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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/14/19 through 01/17/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during this survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/14/19 through 01/17/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 10 complaints were investigated during the survey. The census in this 102 certified bed facility was 84 at the time of the survey. The survey sample consisted of 34 current Resident reviews and 9 closed record reviews.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on resident and family interviews, and staff interviews, the facility staff failed to allow a	F 557	Preparation and submission of this plan of correction does not constitute an	3/1/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/08/2019

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

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resident to retain and/or use personal possessions as desired for 1 of 43 residents (Resident #24), in the survey sample.

The facility staff failed to allow Resident #24 to utilize a motorized wheel chair gifted to her and/or make a decision about disposition of the motorized wheel chair.

The findings included:

Resident #24 was originally admitted to the facility 2/23/18 and readmitted 12/22/18 after a stay in an acute care facility. The current diagnoses included; a brain aneurysm and high blood pressure.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/6/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. That indicated Resident #24's cognitive abilities for daily decision making were moderately impaired.

In section "G" (Physical functioning) the resident was coded as requiring total care of 1 person with bathing, extensive assistance of 1 person with toileting, supervision of 1 person with bed mobility, transfers, locomotion, dressing, eating, and personal hygiene.

An interview was conducted with Resident #24 on 1/15/19 at approximately 11:55 a.m. Resident #24 stated she was gifted a motorized wheel chair from a deceased resident's family member but; the facility's staff would not tell her where the wheel chair was or make it available for her use. She also stated the facility staff told her daughter

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admission , or agreement by the provider of the truth or the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies . The plan of correction is prepared and solely because of the requirement under State and Federal law.

1. Resident #24 wheelchair was donated to an organization. ED meet with residents and responsible party on 2-5-2019 to discuss a resolution to the disposition of the wheelchair .
2. A quality monitoring tool was utilized to ensure that residents were given a choice for the disposition of there property .
3. ED/ADON re-educated staff on disposition of residents belongings on 1-21-2019 .
4. SSD / BDC will monitor the quality monitoring tool 1 times a week for 1 week and then 3 times a week for 4 weeks and then 1 times a month for 1 month and then quarterly thereafter . Results will be discussed at QAPI meeting for review , analysis and recommendations.

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it would be available for her to pick up.

An interview with Resident #24's daughter was conducted on 1/16/19 at approximately 12:05 p.m. She stated her mother had been gifted a wheel chair from a fellow resident's family after his death. Resident #24's daughter also stated the facility staff didn't meet with her mother or herself to determine what was the most appropriate use of the motorized wheel chair. She stated she told the facility staff she would pick the wheel chair up but didn't on the date she stated because her friends truck was not operational on the specified date. The resident's daughter stated at no time did the facility staff ever give her a date the chair had to be removed from the facility prior to the facility taking some actions. The resident's daughter also stated she neither her mother authorized the facility to donate the gifted motorized wheel chair.

A interview was conducted with the Social Worker on 1/16/19, at approximately 4:35 p.m., regarding the motorized wheel chair gifted to Resident #24. The Social Worker stated she thought the wheel chair had been donated after the Interdisciplinary Team determined it was inappropriate for Resident #24 but she would be able to provide additional information later. On 1/17/19 at 11:00 a.m., the Social Worker provided a written statement which read "On Monday 8/20/18, (name of the deceased resident) passed away. He had been using an electric wheel chair to ambulate throughout the facility. On 8/23/18, his daughter wanted to donate her father's wheel chair to Resident#24. The Interdisciplinary Team including therapy, discussed the idea of Resident #24 using an electric wheel chair while here at the facility. It was determined that the wheel chair

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was in poor condition and Resident #24 would not be appropriate for the electric wheel chair as she self propels herself in a manual wheel chair. This is beneficial for Resident #24 in order to keep her strength. She also ambulates at times with a front wheel walker. Resident #24's daughter planned on picking up the electric wheel chair on 9/10/18, but then changed the date to 9/11/18 because that was when she could borrow a truck from a friend. Resident #24's daughter was not able to borrow the truck as it was in need of repair. The electric wheel chair was never picked up and the facility does not have the storage space. The electric wheel chair was eventually donated." The Social Worker stated the statement was written on 1/17/19, because no documentation from the Interdisciplinary Team's decision was available. The Social Worker also stated neither Resident #24 nor her daughter was present for the Interdisciplinary Team's meeting determining the resident was not appropriate for use of a motorized wheelchair.

An interview was conducted on 1/17/19, at approximately 3:45 p.m., with the Rehabilitation Director. The Rehabilitation Director stated they had no documentation from the Interdisciplinary Team's meeting determining Resident #24 was not appropriate for use of a motorized wheel chair.

An interview was also conducted on 1/17/19 at approximately 5:15 p.m., with the individual who gifted the chair to Resident #24. She stated the motorized wheel chair was purchased new and her father had utilized it 2 1/2 years. She further stated it was her father's wish for Resident #24 to have the wheel chair and it was in good condition safe, not in need of repairs. The individual who

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F 557	Continued From page 4 gifted the wheel chair to Resident #24 stated she had spoken with the facility staff and expressed if the Resident #24 couldn't have the wheel chair she was going to carry it with her. The facility's policy provided was only for personal property loss of theft. It didn't address the resident's right to maintain personal possessions. On 1/17/19, at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Administrator stated the facility doesn't have space to store personal possessions indefinitely and the decision made by the Interdisciplinary team was in the resident's best interest.	F 557		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		2/4/19

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F 580	Continued From page 5 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff and family interview, and facility documentation, the facility staff failed to ensure the physician or nurse practitioner was notified of a change in condition for 1 of 43 residents (R#287) in the survey sample. The facility staff failed to promptly notify the physician of a significant change in the resident's condition	F 580	Past noncompliance: no plan of correction required.	

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that included symptoms of unrelieved pain, behavioral changes and possible signs of UTI (urinary tract infection)/sepsis for further guidance that may have required immediate physician intervention or transfer to the hospital. The Resident Representative (RR) elicited an assessment of the resident approximately 19 hours after resident's change in condition that prompted a 911 emergency to be evaluated in the local Emergency Department (ED). The resident was diagnosed in the local hospital with severe urosepsis and AKI (acute kidney injury/acute kidney failure).

The findings included:

Resident #287 was originally admitted to the nursing facility on 11/7/08 with a principle diagnosis of multiple sclerosis with quadriplegia. Other significant diagnoses included diabetes, depression, neuromuscular dysfunction of the bladder with an onset date of 3/5/14 and an indwelling urinary catheter, morbid obesity and high blood pressure. Resident #287's most recent hospital stay was on 10/10/16 through 10/19/16 for complaints of chest pain and readmitted to the nursing facility with diagnoses of chronic atrial fibrillation. The resident was discharged to the local hospital on 6/2/17 and did not return to the nursing facility.

Resident #287's Minimum Data Set (MDS) in effect prior to the 6/2/17 discharge from the facility was a quarterly assessment dated 5/27/17. The resident was coded a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily decision making. The resident had the ability to

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fully understand the staff and was understood. The resident was not coded to reject care that included lab work, taking medications or Activities of Daily Living (ADL) assistance. Resident #287 was assessed to require total dependence on two staff for bed mobility, transfers, toilet use, dressing and bathing. She was coded to need total assistance from one staff for eating, locomotion on and off the facility and personal hygiene. A wheelchair was coded as her main mobility device. The resident was assessed to have an indwelling urinary catheter and was frequently incontinent of bowel.

The care plan dated as last revised on 4/5/17 indicated Resident #287 had a focus area related to altered bladder elimination and the goals set by the staff was that the resident would not develop symptoms of UTI, and that the resident's risk for septicemia would be minimized/prevented via prompt recognition and treatment of symptoms of UTI, and the resident would not experience complications related to catheter use. The care plan did not indicate a diagnosis of UTI in 2017 prior to discharge 6/2/17. Some of the interventions the staff would employ to accomplish these goals included monitor and report to MD (medical doctor) PRN (as needed) for signs and symptoms of UTI that included supra-pubic pain, cloudy urine, altered mental status, abnormal vital signs and behavioral changes. Obtain and monitor labs and diagnostic work as ordered by the physician, report results to MD and follow up as indicated.

The nurse's notes dated 6/2/17 at 6:53 a.m. was written by the 11/7 Licensed Practical Nurse (LPN) #9 (schedule shift at 11 p.m. on 6/1/17 through 7:00 a.m. on 6/2/17) included the

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following: "Resident c/o (complaint of) vaginal burning, peri care and catheter care administered. Shower given on 11/7 shift. Effective. Continuing to monitor".

The same LPN #9 entered the follow-up nurse's note on 6/2/17 at 7:12 a.m.: "Resident has been displaying behaviors during shift. Hollering out. Resident c/o pain, medications administered, ineffective. Resident continues to holler disturbing roommate and causing agitation. Continuing to monitor." LPN #9 was not available for interview, no longer employed by the nursing facility. The facility initiated an investigation on 6/19/17 into the Resident Representative's (RR) concerns about delay in care 6/1/17-6/2/17 and LPN #9 wrote a statement. The statement indicated when she reported to work for the 11/7 shift (6/1/17 at 11:00 p.m. through 6/2/17 at 7:00 a.m.) the resident was "yelling out some". She wrote she and the CNA gave the resident a shower because of her complaints of vaginal burning, performed peri care, administered pain medication between 5:00 a.m. and 6:00 a.m. and reported off to LPN # 10 (6/2/17-7/3 shift).

LPN #10 who took over as the assigned licensed nurse responsible for Resident #287's care on 6/2/17 for the 7/3 shift was not available for interview, no longer employed by the nursing facility. LPN #10's written statement was not included in the investigation file provided to this surveyor.

The Certified Nursing Assistants (C.N.A.) that were assigned to the resident on 6/1/17 and 6/2/17 for all three shifts were not available for interview, no longer employed by the nursing facility. The 6/2/17-7/3 shift CNA indicated in a

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written statement that she was told by the 11/7 shift CNA that the resident had some screaming during the night. She wrote she got the resident up in the chair for breakfast and she only ate 25 % of he breakfast, ate only a few bites for lunch and ask to go lay down, she was tired and wanted to rest.

There were no nurse's notes that demonstrated further assessments and monitoring took place on either the 7/3 shift on 6/2/17 or the 3/11 shift prior to the SBAR (Situation/Background/Assessment/Recommendation) report on 6/2/17 at 6:12 p.m.

The SBAR report indicated the following vital signs: Blood pressure (BP)= 110/60 (marginally low); pulse=120 (tachycardia); respiratory rate (RR)=20 and temperature=98.2 F (Fahrenheit) obtained axillary (underarm), oxygen saturation=90% on room air (95-100=normal range). The narrative nursing note portion of the SBAR included the following: "Sister in to visit resident (5:46 p.m. on 6/2/17) and noted change in her. Resident awake with altered mental status. Resident was assessed and had a heart rate of 120 and O2 sat (Oxygen saturation) of 90% on room air and she was put on O2 @ 5L (liters)/minute via n/c (nasal cannula) & (and) SATs increased to 95%. BS (blood sugar)-113. She will be transferred to (local hospital's name) E.R. (emergency room), 911 called and report called to transfer center." It was annotated on the SBAR that the aforementioned assessment was reported to the physician. The resident had a current operational DNR (do not resuscitate order). LPN #2 signed off as the the licensed nurse who completed the SBAR report, as well as the nurse who was assigned responsible to

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provide care for Resident #287 on 6/2/17 for the 3/11 shift.

On 11/15/19 at 3:45 p.m., an interview was conducted with LPN #2. She stated she could not remember if she was given a report on Resident #287 when she started the 3/11 shift on 6/2/17. She stated the resident was pleasant and she did not recognize any physical problems. She stated she could not remember if she got out of bed for dinner on 6/2/17 as usual. She stated the Administrator and Director of Nursing (DON) told her the RR indicated in a letter that a minister had come in during the 3/11 shift and said he told someone about Resident #287's decrease in responsiveness and ask if she assessed the resident due to the minister's concern. She further stated she did go into the room at that time and asked the resident is she was okay, as she was looking out the window at the birds. When asked why she did not take the opportunity to make an assessment of the resident and document it in the nurse's note's she said, "I maybe should have." On 6/20/17, LPN #2 wrote a statement for the Administrator and DON that on 6/2/17 (no time) the resident was in bed and that the priest who visited stayed in the room no more than 2 minutes and came to her saying the resident was not making much sense. She wrote in her statement that she checked on the resident and asked it she was okay and that the resident said "yeha," 20 minutes later she was being sent to the E.R. This information was not shared with the Administrator or the DON prior to the start of the investigation on 6/19/17. During the interview with this writer, LPN #2 stated she could not remember whether the resident was up for dinner, but wrote in her statement the resident was in bed at the time she checked on her, which

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would have been between 5:00 and 6:00 p.m. LPN #2 also wrote that on the previous day (6/1/17 during the 3/11 shift) the resident's urine was dark and cloudy with sediment, but that it had always been that way since she had the catheter.

LPN #2 further stated during the above interview that although she signed the SBAR, she was not the person who performed the assessment on 6/2/17 at 6:12 p.m., other nurses were present and she recorded their findings. She said the RR came to the nurse's station 6/2/17 to ask that someone come to assess Resident #287 because she was not very responsive. She stated she knew the signs and symptoms of a urinary tract infection to include restlessness, behavioral changes, color and sediment of the urine, as well as a possible elevated temperature. She stated she was not sure of signs and symptoms of sepsis, but did attend the recent skills fair on 10/28/18 but was sure that was not one of the topics. This surveyor verified the skills fair 10/28/18 did not include signs and symptoms of UTI/sepsis. Recent mandatory inservices were conducted on 1/10/19 and 1/11/19 as a requirement for a partnership merger with an organization that assist with strategies to decrease in unnecessary resident readmissions to hospitals. One of the required training's included "Understanding Sepsis." Out of 60 nursing staff, four RN's attended, two of the RNs were the DON and the Assistant Director of Nursing (ADON), 7 LPNs and 16 CNAs. LPN #2 did not complete the mandatory inservice on "Understanding Sepsis".

On 1/16/19 at approximately 9:30 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON). They stated

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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 580	Continued From page 12 on 6/5/17 the RR showed up in the building and wanted to meet with the both of them and that she was tearful and expressed that the resident died the previous day. They stated they started an investigation on 6/19/17 after the Resident Representative (RR) delivered a letter under their door on 6/13/17 alleging neglect in care for Resident #287. The letter which indicated that the RR was told by the visiting minister that checked in on 6/2/17 around 2:56 p.m. that he went to the resident's room to find her moaning and staring in space. The letter indicated the minister approached the nurse's station to let them know of her condition and even mentioned it to the activities director. The activities director wrote a statement 6/19/17 that indicated on 6/2/17 at 3:45 p.m., a church volunteer told her he informed a nurse that the resident was not well and she thanked him for making the staff aware. The activities director was no longer employed by the facility and was not available for interview. The letter indicated no one checked on Resident #287 or if they had they would have taken immediate action based on her level of consciousness. The letter also indicated that when the RR arrived 6/2/17 at 5:15 p.m., she found the resident in bed and not in the dining room as per her usual routine for dinner. The RR indicated in the letter she found the resident in the same condition as the minister and unable to communicate to her what happened, thus she approached the nurse's station to report her condition at which time the the Administrator, DON and a few nurse's went to the resident's room to assess her. The letter indicated the resident was sent to the E.R. admitted to the hospital's ICU and diagnosed with a "bad urinary tract infection." The letter indicated the RR visited the resident in ICU the following day and told her she would be back, but the	F 580		

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resident died 1.5 hours later. She alleged gross neglect by the facility. The facility concluded their investigation on 6/23/17 conducted by the Administrator and DON that consisted of interviews with staff, review of facilities policy and procedures and review of medical record. They found the allegation to be unsubstantiated based on their investigation.

During the aforementioned interview, the DON was asked what was the expectation of the nursing staff in review of the nurse's notes and the documented change in condition during the 11/7 shift (6/1-6/2/17). The DON first stated, "Maybe there was no need to document anything because she was a long-term care resident and we only document by exception. They washed her up and she felt better." Upon taking a closer look, she agreed there were no documented assessments that would reflect monitoring of a possible UTI after it was noted the resident complained of burning and pain which was a potential symptom. The signs of UTI would have come from nursing actions, which would have been the results of their assessment and monitoring (e.g., vital signs, behaviors, appearance of urine) which was not evident in the clinical record (e.g., nursing notes, vital sign records). The DON agreed that there was no follow-up after pain medication administered in the early morning hours of the 11/7 shift was documented in the nurse's notes as "ineffective," as well as further follow-up on hollering and behaviors exhibited during the shift. Additionally, there were no nurse's notes on the 7/3 shift, where in the above CNA's statement she wrote the resident did not eat much, felt bad and requested to go to bed. In addition, the resident did not get up for dinner as usual which exhibited

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F 580	Continued From page 14 potential decline in physical status and a change in her normal activities. The DON then stated she expected to see vital signs obtained and recorded, level of consciousness documented, further record of the color of the urine, expounding on her behaviors they earlier documented on the 11/7 shift, as well as a call to consult with the physician or nurse practitioner to report the findings and accept guidance for any orders. The DON could not explain lack of a documented assessment from LPN #2 during the 3/11 shift, especially if she checked on the resident after she stated the minister said the resident "was not making sense." She could not explain why there was not evidence of any assessment or monitoring until the RR approached the nursing staff to insist someone address Resident #287's change in condition around dinner time on 6/2/17. When this surveyor asked to review the 24 hour reports, the DON stated she would look for them. She and the Administrator returned on 1/16/19 at 10:30 a.m. with the 24 hour report dated 6/2/17 for 11/7 and 7/3 shift which was blank, and the 3/11 block indicated the resident was "sent to the (local hospital name) E.R. at 6:20 p.m. with altered mental status/tachycardia and admitted to the ICU". During the above interview, the Medication Administration Record (MAR) was reviewed to reveal when pain medication was recorded in the nurse's notes as administered on 11/7 shift 6/2/17, the only pain medication would have been acetaminophen, which was not signed off on the MAR as given during the night shift or early morning hours. The DON stated, "She probably gave it and forgot to sign it off on the MAR." The DON stated, "I tell nurses, train nurses, but still	F 580		

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have problems. We will have to do more." The Administrator and DON presented policies that were in effect during Resident #287's stay that outlined clear guidelines for nursing assessment and monitoring and documentation of such for UTI and sepsis. A time line had been presented to this surveyor completed by the regional nurse regarding the resident's output, which was not in question but whether appropriate assessments, monitoring for signs and symptoms of UTI/Sepsis recognized by the nursing staff with notification to the physician/nurse practitioner. The time line revealed there was no assessment or monitoring throughout the 11/7 shift or on the subsequent two shifts to include vital signs or a call to the physician based on the residents expressed symptoms of burning and unrelieved pain. The time line noted that "the sister (RR) was in to visit and noted a change in the resident", after which the staff performed an assessment, exhibited in aforementioned SBAR dated 6/2/17 at 6:12 p.m. and sent her out 911. The most recent laboratory results were sent out with the resident that were obtained 4/13/17, a Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) that checked electrolytes, BUN and creatinine (renal function status) none of which warranted treatment. The Administrator and DON stated there were no other labs in 2017 to include a U/A or C&S.

On 1/16/19 at 10:45 a.m., an interview was conducted with the current Nurse Practitioner (NP). She stated she was not the NP during Resident #287's stay, but the attending physician was the same and she was currently in practice with him and felt she could give her professional take on the Resident #287's case by review of the clinical record. She also stated she would be covering for the attending over the next two days.

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F 580	Continued From page 16 From review of the nurse's notes she stated the nursing staff missed many opportunities to make good assessments and call the physician for further guidance. She stated she actually saw no assessments and monitoring even on the 11/7 shift with the lack of vital signs, visualization of urine, mental and behavioral status. She stated there appeared that nothing was done on the 7/3 and 3/11 shift until the RR informed them something was wrong. Upon review of the SBAR, the NP stated the resident had signs and symptoms of sepsis to include a temperature that was recorded obtained via axilla at 98.2 which was not reliable and 1.5 to 2.0 points would be added for an accurate temperature reading. She stated the resident had just finished antibiotic therapy on 5/27/17 for a skin infection which often can yield antibiotic resistant infections, like Methicillin Resistant Staphylococcus Aureus (MRSA) or Extended Spectrum Beta-Lactamases (ESBL-in urine) so close assessment and monitoring especially in light of what was already noted was vital with a call to physician or NP to let them know what was going on like the burning, behaviors and ineffective pain management from the medication. "The signs and symptoms of Sepsis was brewing and the nursing staff did nothing from what I can see here. To avoid sepsis, the nursing staff have to assess for the signs and symptoms, which it looked like the resident probably had them that required prompt treatment to prevent a septic situation." The NP stated with sepsis the resident's BUN and creatinine would have been elevated upon arrival to the ER with potential Acute Kidney Injury (AKI) with systems failure. During the above interview, the NP stated if there had been a call to the physician during the 11/7	F 580		

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shift on 6/1-2/17 there could have been a dip stick urine ordered STAT that would have shown nitrates and white blood cells. She stated she knows the facility had the reagent strips for the test in the nursing facility accessible to the nurses. Based on those results that are immediate, an antibiotic could have been ordered. She further stated a STAT Urine Analysis (UA) would have come back in a couple of hours at the first of any concern from the nurses that would have shown white blood cells, red blood cells, bacteria which would have also been highly suggestive of a UTI. She stated, the culture and sensitivity report within 3 days would have shown more specificity and possible need to change antibiotic choice based on sensitivity report. She said she would have also ordered a STAT Complete blood count and renal profile to assess renal function or organ failure from systemic infection. She stated if a call had been made to the attending or NP early on, an order could have also been given to the nurses to just send the resident out for evaluation in the E.R.

Review of the hospital records indicated the following: Resident arrival 6/2/17 at 6:35 p.m., vital signs-BP=99/54 (hypotension); pulse=112 (tachycardic); respiratory rate=22 (tachypnea) and temperature=99.7. Oral mucosa dry. Patient was not able to give information about condition. Labs drawn to reveal blood urea nitrogen (BUN), an indicator of renal function, of 60 (9-26=normal range); Creatinine, also an indicator of renal function, of 2.1 (0.4-1.0=normal range); venous lactic acid, an indicator of a severe infection such as sepsis and septic shock, of 6.36 (.50-2.20=normal). The U/A revealed large amounts of blood (negative is normal), positive nitrates (negative is normal); 40 WBC

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(0-5=normal); RBC TNTC (Too numerous to count) with 0-5=normal; and 15 ketones (negative=normal). The final results of the culture and sensitivity report came back on 6/6/17 that indicated an antibiotic resistant organism in the urine of ESBL greater than 100,000 and proteus mirabilis greater that 100,000. The resident was diagnosed with "severe acute sepsis and septic shock with evidence of end organ damage to include acute kidney injury (AKI)/acute kidney failure with the focus of infection likely UTI." The resident was started on Intravenous Fluids (IV) for hydration and kidney perfusion, as well as antibiotics. Resident #287 was diagnosed with severe urosepsis and septic shock with acute renal failure, also referred to as AKI (acute kidney injury). She expired on 6/3/17 at 10:00 p.m. and the cause of death was recorded due to severe urosepsis.

On 1/16/19 at 12:15 p.m., a telephone interview was conducted with the RR. She stated on 6/2/17 at around 5:15 p.m. she went to the dining room to feed the resident per her normal routine, but did not see the resident. She stated the resident "loved to eat" and was always up for meals to include the dinner meal. She stated she went to the resident's room to find her listless and unable to communicate as usual, after which she immediately went to the nurse's station to inform the nurse. She said several nurses converged in the room and started to make assessments. She said she made a suggestion that the resident be sent out to the hospital and that the nursing staff agreed with her and took action. She stated she went to the hospital visited the resident and she was not very responsive to her. She stated the resident died the following day from sepsis. The RR said she visited the nursing facility on 6/5/17

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to share some of her concerns. When she left the meeting, she stated she met a staff person in the parking lot who said she was sorry about her loss and told her a minister had been in and saw the resident in the same state, notified the nursing staff and nothing was done, no one went down to assess the resident. She said she went in to retrieve the name of minister from the visitor's log and made a phone call to him once she returned home. According to the RR, the minister recounted exactly what was told to her by the staff person in the parking lot (no longer employed by the facility). The RR stated she gathered her thoughts about what she observed and what the minister observed and felt there was delay and neglect in the care of the resident. She stated she came back to the facility on 6/13/17 with a letter and a request to address the Administrator and the DON. She said they told her "You have already spoken to us about the matter and there is nothing more to talk about." She stated she was more upset about that inference that she could not talk to them than anything, so she slipped the letter under the door and heard no further word from them. This surveyor reviewed the visitor's log that verified a minister from the church and same name she indicated visited residents on 6/2/17 from 2:35 to 4:25 p.m.

On 1/17/19 at 2:13 p.m., another surveyor completed the infection control review with the DON and the ADON. This surveyor stated the DON and ADON told her regardless of whether a resident had a indwelling urinary catheter or not, they expected assessment and monitoring to take place for resident's that exhibited signs and symptoms of UTI to ensure prompt treatment and to avoid sepsis. They told the surveyor the

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physician should be called, and a urine dip stick could be ordered by the physician for immediate results and or a U/A and C&S. They indicated during the interview changes in condition that warranted immediate attention related to potential sepsis included elevated temperature, low BP, confusion, behavioral changes and pain, abnormal O2 saturation, increased respiratory rate, and a results of a glucose finger stick if diabetic, as well as a call to the physician. They showed the surveyor an algorithm (dated 2014) the facility used to recognize UTI/sepsis that indicated the same, in addition to evaluation of the ordered labs by the physician and decision to treat in the facility with Oral, IV or subcutaneous fluids if needed for hydration, as well as antibiotics, close monitoring with further evaluation in the E.R..

The facility's policy and procedures titled Infections-Clinical Protocol dated revised July 2016 indicated that infection may be suspected based on clinical signs and symptoms and/or temperature. The policy indicated for anyone suspected of having an infection (abrupt change in function, appetite, mental status, etc.), nursing staff will obtain a complete set of vital signs (temperature, heart rate, blood pressure, and respiratory rate) and will identify and document specific details of symptoms and physical findings. Nursing will notify the physician or provider of all pertinent details about the residents condition. The nursing staff will continue this form of monitoring and assessment. The nursing staff and physician or provider will identify possible complications of infection such as sepsis and delirium. Based on the preceding information, the decision would be made by the physician or provider whether additional testing

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(CBC, U/A to check for WBC, pus and nitrate level) is indicated and whether other active conditions related to infection also need treatment.

The facility's policy and procedures titled Notification of Change in Condition dated 11/30/14 indicated the nurse would promptly notify the physician and RR when there is a significant change in the patient/resident's physical, mental, or psychosocial status with a need to start or alter treatment significantly, treat an acute condition or be aware of exacerbation of a chronic condition and/or need to transfer.

The facility implemented a plan of correction effective 7/18/17 resulting from deficient practice related to physician notification identified on the previous annual recertification survey ending 6/15/17. The plan of correction included the following interventions:
1. Resident's physician was notified...
2. A quality monitoring tool was completed on 6-27-17 to identify any resident's with an order for an urinalysis and to identify any resident who have had a change in condition in the last 30 days.
3. Director of Nursing or designee educated staff on policy and procedure for notifying physician...
4. The director of clinical services or designee to monitor Nurses notes, SBAR's and physician orders daily and a quality monitor to be performed 3 times per week for 4 weeks on each shift to ensure compliance with Notification of physician and responsible party and then 1 time weekly for one month then quarterly thereafter. The results of the quality monitoring to be discussed at QAPI meeting for review, analysis and further recommendations.

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F 580	Continued From page 22 5. A.O.C is July 18, 2017. No additional deficient practice was cited after the AOC (allegation of compliance) date. COMPLAINT DEFICIENCY	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		3/1/19

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F 584	Continued From page 23 §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, staff interviews and facility documentation the facility staff failed to ensure resident equipment, to include the standup weight scale, five hoyer lifts, two sit to stand lifts and the wheelchair for Resident #79, was maintained in a sanitary manner. 1. The facility staff failed to ensure that the standup weight scale, five hoyer lifts, and two sit to stand lifts were maintained in a sanitary manner for the residents. 2. The facility failed to ensure that Resident #79's wheelchair was clean. The findings included: 1. On 01/14/19 1:08 PM the following observation was made. The standup weigh scale in hallway between Rosewood and Meadowland halls was noted to be dirty with copious amounts of dust and debris on the scale. Also, 5 hoyer lifts and 2 sit to stand scales in the shower room were observed to also be dirty with copious amounts of dust and debris noted on the scales.	F 584	1. Resident # 79 wheelchair was cleaned on 1-17-2019 , the sit to stands lifts , 5 hoyer lifts and the scale were cleaned on 1-16-2019. 2. A quality monitoring tool was utilized to ensure all wheelchairs were cleaned and also a quality monitoring tool was completed on all lifts and scales on 1-18-2019. 3.Staff were re- educated on the policy and procedure for cleaning wheelchairs and equipment on 1-21-2019 by ED and ADON .DCS implemented a wheelchair cleaning schedule. 4.ED/DCS or designee to monitor the quality monitoring tool weekly times 1 week and then 3 times a week for 1 month and then quarterly thereafter . Results of quality monitoring tool to be discussed at QAPI meeting for review, analysis and further recommendations.	

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On 01/15/19 2:45 PM the following observation was made. The standup weigh scale in hallway between Rosewood and Meadowland halls was still noted to be dirty with copious amounts of dust and debris observed on the scale. Also the 5 hoyer lifts and 2 sit to stand scales in the shower room continued to be dirty with copious amounts of dust and debris noted on them.

On 01/16/19 12:08 PM the following observation was made. The standup weigh scale in hallway between Rosewood and Meadowland halls continued to have copious amounts of dust and debris observed on it. Also, the 5 hoyer lifts and 2 sit to stand scales in the shower room were observed still having copious amounts of dust and debris noted on them.

On 1/16/18 12:15 PM an interview was conducted with the Director of Housekeeping. The Director of Housekeeping was asked if he saw anything wrong with the stand up scale. The Director of Housekeeping stated, "It's very dusty and dirty but housekeeping doesn't clean any of the scales because its not in our contract. I think they are cleaned by nursing the CNA's (Certified Nursing Assistants)." The Administrator was asked to come to the area where all the scales were located. On 1/16/18 at 12:20 PM the Administrator was asked what she thought of the scales. The Administrator stated, "They are very dusty and dirty. I will have to check our contract I thought housekeeping was supposed to clean the standup scale and the CNA's are supposed to clean the hoyer lifts and the sit to stand scales on the 11-7 shift when they clean the wheelchairs."

The facility policy titled "Hospitality Services" effective date 11/30/14 was reviewed and

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documented in part, as follows:

Policy: Standards for routine cleaning of all interior spaces will be followed, including, but not limited to patient rooms, patient and public baths, tub and shower rooms, closets, utility rooms, offices, diet kitchens, storage spaces, TV and sitting rooms.

Procedure: The Hospitality Services Supervisor will: Ensure the cleanliness of all interior areas indicated above.

On 1/17/19 at 4:33 PM a pre-exit de-briefing was conducted with the Administrator, Director of Nursing and the Regional Director of Clinical Services where the above information was shared.

Prior to exit no further information was provided.

2. Resident #79 was admitted to the facility on 01/27/2017. Diagnoses included but were not limited to, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus.

Resident #79's most recent MDS was a Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/21/2018 was coded with a BIMS (Brief Interview for Mental Status) score of 14 which indicated the resident's cognition was intact. The Minimum Data Set coded Resident #79 as requiring supervision with assistance of 1 with transfers, walking in room and corridor, and locomotion on and off unit. Under Section G 0600 Mobility Devices on the assessment, Resident #79 was coded for walker and wheelchair (electric).

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During the interview process on 01/15/2019 at 10:30 a.m., Resident #79's base of wheelchair under the seat was observed to be very dusty, the foot plates were heavily soiled with dirt and hair was in the wheels. At approximately 2:00 p.m., observed Resident #79's wheelchair and it remained soiled and with hair in the wheels.

On 01/16/2019 at approximately 10:00 a.m., observed Resident #79's wheelchair; it remained soiled and with hair in the wheels.

On 01/16/2019 at 1:48 p.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON was asked, "When are the wheelchairs cleaned?" The ADON stated, "Wheelchairs are cleaned on nights." The ADON was asked to walk down to Resident #79's room to look at her wheelchair. The ADON was asked, "What do you see?" The ADON responded by saying, "Looks like dirt." The ADON also said that the resident doesn't go outside. The ADON stated that the managers give the cleaning schedule to the Certified Nursing Assistant's (CNA's) and the managers oversee. The ADON was asked, "What are your expectations for cleaning wheelchairs?" The ADON stated, "The wheelchairs should be cleaned from the wheels to the top. Does not look like it's been cleaned."

On 01/16/2019 at approximately 2:15 p.m., an interview was conducted with Resident #79 and she stated, "The staff just wiped my wheelchair off." Per observation, continued to note dirt on the wheelchair foot plates. Resident #79 said that she was going to clean the foot pedals herself, that night, with a toothbrush. Resident #79 was asked, "When was the last time the staff cleaned your wheelchair?" Resident #79 responded, "About 6

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months ago; had to ask them to do it."

On 01/16/2019 at 3:40 p.m., an interview was conducted with the ADON. The ADON provided staff documentation, dated 12/04/2018 and 12/18/2018, for the cleaning of Resident #79's wheelchair. The ADON also stated that this was the last documentation stating when Resident #79's wheelchair was last cleaned. The ADON stated that Registered Nurse (RN #1) was the nurse on duty on 12/04/2018 and 12/18/2018 when the wheelchairs were cleaned.

On 01/17/2019 at 12:35 a.m., an interview was conducted over the phone with RN #1. RN #1 was asked, "How often are the wheelchairs cleaned? RN #1 stated, "The wheelchairs are cleaned weekly according to a schedule. Each night a certain number of wheelchairs are cleaned according to the room number. The staff go by the shower schedule since the staff don't give showers at night." RN #1 was asked, "Do the staff document after cleaning a wheelchair?" RN #1 said "yes." RN #1 was asked, "Who oversees to ensure wheelchairs are cleaned?" RN #1 responded, "The nurses on the units oversee."

On 01/17/2019 at 11:15 a.m., Resident #79's wheelchair was observed to be cleaned, free of dirt and hair.

On 01/17/2019 at 11:35 a.m., an interview was conducted with the ADON. The ADON was asked if she had any other documentation stating that Resident #79's wheelchair was cleaned after 12/18/2018. The ADON stated, "No."

On 01/17/2019 at approximately 4:45 p.m. at pre-exit meeting the Administrator and the

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F 584	Continued From page 28 Director of Nursing was informed of the findings. The Director of Nursing was asked, "What are your expectations of cleaning resident wheelchairs?" The Director of Nursing stated, "Wheelchairs should be cleaned twice a week along with the shower schedule and as needed." The facility did not present any further information.	F 584		
F 622 SS=D	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	F 622		3/1/19

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F 622	Continued From page 29 resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this 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	F 622		

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necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review and facility documentation review the facility staff failed, for 1 of 48 residents in the survey sample, to send a copy of the Resident's Care Plan (Resident #78) after being transferred to the hospital on 10/24/18.

The facility staff failed to send Resident #78's care plan when discharged and admitted to the hospital on 10/24/18.

The findings included:

Resident #78 was originally admitted on 06/02/17 with a readmission date of 10/26/18. Diagnosis for Resident #78 included but not limited to *Lewy Body Dementia and *Muscle Weakness and Atrophy (muscle wasting).

The current Minimum Data Set (MDS), a quarterly

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1. Residents # 78 has been re- admitted to facility.
2. A quality monitoring tool was utilized to monitor residents transferred to the hospital within the last 30 days to ensure the care plan was sent to the hospital with the residents.
3. Staff were re- educated on the policy and procedure for sending the care plan to the hospital when a resident transfers on 1-21-2019 .
4. DON/ADON or designee will monitor the quality monitoring tool weekly times 1 week and then 3 times a week for 4 weeks and 1 times a week for a month and then quarterly . The results of the quality monitoring to be discussed at the QAPI meeting for review , analysis and further recommendations.

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assessment with an Assessment Reference Date (ARD) of 12/21/18 coded the resident with a 05 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicates severe cognitive impairment.

The Discharge MDS assessment was dated for 10/24/18-return anticipated.

On 10/24/18, according to the facility's documentation created by the Director of Nursing (DON) at approximately 09:52 a.m. Resident #78 got up alone to go to the bathroom without calling for assistance. Resident #78 loss his balance and fell hitting the back of his head. The facility's documentation also stated the following, "Resident needed to go to bathroom, had on shoes/hit the back of his head, neuro assessment done, vital signs taken, change in condition later sent to the Emergency Room (ER) and admitted." Resident returned to the facility on 10/26/18.

An interview was conducted with the Administrator and DON on 01/15/19 at approximately 9:55 a.m. The Administrator stated, "The nurses usually print and send the resident's care plan with them when they are discharged out to the hospital but it was not done on this particular resident."

The facility administration was informed of the findings during a briefing on 01/17/19 at approximately 5:30 p.m. The facility did not present any further information about the findings.

The facility's policy titled Transfer/Discharge Notification & Right to Appeal (Revision date: 03/26/18).

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F 622	Continued From page 32 Policy: Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements. Procedure to read in part: -Documentation: Information provided to the receiving provider must include but is not limited to: -Special care instructions or precautions for ongoing care as indicated. -Comprehensive care plan goals. -All other necessary information, including copies of the resident's discharge summary and other documentation, as applicable to ensure safe and effective transition of care. *Lewy body dementia causes a progressive decline in mental abilities. People with Lewy body dementia may experience visual hallucinations and changes in alertness and attention (www.mayoclinic.org). *Muscle Weakness is reduced strength in one or more muscles (https://medlineplus.gov/ency/article/007365.htm).	F 622		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the	F 626		3/1/19

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F 626	Continued From page 33 State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on a closed clinical record review, staff and Resident Representative interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to allow 1 of 43 residents (Resident # 85) to return to the facility once medically cleared after hospitalization. The findings include: Resident #85 was originally admitted to the facility	F 626	1. Resident # 85 is no longer in facility . 2. A quality monitoring tool was completed for all discharges in last 30 days to ensure compliance on 1-21-2019. 3. ED/ ADON re-educated staff on the policy and procedure for allowing a residents to return to facility on 1-21-2019 . 4.ED / SSD or designee to monitor quality monitoring tool 1 times a week for 1 week and then 3 times a week for 4 weeks and	

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06/21/16 and readmitted 07/23/16. The resident was discharged from the facility on 07/01/17. Resident # 85 diagnoses included catheter associated urinary tract infection, sepsis, hematuria, and hypertension.

The Significant Change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/30/16 coded the resident as not having the ability of completing the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired for daily decision making.

In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 1 person with transfers, bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing

A telephone interview was conducted with Resident #85's daughter (daughter #1) at approximately 1:50 PM. She was notified that the survey team was onsite. She stated she was pleased the complaint was being looked in to and asked if her brother and sister be called as well for further input. There were no additional concerns but the Resident's daughter elaborated on the concern. The Resident's daughter (# 1) stated that they took her mom out of the facility to attend a family event. The resident had an indwelling catheter. The Resident's daughter (#1) stated that shortly after her mother was picked up from the facility the family noticed the resident was bleeding. The resident was transported to the hospital ER for evaluation. The daughter stated the facility refused to accept resident # 85 back into the nursing facility.

then 1 time a week for 1 month and then quarterly thereafter . Results of the quality monitoring to be discussed at QAPI meeting for review, analysis and recommendations.

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A telephone interview was conducted with the son (Responsible Party/POA) of Resident #85 on 01/15/19 at 8:45 PM. His chief concern was that the hospital informed him that the nursing facility wasn't going to accept the resident back into the nursing facility. He said that someone in the nursing facility stated "that it was best to find another facility for placement."

A telephone interview was also conducted with Resident # 85's other daughter (daughter# 2) on 01/16/2019 at 12:10 PM. She stated that she was informed by the social worker at (Hospital Name) that they did not accept resident back in the nursing facility (NF) because of the daughter's (sister of daughter # 2) behavior. Daughter # 2 stated that she spoke to a staff member (name unknown) at the nursing facility and they informed her of the above. She said that no further contact was made with the facility. She stated that she was informed that they could pick up Resident's belongings in the hallway of the lobby.

The nursing facility progress notes were reviewed and included the following documentation:

On 06/28/17 at 10:30 AM, a meeting was held with the son (RP/Responsible Party/POA-Power of Attorney) and daughter related to concerns of the family and behaviors noted with the family on visits to see the resident. The following concerns were made from the Interdisciplinary Team (IDT): Concerns were made about daughter # 1 coming in taking pictures of resident's buttocks, repositioning the resident then complaints that her knee is swollen. Daughter wanting resident taken to the emergency room when the facility MD/Nurse Practitioner is present when there's no

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emergency situation. In closing, the son of the resident stated that he was sorry for the way his sister has been acting and that he will take another step to prevent her from visiting because it's not healthy or productive for his mother or for him related to the things that she is doing. The staff also discussed that both daughters of the resident stop bringing in foods that are difficult for the resident to chew and swallow.

On 06/29/17 at 15:30 (3:30 PM) a 16 French 10 cc Foley catheter was inserted, resident tolerated procedure and that the responsible party (resident's son) was made aware of the insertion.

On 06/29/17 at 15:40 (3:40 PM), per family and intervention related to excoriation to buttocks, per family request and MD order, a 16 French 10 cc Foley catheter was inserted. The progress note read that the excoriation is resolving. The Foley catheter will remain in place until excoriation resolves.

On 07/01/17 resident left the facility with her daughter to attend an outing at 15:01 (3:01 PM). Resident was alert and verbally responsive with no new changes observed at this time. Tolerated all medications. Denies pain/discomfort. No new changes to skin integrity noted at this time, Foley catheter care provided, intact draining amber color urine.

A review of progress notes dated on 07/01/17 at 17:30 (5:30 PM) included that nursing staff spoke to RP (Responsible Party) to inform him that resident was admitted to the hospital. The RP stated that he was aware of his sister taking the resident to the emergency room

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A review of progress notes dated on 07/01/17 at 18:00 (6:00 PM) noted by the Director of Nursing, included that the facility was notified that resident was admitted to (Hospital Name).

A review of progress notes states that resident was taking to the Emergency Room for hematuria (blood in urine) in her catheter. The son was called and notified by the nurse at 18:20 (6:20 PM). The son was also called on 07/02/17 to see what the diagnoses was and he reported that his sister never told him. The hospital released no information on 07/01/17 and 07/02/17.

The Emergency Room hospital notes were obtained and reviewed. The notes revealed the following: on 07/01/17 at 8:14 PM "patient to the ER (Emergency Room) with blood in urine." "Patient is non-verbal." " Patient's family noticed blood in patient's Foley catheter." "Per family Foley catheter placed two days ago." " Patient's daughter states that patient was "crying out in pain." On 07/02/17, states patient's genitourinary system shows patient is positive for hematuria.

A review of Hospital progress notes revealed the following: History and Physical notes dated on 07/02/17 at 3:34 AM included that Resident #85 was observed to be confused and altered at family reunion as well as family noticed blood in the Foley catheter. Patient's diagnosis was Catheter Associated Urinary Tract Infection. As evidenced by pyuria, leucocyte esterase and bacteria on urinalysis. She was given Levaquin in the Emergency Room. They will continue antibiotics with Zosyn to cover pseudomonas. To follow up on urine culture. The patient was also diagnosed with having Toxic metabolic Encephalopathy; secondary to sepsis. On

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07/05/17 at 9:47 AM the note read: the patient does have a history of renal calculi, her current urinary tract infection maybe associated with the recent placement of a Foley catheter.

Information documented on 07/06/17 at 11:35 AM revealed that two nursing facilities declined admissions due to no available LTC (Long Term Care) beds per the hospital Utilization Review Manager.
A continual review of medical records state on 07/11/17 at 12:43 PM that the patient has been accepted for LTC bed at a nursing facility. Family was informed family at bedside. Son is now back from out of town and reports he may want to go visit the facility first.

The hospital documentation on 07/12/17 at 11:45 AM read that the Utilization Manager spoke to the family by phone and they are in agreement with resident being transferred to another nursing facility. The facility was contacted to see if they could still accommodate.
Documentation read that "Case Manager will notify MD once confirmed."

A review of progress notes dated on 07/12/17 at 12:02 PM stated that a nursing facility was able to accommodate patient for Long Term Care on 07/13/17. MD was paged to confirm. Medical record dated on 07/12/17 at 3:15 PM, revealed that patient was accepted to a Skilled Nursing Facility: "Disposition to nursing facility tomorrow." Further documentation revealed that resident was discharged from the hospital on 07/13/17 and did not return to the nursing facility.

A note was received from the Admissions Coordinator from the nursing facility on 01/16/19

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which read that she had tried to reach the resident's POA. A message was left on his voicemail asking him if he wanted the facility to do a "bed hold" for his family member while she was hospitalized. The note was signed and dated on 07/05/17 at 11:06 AM. The admissions coordinator was asked if there was a bed hold in place or was the ombudsman notified, she stated no, because there was no system in place at the time.

On 01/16/19 at approximately 10:15 AM an interview was conducted with the facility Social Worker concerning family grievances filed concerning this matter. She stated that there were no records of grievances on file.

On 01/16/19 an interview was conducted with the facility Administrator concerning resident # 85. She presented a memo of records dated on 07/11/17 stating that the residents son came to the facility requesting his mother's medical records. He also stated that his mother was transferred to another facility.

On 1/17/19 at approximately 11 AM an interview was conducted with LPN (Licensed Practical Nurse) # 6 concerning the resident and her family. She stated that family was very nice and attentive to resident. Not aware of any other events.

On 1/17/19 at approximately 11:10 AM an interview was conducted with CNA (Certified Nursing Assistant) # 5 concerning resident #85 and her family. She stated that she had a very good rapport with the resident's family and that the Resident's daughter mentioned she wanted to move her back home.

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On 1/16/19 at 2:55 PM a phone call was received from the Inpatient Director Of Care Coordination, from the hospital where Resident #85 was admitted to on 07/01/17. She stated that she received a phone call from Resident's daughter (#1) to provide us with any important information. The Care Coordinator said that the computer response system from the nursing facility declined the patient's admission on 7/05/17 1:53 PM.

A phone call was received from the Inpatient Director of Care from the hospital on 01/16/19 at 3:37 PM concerning Resident # 85 declined readmission to the nursing facility. The Inpatient Director of Care said that the hospitals internal discharge planning information system read that the nursing home Administrator declined admission. She also stated that a recent status was changed to "decline due to non-compliance" per the hospital computer system.

On 1/17/19 the daily census was received from the nursing facility Admissions Coordinator. The following dates and beds available were documented: 07/06/17, had 7 open rooms available; on 7/7/17, had 7 open rooms available; on 7/8/17, had 9 open rooms available; on 07/09/17, had 9 open rooms available; on 7/10/17 had 9 open rooms available; on 07/11/17, had 9 open rooms available.

On 1/17/19 an interview was conducted with the Admissions Coordinator at the nursing facility concerning how the facility receives alerts when a resident is ready to return from the hospital. She stated that the hospital computer discharge system will send alerts, giving all information

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through their computer system. "Then they will review clinical and insurance information to see if they meet the needs of the facility." They will send internal and external messages between the coordinator and case manager/care liaison. "Care liaison is in the system that work on weekends." She stated, "Once the information is received that someone is ready to return back to the facility" and "When a patient returns to baseline the resident will return to the facility." The Admission's Coordinator stated that somebody else received the referral before she received it.

The facility's policy titled/date- Bed Hold effective 03/01/2015, revised on 11/01/17 was reviewed and included:
POLICY: Resident or Resident Representative will be notified on admission, and at the time of transfer (to the hospital or therapeutic leave) of bed hold policies, according to Federal and /or State requirements. PROCEDURE: #2 States at the time of transfer to the hospital of therapeutic leave, the center will provide a copy of notification of bed hold. #3 The resident or resident representative to sign the bed hold authorization, of possible, or if not available, telephone authorization may be used and documented in the clinical record or on a bed hold authorization form.
#4. A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the center to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident (A) Requires the services provided by the center; and (B) Is eligible for Medicare skilled nursing center services or Medicaid nursing center services.

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F 626	Continued From page 42 An interview was conducted with the Administrator on 01/17/19 at approximately 3:30 PM. She stated they did not have a bed available in the facility. She stated she never denied the resident from returning to the facility. The Director of Nursing was not available for comment. During the debriefing on 1/17/19 at 3:55 PM , no further information was offered by the Administrator. Complaint deficiency.	F 626		
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, staff interviews and facility documentation, the facility staff failed to ensure that 2 of 43 residents (Resident #86B and 48) in the survey sample received a complete and accurate assessment Minimum Data Set (MDS). 1. The facility staff failed to ensure the discharge MDS for Resident #86B was accurately coded for discharge to home. 2. The facility staff failed to ensure the Admission MDS for Resident #48 was accurately coded for hospice services. The findings included; 1. Resident #86 B was originally admitted to the	F 641	1. Resident # 86B and resident #48 MDS was modified on 1-15-2019. 2.A quality monitoring tool was completed on 1-21-2019 for residents discharged in last 30 days and any assessment that needed modification was completed. 3. Staff were re-educated on MDS accuracy on 2-5-2019 by regional case mix coordinator. 4. RCMC or designee will monitor the quality monitoring tool 1 time a week for 1 week and then 2 times a week for 4 weeks then 1 times for 1 month and then quarterly thereafter . Results of quality monitoring to be discussed at QAPI meeting for review , analysis and recommendations.	3/1/19

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facility 10/05/2018 and was discharged from the facility on 10/19/2018, therefore a closed record review was conducted. The diagnoses included Acute Diastolic Congestive Heart Failure, Muscle Weakness, History Of Falls, Difficulty Walking, Type II Diabetes Mellitus, Alcohol Dependence, Hypertension.

Resident # 86 B had a quarterly MDS assessment completed with an ARD (Assessment Reference Date) of 10/19/18. MDS coded the resident completing the Brief Interview for Mental Status with a score of 15 which indicated intact cognition.

The 10/05/18 admission MDS at section "A" Identification Information was coded as follows: Section A2100 was coded as Resident having a discharge status as "Acute Hospital" instead as being discharged to the community.

On 01/16/19 at approximately 2:30 PM, the DON, (Director Of Nursing) was asked to review the MDS section "A" concerning Resident #86B's discharge. She stated that she was the one who signed off on the MDS, and that she would get back with me later.

On 01/16/19 at approximately 3:00 PM, the Administrator was asked to provide copies of Resident #86B's discharge summary and progress notes.

The discharge summary note dated on 10/18/18 at 10:07 AM was electronically signed by the nurse practitioner, included "patient to follow up with (PCP) Primary Care Physician in 1 week following discharge." "Patient to go home with home health on discharge."

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The Social Services progress note dated on 10/17/18 at 10:49 AM included: "states discharge home on Friday 10/19/18, He does not need any (DME) Durable Medical Equipment upon discharge and that the resident declined Home Health at first, but then stated if it was needed that he will take it."

The Social Services progress note dated 10/17/18 at 17:17, included: "His daughters will be picking him up on Friday 10/19/18 at 9 AM to transport him home.

On 01/16/19 at approximately 2:30 PM, the Director of Nursing (DON) was asked to provide the facility's policy on MDS assessments.

On 01/16/17 at approximately 2:45 PM the above findings were shared with the Administrator. No additional information was provided.

On 01/17/19 at 5:30 PM a pre-exit interview was conducted. The Facility Administrator, Director Of Nursing, Assistant Director Of Nursing and the Regional Director Of Clinical Services were present. No additional information was provided by the facility staff concerning Resident # 86.

The facility's policy titled MDS, with a revision date of 9/25/17 read; the center conducts initial and periodic standardized, comprehensive and reproducible assessments no less than every 3 months for each resident ... Procedure #3 read; each person completing a section or portion of a section of the MDS signs the attestation statement indicating its accuracy.

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2. Resident #48 was originally admitted to the facility 12/4/18 and has never been discharged from the facility. The current diagnoses included; chronic kidney disease, high blood pressure and an anxiety disorder.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/12/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of 15 which indicated the resident was with severely impaired daily decision making abilities.

In section "O0100k2"of the 12/12/18, MDS assessment; the resident was not coded for hospice care while a resident.

A physician's order dated 12/5/18 revealed an order for (Name) Hospice services for a diagnosis of end stage kidney disease.

The active care plan dated 1/13/19 had a problem reading; discharge plans (name of the resident) is here for long term care/hospice. The goal read; The resident will express satisfaction in nursing home placement as evidenced by positive verbalization/verbal expressions by 3/1/19. The interventions included; Allow time to express feelings, concerns and fears as needed. Medications as ordered.

An interview was conducted with the MDS Coordinator on 1/16/19 at approximately 1:30 p.m.; the MDS Coordinator stated the 12/12/18, MDS assessment was not coded for hospice care but; it should have been coded for hospice care. At approximately 4:35 p.m., the MDS Coordinator stated a modification was made to the 12/12/18,

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F 641	Continued From page 46 MDS assessment and presented a copy of the modified assessment. The facility's policy titled MDS, with a revision date of 9/25/17 read; the center conducts initial and periodic standardized, comprehensive and reproducible assessments no less than every 3 months for each resident ... Procedure #3 read; each person completing a section or portion of a section of the MDS signs the attestation statement indicating its accuracy. On 1/17/19, at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Administrator stated she was aware of the inaccurately coded MDS assessments.	F 641		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be	F 660		3/1/19

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F 660	Continued From page 47 updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent	F 660		

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F 660	Continued From page 48 the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, a complaint investigation and staff interviews, the facility staff failed to provide one (Resident #285) of 43 residents in the survey sample, with adequate discharge planning. The facility staff failed to ensure the discharge destination met the resident's needs for health and safety and preference. The findings included: Resident #285 was admitted to the facility on 12/16/17 with diagnoses which included chronic embolism and thrombosis of unspecified deep vain of lower extremity, bilateral impingement syndrome of right shoulder, muscle weakness, spinal stenosis, cervical region, peripheral vascular disease, anxiety disorder, hypertension, angina, major depression disorder recurrent, xerosis cutis, cellulitis of right lower limb.	F 660	1. Resident #285 is no longer in the facility. 2.A quality monitoring tool was completed on all discharges in the last 30 days to ensure that staff developed and implemented and effective discharge plan to include the resident in the discharge process and to ensure the discharge needs of the resident were identified on 1-21-2019 . 3. ED/ADON re-educated staff on discharge process on 1-21-2019. 4. ED / SSD or designee to monitor quality monitoring tool weekly times 1 week , then 3 times a week for 4 weeks and then 1 time a month and then quarterly thereafter. Results of quality monitoring to be discussed at QAPI meeting for review, analysis and recommendations .	

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F 660	Continued From page 49 A Quarterly Minimum Data Set (MDS) dated 09/21/18 assessed this resident as able to make himself understood and able to understand others. This resident was assessed as having adequate hearing and speech. In the area of Brief Interview for Mental Status (BIMS) the resident was as assessed at a (15)-intact cognition. The resident was assessed in the area of Activities of Daily Living (ADL'S) as requiring limited assist with bed mobility, dressing, and eating. The resident was assessed as not able to walk and required extensive assistance with toileting and personal hygiene. In the area of swallowing and Nutritional Status the resident was assessed as being 84 inches in height and weighing 418 pounds. In the area of Discharge Planning Resident #285 was assessed as not having active discharge planning. In the area of Return to Community this resident was assessed as not wanting to talk about the possibility of leaving the facility and returning to live and receive services in the community. A Care Plan revised on 11/27/18 included: Focus-The resident has the potential for altered psychosocial well being. Major Depressive Disorder recurrent and Anxiety Disorder. Due to him being unable to return to the community due to his need for nursing home level of care. 8/21/18 reported verbal allegation of abuse between roommate and staff member. 11/22/18 Resident made a complaint. Goal-The resident will verbalize emotions appropriately through the review date. Resident #285 will verbalize decreased episodes of anxiety, depression through the review date. Interventions-DON (Director of Nursing) attempted to talk to the	F 660		

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F 660	Continued From page 50 resident but he will not talk. Complaint investigated (Date initiated 11/26/18). New med per the Nurse Practitioner as ordered (Date initiated (11/26/18). A Discharge Care Plan dated 12/03/18 included: Resident #285 wishes to transfer to another facility when a bed is available. He wishes to be closer to his son/family. Goal-Resident will be transferred to another facility when a bed is available per his wishes (date initiated 02/21/18). Fax clinical's to other facilities in order for them to consider transfer (date initiated 12/03/18). Set up stretcher transportation when his transfer is finalized (Date initiated 12/03/18). A Social Service Progress Note dated 12/03/18 at 14:02 P.M. (2:02 P.M.) indicated: "D/C (discharge) Note- Resident #285 will be transferring to a new facility. He has been requesting a transfer to a facility that was closer to family in order for his son to visit more. A bed became available today. Stretcher transportation will be set up for his transfer." A Nurse Practitioner Progress note dated 12/03/18 at 14:08 P.M. (2:08 P.M.) indicated: "This is a 52 year old male with an extensive history of blood clots. Within the past year patient was admitted and treated for cellulitis. Sent (sic) to an inpatient rehab facility until surgery for cervical stenosis could be arranged. He later obtained Surgery which was fusion of the cervical spine. He later was diagnosed with multiple DVT requiring a filter to be placed in the event of clot mobility. During his stay patient complained of leg swelling, a venous Doppler was ordered which was + (positive) for DVT however patient was known to have these clots on admission. We	F 660		

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have gone back in forth with ted hose due to patients leg size, patient needs to be measured and special stocking ordered. He also inquired about gastric bypass during his stay but due to transportation complications patients appointment was rescheduled. Over all patient is pleasant with myself and was a delightful patient."

A Nursing note dated 12/03/18 at 21:30 (9:30 P.M.) included: "Transportation arrived to transfer patient. The (sic) was a substantial delay secondary to an unwitnessed conversation between the transport team and the patient. Eventually a supervisor arrived and patient was assisted onto stretcher by 6. On the way out the team stopped to pick up the patients discharge paperwork. Staff asked the patient to sign his discharge instructions and the patient stated, I am not signing _____ you all screwed me over now I am going to screw you over, now get out of my face. Transferred to another facility two hours a way in company of transport team."

During an interview on 1/16/19 at 2:15 P.M. with the Director of Social Services she stated, Resident #285 had been attempting to relocate to a facility closer to his son who lives about 4 hours from the facility. The Social Service Director stated a bed became available at a sister facility which would place the resident about two hours from his family vs the four hours current distance. The Social Service Director was asked if any any information regarding the new facility had been presented to the resident for his approval? The Social Service Director stated, No. "He had been asking for a transfer and a bed became open at the sister facility."

During an interview on 1/17/19 at 2:20 P.M. with

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F 660	Continued From page 52 the Administrator she was asked if Resident #285 had been presented with information regarding the new facility prior to transfer. The Administrator stated, staff had been working with him on finding a facility closer to his son. The Administrator was asked why the Nurse Practitioner had written discharge orders only hours prior to Resident #285 discharge she stated, the bed only became open today. When asked if Resident #285 had any special needs. The Administrator stated, he required a bariatric bed because of his weight. The facility he was being transferred to did not have a bariatic bed available when Resident #285 arrived at the new facility. The Administrator was asked why was there not a bariatric bed available for Resident #285 when he arrived. The administrator stated, it was an oversight. The Administrator was asked what happened to Resident #285 during this wait. She stated, the facility was able to locate a bariatric bed after several hours. The facility staff failed to develop and implement an effective discharge plan, include the resident in the discharge process and ensure the discharge needs of the resident were identified. Compliant Deficiency.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab,	F 661		3/1/19

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F 661	Continued From page 53 radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review, a complaint investigation and staff interviews, the facility staff failed to provide one (Resident #285) of 43 residents in the survey sample, with a recapitulation of the resident's stay. The facility staff failed to ensure discharge planning to include a summary of care to care for the resident after discharge. The findings included: Resident #285 was admitted to the facility on 12/16/17 with diagnoses which included chronic embolism and thrombosis of unspecified deep vain of lower extremity, bilateral impingement	F 661	1. Resident # 285 is no longer in the facility. 2. A quality monitoring tool was completed on 1-21-2019 for residents that discharge in the last 30 days to ensure compliance . 3. ED/ADON re-educated staff on 1-21-2019 on the policy and procedure of the discharge summary. 4. ED/SSD or designee to monitor the quality monitoring tool weekly times 1 week then 3 times a week for 4 weeks and then 1 times a week for a month and quarterly thereafter. Results of quality monitoring tool will be discussed at QAPI meeting for review, analysis and recommendations.	

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syndrome of right shoulder, muscle weakness, spinal stenosis, cervical region, peripheral vascular disease, anxiety disorder, hypertension, angina, major depression disorder recurrent, xerosis cutis, cellulitis of right lower limb.

A Quarterly Minimum Data Set (MDS) dated 09/21/18 assessed this resident as able to make himself understood and able to understand others. The resident was assessed as having adequate hearing and speech. In the area of Brief Interview for Mental Status (BIMS) the resident was as assessed at a (15)-intact cognition. The resident was assessed in the area of Activities of Daily Living (ADL'S) as requiring limited assist with bed mobility, dressing, and eating. The resident was assessed as not able to walk and required extensive assistance with toileting and personal hygiene.
In the area of swallowing and Nutritional Status this resident was assessed as being 84 inches in height and weighing 418 pounds.
In the area of Discharge Planning Resident #285 was assessed as not having active discharge planning. In the area of Return to Community the resident was assessed as not wanting to talk about the possibility of leaving the facility and returning to live and receive services in the community.

A Care Plan revised on 11/27/18 included:
Focus-The resident has the potential for altered psychosocial well being. Major Depressive Disorder recurrent and Anxiety Disorder. Due to him being unable to return to the community due to his need for nursing home level of care. 8/21/18 reported verbal allegation of abuse between roommate and staff member. 11/22/18 Resident made a complaint. Goal-The resident

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F 661	Continued From page 55 will verbalize emotions appropriately through the review date. Resident #285 will verbalize decreased episodes of anxiety, depression through the review date. Interventions-DON (Director of Nursing) attempted to talk to the resident but he will not talk. Complaint investigated (Date initiated 11/26/18). New med per the Nurse Practitioner as ordered (Date initiated (11/26/18). A Discharge Care Plan dated 12/03/18 indicated: Resident #285 wishes to transfer to another facility when a bed is available. He wishes to be closer to his son/family. Goal-Resident will be transferred to another facility when a bed is available per his wishes (date initiated 02/21/18). Fax clinical's to other facilities in order for them to consider transfer (date initiated 12/03/18). Set up stretcher transportation when his transfer is finalized (Date initiated 12/03/18). A Social Service Progress Note dated 12/03/18 at 14:02 P.M. (2:02 P.M.) included: "D/C (discharge) Note- Resident #285 will be transferring to a new facility. He has been requesting a transfer to a facility that was closer to family in order for his son to visit more. A bed became available today. Stretcher transportation will be set up for his transfer." A Nurse Practitioner Progress note dated 12/03/18 at 14:08 P.M. (2:08 P.M.) indicated: "This is a 52 year old male with an extensive history of blood clots. Within the past year patient was admitted and treated for cellulitis. Sent (sic) to an inpatient rehab facility until surgery for cervical stenosis could be arranged. He later obtained Surgery which was fusion of the cervical spine. He later was diagnosed with multiple DVT	F 661		

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requiring a filter to be placed in the event of clot mobility. During his stay patient complained of leg swelling, a venous Doppler was ordered which was + (positive) for DVT however patient was known to have these clots on admission. We have gone back in forth with ted hose due to patients leg size, patient needs to be measured and special stocking ordered. He also inquired about gastric bypass during his stay but due to transportation complications patients appointment was rescheduled. Over all patient is pleasant with myself and was a delightful patient."

A Nursing note dated 12/03/18 at 21:30 (9:30 P.M.) indicated: "Transportation arrived to transfer patient. The (sic) was a substantial delay secondary to an unwitnessed conversation between the transport team and the patient. Eventually a supervisor arrived and patient was assisted onto stretcher by 6. On the way out the team stopped to pick up the patients discharge paperwork. Staff asked the patient to sign his discharge instructions and the patient stated, I am not signing _____ you all screwed me over now I am going to screw you over, now get out of my face. Transferred to another facility two hours a way in company of transport team."

During an interview on 1/16/19 at 2:15 P.M. with the Director of Social Services she stated, Resident #285 had been attempting to relocate to a facility closer to his son who lives about 4 hours from the facility. The Social Service Director stated a bed became available at a sister facility which would place the resident about two hours from his family vs the four hours current distance. The Social Service Director was asked if any any information regarding the new facility had been presented to the resident for his approval? The

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F 661	Continued From page 57 Social Service Director stated, No, he had been asking for a transfer and a bed became open at the sister facility. During an interview on 1/17/19 at 2:20 P.M. with the Administrator she was asked if Resident #285 had been presented with information regarding the new facility prior to transfer. The Administrator stated, staff had been working with him on finding a facility closer to his son. The Administrator was asked why the Nurse Practitioner had written discharge orders only hours prior to Resident #285 discharge she stated, the bed only became open today. When asked if Resident #285 had any special needs. The administrator stated, he required a bariatric bed because of his weight. The facility he was being transferred to did not have a bariatric bed available when Resident #285 arrived at the new facility. The administrator was asked why the bariatric bed not been available upon Resident #285 arrival. The administrator stated, it was an oversight. The administrator was asked what happened to Resident #285 during this wait. She stated, the facility was able to locate a bariatric bed after several hours. He remained on the stretcher until a bed was provided. Resident #285 was noted to weigh 415 pounds and was 84 inches tall. The was no evidence that a discharge summary was provided to the receiving facility. The facility staff failed to provide necessary information and a discharge summary of his stay. Compliant Deficiency	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		3/1/19

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§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility documentation and clinical recorded review, the facility staff failed to follow physician orders for 2 out 43 Residents in the survey sample (Residents #86A and #62).

1. The facility staff failed to follow physician orders for the prescribe administration times for the following medications: *Midodrine 5 mg, *Insulin Glargine, *Guaifenesin ER, *Proventil HFA and *Novolog insulin for Resident #86A.

2. The facility staff failed to obtain a neurological consult prior to identification by the survey team for Resident #62.

The findings included:

1. Resident #86A was originally admitted to the facility on 09/07/18 and readmitted on 09/18/18. Diagnoses for Resident #86A included, but not limited to, *End Stage Renal Disease (ESRD), *Hypertension (HTN), *Type 2 Diabetes Mellitus and *Coronary Artery Disease.

Resident #86A's Minimum Data Set (MDS) with an Assessment Reference Date of 09/14/18

F 684

1. Residents #86A is no longer in the facility. Resident #62 was sent to the neurologist and evaluated on 2-1-2019.
2. A quality monitoring tool was completed with a 30 day look back on 10 randomly selected residents to ensure physician orders for appointments and medications administration times were in compliance on 1-18-2019 .
3. ED/ADON re - educated staff on policy and procedure of medication administration times and also following physicians orders for referrals to another physician on 1-21-2019 .
4. DCS /ADCS to monitor quality monitoring tool weekly times 1 week, then 3 times a week for 4 weeks then 1 times a week for 1 month and then quarterly thereafter . Results of quality monitoring to be discussed at QAPI meeting for review, analysis and recommendations.

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coded the Brief Interview for Mental Status (BIMS) score an 15 out of a possible 15 indicating the resident was cognitively intact with no problems in decision-making.

Review of Resident's #86A's Physician orders and Medication Administration Record for September 2018 included the following medication orders:

1) Midodrine HCL tablet 5 mg - give 1 tablet by mouth two times a day at 8:00 a.m. and 5:00 p.m., for HTN.
2) Insulin Glargine - inject 36 unit subcutaneously one time a day at 9:00 a.m., for Diabetes.
3) Guaifenesin ER - give 1 tablet every 12 hours at 9:00 a.m., and 9:00 p.m., for respiratory distress.
4) Amiodarone 200 mg - give 1 tablet mouth daily at 9:00 a.m., for Coronary Artery Disease.
5) Novolog-inject 5 units subcutaneously three times a day with meals at 8:00 a.m., 12:00 p.m., and 5:00 p.m., for diabetes.
6) Proventil HFA inhaler - 2 puffs inhale orally every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m., for shortness of breath.

Review of Resident #86A's Medication Administration Audit Record for September 2018 revealed the following medication administration times:

1). Midodrine 5 mg was document as administered at the following time for the 8 a.m. dose: on 9/08 @ 4:47 p.m.
2). Insulin Glargine was documented as administered at the following times for the 9 a.m. dose: on 9/08 @ 4:54 p.m.
3). Guaifenesin ER was documented as

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administered at the following time for the 9 a.m. dose: 9/08 @ 4:52 p.m.
4). Amiodarone 200 mg was documented as administered at the following time for the 9 a.m. dose: on 9/08 @ 4:53 p.m.
5). Novolog was documented as administered at the following time for the 12 p.m. dose: on 9/08 @ 4:56 p.m.
6). Proventil HFA inhaler was documented as administered at the following time for the 12 p.m. dose: on 9/08 @ 4:57 p.m.

An interview was conducted with License Practical Nurse (LPN) #5 on 01/17/18 approximately 5:15 p.m. The Medication Administration Audit Report for Resident #86A was reviewed with the LPN in the presence of the Director of Nursing (DON) and another surveyor. After the LPN reviewed the Medication Administration Audit Report she stated, "There is no reasonable explanations as why I administered Resident #86A's medication late on 09/08/18." The surveyor asked, "When do you administer scheduled medications" she replied, "One hour before and one hour after the medication is scheduled to be administered."

An interview was conducted with the DON on 01/17/18 at approximately 5:30 p.m. The DON stated, "I expect for the medications to be administered as ordered." Scheduled medication can be given 1 hr before or 1 hour after a scheduled medication is due. The DON proceeded to say, "If the medication could not be administered as prescribed then the physician should be notified and documented in the nurses notes.

The facility administration was informed of the

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finding during a briefing on 01/17/19 at approximately 5:30 p.m. The facility did not present any further information about the findings.

Definitions:
1). Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position) (https://medlineplus.gov/coronaryarterydisease.html).

2). Insulin Glargine is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood) (https://medlineplus.gov/coronaryarterydisease.html).

3). Guaifenesin ER is used to temporarily relieve sinus congestion and pressure. It works by causing narrowing of the blood vessels in the nasal passages (https://medlineplus.gov/coronaryarterydisease.html).

4). Proventil HFA is used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) (https://medlineplus.gov/coronaryarterydisease.html).

5). Novolog insulin is used to treat type 1 diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood)

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(https://medlineplus.gov/coronaryarterydisease.html).

6). ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure).

7). Hypertension is when your blood pressure, the force of your blood pushing against the walls of your blood vessels, is consistently too high (<https://medlineplus.gov/ency/article/007365.htm>).

8). Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (<https://medlineplus.gov/ency/article/007365.htm>).

9). Coronary Artery Disease is the most common type of heart disease. CAD happens when the arteries that supply blood to heart muscle become hardened and narrowed. It is the leading cause of death in the United States in both men and women (https://medlineplus.gov/coronaryarterydisease.html).

Compliant deficiency.

2. Resident #62 was originally admitted to the facility 5/28/13 and readmitted 12/7/18 after an acute hospital stay. The current diagnoses included; a seizure disorder.

The quarterly Minimum Data Set (MDS)

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assessment with an assessment reference date (ARD) of 12/14/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. Which indicated Resident #62's cognitive abilities for daily decision making were moderately impaired.

In section "G" (Physical functioning) the resident was coded as requiring total care of 2 people with transfers,total care of 1 person eating and bathing, extensive assistance of 2 people with bed mobility, extensive assistance of 1 person with personal hygiene, dressing, toileting, and locomotion.

A physician's order for an anticonvulsive medication was dated 1/14/19, it read; Dilantin suspension 125 milligrams/5 milliliters. Give 400 milligrams via peg at bedtime related to epileptic syndromes with complex partial seizures. Turn off the tube feeding for 1 hour before medicine and 1 hour after.
A physician's order was dated 12/10/18, for Valproate Sodium solution 250 milligrams/5 milligrams. More physician's orders for anticonvulsives were dated 12/7/18, for Keppra solution 100 milligrams/milliliter. Give 750 milligrams via peg every 12 hours for seizures. Give 20 milliliters via peg every 8 hours for seizures, 1,000 milligrams 3 times per day, and Zionism capsules 100 milligrams; Give 2 capsules via peg at bedtime for seizures, and Zonisamide capsules 50 milligrams; Give 1 capsule via peg at bedtime with 200 milligram capsules.

The current care plan with a revision date of 1/13/19, read; (name of resident) has a potential

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for injury as evidenced by seizures, quadriplegia, fall risk, and decreased vision. 12/28/18 had a seizure, 1/13/19 had a seizure. The goal read, (name of resident) potential for injury will be minimized through next review, 3/29/19. The interventions included, nurse monitored seizures.

Laboratory results were as follows:
8/28/18, Dilantin level 30.3 (critically high), 9/10/18 Dilantin level 19.3 (normal level). 1/13/19, Dilantin level 3.0 (very low). 1/13/19, Valproic level 7.0 (very low). A normal Valproic level is 50.0 - 100.0. A normal Dilantin level is 10.0 - 20.0.

A physician's order was given on 12/31/18, for the facility's staff to obtain a neurology consult for Resident #62 because of his frequent seizure activity and subtherapeutic blood levels of the anticonvulsives ordered.

A physician's progress note dated 12/31/18 read; "patient had another seizure this morning, we recently started him on a medication for his schizophrenia which will take time to start working but his seizures are becoming more frequent. Reviewed his lab work, showing he is on a good amount of seizure support. He is on Keppra, Dilantin 300 milligrams every day, Valporic sodium 1,000 milligrams every 8 hours (3,000 milligrams every day), and Zonisamide and we will also be starting him on Aptiom due to the amount of medication he is on. I believe patient will need to see a neurologist for medication management." A physician's progress note dated 1/14/19 read; "patient had a few seizures over the weekend but specifically he had one this morning that lasted about 3 minutes. Patient's Dilantin level continues to be low despite being maxed out

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F 684	Continued From page 65 on his medication. We will be changing the tablet to a liquid and holding tube feedings during administration to help with better absorption, secondarily patient has increased seizure activity when there is an infection. We will be obtaining another culture from his suprapubic catheter and starting him on bowel regimen medication to help with a bowel routine." An interview was conducted with the Nurse Practitioner on 1/16/19 at approximately 4:15 p.m., the Nurse Practitioner stated she had been monitoring Resident #62's status closely since his return from the hospital in December 2018, because while he was hospitalized his anticonvulsive levels had been high and held but since his return to the facility they had been low and she had maxed out medications she could administer therefore; she added orders to hold the tube feedings when administering the anticonvulsive medications. She also stated the resident had been on an antibiotic upon return from the hospital which reduced the levels of the Valporic Acid. On 1/17/19, at approximately 11:00 a.m., an interview was conducted with Registered Nurse (RN) #1. RN #1 stated she spoke with the nurse who took the order off and the nurse stated she didn't contact the neurologist practice to obtain an appointment for Resident #62. RN #1 stated she would work on making the appointment and at approximately 4:00 p.m., RN #1 presented an appointment for Resident #62's consult with the neurologist on 2/1/19. On 1/17/19, at approximately 5:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate	F 684		

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F 684	Continued From page 66 Consultant. The Director of Nursing and Administrator stated they recognized on 1/16/19, the appointment hadn't been made, and it would likely have been noticed 1/14/19, if the survey team had not arrived prior to their meeting.	F 684		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		3/1/19

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F 690	Continued From page 67 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff and family interview, and facility documentation, the facility staff failed to ensure 1 of 43 residents (Resident #287) with an indwelling urinary catheter received care and services to include prompt recognition of signs and symptoms of a urinary tract infection and sepsis. The facility staff failed to demonstrate ongoing assessment and monitoring, as well as implement UTI/Sepsis protocols for Resident #287 who presented as symptomatic for UTI and Sepsis. The resident was diagnosed in the local hospital with severe urosepsis and AKI (acute kidney injury/acute kidney failure) resulting in harm. The finding include: Resident #287 was originally admitted to the nursing facility on 11/7/08 with a principle diagnosis of multiple sclerosis with quadriplegia. Other significant diagnoses included diabetes, depression, neuromuscular dysfunction of the bladder with an onset date of 3/5/14 and an indwelling urinary catheter, morbid obesity and high blood pressure. Resident #287's most recent hospital stay was on 10/10/16 through 10/19/16 for complaints of chest pain and readmitted to the nursing facility with diagnoses of chronic atrial fibrillation. The resident was discharged to the local hospital on 6/2/17 and did not return to the nursing facility.	F 690	1. Resident #287 is no longer in the facility. 2. A quality monitoring tool was utilized for look back for 30 days for residents with indwelling urinary catheters that they received care and services to include prompt recognition of signs an symptoms of urinary tract infection and sepsis and demonstrate ongoing assessment and monitoring of signs and symptoms of UTI/sepsis. 3. ED/ADON re-educated staff on policy and procedures for prompt recognition of signs and symptoms of UTI and sepsis and assessment of residents and ongoing monitoring of residents with signs and symptoms of UTI or sepsis on 1-21-2019 . 4. DCS/ADCS to monitor quality monitoring tool weekly times 1 week and then 3 times a week for 4 weeks and then 1 times a week for 1 month and then quarterly thereafter . Results of quality monitoring to be discussed at QAPI meeting for review, analysis and recommendations.	

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F 690	Continued From page 68 Resident #287's Minimum Data Set (MDS) in effect prior to the 6/2/17 discharge from the facility was a quarterly dated 5/27/17. The resident was coded a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was cognitively intact in the skills needed for daily decision making. The resident had the ability to fully understand the staff and was understood. The resident was not coded to reject care that included lab work, taking medications or Activities of Daily Living (ADL) assistance. Resident #287 was assessed to require total dependence on two staff for bed mobility, transfers, toilet use, dressing and bathing. She was coded to need total assistance from one staff for eating, locomotion on and off the facility and personal hygiene. A wheelchair was coded as her main mobility device. The resident was assessed to have an indwelling urinary catheter and was frequently incontinent of bowel. The care plan dated as last revised on 4/5/17, included Resident #287 had a focus area related to altered bladder elimination and the goals set by the staff was that the resident would not develop symptoms of UTI, and that the resident's risk for septicemia would be minimized/prevented via prompt recognition and treatment of symptoms of UTI, and the resident would not experience complications related to catheter use. The care plan did not indicate a diagnosis of UTI in 2017 prior to discharge 6/2/17. Some of the interventions the staff would employ to accomplish these goals included monitor and report to MD (medical doctor) PRN (as needed) for signs and symptoms of UTI that included supra-pubic pain, cloudy urine, altered mental status, abnormal vital signs and behavioral	F 690		

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changes. Obtain and monitor labs and diagnostic work as ordered by the physician, report results to MD and follow up as indicated.

The nurse's notes dated 6/2/17 at 6:53 a.m. was written by the 11/7 Licensed Practical Nurse (LPN) #9 (schedule shift at 11 p.m. on 6/1/17 through 7:00 a.m. on 6/2/17) indicated the following: "Resident c/o (complaint of) vaginal burning, peri care and catheter care administered. Shower given on 11/7 shift. Effective. Continuing to monitor."

The same LPN #9 entered the follow-up nurse's note on 6/2/17 at 7:12 a.m.: "Resident has been displaying behaviors during shift. Hollering out. Resident c/o pain, medications administered, ineffective. Resident continues to holler disturbing roommate and causing agitation. Continuing to monitor." LPN #9 was not available for interview, no longer employed by the nursing facility. The facility initiated an investigation on 6/19/17 into the Resident Representative's (RR) concerns about delay in care 6/1-2/17 and LPN #9 wrote a statement. The statement indicated when she reported to work for the 11/7 shift (6/1/19 at 11:00 p.m. through 6/2/17 at 7:00 a.m.) the resident was "yelling out some." She wrote she and the CNA gave the resident a shower because of her complaints of vaginal burning, performed peri care, administered pain medication between 5:00 a.m. and 6:00 a.m. and reported off to LPN # 10 (6/2/17-7/3 shift).

LPN #10 who took over as the assigned licensed nurse responsible for Resident #287's care on 6/2/17 for the 7/3 shift was not available for interview, no longer employed by the nursing facility. LPN #10's written statement was not

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included in the investigation file provided to this surveyor.

The Certified Nursing Assistants (CNA's) that were assigned to the resident on 6/1/17 and 6/2/17 for all three shifts were not available for interview, no longer employed by the nursing facility. The 6/2/17-7/3 shift CNA indicated in a written statement that she was told by the 11/7 shift CNA that the resident had some screaming during the night. She wrote she got the resident up in the chair for breakfast and she only ate 25 % of he breakfast, ate only a few bites for lunch and ask to go lay down, she was tired and wanted to rest.

There were no nurse's notes that demonstrated further assessments and monitoring took place on either the 7/3 shift on 6/2/17 or the 3/11 shift prior to the SBAR (Situation/Background/Assessment/Recommendation report on 6/2/17 at 6:12 p.m.

The SBAR report indicated the following vital signs: Blood pressure (BP)= 110/60 (marginally low); pulse=120 (tachycardia); respiratory rate=20 and temperature=98.2 F (Fahrenheit) obtained axillary (underarm), oxygen saturation=90% on room air (95-100=normal range). The narrative nursing note portion of the SBAR included the following: "Sister in to visit resident (5:46 p.m. on 6/2/17) and noted change in her. Resident awake with altered mental status. Resident was assessed and had a heart rate of 120 and O2 sat (Oxygen saturation) of 90% on room air and she was put on O2 @ 5L (liters)/minute via n/c (nasal cannula) & (and) SATs increased to 95%. BS (blood sugar)-113. She will be transferred to (local hospital's name) E.R. (emergency room),

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F 690	Continued From page 71 911 called and report called to transfer center." It was annotated on the SBAR that the aforementioned assessment was reported to the physician. The resident had a current operational DNR (do not resuscitate order). LPN #2 signed off as the the licensed nurse who completed the SBAR report, as well as the nurse who was assigned responsible to provide care for Resident #287 on 6/2/17 for the 3/11 shift. On 11/15/19 at 3:45 p.m., an interview was conducted with LPN #2. She stated she could not remember if she was given a report on Resident #287 when she started the 3/11 shift on 6/2/17. She stated the resident was pleasant and she did not recognize any physical problems. She stated she could not remember if she got out of bed for dinner on 6/2/17 as usual. She stated the Administrator and Director of Nursing (DON) told her the RR indicated in a letter that a minister had come in during the 3/11 shift and said he told someone about Resident #287's decrease in responsiveness and ask if she assessed the resident due to the minister's concern. She further stated she did go into the room at that time and asked the resident is she was okay, as she was looking out the window at the birds. When asked why she did not take the opportunity to make an assessment of the resident and document it in the nurse's note's she said, "I maybe should have." On 6/20/17, LPN #2 wrote a statement for the Administrator and DON that on 6/2/17 (no time) the resident was in bed and that the priest who visited stayed in the room no more than 2 minutes and came to her saying the resident was not making much sense. She wrote in her statement that she checked on the resident and asked it she was okay and that the resident said "yeha," 20 minutes later she was	F 690		

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F 690	Continued From page 72 being sent to the E.R. This information was not shared with the Administrator or the DON prior to the start of the investigation on 6/19/17. During the interview with this writer, LPN #2 stated she could not remember whether the resident was up for dinner, but wrote in her statement the resident was in bed at the time she checked on her, which would have been between 5:00 and 6:00 p.m. LPN #2 also wrote that on the previous day (6/1/17 during the 3/11 shift) the resident's urine was dark and cloudy with sediment, but that it had always been that way since she had the catheter. LPN #2 further stated during the above interview that although she signed the SBAR, she was not the person who performed the assessment on 6/2/17 at 6:12 p.m., other nurses were present and she recorded their findings. She said the RR came to the nurse's station 6/2/17 to ask that someone come to assess Resident #287 because she was not very responsive. She stated she knew the signs and symptoms of a urinary tract infection to include restlessness, behavioral changes, color and sediment of the urine, as well as a possible elevated temperature. She stated she was not sure of signs and symptoms of sepsis, but did attend the recent skills fair on 10/28/18 but was sure that was not one of the topics. This surveyor verified the skills fair 10/28/18 did not include signs and symptoms of UTI/sepsis. Recent mandatory inservices were conducted on 1/10/19 and 1/11/19 as a requirement for a partnership merger with an organization that assist with strategies to decrease in unnecessary resident readmissions to hospitals. One of the required training's included "Understanding Sepsis." Out of 60 nursing staff, four RN's attended, two of the RNs were the DON and the Assistant Director of	F 690		

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Nursing (ADON), 7 LPNs and 16 CNAs. LPN #2 did not complete the mandatory inservice on "Understanding Sepsis."

On 1/16/19 at approximately 9:30 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON). They stated on 6/5/17 the RR showed up in the building and wanted to meet with the both of them and that she was tearful and expressed that the resident died the previous day. They stated they started an investigation on 6/19/17 after the Resident Representative (RR) delivered a letter under their door on 6/13/17 alleging neglect in care for Resident #287. The letter which indicated that the RR was told by the visiting minister that checked in on 6/2/17 around 2:56 p.m. that he went to the resident's room to find her moaning and staring in space. The letter indicated the minister approached the nurse's station to let them know of her condition and even mentioned it to the activities director. The activities director wrote a statement 6/19/17 that indicated on 6/2/17 at 3:45 p.m., a church volunteer told her he informed a nurse that the resident was not well and she thanked him for making the staff aware. The activities director was no longer employed by the facility and was not available for interview. The letter indicated no one checked on Resident #287 or if they had they would have taken immediate action based on her level of consciousness. The letter also indicated that when the RR arrived 6/2/17 at 5:15 p.m., she found the resident in bed and not in the dining room as per her usual routine for dinner. The RR indicated in the letter she found the resident in the same condition as the minister and unable to communicate to her what happened, thus she approached the nurse's station to report her condition at which time the

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the Administrator, DON and a few nurse's went to the resident's room to assess her. The letter indicated the resident was sent to the E.R. admitted to the hospital's ICU and diagnosed with a "bad urinary tract infection". The letter indicated the RR visited the resident in ICU the following day and told her she would be back, but the resident died 1.5 hours later. She alleged gross neglect by the facility. The facility concluded their investigation on 6/23/17 conducted by the Administrator and DON that consisted of interviews with staff, review of facilities policy and procedures and review of medical record. They found the allegation to be unsubstantiated based on their investigation.

During the aforementioned interview, the DON was asked what was the expectation of the nursing staff in review of the nurse's notes and the documented change in condition during the 11/7 shift (6/1-2/17). The DON first stated, "Maybe there was no need to document anything because she was a long-term care resident and we only document by exception. They washed her up and she felt better." Upon taking a closer look, she agreed there were no documented assessments that would reflect monitoring of a possible UTI after it was noted the resident complained of burning and pain which was a potential symptom. The signs of UTI would have come from nursing actions, which would have been the results of their assessment and monitoring (e.g., vital signs, behaviors, appearance of urine) which was not evident in the clinical record (e.g., nursing notes, vital sign records). The DON agreed that there was no follow-up after pain medication administered in the early morning hours of the 11/7 shift was documented in the nurse's notes as "ineffective,"

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as well as further follow-up on hollering and behaviors exhibited during the shift. Additionally, there were no nurse's notes on the 7/3 shift, where in the above CNA's statement she wrote the resident did not eat much, felt bad and requested to go to bed. In addition, the resident did not get up for dinner as usual which exhibited potential decline in physical status and a change in her normal activities. The DON then stated she expected to see vital signs obtained and recorded, level of consciousness documented, further record of the color of the urine, expounding on her behaviors they earlier documented on the 11/7 shift, as well as a call to consult with the physician or nurse practitioner to report the findings and accept guidance for any orders. The DON could not explain lack of a documented assessment from LPN #2 during the 3/11 shift, especially if she checked on the resident after she stated the minister said the resident "was not making sense." She could not explain why there was not evidence of any assessment or monitoring until the RR approached the nursing staff to insist someone address Resident #287's change in condition around dinner time on 6/2/17. When this surveyor asked to review the 24 hour reports, the DON stated she would look for them. She and the Administrator returned on 1/16/19 at 10:30 a.m. with the 24 hour report dated 6/2/17 for 11/7 and 7/3 shift which was blank, and the 3/11 block indicated the resident was "sent to the (local hospital name) E.R. at 6:20 p.m. with altered mental status/tachycardia and admitted to the ICU."

During the above interview, the Medication Administration Record (MAR) was reviewed to reveal when pain medication was recorded in the

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nurse's notes as administered on 11/7 shift 6/2/17, the only pain medication would have been acetaminophen, which was not signed off on the MAR as given during the night shift or early morning hours. The DON stated, "She probably gave it and forgot to sign it off on the MAR." The DON stated, "I tell nurses, train nurses, but still have problems. We will have to do more." The Administrator and DON presented policies that were in effect during Resident #287's stay that outlined clear guidelines for nursing assessment and monitoring and documentation of such for UTI and sepsis. A time line had been presented to this surveyor completed by the regional nurse regarding the resident's output, which was not in question but whether appropriate assessments, monitoring for signs and symptoms of UTI/Sepsis recognized by the nursing staff with notification to the physician/nurse practitioner. The time line revealed there was no assessment or monitoring throughout the 11/7 shift or on the subsequent two shifts to include vital signs or a call to the physician based on the residents expressed symptoms of burning and unrelieved pain. The time line noted that "the sister (RR) was in to visit and noted a change in the resident," after which the staff performed an assessment, exhibited in aforementioned SBAR dated 6/2/17 at 6:12 p.m. and sent her out 911. The most recent laboratory results were sent out with the resident that were obtained 4/13/17, a Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) that checked electrolytes, BUN and creatinine (renal function status) none of which warranted treatment. The Administrator and DON stated there were no other labs in 2017 to include a U/A or C&S.

On 1/16/19 at 10:45 a.m., an interview was conducted with the current Nurse Practitioner

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F 690	Continued From page 77 (NP). She stated she was not the NP during Resident #287's stay, but the attending physician was the same and she was currently in practice with him and felt she could give her professional take on the Resident #287's case by review of the clinical record. She also stated she would be covering for the attending over the next two days. From review of the nurse's notes she stated the nursing staff missed many opportunities to make good assessments and call the physician for further guidance. She stated she actually saw no assessments and monitoring even on the 11/7 shift with the lack of vital signs, visualization of urine, mental and behavioral status. She stated there appeared that nothing was done on the 7/3 and 3/11 shift until the RR informed them something was wrong. Upon review of the SBAR, the NP stated the resident had signs and symptoms of sepsis to include a temperature that was recorded obtained via axilla at 98.2 which was not reliable and 1.5 to 2.0 points would be added for an accurate temperature reading. She stated the resident had just finished antibiotic therapy on 5/27/17 for a skin infection which often can yield antibiotic resistant infections, like Methicillin Resistant Staphylococcus Aureus (MRSA) or Extended Spectrum Beta-Lactamases (ESBL-in urine) so close assessment and monitoring especially in light of what was already noted was vital with a call to physician or NP to let them know what was going on like the burning, behaviors and ineffective pain management from the medication. "The signs and symptoms of Sepsis was brewing and the nursing staff did nothing from what I can see here. To avoid sepsis, the nursing staff have to assess for the signs and symptoms, which it looked like the resident probably had them that required prompt treatment to prevent a septic situation." The NP	F 690		

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F 690	Continued From page 78 stated with sepsis the resident's BUN and creatinine would have been elevated upon arrival to the ER with potential Acute Kidney Injury (AKI) with systems failure. During the above interview, the NP stated if there had been a call to the physician during the 11/7 shift on 6/1-6/2/17 there could have been a dip stick urine ordered STAT that would have shown nitrates and white blood cells. She stated she knows the facility had the reagent strips for the test in the nursing facility accessible to the nurses. Based on those results that are immediate, an antibiotic could have been ordered. She further stated a STAT Urine Analysis (UA) would have come back in a couple of hours at the first of any concern from the nurses that would have shown white blood cells, red blood cells, bacteria which would have also been highly suggestive of a UTI. She stated, the culture and sensitivity report within 3 days would have shown more specificity and possible need to change antibiotic choice based on sensitivity report. She said she would have also ordered a STAT Complete blood count and renal profile to assess renal function or organ failure from systemic infection. She stated if a call had been made to the attending or NP early on, an order could have also been given to the nurses to just send the resident out for evaluation in the E.R. Review of the hospital records indicated the following: Resident arrival 6/2/17 at 6:35 p.m., vital signs-BP=99/54 (hypotension); pulse=112 (tachycardic); respiratory rate=22 (tachypnea) and temperature=99.7. Oral mucosa dry. Patient was not able to give information about condition. Labs drawn to reveal blood urea nitrogen (BUN), an indicator of renal function, of 60 (9-26=normal	F 690		

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range); Creatinine, also an indicator of renal function, of 2.1 (0.4-1.0=normal range); venous lactic acid, an indicator of a severe infection such as sepsis and septic shock, of 6.36 (.50-2.20=normal). The U/A revealed large amounts of blood (negative is normal), positive nitrates (negative is normal); 40 WBC (0-5=normal); RBC TNTC (Too numerous to count) with 0-5=normal; and 15 ketones (negative=normal). The final results of the culture and sensitivity report came back on 6/6/17 that indicated an antibiotic resistant organism in the urine of ESBL greater than 100,000 and proteus mirabilis greater that 100,000. The resident was diagnosed with "severe acute sepsis and septic shock with evidence of end organ damage to include acute kidney injury (AKI)/acute kidney failure with the focus of infection likely UTI". The resident was started on Intravenous Fluids (IV) for hydration and kidney perfusion, as well as antibiotics. Resident #287 was diagnosed with severe urosepsis and septic shock with acute renal failure, also referred to as AKI (acute kidney injury). She expired on 6/3/17 at 10:00 p.m. and the cause of death was recorded due to severe urosepsis.

On 1/16/19 at 12:15 p.m., a telephone interview was conducted with the RR. She stated on 6/2/17 at around 5:15 p.m. she went to the dining room to feed the resident per her normal routine, but did not see the resident. She stated the resident "loved to eat" and was always up for meals to include the dinner meal. She stated she went to the resident's room to find her listless and unable to communicate as usual, after which she immediately went to the nurse's station to inform the nurse. She said several nurses converged in the room and started to make assessments. She

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said she made a suggestion that the resident be sent out to the hospital and that the nursing staff agreed with her and took action. She stated she went to the hospital visited the resident and she was not very responsive to her. She stated the resident died the following day from sepsis. The RR said she visited the nursing facility on 6/5/17 to share some of her concerns. When she left the meeting, she stated she met a staff person in the parking lot who said she was sorry about her loss and told her a minister had been in and saw the resident in the same state, notified the nursing staff and nothing was done, no one went down to assess the resident. She said she went in to retrieve the name of minister from the visitor's log and made a phone call to him once she returned home. According to the RR, the minister recounted exactly what was told to her by the staff person in the parking lot (no longer employed by the facility). The RR stated she gathered her thoughts about what she observed and what the minister observed and felt there was delay and neglect in the care of the resident. She stated she came back to the facility on 6/13/17 with a letter and a request to address the Administrator and the DON. She said they told her "You have already spoken to us about the matter and there is nothing more to talk about." She stated she was more upset about that inference that she could not talk to them than anything, so she slipped the letter under the door and heard no further word from them. This surveyor reviewed the visitor's log that verified a minister from the church and same name she indicated visited residents on 6/2/17 from 2:35 to 4:25 p.m.

On 1/17/19 at 2:13 p.m., another surveyor completed the infection control review with the

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F 690	Continued From page 81 DON and the ADON. This surveyor stated the DON and ADON told her regardless of whether a resident had a indwelling urinary catheter or not, they expected assessment and monitoring to take place for resident's that exhibited signs and symptoms of UTI to ensure prompt treatment and to avoid sepsis. They told the surveyor the physician should be called, and a urine dip stick could be ordered by the physician for immediate results and or a U/A and C&S. They indicated during the interview changes in condition that warranted immediate attention related to potential sepsis included elevated temperature, low BP, confusion, behavioral changes and pain, abnormal O2 saturation, increased respiratory rate, and a results of a glucose finger stick if diabetic, as well as a call to the physician. They showed the surveyor an algorithm (dated 2014) the facility used to recognize UTI/sepsis that indicated the same, in addition to evaluation of the ordered labs by the physician and decision to treat in the facility with Oral, IV or subcutaneous fluids if needed for hydration, as well as antibiotics, close monitoring with further evaluation in the E.R. The facility's policy and procedures titled Infections-Clinical Protocol dated revised July 2016 indicated that infection may be suspected based on clinical signs and symptoms and/or temperature. The policy indicated for anyone suspected of having an infection (abrupt change in function, appetite, mental status, etc.), nursing staff will obtain a complete set of vital signs (temperature, heart rate, blood pressure, and respiratory rate) and will identify and document specific details of symptoms and physical findings. Nursing will notify the physician or provider of all pertinent details about the	F 690		

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F 690	Continued From page 82 residents condition. The nursing staff will continue this form of monitoring and assessment. The nursing staff and physician or provider will identify possible complications of infection such as sepsis and delirium. Based on the preceding information, the decision would be made by the physician or provider whether additional testing (CBC, U/A to check for WBC, pus and nitrate level) is indicated and whether other active conditions related to infection also need treatment. COMPLAINT DEFICIENCY	F 690		
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 general observation and staff interview, the facility staff failed to serve food that is palatable and at safe temperatures. The findings included: The follow up tour of the kitchen was completed with the Dietary Manager on 01/15/19 at approximately 11:45 a.m. Initial steam table temperatures were obtained on 01/15/19 at 11:45 a.m. and recorded as follows: Noodles 173F	F 804	1.The DSM tested the last tray for the evening meal on 1-15-2019 to ensure all temperature tested within range . 2. DSM is doing temperature tests at the beginning of serving each meal and then the last tray served of the tray line and ED received the last tray of each meal to ensure compliance 20 minutes after the last tray was delivered to the floor and tested it for temperature on 1-18-2019. 3. DSM re-educated staff on proper	3/1/19

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F 804	Continued From page 83 (Fahrenheit), Meatballs 192F, Ground Beef 211F, Rice 185F, Puree Vegetable 203F, Puree Noodles 202F, Puree Bread 188F, and Puree Meat 192F. A Test Tray was prepared after all other resident lunch trays had been prepared and placed on respective unit carts. The test tray contained Meatballs, Puree Noodles, Rice, Tossed Salad, and Butterscotch Pudding. The test tray left the kitchen on 01/15/19 at approximately 12:38 p.m. and reached Meadowland unit at 12:39 p.m. The cart containing the test tray was moved further down unit hallway at 12:41 p.m. and last resident tray was pulled off of cart at 12:52 p.m. Dietary Manager arrived at tray cart for re-temperatures on 01/15/19 at 12:53 p.m. Test tray temperatures recorded as follows: Meatballs 139F (53 degree drop), Puree Noodles 115F (87 degree drop), and Rice 116F (69 degree drop). Upon observation and manual manipulation with a spoon, Butterscotch Pudding was noted to be frozen solid. An interview with the Dietary Manager on 01/15/19 at 1:00 p.m. stated, "This tray did not pass for temps. That meat should be at least 145F. And there is no way the resident could easily eat that frozen pudding." The Administrator was informed of the finding on 01/17/19 at 5:50 p.m. during a pre-exit conference meeting. The facility did not present any further information about the findings. The facility's policy and procedure titled Food: Quality and Palatability effective 5/2014 and revised 9/2017 was reviewed and included:	F 804	temperatures of food. 4. DSM or designee will monitor quality monitoring tool weekly times 1 , then 3 times a week for 4 weeks and then 1 times a month and quarterly thereafter . Results of quality monitoring to be discussed at QAPI meeting for review, analysis and recommendations.	

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F 804	Continued From page 84 Policy Statement: Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs.	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. This REQUIREMENT is not met as evidenced by: Based on general observation and staff interview, the facility staff failed to store and label food in accordance with food safety guidelines. The findings included:	F 812	1. The clear plastic storage containers lid that was cracked was disposed of and replaced with a new one on 1-14-2019 and container was dated . 2. A quality monitoring tool was utilized to ensure that food is labeled and stored in	3/1/19

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Continued From page 85

The initial tour of the kitchen was completed with the Dietary Manager on 01/14/19 at approximately 3:00 p.m. In the dry walk in pantry there was a clear plastic storage container with lid containing frosted flaked cereal. The lid to container was noted to be cracked and lifted at cracked area exposing dry cereal to room air. The clear plastic storage container was also noted to not be labeled or dated.

An interview with the Dietary Manager on 01/14/19 at approximately 3:00 p.m. stated, "That food in there (referring to clear plastic storage container) could get stale, or roaches or other animals could get in there. We should have thrown that away."

The Administrator was informed of the finding on 01/17/19 at 5:50 p.m. during a pre-exit conference meeting. The facility did not present any further information about the findings.

The facility's policy and procedure titled Food Storage: Dry Goods effective 5/2014 and revised 9/2017.

Policy: All dry goods will be appropriately stored in accordance with the FDA Food Code.
Procedures
1. All items will be stored on shelves at least 6 inches above the floor.
2. Foods stored on moveable racks or dollies may be stored at less than 6 inches from the floor.
3. Items will not be stored within 18 inches of a sprinkler unit.
4. The Dining Services Director or designee regularly inspects the dry storage are to ensure it is well lit, will ventilated and not subject to sewage

F 812

accordance with food safety guidelines.
3. DSM re-educated staff on 1-15-2019 on policy and procedure for dating food and also ensuring food is stored and label in accordance with food safety guidelines.
4. DSM or designee to monitor quality monitoring tool weekly times 1 week and then 3 times a week for 4 weeks and then 1 times a month for 1 month and then quarterly thereafter . Results of quality monitoring will be discussed at QAPI meeting for review , analysis and recommendations.

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F 812	Continued From page 86 or wastewater back flow or contamination by condensation, leakage, rodents or vermin. 5. All packaged and canned food items will be kept clean, dry, and properly sealed. 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate.	F 812		
F 880 SS=C	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		3/1/19

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F 880	Continued From page 87 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's Infection Prevention and Control Program (IPCP) the facility staff failed to ensure	F 880	1. Facilities policy and procedure were reviewed on 1-23-2019 . 2. The facilities IPCP was discussed on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495340	A. BUILDING ______ B. WING ______	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 88	F 880		

the policy and procedures were reviewed at least annually.

The facility staff failed to review and revise the Infection Control Performance Improvement (IPCP) policy annually.

The findings included:

On 01/17/19 at 2:13 p.m., the facility's infection control program was reviewed with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The Director of Nursing printed off the IPCP. The IPCP had a revision date of 09/01/17. The surveyor asked, "Who is responsible for ensuring the IPCP was reviewed and updated on an annual basis." The DON stated, "The ADON is responsible for bringing the IPCP policy to the
Quality Assurance and Performance Improvement (QAPI) meeting annually for review."

The facility administration was informed of the finding during a briefing on 01/17/19 at approximately 5:30 p.m. The surveyor asked who is responsible for updating the IPCP on an annual basis. The Regional Director of Clinical Services stated, "Corporate is responsible for making sure policies and procedures are updated annually."

1-23-2019 with ED, DCS , ADCS and medical director and discussed at QAPI meeting.
3. ED/ADON re-educated staff on 1-21-2019 policy and procedure of annual policy review .
4. ED/ADCS will monitor a quality monitoring tool to ensure compliance with annual review of policy weekly times one and then quarterly thereafter and results will be discussed in QAPI meeting for review , analysis and recommendations.