STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING AND REHABILITATION	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/7/19 through 7/9/19. Corrections are required for compliance with 42 CFR Part 483.73 Requirements for Long Term Care facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 006 SS=D	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, facility-based and community-based risk	E 006		8/23/19

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

Electronically Signed | 07/26/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 006	Continued From page 1 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 staff interview and facility document review, the facility staff failed to ensure that the facility emergency preparedness plan included a documented facility-based and community based risk assessment that utilized an all hazards	E 006	E006 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated utilizing a documented facility-based and	

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E 006	Continued From page 2 approach. The findings included: The facility staff failed to include a documented facility-based and community based risk assessment that utilized an all hazards approach in the facility's emergency preparedness plan. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility did not have a documented facility-based and community based risk assessment that utilized an all hazards approach.included within the facilitiy emergency preparedness plan. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 006	community based risk assessment all hazards approach Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for utilization of an all hazards facility and community based risk assessment has been reviewed and no changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	
E 007 SS=D	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3),	E 007		8/23/19

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E 007	Continued From page 3 §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] 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 all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that addressed the Resident population, and included, but was not limited to, persons at-risk; the type of services the	E 007	E007 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated to ensure that it addressed the resident	

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E 007	Continued From page 4 facility has the ability to provide in an emergency; and continuity of operations. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan addressed the Resident population, and included, but was not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility did not address the Resident population, and included, but was not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 007	population including, but not limited to, persons at-risk; the types of services the facility the ability to provide in an emergency; and continuity of operations Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the resident population, including, but not limited to, persons at-risk; the types of services the facility has the ability to provide in an emergency; and continuity of operations has been reviewed and no changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	

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E 013 SS=D	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical	E 013		8/23/19

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E 013	Continued From page 6 emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included policies and procedures that were developed based on the facility and community based risk assessment and communication plan that utilized an all-hazards approach. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan included policies and procedures that were developed based on the facility and community based risk assessment and communication plan that utilized an	E 013	E013 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated to ensure that it included policies and procedures that were developed based on the facility and community based risk assessment and communication plan that utilized an all-hazards approach. Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the	

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E 013	Continued From page 7 all-hazards approach. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility emergency preparedness pan did not include policies and procedures that were developed based on the facility and community based risk assessment and communication plan that utilized an all-hazards approach. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 013	Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included policies and procedures that were developed based on the facility and community based risk assessment and communication plan that utilized an all-hazards approach have been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must	E 015		8/23/19

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E 015	Continued From page 8	E 015		

develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):]
Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the

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E 015	Continued From page 9 following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included policies and procedures to provide for sewage and waste disposal. The findings included: The facility staff failed to include policies and procedures to provide for sewage and waste disposal in the facility's emergency preparedness plan. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility did not have policies and procedures to provide for sewage and waste disposal included within the facility emergency preparedness plan. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 015	E015 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated to ensure that it included policies and procedures to provide for sewage and waste disposal. Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included policies and procedures to provide for sewage and waste disposal has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training	

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E 015	Continued From page 10	E 015	to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	
E 018 SS=D	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the	E 018		8/23/19

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E 018	Continued From page 11	E 018		

specific name and location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of

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SOUTH ROANOKE NURSING AND REHABILITATION	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	Continued From page 12 assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that that included a tracking system to be used to document locations of residents and staff during an emergency. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan included a tracking system to be used to document locations of Residents and staff during an emergency. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility emergency preparedness plan did not include a tracking system to be used to document locations of Residents and staff during an emergency.	E 018	E018 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated to ensure that it included a tracking system to be used to document locations of residents and staff during an emergency. Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included a tracking system to be used to document locations	

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E 018	Continued From page 13 On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 018	of residents and staff during an emergency has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	
E 022 SS=D	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 022		8/23/19

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E 022	Continued From page 14 [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included policies and procedures that are aligned with the facility's emergency plan and risk assessment that addressed how the facility will provide a means for sheltering in place for Residents, staff, and volunteers who remain in the facility during an emergency. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan included policies and procedures that are aligned with the facility's emergency plan and risk assessment that addresses how the facility will provide a means for sheltering in place for Residents, staff, and volunteers who remain in the facility during an emergency. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the	E 022	E022 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated to ensure that it addressed how the facility will provide a means for sheltering in place for residents, staff, and volunteers who remain in the facility during an emergency. Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency	

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E 022	Continued From page 15 facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility emergency preparedness plan did not include policies and procedures that are aligned with the facility's emergency plan and risk assessment that addresses how the facility will provide a means for sheltering in place for Residents, staff, and volunteers who remain in the facility during an emergency. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 022	Preparedness Plan addressed how the facility will provide a means for sheltering in place for residents, staff, and volunteers who remain in the facility during an emergency has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	
E 023 SS=D	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 023		8/23/19

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E 023	Continued From page 16 this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included policies and procedures to preserve resident information, protect the confidentiality of resident information, and secures and maintains availability of records during an emergency. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan addressed the	E 023	E023 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated to ensure that it included policies and procedures to preserve resident information; protect the confidentiality of resident information; and secures and maintains availability of records during an emergency. Identification of Deficient Practice(s) &	

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E 023	Continued From page 17 Resident population, and included policies and procedures to preserve Resident information, protect the confidentiality of Resident information, and secures and maintains availability of records during an emergency. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility emergency preparedness plan did not include policies and procedures to preserve Resident information, protect the confidentiality of Resident information, and secures and maintains availability of records during an emergency. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 023	Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included policies and procedures to preserve resident information; protect the confidentiality of resident information; and secures and maintains availability of records during an emergency has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	
E 024 SS=D	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)	E 024		8/23/19

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E 024	Continued From page 18 §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024		

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E 024	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included policies and procedures that addressed the use of volunteers and other emergency staffing strategies to address surge needs during an emergency. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan included policies and procedures that addressed the use of volunteers and other emergency staffing strategies to address surge needs during an emergency. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility emergency preparedness plan did not include policies and procedures that addressed the use of volunteers and other emergency staffing strategies to address surge needs during an emergency. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 024	E024 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated to ensure that it included policies and procedures that addressed the use of volunteers and other emergency staffing strategies to address surge needs during an emergency. Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included policies and procedures that addressed the use of volunteers and other emergency staffing strategies to address surge needs during an emergency has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan.	

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E 024	Continued From page 20	E 024	Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	
E 026 SS=D	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance	E 026		8/23/19

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E 026	Continued From page 21 with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included policies and procedures that addressed the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan included policies and procedures that addressed the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility's emergency preparedness plan did not address the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 026	E026 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated to ensure that it addressed the facility□s role in providing care and treatment at alternate care sites under an 1135 waiver. Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included policies and procedures that addressed the facility□s role in providing care and treatment at alternate care sites under an 1135 waiver has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan.	

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E 026	Continued From page 22	E 026	Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	
E 033 SS=D	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)]	E 033		8/23/19

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E 033	Continued From page 23 (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included a communication plan that included a method for sharing information and medical documentation for Residents under the facility's care, as necessary, with other health providers to maintain the continuity of care, and to address the means the facility will use to release Resident information to include the general conditon and location of Residents. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan that included a communication plan that included a method for sharing information and medical documentation for Residents under the facility's care, as	E 033	E033 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated to ensure that it included a communication plan that included a method for sharing information and medical documentation for residents under the facility□s care, as necessary, with other health providers to maintain the continuity of care, and to address the means the facility will use release the resident information to include the general condition and location of residents. Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing	

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E 033	Continued From page 24 necessary, with other health providers to maintain the continuity of care, and to address the means the facility will use to release Resident information to include the general condition and location of Residents. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility emergency preparedness plan did not include a communication plan that included a method for sharing information and medical documentation for Residents under the facility's care, as necessary, with other health providers to maintain the continuity of care, and to address the means the facility will use to release Resident information to include the general condition and location of Residents. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 033	or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness included a communication plan that included a method for sharing information and medical documentation for residents under the facility□s care, as necessary, with other health providers to maintain the continuity of care, and to address the means the facility will use release the resident information to include the general condition and location of residents has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	
E 035 SS=D	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)	E 035		8/23/19

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E 035	Continued From page 25 §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop an emergency preparedness plan that included a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with Residents or clients and their families or representatives. The findings included: The facility staff failed to ensure that the facility emergency preparedness plan included a method for sharing information from the emergency plan, and that the facility has determined it is	E 035	E035 Corrective Action(s): The Facility□s Emergency Preparedness Plan has been revised and updated to ensure that it included a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives. Identification of Deficient Practice(s) & Corrective Action(s): The entire Emergency Preparedness Plan has been reviewed to identify any missing	

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E 035	Continued From page 26 appropriate with Residents or clients and their families or representatives. On 7/9/19 at 1:02 pm, the surveyor and the facility administrator who was responsible for the emergency preparedness plan reviewed the facility's emergency preparedness plan. The facility administrator informed the surveyor that the facility emergency preparedness plan did not include a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with Residents or clients and their families or representatives.. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	E 035	or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness included a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives has been reviewed. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/7/19 through 7/9/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code	F 000		

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F 000	Continued From page 27 survey/report will follow. The census in this 98 certified bed facility was 86 at the time of the survey. The survey sample consisted of 22 current Resident reviews and 2 closed record reviews.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (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	F 578		8/23/19

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F 578	Continued From page 28 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review, and clinical record review, it was determined the facility staff failed to ensure Durable Do Not Resuscitate Order (DDNR) forms and/or the facility's advance directive processes were correctly implemented for 2 of 24 residents (Resident #336 and Resident #80). The findings include: 1. The facility staff failed to ensure provider/physician involvement in the implementation of DDNR forms as evidenced by finding thirty (30) DDNR forms that had been pre-signed by the facility's medical director (MD). These pre-signed DDNR forms did not include patient information. Eight (8) of the pre-signed forms included the medical director's name (printed) and the medical director's phone number. Resident #336 was admitted to the facility on 7/5/19. Resident #336's diagnoses included, but were not limited to: Parkinson's disease, hyperlipidemia, arthritis, and thoracic compression fracture. Resident #336's initial minimum data set (MDS) assessment had not yet	F 578	F578 Corrective Action(s): Resident #336 has had their DDNR form reviewed by the DON and the attending physician and it has been correctly completed in accordance with the facility□s advance directive process to accurately reflect resident #336□s code status. An Incident and Accident form was completed for this incident. Resident #80 has had their DDNR form has been correctly completed in accordance with the facility□s advance directive process to accurately reflect resident #80□s code status. An Incident and Accident form was completed for this incident. Identification of Deficient Practice(s) & Corrective Action(s): All other residents may have been potentially affected. The Admission Director and/or Social Services Director will review all resident□smedical records to ensure the DDNR is accurately completed and is completed in	

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F 578	Continued From page 29 been completed but other clinical documentation indicated the resident was not cognitively impaired, did require assistance with hygiene and bathing, and used assistive devices when ambulating. Review of Resident #336's clinical documentation on the morning of 7/8/19 revealed a completed DDNR form that had been signed by a physician and dated 7/5/19 but no documentation was found of an 7/5/19 resident assessment completed by the physician. Resident #336's clinical documentation included a telephone/verbal order dated 7/5/19 for "Full code unless otherwise ordered"; documentation indicted this order was given by the same physician who had signed the aforementioned DDNR. On 7/8/19 at 8:35 a.m., LPN (licensed practical nurse) #1 was asked about the physician completing the DDNR on 7/5/19 but not writing a progress note or signing all orders. LPN #1 directed the surveyor to the DON (Director of Nursing). On 7/8/19 at 8:45 a.m., the DON was asked about the facility's DDNR forms. The DON was asked where the forms were kept. The DON provided the surveyor with a file folder which included thirty (30) DDNR forms which had been pre-signed by the facility's Medical Director. On 7/8/19 at 9:30 a.m., the physician whose signature was on the aforementioned DDNR was interviewed via telephone. The physician reported he did have some pre-signed DDNR forms at the facility for times when he is not available. On 7/8/19 at 3:10 p.m., the DON reported the	F 578	accordance with the facility□s advance directive process. An incident and accident form will be completed for each negative finding. Systemic Change(s); The Facility policy and procedure was reviewed and no changes are warranted at this time. The Admissions Director and/or Social Worker, and nursing administration have been inserviced on the proper completion of a DDNR in accordance with the facility□s advance directive process. Monitoring: The Admission Director and/or Social Services Director are responsible for maintaining compliance. The Admission Director and/or Social Service Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation.	

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F 578	Continued From page 30	F 578		

pre-signed DDNR forms were used when obtaining a telephone/verbal order for the DDNR.

The following information was found in a policy titled, "DNR - DO NOT RESUSCITATE" (with an approval date of 10/27/16): "A DDNR may be issued to the resident by a physician, with whom the resident has established a bona fide physician/resident relationship ... The physician or designee shall explain to the resident or the person authorized to consent on the resident's behalf, the alternatives available, including the issuance of a DDNR Order. If the option of a DDNR is agreed upon, the physician or designee has the following responsibilities: 1. Obtain the signature of the resident or the person authorized to consent on the resident's behalf; 2. Execute and date the Physician Order on the DDNR Order Form; 3. Issue the original DDNR Order Form; and 4. Explain how to and who may revoke the DDNR Order." The DON explained to the survey team that the aforementioned designee would be a specific physician assistant (PA).

During a survey team meeting with the facility's Regional Nurse Consultant (RNC), Director of Nursing (DON), and Facility Administrator (FA) on the afternoon of 7/9/19, the DDNR forms that were pre-signed by a physician were discussed for a final time. No additional documentation was provided to the survey team during this meeting. The FA reported the pre-signed DDNR forms had disposed of.

2. The facility staff failed to ensure the Virginia Department of Health Durable Do Not Resuscitate Order was complete for Resident # 80.

The clinical record of Resident #80 was reviewed

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F 578	Continued From page 31	F 578		

7/7/19 through 7/9/19. Resident #80 was admitted to the facility 6/17/19 with diagnoses that included but not limited to dementia, decreased comprehension and memory, pain, constipation, and depression.

Resident #80's admission minimum data set (MDS) with an assessment reference date (ARD) of 6/24/19 assessed the resident with a BIMS (brief interview for mental status) as 02/15. Resident #80's baseline care plan for new admissions identified Resident #80 was a "DNR."

The July 2019 physician's orders in Resident #80's clinical record were reviewed. Resident #80 had an order that read "DNR."

The Virginia Department of Health Durable Do Not Resuscitate Order dated 6/17/19 was incomplete. Section 1 certifies if the patient is capable or incapable of making an informed decision about health care decisions. Resident #80's was marked to indicate the resident was incapable of making that decision. Section 2 certifies that A. an advanced directive had been executed by the patient making an informed decision about life-prolonging procedures, B. the patient has appointed a designated person to make those decisions, or C. an advanced directive had not been executed in writing. The second option (B) was marked for Resident #80. The order was signed by Resident #80's authorized person but did not include the physician's printed name, the physician signature and the emergency phone number.

The surveyor informed the administrator, the director of nursing, and the regional corporate registered nurse on 7/9/19 at 8:13 a.m. of the

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F 578	Continued From page 32 above concern and requested the facility policy on DNRs. The surveyor reviewed the facility policy titled "DNR-Do Not Resuscitate" on 7/9/19. The policy read in part "A valid DDNR Form must include all of the following: 1. Patient's Full Legal Name 2. Date of Issue 3. Either Block #1 or #2 is checked 4. If Block #2 is checked, then either Block #A, B, C must be checked 5. Physician's Signature 6. Either patient's signature (if Block #1 is checked) or RP (responsible party) signature (if Block #2 is checked)." No further information was provided prior to the exit conference on 7/9/19.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		8/23/19

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F 580	Continued From page 33 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide notification of changes for 1 of 24 Residents in the survey sample, Resident # 30. The findings included:	F 580	F580 Corrective Action(s) Resident #30□s attending physician has been notified of the resident□s falls that occurred on 5/8/19, 5/31/19, 6/15/19, and 6/21/19. A Facility Incident & Accident	

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F 580	Continued From page 34 The facility staff failed to ensure that the physician was notified that Resident # 30 had falls. Resident #30 was a 92-year-old-female who was admitted to the facility on 4/29/19. Diagnoses included but were not limited to, dementia, agitation, depression, and hypertension. The clinical record for Resident # 30 was reviewed on 7/7/19 at 1:59 pm. The most recent MDS (minimum data set) assessment for Resident # 30 was an admission assessment with an ARD (assessment reference date) of 5/6/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 30 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicated that Resident # 30's cognitive status was severely impaired. The current plan of care for Resident # 30 was reviewed and revised on 5/19/19. The facility staff documented a focus area for Resident # 30 as, "The resident is high risk for falls r/t (related to) dementia, weakness medications hx (history) of fall." Interventions included but were not limited to, "Anticipate and meet the resident's needs." On 7/7/19 at 2:00 pm, the surveyor observed a nurse's note for Resident # 30 that had been documented on 5/8/19 at 7:00 pm. The nurse's note was documented as, "Nurse entered room to sounding alarm. Observed resident lying on floor beside bed. "I was going home, I just slipped." Resident said she hit her head. Skin tear noted to right elbow. ROM (range of motion) of x 4 extremities all WNL (within normal limits). Resident assisted to bed and CNA (certified	F 580	form has been completed for this incident. Identification of Deficient Practices & Corrective Action(s): All other residents experiencing falls may have potentially been affected. The DON and Unit Managerwill conduct a 100% review of all incident and accident forms for the last 30 days to identify residents at risk. An incident & accident form will be completed for all negative findings and will be corrected at time of discovery. Systemic Change(s): The facility policy and procedures havebeen reviewed and no changes are warranted at this time. The 24 Hour Report and documentation in the medical record will serve as the source document for communicating changes in resident condition/status, to include resident□s who experience a fall. Licensed staff will be inserviced by the DON and/or Regional nurse consultant on the notification of physician□s regarding changes in resident condition and incidents involving a resident. Monitoring: The DON is responsible for maintaining compliance. The DON will complete weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be corrected at time of discovery. Aggregate findings of these audits will be reported to the QA committee for review, analysis and recommendationfor changes in facility policy, procedure and/or	

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nursing assistant) helped prepare resident for bed. Skin tear cleaned and dressed by nurse Neuro checks put in place. Fax written to (Medical Director's name withheld). Daughter (Daughter's name withheld) notified." The surveyor observed that the documentation in the nurse's note reflected that the facility medical director and Resident # 30's representative had been notified, but there was no documentation that reflected that the hospice physician had been notified that Resident # 30 fell on 5/8/19.

A nurse's note that was documented on 5/31/19 at 5:00 pm was documented as, "Called to res (resident) room per CNA. Res fell on floor when being assisted to BR (bathroom). Noted resident lying on her right side. CNA states she hit her head on floor. Noted hematoma on back of head. Assessed res, able to move all extremities well. VS (vital signs) 98.2-85-24-186/78. Assisted res to BR Neuro checks initiated PERL (pupils equal and reactive to light) bilateral grips strong. CNA stated that while ambulating with res to BR her O2 (oxygen) tubing was around her feet. CNA tried to move O2 tubing out of the way and res lost her balance and fell."
A nurse's note that was documented on 5/31/19 at 5:30 pm was documented as, "POA (power of attorney) notified of fall and fax written for (Medical Director's name withheld)." The surveyor observed that the documentation in the nurse's note reflected that the facility medical director and Resident # 30's representative had been notified, but there was no documentation that reflected that the hospice physician had been notified that Resident # 30 fell on 5/31/19.

A nurse's note was documented on 6/15/19 at 4:00 pm. The nurse's note was documented as,

practice.

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"Heard alarm and CNA stated resident was on the floor. Noted lift chair in high position and forward. Appears to have pitched resident in the floor. Unsure if hit forehead, no hematoma noted. Neuro checks initiated anyway. 97.8- P (pulse) 87- R (respirations) 24, B/P (blood pressure) 193/83. Resident's daughter (Daughter's name withheld) notified." The surveyor did not observed any documentation that reflected that the facility medical director or the hospice physician had been notified that Resident # 30 fell on 6/15/19.

A nurse's note documented on 6/21/19 at 10:30 pm was documented as, "Rsd (resident) observed sitting on floor in front of recliner with alarm sounding. Rsd denies any pain at this time. No apparent injuries. POA notified of fall and fax written for (Medical director's name withheld). V/S 136/82, 88, 98.3, 20, and 97%." The surveyor did not observe any documentation that reflected that the hospice physician had been made aware that Resident # 30 fell on 6/21/19.

The "Nursing Facility Agreement" for hospice contained documentation that included but was not limited to,
..."4.2.3 Ensuring that the Facility communicates with the Hospice Medical Director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians." ...

On 7/8/19 at 3:15 pm, the administrative team was made aware of the findings as stated above.

On 7/9/19 at 1:20 pm, the director of nursing acknowledged that there was no documentation in Resident # 30's clinical record that supported

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F 580	Continued From page 37 that the hospice physician had been made aware that Resident # 30 had fallen on 5/8/19, 5/31/19, 6/15/19, and 6/21/19, and there was no documentation that reflected that the facility medical director had been made aware that Resident # 30 had fallen on 6/15/19. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a	F 622		8/23/19

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resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this 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)

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F 622	Continued From page 39 (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide the receiving provider with the appropriate information to include the basis for the transfer, contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advanced Directive information, all special instructions or precautions for ongoing care, comprehensive care plan goals, and all other necessary information including a copy of the resident's discharge summary and the facility failed to document information provided to the receiving provider in the clinical record for 2 of 24 residents (Resident #34 and Resident #37). The findings included:	F 622	F622 Corrective Action(s): The facility staff failed to document what information was sent to the receiving provider when Resident #37 was transferred to the emergency room on 5/24/19. A facility incident and accident form has been completed for this incident. The facility staff failed to document what information was sent to the receiving provider when Resident #34 was transferred to the emergency room on 6/29/19. A facility incident and accident form has been completed for this incident. Identification of Deficient Practices/Corrective Action(s):	

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F 622	Continued From page 40 1. The facility staff failed to document what information was sent to the receiving provider when Resident #37 was transferred to the emergency room 5/24/19. The clinical record of Resident #37 was reviewed 7/7/19 through 7/9/19. Resident #37 was admitted to the facility 1/10/19 and readmitted 5/28/19 with diagnoses that included but not limited to pneumonia, urinary tract infection, gastroesophageal reflux disease (GERD), hypertension, hypothyroidism, peripheral neuropathy, anxiety, fibromyalgia, dementia, near syncope, first degree AV (atrioventricular), hyperlipidemia, and chronic kidney disease. Resident #37's quarterly MDS (minimum data set) with an assessment reference date (ARD) of 5/16/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The nursing progress note dated 5/24/19 at 9:00 a.m. read, "Rsd (resident) sent to hospital (name omitted) per dtr's (daughter's) request d/t (due to) URI (upper respiratory infection), UTI (urinary tract infection) with SOB (shortness of breath) and severe discomfort. VS (vital signs) @ (at) transfer 129/70 (blood pressure), 86 (pulse), 24 (respirations), 98.8 (temperature), 93% (oxygen saturation level) 2L (liters) O2 (oxygen)." The clinical record did not document what information was sent with Resident #37 when transferred to the hospital on 5/24/19. The surveyor interviewed the director of nursing on 7/9/19 at 10:00 a.m. The DON provided the surveyor the documentation of the papers that are to be sent with the resident when the	F 622	All other residents discharged and/or transferred from the facility may have been affected. The DON and/or designee will conduct a 100% audit of all residents who have been discharged and/or transferred from the facility in the past 30 days to identify residents that did not have documentation regarding what information was sent with the resident to the provider. A facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON and/or Regional Nurse Consultant will inservice facility licensed staff on the information required to be submitted to the receiving facility when a resident is being transferred or discharged to the hospital or other outside health care facility. The inservice will also include the requirement that there be documentation of that information being sent. Monitoring: The DON/designee will be responsible for maintaining compliance. The DON and/or designee will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure,	

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F 622	Continued From page 41 residents are sent to the emergency room/hospital. The form read "Attention all RN/LPNs (registered nurses/licensed practical nurses) Any time a resident goes to the ER/Hospital, you must document in the nursing notes all papers you sent with them. They will need the following sent. 1. Transfer sheet 2. Copy of MAR (medication administration record)/prn (as needed) sheet 3. Copy of face sheet 4. Copy of DNR (do not resuscitate) form if they have one 5. Copy of their care plan You must document who you talked to at the hospital when you call to give report. Also that you talked with RP (responsible party)." The 5/24/19 nursing note did not have documentation of paper work sent to the hospital when Resident #37 was transferred or documentation of whom the report was given to at the hospital. The surveyor interviewed registered nurse #1 on 7/9/19 at 10:30 a.m. on the information that was provided to the receiving hospital when Resident #37 was transferred on 5/24/19. R.N. #1 stated two (2) copies of the transfer form are made-one to give to the rescue squad and one for the hospital, care plan, medication list, face sheet, and DNR. R.N. #1 stated he/she calls the hospital but evidently didn't document that in the nursing note. The DON provided the list of forms to R.N. #1 that require documentation in the clinical record. R.N. #1 acknowledged he/she had not seen the form and didn't know to document.	F 622	and/or practice.	

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The surveyor requested the facility policy for transfers/ombudsman notification, and bed hold from the DON. The DON was asked if he/she would expect the nursing staff to document what information was sent with the resident to the hospital. The DON stated he/she would expect nurses to document in the clinical record who they talked to at the hospital and document such.

The surveyor reviewed the facility policy on transfers on 7/9/19. The policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or resident representative (sponsor) will be notified in writing of the following information:
a. The reason for the transfer or discharge
b. The effective date of the transfer or discharge
c. The location to which the information is being transferred or discharged
d. A statement of the resident's rights to appeal the transfer or discharge, including;
(1) the name, address, email and telephone number of the entity which receives such requests;
(2) information about how to obtain, complete and submit an appeal form; and
(3) how to get assistance completing the appeal process;
e. The facility bed-hold policy;
5. The reasons for the transfer or discharge will be documented in the resident's medical record."

No further information was provided prior to the exit conference on 7/9/19.
2. For Resident #34 the facility staff failed to document information sent to the receiving provider when the Resident was transferred to the hospital.

Resident #34 was admitted to the facility on

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05/02/19 and readmitted on 07/02/19. Diagnoses included but not limited to hypertension, diabetes mellitus, arthritis, dementia, chronic obstructive pulmonary disease, hip fracture and glaucoma.

The admission MDS (minimum data set) with an ARD (assessment reference date) of 05/09/19 assigned the Resident a BIMS (brief interview for mental status) score of 15 out of 15.

Resident #34's clinical record was reviewed on 07/09/19. It contained a nurse's progress note, which read in part "06/29/19 1:30 pm ...called Resident's husband. She was sent to ER for eval due to temp and full code. Have not had anything from ER at ... (name omitted) or husband at this time." and "06/29/19 2 pm When Resident went to hospital a copy of meds/MARS (medication administration record), face sheet, transfer sheet was sent."

Surveyor spoke with the DON (director of nursing) on 07/08/19 and asked what information was sent when a Resident was transferred and the DON provided the surveyor with a checklist, which read as follows:
"Attention all RN/LPNs (registered nurses/licensed practical nurse)
Anytime a Resident goes to the ER/Hospital, you must document in the nursing notes all papers you sent with them.
They will need the following sent.
1. Transfer sheet
2. Copy of MAR/PRN (as needed) sheet
3. Copy of face sheet
4. Copy of DNR (do not resuscitate) if they have one
5. Copy of their care plan
You must document who you talked to at the

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F 622	Continued From page 44 hospital when you call to give report. Also that you talked with RP (responsible party)." There was no documentation in the clinical record of a report given to the hospital or the person spoken with at the hospital. There was also no documentation that a copy of the Resident's care plan was provided. The DON stated that she would expect the nurses to document whom they spoke with at the hospital. The concern of not documenting information sent to the hospital was discussed with the administrative team during a meeting on 07/09/19 at approximately 1:20 pm No further information was provided 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.	F 623		8/23/19

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F 623	Continued From page 45 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (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	F 623		

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	495002	A. BUILDING _____ B. WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING AND REHABILITATION	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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 623	Continued From page 46 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §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, clinical record review and facility document review the facility staff failed	F 623	F623 Corrective Action(s):	

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F 623	Continued From page 47 to provide notifications to the ombudsman and Resident's RP (responsible party) when a Resident was transferred for 2 of 24 Residents, Resident #34 and Resident #37. The findings included: 1. For Resident #34 the facility staff failed to notify the local state ombudsman that the Resident had been transferred to the hospital. Resident #34 was admitted to the facility on 05/02/19 and readmitted on 07/02/19. Diagnoses included but not limited to hypertension, diabetes mellitus, arthritis, dementia, chronic obstructive pulmonary disease, hip fracture and glaucoma. The admission MDS (minimum data set) with an ARD (assessment reference date) of 05/09/19 assigned the Resident a BIMS (brief interview for mental status) score of 15 out of 15. Resident #34's clinical record was reviewed on 07/09/19. It contained a nurse's progress note, which read in part "06/29/19 1:30 pm ...called Resident's husband. She was sent to ER for eval due to temp and full code. Have not had anything from ER at ... (name omitted) or husband at this time." and "06/29/19 2 pm When Resident went to hospital a copy of meds/MARS (medication administration record), face sheet, transfer sheet was sent." Surveyor spoke with the DON (director of nursing) on 07/09/19 at approximately 11 am regarding notifications sent to the local ombudsman. DON stated that she did not notify the ombudsman. Surveyor then spoke with the facility SW (social worker) regarding notifying the	F 623	Resident #34□s responsible party and the state ombudsman office have been notified that the facility failed to provide a discharge/transfer notice for the resident□s transfer to the hospital on 6/28/19. Resident #37□s responsible party and the state ombudsman office have been notified that the facility failed to provide a written discharge/transfer notice for the resident□s transfer to the hospital on 5/24/19. Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director and/or Admissions Director will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 60 days. Residents identified at risk will be corrected at time of discovery and the required notifications to the residents□ responsible party and the state ombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility□s social worker(s) and nursing administration on the requirement that a resident□s responsible party and the state ombudsman be notified of resident	

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F 623	Continued From page 48 ombudsman. SW stated that she did not notify the ombudsman, and "This is the first I've heard of it". The surveyor requested and was provided with a facility policy entitled "Transfer or Discharge Notice" which read in part, "Our facility shall provide a Resident and/or the Resident's representative (sponsor) with a thirty (30)-day written notice of an impending transfer or discharge. 2. Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge: a. The transfer is necessary for the Resident's welfare and the Resident's needs cannot be met in the facility; 4. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman." The concern of not notifying the local state ombudsman of Resident transfers was discussed with the administrative team during a meeting on 07/09/19 at approximately 1:20 pm. No further information was provided prior to exit. 2. The facility staff failed to provide written notice of transfer to the resident and the resident representative when the resident was transferred to the hospital, failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such and failed to document in the medical record ombudsman notification when Resident #37 was transferred to the hospital. The clinical record of Resident #37 was reviewed 7/7/19 through 7/9/19. Resident #37 was admitted to the facility 1/10/19 and readmitted	F 623	discharges/transfers. Monitoring: The Social Services Director will be responsible for maintaining compliance. The Social worker, and/or Admissions Director will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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5/28/19 with diagnoses that included but not limited to pneumonia, urinary tract infection, gastroesophageal reflux disease (GERD), hypertension, hypothyroidism, peripheral neuropathy, anxiety, fibromyalgia, dementia, near syncope, first degree AV (atrioventricular), hyperlipidemia, and chronic kidney disease.

Resident #37's quarterly MDS (minimum data set) with an assessment reference date (ARD) of 5/16/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

The nursing progress note dated 5/24/19 at 9:00 a.m. read, "Rsd (resident) sent to hospital (name omitted) per dtr's (daughter's) request d/t (due to) URI (upper respiratory infection), UTI (urinary tract infection) with SOB (shortness of breath) and severe discomfort. VS (vital signs) @ (at) transfer 129/70 (blood pressure), 86 (pulse), 24 (respirations), 98.8 (temperature), 93% (oxygen saturation level) 2L (liters) O2 (oxygen)."

The surveyor was unable to locate documentation in the clinical record of the above information when Resident #37 was transferred on 5/24/19.

The surveyor interviewed the director of nursing on 7/9/19 at 10:00 a.m. The DON provided the surveyor the documentation of the papers that are to be sent with the resident when the residents are sent to the emergency room/hospital. The form read "Attention all RN/LPNs (registered nurses/licensed practical nurses) Any time a resident goes to the ER/Hospital, you must document in the nursing notes all papers you sent with them.
They will need the following sent.
1. Transfer sheet

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2. Copy of MAR (medication administration record)/prn (as needed) sheet
3. Copy of face sheet
4. Copy of DNR (do not resuscitate) form if they have one
5. Copy of their care plan

You must document who you talked to at the hospital when you call to give report. Also that you talked with RP (responsible party)."

The 5/24/19 nursing note did not have documentation that written notice of transfer was provided to the resident and resident representative, the appeals process information and documentation that the state long-term care ombudsman was informed of the transfer.

The surveyor interviewed the social worker on 7/9/19 at 11:00 a.m. if the state long-term care ombudsman was informed of Resident #37's transfer to the hospital. The social worker stated she had not informed the ombudsman of transfers to the hospital. "First I've heard of it."

The DON was also interviewed on 7/9/19 at 12:01 p.m. about written notice provided to the resident and the resident representative about the transfer. The DON stated the resident's families are usually here and given a copy of the transfer form but there's no documentation of such.

The surveyor reviewed the facility policy on transfers on 7/9/19. The policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or resident representative (sponsor) will be notified in writing of the following information:
a. The reason for the transfer or discharge
b. The effective date of the transfer or discharge

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F 623	Continued From page 51 c. The location to which the information is being transferred or discharged d. A statement of the resident's rights to appeal the transfer or discharge, including; (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; 5. The reasons for the transfer or discharge will be documented in the resident's medical record." No further information was provided prior to the exit conference on 7/9/19.	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 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	F 625		8/23/19

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F 625	Continued From page 52 (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, the facility staff failed to provide to the resident and the resident representative at the time of transfer/discharge written notice that specifies the duration of the bed-hold policy for 2 of 24 residents (Resident #34 and Resident #37). The findings included: 1. The facility staff failed to provide Resident #37 and the resident representative written information about bed-hold when the resident was transferred to the hospital 5/24/19. The clinical record of Resident #37 was reviewed 7/7/19 through 7/9/19. Resident #37 was admitted to the facility 1/10/19 and readmitted 5/28/19 with diagnoses that included but not limited to pneumonia, urinary tract infection, gastroesophageal reflux disease (GERD), hypertension, hypothyroidism, peripheral neuropathy, anxiety, fibromyalgia, dementia, near syncope, first degree AV (atrioventricular), hyperlipidemia, and chronic kidney disease. Resident #37's quarterly MDS (minimum data	F 625	F625 Corrective Action(s): Resident #37 and their RP have been notified that the facility failed to review and offer notice of bed-hold when Resident #37 was transferred to the hospital on 5/24/19. An Incident and Accident form has been completed for this resident. Resident #34 and their RP have been notified that the facility failed to review and offer notice of bed-hold when Resident #34 was transferred to the hospital on 6/29/19. An Incident and Accident form has been completed for this resident. Identification of Deficient Practice(s) and Corrective Action(s): All other residents could potentially be affected. The Bed-Hold policy and forms are now kept at the nursing station for after hour□s transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of all bed-holds to residents and/or Responsible	

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F 625	Continued From page 53 set) with an assessment reference date (ARD) of 5/16/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The nursing progress note dated 5/24/19 at 9:00 a.m. read, "Rsd (resident) sent to hospital (name omitted) per dtr's (daughter's) request d/t (due to) URI (upper respiratory infection), UTI (urinary tract infection) with SOB (shortness of breath) and severe discomfort. VS (vital signs) @ (at) transfer 129/70 (blood pressure), 86 (pulse), 24 (respirations), 98.8 (temperature), 93% (oxygen saturation level) 2L (liters) O2 (oxygen)." The clinical record did not have documentation that written notice of bed hold information was provided to the resident and the resident representative when Resident #37 was transferred to the hospital 5/24/19. The DON was interviewed on 7/9/19 at 12:01 p.m. about written notice provided to the resident and the resident representative about bed holds. The DON stated as of 6/1/19, bed holds are being done. The DON stated the beds were always held until the staff spoke with the family about the resident's transfer. The surveyor requested the facility policy on bed holds. The surveyor reviewed the facility policy on transfers on 7/9/19. The policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or resident representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge b. The effective date of the transfer or discharge c. The location to which the information is being transferred or discharged d. A statement of the resident's rights to appeal	F 625	parties. Systemic Change(s): The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social Services Director/ Admissions Director and licensed staff have been inserviced by the administrator and/or the Regional Nurse Consultant on the bed-hold requirement and the proper use and notification of the Bed-Hold policy. Monitoring: The Admissions Director and/or Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service director and/or Admissions Director to ensure proper bed-hold notification was completed at the time of transfer or therapeutic leave. Any/all negative findings will be corrected at time of discovery. The results of these audits will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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the transfer or discharge, including;
(1) the name, address, email and telephone number of the entity which receives such requests;
(2) information about how to obtain, complete and submit an appeal form; and
(3) how to get assistance completing the appeal process;
e. The facility bed-hold policy;
5. The reasons for the transfer or discharge will be documented in the resident's medical record."

No further information was provided prior to the exit conference on 7/9/19.

2. For Resident #34 the facility staff failed to provide written notification of a bed hold offer when the Resident was transferred to the hospital.

Resident #34 was admitted to the facility on 05/02/19 and readmitted on 07/02/19. Diagnoses included but not limited to hypertension, diabetes mellitus, arthritis, dementia, chronic obstructive pulmonary disease, hip fracture and glaucoma.

The admission MDS (minimum data set) with an ARD (assessment reference date) of 05/09/19 assigned the Resident a BIMS (brief interview for mental status) score of 15 out of 15.

Resident #34's clinical record was reviewed on 07/09/19. It contained a nurse's progress note, which read in part "06/29/19 1:30 pm ...called Resident's husband. She was sent to ER for eval due to temp and full code. Have not had anything from ER at ... (name omitted) or husband at this time." and "06/29/19 2 pm When Resident went to hospital a copy of meds/MARS (medication

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F 625	Continued From page 55 administration record), face sheet, transfer sheet was sent." The surveyor could not locate information regarding the offer of a bed hold. Surveyor spoke with the DON (director of nursing) on 07/09/19 at approximately 11:05 am regarding the offer of a bed hold for Resident #34. The DON stated, "We always hold their beds until we are told otherwise. This is their home". The concern of not offering a bed hold was discussed with the administrative staff during a meeting on 07/09/19 at approximately 1:20 pm. No further information was provided prior to exit.	F 625		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to follow physician orders for 1 of 24 Residents, Resident #49. The findings included: The facility staff failed to administer the Residents	F 684	F684 Corrective Action(s): Resident #49□s attending physician was notified that the facility failed to administer eye ointment as ordered. A facility Medication Error form was completed for this incident. Identification of Deficient	8/23/19

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F 684	Continued From page 56 eye ointment as ordered by the physician. The order read to administer to the left eye when in fact the nurse administered the medication to both eyes. The record review revealed that Resident #49 had been admitted to the facility on 03/01/19. Diagnoses included, but were not limited to, trichiasis left lower eyelid, dementia without behavioral disturbance, hypertension, dry eyes, bladder spams, depression, and insomnia. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/23/19 included a BIMS (brief interview for mental status) summary score of 6 out of a possible 15 points. On 07/08/19 beginning at approximately 8:34 a.m., the surveyors observed RN (registered nurse) #1 prepare and administer Resident #49's morning medications. During this observation RN #1 was observed administering the Residents lubifresh pm artificial eye ointment (refresh pm eye ointment). RN #1 was observed to administer this medication to both eyes. The Residents clinical record included orders for refresh pm instill by ophthalmic route 2-3 times every day into the left eye. During an interview with RN #1 on 07/08/19 at approximately 9:28 a.m., RN #1 verbalized to the surveyor that she had administered this medication into both eyes. The administrative staff were notified of the medication error during a meeting with the survey	F 684	Practices/Corrective Action(s): All other residents receiving medications may have potentially been affected. The DON and/or designee will conduct a 100% audit of all resident□s current physician orders and MARs to identify resident at risk. Residents identified at risk will be corrected at time of discovery and theattending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): Facility policy and procedures have been reviewed. No revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record and physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician medication & treatment orders. The DON and/or Regional nurse consultant will inservice all licensed staff on the procedure for obtaining, transcribing, and completing physician ordered medication and treatment orders. Monitoring: The DON will be responsible for maintaining compliance. The DON and/or designee will perform weekly MAR audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action	

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F 684	Continued From page 57 team on 07/08/19 at approximately 3:09 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684	will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure that 1 of 24 Residents in the survey sample received respiratory care consistent with professional standards of practice, Resident # 30. The findings included The facility staff failed to ensure that Resident # 30 received 3 liters of oxygen per physician's orders. Resident #30 was a 92-year-old-female who was admitted to the facility on 4/29/19. Diagnoses included but were not limited to, dementia, agitation, depression, and hypertension. The clinical record for Resident # 30 was	F 695	F 695 Corrective Action(s): Resident #30 has had their oxygen administration orders clarified with the attending physician. The attending physician has been notified that Resident #30 did not receive oxygen at the correct flow rate as ordered by the physician. A facility Incident & Accident form has been completed for this incident. Identification of Deficient Practices & Corrective Action(s): All residents receiving oxygen therapy may have potentially been affected. A 100% review of all resident□s oxygen orders will be conducted by the DON and/or designee to identify residents at	8/23/19

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F 695	Continued From page 58 reviewed on 7/7/19 at 1:59 pm. The most recent MDS (minimum data set) assessment for Resident # 30 was an admission assessment with an ARD (assessment reference date) of 5/6/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 30 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicated that Resident # 30's cognitive status was severely impaired. Section O of the MDS assesses special treatments, procedures, and programs. In Section O0100, the facility staff documented that Resident # 30 had received oxygen within the last 14 days during the look back period for the 5/6/19 ARD. Resident # 30 had current orders that were signed by the physician on 7/1/19. Resident # 30's orders included but were not limited to, "O2 (oxygen) ae 3L/min (3 liters per minute) via NC (nasal cannula) at all times may remove for showers only." On 7/7/19 at 1:32 pm, the surveyor was in Resident # 30's room conducting a Resident representative interview with Resident # 30's daughter. The surveyor observed that Resident # 30 was receiving oxygen via nasal cannula. The surveyor observed that the concentrator that delivered oxygen to Resident # 30 was set to deliver 2 liters of oxygen per minute. On 7/9/19 at 9:03 am, the surveyor and RN #1 (registered nurse) observed Resident # 30 in her room as she received oxygen via nasal cannula. The surveyor and RN # 1 observed the oxygen concentrator that delivered oxygen to Resident # 30. The surveyor and RN # 1 observed that the oxygen concentrator was set to deliver 2 liters of oxygen per minute to Resident # 30. RN # 1 and	F 695	risk. Residents found to be at risk will be corrected at the time of discovery. A facility Incident & Accident form will be completed for each item discovered. Systemic Change(s): The facility policy and procedure for Oxygen administration has been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced by the DON and/or Regional Nurse Consultant on the facility policy and procedure for accurate oxygen administration and monitoring per physician order. Inservices will include the delivery of oxygen per physician order. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will perform daily audits of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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F 695	Continued From page 59 the surveyor reviewed the current orders for Resident # 30. RN # 1 agreed that Resident # 30 was not receiving oxygen at the physician ordered rate of 3 liters per minute. RN # 1 stated, "I will fix it." On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 7/9/19.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		8/23/19

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F 755	Continued From page 60 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and during a medication pass and pour observation, the facility staff failed to ensure a medication was available for administration for 1 of 24 Residents, Resident #49. The findings included: The facility staff did not have the physician ordered medication refresh tears available for administration. This resulted in Resident #49 missing their scheduled dose at 9:00 a.m. The record review revealed that Resident #49 had been admitted to the facility on 03/01/19. Diagnoses included, but were not limited to, trichiasis left lower eyelid, dementia without behavioral disturbance, hypertension, dry eyes, bladder spasms, depression, and insomnia. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/23/19 included a BIMS (brief interview for mental status) summary score of 6 out of a possible 15 points. The Residents clinical record included a	F 755	F755 Corrective Action(s): Resident 49□s attending physician has been notified that the facility failed to ensure that the physician ordered Namzaric medication was available from pharmacy for administration to Resident #49. A facility Incident and Accident form has been completed for this incident. Identification of Deficient Practices & Corrective Action(s): All residents may have potentially been affected. A 100% review of all resident□s medication orders has been conducted by the DON/designee to identify residents at risk. Residents found to be at risk due the medications being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each. Systemic Changes: The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been inserviced by DON and/or Regional	

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F 755	Continued From page 61 physicians order for refresh tears instill one 1 drop into both eyes four times daily for dry eyes. The administration times were documented as 9:00 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m. On 07/08/19 beginning at approximately 8:34 a.m. the surveyor observed RN (registered nurse) #1 during a medication pass and pour observation. During this observation, the surveyor did not observe the nurse administer the Residents refresh tears. On 07/08/19 at 9:28 a.m., RN #1 verbalized to the surveyor that she did not have the Residents refresh tears for administration and she would obtain them from their automatic medication dispensing system. On 07/08/19 at 10:43 a.m., RN #1 verbalized to the surveyor that the eye drops were not available in the facility system for administration, the pharmacy would send before the next scheduled dose, and the physician had been notified. Indicating Resident #49 would miss their 9:00 a.m. dose. The administrative staff were notified of the issue regarding the Residents refresh tears during a meeting with the survey team on 07/08/19 at 3:09 p.m. The facility policy titled, "Medication Shortages/Unavailable Medications" read in part, "...Upon discovery that facility has an inadequate supply of a medication to administer to a resident, the nurse will notify the DON (director of nursing) or designee and initiate action to obtain the medication from the pharmacy...If the next available delivery would cause a delay or a	F 755	Nurse Consultant on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy for administration. The inservice will include the steps the nurses should take should a medication not be delivered timely from the pharmacy. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will conductweekly audits of resident MAR□s each week to confirm the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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F 755	Continued From page 62 missed dose in the resident's medication schedule, the nurse will obtain the medication from the pharmacy STAT box/med dispense. If the medication is not available in the STAT box, the nurse will notify pharmacy and arrange for an emergency delivery or use of an emergency (back-up) third party pharmacy..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		8/23/19

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F 758	Continued From page 63 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that 2 of 24 Residents in the survey sample were free of unnecessary psychotropic medications, Resident # 13 and Resident # 14. The findings included: 1. The facility staff failed to appropriately monitor Resident # 13 for behaviors, side effects, and effectiveness associated with the use of Risperidone. Resident # 13 was an 87-year-old-female who was admitted to the facility on 9/1/16. Diagnoses	F 758	F 758 Corrective Action(s): Resident 13□s attending physician and consulting pharmacist was notified that resident #13 did not receive appropriate psychotropic drug monitoring for the physician ordered Risperidone . Resident 13□s physician and consulting pharmacist has reviewed resident 13□s medication regime and made adjustments to the medication regime. A facility Incident & Accident form was completed for this incident. Resident #14□s attending physician and	

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F 758	Continued From page 64 included but were not limited to, Alzheimer's disease, dementia, hallucinations, and psychosis with behavioral disorder. The clinical record for Resident # 13 was reviewed on 7/7/19 at 2:20 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/16/19. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 13's cognitive status was moderately impaired. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 13 had received an antipsychotic medication for 7 days during the look back period for the 4/16/19 ARD. The plan of care for Resident # 13 was reviewed and revised on 4/23/19. The facility staff documented a focus area for Resident # 13 as, "The resident has impaired cognitive function/dementia or impaired thought processes r/t (related to) dx (diagnosis) of Alzheimer's disease." Interventions included but were not limited to, "Observe for adverse effects of antipsychotic and report to MD (medical doctor) promptly." The physician signed resident # 13's current orders on 7/1/19. Orders included but were not limited to, "Risperidone 1 mg/ml (milligram per milliliter) oral solution. Take 0.5 ml by mouth every morning for psychosis/mood." On 7/7/19 at 3:05 pm, the surveyor reviewed the nurse's notes and behavior monitoring sheets for Resident # 13. The surveyor observed that the facility staff failed to monitor Resident # 13 for	F 758	consulting pharmacist was notified that the facility staff failed to document behaviors for Resident #14 that justified an increase in the dosage of Seroquel. A facility Incident & Accident form was completed for this incident. Identification of Deficient Practice(s) and Corrective Action(s): All other residents receiving psychotropic medications may have been potentially affected. The DON, designee, and/or Pharmacy consultant will review the medication orders of all residents receiving psychotropic medication to identify residents without appropriate psychotropic medication monitoring or without proper documentation in the presence of a dosage increase. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of psychotropic medication. Additionally, the inservice will include documentation standards for residents receiving psychotropic medications Monitoring:	

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F 758	Continued From page 65 behaviors, side effects, and effectiveness associated with the use of Risperidone on the following dates: 4/3/19-evening shift 4/4/19- evening shift 4/7/19-evening shift 4/11/19-evening shift 4/19/19-day shift 4/20/19-day shift 4/22/19-day and evening shift 4/25/19-day shift 4/27/19-day shift 4/28/19-day shift 4/30/19-evening shift 5/2/19-day shift 5/3/19-day and evening shift 5/9/19-evening shift 5/24/19-night shift 5/30/19-day shift On 7/9/19 at 7:29 am, the surveyor reviewed the facility "Behavior/Intervention Monthly Flow Record" for April 2019 and May 2019 with the director of nursing. The director of nursing reviewed the April 2019 and May 2019 behavior/intervention monthly flow record for Resident # 13 along with the surveyor. The director of nursing stated, "Yes there are several holes and agreed that the facility staff failed to monitor Resident # 13 for behaviors, side effects, and effectiveness associated with the use of Risperidone. The facility policy on "Psychoactive Medications" contained documentation that included but was not limited to, ..."Monitoring of Effectiveness and Adverse Effects of Psychoactive Medications 2. The monitoring of specific behaviors continues	F 758	The DON is responsible for maintaining compliance. The DON and/or designee will complete weekly physician orders and MAR audits coinciding with the Care plan calendar to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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F 758	Continued From page 66	F 758		

as long as resident is on the psychoactive medication.
4. Behavioral sheets need to be documented daily." ...

On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was presented to the survey team prior to the exit conference on 7/9/19.

2. The facility staff failed document behaviors for Resident # 14 that justified an increase in the dosage of Seroquel.

Resident # 14 was an 86-year-old-male that was admitted to the facility on 10/10/18. Diagnoses included but were not limited to, dementia, psychosis, memory loss, and arthritis.

The clinical record for Resident # 14 was reviewed on 7/8/19 at 9:11 am. The most recent MDS (minimum data set) assessment for Resident # 14 was a quarterly assessment with an ARD (assessment reference date) of 4/17/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 14 had a BIMS (brief interview for mental status) score of 6 out of 15, which indicated that Resident # 14's cognitive status was severely impaired. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 14 has antipsychotic medication for 7 days during the look back period for the 4/17/19 ARD.

The current plan of care for Resident # 14 was reviewed and revised on 6/10/19. The facility staff

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documented a focus area for Resident # 14 as, "The resident has impaired cognitive function/dementia or impaired thought processes r/t (related to) dx (diagnosis) of dementia memory loss bims score of 6 on admission mds." Interventions included but were not limited to, "Administer medications as ordered. Monitor/document for side effects and effectiveness."

Resident # 14 had current orders that included but were not limited to, "Quetiapine (Seroquel) 50 mg (milligram) tablet take one tablet by mouth three times daily for psychosis," which was initiated by the physician on 4/17/19.

On 7/9/19 at 7:48 am, the surveyor reviewed a nurse's note for Resident # 14 that had been documented on 4/17/19 at 7:00 am. The nurse's note was documented as, "(Medical director's name withheld) in sick visit. Reviewed meds D/C (discontinue) Lexapro and Lipitor. Increase Seroquel to 50 mg po (by mouth) tid (three times daily). Wife requested meds be reviewed." The surveyor reviewed the nurse's notes for Resident # 14 for April 2019. The surveyor did not observe any behaviors documented from 4/1/19 through 4/10/19.

The surveyor reviewed a nurse's note for Resident # 14 that had been documented on 4/10/19 at 7:00 am. The nurse's note was documented as, "(Medical director's name withheld) in for recert. NNO (no new orders)."

The surveyor reviewed the April 2019 nurse's notes for Resident # 14 further and observed a nurse's note that had been documented on 4/12/19 at 10:00 pm. The nurse's note was

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documented as, "Resident has been observed going in residents rooms and going through the drawers. He is looking for "his glasses" (sunglasses) He was on unit 1 going in other residents rooms. When I gave him his hs (bedtime) med, noted a pair of womens bifocals on his bedside table. Took those and brought them to the desk. I went to resident 112-A room to turn off her overbed light and found Resident # 14's sunglasses on her bedside table. I took those and put them on Resident # 14's bedside table." The surveyor did not observe any documentation that reflected that behavior displayed by Resident # 14 presented a danger to self or others nor did the surveyor observe documentation of unsuccessful non pharmacological interventions associated with the wandering episode displayed by Resident # 14 on 4/12/19.

The surveyor reviewed the April 2019 facility "Behavior/Intervention Monthly Flow Record" for Resident # 14. The surveyor observed that facility staff documented that Resident # 12 had 1 only behavioral episode of being verbally abusive and/or threatening to staff on 4/12/19. The facility staff documented an intervention of returning Resident # 14 to his room.
Upon further review of Resident # 14's clinical record, the surveyor did not locate any documented behaviors that justified the increase in the dosage of Seroquel for Resident # 14 on 4/17/19.

On 7/9/19 at 7:55 am, the surveyor interviewed the director of nursing to obtain information regarding the rationale for the increase in dosage of Seroquel for Resident # 14. The director of nursing stated that she would look into it and

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follow up with the surveyor.

The facility policy on "Psychoactive Medications" contained documentation that included but was not limited to,
..."Policy Statement
This facility's policy is to ensure the safe and effective administration of psychoactive medications at the lowest possible dose of medication with the least side effects. Residents receive psychoactive medications only when medically necessary with every effort made to ensure that residents receive the intended benefit of the medications and to minimize the unwanted effects of the medication.
I. Antipsychotic Medications:
1. The clinical record must reflect the specific conditions and/or diagnosis appropriate for antipsychotic medication use before antipsychotic medications are prescribed.
4. Attempts will be made to modify the resident's behavior (s) using non pharmacologic approaches, including staff approaches to care and environmental changes, to the largest degree possible to accommodate the resident's behaviors/disturbances." ...

On 7/9/19 at 1:00 pm, the surveyor spoke with the director of nursing and regional nurse consultant. The surveyor reviewed that Resident # 14 had only had one documented behavioral episode, which was wandering during the month of April 2019 prior to the increase of Seroquel on 4/17/19. The surveyor asked the director of nursing if it could be verified that behavioral episode of wandering displayed by Resident # 14 on 4/12/19 was not associated with dementia or an underlying condition. The surveyor informed the director of nursing that after a review of

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F 758	Continued From page 70 Resident # 14's clinical record, there was no documentation of behaviors that supported an increase in the dosage of Seroquel for Resident # 14 on 4/17/19. The director of nursing informed the surveyor that it could not be ruled out that Resident # 14's episode of wandering was not attributed to dementia or an underlying cause, and agreed that there was not appropriate documentation to support and increase in the dosage of Seroquel for Resident # 14. On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 7/9/19.	F 758		
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 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	F 761		8/23/19

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F 761	Continued From page 71 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, the facility staff failed to ensure a narcotic medication (lorazepam/ativan) with the potential for abuse was stored in a locked permanently affixed box on 1 of 2 wings, wing 2. The findings included: The medication refrigerator in the wing 2 medication room contained two-2 mg vials of lorazepam. This box was not permanency affixed and was able to be removed from the refrigerator. On 07/08/19 at approximately 2:00 p.m., the surveyor checked the medication refrigerator on wing 2. This refrigerator contained a plastic box with a plastic breakaway lock. Inside this box, the surveyor observed two-2 mg vials of lorazepam. The surveyor was able to pick this plastic box up and remove it from the refrigerator. The facility policy titled "Storage of Medication" read in part, "The facility shall store all drugs and biological's in a safe, secure, and orderly manner..." The administrative staff were notified of the issue regarding the lorazepam during a meeting with the survey team on 07/08/19 at approximately 3:10 p.m.	F 761	F761 Corrective Action(s): The refrigerator narcotic box in the Wing 2 med room refrigerator has been permanently affixed to the medication refrigerator. A facility Incident and Accident form has been completed for this incident. Identification of Deficient Practices & Corrective Action(s): All unit medication rooms refrigerators with narcotic boxes may have been potentially affected. The DON and/or designee will conduct a 100% review of the medication room refrigerators to identify any narcotic boxes that are not permanently affixed. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident Form will be completed for each incident identified. Systemic Change(s): Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the facility policy and procedure for storing	

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F 761	Continued From page 72 Per the national institute of health website https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=89057c93-8155-4040-acec-64e877bd2b4c accessed 07/10/19-"...ATIVAN is a prescription medicine used: to treat anxiety disorders...ATIVAN is a federal controlled substance...because it can be abused or lead to dependence. Keep ATIVAN in a safe place to prevent misuse and abuse..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 761	medications and biologicals. The nursing staff will also be inserviced on the Medication Administration Policy and Procedure to include narcotics which must be stored in refrigerators. In addition, The Pharmacy consultant will check each medication room refrigerators during scheduled visits. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will perform weekly Medication room and Medication cartaudits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		8/23/19

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F 812	Continued From page 73 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to prepare, store, and serve foods in a sanitary manner. The findings included: a. The facility staff failed to ensure that perishable food items were secured and appropriately labeled. b. The facility staff failed to ensure that perishable food items were discarded appropriately. c. The facility staff failed to ensure that facial hair was secured with a chin guard. d. The facility staff failed to ensure a clean and sanitary working environment in the facility kitchen. e. The facility staff failed to ensure that personal items were not in the facility kitchen. On 7/7/19 at 12:00 pm, the surveyor conducted an initial tour of the kitchen with dietary cook # 1. During the initial kitchen tour the surveyor observed and empty 16-ounce water bottle on the counter near the coffee maker and spices. The surveyor observed that there was a small amount of red liquid left in the bottle. The surveyor also observed a large amount of dried brown, yellow, and white debris on the stand beneath the tray line where dried pans were stored. The surveyor	F 812	F 812 Corrective Action(s): The water bottle was removed from the counter in the kitchen. The Aquafiina water bottle was removed from the pots/pans storage area. The counters, floors, refrigerators, freezers, and equipment in the kitchen have been thoroughly cleaned. The open lettuce bag; bag of carrots; container of strawberries; and molded tomatoes were discarded from the walk in cooler. Dietary staff member #2 put a hair restraint in place and has received one on one education regarding the requirements for the use of hair restraint. The pans in the pots/pans storage area have all been washed and dried appropriately. Identification of Deficient Practices & Corrective Action(s): All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will	

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F 812	Continued From page 74 observed a large amount of black and brown build up on the floor underneath a large rack that was located next to the reach in refrigerator that held large cans of food. The surveyor observed that the can opener was heavily soiled with dark brown and black debris. Dietary cook # 1 observed all areas mentioned above along with the surveyor and agreed that personal items should not be kept in the kitchen work area and that the areas mentioned above needed to be cleaned. On 7/7/19 at 12:05 pm, the surveyor and dietary cook # 1 entered the walk in cooler. The surveyor observed an opened bag of lettuce that had not been secured and was not labeled with an opened and discard date. The surveyor observed that the lettuce had several brown spots. The surveyor also observed an opened bag of carrots that had two carrots contained two. The bag was not secured and the bag was not labeled an opened and discard. The surveyor observed a container of strawberries that had 4 strawberries. The surveyor observed that the strawberries were soft and had dark spots and red liquid was draining from the container. The surveyor also observed 3 tomatoes in the walk in cooler that had molded areas on them. Dietary cook # 1 agreed that all items mentioned should have been labeled appropriately and/or discarded. On 7/7/19 at 12:15 pm, the surveyor observed a black purse, a set of keys, and bottle of seltzer water that was placed the on the soft drink mix boxes. Dietary cook # 1 agreed that the personal items should not have been in the work area and removed the items. On 7/8/19 at 11:07 am, the surveyor observed	F 812	randomly monitor the kitchen preparation and food storage area to identify any negative findings. All items identified to be out of compliance will be discarded and a Facility Incident and Accident form will be completed for each negative finding identified. Any/All negative findings may result in disciplinary action. Systemic Change(s): Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the Food Service Manager and dietary staff on the preparing, storing, and serving foods in a sanitary manner Monitoring: The Food Service Manager is responsible for maintaining compliance. The Food Service manager or Cook in charge will monitor the refrigerators and food storage areas for proper labeling and dating of food and beverage items and disposal of those items per policy to monitor and maintain compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice.	

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dietary staff # 2 in the kitchen. The surveyor observed that dietary staff # 2 had a beard and was not wearing a beard guard. The surveyor asked dietary staff # 2 if he should be wearing a beard guard. Dietary staff # 2 agreed that he should have been wearing a beard guard and retrieved a beard guard from the holder on the wall and applied it to his face and covered his beard.

On 7/8/19 at 11:20 am, the surveyor observed an Aquafina water bottle that was half-full with a red liquid substance in it on the stand with the pots and pans. The surveyor observed that dietary Cook # 1 removed the Aquafina bottle and discarded it into the trash.

On 7/8/19 at 11:30 am, the surveyor observed dietary staff # 3 lift a pan from the rack that contained the dried pans. The surveyor observed several drops of water on the pan. Dietary staff # 3 agreed that the pan that she had retrieved from the dry pan rack was actually still wet.

The facility policy on "Dishwashing" contained documentation that included but was not limited to,
..."Allow all dishes to air dry. Do not dry with towels." ...

The facility policy on "Labeling, Dating, & Storage" contained documentation that included but was not limited to,
..."Procedure
1. All perishable foods will be appropriately labeled with the item description, "use by" date and discarded appropriately."
4. All foods not appropriately labeled must be discarded." ...

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F 812	Continued From page 76 The facility dietary department "Dress Code Guidelines" contained documentation that included but was not limited to, ..." Hair- ALL hair must be covered by a hair net. (No pieces or bangs hanging out.) No Beards! If facial hair is not kept trimmed you must wear a chin guard." ... On 7/8/19 at 3:15 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 7/9/19.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		8/23/19

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F 842	Continued From page 77 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 78 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 2 of 24 Residents, Resident #22 and Resident #30. The findings included: For Resident #22 the facility staff failed to ensure daily CNA (certified nursing assistant) flow sheets were completed. Resident #22 was admitted to the facility on 08/21/17 and readmitted on 02/01/18. Diagnoses included but not limited to congestive heart failure, aphasia, dementia, anxiety, depression, and glaucoma. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 04/23/19 assigned the Resident a BIMS (brief interview for mental status) score of 4 out of 15 in section C, cognitive patterns. Resident #22's clinical record was reviewed on 07/09/19. It contained CNA flowsheets and Resident Care Rosters for the months of February, March, April, May, June and July of 2019. These forms contain information on food/fluid intake, toileting, bathing, ADL's (activities of daily living) and mobility. Each of these forms was incomplete on multiple days.	F 842	F842 Corrective Action(s): Resident #22□s attending physician has been notified that facility staff failed to ensure daily CNA flow sheets were accurately completed. A facility Incident and Accident Form has been completed for this incident. Resident #30□s attending physician has been notified that the facility staff failed to include an advance directive/DDNR which had been properly signed by the physician in the resident□s record. A facility Incident and Accident Form has been completed for this incident. Identification of Deficient Practices & Corrective Action(s): All other residents may have potentially been affected. A 100% review of all residents medical records will be conducted by the DON and/or designee to identify residents at risk for incomplete CNA flow sheets or missing/incomplete advance directives/DDNRs. All negative findings will be clarified and/or correct at time of discovery. A facility Incident & Accident form will be completed for each negative finding. Systemic Change(s):	

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F 842	Continued From page 79 The concern of the incomplete CNA flowsheets was discussed with the administrative staff during a meeting on 07/07/19 at approximately 1:20 PM. No further information was provided prior to exit. 2. The facility staff failed to ensure that Resident # 30's clinical record included an advanced directive. Resident #30 was a 92-year-old-female who was admitted to the facility on 4/29/19. Diagnoses included but were not limited to, dementia, agitation, depression, and hypertension. The clinical record for Resident # 30 was reviewed on 7/7/19 at 1:59 pm. The most recent MDS (minimum data set) assessment for Resident # 30 was an admission assessment with an ARD (assessment reference date) of 5/6/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 30 had a BIMS (brief interview for mental status) score of 7 out of 15, which indicated that Resident # 30's cognitive status was severely impaired. Resident # 30 had orders that included but were not limited to, "DNR (do not resuscitate) (Hospice company's name withheld) Hospice-No antibiotics, hospitalizations unless major injury, IV (intravenous) fluid, No lab (per family) weights, tube feeding," which was signed by the physician on 7/1/19. On 7/7/19 at 2:00 pm, the surveyor observed a durable do not resuscitate form for Resident # 30. The surveyor observed a handwritten X documented nest to "2. The patient is INCAPABLE of making an informed decision	F 842	The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff and C.N.A's will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice.	

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	495002	A. BUILDING _____ B. WING _____	07/09/2019

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F 842	Continued From page 80 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 alternatives to that decision." The surveyor also documented a hand written X next to "B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of Person Authorized to consent on the Patient's Behalf is required.)" The surveyor reviewed the clinical record for Resident # 30 further and did not locate a written advanced directive for Resident # 30. On 7/8/19 at 3:15 pm, the surveyor asked the administrative team to provide the surveyor with a copy of the written advanced directive for Resident # 30. On 7/9/19 at 8:36 am, the facility staff provided the surveyor with a copy of a social progress note that had been documented on 7/8/19 at 6:15 pm. The social progress note was documented as, "Social worker left phone message for resident's daughter (Daughter's name withheld), she lives in Arizona, asking her to fax copies of resident's POA (power of attorney) and advanced directive." On 7/9/19 at 1:20 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 7/9/19.	F 842		
F 880 SS=F	Infection Prevention & Control	F 880		8/23/19

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F 880	Continued From page 81 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 82 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure an effective infection control program for 1 of 24 Residents, Resident #18 and failed to follow their infection control program/plan for use of an SBAR (situation, background, assessment, recommendation) technique. The findings included:	F 880	F880 Corrective Action(s): LPN #1 involved in the Medication Administration Observation for Resident□s #18 has received one-on-one inservice training on proper infection control practices to be followed during medication administration. A Facility Incident & Accident form was completed for this incident.	

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F 880	Continued From page 83 1. For Resident #18, the facility staff dropped 2 medication capsules on the top of the medication cart, picked them up with their bare hands, and administered them to the Resident. The clinical record review revealed that Resident #18 had been admitted to the facility 04/15/19. Diagnoses included, but were not limited to, Parkinson's disease, hypertension, osteopenia, gait difficulties, and frequent falls. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/22/19 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. On 07/08/19 at approximately 9:02 a.m., during a medication pass and pour observation LPN (licensed practical nurse) #1 was observed preparing Resident #18's morning medications for administration. When removing the Residents amantadine and potassium from their medication cassette (packaging system) LPN #1 was observed to tap the cassettes on to the top of the medication cart causing the capsules to fall from their individual cassette and land on top of the medication cart. LPN #1 was then observed to pick up the capsules with their bare hands and place the capsules into the medication cup, enter the Residents room, and administer the medications to Resident #18. On 07/08/19 at 9:17 a.m., during an interview with LPN #1, LPN #1 stated she had picked up the capsules and she should have used a glove or threw them away and used the spares that were	F 880	The Medical Director has been notified that the facility failed to follow its infection control program in regards to using an SBAR criteria worksheet for suspected infection as outlined in the facility□s infection control program. Identification of Deficient Practice(s) & Corrective Action(s): All other residents may have potentially been affected. The DON/designee will conduct a 100% audit of all nurses who pass medications to identify improper medication administration infection control practices. Negative findings will be reviewed with each nurse involved. A facility Incident and Accident form will be completed for each negative finding. The facility IP/designee will conduct a complete review of the infection control program to identify other program items which have not been put in place. Systemic Change(s): The facility policy and procedures have been reviewed and no changes are warranted at this time. All licensed staff will be inserviced on the facility policy and procedure for proper infection control practices during medication administration by the DON and/or Regional Nurse Consultant. The facility infection control program has been reviewed and no changes are warranted at this time. All licensed nursing staff have been inserviced on the use of the SBAR criteria worksheet for all	

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F 880	Continued From page 84 packaged. On 07/08/19 at 11:24 a.m., the designated infection control nurse was interviewed and stated LPN #1 should have used the red box to discard the medications and either used the spare medication from the cassettes or obtained new medications from their automatic dispensing unit. The administrative staff were notified of the above issue during a meeting with the survey team on 07/08/19 at 3:09 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility failed to follow their infection control program/plan in regards to using an SBAR (Situation, Background, Assessment, Recommendation - a technique/worksheet used to facilitate communication to a physician about a resident's symptoms) criteria worksheet for suspected infections. The facility only had this SBAR in place for urinary tract infections (UTI). The director of nursing (DON) who was the designated infection preventionist (IP) was interviewed by two (2) surveyors on 7/09/19 at 8:49 a.m. in their office. The facility's regional nurse consultant was present during the interview. The facility's infection control and antibiotic stewardship program binder was reviewed which included a form titled, "Suspected UTI SBAR." During the discussion and program review, the DON was asked what the facility uses as a surveillance tool for suspected infections other than UTIs. The DON acknowledged there were no other tools available at this time and	F 880	infections and not just UTI□s. Monitoring: The DON is responsible for maintaining compliance. The DON/designee will perform 2 random weekly Med Pass audits to monitor nursing staff for compliance. The IP/designee will review each documented infection to monitor for compliance. Findings of the audits will be reported to the QA Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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F 880	Continued From page 85 stated the facility staff (nurses) were educated on how to assess residents and report their assessments to physicians for other suspected infections such as upper respiratory infections. The regional nurse consultant would provide evidence of the facility nurses' education if found. The facility's document titled, "Antibiotic Stewardship Program (ASP)" was reviewed on 07/09/19. The document read in part that accountability for the program rests partially with the DON and/or IP who was expected to work with nurses to ensure that SBAR/McGeer's Criteria was utilized to communicate relevant clinical data to providers, and that nursing evaluations of patient clinical status and patient response to treatment were documented in the medical record. The ASP document also read the expected action was to "Utilize a standard assessment and communication tool for patients suspected of having an infection - SBAR/McGeer's." The administrative staff consisting of the administrator, the director of nursing and the regional nurse consultant were informed of the lack of SBAR tools for any suspected infection other than UTIs during a meeting with the survey team on 07/09/19 at 1:20 p.m. The regional nurse consultant acknowledged there had been no evidence of nursing education on communicating suspected infections other than UTIs with physicians/providers found. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 880		
F 926 SS=D	Smoking Policies	F 926		8/23/19

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F 926	Continued From page 86 CFR(s): 483.90(i)(5) §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, clinical record review, and facility document review the facility staff failed to follow their policy and procedure regarding the Residents smoking supplies for 1 (one) of 24 Residents, Resident #38. The findings: The facility's smoking policy indicated that Residents who desire to smoke may not keep smoking related materials (cigarettes, cigars, pipes, tobacco, lighter, lighter fluid, match etc.) on their person when not smoking or in their room. Resident #38 kept their cigarettes and lighter with them at all times. During an interview with Resident #38 on 07/08/19 at 12:20 p.m. the resident explained they kept their own cigarettes and own lighter in a bag they kept at their side at all times. Resident #38 showed the bag to two (2) surveyors by picking it up from where it was sitting beside the resident's leg in their wheelchair. Resident #38 stated they had permission to smoke without supervision. The surveyors also observed an oxygen concentrator with tubing in Resident #38's room. The clinical record review revealed Resident #38	F 926	F926 Corrective Action(s): Resident #38 surrendered the lighter and cigarettes they had in their possession at the time of the observation. A facility Incident and Accident form has been completed for this incident. Identification of Deficient Practice(s) and Corrective Action(s): All other residents who smoke may have been affected. Resident #38 has a grandfathered status regarding smoking. Systemic Change(s): The facility□s smoking policy has been reviewed and updated to address Resident #38□s grandfathered status. The revised smoking policy has been reviewed with Resident #38 and facility administration. Monitoring: The Admission director is responsible for maintaining compliance by educating newly admitted residents about the facility smoking policy. The QA Program includes facility audit tools for monitoring compliance. The results of these audits will be reported to the Quality Assurance	

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F 926	Continued From page 87 had been admitted to the facility on 12/17/12. Their diagnoses included, but were not limited to hypertension, polyosteoarthritis, chronic obstructive pulmonary disease, and nicotine dependence. Section C (cognitive patterns) of the Resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/17/19 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section O (special treatments, procedures, and programs) had been coded to indicate the resident had oxygen therapy. The Resident's care plan, dated 05/21/19, included the focus area "(Resident's first name) is a smoker. Assessed for being able to smoke as desired, unsupervised." Interventions included but were not limited to, "Instruct resident about the facility policy on smoking: locations, times, safety concerns" and "Notify charge nurse immediately if it is suspected resident has violated facility smoking policy." The Resident's EHR (electronic health record) included a "SMOKING-SAFETY SCREEN" dated 05/17/19 that had been completed by facility staff. The safety screen document read in part, Can resident light own cigarette? Yes. Does resident need facility to store lighter and cigarettes? No. Plan of care is used to assure resident is safe while smoking? Yes. The Smoking - Safety Screen showed a score of "1" which indicated the team decision was "Safe to smoke without supervision." The screen also read under rationale/conditions: "Does become SOB (short of breath) with self propelling w/c (wheelchair),	F 926	Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice.	

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F 926	Continued From page 88	F 926		

opening door but waits a while before lighting cig., able to bring self back in doorway." The EHR also contained a physician's order last dated and signed by the physician on 07/01/19 for "nasal O2 (oxygen) at 2L (liters) as needed."

The facility policy related to smoking read in part, "Procedure: 2. Residents who desire to smoke may not keep smoking related materials (cigarettes, cigars, pipes, tobacco, lighter, lighter fluid, match etc.) on their person when not smoking or in their room. 3. Residents will be assessed for their ability to smoke independently. Assessments will be reviewed by the interdisciplinary team at least quarterly and as the resident's condition or behavior changes that impacts the ability to smoke safely. a) Residents who are determined by the interdisciplinary team as safe for independent smoking will request smoking materials when desiring to smoke and will return them upon completion of the smoking session."

The administrative staff consisting of the administrator, the director of nursing and the regional nurse consultant were informed of the issues regarding Resident #38 having their smoking supplies at all times during a meeting with the survey team on 07/08/19 at 3:10 p.m. and again on 07/09/19 at 1:20 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.