rehab Director stated Resident #96 was screened 9/23/19 due to a cognitive decline and received speech therapy from 9/23/19 through 10/30/19 to facilitate safety and efficiency with visual aids to increase comprehension with receptive and expressive language training. There was a note that the resident was scheduled for an audiology appointment for hearing aids to decrease need for visual aids. The speech recommended and	F 804		

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F 804	Continued From page 127 physician ordered diet dated 10/28/19 was for NAS (no added salt) diet mechanical soft texture, thin liquids consistency. The resident was screened again on 2/18/20 due to decrease in intake and significant weight loss (12/19/19=122.0; 1/20/20=120; 2/1/20=104). Her diet had been downgraded to a pureed texture during the January 2020 hospitalization. Resident #89 was assessed with a moderate to severe oropharyngeal dysphagia requiring modified diet of pureed texture and thin liquid with close supervision and severe weight loss risk due to poor intake with meals. During the above interview with the Rehab Director she called the Speech Therapist that serviced the resident to ask her if soup could be pureed. The Speech Therapist returned her call and stated "Yes". This speech therapist wrote in one of her daily skilled service notes dated 2/21/20 that the resident requested soup and the speech therapist provided prepared pureed texture soup which was tolerated well with minimal throat clearing. The note further indicated, "Speech Therapy instructed nurse manager regarding patient's risk of further weight loss and dehydration, and minimum to no intake with meals." The Rehab Director stated she did not understand why the resident was receiving broth/strained soup instead of pureed soup which was recommended in light of the resident's preference, her toleration of the textured soup and that there would be more nutritional value to assist resident and minimize weight loss. On 3/5/20 at 11:30 a.m., Resident #89's Speech Therapist joined the above interview and said that the resident was receiving the minimal of everything with strained soup/broth. The Dietary	F 804		

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F 804	Continued From page 128 Manager joined the interview and stated although he did not have any notes or dates to refer to, he had a meeting with the family in February 2020 and told them that he would provide the resident with the broth of the soup of the day (cream of potato, cream of broccoli, noodle rice, Italian wedding, gumbo and tomato soup) and that the resident's family accepted his explanation. He stated, "What do you expect me to do, pureed 4 ounces of soup. I would need to puree at least 20 ounces. If not done in bulk, it is difficult to puree. I don't have the equipment to puree small amounts and it would be a problem to reheat as well." The Registered Dietitian's (RD) progress notes dated 2/17/20 indicated a weight warning and that he recommended fortified foods at every meal related to poor intake and significant weight loss. The RD was on vacation and not available for interview. On 3/5/20 at 12:50 p.m., further interview was conducted with the Dietary Manager. He stated fortified foods included cereal, cream of wheat, oatmeal, house shake, frozen nutritional treats, mighty cups, yogurts and Jello pudding. He said although he did not have a date or had any notes of his discussion with the RD, he told her he was providing house shake, pudding, ice cream that would be equal to fortified foods. He stated he could not recall if he spoke to the RD about providing the resident broth of the soup of the day instead of the physician ordered pureed diet that could include pureed soup. On 3/5/20 at 1:50 p.m. Licensed Practical Nurse (LPN) on Unit 1 said that all of the residents that are served the pureed meals told her it looked "nasty" and had difficulty eating it based on looks	F 804		

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F 804	Continued From page 129	F 804		

and taste. She stated she sent the diet communication to the kitchen on 2/24/20 about adding a cup of broth with meals not based on a physician's order, but what the Dietary Manager said he was going to be sending the resident.

On 3/5/20 at 2:30 p.m., the Director of Nursing (DON) stated although she was new in her position, she felt a different presentation of the meal could be more appealing to the residents on a pureed diet, either in individual small serving bowls or molds to represent the item served. She presented a list of 25 residents on pureed diet and stated that there would be no reason not the puree the soup of the day because there would be plenty of residents that could be offered pureed soups that could be prepared in bulk that would exceed 20 ounces. She stated she expected the resident to be provided as many fortified foods as possible at meal times and in between meals to foster an increase in calories. She said the resident required set up of all meals and that she expected the nursing staff to take the time to assist the resident to eat. Additionally, she said she did not know Resident #96 was receiving only broth and that she felt it was not offering enough calories to sustain the resident.

On 3/5/20 at approximately 4:30 p.m., a debriefing session was conducted with the Administrator, Director of Nursing and the Regional Director of Operations. The aforementioned issue was reviewed and discussed. No further information was provided prior to survey exit.

The Dietary Manager's signed job description dated 12/9/19 indicated one of his many administrative functions was to process diet

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F 804	Continued From page 130 changes and new diets as received from nursing services, assist in developing methods for determining quality and quantity of food served, visit residents periodically to evaluate the quality of meals served, likes and dislikes, involve the resident, as well as the family in planning objectives and goals for the resident, follow directives from the Registered Dietician, review therapeutic and regular diet plans and menus to assure they are in compliance with the physician's orders and provide substitute foods similar in nutritive value to the residents who refuse foods served. The facility policy and procedure titled Nutrition (impaired)/Unplanned Weight loss-Clinical protocol dated 9/2012 indicated the physician will authorize and the staff will implement appropriate general or cause-specific interventions to include resident choice, nutritional needs (dietician and physician to determine appropriate diet, supplemental needs), hydration needs and functional factors (providing feeding assistance as needed). The facility's policy and procedures titled Resident Nutrition Services dated 7/2017 indicated that each resident is provided with a nourishing, palatable and attractive well-balanced diet that meets his or her nutritional and special dietary needs, taking into consideration the preferences of each resident. Residents shall receive prompt meal service and appropriate feeding assistance. The facility policy and procedure titled Assistance with Meals dated 7/2017 indicated residents shall receive assistance with meals in a manner that meets the individual needs of each resident.	F 804		

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F 804	Continued From page 131 *People with dysphagia have difficulty swallowing and may even experience pain while swallowing (odynophagia). Some people may be completely unable to swallow or may have trouble safely swallowing liquids, foods, or saliva(https://www.nidcd.nih.gov/health/dysphagia #1). *Meniere's disease is a disorder of the inner ear that can lead to dizzy spells (vertigo) and hearing loss. In most cases, Meniere's disease affects only one ear (https://www.mayoclinic.org/diseases-conditions/meniere's-disease/symptoms-causes/syc-20374910).	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		

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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 812	Continued From page 132 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility document review the facility staff failed to store and prepare food in accordance with professional standards for food service safety. The findings included: On 3/2/20 at approximately 11:30 A.M. during the initial kitchen tour, the following observations were made: Dry Storage Room: 1-25 pound bag of parboiled rice not sealed, open to air with no date. 1-10 pound bag of macaroni noodles not sealed, open to air. 1 bag of bowtie pasta not sealed, open to air. Reach in Refrigerator #2: 1 gallon ziplock bag with a drink and a protein bar in it, which was immediately removed by the dietary aide that the food bag belonged to, stating it belonged to staff. 1 -2 pound package of smoked turkey breast sandwich meat not sealed, open to air. 1 open bag of boiled eggs with fluid leaking over other food contents in metal container. Main kitchen area: 1-50 pound bag of potato starch on back kitchen table not sealed, open to air, not dated and a large scoop sitting on top of the bag. 1-2 pound bag of light brown cane sugar not sealed and open to air that was sitting on a shelf below a return air vent.	F 812		

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	495150	A. BUILDING _____ B. WING _____	C 03/05/2020

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F 812	Continued From page 133 The return air vent was covered in a copious amount of dark gray sticky material. 1- 25 pound box of instant food thickener not sealed, open to air and a large scoop noted inside of the box lying on top of the food thickener. Drain flies were observed flying around the steam table, the trash can and the handwashing sink. Three drains were inspected in the dishwashing area. All three drains were noted to have copious amounts of thick black grease build up. One drain was noted to have 3 fruit flies inside of it. On 3/2/20 at 11:50 A.M. an interview was conducted with the Dietary Aide regarding fruit flies. The Dietary Aide stated, "They are mainly in the dishwasher area." The Dietary Manager was informed of all the above findings. On 3/2/20 at approximately 12:15 P.M. the Dietary Manager was asked about his expectations for the storage of food and pests in the kitchen. The Dietary Manager stated, "When something is opened it should sealed so it is not open to air or pests and dated. Also scoops are single use and should be washed after each use. The drains need to be cleaned." On 3/2/20 at approximately 12:25 P.M. the Director of Maintenance arrived in the kitchen and was shown the drains in the dishwasher area. The Director of Maintenance stated, "I see the flies." The facility policy titled "Food Receiving and Storage" revised July 2014 was reviewed and is documented in part, as follows:	F 812		

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F 812	Continued From page 134 Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: 1. Food Services, or other designated staff, will maintain clean food storage areas at all times. 4. Non-refrigerated foods, disposable dishware and napkins will be stored in a designated "dry storage" unit which is temperature and humidity controlled, free of insects and rodents and kept clean. 6. Dry foods that are stored in bins will be removed from original packaging, labeled and dated ("use by" date). Such foods will be rotated using a "first in-first out" system. 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date). On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided.	F 812		
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.	F 842		

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F 842	Continued From page 135 §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 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	F 842		

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F 842	Continued From page 136 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 staff interview, clinical record review, review of facility documentation, and in the course of a complaint investigation, the facility failed to maintain complete and accurately documented medical records for 2 out of 57 resident records reviewed, Resident #53 and Resident #77. The findings included: 1. Resident #53 was initially admitted to the facility on 12/30/2019 with diagnoses including, but not limited to, dysphagia, repeated falls, other Escherichia coli, urinary tract infection and metabolic encephalopathy. Resident #53's most recent MDS (Minimum Data Set) assessment was a Quarterly Review Assessment with an ARD (Assessment Review Date) of 12/30/2019. Resident #53's BIMS (Brief Interview for Mental Status) score was recorded	F 842		

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F 842	Continued From page 137 as unobtainable. A review of the medical record for Resident #53 revealed a note documented on 12/24/2020 at 11:00 p.m., stating, Resident #53 "remained in bed after returning from the ER." Further review of facility progress notes failed to provide dates and a description of events resulting in transfer to the Emergency Room (ER). On 3/5/2020 at approximately 12:10 p.m. the Corporate Director of Nursing responded to a documentation request with a SNF/NF to Hospital Transfer form dated 12/24/2019 detailing a "hematoma to forehead". Surveyor asked the Corporate DON, "Does this form accurately, thoroughly describe the events leading up to the hospitalization on or about 12/24/2020?, she responded, "This transfer form describes why he was transferred to the hospital. He experienced a hematoma." Surveyor asked, "Does this form describe how he received a hematoma? The Corporate DON responded, "It details that he received a hematoma and that is why he was transferred to the hospital." These findings were reviewed with the Facility Administrator, DON and Corporate Staff during a briefing held on 3/5/2020 at approximately 5:00 p.m. There was no additional information provided. 2. Resident #77 was admitted to the facility on 2/8/18 with diagnoses to include but not limited to Dementia, History of Falling and Schizoaffective Disorder. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 1/14/20. The Brief	F 842		

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F 842	Continued From page 138 Interview for Mental Status (BIMS) was a 9 out of a possible 15 indicating the resident has moderate cognitive impairment. Resident #77's Comprehensive Care Plan was reviewed and is documented in part, as follows: Focus: The resident has had episodes of Constipation related to diagnosis of Dementia and impaired mobility at times. Intervention: Record bowel movement pattern each day. Describe amount, color and consistency. During a complaint investigation Resident #77's Bowel Continence Documentation Flow Sheets for November 2019 were reviewed. Friday November 1st through the 4th for all three shifts were blank with no data entered. Resident #77's medical record and admission was reviewed and showed the resident was in the facility and receiving care from November 1-4, 2019. On 3/5/20 at 9:45 A.M. an interview was conducted with the Director of Nursing regarding the missing data for Resident #77 on the Bowel Continence Documentation Flow Sheets for Friday November 1st through the 4th for all three shifts. After reviewing the document the Director of Nursing stated, "It's an incomplete record. I expect the staff to document and not leave any holes. The facility policy titled "Charting and Documentation" revised April 2008 was reviewed and is documented in part, as follows: Policy Statement: All services provided to the resident, or any changes in the resident's medical	F 842		

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F 842	Continued From page 139 or mental condition, shall be documented in the resident's medical record. Policy Interpretation and Implementation: 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical record. On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided. Complaint deficiency.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		

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F 883	Continued From page 140 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on family interview, medical record review, staff interviews and facility document review the facility staff failed to follow the informed consent for the administration of the	F 883		

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F 883	Continued From page 141 influenza vaccine for 1 of 57 Residents in the survey sample, Resident #77. The findings included: Resident #77 was admitted to the facility on 2/8/18 with diagnoses to include but not limited to Dementia, History of Falling and Schizoaffective Disorder. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 1/14/20. The Brief Interview for Mental Status (BIMS) was a 9 out of a possible 15 indicating the resident has moderate cognitive impairment. Under Section O Special Treatments, Procedures and Programs 00250 Influenza Vaccine A. Did the resident receive the influenza vaccine in the facility Resident #77 was coded as 1-Yes. On 3/3/20 at 12:20 P.M. a phone interview was conducted with Resident #77's daughter who was also the Resident's Responsible Party (RP) and Power of Attorney (POA). During the interview the POA stated, "They gave her the flu shot after I told them I refused for her to have it." Resident #77's Informed Consent for Influenza Vaccine was reviewed and is documented in part, as follows: Under Informed Consent the following box was checked and Resident #77's POA's name was written in: I hereby DO NOT GIVE the facility permission to administer an influenza vaccination. Document was signed by LPN (Licensed Practical Nurse) #6.	F 883		

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F 883	Continued From page 142 Resident #77's Electronic Medical Record was reviewed under the Immunization tab which indicated the following information: Update Immunization: Immunization: Influenza Given: Refused Reason Refused: POA Refused Consent Confirmed By: (Name) RN (Registered Nurse) #2 Consent Confirmed Date: 11/25/19 Resident #77's Physician Orders were reviewed and are documented in part, as follows: Order Date: 12/09/2019 Order Status: Completed Order Summary: Afluria Quadrivalent Suspension Prefilled Syringe 0.5 ML (milliliters) (Influenza Vac Split Quad) Inject 0.5 ml intramuscularly one time only for Routine Immunization for 1 Day. Resident #77's Medication Administration Record dated 12/1/2019-12/31/2019 was reviewed and is documented in part, as follows: Date 12//9/2019 Afluria Quadrivalent Suspension Prefilled Syringe 0.5 ML (milliliters) (Influenza Vac Split Quad) Inject 0.5 ml intramuscularly one time only for Routine Immunization for 1 Day. -Start Date- 12/09/2019 Temp: 98.7 One Time: Nurse's Initials Time: 21:19 P.M. On 3/5/20 at 2:00 P.M. an interview was conducted with Registered Nurse (RN) #2 who is also the Staff Development Coordinator regarding	F 883		

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F 883	Continued From page 143 Resident #77's Informed Consent for the Influenza Vaccine. RN #2 stated, "I called the daughter on the phone and explained what the shot was for and the precautions and she said "No, I don't want her to have the flu shot because she got it last year and no one asked me if she could have it." I said ok. Once I had the refusal I went into the computer and marked her as refusing under the immunization tab. The nurse that gives the shot should check for allergies and the consent in the computer before giving the medication. The nurse that gave her the flu shot doesn't work here anymore." On 3/5/20 at 2:40 P.M. an interview was conducted with Licensed Practical Nurse (LPN) #6 regarding Resident #77's Influenza Vaccine. LPN #6 stated, "Before I wrote the order I went into the immunizations tab but I didn't open it all the way so I didn't see the consent was refused. I tried to stop the order but the nurse already gave it." On 3/5/20 at 2:35 P.M. an interview was conducted with the Director of Nursing regarding what were her expectations of the staff with influenza vaccines. The Director of Nursing stated, "I expect for them to follow the consent that is received." The facility policy titled "Influenza Vaccine" revised August 2016 was reviewed and is documented in part, as follows: 6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record.	F 883		

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F 883	Continued From page 144 On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided.	F 883		
F 925 SS=E	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, staff interviews and facility document review the facility staff failed to maintain an effective pest control program. The findings included: 1. On 3/2/20 at approximately 1130 A.M. during the initial kitchen tour the following observations were made: Drain flies were observed flying around the steam table, the trash can and the handwashing sink. Three drains were inspected in the dishwashing area. All three drains were noted to have copious amounts of thick black grease build up. One drain was noted to have 3 fruit flies inside of it. On 3/2/20 at 11:50 A.M. an interview was conducted with the Dietary Aide regarding fruit flies. The Dietary Aide stated, "They are mainly in the dishwasher area." The Dietary Manager was informed of all the above findings. On 3/2/20 at approximately 12:15 P.M. the Dietary Manager was asked about his	F 925		

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F 925	Continued From page 145 expectations for the storage of food and pests in the kitchen. The Dietary Manager stated, "When something is opened it should sealed so it is not open to air or pests and dated...The drains need to be cleaned." On 3/2/20 at approximately 12:25 P.M. the Director of Maintenance arrived in the kitchen and was shown the drains in the dishwasher area. The Director of Maintenance stated, "I see the flies." Throughout the survey gnats and fruit flies were also observed on Units 4 and 5. On 3/5/20 at 9:40 A.M. an interview was conducted with the Director of Maintenance regarding the pest observed in the facility. The Director of Maintenance provided documentation to show on 1/24/20 that 1 box of Terro Fruit Fly Traps had been ordered. The Director of Maintenance was asked if the traps had been effective. The Director of Maintenance stated, "It has slowed them down." The facility policy titled "Pest Control" revised May 2008 was reviewed and is documented in part, as follows: Policy Statement: Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. On 3/5/20 at 3:50 P.M. a pre-exit debriefing was held with the Administrator, the Director of	F 925		

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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 925	Continued From page 146 Nursing and the Regional Director of Operations where the above information was discussed. Prior to exit no further information was provided. 2. During an observation on 3/4/2020 at approximately 11:42 a.m., a live roach was seen swept by (Housekeeping) staff #12 on the Unit 1 hallway near room #41. On 3/5/2020 at approximately 9:35 a.m., an inspection of the Unit 1 hallway was conducted along with the Facility Maintenance Director. Surveyor pointed out areas of missing baseboards on the walls of the hallway. The Facility Maintenance Director responded, "We will fix that today. It's an issue in controlling pests. We are in the process of repairing those to help control pests getting into the facility." An interview held with Other (Housekeeping) staff #12 on 3/5/2020 at approximately 11:00 a.m. regarding sightings of roaches within the facility, Other #12 responded, "I usually see roaches around two times per week and they are usually dead." A review of Facility Pest Sighting/Evidence Logs revealed: Unit 1: Sightings of live roaches in the dining room on 10/9/2019. Sightings of roaches in Room #39 on 1/9/2020. Unit 2: Sightings of several roaches within the Social Services Office on 11/17/2019. Sightings of roaches in Room #15. Sightings in Room #20 (unspecified type).	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL VIRGINIA BEACH LLC	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(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 925	Continued From page 147 Sightings of several roaches in the Social Services Office on 1/29/2020. Unit 4: Sightings of roaches on the main floors within rooms 115-123 on 1/28/2020. Sightings of roaches on main floors by Room 114 on 2/5/2020. Unit 5: Sightings of roaches within rooms 83, 85 and the Dining Room on 12/2/2019. A review of Facility Vendor Customer Service Reports revealed, in part, the following: 1. A finding of "floor tiles or baseboards loose/missing within resident rooms and kitchen area" with a recommendation to "repair to eliminate potential pest harborage/breeding site" on 10/21/2019 and 11/21/2019. 2. A finding of "spilled food material found on the floor", floor drains in need of cleaning and trash cans in need of cleaning, with a recommendation to "clean to reduce pest attraction and source for breeding", on 1/24/2020. 3. A finding of "hole/gap noted cracks and open areas around upper window frames and around air conditioner units allow for pest entry outside/inside, with a recommendation to "seal to prevent pest entry or harborage" on 2/20/2020. The Facility policy on Pest Control (rev. 5/2008) included: Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation 1. This facility maintains an on-going pest control program to ensure that the building is kept free of	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL VIRGINIA BEACH LLC	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(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 925	Continued From page 148 insects and rodents. 3. Windows are screened at all times. 4. Only approved "FDA" and "EPA" insecticides and rodenticides are permitted in the facility and all such supplies are stored in areas away from food storage areas. 5. Garbage and trash are not permitted to accumulate and are removed from the facility daily. 6. Maintenance services assist, when appropriate and necessary, in providing pest control services. These findings were reviewed with the Facility Administrator, DON and Corporate Staff during a briefing held on 3/5/2020 at approximately 5:00 p.m. There was no additional information provided.	F 925		

Plan of Correction E 007

EP Program Patient Population

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Risk assessment of resident population to determine those at risk during an emergency updated in the EP binder.
   Documented delegation of authority during an emergency updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents deemed at risk during an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Director of Nursing (or assigned person) to provide weekly updates to risk assessment of resident population deemed at risk during an emergency.
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Director of Nursing (or assigned person) will ensure that assessed list is updated weekly for three weeks, then monthly for four months.
   Administrator (or assigned person) will ensure that documented delegation of authority is updated weekly for three weeks, then monthly for four months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 5, 2020.

Helene Melnar
3.27.2020

Plan of Correction E 015

Subsistence Needs for Staff and Patients

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Policies and procedures for emergency lighting, fire detection, extinguishing, alarm system sewage and waste disposal updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Maintenance Director to ensure that policies and procedures are included in the EPP binder, and are updated as necessary.
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will audit policies and procedures weekly for 3 weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 5, 2020.

Plan of Correction E 018

Procedures For Tracking Of Staff and Patients

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Tracking system for tracking on-duty staff and sheltered patients who may be relocated during an emergency, updated in EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents who may be relocated during an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Business Office Manager/ HR Manager (or assigned person) to maintain an updated log of staff member's names and contact information (to include email addresses and phone numbers).
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.
   SDC to educate staff on tracking system protocol.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Business Office Manager/ HR Manager (or assigned person) will audit tracking system log in EP (Emergency Plan) binder weekly for 3 weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 5, 2020.

Plan of Correction E 020

Policies for Evacuation and Primary/ Alternate Communication

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Policies and procedures for safe evacuation, transportation, identification of evacuation locations and alternate means of communications with external resources and staff responsibilities have been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents who may evacuate during an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.
   SDC to educate staff on evacuation policies and procedures.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will monitor and update when applicable evacuation policies and procedures, the identification of evacuation location(s), and alternate means of communication with external resources in the EP binder weekly for 3 weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20, 2020.

Plan of Correction E 023

Policies/ Procedures for Medical Documentation

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Policies and procedures for the preservation and protection of patient information, as well as the availability of resident records, have been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents who may evacuate during an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.
   SDC to educate staff on evacuation policies and procedures, that pertain to the preservation and protection of patient information during an evacuation, as well as how to maintain the availability of resident records.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will monitor and update when applicable policies and procedures pertaining to the preservation and protection of patient information during an evacuation, as well as the availability of resident records monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 026

Roles Under a Waiver Declared by Secretary

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Documentation describing the facility's role in providing care at an alternate care site has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents who may evacuate during an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.
   SDC to educate staff on facility role in providing care at an alternate care site, when evacuated.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will monitor and update when applicable policies and procedures pertaining to the facility's role in providing care at an alternate care site when evacuated, monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 030

Names and Contact Information

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Names of all staff members and contact information have been updated in the EP binder. Information regarding entities providing services during an emergency updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents in an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Business Office Manager/ HR Manager (or assigned person) will monitor and update when applicable staff member list and contact information, weekly for four weeks and monthly for six months.
   Maintenance Director will monitor and updated when applicable policies and procedures pertaining to the facility's role in providing care at an alternate care site when evacuated, and vendor (i.e., entities) contracts/ information of those providing services during emergency, weekly for four weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 032

Primary/ Alternate Means for Communication

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An Emergency Preparedness Communication Plan, which includes alternate means of communication in an emergency, has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents in an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director will monitor and updated when applicable the Emergency Preparedness Communication Plan, weekly for four weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 033

Methods for Sharing Information

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   A communication plan, including a method for sharing information and medical documentation to maintain continuity of care, has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents in an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director will monitor and updated when applicable the Communication Plan, weekly for four weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 034

Information on Occupancy/ Needs

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Documentation about facility's occupancy needs and its ability to provide assistance has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents in an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director will monitor and updated when applicable the documentation on facility occupancy needs, and the ability to provide assistance, weekly for four weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 036

EP Training and Testing

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Emergency Preparedness Training and Testing Program Review was updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents in an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director will monitor and updated when applicable the Emergency Preparedness Training and Testing Program, weekly for four weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 037

EP Training Program

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Documentation of Emergency Preparedness Training has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.
   SDC to provide Emergency Preparedness Training.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will monitor and update when applicable documentation of Emergency Preparedness Training in the EP binder weekly for 3 weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20, 2020.

Plan of Correction E 039

EP Testing Requirements

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Documentation of EP Testing Requirements has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting. Interdisciplinary team to analyze results of emergency preparedness exercise.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will monitor and update when applicable documentation of EP Testing Requirements in the EP binder weekly for 3 weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20, 2020.

Audit: EP Testing Requirements

Plan of Correction F 578

Request/ Refuse/ Discontinue Treatment: Formulate Advance Directive

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of the Advance Directives Discussion Documents was conducted on residents #63, #82, and #109.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   A blank Advanced Directive Discussion Document will be added to the Social Services admission folder to review with resident/ responsible party during the 72-hour meeting.
   Readmissions will have code status verified, and a new discussion document will be created if readmission has a change in code status or other advanced directive during hospital stay.
   Staff Development Coordinator to educate all nurses on Completing Transfer Form 100%, Signing and Closing Out.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will audit for 8 weeks, then monthly for 4 months, that facility maintains updated and accurate Advanced Directives Discussion Documents for residents, including new admits, readmits, and residents who have had a change in code status.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 582
Medicaid/ Medicare Coverage & Liability Notice

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of NOM-NC and ABN documents was conducted for residents #3 and #87.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any resident who would receive a NOM-NC letter has the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Social Services Director to utilize the SNF Beneficiary Protection Notification Review Pathway provided by CMS regarding the issuance of both the NOMNC and ABN to ensure that the most recent and accurate forms are being provided upon the termination of benefits.
   Administrator to discuss at QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director will complete weekly audits for three months, then monthly for three months to ensure 100% compliance of NOM-NC/ ABN requirements.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 25th, 2020.

Plan of Correction F 584

Safe/ Clean/ Comfortable/ Homelike Environment

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of Units 3, 4, and 5 was conducted on 3.13.2020.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Missing baseboards will be replaced on Units 3, 4, and 5.
   Maintenance Director to discuss at March QAPI meeting with interdisciplinary committee.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will conduct weekly audits for two months, then monthly audits for two months, to repair any damaged cove base/ baseboard.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 25th, 2020.

Plan of Correction F 607

Develop/ Implement/ Abuse/ Neglect Policies

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Social Services Director was educated on Abuse/ Neglect Investigation and Reporting Policy.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   SDC (Staff Development Coordinator) to provide education on Abuse/ Neglect policies to all staff members.
   Deer Oaks Behavioral Health to provide in-service training for management team, regarding deescalating behaviors. SDC will train floor staff.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will audit for 8 weeks, then monthly for 4 months, that the Abuse Investigation/ Reporting Tool is used appropriately for an abuse allegation.
   SDC (or assigned person) will conduct weekly audits for 8 weeks, then monthly audits for 4 months, to ensure that all staff members are educated on Abuse/ Neglect policies/ procedures.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 609

Reporting of Alleged Violations

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Social Services Director was educated on Reporting of Alleged Violations.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   SDC (Staff Development Coordinator) to provide education on Abuse/ Neglect policies, as well as reporting guidelines for suspected abuse or neglect to all staff members.
   Alleged abuse notification checklist will be reviewed with Administrator or DON following each reportable incident.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will audit for 8 weeks, then monthly for 4 months, that allegations of abuse/ mistreatment are reported to the State Survey Agency and Adult Protective Services within the required time frame.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 610

Investigate/ Prevent/ Correct Alleged Violation

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Social Services Director was educated on thoroughly investigating a witnessed allegation of abuse/ mistreatment. A thorough investigation was conducted, and the event involving resident #64 was determined to *not* be abuse.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   SDC (Staff Development Coordinator) to provide education on Abuse/ Neglect policies, as well as reporting guidelines for suspected abuse or neglect to all staff members.
   Alleged abuse notification checklist will be reviewed with Administrator or DON (or assigned person) following each reportable incident.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will audit for 8 weeks, then monthly for 4 months, that allegations of abuse/ mistreatment are thoroughly investigated.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 622

Transfer and Discharge Requirements

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of hospital transfers was conducted.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Administrator to provide education to Social Services Director regarding Transfer and Discharge Requirements.
   Staff Development Coordinator will educate all charge nurse regarding the completion of Interact Transfer Assessment on PCC.
   Social Services Director will create a discharge/ transfer packet for each unit to use as a template for discharges and transfers to ensure 100% compliance.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will conduct weekly audits for two months, then monthly audits for four months, to verify that comprehensive care plan goals are sent with any transfer to the hospital.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 25th, 2020.

Plan of Correction F 625

Notice of Bed Hold Policy Before/ Upon Transfer

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Audit conducted to ensure all bed hold notices are provided to the resident or resident representative at time of transfer to a hospital.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Administrator to provide education to Social Services Director regarding Notice of Bed Hold Policy Before/ Upon Transfer.
   Staff Development Coordinator will educate all charge nurses regarding the notification of state bed hold policy before or upon each transfer.
   Social Services Director will create a discharge/ transfer packet for each unit to use as a template for discharges and transfers to ensure that the correct documents are utilized across the facility.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will conduct weekly audits for two months, then monthly audits for four months, to verify that each resident/ resident representative receives a Bed Hold Policy Before/ Upon Transfer.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 640

Encoding/Transmitting Resident Assessments

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**

   A completed discharge MDS Assessment, along with validation report indicating the MDS assessment was transmitted to the CMS, was completed for residents #1 and #91. MDS Coordinators were educated on Discharge MDS Assessments.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss at QAPI meeting.
   MDS Coordinators to conduct 100% audit on missing assessments and complete any that are in deficient practice.
   MDS Coordinators to audit MDS Assessments for the past 90-day discharges.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   MDS Coordinators will audit Discharge: MDS Assessments weekly for 8 weeks, then monthly for 6 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 25th, 2020.

Plan of Correction F 641

Accuracy of Assessments

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Modification on the MDS Assessment was completed for resident #76. MDS Coordinators educated on Accurate Coding of Section J&O for Hospice Residents.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss at QAPI meeting.
   MDS Coordinators to conduct 100% audit on all Hospice residents. MDS Coding for past 90 days will be reviewed to resolve any deficient practice.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   MDS Coordinators will audit MDS assessments weekly for 8 weeks, then monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 25th, 2020.

Plan of Correction F 656

Develop/Implement Comprehensive Care Plan

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Comprehensive care plan was updated to include depression/ anxiety for resident #100.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss at QAPI meeting.
   MDS Coordinators to conduct a 100% audit on care plans, ensure they are complete and up to date, and address any deficient practices.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   MDS Coordinators will audit care plans weekly for 8 weeks, then monthly for six months.

5. **Include dates when corrective action will be completed:**

   Corrective actions will be complete by April 25th, 2020.

Plan of Correction F 657

Care Plan Timing and Revision

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Care Plan was revised for resident #96. MDS Coordinators educated on Significant Change MDS's.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any resident has the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss at QAPI meeting.
   MDS Coordinator to conduct a 100% audit on Care Plans, complete any that are in deficient practice, and ensure that care plans are current and updated.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   MDS Coordinator to audit Care Plans with Significant Change weekly for 8 weeks, then monthly for 6 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 25th, 2020.

Plan of Correction F689

Free of Accident Hazards/ Supervision/ Devices

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   100% elopement reassessment on all residents completed. Wander-guards checked. Resident #167 placed on secure unit after hospital return for additional safety.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   SDC to Reeducate licensed clinical staff on accurate completion of elopement assessment and appropriate reassessment as indicated by residents change of condition.
   Review elopement risks, wandering behaviors or other behaviors that may indicate need at weekly risk meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Director of Nursing (or designee) to perform audits of risk for elopement assessments on new admissions and residents with COC to identify those at risk, weekly for 8 weeks, then monthly for 4 months.
   Central Supply Manager to conduct audits of Wander-guard supplies weekly for 8 weeks, then monthly for 4 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F727

RN 8 HRS/ 7 DAYS a Week. Full Time DON

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   RN coverage provided 8 hours per day, 7 days a week.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Administrator to monitor daily coverage on Key Factor Report.
   Staffing Coordinator to ensure sufficient RN coverage.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Director of Nursing (or designee) will audit the daily schedule with the Staffing Coordinator, weekly for 6 weeks, then monthly for 4 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 755

Pharmacy Services/ Procedures/ Pharmacist/ Records

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   100% controlled medication count complete and accurate. Variances included in weekly risk meeting, to include errors in narc count, PCC documentation that doesn't match narcotic book.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Unit Manager (or designee) to observe shift-to-shift count on all shifts to verify count is accurate. Education to be provided when areas of opportunity are identified.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Unit Managers (or designee) will conduct cart audits to include count of controlled meds weekly for 8 weeks, then monthly for 4 months. Variations will be followed up on and reported to DON.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 756

Drug Regimen Review, Report Irregular, Act On

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Staff educated on state guidelines regarding medication administration. Discrepancies resulted in immediate cart count. Corrections made for residents #21, #61, and #71. Physician reviewed pharmacy recommendations corrected for resident #112.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Medication errors, errors in narc count, PCC documentation that does not match narc book added to weekly Risk Meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   DON (or designee) to conduct cart audits weekly for 4 weeks, then monthly for 3 months.
   DON (or designee) to conduct audits physician reviewed pharmacy recommendations weekly for 4 weeks, monthly for 3 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 757

Drug Regimen is Free from Unnecessary Drugs

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Two-nurse verification implemented. 100% flu consent audit performed; medication error report filed. Family and MD received notification for resident #77. Education on proper administration of vaccines with consent completed.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Two nurse signatures required for obtaining all flu and pneumonia vaccination consents.
   Consent to be verified prior to administration.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Infection Control Preventionist will audit consents and provide a list of residents who do not wish to receive the flu vaccine to DON, weekly for 6 weeks, then monthly for 3 months.
   DON (or designee) will audit MAR to ensure those residents that did not give consent are not scheduled for flu vaccine administration, weekly for 6 weeks, then monthly for 3 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 758

Free from Unnecessary Psychotropic Meds/ PRN Use

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Audit conducted to remove all PRN psychotropic orders. If greater than 14 days, justification for continued use by MD will be indicated. Indication of the duration for an as needed psychotropic medication for resident #100 was completed. Gradual dose reduction for resident #20 was completed.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Staffing Development Coordinator (SDC) to educate nurses on federal law, which restricts PRN psychotropic drug orders to 14 days.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Director of Nursing (DON) to audit PRN psychotropics, and gradual dose recommendations to verify that GDR is being followed.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 761

Label/ Store Drugs and Biologicals

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Unlabeled medication removed and replaced to ensure efficacy for resident #109. Medications with illegible labels removed and reordered. Medications labeled in accordance with currently accepted professional principles and stored according to manufacture guidelines on all medication carts.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   DON (or designee) to ensure that medications are properly labeled.
   SDC to educate nurses on labeling medications correctly and following manufacture recommendations. (to include labeling insulin, eyedrops and other meds that require date upon opening).
   Pharmacy to provide cart audits to DON, including legible labels and properly dated medication indications. Pharmacy to report inappropriate storage of medication on carts, including those that must be refrigerated. Discrepancies to be addressed with nurse, with noncompliance including education and potential disciplinary action. Pharmacy audits to be shared with interdisciplinary team during risk meeting. Results to be documented.
   Random med pass observations to be performed to verify medications being administered are labeled, dated and stored appropriately.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   DON (or designee) to audit medication carts to ensure that medications are properly labeled, weekly for 6 weeks, then monthly for 4 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F804

Nutritive Value/ Appearance, Palatable/ Prefer Temp

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of resident diets conducted. Food methods that conserve nutritive value and provision and presentation of food that is palatable and attractive (i.e., pureed soup) provided to resident #89.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents who require a puree diet have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Through food preferences and mechanically altered diets listed on tray cards, puree soup will be available to any resident who needs or requests it, for every meal. All with puree requirements will be offered daily pureed soup.
   Dietary Manager to educate dietary team regarding the implementation of puree soup availability for each meal.
   Dietary Manager to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Dietary Manager (or assigned person) will conduct daily for three weeks, to ensure puree soup is available for all meals. Weekly inspections will be conducted for three months.
   Through resident interviews, quarterly reviews and care plan meetings, Dietary Manager will monitor to ensure resident's requests and needs for food items are being met.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by March 28, 2020.

Plan of Correction F 812

Food Procurement, Store/ Prepare/ Serve- Sanitary

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Kitchen cleaned, scoop washed, food sealed and properly dated, personal items removed from refrigerator.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Dietary Manager to in-service staff of proper storage of food items, proper label and dating items, and proper use of utensils while using food items.
   Daily cleaning by Dietary Manager (or assigned person) of the three inspected drains in the kitchen, for gnats and/or fruit flies. Maintenance Director or designee will clean drains monthly.
   Dietary Manager to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Dietary Manager (or assigned person) will audit dry goods storage, refrigerator storage, personal items storage and proper cleaning of kitchen daily for three weeks, and weekly for three months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 5, 2020.

Plan of Correction F 842

Resident Records- Identifiable Information

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Education provided to nurses and CNA's on accurate and thorough documentation of patient bowel and bladder movements, and any changes or lack of evacuation of bowel or bladder.
   Resident #53 incident report documenting 12/24 resident had a fall causing a hematoma resulting in an order to send to the ER.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Daily review at clinical meeting, all residents transferred to hospital, to ensure supporting documentation and reason for transfer.
   Compliance rate to be addressed at weekly Risk Management meetings.
   Residents transferred to hospital will be reviewed during weekly Risk Management meetings.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   ADON (or designee) to conduct audits of documentation of bowel and bladder for each patient, weekly for 6 weeks and monthly for 4 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20th, 2020.

Plan of Correction F 883

Influenza and Pneumococcal Immunizations

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Licensed nursing staff educated on consent policy, as well as PCC education on where to locate immunization consents for residents.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss at QAPI meeting.
   Staff Development Coordinator will audit new admissions influenza and pneumococcal consents.
   Daily review of influenza and pneumococcal percentages to be reviewed every weekday morning with interdisciplinary team.
   Influenza and Pneumococcal log will be maintained by Staff development Coordinator.
   Unit Managers to review consents in 72-hour care plan meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Staff Development Coordinator to conduct audits of PCC consent weekly for 8 weeks, then monthly for four months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 20, 2020.

Plan of Correction F 925

Maintains Effective Pest Control Program

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of facility was conducted 3.6.2020, and all dead pests were removed. Contracted pest control company was contacted and visit was scheduled.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Pest control company serviced the facility on 3.10.2020, and will continue at least monthly, but more frequently if necessitated.
   Missing baseboards will be replaced on Unit 1.
   Pest control log will be maintained by Maintenance Director.
   Maintenance Director to discuss at March QAPI meeting with interdisciplinary committee.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   The Dietary Manager will conduct the three inspected drains in the kitchen,and the steam table and trash can for gnats and/or fruit flies, for 3 weeks. Weekly inspections will be conducted for three months.
   Daily cleaning by Dietary Manager (or assigned person) of the three inspected drains in the kitchen, for gnats and/or fruit flies, for 3 weeks. Maintenance Director will conduct weekly inspections for three months and will clean drains monthly for three months.
   Maintenance Director (or assigned person) will conduct daily audits of Unit 1, Unit 4, and Unit 5. Weekly audits of baseboards on Unit 1 will be conducted for 8 weeks, then once a month for two months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 25th, 2020.

Plan of Correction E 007

EP Program Patient Population

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Risk assessment of resident population to determine those at risk during an emergency updated in the EP binder.
   Documented delegation of authority during an emergency updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents deemed at risk during an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Director of Nursing (or assigned person) to provide weekly updates to risk assessment of resident population deemed at risk during an emergency.
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Director of Nursing (or assigned person) will ensure that assessed list is updated weekly for three weeks, then monthly for four months.
   Administrator (or assigned person) will ensure that documented delegation of authority is updated weekly for three weeks, then monthly for four months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 5, 2020.

Helene Molnar

4.2.2020

Plan of Correction E 015

Subsistence Needs for Staff and Patients

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Policies and procedures for emergency lighting, fire detection, extinguishing, alarm system sewage and waste disposal updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Maintenance Director to ensure that policies and procedures are included in the EPP binder, and are updated as necessary.
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will audit policies and procedures weekly for 3 weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 5, 2020.

Plan of Correction E 018

Procedures For Tracking Of Staff and Patients

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Tracking system for tracking on-duty staff and sheltered patients who may be relocated during an emergency, updated in EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents who may be relocated during an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Business Office Manager/ HR Manager (or assigned person) to maintain an updated log of staff member's names and contact information (to include email addresses and phone numbers).
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.
   SDC to educate staff on tracking system protocol.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Business Office Manager/ HR Manager (or assigned person) will audit tracking system log in EP (Emergency Plan) binder weekly for 3 weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 5, 2020.

Plan of Correction E 020

Policies for Evacuation and Primary/ Alternate Communication

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Policies and procedures for safe evacuation, transportation, identification of evacuation locations and alternate means of communications with external resources and staff responsibilities have been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents who may evacuate during an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.
   SDC to educate staff on evacuation policies and procedures.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will monitor and update when applicable evacuation policies and procedures, the identification of evacuation location(s), and alternate means of communication with external resources in the EP binder weekly for 3 weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Helene Molnar
4-2-2020

Plan of Correction E 023

Policies/ Procedures for Medical Documentation

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Policies and procedures for the preservation and protection of patient information, as well as the availability of resident records, have been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents who may evacuate during an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.
   SDC to educate staff on evacuation policies and procedures, that pertain to the preservation and protection of patient information during an evacuation, as well as how to maintain the availability of resident records.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will monitor and update when applicable policies and procedures pertaining to the preservation and protection of patient information during an evacuation, as well as the availability of resident records monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 026

Roles Under a Waiver Declared by Secretary

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Documentation describing the facility's role in providing care at an alternate care site has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents who may evacuate during an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.
   SDC to educate staff on facility role in providing care at an alternate care site, when evacuated.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will monitor and update when applicable policies and procedures pertaining to the facility's role in providing care at an alternate care site when evacuated, monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 030

Names and Contact Information

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Names of all staff members and contact information have been updated in the EP binder. Information regarding entities providing services during an emergency updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents in an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Business Office Manager/ HR Manager (or assigned person) will monitor and update when applicable staff member list and contact information, weekly for four weeks and monthly for six months.
   Maintenance Director will monitor and updated when applicable policies and procedures pertaining to the facility's role in providing care at an alternate care site when evacuated, and vendor (i.e., entities) contracts/ information of those providing services during emergency, weekly for four weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 032

Primary/ Alternate Means for Communication

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An Emergency Preparedness Communication Plan, which includes alternate means of communication in an emergency, has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents in an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director will monitor and updated when applicable the Emergency Preparedness Communication Plan, weekly for four weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 033

Methods for Sharing Information

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   A communication plan, including a method for sharing information and medical documentation to maintain continuity of care, has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents in an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director will monitor and updated when applicable the Communication Plan, weekly for four weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 034

Information on Occupancy/ Needs

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Documentation about facility's occupancy needs and its ability to provide assistance has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents in an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director will monitor and updated when applicable the documentation on facility occupancy needs, and the ability to provide assistance, weekly for four weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 036

EP Training and Testing

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Emergency Preparedness Training and Testing Program Review was updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents in an emergency have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director will monitor and updated when applicable the Emergency Preparedness Training and Testing Program, weekly for four weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 037

EP Training Program

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Documentation of Emergency Preparedness Training has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting.
   SDC to provide Emergency Preparedness Training.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will monitor and update when applicable documentation of Emergency Preparedness Training in the EP binder weekly for 3 weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction E 039

EP Testing Requirements

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Documentation of EP Testing Requirements has been updated in the EP binder.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator (or assigned person) to discuss change with interdisciplinary team at March QAPI meeting. Interdisciplinary team to analyze results of emergency preparedness exercise.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will monitor and update when applicable documentation of EP Testing Requirements in the EP binder weekly for 3 weeks, and monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Audit: EP Testing Requirements

Plan of Correction F 578

Request/ Refuse/ Discontinue Treatment: Formulate Advance Directive

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of the Advance Directives Discussion Documents was conducted on residents #63, #82, and #109.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   During MDS and Care Plan meetings, MDS will ensure that their records are correct and that Advanced Directives match up, and changes will be addressed whenever needed.
   A blank Advanced Directive Discussion Document will be added to the Social Services admission folder to review with resident/ responsible party during the 72-hour meeting.
   Readmissions will have code status verified, and a new discussion document will be created if readmission has a change in code status or other advanced directive during hospital stay.
   Staff Development Coordinator to educate all nurses on Completing Transfer Form 100%, Signing and Closing Out.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will audit for 8 weeks, then monthly for 4 months, that facility maintains updated and accurate Advanced Directives Discussion Documents for residents, including new admits, readmits, and residents who have had a change in code status.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Helene Molnar

4.2.2020

Plan of Correction F 582
Medicaid/ Medicare Coverage & Liability Notice

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of NOM-NC and ABN documents was conducted for residents #3 and #87.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any resident who would receive a NOM-NC letter has the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Social Services Director to utilize the SNF Beneficiary Protection Notification Review Pathway provided by CMS regarding the issuance of both the NOMNC and ABN to ensure that the most recent and accurate forms are being provided upon the termination of benefits.
   Administrator to discuss at QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director will complete weekly audits for three months, then monthly for three months to ensure 100% compliance of NOM-NC/ ABN requirements.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 584

Safe/ Clean/ Comfortable/ Homelike Environment

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of Units 3, 4, and 5 was conducted on 3.13.2020.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Missing baseboards will be replaced on Units 3, 4, and 5.
   Maintenance Director to discuss at March QAPI meeting with interdisciplinary committee.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Maintenance Director (or assigned person) will conduct weekly audits for two months, then monthly audits for two months, to repair any damaged cove base/ baseboard.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 607

Develop/ Implement/ Abuse/ Neglect Policies

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Social Services Director was educated on Abuse/ Neglect Investigation and Reporting Policy. A thorough investigation was conducted on the event involving Resident #64.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   SDC (Staff Development Coordinator) to provide education on Abuse/ Neglect policies to all staff members.
   Deer Oaks Behavioral Health to provide in-service training for management team, regarding deescalating behaviors. SDC will train floor staff.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will audit for 8 weeks, then monthly for 4 months, that the Abuse Investigation/ Reporting Tool is used appropriately for an abuse allegation.
   SDC (or assigned person) will conduct weekly audits for 8 weeks, then monthly audits for 4 months, to ensure that all staff members are educated on Abuse/ Neglect policies/ procedures.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 609

Reporting of Alleged Violations

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Social Services Director was educated on Reporting of Alleged Violations. The event allegedly involving Resident #64 was reported, and the investigation was closed.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   SDC (Staff Development Coordinator) to provide education on Abuse/ Neglect policies, as well as reporting guidelines for suspected abuse or neglect to all staff members.
   Alleged abuse notification checklist will be reviewed with Administrator or DON following each reportable incident.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will audit for 8 weeks, then monthly for 4 months, that allegations of abuse/ mistreatment are reported to the State Survey Agency and Adult Protective Services within the required time frame.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 610

Investigate/ Prevent/ Correct Alleged Violation

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Social Services Director was educated on thoroughly investigating a witnessed allegation of abuse/ mistreatment. A thorough investigation was conducted regarding Resident #64 and the event involving resident was determined to *not* be abuse.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   SDC (Staff Development Coordinator) to provide education on Abuse/ Neglect policies, as well as reporting guidelines for suspected abuse or neglect to all staff members.
   Alleged abuse notification checklist will be reviewed with Administrator or DON (or assigned person) following each reportable incident.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will audit for 8 weeks, then monthly for 4 months, that allegations of abuse/ mistreatment are thoroughly investigated.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 622

Transfer and Discharge Requirements

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of hospital transfers was conducted, to ensure that comprehensive Care Plan goals are sent upon transfer to the hospital. Residents #53, 82, and 21 presently reside at the facility, and Resident #119 has discharged.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Administrator to provide education to Social Services Director regarding Transfer and Discharge Requirements.
   Staff Development Coordinator will educate all charge nurse regarding the completion of Interact Transfer Assessment on PCC.
   Social Services Director will create a discharge/ transfer packet for each unit to use as a template for discharges and transfers to ensure 100% compliance.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will conduct weekly audits for two months, then monthly audits for four months, to verify that comprehensive care plan goals are sent with any transfer to the hospital.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 625

Notice of Bed Hold Policy Before/ Upon Transfer

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Audit conducted to ensure bed hold notices are provided to the resident or resident representative at time of transfer to a hospital, including Residents #21, 82, and 89.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Administrator to provide education to Social Services Director regarding Notice of Bed Hold Policy Before/ Upon Transfer.
   Staff Development Coordinator will educate all charge nurses regarding the notification of state bed hold policy before or upon each transfer.
   Social Services Director will create a discharge/ transfer packet for each unit to use as a template for discharges and transfers to ensure that the correct documents are utilized across the facility.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Social Services Director (or assigned person) will conduct weekly audits for two months, then monthly audits for four months, to verify that each resident/ resident representative receives a Bed Hold Policy Before/ Upon Transfer.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 640

Encoding/Transmitting Resident Assessments

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**

   A completed discharge MDS Assessment, along with validation report indicating the MDS assessment was transmitted to the CMS, was completed for residents #1 and #91. MDS Coordinators were educated on Discharge MDS Assessments.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss at QAPI meeting.
   MDS Coordinators to conduct 100% audit on missing assessments and complete any that are in deficient practice.
   MDS Coordinators to audit MDS Assessments for the past 90-day discharges.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   MDS Coordinators will audit Discharge: MDS Assessments weekly for 8 weeks, then monthly for 6 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 641

Accuracy of Assessments

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Modification on the MDS Assessment was completed for resident #76. MDS Coordinators educated on Accurate Coding of Section J&O for Hospice Residents.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss at QAPI meeting.
   MDS Coordinators to conduct 100% audit on all Hospice residents. MDS Coding for past 90 days will be reviewed to resolve any deficient practice.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   MDS Coordinators will audit MDS assessments weekly for 8 weeks, then monthly for six months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 656

Develop/Implement Comprehensive Care Plan

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Comprehensive care plan was updated to include depression/ anxiety for resident #100.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss at QAPI meeting.
   MDS Coordinators to conduct a 100% audit on care plans, ensure they are complete and up to date, and address any deficient practices.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   MDS Coordinators will audit care plans weekly for 8 weeks, then monthly for six months.

5. **Include dates when corrective action will be completed:**

   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 657

Care Plan Timing and Revision

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Care Plan was revised for resident #96. MDS Coordinators educated on Significant Change MDS's.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any resident has the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss at QAPI meeting.
   MDS Coordinator to conduct a 100% audit on Care Plans, complete any that are in deficient practice, and ensure that care plans are current and updated.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   MDS Coordinator to audit Care Plans with Significant Change weekly for 8 weeks, then monthly for 6 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F689

Free of Accident Hazards/ Supervision/ Devices

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   100% elopement reassessment on all residents completed. Wander-guards checked. Resident #167 placed on secure unit after hospital return for additional safety.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   SDC to Reeducate licensed clinical staff on accurate completion of elopement assessment and appropriate reassessment as indicated by residents change of condition.
   Review elopement risks, wandering behaviors or other behaviors that may indicate need at weekly risk meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Director of Nursing (or designee) to perform audits of risk for elopement assessments on new admissions and residents with COC to identify those at risk, weekly for 8 weeks, then monthly for 4 months.
   Central Supply Manager to conduct audits of Wander-guard supplies weekly for 8 weeks, then monthly for 4 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F727

RN 8 HRS/ 7 DAYS a Week. Full Time DON

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   RN coverage provided 8 hours per day, 7 days a week.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Administrator to monitor daily coverage on Key Factor Report.
   Staffing Coordinator to ensure sufficient RN coverage.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Director of Nursing (or designee) will audit the daily schedule with the Staffing Coordinator, weekly for 6 weeks, then monthly for 4 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 755

Pharmacy Services/ Procedures/ Pharmacist/ Records

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   100% controlled medication count complete and accurate. Variances included in weekly risk meeting, to include errors in narc count, PCC documentation that doesn't match narcotic book.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Unit Manager (or designee) to observe shift-to-shift count on all shifts to verify count is accurate. Education to be provided when areas of opportunity are identified.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Unit Managers (or designee) will conduct cart audits to include count of controlled meds weekly for 8 weeks, then monthly for 4 months. Variations will be followed up on and reported to DON.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 756

Drug Regimen Review, Report Irregular, Act On

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Staff educated on state guidelines regarding medication administration. Discrepancies resulted in immediate cart count. Corrections made for residents #21, #61, and #71. Physician reviewed pharmacy recommendations corrected for resident #112.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Medication errors, errors in narc count, PCC documentation that does not match narc book added to weekly Risk Meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   DON (or designee) to conduct cart audits weekly for 4 weeks, then monthly for 3 months.
   DON (or designee) to conduct audits physician reviewed pharmacy recommendations weekly for 4 weeks, monthly for 3 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 757

Drug Regimen is Free from Unnecessary Drugs

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Two-nurse verification implemented. 100% flu consent audit performed; medication error report filed. Family and MD received notification for resident #77. Education on proper administration of vaccines with consent completed.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Two nurse signatures required for obtaining all flu and pneumonia vaccination consents.
   Consent to be verified prior to administration.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Infection Control Preventionist will audit consents and provide a list of residents who do not wish to receive the flu vaccine to DON, weekly for 6 weeks, then monthly for 3 months.
   DON (or designee) will audit MAR to ensure those residents that did not give consent are not scheduled for flu vaccine administration, weekly for 6 weeks, then monthly for 3 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 758

Free from Unnecessary Psychotropic Meds/ PRN Use

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Audit conducted to remove all PRN psychotropic orders. If greater than 14 days, justification for continued use by MD will be indicated. Indication of the duration for an as needed psychotropic medication for resident #100 was completed. Gradual dose reduction for resident #20 was completed.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Staffing Development Coordinator (SDC) to educate nurses on federal law, which restricts PRN psychotropic drug orders to 14 days.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Director of Nursing (DON) to audit PRN psychotropics, and gradual dose recommendations to verify that GDR is being followed.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 761

Label/ Store Drugs and Biologicals

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Unlabeled medication removed and replaced to ensure efficacy for resident #109. Medications with illegible labels removed and reordered. Medications labeled in accordance with currently accepted professional principles and stored according to manufacture guidelines on all medication carts.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   DON (or designee) to ensure that medications are properly labeled.
   SDC to educate nurses on labeling medications correctly and following manufacture recommendations. (to include labeling insulin, eyedrops and other meds that require date upon opening).
   Pharmacy to provide cart audits to DON, including legible labels and properly dated medication indications. Pharmacy to report inappropriate storage of medication on carts, including those that must be refrigerated. Discrepancies to be addressed with nurse, with noncompliance including education and potential disciplinary action. Pharmacy audits to be shared with interdisciplinary team during risk meeting. Results to be documented.
   Random med pass observations to be performed to verify medications being administered are labeled, dated and stored appropriately.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   DON (or designee) to audit medication carts to ensure that medications are properly labeled, weekly for 6 weeks, then monthly for 4 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F804

Nutritive Value/ Appearance, Palatable/ Prefer Temp

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of resident diets conducted. Food methods that conserve nutritive value and provision and presentation of food that is palatable and attractive (i.e., pureed soup) provided to resident #89.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents who require a puree diet have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Through food preferences and mechanically altered diets listed on tray cards, puree soup will be available to any resident who needs or requests it, for every meal. All with puree requirements will be offered daily pureed soup.
   Dietary Manager to educate dietary team regarding the implementation of puree soup availability for each meal.
   Dietary Manager to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Dietary Manager (or assigned person) will conduct daily for three weeks, to ensure puree soup is available for all meals. Weekly inspections will be conducted for three months.
   Through resident interviews, quarterly reviews and care plan meetings, Dietary Manager will monitor to ensure resident's requests and needs for food items are being met.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by March 28, 2020.

Plan of Correction F 812

Food Procurement, Store/ Prepare/ Serve- Sanitary

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Kitchen cleaned, scoop washed, food sealed and properly dated, personal items removed from refrigerator.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Dietary Manager to in-service staff of proper storage of food items, proper label and dating items, and proper use of utensils while using food items.
   Daily cleaning by Dietary Manager (or assigned person) of the three inspected drains in the kitchen, for gnats and/or fruit flies. Maintenance Director or designee will clean drains monthly.
   Dietary Manager to discuss change with interdisciplinary team at March QAPI meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Dietary Manager (or assigned person) will audit dry goods storage, refrigerator storage, personal items storage and proper cleaning of kitchen daily for three weeks, and weekly for three months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 5, 2020.

Plan of Correction F 842

Resident Records- Identifiable Information

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Education provided to nurses and CNA's on accurate and thorough documentation of patient bowel and bladder movements, and any changes or lack of evacuation of bowel or bladder, to include Resident #77. Resident #53 incident report documenting 12/24 resident had a fall causing a hematoma resulting in an order to send to the ER.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss with interdisciplinary team at QAPI.
   Daily review at clinical meeting, all residents transferred to hospital, to ensure supporting documentation and reason for transfer.
   Compliance rate to be addressed at weekly Risk Management meetings.
   Residents transferred to hospital will be reviewed during weekly Risk Management meetings.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   ADON (or designee) to conduct audits of documentation of bowel and bladder for each patient, weekly for 6 weeks and monthly for 4 months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.

Plan of Correction F 883

Influenza and Pneumococcal Immunizations

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Licensed nursing staff educated on consent policy, as well as PCC education on where to locate immunization consents for residents.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator to discuss at QAPI meeting.
   Staff Development Coordinator will audit new admissions influenza and pneumococcal consents.
   Daily review of influenza and pneumococcal percentages to be reviewed every weekday morning with interdisciplinary team.
   Influenza and Pneumococcal log will be maintained by Staff development Coordinator.
   Unit Managers to review consents in 72-hour care plan meeting.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Staff Development Coordinator to conduct audits of PCC consent weekly for 8 weeks, then monthly for four months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10, 2020.

Plan of Correction F 925

Maintains Effective Pest Control Program

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   An audit of facility was conducted 3.6.2020, and all dead pests were removed. Contracted pest control company was contacted and visit was scheduled.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Pest control company serviced the facility on 3.10.2020, and will continue at least monthly, but more frequently if necessitated.
   Missing baseboards will be replaced on Unit 1.
   Pest control log will be maintained by Maintenance Director.
   Maintenance Director to discuss at March QAPI meeting with interdisciplinary committee.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   The Dietary Manager will conduct the three inspected drains in the kitchen,and the steam table and trash can for gnats and/or fruit flies, for 3 weeks. Weekly inspections will be conducted for three months.
   Daily cleaning by Dietary Manager (or assigned person) of the three inspected drains in the kitchen, for gnats and/or fruit flies, for 3 weeks. Maintenance Director will conduct weekly inspections for three months and will clean drains monthly for three months.
   Maintenance Director (or assigned person) will conduct daily audits of Unit 1, Unit 4, and Unit 5. Weekly audits of baseboards on Unit 1 will be conducted for 8 weeks, then once a month for two months.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by April 10th, 2020.