STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHELSEA REHABILITATION AND HEALTHCARE CENTER	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(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 on 12/11/22-12/13/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/11/2022 through 12/13/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 84 certified bed facility was 68 at the time of the survey. The survey sample consisted of 27 current resident reviews and six closed record reviews. Three complaints, VA00054843- Unsubstantiated without deficiency, VA00054117- Substantiated with deficiency and VA00053718- Substantiated without deficiency were investigated during the survey dates.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those	F 582		1/27/23

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

Electronically Signed | 01/03/2023

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F 582	Continued From page 1	F 582		

services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

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

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F 582	Continued From page 2 these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide notice of Medicare non-coverage for two of three residents identified during the beneficiary protection notification resident reviews, Resident #6 and Resident #320. The findings include: 1. For Resident #6 (R6), the facility failed to provide a resident and/or the resident's representative with an ABN (Advance Beneficiary Notice of Non-coverage) waiver of liability when a change in coverage occurred. R6's last covered day of Medicare part A services was 10/20/2022. R6 remained in the facility at the time of the survey. On 12/13/2022 at 8:05 a.m., an interview was conducted with OSM (other staff member) #3, the social services director. OSM #3 stated that they were responsible for providing the ABN notices to residents now. OSM #3 stated that when a resident had Medicare Part A and were discontinued from services with days remaining they provided them the required notices. OSM #3 stated that often residents only used a certain amount of their allotted days and they were required to provide the notices to the residents in order to give them the choice to appeal or continue the services at a cost. OSM #3 stated that residents were given three options to choose from on the notice and the purpose of the notice was to inform the resident that there may be financial liability to them. OSM #3 stated that R6 remained in the facility at the end of service and	F 582	1.Residents #6 & #320 did not suffer negative or adverse outcomes when not provided with an Advance Beneficiary Notice of Non-coverage waiver of liability prior to the last covered day of Medicare part A services on 10/20/2022 (R6) & 10/10/2022 (R320). 2.Current residents that are ending Medicare Part A covered days are at risk. ABN notifications in the last 30 days will be audited by the Business Office Manager/designee to ensure that ABN notifications are provided timely. 3.Business Office Manager and Social Worker educated 12/13/2022 on providing ABN notification 48 hours prior to resident being discharged from Medicare Part A covered days. Social Worker will provide ABN after receiving notification from Business Office Manager of last covered day for resident. BOM will monitor and track ABN notifications. 4.ABN notifications will be reviewed daily by BOM/designee. Facility will audit 10 resident files a week for 4 weeks, 5 resident files for 2 weeks, then 3 resident files for 2 weeks. The results of the quality monitoring data tool to be reviewed by members of the QAPI committee for review, analysis and further recommendations. 5.Date of Compliance January 27, 2023.	

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should have received an ABN notice but they did not have evidence that it was provided.

The facility policy "Medicare Advanced Beneficiary Notices" dated October 2022 documented in part, "...The SNFABN (skilled nursing facility advanced beneficiary notice of non-coverage) provides information to beneficiaries in advance of changes so that beneficiaries can decide if they wish to continue receiving the skilled service(s) that may not be paid for by Medicare and assume financial responsibility...."

On 12/13/2022 at 11:11 a.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

2. For Resident #320 (R320), the facility failed to provide a resident and/or the resident's representative with an ABN (Advance Beneficiary Notice of Non-coverage) waiver of liability when a change in coverage occurred. R320's last covered day of Medicare part A services was 8/27/2022. R320 was discharged from the facility on 10/10/2022.

On 12/13/2022 at 8:05 a.m., an interview was conducted with OSM (other staff member) #3, the social services director. OSM #3 stated that they were responsible for providing the ABN notices to residents now. OSM #3 stated that when a resident had Medicare Part A and were discontinued from services with days remaining they provided them the required notices. OSM #3 stated that often residents only used a certain

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F 582	Continued From page 4 amount of their allotted days and they were required to provide the notices to the residents in order to give them the choice to appeal or continue the services at a cost. OSM #3 stated that residents were given three options to choose from on the notice and the purpose of the notice was to inform the resident that there may be financial liability to them. OSM #3 stated that R320 remained in the facility at the end of service and should have received an ABN notice but they did not have evidence that it was provided. On 12/13/2022 at 11:11 a.m., ASM (administrative staff member) #1, the executive director and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit.	F 582		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		1/27/23

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F 600	Continued From page 5 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to prevent verbal abuse for two of 33 residents in the survey sample, Residents # 30 (R30) and Resident #119 (R119). The findings include: For R30 and R119, the facility staff failed to prevent verbal abuse towards the residents, by a facility staff member, on 4/8/2022. R30's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/16/2022, coded R30 as having both short- and long-term memory difficulties. The resident was coded as being severely impaired for making cognitive daily decisions. R119 no longer resided in the facility. On the most recent MDS assessment, prior to the incident, an admission assessment, with an ARD of 3/23/2022, the resident was coded as scoring a 7 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. The Facility Reported Incident (FRI) dated 4/9/2022, documented in part, " Incident Date: 4/8/2022. Residents involved: [name of R30] and [name of R119]. Incident type: allegation of abuse/mistreat. Possible verbal comments directed towards residents. Name of Employee(s) involved and their positions: [Name of LPN (licensed practical nurse) #5]. Employee action initiated or taken: Immediate suspension pending investigation, residents assessed."	F 600	1.LPN #5 employment was terminated. 2.Current residents are at risk. Current residents will be interviewed to ensure safety and free from abuse. 3.Current and active staff will be educated on facility abuse and neglect policy by January 27, 2023, by the Social Worker/designee. IDT team educated on abuse and neglect and provided with abuse screening questions to utilize with residents on December 13, 2022. 4.IDT will interview 10 residents 5 days a week for 4 weeks, then 10 residents 3 days a week for 2 weeks, and then 1 resident a week for 2 weeks. The results of the quality monitoring data tool to be reviewed by members of the QAPI committee for review, analysis and further recommendations. 5.Date of compliance January 27, 2023.	

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The final report to the Virginia Department of Health, Office of Licensure and Certification, dated 4/12/12022, documented in part, "On April 10, 2022 it was reported to myself (name of former director of nursing) by staff that resident [name of Resident #54] and several staff had observed [LPN #5] being verbally abusive to [R30] and [R119]. RN (registered nurse)[name of RN #2] was acting as Weekend Supervisor, was immediately informed of accusations and instructed to get do skin assessment, get witness statements and ensure wellbeing of residents. [RN #2] interviewed [R30] and [R119] also performing skin assessments with no findings. Neither resident was able to recall above mentioned accusations. Both residents where (sic) in good spirits and had no complaints. [RN #2] interviewed [R54] and [R56]. Both gentleman occupy rooms on the hallway where reported alleged incident occurred, both confirm that [R30] was yelling out as the norm of his documented behaviors when [LPN #5] began yelling "Shut the F++K up" at him while in the hallway from her medication cart. [R54] and [R56] state that at no time did they witness [LPN #5] being physically abusive toward [R30], however [R54] does state witnessing [LPN #5] aggressively pulling Geri chair [R119] occupied. No other staff member can corroborate this accusation. Staff members were interviewed from that evening, several witnessed [LPN #5]'s verbal behavior, no one witnessed any physical behavior or aggression from [LPN #5]. Staff members and [R54[report witnessing, [LPN #5] saying to [R119], "You need to shut up and get your A++ in bed because I need you to sleep." Staff report [LPN #5] requesting them to lay [R119] in bed as she was tired. [R119] had been up for several hours in geri chair and had reported behaviors of attempting to roll out of the

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chair and yelling. [LPN #5] was suspended immediately pending this investigation and removed from the staff schedule. [RN #2] performed random skin assessments and interview of residents assigned to [LPN #5] during that schedule with no findings of suspected abuse. Psychosocial assessments where (sic) performed by [RN #2]. Findings: Based on facilities (sic) investigation I find no evidence of physical abuse however based on multiple statements the Allegation of Verbal abuse/mistreat is substantiated. Conclusion: [LPN #5] will be terminated with a status of not eligible for rehire with [name of facility]. Board of Nursing will be notified."

The Witness statement dated 4/9/2022, documented, "On Friday 4/8/22 around 9pm, I herd (sic) charge nurse [LPN #5] yelling at a resident, telling the resident to shut the F*** up and go to sleep then later that evening I herd (sic) nurse [LPN #5] tell another patient to shut the hell up and go to bed." This was signed by CNA (certified nursing assistant) #6, an agency CNA.

The Witness Statement dated 4/9/2022, document, "On the night of 4/8/22, Charge nurse [LPN #5] was yelling and screaming in the hallway on 100 hall. Charge nurse [LPN #5] yelled at a resident b/c (because) he was repeating the same thing, she yelled and said "Shut the F*** Up" and go to sleep to him...Charge nurse [LPN #5] also yelled at another resident and told her "you need to shut up and get your ass in bed b/c I no (sic) you need sleep." this was signed by CNA #7, an agency CNA.

The Witness Statement dated, 4/8/22,

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documented, "Resident reported while in his bed he overheard nurse cussing at resident from hallway, "Shut the f*** up." Happened late evening." This was statement for [R56].

The Witness Statement dated, 4-8-22, documented, "Resident stated he observed charge nurse [LPN #5] aggressively pulling another residents broda chair with resident in it saying, "You need to get your ass in the bed." At which time she slung the chair he witnessed her tell another resident to "Shut the f*** up." This was statement for [R54].

The Witness Statement from LPN #5, dated, 4-9-22, documented in part, "I didn't have any interactions with [R30] ... [listed names of three staff members] and myself took turns watching [R119] all shift. I did not witness or was involved with any verbal abuse on this shift."

The above three employees were unavailable for interview.

R54, on the most recent MDS (minimum data set) assessment, an annual assessment, with an ARD of 10/18/2022, scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. On the MDS assessment, prior to the incident, a quarterly assessment, with an ARD of 3/7/2022, the resident scored a 14 out of 15 on the BIMS score, indicating they were not cognitively impaired for making daily decisions.

An interview was conducted with R54 on 12/12/2022 at 3:01 p.m. When asked if they recalled the incident above, R54 stated they only

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thing that isn't correct on the witness statement is that they didn't observe it. R54 stated they were in the bed and heard both conversations with the curse words in it. R54 stated they didn't know who the nurse was they just heard the words said to a resident.

R56, on the most recent MDS assessment, an admission assessment, with an ARD of 11/15/2022, scored a 14 out of 15 on the BIMS score, indicating R56 was not cognitively impaired for making daily decisions. On the MDS assessment, prior to the incident, a quarterly assessment, with an ARD of 2-25-2022, R56 scored a 13 out of 15 on the BIMS score, indicating the resident was not cognitively impaired for making daily decisions.

An interview was conducted with R56 on 12/12/2022 at 3:07 p.m. When asked if they recalled the incident above, R56 stated yes and verified their statement. R56 stated they were in room (number) at the time and heard the nurse curse at the two residents.

The former director of nursing was not available for interview.

An interview was conducted with RN (registered nurse) #2 on 12/13/2022 at 8:51 a.m. When asked her role in the incident above, RN #2 stated she was called by the director of nursing to go into the facility and assess the residents involved. She did assess each resident and there were no noted injuries, neither resident could recall the incident. RN #2 stated she initiated the FRI report and sent it off to the state. When asked if she obtained any witness statements, she stated she interviewed [R54] and [R56]. RN

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F 600	Continued From page 10 #2 stated the former director of nursing did the rest of the investigation. RN #2 stated the nurse was suspended and was terminated after the incident. The facility policy, "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," documented in part, "Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation by anyone including but not necessarily limited to: a. facility staff....2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents." ASM #1, the executive director and ASM #2 were made aware of the above concern on 12/13/2022 at 11:03 a.m. No further information was obtained prior to exit.	F 600		
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-	F 622		1/27/23

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

§483.15(c)(2) Documentation.
When the facility transfers or discharges a

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CHELSEA REHABILITATION AND HEALTHCARE CENTER	2715 DOGTOWN ROAD GOOCHLAND, VA 23063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure

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F 622	Continued From page 13 a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to implement a facility-initiated discharge requirement for one of 33 residents in the survey sample, Resident #218. The findings include: For Resident #218 (R218), the physician failed to document the basis for the resident's discharge, the specific resident needs that could not be met at the facility, the facility attempts to meet R218's needs, and the services available at the receiving facility to meet R218's needs, when R218 was discharged from the facility on 10/5/21. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/5/22, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. A review of R218's clinical record revealed a nurse's note dated 10/5/21 that documented R218 was transferred to a local emergency department for shortness of breath, chest pain, nausea and a headache. Another nurse's note dated 10/5/21 documented R218 called the facility and stated the resident was being admitted to a local hospital. A document dated 10/5/21 and titled, "Virginia Involuntary Transfer/Discharge Notice" documented, "To: (R218). From: (Name of	F 622	1.Resident 218 is not a current resident. No noted negative outcomes related to the discharge on 10/5/2021. 2.Current residents that discharge from the facility are at risk. Involuntary discharges audited for the last 30 days by the Social Worker/Designee to ensure transfer/discharge policy and procedure is followed and there is physician documentation of the discharge/transfer. 3.IDT Team educated by ED on December 13, 2022 on requirement of physician documentation requirement for involuntary discharge. 4.Resident Discharges/Transfers will be reviewed daily by the Social Worker/Designee to ensure physicians document on the discharge. Facility will audit 10 discharges resident files weeks for 4 weeks, 5 discharged files for 2 weeks, then 2 discharged files for 2 weeks. The results of the quality monitoring data tool to be reviewed by members of the QAPI committee for review, analysis and further recommendations. 5.Date of Compliance January 27, 2023.	

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former Executive Director) - (name of facility).
Re: Discharge Notice- This is to notify you that you, (R218), will be transferred/discharged from our facility to an alternate skilled nursing facility or healthcare setting that can meet your needs no later than the end of 30 days 11/4/2021. At the time of your discharge your transfer will be set up in accordance with industry standards. This plan has been reviewed with our Medical Director and meets with their approval. Should you choose an alternative location services will be set up to that alternate address. You are being discharged because: The facility can no longer meet the resident's medical needs; The health and safety of the resident, other residents or staff is endangered..."

Resident #218 never returned to the facility.

Further review of R218's clinical record failed to reveal any physician documentation regarding the resident's discharge until 12/23/21. A physician's note dated 12/23/21 documented, "To Whom It May Concern:
(R218) was found guilty of assaulting a staff member attempting to provide care to (the resident). (R218) exhibited behaviors of refusing staff assistance, remaining in same position for long hours causing skin deterioration. Unable to meet (the resident's) needs for ADL's (activities of daily living) causing great concern for UTI's (urinary tract infections), pneumonia and sepsis and proving to be accurate as this was the reason for (the resident's) admission to the hospital. The psychological aspect of anger was being managed by (name of psychology services) until (R218) refused that service as well."

On 12/13/22 at 12:49 p.m., an interview was

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F 622	Continued From page 15 conducted with ASM (administrative staff member) #4 (the physician). ASM #4 stated he usually writes a note when a resident is discharged so the physicians at the receiving facility have information regarding the resident. ASM #4 stated his discharge notes usually contain an admission history and physical, documentation regarding the resident's stay at the facility and documentation regarding the discharge. ASM #4 stated he could not recall why he did not document a note when R218 discharged from the facility. On 12/13/22 at 1:30 p.m., ASM #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Discharge of Residents" failed to document information regarding physician documentation of discharge. No further information was presented prior to exit. Complaint deficiency.	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	F 623		1/27/23

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discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(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),

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and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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

§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

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F 623	Continued From page 18 the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide a discharge notice containing all required contents for one of 33 residents in the survey sample, Resident #218. The findings include: For Resident #218 (R218), the facility staff issued an involuntary discharge notice on 10/5/21. The involuntary discharge notice failed to contain the specific location to which the resident was being discharged. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/5/22, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. A document dated 10/5/21 and titled, "Virginia Involuntary Transfer/Discharge Notice" documented, "To: (R218). From: (Name of former Executive Director) - (name of facility). Re: Discharge Notice- This is to notify you that you, (R218), will be transferred/discharged from our facility to an alternate skilled nursing facility or healthcare setting that can meet your needs no later than the end of 30 days 11/4/2021. At the time of your discharge your transfer will be set up in accordance with industry standards. This plan	F 623	1.Resident 218 is not a current resident. No noted negative outcomes related to the discharge on 10/5/2021. 2.Current residents that discharge from the facility are at risk. An audit of involuntary resident discharged in the last 30 days to ensure policies and procedures were followed for Notice Requirements before transfer/Discharge by Social Worker/designee, including a specific location of discharge. 3.IDT Team educated by Administrator on the process for Notice Requirement before transfer/Discharge on December 13, 2022. 4.Resident Discharges/Transfers will be reviewed daily by the Social Worker/Designee to ensure accurate and complete notifications are provided to residents. Facility will audit 10 discharges resident files weeks for 4 weeks, 5 discharged files for 2 weeks, then 2 discharged files for 2 weeks. The results of the quality monitoring data tool to be reviewed by members of the QAPI committee for review, analysis and further recommendations. 5.Date of Compliance January 27, 2023.	

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F 623	Continued From page 19 has been reviewed with our Medical Director and meets with their approval. Should you choose an alternative location services will be set up to that alternate address. You are being discharged because: The facility can no longer meet the resident's medical needs; The health and safety of the resident, other residents or staff is endangered..." The notice failed to document the specific location to which R218 was being discharged. On 12/13/22 at 1:23 p.m., an interview was conducted with ASM (administrative staff member) #1 (the executive director). ASM #1 stated an involuntary discharge notice should document a safe and specific discharge location. On 12/13/22 at 1:30 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Discharge of Residents" documented, "6. The date and reason for discharge or transfer, the destination of the resident, if known, shall be recorded in the resident's file." No further information was presented prior to exit.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the	F 641	1.Residents #29 and #30 MDS assessment section B and section C	1/27/23

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F 641	Continued From page 20 facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment, for two of 33 residents in the survey sample, Resident #29 (R29) and #30 (R30). The findings include: 1. For R29, the facility staff failed to code Section C - Cognitive patterns accurately on the annual assessment of 11/28/2022 and the quarterly assessment of 8/28/2022. On the most recent MDS assessment, an annual assessment, with an ARD (assessment reference date) of 11/28/2022, R29 was coded in Section B - Hearing, Speech and Vision as understanding others and being understood. In Section C - Cognitive Patterns, the resident interview was not completed. It was coded "Should brief interview for mental status be conducted?" A "No, resident is rarely/never understood." On the quarterly assessment, with an ARD of 8/28/2022, R29 was coded in Section B - Hearing, Speech and Vision as understanding others and being understood. In Section C - Cognitive Patterns, the resident interview was not completed. It was coded "Should brief interview for mental status be conducted?" A "No, resident is rarely/never understood." On 12/12/2022 at 4:36 p.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 stated the MDS nurse completes Section B and social services completes Section C. When asked should the two sections be consistent and agree, RN #1 stated, "My assumption would be yes." When asked when she does Section B, does she go an	F 641	updated for completeness and accuracy on December 12, 2022. 2.Current residents with completed MDS assessments are at risk. Current resident MDS assessments will be reviewed by MDS Coordinator/designee by January 27, 2023. 3.MDS Coordinator/Social Worker will be educated on interviewing residents for the MDS based on RAI Manual by Regional Case Manager by January 27, 2023. 4.Resident MDS Assessments will be reviewed by MDS Coordinator/Designee to ensure accuracy and completing. Facility will audit 10 MDS assessments per week for 4 weeks, 5 MDS assessments per week for 4 weeks. The results of the quality monitoring data tool to be reviewed by members of the QAPI committee for review, analysis and further recommendations. 5.Date of Compliance January 27, 2023.	

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interview the resident, RN #1 stated, yes. When asked if she knows R29 and if R29 is understood and understands, RN #1 stated, yes.

On 12/12/2022 at 4:47 p.m. an interview was conducted with other staff member (OSM) #3, the social worker When asked who codes Section B of the MDS, OSM #3 stated she believed it was the MDS nurse, and that she completes Section C. When asked if R29 can answer the questions, OSM #3 stated they cannot usually answer the questions that would make sense. When asked how she determines if the resident is never or rarely understood, OSM #3 stated R29 can answer some questions; if they can answer some questions, they are then rarely understood. OSM #3 stated, Section B and Section C should be consistent. When asked what reference is used to complete the MDS, OSM #3 stated a manual, RAI (resident assessment instrument) manual.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 12/12/2022 at 4:56 p.m. When asked if the resident is interviewed for Section B, ASM #2 stated the nurse completing the assessment, should go talk to the resident; and for Section C, ASM #2 stated the person completing the Section should interview the resident. The above MDS assessments were reviewed with ASM #2. When asked if the MDS assessments were correct, ASM #2 stated, no, they are not correct. ASM #2 stated R29 does crossword puzzles all day, they can answer these questions.

RAI Manual 1.17.1 - October 2019
Health-related Quality of Life:
-Most residents are able to attempt the Brief Interview for Mental Status (BIMS).

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-A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis. Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care... Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards...Code 0, no: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status...Attempt to conduct the interview with ALL residents."

ASM #1, the executive director and ASM #2 were made aware of the above concern on 12/13/2022 at 11:03 a.m.

No further information was obtained prior to exit.

2. For R30, the facility staff failed to code Section C - Cognitive patterns accurately on the quarterly assessment of 11/16/2022 and the quarterly assessment of 8/16/2022.

On the most recent MDS assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/16/2022, R29 was coded in Section B - Hearing, Speech and Vision as understanding others and being understood. In Section C -

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Cognitive Patterns, the resident interview was not completed. It was coded "Should brief interview for mental status be conducted?" A "No, resident is rarely/never understood."

On the quarterly assessment, with an ARD of 8/16/2022, R30 was coded in Section B - Hearing, Speech and Vision as understanding others and being understood. In Section C - Cognitive Patterns, the resident interview was not completed. It was coded "Should brief interview for mental status be conducted?" A "No, resident is rarely/never understood."

On 12/12/2022 at 4:36 p.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 stated the MDS nurse completes Section B and social services completes Section C. When asked should the two sections be consistent and agree, RN #1 stated, "My assumption would be yes." When asked when she does Section B, does she go an interview the resident, RN #1 stated, yes. When asked if she knows R30, RN #1 stated, yes and that R30 usually is understood and understands.

On 12/12/2022 at 4:47 p.m. an interview was conducted with other staff member (OSM) #3, the social worker When asked who codes Section B of the MDS, OSM #3 stated she believed it was the MDS nurse, and that she completes Section C. When asked if R30 can answer the questions, OSM #3 stated they cannot usually answer the questions that would make sense. When asked how she determines if the resident is never or rarely understood, OSM #3 stated R30 can answer some questions; if they can answer some questions, they are then rarely understood. When asked should Section B and Section C coordinate

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 24 together, OSM #3 stated, they should be consistent. An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 12/12/2022 at 4:56 p.m. When asked if the resident is interviewed for Section B, ASM #2 stated the nurse completing the assessment, should go talk to the resident. When asked about Section C, ASM #2 stated the person completing the Section should interview the resident. The above MDS assessments were reviewed with ASM #2. When asked if the MDS assessments were correct, ASM #2 stated, no, they are not correct. ASM #2 stated R30 usually can state their needs and answer questions about their care. ASM #1, the executive director and ASM #2 were made aware of the above concern on 12/13/2022 at 11:03 a.m. No further information was obtained prior to exit.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		1/27/23

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F 657	Continued From page 25 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plans for three of 33 residents in the survey sample, Residents #11 (R11), #29 (R29), #30 (R30). The findings include: 1. For R11, the facility staff failed to review and revised the comprehensive care plan when psychoactive medications were discontinued. On the most recent MDS (minimum data set) assessment, the resident scored a three out of 15 on the BIMS (brief interview for mental status) score, indicating the resident severely cognitively impaired for making daily decisions. In Section N - Medications, the resident was coded as receiving anti-depressants for seven days of the look back period. R11 was not coded as taking any anti-anxiety medications during the look back	F 657	1.Resident #11, #29, and #30 comprehensive care plan was reviewed for psychoactive medications that were discontinued and revised on December 13, 2022, by DON. 2.Current residents with psychoactive medications are at risk. Current residents will be reviewed by DON/ADON/Designee to ensure comprehensive care plans are accurately reflecting psychoactive medication orders by January 27, 2023. 3.IDT staff that make care plan revisions to be educated by DON/ADON/Designee on comprehensive care plans being revised timely and accurately by January 27, 2023. 4.DON/ADON/Designee to conduct 10 resident comprehensive care plan audits per week for 4 weeks, then 5 resident comprehensive care plans for 4 weeks. The results of the quality monitoring data tool to be reviewed by members of the	

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F 657	Continued From page 26 period. The comprehensive care plan dated, 3/5/2020 and revised on 11/3/2022, documented, "Focus: (R11) uses anti-depressant medication r/t (related to) Depression." The "Interventions" documented, "Administer ANTIDEPRESSANT medications a ordered by physician. Observe/document side effects and effectiveness Q-SHIFT (every shift). Observe/document/report PRN (as needed) adverse reactions to ANTIDEPRESSANT therapy." The care plan further documented, dated 3/6/2020 and revised on 11/3/2022, "Focus: (R11) uses anti-anxiety medications r/t Anxiety disorder." The "Interventions" documented, "Administer ANTI-ANXIETY mediations as ordered by physician. Observe for side effects and effectiveness Q-SHIFT. Observe/document/report PRN (as needed) adverse reactions to ANTI-ANXIETY therapy." Review of the physician orders reviewed last on, 11/22/2022, failed to evidence documentation of a physician order for an anti-anxiety medication, or an antidepressant medication. An interview was conducted with RN (registered nurse) #1, the MDS coordinator, on 12/13/2022 at 8:33 a.m. When asked who is responsible for updating the care plan, RN #1 stated it depends, she does it a lot of the time. RN #1 stated she did the majority of it but if something happens, then nursing should be doing it. When asked if the care plans are reviewed for accuracy, RN #1 stated she sets up the care plan meeting and read off the care plan, [name of the director of nursing] signs off on them. RN #1 was asked to review the clinical record to determine the last time R11 received an anti-anxiety medication and	F 657	QAPI committee for review, analysis and further recommendations. 5.Date of compliance January 27, 2023.	

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an anti-depressant medication.

On 12/13/2022 at 9:24 a.m. RN #1 stated after she reviewed the clinical record, [R11] had last received a PRN (as needed) anti-anxiety medication on 1/21/2022. RN #1 stated, [R11] had last received an antidepressant, Remeron, on 11/8/2022. When asked if the care plan should have been updated, RN #1 stated, yes.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 12/13/2022 at 10:16 a.m. When asked the purpose of the care plan, ASM #2 stated it is to guide us in the care plan of the patient and it should be complete and accurate. When asked in the care plan meetings, how does she sign off on it, ASM #2 stated they are supposed to sit in the meeting with the IDT (interdisciplinary team) and review the care plan, once we all deem it is correct and accurate, we sign off on it.

The facility policy, "Care Plans, Comprehensive Person-Centered," documented in part, "11. Assessments of resident are ongoing and care plans are revised as information about the resident and the residents' condition change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition...d. at least quarterly, in conjunction with the required quarterly MDS assessment,"

ASM #1, the executive director, and ASM #2 were made aware of the above concern on 12/13/2022 at 11:03 a.m.

No further information was obtained prior to exit.

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2. For R29, the facility staff failed to review and revised the comprehensive care plan when psychoactive medications were discontinued.

On the most recent MDS assessment, an annual assessment, with an assessment reference date (ARD) of 11/28/2022, the resident was coded as having both short- and long-term memory difficulties. The resident was coded as being severely impaired for making cognitive daily decisions. In Section N - Medications, the resident was coded as not taking any psychoactive medications.

The comprehensive care plan dated, 3/26/2022, and revised on 11/3/2022, documented, "Focus: (R29) has depression and uses antidepressant medication r/t (related to) depression." The "Interventions" documented, "Administer ANTIDEPRESSANT medications as ordered by physician. Observe/document side effects and effectiveness Q-SHIFT.
Observe/document/report PRN adverse reactions to ANTIDEPRESSANT therapy."

Review of the physician orders reviewed last on, 11/23/2022, failed to evidence documentation of a physician order for an antidepressant medication.

An interview was conducted with RN (registered nurse) #1, the MDS coordinator, on 12/13/2022 at 8:33 a.m. When asked who is responsible for updating the care plan, RN #1 stated it depends, she does it a lot of the time. RN #1 stated she did the majority of it but if something happens, then nursing should be doing it. When asked if the care plans are reviewed for accuracy, RN #1 stated she sets up the care plan meeting and

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read off the care plan, [name of the director of nursing] signs off on them. RN #1 was asked to review the clinical record to determine the last time R29 received anti-depressant medication.

On 12/13/2022 at 9:24 a.m. RN #1 returned and stated after she reviewed the clinical record, the R29 had last received an antidepressant, Remeron, on 8/11/2022. When asked if the care plan should have been updated, RN #1 stated, yes.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 12/13/2022 at 10:16 a.m. When asked the purpose of the care plan, ASM #2 stated it is to guide us in the care plan of the patient and it should be complete and accurate. When asked in the care plan meetings, how does she sign off on it, ASM #2 stated they are supposed to sit in the meeting with the IDT (interdisciplinary team) and review the care plan, once we all deem it is correct and accurate, we sign off on it.

ASM #1, the executive director, and ASM #2 were made aware of the above concern on 12/13/2022 at 11:03 a.m.

No further information was obtained prior to exit.

3. For R30, the facility staff failed to review and revised the comprehensive care plan when psychoactive medications were discontinued.

On the most recent MDS assessment, a quarterly assessment, with an ARD of 11/16/2022, the resident was coded as having both short- and long-term memory difficulties. The resident was

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coded as being severely impaired for making cognitive daily decisions. In Section N - Medications, the resident was not coded as receiving any psychoactive medications.

Review of the physician orders, last reviewed on 11/23/2022 failed to evidence documentation of a physician order for an anti-anxiety medication.

The comprehensive care plan dated 8/25/2022, and last revised on 10/31/2022, documented, "Focus: The resident uses anti-anxiety medications r/t anxiety disorder and treatments." The "Interventions" documented, "Administer ANTI-ANXIETY medications as ordered by physician. Observe for side effects and effectiveness Q-SHIFT."

An interview was conducted with RN (registered nurse) #1, the MDS coordinator, on 12/13/2022 at 8:33 a.m. When asked who is responsible for updating the care plan, RN #1 stated it depends, she does it a lot of the time. RN #1 stated she did the majority of it but if something happens, then nursing should be doing it. When asked if the care plans are reviewed for accuracy, RN #1 stated she sets up the care plan meeting and read off the care plan, [name of the director of nursing] signs off on them. RN #1 was asked to review the clinical record to determine the last time R30 received anti-anxiety medication.

On 12/13/2022 at 9:24 a.m. RN #1 stated after she reviewed the clinical record, the R30 had last received an anti-anxiety medication, was on 9/4/2022. When asked if the care plan should have been updated, RN #1 stated, yes.

An interview was conducted with ASM

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F 657	Continued From page 31 (administrative staff member) #2, the director of nursing, on 12/13/2022 at 10:16 a.m. When asked the purpose of the care plan, ASM #2 stated it is to guide us in the care plan of the patient and it should be complete and accurate. When asked in the care plan meetings, how does she sign off on it, ASM #2 stated they are supposed to sit in the meeting with the IDT (interdisciplinary team) and review the care plan, once we all deem it is correct and accurate, we sign off on it. ASM #1, the executive director, and ASM #2 were made aware of the above concern on 12/13/2022 at 11:03 a.m. No further information was obtained prior to exit.	F 657		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide dialysis care and services for one of 33 residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to ensure adequate communication and collaboration for care with the resident's	F 698	1.Resident #1 did not suffer negative or adverse outcomes due to evidence not being shown of communication between facility and dialysis center. 2.Current residents who are on dialysis are at risk. Current dialysis residents will be reviewed by DON/ADON/Designee to ensure communication between with facility and dialysis center are done timely and completely by December 30, 2022.	1/27/23

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F 698	Continued From page 32 hemodialysis center. On the most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 11/25/22, the resident's cognitive skills for daily decision making were coded as severely impaired. A review of R1's clinical record revealed a physician's order dated 11/21/22 for hemodialysis every Monday, Wednesday and Friday. R1's comprehensive care plan revised on 11/21/22 failed to document information regarding communication with the dialysis center. A review of R1's dialysis communication book (a book that contained communication forms to be completed by facility staff, sent with the resident to dialysis and returned with documented communication from the dialysis center) revealed multiple communication forms for November 2022 and December 2022. The top section of the form documented, "FACILITY TO COMPLETE PRIOR TO DIALYSIS." This section contained areas for the facility staff to document R1's vital signs, medications administered prior to dialysis, pain, any concerns, any changes in condition since the last visit, any physician order changes since the last visit and any new labs since the last visit. Further review of R1's dialysis communication book failed to reveal evidence that communication forms were completed on Monday 11/28/22, Wednesday 11/30/22 and Friday 12/2/22. Also, the section to be completed by the facility staff was not completed on Friday 12/9/22. On 12/13/22 at 8:02 a.m., an interview was conducted with LPN (licensed practical nurse) #2.	F 698	3.Nursing staff to be educated by DON/ADON/Designee on the facility□s communication mechanism with the dialysis center by January 27, 2023. 4.DON/ADON/Designee to conduct weekly audit of resident communication book for all dialysis residents 5 times per week for 4 weeks, then for all dialysis residents 3 times a week for 2 weeks, finally for all dialysis residents 1 time per week for 2 weeks. The results of the quality monitoring data tool to be reviewed by members of QAPI committee for review, analysis, and further recommendations. 5.Date of compliance January 27, 2023.	

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LPN #2 stated the nurses are supposed to complete the facility section of the dialysis communication form prior to dialysis every day R1 goes to dialysis. LPN #2 stated the purpose of the dialysis communication forms is for communication with dialysis and continuity of care. LPN #2 stated the dialysis communication forms are kept in the dialysis communication book and the book goes back and forth to dialysis with R1. LPN #2 stated she was pretty sure there were times that the dialysis communication book stays at the dialysis center and doesn't return to the facility. LPN #2 stated the people transporting R1 from dialysis are supposed to hand the communication book off to the facility nurse when R1 returns and it is the nurses' responsibility to make sure the book returns.

On 12/13/22 at 1:30 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Dialysis Communication" documented, "The facility and dialysis center will establish a communication and reporting mechanism to promote situational awareness between both facilities.
Policy Interpretation and Implementation
1. Routine communication of relevant information will be provided by the facility to the dialysis center on treatment days, and more frequently as necessary.
2. The facility will designate persons within the facility who are responsible for the exchange of information between the facility and the dialysis center.
3. The facility and dialysis center will determine a method to exchange written information between

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F 698	Continued From page 34 the centers on dialysis days. Examples of communication methods may include but are not limited to: forms, binders, books and copies of medical records." No further information was presented prior to exit.	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		1/27/23

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F 732	Continued From page 35 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to post daily staffing for one of three days reviewed. The findings include: During the Sufficient and Competent Staffing facility task review started on 12/11/22 and ending on 12/13/22, a review of the daily staffing evidenced the following: On 12/11/22 at 12:15 PM the survey team entered the facility for the survey. On the bulletin board in the main lobby there was nurse staff posting with a date of 12/9/22 on posting. The daily staffing was posted correctly the remainder of the survey, 12/12/22 and 12/13/22. On 12/13/22 at 11:00 AM, an interview was conducted with CNA (certified nursing assistant) #1, the staffing coordinator. When asked the process for posting of the daily staffing, CNA #1 stated, on the weekends, the nurse posts the staffing. An interview was conducted on 12/13/22 at 11:15 with ASM (administrative staff member) #2, the director of nursing. When asked about the daily	F 732	1.Staffing posting posted upon notification by staffing coordinator on 12/11/2022. Residents did not suffer negative or adverse outcomes due to staffing information posted. 2.Facility is required to post accurate staffing numbers and in-house census daily. 3.Staffing Coordinator and nursing staff educated on ensuring staffing numbers are posted daily by December 13, 2022. 4.Staffing coordinator/Designee to review and track staff posting 5 days a week for 4 weeks, then audit 3 days a week for 2 weeks, and finally 1 day a week for 2 weeks. The results of the quality monitoring data tool to be reviewed by members of the QAPI committee for review, analysis and further recommendations. 5.Date of compliance January 27, 2023.	

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F 732	Continued From page 36 staff posting, ASM #1 stated, the pages were behind the 12/9 posting, they just were not pulled out to see. On 12/13/22 at 11:30 AM, ASM #1, the executive director and ASM #2, the director of nursing was made aware of the findings. According to the facility's "Posting Direct Care Daily Staffing Numbers" policy with no date, revealed, "Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format." No further information was provided prior to exit.	F 732		
F 839 SS=E	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 839	1.License verification obtained for CNA	1/27/23

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	495236	A. BUILDING _____ B. WING _____	C 12/13/2022

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F 839	Continued From page 37 and employee record review, it was determined that the facility staff failed to evidence maintenance of required certification for four of five CNA (certified nursing assistants), CNA #1, CNA #2, CNA #3 and CNA #4 The findings include: The facility staff failed to provide the evidence of required certification verification prior to expiration, for four CNAs that were employed for greater than on year. During the Sufficient and Competent Staffing facility task review conducted on 12/13/22 at 9:30 AM the following CNA employee records and certifications were reviewed and revealed the following: 1. CNA #1 with a date of hire of 9/17/19, had a previous certification that expired 1/31/22, however updated certification was not verified through the Department of Health Professions (DHP) until 2/22/22. 2. CNA #2 with a date of hire of 1/11/17, had a previous certification that expired 7/31/22, however updated certification was not verified through DHP until 9/28/22. 3. CNA #3 with a date of hire of 5/22/12, had a previous certification that expired 3/31/22, however updated certification was not verified through DHP unit 9/28/22. 4. CNA #4 with a date of hire of 8/16/04, had a previous certification that expired 11/30/22, however updated certification was not verified through DHP until 12/11/22. On 12/13/22 at 10:30 AM, OSM #4, the human resources director stated, "Audits are done on the	F 839	#1, #2, #3 and #4. Residents did not suffer negative or adverse outcomes due license verifications being obtained past license expiration date. 2.Current residents are at risk. Employee files will be reviewed by HRM/Designee to ensure all active employee licenses are current. 3.HRM educated by ED on obtaining license verification prior to license expiration on December 13, 2022. 4.HRM/Designee to conduct 10 employee license audits weekly for 4 weeks, audit 5 employee files weekly for 2 weeks, then 3 employee files weekly for two weeks. The results of the quality monitoring data tool to be reviewed by members of the QAPI committee for review, analysis and further recommendations. 5.Date of compliance January 27, 2023.	

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F 839	Continued From page 38 employee files and I have a book by month of when employee certifications expire. I help them with the on-line process for their certification, but I do not always go back in and print the certificate." On 12/13/22 at 11:30 AM, ASM #1, the executive director and ASM #2, the director of nursing was made aware of the findings. According to the facility's "Licensure, Certification, and Registration of Personnel" policy with no date, revealed "A copy of recertifications (e.g., annual, bi-annual, etc., as applicable) must be presented to the human resources director/designee upon receipt of such recertifications and prior to the expiration of current licensure, certification, and/or registration. A copy of the recertification must be filed in the employee's personnel record." No further information was provided prior to exit.	F 839		
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.	F 842		1/27/23

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§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches

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F 842	Continued From page 40 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain and complete and accurate clinical record for one of 33 residents in the survey sample, Resident #15 (R15). The findings include: For R15, the facility staff failed to document changes in the discharge planning. On the most recent MDS (minimum data set), a quarterly assessment, with an assessment reference date of 9/10/2022, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. The Social Services Progress Note dated, 11/1/2022 at 9:10 a.m. documented, "SW (social worker) received a call from (name of another nursing facility) requesting additional info (information) concerning transfer referral. SW	F 842	1.Resident #15 did not suffer negative or adverse outcomes due to resident record not reflecting accurate transfer plans. 2.Current resident with discharge/transfer plans are at risk. Current residents will be reviewed by the Social Worker/Designee to ensure transfer/discharge plans are followed up on accordingly by January 27, 2023. 3.IDT educated by the ED on accurate and timely resident records on December 13, 2022. 4.Social Worker/Designee to conduct 10 resident file audits weekly for 4 weeks, then 5 resident files weekly for 3 weeks. The results of the quality monitoring data tool to be reviewed by members of the QAPI committee for review, analysis and further recommendations. 5.Date of compliance January 27, 2023.	

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provided requested info (information)."

The Social Services Progress Note dated, 11/10/2022 at 2:35 p.m. documented, "Received a call from daughter [name of daughter] asking if we could assist with transporting her mom to [name of other facility]. SW said she knows of very reputable transport services which she can pay privately to have her mom transferred but our facility cannot provide transport and Medicaid will not pay for facility-to-facility transport. Daughter indicated she has a minivan but that she does not think her mom can safely transfer from her WC (wheelchair) to the seat of the minivan. Daughter said she would see what other solution is available and call SW back."

Further review of the clinical record failed to evidence any documentation related to the transfer or discontinuation of the transfer for R15.

An interview was conducted with OSM (other staff member) #3, the social services director, on 12/13/2022 at 8:19 a.m. The social services notes were reviewed with OSM #3. When asked what the status of R15's transfer to the other facility was, OSM #3 stated the facility wouldn't take R15 as they were no longer on skilled services. When asked where the notes are related to the cancellation of the transfer for R15, OSM #3 stated, "I guess I should do an update in the chart."

The facility policy, "Charting and Documentation" documented in part, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The

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F 842	Continued From page 42 medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were made aware of the above concern on 12/13/2022 at 11:03 a.m. No further information was obtained prior to exit.	F 842		