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	495330	A. BUILDING _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIER REGIONAL MEDICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07-20-21 through 07-22-21. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaint(s) were investigated during the survey.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/24/2021

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facility-based and community-based risk assessment, utilizing an all-hazards approach.
(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.
(2) Include strategies for addressing emergency events identified by the risk assessment.

*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.
(2) Include strategies for addressing emergency events identified by the risk assessment.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to ensure the facility emergency preparedness plan was reviewed and updated annually based on the facility's risk assessment.

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E 006	Continued From page 2 The findings included: The facility's Emergency Preparedness plan was dated April 1, 2019. The risk assessment indicated a date of May 31, 2019. The risk assessment did not include data for epidemic and infections. The risk assessment ranked epidemic as #8 on a scale of 10 with zero (0) occurrences. When asked for the updated emergency preparedness plan information based on the facility's risk assessment, the interim administrator stated, "The facility had not updated the emergency preparedness plan."	E 006		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and	E 036		

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procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

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

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of

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E 036	Continued From page 4 this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have an emergency preparedness training program based on the facility's risk assessment. The findings included: During an interview on 07/21/21 at 11: 56 A.M. with the interim administrator, he was asked for documentation of training and testing program in emergency preparedness risk assessment policies and procedures for five current staff. The interim administrator was not able to provide documentation of training and testing information for the five employee's. The risk assessment indicated a date of May 31, 2019. The risk assessment did not include data for epidemic and infections. The risk assessment ranked epidemic as #8 on a scale of 10 with zero (0) occurrences. The Emergency Preparedness plan was dated April 1, 2019. When asked for the updated risk assessment information, the interim administrator stated, the facility did not review and update the risk assessment.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1),	E 037		

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E 037	Continued From page 5 §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 6 (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 7 (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services

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under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to provide emergency preparedness training program based on the facility's risk assessment.

The findings included:

During an interview on 07/21/21 at 11: 56 A.M. with the interim administrator, he was asked for documentation of annual emergency preparedness training and testing program in emergency preparedness risk assessment policies and procedures for five current staff. The interim administrator was not able to provide training and testing information for the five employee's.

The risk assessment indicated a date of May 31, 2019. The risk assessment did not include data for epidemic and infections. The risk assessment ranked epidemic as #8 on a scale of 10 with zero (0) occurrences.

The Emergency Preparedness plan was dated April 1, 2019. When asked for the updated risk assessment information, the interim administrator stated, the facility did not review and update the risk assessment nor had staff receive annual testing and training in emergency preparedness.

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F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted 7/20/21 through 7/22/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 120 certified bed facility was 88 at the time of the survey. The survey sample consisted of 56 Resident reviews			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		

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§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, and staff interview, the facility's staff failed to maintain a resident's dignity by ensuring the bedside drainage bag fluid was concealed from view for 1 of 56 residents (Resident #14), in the survey sample.

The findings included:

Resident #14 was originally admitted to the facility 12/11/18 and has never been discharged from the facility. The current diagnoses included; Multiple Sclerosis and neurogenic bladder.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/11/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #14's cognitive abilities for

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daily decision making were severely impaired.

In section "G" (Physical functioning) the resident was coded as requiring total care of two people with bed mobility and transfers, total care of one person with dressing, toileting, personal hygiene and bathing, and supervision after set-up with eating. In section "H" (Bladder and Bowel) the resident was coded at "H0100" as requiring use of an indwelling catheter.

The current Physician's Order summary revealed an order which read; suprapubic catheter 18 French/10 milliliters bulb to bedside drainage, diagnosis neuromuscular dysfunction of the bladder. Catheter change by the urologist.

On 7/20/21 at approximately 1:45 p.m., Resident #14 was observed in bed with a bedside drainage bag viewable from the hallway. The drainage bag contained yellow urine.

On 7/21/21 at approximately 11:00 a.m., Resident #14 was again observed in bed. Viewable from the hallway was a bedside drainage bag holding yellow urine with whitish looking particles.

An interview was conducted with the Unit Manager on 7/21/21 at approximately 10:55 a.m. The Unit Manager stated the resident should have a fig leaf drainage bag (is a urinary drain bag that preserves the dignity of the patient by hiding the fluid from view with a built in Fig Leaf Cover) and it would be taken care of immediately.

On 7/22/21 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Clinical Specialist. The facility's Clinical Specialist the resident's drainage

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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 550	Continued From page 13 bag contents should not have been viewable from the hallway.	F 550		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on information obtained during the Resident Council Meeting, and interviews, the facility staff failed to inform residents of the location of the survey book which listed the results of the most recent surveys.	F 577		

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	495330	A. BUILDING _____ B. WING _____	07/22/2021

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F 577	Continued From page 14 The findings included: A resident council meeting was held in the resident dining hall on 7/21/21 at approximately, 11:00 AM. Six residents attended the meeting. The residents stated they were not aware of the location of the survey results book or were not aware they could see the results of past surveys conducted... Upon inspection of the survey results book it was determined that the most recent complaint survey results were not posted in the survey book. The last survey posted in the survey book was dated 12/23/2019. According to the Office of Licensure and Certification complaint surveys were conducted on the following dates: 12/12/20, 2/12/21 and 4/15/21. These surveys should have been posted in the survey book for residents, family members and legal representatives to view. On 7/21/21 at approximately 11:45 AM an interview was conducted with the Activity Director (OSM/Other Staff Member #2) regarding the residents in the Resident Council staff stating they were not aware of the location of the survey book or the purpose of the survey book. The Activity Director stated, "I haven't been working here that long." The above findings were shared with the Administrator, The Director of Nursing, The Assistant Director of Nursing (ADON) and the Corporate Nurse on 7/21/21 at approximately 4:40 PM during the pre-exit interview. No further comments were made.	F 577		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		

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§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the

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appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on medical record review, staff interviews and facility document review the facility failed to ensure that 10 of 56 residents in the survey sample were afforded the opportunity to formulate an Advance Directive upon admission, Residents' #52, #257, #258, #255, #26, #57, #48, #7, #25 and #94.

The findings included:

1. Resident #52 was admitted to the facility initially on 8/12/20 and readmitted on 6/29/20 with diagnoses to include but not limited to Diabetes Mellitus, Hypertension and Major Depressive Disorder.

Resident #52's most recent MDS (Minimum Data Set) was a Quarterly with an ARD (Assessment Reference Date) of 6/4/21. Resident #52's BIMS (Brief Interview for Mental Status) was coded as a 7 out of a possible 15 indicating the resident was moderately cognitively impaired but capable of some daily decision making.

Resident #52's Physician Progress Note dated 7/7/21 was reviewed and is documented in part, as follows:

Care Plan:
Recommendations: Code Status-Full Code

Resident #52's Comprehensive Care Plan last revised 6/29/21 was reviewed and is documented in part, as follows:

Full Code

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Resident #52's Physician Orders were reviewed and are documented in part, as follows:

Start Date: 10/22/19
Order Description: Full Code

Resident #52's electronic medical record was reviewed and there was no advance directive document located.

On 7/21/21 at 2:15 P.M. the ASM (Administrative Staff Member) #1 was asked if he could located the advance directive for Resident #52.

On 7/22/21 at 9:53 A.M. an interview was conducted with the ASM#1. The ASM#1 stated, "We don't have any documentation to support that an Advance Directive was reviewed with the resident upon admission.

The facility policy titled "Advance Directives" revised December 2006 was reviewed and is documented in part, as follows:

Policy Statement: Advance Directives will be respected in accordance with state law and facility policy.

Policy Interpretation and Implementation:

1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.

6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire

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of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.

7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives.

On 7/22/21 at 4:25 P.M. a pre-exit debriefing was held with the ASM #1, ASM #, ASM #3 and ASM #4 were the above information was shared. Prior to exit no further information was provided.

2. Resident #257 was admitted to the facility on 6/30/21 with diagnoses to include but not limited to Fracture of Right Lower Leg, Diabetes Mellitus, Hypertension and Acute Kidney Failure.

Resident #257's most recent MDS (Minimum Data Set) was an Admission 5-Day with an ARD (Assessment Reference Date) of 7/6/21. Resident #257's BIMS was coded as a 12 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making.

Resident #257's Physician Progress Note dated 7/14/21 was reviewed and is documented in part, as follows:

History:
Code Status-Full Code

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Resident #257's Comprehensive Care Plan last revised 7/14/21 was reviewed and is documented in part, as follows:

Full Code

Resident #257's Physician Orders were reviewed and are documented in part, as follows:

Start Date: 6/30/21
Order Description: Full Code

Resident #257's electronic medical record was reviewed and there was no advance directive document located.

On 7/21/21 at 2:15 P.M. the ASM#1 was asked if he could located the advance directive for Resident #257.

On 7/22/21 at 9:53 A.M. an interview was conducted with the ASM#1. The ASM#1 stated, "We don't have any documentation to support that an Advance Directive was reviewed with the resident upon admission.

The facility policy titled "Advance Directives" revised December 2006 was reviewed and is documented in part, as follows:

Policy Statement: Advance Directives will be respected in accordance with state law and facility policy.

Policy Interpretation and Implementation:

1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment

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and to formulate an advance directive if he or she chooses to do so.

6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.

7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives.

On 7/22/21 at 4:25 P.M. a pre-exit debriefing was held with the ASM #1, ASM #, ASM #3 and ASM #4 were the above information was shared. Prior to exit no further information was provided.

3. Resident #258 was admitted to the facility on 7/12/21 with diagnoses to include but not limited to Spinal Stenosis, Hypertension and Anxiety Disorder.

Resident #258's Admission 5-day MDS is in progress due to resident being a new admission. Resident #258's BIMS was coded as a 14 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making.

Resident #258's Physician Progress Note dated 7/20/21 was reviewed and is documented in part, as follows:

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History:
Code Status-Full Code

Resident #258's Baseline Care Plan last revised 7/20/21 was reviewed and is documented in part, as follows:

Full Code

Resident #258's Physician Orders were reviewed and are documented in part, as follows:

Start Date: 7/12/21
Order Description: Full Code

Resident #258's electronic medical record was reviewed and there was no advance directive document located.

On 7/21/21 at 2:15 P.M. the ASM#1 was asked if he could located the advance directive for Resident #258.

On 7/22/21 at 9:53 A.M. an interview was conducted with the ASM#1. The ASM#1 stated, "We don't have any documentation to support that an Advance Directive was reviewed with the resident upon admission.

The facility policy titled "Advance Directives" revised December 2006 was reviewed and is documented in part, as follows:

Policy Statement: Advance Directives will be respected in accordance with state law and facility policy.

Policy Interpretation and Implementation:

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F 578	Continued From page 22 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. 8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. On 7/22/21 at 4:25 P.M. a pre-exit debriefing was held with the ASM #1, ASM #, ASM #3 and ASM #4 were the above information was shared. Prior to exit no further information was provided. 4. Resident #255 was admitted to the facility on 7/9/21 with diagnoses to include but not limited to Dementia, Paraplegia and Pressure Ulcers. Resident #255's Admission 5-day MDS is in progress due to resident being a new admission. Resident #255's BIMS was coded as a 5 out of a possible 15 indicating the resident was severely cognitively impaired but capable of some daily decision making. Resident #255's Physician Progress Note dated	F 578		

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7/12/21 was reviewed and is documented in part, as follows:

History:
Code Status-Full Code

Resident #255's Baseline Care Plan last revised 7/12/21 was reviewed and is documented in part, as follows:

Full Code

Resident #255's Physician Orders were reviewed and are documented in part, as follows:

Start Date: 7/9/21
Order Description: Full Code

Resident #255's electronic medical record was reviewed and there was no advance directive document located.

On 7/21/21 at 2:15 P.M. the ASM#1 was asked if he could located the advance directive for Resident #255.

On 7/22/21 at 9:53 A.M. an interview was conducted with the ASM#1. The ASM#1 stated, "We don't have any documentation to support that an Advance Directive was reviewed with the resident upon admission.

The facility policy titled "Advance Directives" revised December 2006 was reviewed and is documented in part, as follows:

Policy Statement: Advance Directives will be respected in accordance with state law and facility policy.

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Policy Interpretation and Implementation:

1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.

6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.

7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives.

On 7/22/21 at 4:25 P.M. a pre-exit debriefing was held with the ASM #1, ASM #, ASM #3 and ASM #4 were the above information was shared. Prior to exit no further information was provided.

5) Resident #26 was admitted to the facility on 9/14/16 and readmitted on 7/20/20 with diagnoses that included but were not limited to high blood pressure, high cholesterol, dementia, and schizophrenia. Resident #26's most recent MDS (Minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/15/21. Resident #26 was coded as being severely impaired in cognitive

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function scoring 00 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 7/21/21 at 10:12 a.m., an interview was conducted with Resident #26's responsible party, her husband. Her husband had stated that upon admission, staff had only went over DNR (Do Not Resuscitate) or Full Code Status. Her husband stated that the discussion regarding additional life prolonging measures such as enteral feeding, intravenous fluids and a ventilator/tracheotomy if needed; did not occur.

Review of Resident #26's clinical record revealed a Durable Do Not Resuscitate Order signed by the physician and dated for 2008 from the hospital. The following was documented:

"The patient is incapable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent, or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternative to the decision...While capable of making an informed decision, the patient has executed a written advanced directive which directs that life prolonging measures be withheld or withdrawn." This document was signed by the Responsible Party.

Resident #26's advanced directive could not be found in her clinical record.

On 7/22/21 at 9:50 a.m., an interview was conducted with ASM (Administrative Staff Member) #1 and ASM #2, the DON (Director of

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Nursing). ASM #1 stated that they didn't have the advanced directive for Resident #26. ASM #1 stated that if residents have an advanced directive upon admission from the hospital, they will file that into the record. ASM #1 stated that they will offer residents to formulate an advanced directive, but if the resident refuses, they do not attempt again. ASM #1 stated that they didn't have the documentation to support that advanced directives was discussed with each resident upon admission.

On 7/22/21 at approximately 4:30 p.m., ASM (Administrative Staff Member) #1, the interim Administrator; ASM #2, the DON (Director of Nursing), ASM #3, the ADON (Assistant Director of Nursing) and the Corporate Nurse #1 were made aware of the above concerns. No further information was presented prior to exit.

6) Resident #57 was admitted to the facility on 10/17/20 with diagnoses that included but were not limited to Anemia, atrial fibrillation, renal insufficiency requiring dialysis, and high blood pressure. Resident #57's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/11/21. Resident #57 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 7/21/21 at 2:00 p.m., an interview was conducted with Resident #57. Resident #57 could not determine if she was offered to formulate an advanced directive upon admission. Resident #57 seemed confused about what an advanced

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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
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directive was.

Review of Resident #57's clinical record revealed a Durable Do Not Resuscitate Order signed by the physician and resident on 7/8/20 from the hospital. The following was documented:

"The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment..." The next section regarding whether Resident #57 had executed an advanced directive was left blank.

Resident #57's advanced directive could not be found in her clinical record or any evidence that the facility offered to assist Resident #57 with formulating an advanced directive.

On 7/22/21 at 9:50 a.m., an interview was conducted with ASM (Administrative Staff Member) #1 and ASM #2, the DON (Director of Nursing). ASM #1 stated that they didn't have the advanced directive for Resident #57. ASM #1 stated that if residents have an advanced directive upon admission from the hospital, they will file that into the record. ASM #1 stated that they will offer residents to formulate an advanced directive, but if the resident refuses, they do not attempt again. ASM #1 stated that they didn't have the documentation to support that advanced directives was discussed with each resident upon admission.

On 7/22/21 at approximately 4:30 p.m., ASM (Administrative Staff Member) #1, the interim Administrator; ASM #2, the DON (Director of Nursing), ASM #3, the ADON (Assistant Director of Nursing) and the Corporate Nurse #1 were

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made aware of the above concerns. No further information was presented prior to exit.

7) Resident #48 was admitted to the facility on 1/13/20 and readmitted on 1/24/21 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes mellitus, high cholesterol, Alzheimer's disease, and dementia. Resident #48's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 4/2/21. Resident #48 was coded as being severely impaired in cognitive function scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status Exam).

Review of Resident #48's clinical record revealed a Durable Do Not Resuscitate Order signed by the physician and responsible party on 4/20/20 from the hospital. The following was documented:

"The patient is incapable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent, or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternative to the decision...While capable of making an informed decision, the patient has executed a written advanced directive which directs that life prolonging measures be withheld or withdrawn." This document was signed by the Responsible Party...The patient has not executed a written advanced directive (living will or durable power of attorney for health care)."

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F 578	Continued From page 29 There was no evidence that the facility offered and assisted Resident #48 with formulating an advanced directive. On 7/22/21 at 9:50 a.m., an interview was conducted with ASM (Administrative Staff Member) #1 and ASM #2, the DON (Director of Nursing). ASM #1 stated that they didn't have the advanced directive for Resident #48. ASM #1 stated that if residents have an advanced directive upon admission from the hospital, they will file that into the record. ASM #1 stated that they will offer residents to formulate an advanced directive, but if the resident refuses, they do not attempt again. ASM #1 stated that they didn't have the documentation to support that advanced directives was discussed with each resident upon admission. On 7/22/21 at approximately 4:30 p.m., ASM (Administrative Staff Member) #1, the interim Administrator; ASM #2, the DON (Director of Nursing), ASM #3, the ADON (Assistant Director of Nursing) and the Corporate Nurse #1 were made aware of the above concerns. No further information was presented prior to exit. 8. Resident #7 was admitted to the facility on 1/18/19 and readmitted on 11/25/20 with diagnoses that included but were not limited to End Stage Renal Disease and Major Depressive Disorder. Resident #7's most recent MDS (Minimum Data	F 578		

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Set Assessment) was a quarterly revision assessment with an ARD (assessment reference date) of 03/03/21. Resident #7 was coded as scoring 5 out of possible 15 on the BIMS (Brief Interview for Mental Status exam). This indicated Resident #7's cognitive abilities for daily decision making were severely impaired.

A review of the clinical records on 7/21/21 revealed there were no advance directives in the clinical record for resident #7.

9. Resident #32 was admitted to the facility on 06/04/18 and readmitted on 07/08/20. The current diagnoses included; Parkinson's disease and Unspecified Dementia without Behavioral Disturbance.

** Resident #32's most recent MDS (Minimum Data Set Assessment) was an annual assessment with an ARD (assessment reference date) of 03/10/21. Resident #32 was coded as scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status exam). This indicated Resident #32's cognitive abilities for daily decision making were moderately impaired.

A review of the clinical records on 7/21/21 revealed there were no advance directives in the clinical record for resident #32.

10. Resident #94 was admitted to the facility on 05/09/19 and readmitted on 05/23/19. The current diagnoses included; Unspecified Dementia without Behavioral Disturbance and Essential Hypertension.

Resident #94's most recent MDS (Minimum Data

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F 578	Continued From page 31 Set Assessment) an annual assessment with an ARD (assessment reference date) of 05/23/21. Resident #94 was coded as scoring 3 out of possible 15 on the BIMS (Brief Interview for Mental Status exam). This indicated Resident #94's cognitive abilities for daily decision making were severely impaired. A review of Resident #94's clinical record on 7/21/21 revealed no Advanced Directive. On 07/21/21 at approximately 12:52 PM an interview was conducted with OSM #1 concerning Advance Directives on Resident #7, Resident #25 and Resident #94. She stated, "No advance directives are on file." On 07/22/21 at approximately 9:45 AM an interview was conducted with the Administrator and DON (Director of Nursing) concerning Advance Directives. The Administrator stated, "There is no document supporting that the Advance Directives were reviewed upon admission." On 7/22/21 at approximately 4:20 PM a Pre-exit meeting was conducted with the Administrator, Director of Nursing, The Assistant Director of Nursing and with the Corporate Clinical Nurse concerning the above issues. No supporting documents were offered.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing	F 582		

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facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

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

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discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 2 of 3 residents (Resident #34 and Resident 55) in the survey sample.

The findings included:

1. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #34 who was discharged from skilled services with Medicare days remaining. Resident #34 was originally admitted to the nursing facility on 03/17/21. Diagnosis for Resident #34 included but not limited to Congestive Heart Failure (CHF). Resident #34's Minimum Data Set (MDS) an OBRA quarterly assessment with an Assessment Reference Date (ARD) date of 03/22/21 coded Resident #34 a 10 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicated moderate cognitive impairment.

Review of the SNF Beneficiary Notification Review provided by the facility to surveyor, was noted that Resident #34 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice.). The

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resident had received a NOMNC (Notice of Medicare Provider Non-Coverage), however; no copy of the SNF ABN was provided.

Resident #34 started a Medicare Part A stay on 03/17/21 and the last covered day of this stay was 04/02/20. Resident #34 was discharged from Medicare Part A services when benefit days were not exhausted. Resident #34 had only used 32 days of his Medicare Part A services with 68 days remaining. Resident #34 should have been issued a SNF ABN and an NOMNC. Resident #34 was only issued an NOMNC.

An interview was conducted with Social Worker (SW) on 07/21/21 at approximately 11:10 a.m. When asked if Resident #34 was issued and ABN, she replied, "No, I thought an ABN was only to be issued if the resident wanted to continue with skilled services and knowing that Medicaid wasn't' going to pay for the rest of their stay."

2. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #55 who was discharged from skilled services with Medicare days remaining. Resident #55 was admitted to the nursing facility on 01/08/21. Diagnosis for Resident #55 included but not limited to muscle weakness. Resident #55's Minimum Data Set (MDS) an OBRA Quarterly Assessment with an Assessment Reference Date (ARD) date of 04/09/21 coded Resident #55 a 09 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicated moderate cognitive impairment.

Review of the SNF Beneficiary Notification Review provided by the facility to surveyor, was noted that Resident #55 was not listed for having

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F 582	Continued From page 35 been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice.) The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage), however; no copy of the SNF ABN was provided. Resident #55 started a Medicare Part A stay on 01/08/21, and the last covered day of this stay was 02/08/21. Resident #55 was discharged from Medicare Part A services when benefit days were not exhausted. Resident #55 only used 17 days of her Medicare Part A services with 83 days remaining. Resident #55 should have been issued a SNF ABN and an NOMNC. Resident #55 was only issued an NOMNC. An interview was conducted with Social Worker (SW) on 07/21/21 at approximately 11:10 a.m. When asked if Resident #55 was issued and ABN, she replied, "No, I thought an ABN was only to be issued if the resident wanted to continue with skilled services and knowing that Medicaid wasn't' going to pay for the rest of their stay." The Administrator and Director of Nursing DON) was informed during the debriefing on 07/21/21 at approximately 1:45 p.m. The facility did not present any further information about the findings. The facility did not have a policy on NOMNC, ABN or Cut Letter.	F 582		
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	F 622		

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

§483.15(c)(2) Documentation.

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

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any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure all the required documentation including care plan goals and physician/RP (responsible party) contact information were sent with one of 56 residents; Resident #48 upon transfer to the hospital on 1/19/21.

The findings included:

Resident #48 was admitted to the facility on 1/13/20 and readmitted on 1/24/21 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes mellitus, high cholesterol, Alzheimer's disease, and dementia. Resident #48's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 4/2/21. Resident #48 was coded as being severely impaired in cognitive function scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status Exam).

Review of Resident #48's clinical record revealed that she was sent out to the hospital on 1/19/21. The following nursing note was documented in part: "During nursing rounds, this writer noted that resident was sweating profusely. No elevation in temp (temperature) at this time. Blood pressure was noted to be 166/144, BS (Blood Sugar) 188. Eyes fixed and dilated, non reactive to light. Resident started to display some seizure like activity. Oxygen applied at 2 lpm (liters per minute) via nasal cannula...Upon reassessment,

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resident noted to have some facial distortion and continued convulsions. 911 called and resident transferred to (Name of hospital) for further eval. (Evaluation)."

There was no evidence in the clinical record or on the SBAR (Situation, background, assessment and recommendation) form dated 1/19/21 that the following documentation was sent with Resident #48 upon transfer to the hospital:

(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Comprehensive care plan goals

On 7/21/21 at 10:04 a.m. and 12:04 p.m., an interview was attempted with Resident #48's responsible party. She could not be reached for an interview.

On 7/22/21 at 1:51 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. Resident #48's current nurse. When asked what was sent with each resident to the hospital at the time of an acute care transfer, LPN #2 stated that the facesheet, medication list, care plan goals, and the bed hold policy would be sent with the resident. When asked if information sent would be documented, LPN #2 stated that all documents sent with the resident should be documented in a nursing note. When asked how we would know if these documents were sent if there is no evidence of a nursing note or documentation showing evidence that the above documents were sent with the resident at the time of transfer, LPN #2 stated, "We wouldn't know."

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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 622	Continued From page 40 On 7/22/21 as of 3:00 p.m., the nurse who had sent Resident #48 out to the hospital on 1/19/21 could not be reached for an interview. On 7/22/21 at approximately 4:30 p.m., ASM (Administrative Staff Member) #1, the interim Administrator; ASM #2, the DON (Director of Nursing), ASM #3, the ADON (Assistant Director of Nursing) and the Corporate Nurse #1 were made aware of the above concerns. No further information was presented prior to exit. Facility policy titled, "Transfer or Discharge notice" did not address the above concerns. No further information was presented prior to exit.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		

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discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to notify the local long term care ombudsman of an acute care

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transfer to the hospital for two of 56 sampled residents; Resident #48 and #52.

The findings included:

1. Resident #48 was admitted to the facility on 1/13/20 and readmitted on 1/24/21 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes mellitus, high cholesterol, Alzheimer's disease, and dementia. Resident #48's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 4/2/21. Resident #48 was coded as being severely impaired in cognitive function scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status Exam).

Review of Resident #48's clinical record revealed that she was sent out to the hospital on 1/19/21. The following nursing note was documented in part: "During nursing rounds, this writer noted that resident was sweating profusely. No elevation in temp (temperature) at this time. Blood pressure was noted to be 166/144, BS (Blood Sugar) 188. Eyes fixed and dilated, non reactive to light. Resident started to display some seizure like activity. Oxygen applied at 2 lpm (liters per minute) via nasal cannula...Upon reassessment, resident noted to have some facial distortion and continued convulsions. 911 called and resident transferred to (Name of hospital) for further eval. (Evaluation)."

Further review of Resident #48's clinical record revealed that Resident #48 had returned to the facility on 1/24/21.

Facility staff could not provide evidence that the

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local long term care (LTC) ombudsman was notified of this acute transfer to the hospital.

On 7/22/21 at 11:00 a.m., an interview was conducted with OSM (Other Staff Member) #1, the social services assistant as the facility did not have a social worker. When asked the process for notifying the long term care ombudsman of facility discharges; OSM #1 stated that in her computer system she will just hit a button that says "Discharges" and send that generated report every month to the long term care ombudsman. OSM #1 then stated that it looked like the generated report was not capturing residents who were transferred to the hospital. OSM #1 stated that she was not aware of this until survey. When asked if she does a check system to ensure that all transfers are being reflected monthly to the LTC ombudsman, OSM #1 stated that the they were going to start doing that. OSM #1 confirmed that she could not find evidence that the LTC ombudsman was notified of Resident #48's transfer to the hospital.

On 7/22/21 at approximately 4:30 p.m., ASM (Administrative Staff Member) #1, the interim Administrator; ASM #2, the DON (Director of Nursing), ASM #3, the ADON (Assistant Director of Nursing) and the Corporate Nurse #1 were made aware of the above concerns.

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2. Resident #52 was admitted to the facility initially on 8/12/20 and readmitted on 6/29/20 with diagnoses to include but not limited to Diabetes Mellitus, Hypertension and Major Depressive Disorder.

Resident #52's most recent MDS (Minimum Data Set) was a Quarterly with an ARD (Assessment Reference Date) of 6/4/21. Resident #52's BIMS (Brief Interview for Mental Status) was coded as a 7 out of a possible 15 indicating the resident was moderately cognitively impaired but capable of some daily decision making.

Resident #52's Face Sheet was reviewed and is documented in part, as follows:

Last Qualifying Hospital Stay:
06/25/2020-06/29/2020

Resident #52's Progress Notes were reviewed and are documented in part, as follows:

6/25/2020 3:22 A.M.: resident vs (vital signs) 114/66 (blood pressure), 83 (pulse), 18 (respirations), 98.2 (temperature), O2 sats (oxygen saturations) 86% percent on room air at 3 liters via n/c (nasal cannula). Nursing call placed to md(medical doctor)/awaiting return call. resident sent out via 911 to Name (hospital) for eval(evaluation) and tx (treatment). be hold and car plan sent with resident. rp (representative) called.

6/25/20 12:58 P.M.: RP notified of resident's admittance to Name (hospital).

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F 623	Continued From page 46 On 7/21/21 the ASM(Administrative Staff Member) #1 was asked for documentation that the local Ombudsman was notified of Resident #55's discharge on 6/25/21. On 7/22/21 at 11:02 A.M. an interview was conducted with OSM(Other Staff Member)#1 regarding Ombudsman notification for Resident #52 hospital discharge on 6/25/21. OSM#1 stated, "I wasn't here when she was discharged, I started in September. I looked through the the binder and I did not see where the Ombudsman was notified of the discharge." OSM#1 was asked when should the Ombudsman be notified. OSM #1 stated, "The Ombudsman should be notified of all discharges and if there are any resident concerns." The facility policy titled "Transfer or Discharge Notice" last revised December 2016 was reviewed and is documented in part, as follows: Policy Interpretation and Implementation: 4. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman. On 7/22/21 at 4:25 P.M. a pre-exit debriefing was held with the ASM #1, ASM #, ASM #3 and ASM #4 were the above information was shared. Prior to exit no further information was provided.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the	F 625		

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nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure the written bed hold policy was sent with one of 56 residents; Resident #48 upon transfer to the hospital on 1/19/21.

The findings included:

Resident #48 was admitted to the facility on 1/13/20 and readmitted on 1/24/21 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes mellitus, high cholesterol, Alzheimer's disease, and dementia. Resident #48's most recent MDS

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(minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 4/2/21. Resident #48 was coded as being severely impaired in cognitive function scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status Exam).

Review of Resident #48's clinical record revealed that she was sent out to the hospital on 1/19/21. The following nursing note was documented in part: "During nursing rounds, this writer noted that resident was sweating profusely. No elevation in temp (temperature) at this time. Blood pressure was noted to be 166/144, BS (Blood Sugar) 188. Eyes fixed and dilated, non reactive to light. Resident started to display some seizure like activity. Oxygen applied at 2 lpm (liters per minute) via nasal cannula...Upon reassessment, resident noted to have some facial distortion and continued convulsions. 911 called and resident transferred to (Name of hospital) for further eval. (Evaluation)."

There was no evidence in the clinical record or on the SBAR (Situation, background, assessment and recommendation) form dated 1/19/21 that the written bed hold notice was sent with Resident #48 upon transfer to the hospital.

On 7/21/21 at 10:04 a.m. and 12:04 p.m., an interview was attempted with Resident #48's responsible party. She could not be reached for an interview.

On 7/22/21 at 1:51 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. Resident #48's current nurse. When asked what was sent with each resident to the hospital at the time of an acute care transfer, LPN #2

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stated that the facesheet, medication list, care plan goals, and the bed hold policy would be sent with the resident. When asked if information sent would be documented, LPN #2 stated that all documents sent with the resident should be documented in a nursing note. When asked how we would know if these documents were sent if there is no evidence of a nursing note or documentation showing evidence that the above documents were sent with the resident at the time of transfer, LPN #2 stated, "We wouldn't know."

On 7/22/21 as of 3:00 p.m., the nurse who had sent Resident #48 out to the hospital on 1/19/21 could not be reached for an interview.

On 7/22/21 at approximately 4:30 p.m., ASM (Administrative Staff Member) #1, the interim Administrator; ASM #2, the DON (Director of Nursing), ASM #3, the ADON (Assistant Director of Nursing) and the Corporate Nurse #1 were made aware of the above concerns. No further information was presented prior to exit.

Facility policy titled, "Bed-Holds and Returns" documents in part, the following: "Prior to a transfer, written information will be given to the residents and the resident representative that explains in detail:
a. The rights and limitations of the resident regarding bed holds;
b. The reserve bed payment policy as indicated by the state plan (Medicaid residents);
c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond that state bed-hold periods (Medicaid residents); and
d. The details of the transfer (per the Notice of Transfer)... "

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F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to complete a significant change MDS (Minimum Data Set) assessment for one of 56 residents; Resident #41, after being admitted to hospice services. The findings included: Resident #48 was admitted to the facility on 1/13/20 and readmitted on 1/24/21 with diagnoses that included but were not limited to heart failure, high blood pressure, diabetes mellitus, high cholesterol, Alzheimer's disease, and dementia. Resident #48's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 4/2/21. Resident #48 was coded as being severely impaired in cognitive function scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status Exam).	F 637		

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Review of Resident #48's clinical record revealed that he was put on hospice services on 6/17/21. The following current order was documented: "Admission to receive hospice services from (Name of Hospice Provider)."

Review of Resident #48's care plan dated 6/21/21 documented the following: "Special Services-Hospice. Resident requires hospice R/T (related to) family wishes and current condition...Resident will experience death with dignity and physical comfort. Advanced Directive wishes will be honored. Administer pain medication as ordered. Communicate with hospice when any changes are indicated to the plan of care. Identify the care and services to be provided by the facility and the hospice agency. Involve responsible party in care and decision making to maximal potential. Manage pain and other uncomfortable symptoms shceduled anagesicis. Medication and medical supplies to be provided by hospice as needed for palliation and management of the terminal illness and related conditions..."

Review of Resident #48's MDS assessments revealed that a significant change MDS had not been completed for Resident #48. The last completed MDS in Resident #48's recored was the quarterly assessment dated 4/2/21.

On 7/22/21 at 11:48 a.m., a telephone interview was conducted with RN #1 , the regional MDS nurse. The facility during survey did not have a MDS nurse onsite. When asked if a resident was admitted to hospice services, if a significant change MDS assessment would be completed, RN #1 stated, "It's supposed to be." When asked when a significant change assessment would be completed for Resident #48 who had been

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F 637	Continued From page 52 admitted to hospice on 6/17/21; RN #1 stated that a significant change assessment should have been completed by 7/1/21 and then transcribed on 7/22/21 (that day). RN #1 stated the reason why a significant change assessment had not been completed for Resident #48 was because he was never changed on the census side to hospice. On 7/22/21 at approximately 4:30 p.m., ASM (Administrative Staff Member) #1, the interim Administrator; ASM #2, the DON (Director of Nursing), ASM #3, the ADON (Assistant Director of Nursing) and the Corporate Nurse #1 were made aware of the above concerns. No further information was presented prior to exit. Facility policy titled, "Change in a Resident's Condition or Status" documents in part, the following: "If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by the current OBRA regulations governing resident assessments and as outlined in the MDS RAI (Resident Assessment Instrument) Instruction Manual."	F 637		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff	F 638		

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interviews, the facility's staff failed to complete a quarterly Minimum Data Set (MDS) assessment at least every 92 days for each resident.

The findings included;

During the course of the survey 7/20/21 through 7/22/21 many residents reviewed didn't have a current MDS assessment in the clinical record. Twenty residents were included in the survey for investigations. Eight of the twenty were missing a quarterly review and two of the twenty had missing annual MDS assessments.

The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. (CMS Resident Assessment Instrument Version 3.0 Manual, dated October 2019, Chapter 2, page 2-33)

On 7/20/21 at approximately 4:10 p.m., the Director of Nursing was asked to identify the MDS Coordinator and she stated the MDS Coordinator position was currently vacant but; they could telephone the regional MDS Coordinator for any questions.

On 7/21/21 at approximately 2:00 p.m., the Clinical Specialist provided a schedule of late MDS assessment, a total of forty-five.

On 7/22/21 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Clinical

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F 638	Continued From page 54 Specialist. The Clinical Specialist stated the Regional MDS Coordinator knew of the problem and was working towards addressing it. The Administrator stated a MDS Coordinator for the facility had been hired this week.	F 638		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.	F 640		

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(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interviews, the facility's staff failed to complete the resident required discharge Minimum Data Set (MDS) assessment within the required timeframe after each discharge from the facility.

The findings included;

On 7/20/21 at the end of the day meeting, a review of all offsite selected residents was conducted. CMS had identified 12 residents. Of the 12 residents six had been discharged from the facility, four had been discharged for more than 28 calendar days yet the discharge MDS assessment wasn't included in the clinical record or transmitted to CMS.

CMS's Resident Assessment Instrument Version 3.0 Manual, dated October 2019, Chapter 2, page 2-37 instructions read; a discharge MDS

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F 640	Continued From page 56 assessment must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days) and the assessment must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). On 7/20/21 at approximately 4:10 p.m., the Director of Nursing was asked to identify the MDS Coordinator and she stated the MDS Coordinator position was currently vacant but; they could telephone the regional MDS Coordinator for any questions. On 7/21/21 at approximately 2:00 p.m., the Clinical Specialist provided a schedule of discharge MDS assessment which hadn't been completed as required among many others. On 7/22/21 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Clinical Specialist. The Clinical Specialist stated the Regional MDS Coordinator knew of the problem and was working towards addressing it. The Administrator stated a MDS Coordinator for the facility had been hired this week.	F 640		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		

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F 657	Continued From page 57 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to inform one resident representative of care plan meetings and follow ups after conducting CP meetings. The findings included: Resident #7 was admitted to the facility on 1/18/19 and readmitted on 11/25/20 with diagnoses that included but were not limited to End Stage Renal Disease and Major Depressive Disorder. Resident #7's most recent MDS (Minimum Data Set Assessment) was a quarterly revision assessment with an ARD (assessment reference	F 657	Past noncompliance: no plan of correction required.	

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date) of 03/03/21. Resident #7 was coded as scoring 5 out of possible 15 on the BIMS (Brief Interview for Mental Status exam). This indicated Resident #7's cognitive abilities for daily decision making were severely impaired.

On 7/21/21 at approximately, 9:09 A.M., an interview was conducted with Resident #7 during the initial tour. She could not recall receiving a recent invitation for a care plan meeting. Resident #7 stated, "What care plan meeting."

On 7/22/21 at approximately 10:56 A.M., a phone call was made to Resident #7's RP (Responsible Party) concerning care plan meetings. She stated, "They used to call me for the meetings then they stopped calling me." She was asked if anyone from the facility was calling her with updates concerning the care plan meeting outcomes. She stated, "No."

On 07/22/21 at approximately 11:04 AM an interview was conducted with OSM (Other Staff Member/Social Services Worker) #1 concerning Resident #7's care plan meetings. She stated. "The care plan meetings are every three months on Tuesday and Thursdays. The notices are generated at the end of each month. I asked the residents if they wanted their families to participate. Resident #7 has a right to make her own decision and chooses not to have her sister attend the meetings. Resident #7 had a care plan meeting on June 10th but refused to attend. Me and the MDS (Minimum Data Set) coordinator attended the meeting. I didn't document it (The care plan meeting)."

On 7/22/1 Surveyor received a copy of the care plan invite letter from OSM #1. The document

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Reads: The care plan meeting is scheduled on 6/10/21 at 1:00 PM. Refused to allow notification of other parties was marked on the document as well.

According to Resident #7's face sheet her sister is her RP (Responsible Party).

According to the MDS. Resident #7 BIMS was coded as a 5 out of 15 which indicated that Resident's cognitive abilities for daily decision making were severely impaired.

On 7/22/21 at approximately 5:05 PM Spoke to Resident #7 concerning her sister attending her care plan meetings. She stated, "It don't make no difference if my sister want to go to the meetings. Ima do what I want anyway."

On 7/22/21 at approximately 5:15 PM The above information discussed with Resident #7 was shared with OSM #1. She stated that she would reach out to the resident's sister for now on."

On 7/22/21 at approximately 4:20 PM a Pre-exit meeting was conducted with the Administrator, Director of Nursing, The Assistant Director of Nursing and with the Corporate Clinical Nurse concerning the above issues. No comments were voiced.
The facility staff failed to ensure the timeliness of each resident's person-centered, comprehensive care plan, and that each resident and resident representative were involved in developing and making care plan decisions.

Past Non Compliance:

An Ad Hoc QAPI meeting date 06/21/21 with an

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F 657	Continued From page 60 Estimated completion date:08/30/21 The Identified Opportunity for Improvement/Deficient Practice: Care Plan Meeting 1. Immediate Corrective Action for those affected by the deficient practice: The IDT will be present to speak on each discipline that contributes to the patient's holistic care. Proof of communication to the patient and the RP will be made in concerns of the date and time of the care plan meeting to ensure that the time and date works for them by way of charting in the Matrix System. Care Conference will be charted in Matrix of what was discussed and who attended. Proof of documents provided to the resident and the RP. Care Plan will be updated after each assessment is completed. 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: Ensure care plan reflects resident current state Chart in matrix in concerns of care plan Review assessment dates IDT 3. Measures put in to place/systematic changes to ensure the deficient practice does not recur Social Services/Designee to schedule care plan meetings with residents and their family/RP's Daily clinical meeting with IDT to discuss residents care conference that will be approaching Charting all care plan meetings and the attendee Charting that RP and resident received a copy of care plan documents 4. Plan to monitor performance to ensure solutions are sustained: Weekly wound reviews of all care plan meeting notes with IDT QIPI for any non-compliant areas	F 657		

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F 686	Continued From page 61	F 686		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to complete weekly wound assessments for a pressure ulcer* to the right heel that was present upon admission for one of 56 sampled residents, Resident #57. *Pressure Injury (ulcer)- A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. https://npuap.org/page/PressureInjuryStages.	F 686		

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The findings included:

Resident #57 was admitted to the facility on 10/17/20 with diagnoses that included but were not limited to Anemia, atrial fibrillation, renal insufficiency requiring dialysis, and high blood pressure. Resident #57's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/11/21. Resident #57 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #57 was coded as having one unstageable pressure ulcer (1).

Review of Resident #57's clinical record revealed that she was admitted from the hospital was an unstageable pressure ulcer to her right heel. The following was documented on the hospital discharge summary dated 10/15/21: " Hospitalist progress note...Right heel ulcer, unstageable with eschar (dead tissue), present on admission."

Review of a weekly wound assessment dated 10/19/20 documented the following: "Wound Location: Right heel. Present on admission- Yes. Length: 2 Width 1.3. Can depth be measured: No. Exudate: Moderate. Tissue Type: Necrotic Tissue...Comments: Resident seen by wound MD (medical doctor), A/O (Alert/Oriented) with confusion, 0/10 pain level. this wound is inflammatory stage, necrotic tissue removed and viable tissue was established. wound cleaned and dressed, (Name of RP (responsible party) made aware of wound update."

An order dated 10/19/20 for "Skin prep daily (2) "

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was documented as being implemented by staff as evidence by the October TAR (Treatment Administration Record). This order was changed to "Rt (Right) heel: Paint with betadine (3) daily" on 10/29/20 through 3/16/21.

Further review of Resident #57's clinical record revealed weekly wound assessments until 11/23/20. No other weekly wound assessments or notes from the wound care physician could be found after 11/23/20 until 3/4/21 (13 weeks). The following was documented on the 11/23/20 weekly wound assessment from the wound care physician: "Unstageable due to necrosis of the right heel 2.3 x 2.7 x not measurable. Thick adherent black necrotic tissue 100 percent. Wound status: Improved. Primary Dressing: Betadine once daily."

Further review of the November, December 2020 and January, February and March 2021 TARS revealed that staff continued to implement the order for Betadine daily.

Review of the next wound assessment from the wound care physician dated 3/4/21 documented the following: "Unstageable due to necrosis of the right heel. Wound size: 3.0 x 2.5 x not measurable. Exudate: None. 100 percent thick adherent black necrotic tissue. Wound Progress: No Change. Dressing: Betadine apply twice daily for 30 days. Reason for no debridement: Non -infected heel necrosis."

There was no evidence of any further weekly wound assessments from the wound care physician or facility staff after 3/12/21 until 4/7/21 (3 weeks). The following was documented on the 4/7/21 weekly wound assessment: "Unstagebale

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due to necrosis of the right heel: 3.5 x 3.5 x not measurable. 100 percent thick adherent necrotic tissue. Wound progress: No change. Dressing: Betadine apply twice daily for 30 days."

Review March 2021 TARS revealed that staff were implementing the above orders for Betadine until 4/15/21 when the order had changed to "Santyl apply once daily for 30 days; apply calcium alginate for 30 days. Gauze roll. Skin prep."

Further review of the weekly wound assessments revealed assessments up until 6/14/21. There was no evidence of any assessments conducted after 6/14/21 to current (5 weeks). The most recent weekly wound assessment dated 6/14/21 documented the following: "Right heel. 1.5 x 1 x 0.1 (Depth). Stage III (4). Tissue Type: Granulation Tissue. Wound healing status improving: Improving." The treatment for Santyl remained unchanged at that time.

Review of Resident #57's current wound care orders for July 2021 revealed that her Santyl (5) orders had not changed.

Further review of the June and July 2021 TARS revealed that staff were implementing the above order for Santyl daily.

Review of Resident #57's current care plan dated 10/22/20 documented in part, the following: "Pressure Injury...(Name of Resident #57's will heal without complications through next review date...Assess the pressure ulcer for location, stage, size, (length, width, depth), presence/absence of granulation tissue and epithelization..."

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On 7/22/21 at 2:12 p.m., an interview was conducted with ASM #2, the DON (Director of Nursing). This interview was conducted after multiple requests for the facility to obtain the above missing weekly wound assessments for Resident #57. When asked how often already identified wounds were assessed, ASM #2 stated that wounds should be assessed weekly by the wound care physician. When asked who was responsible for assessing wounds if the wound care physician is not present or cannot see the resident, ASM #2 stated that they used to have a wound care nurse who was doing all the weekly wound assessments but that she had left the job a month and 1/2 ago. ASM #2 stated that the floor nurses should dress the wounds per order and that they should measure the wounds weekly. ASM #2 stated that the nurses should then call on her (the DON) to come in and stage the wound for every resident wound. ASM #2 stated that she would then measure the wound as well. ASM #2 stated that she then expected her nursing staff to document her own observations of stages and measurements in the computer system (the clinical record) on a weekly wound management document. When asked if her nursing staff were coming to get her from 6/14/21 through current to stage and measure wounds on Resident #57, ASM #2 stated that they were. When asked where the documentation was located for these dates, ASM #2 stated that she thought her staff were documenting but that they were not. When asked why her staff were expected to document on a weekly wound measurement assessment if they were in fact her observations; ASM #2 stated that she would give them the assessment and they were supposed to enter into the computer. ASM #2 handed this

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writer "At Risk Management Meetings" for dates June 20th through July 3rd (two week period). This form had a measurement documented for Resident #57's right heel of "1.5 x 1.5 x 0.2. Stage 3." There was no date showing when this measurement was obtained. There was no description of the wound during this time. ASM #2 also handed this writer an "At risk Management Meeting" for date July 4th through July 17th. The form had a measurement documented for Resident #57's right heel of "2.5 x 1.5 x 0.1 cm" No stage was documented. There was no date showing when this measurement was obtained. There was no description of the wound during this time. When asked the exact dates of when these measurements were obtained, ASM #2 stated that she could not recall the exact dates the measurements were obtained that were located on the "At Risk Meeting" forms. When asked about the location of all other missing weekly wound measurements from 11/23/21 through 3/4/21 and 3/12/21 through 4/7/21; ASM #2 stated that she would have to look for those. When asked the purpose of weekly wound assessments, ASM #2 stated that the purpose was to see if the wound was making progress with healing or to see if it was declining, to see if a treatment/medication/intervention needed to be changed to promote healing.

On 7/22/21 at approximately 2:30 p.m., the Corporate Nurse #1, stated that Resident #57 had arrived back from dialysis and that she was going to make staff do a current measurement and assessment to see if the wound to her right heel had declined or improved. When asked why the wound care physician hadn't been coming in on weekly basis for periods at at time, the Corporate Nurse #1 stated that she thought it was

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because the resident would always be at dialysis when the wound care physician would make her rounds. When asked if they should coordinate the wound care physician's schedule with Resident #57's dialysis, the Corporate Nurse #1 stated that she was going to start working on a plan for that.

On 7/22/21 at approximately 3:00 p.m., wound care observation was conducted with ASM (Administrative Staff Member) #3, the ADON (Assistant Director of Nursing) and LPN (Licensed practical nurse) #1, Resident #57's assigned nurse. Resident #57's wound appeared to remain a Stage three; with no depth. The following measurements were recorded: 1.4 x 1 cm (centimeters); indicating that her right heel wound had not declined since 6/14/21. There was no evidence of escarp (necrotic) tissue).

On 7/22/21 at approximately 4:30 p.m., ASM (Administrative Staff Member) #1, the interim Administrator; ASM #2, the DON (Director of Nursing), ASM #3, the ADON (Assistant Director of Nursing) and the Corporate Nurse #1 were made aware of the above concerns. No further information was presented prior to exit. The only policy that could be provided was a policy on performing wound care.

(1) Unstageable pressure ulcer: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural

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(biological) cover" and should not be removed. This information was obtained from: National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

(2) Skin-Prep Protective Barrier Wipes: Skin-Prep is a liquid film-forming dressing that forms a protective film to help reduce friction during removal of tapes and films. The Skin Prep also protects fragile skin and reduces adhesive removal trauma. This information was obtained from the website: www.allegromedical.com

(3) Betadine is used to help treat and prevent infection in minor cuts, scrapes and burns. This information was obtained from https://betadine.com/what-is-betadine/.

(4) Stage three pressure ulcer: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable. This information was obtained from: National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

(5) Santyl- *SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris,

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F 686	Continued From page 69 allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>).	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility's staff failed to ensure the resident's call bell was kept within reach for 1 of 56 residents (Resident #39), in the survey sample. The findings included: Resident #39 was originally admitted to the facility 5/2/15 and has never been discharged from the facility. The current diagnoses included; schizophrenia and a psychotic disorder. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/22/21 coded the resident as not completing the Brief Interview for Mental Status (BIMS) therefore a staff interview was conducted. It revealed the resident recalls the season, staff names and faces, room location and that he is in a nursing home. The conclusion was with modified independence decision making in new	F 689		

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situations. In section "G" (Physical functioning) the resident was coded as requiring total care with bathing, extensive assistance of one person with personal hygiene and bathing, limited assistance with transfers and toileting and supervision after set-up with eating.

On 7/20/21 at approximately 1:35 p.m., Resident #39 was observed in bed without the call bell within reach. The resident was asked to push the call bell but was unable to locate the end of the call bell with the push button.

On 7/21/21 at approximately 10:50 a.m., Resident #39 was again observed in bed. The call bell was observed to be connected in the wall and the resident was asked to activate the call bell. Resident #39 reached for the call bell but was unable to obtain the call button. Beneath the bed two call bell buttons were observed. One was red, the other white. The Unit Manager was asked to make an observation of the resident's call bell status.

There was signage on the resident's wall which read; ensure the call bell is within reach and the mat is beside the bed when the resident is in bed.

Review of Resident #39's care plan was a Fall problem dated 4/7/21. The goal read; The resident will remain free from serious injury related to falls through 7/7/21. The interventions included; keep the call light within reach at all times.

An interview was conducted with the Unit Manager on 7/21/21 at approximately 10:55 a.m. The Unit Manager stated the resident wasn't capable of using the call bell because of it's

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F 689	Continued From page 71 positioning. The Unit Manager retrieved the resident's call bell from beneath the bed and placed it to the resident's left side attaching it to the bed linen. The Unit Manager further stated he wasn't aware of the signage on the wall but after reading it he felt it was inappropriate and it would be removed. On 7/22/21 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Clinical Specialist. The Clinical Specialist stated the Unit Manager was new in the role and she was sure he appreciated receiving the information. The Clinical Specialist also stated the resident's call bell should be within reach at all times.	F 689		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of facility documents and staff interview, the facility's staff failed to ensure a Registered Nurse was on duty for 8 consecutive	F 727		

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F 727	Continued From page 72 hours each day The findings included: During review of staffing it was identified that a Registered Nurse (RN) had not worked at least 8 consecutive hours a day, 7 days a week over a six month timespan. The deficits were on the weekends and major holidays. An interview was conducted with the previous staffing coordinator. After a careful review of the schedules she concluded the RN coverage wasn't available 8 consecutive hours a day, 7 days a week. On 7/22/21 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Clinical Specialist. The Clinical Specialist stated she wasn't aware of the RN staffing concerns. The Director of Nursing stated that was in the past but the review revealed as recent as 7/11/21 and 7/17/21, a RN didn't work 8 consecutive hours.	F 727		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		

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Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that facility staff failed to appropriately store medications on one of four facility medication carts; the 400 hall medication cart.

The findings included:

On 7/21/21 at 11:56 a.m., observation of the 400 hall medication cart was conducted. The top drawer to the medication cart had a medication cup full of eight pills that were unidentified. When asked the nurse (LPN (Licensed Practical Nurse) #3 who the pills belonged to, LPN #3 stated that the pills belonged to a resident who didn't want to take them right away at 9 a.m. LPN #3 stated that this resident wanted her to leave the pills in his room but that she didn't think that was appropriate. LPN #3 stated that she left the pills in the top drawer because she as going to attempt to give him his medication later. When asked if his medication should have been discarded at the time of refusal,. LPN #3 stated,

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F 761	Continued From page 74 "Yes." LPN #3 stated that she shouldn't have left the cup of pills in the first drawer of the medication cart. On 7/22/21 at approximately 4:30 p.m., ASM (Administrative Staff Member) #1, the interim Administrator; ASM #2, the DON (Director of Nursing), ASM #3, the ADON (Assistant Director of Nursing) and the Corporate Nurse #1 were made aware of the above concerns. No further information was presented prior to exit. A policy regarding medication storage could not be provided.	F 761		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure that the garbage disposal area was free from garbage and refuse. The findings included: On 07/20/21 at approximately 11:40 a.m., a tour of the outside dumpster area was made with the Dietary Manager. Four dumpsters were observed outside in the dumpster area. The smallest dumpster observed with the following: The bottom of the dumpster was coming apart with used briefs, used gloves, trash coming from the opening (front and back of the dumpster). Surrounding the dumpster on the ground (front and back) were used gloves, used briefs, paper,	F 814		

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plastic bottles and food. Flies and nets were observed flying around the garbage and refuse that was coming from the bottom of dumpster where it was coming apart. Behind the dumpster was the following: 3 old ripped/torn mattresses with standing water on the top mattress and trash scattered all over the back area near the fence. The Dietary Manager was asked, "Who is responsible for ensuring the dumpster area is free from garbage and refuse, she replied, "I must be honest, I really don't know."

On 07/20/21 at approximately 1:10 p.m., the dumpster area was toured with the Maintenance Director. He stated, "I had no idea the dumpster area looked like that (trash, debris and refuse) everywhere." The Maintenance Director also stated, "I had no idea the dumpster was coming apart; it need to be replaced right away." The Maintenance Director called (name of trash/dumpster Company), informed them there was a dumpster that was coming apart and need to be replaced as soon as possible. After the Maintenance Director got off the phone, he replied, "They will be here to tomorrow to replace the small dumpster that is falling apart."

On 07/21/21 at approximately 2:05 p.m., the Maintenance Director came into the conference room and stated, (name of dumpster company) just delivered a new dumpster and removed the dumpster that was coming apart.

The Administrator and Director of Nursing (DON) was informed during the debriefing on 07/21/21 at approximately 1:45 p.m. When asked who is responsible for keeping the dumpster area free from debris and refuse, the Administrator replied, "Maintenance, they should be making daily

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F 814	Continued From page 76 rounds of the dumpster area." The Facility Policy titled, "Food-Related Garbage and Refuse Disposal with a revision date of 10/2017. Policy statement: Food-related garbage and refuse are disposed of in accordance with current state laws. Policy Interpretation and Implementation include but not limited to: 5. Garbage and refuse containing food wastes will be store in a manner that is inaccessible to pets. 7. Outside dumpster provided by garbage pickup services will be kept closed and free of surrounding litter.	F 814		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services	F 947		

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to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:
Based on review of facility documents and staff interviews, the facility's staff failed to ensure two of two Certified Nurse Aides (CNA) in-service training included dementia management and resident abuse prevention training.

The findings included;

A review was conducted on two CNA's training program. The training records didn't include dementia management and resident abuse prevention training.

On 7/21/21 at approximately 11:40 a.m., an interview was conducted with CNA #1. CNA #1 stated she had received training in working with dementia residents and she was capable of stating best practice information regarding working with resident's with dementia with or without behaviors. CNA #1 was also capable of stating some types of abuse and what to do if a resident was not compliant with care. An observation was made on 7/21/21 as CNA #1 provided care to a resident with dementia and behaviors. No concerns were observed. CNA #1 stated education is always welcomed.

On 7/22/21 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Clinical Specialist. The Clinical Specialist stated the facility was in the process of regrouping and boosting morale and all staff education would be a priority.