STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIE NURSING AND REHABILITATION CENTER	498 MADISON ROAD MOCKSVILLE, NC 27028

(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 recertification survey was conducted on 2/9/2020 through 2/13/2020. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# K16811.	E 000		
F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted during a recertification survey from 2/9/20 through 2/13/20. Five of five allegations investigated were unsubstantiated. The 2567 was amended to correct residents' identification numbers in tag F582.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when 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	F 582		3/4/20

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

Electronically Signed | 03/04/2020

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F 582	Continued From page 1 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to provide a CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare part A skilled services to two of four residents (Resident #36 and Resident #183) reviewed for SNF Beneficiary Protection	F 582	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements.	

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F 582	Continued From page 2 Notification. Findings included: 1. Resident #36 was admitted on 08/21/19 and currently resided in the facility during the review. A review of the SNF Beneficiary Protection Notification records for Resident #36 revealed Medicare Part A skilled service start date was 08/21/19 and ended on 09/03/19. The services were terminated because Resident #36 had achieved the highest practical level according to therapy. Form CMS-10055 was not provided to Resident #36 or their Responsible Party (RP). During an interview on 02/12/20 at 3:28 PM, the Business Office Manager (BOM) confirmed she did not provide the SNF/ABN, form CMS-10055 to Resident #36, or the resident's RP. Her interpretation of when to issue the form was if the resident chose to continue with therapy services after being discharged then she provided a SNF/ABN, form CMS-10055. If the resident chose not to continue with therapy services, she only provided the CMS-10123 form. The BOM stated going forward both forms would be provided for residents who remained in the facility to ensure if therapy services were to continue Medicare A may not pay making the resident responsible. During an interview on 02/13/19 at 3:07 PM, the Administrator understood that both forms needed to be provided to the resident or the resident's responsible party. He stated that he was unaware that the BOM did not know this and that going forward, he would make sure it was clear that when a resident remained in the facility and	F 582	Resident #36'□s responsible party was educated on resident rights including liability notice. Resident #183 is no longer in facility. Neither resident had any negative outcome as a result of this event. To identify other residents who have the potential to be affected, all residents that experienced a discontinuation of skilled service coverage since 2/1/2020 were reviewed by the facility business office manager and administrator, to ensure that they were given an Advanced Beneficiary Notice (ABN) and this was properly documented. Any residents identified with negative outcomes will have resident rights education provided. Resident rights were also reviewed with resident council on 2/27/2020. To prevent this from recurring, the business office manager, and social worker were educated by the Corporate Director of Social Services and Activities on the process for providing residents or responsible parties an ABN and documentation of providing the ABN on 2/27/2020. Once a discharge date is determined, the business office manager will notify the facility social worker. The facility social worker or designee, then issues the ABN to the resident or responsible party and completes documentation in the record. To monitor and maintain ongoing compliance, facility administrator will audit three residents per week who had a discontinuation of skilled services, for 12 weeks, to ensure ABNs were provided timely and documented beginning the	

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F 582	Continued From page 3 was discharged from Medicare Part A services with remaining days both the CMS-10055 and CMS-10123 forms were provided to either the resident or their RP. 2. Resident #183 was admitted on 09/11/19 and was not residing in the facility during the review. A review of the SNF Beneficiary Protection Notification records for Resident #183 revealed Medicare Part A skilled service start date was 09/11/19 and ended on 09/24/19. The services were terminated because Resident #183 had achieved the highest practical level according to therapy. Form CMS-10055 was not provided to Resident #183 or their Responsible Party (RP). During an interview on 02/12/20 at 3:28 PM, the Business Office Manager (BOM) confirmed she did not provide the SNF/ABN, form CMS-10055 to Resident #183 or the resident's RP. Her interpretation of when to issue the form was if the resident chose to continue with therapy services after being discharged then she provided a SNF/ABN, form CMS-10055. If the resident chose not to continue with therapy services, she only provided the CMS-10123 form. The BOM stated going forward both forms would be provided for residents who remained in the facility to ensure if therapy services were to continue Medicare A may not pay making the resident responsible. During an interview on 02/13/19 at 3:07 PM, the Administrator understood that both forms needed to be provided to the resident or the resident's responsible party. He stated that he was unaware that the BOM did not know this and that going forward, he would make sure it was clear	F 582	week of 2/28/2020. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing. Administrator is responsible for compliance.	

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F 582	Continued From page 4 that when a resident remained in the facility and was discharged from Medicare Part A services with remaining days both the CMS-10055 and CMS-10123 forms were provided to either the resident or their RP.	F 582		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or 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	F 623		3/4/20

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F 623	Continued From page 5	F 623		

this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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

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F 623	Continued From page 6 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 resident, resident representative and staff interviews and record review, the facility failed to provide the resident and resident representative a written notification for the reason for transfer to the hospital for 2 of 3 residents (Resident #19 and Resident #59) reviewed for hospitalization. Findings included: 1. Resident #19 was admitted to the facility on 3/11/19 with diagnoses that included, in part, diabetes and hypertension.	F 623	Resident #19 and resident #59 were admitted back to facility prior to survey exit of 2/13/2020. Both residents received education of the requirement of transfer/discharge notifications. Neither resident had any negative outcomes from this event. To identify other residents who have the potential to be affected, the facility administrator completed an audit of all residents currently in the hospital as of 2/13/2020, in order to ensure residents had received the proper transfer/discharge notifications. There	

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F 623	Continued From page 7 The comprehensive minimum data set assessment dated 12/12/19 revealed Resident #19 was cognitively intact. The medical record indicated Resident #19's representative was a family member. A nurse's note in the medical record reported Resident #19 was transferred to the hospital on 1/21/20 due to low hemoglobin and bleeding. The note indicated Resident #19's representative was notified of the transfer to the hospital. The resident was re-admitted to the facility on 1/26/20. No written notice of transfer was documented to have been provided to the resident or resident representative. On 2/10/20 at 9:59 AM an interview was completed with Resident #19. She stated approximately three weeks earlier she transferred to the hospital because "I was bleeding." She recalled she had not received a written notice of transfer/discharge from the facility when she went to the hospital. During an interview with Resident #19's representative on 2/12/20 at 1:50 PM he expressed he was notified over the phone on 1/21/20 when Resident #19 was sent to the hospital but had not received a written notice of transfer/discharge. On 2/11/20 at 1:23 PM a phone call was placed to Nurse #1, who was on duty when Resident #19 was sent to the hospital. A message was left for Nurse #1 but the phone call was not returned. An interview was completed with the Admissions Coordinator on 2/11/20 at 9:44 AM during which she stated the nursing department sent out the	F 623	were no residents in the hospital as of 2/13/2020. Resident rights were also reviewed at resident council on 2/27/2020. To prevent this from recurring, the Business Office Manager and Social Worker were educated by the corporate Director of Social Services and Activities on the process for providing Notice of Transfer Discharge paperwork and proper documentation on 2/27/2020. Education was completed on 02-28-2020 by the Director of Nursing, to the nurses, to provide the discharge packet containing the Notice of Transfer Discharge. The checklist for discharge was updated to include this item. This education will be provided to any new hired nurses and any agency nurses. The Business Office Manager is responsible for sending a certified letter containing the Notice of Transfer Discharge. The Business Office Manager will also call the resident or responsible party by the day next business day to ensure that this information was received. To monitor and maintain ongoing compliance, Administrator will audit three discharges per week for 12 weeks, to ensure that the Notice of Transfer Discharge was sent and properly documented beginning 2/28/2020. Any negative findings will be corrected. These results will be documented on an audit tool. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing.	

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F 623	Continued From page 8 transfer/discharge notice when a resident was transferred to the hospital. Nurse Supervisor #1 was interviewed on 2/11/20 at 4:10 PM. She explained nurses were educated in their initial training about what forms needed to be sent when a resident went to the hospital. She said the forms that were sent included a facesheet, discharge summary, medication administration record, the physician's order to transport to the hospital, code status and bed hold policy. Nurse Supervisor #1 stated the transfer/discharge notice was not sent with the resident when transferred to the hospital. During an interview with the Assistant Director of Nursing on 2/12/20 at 3:08 PM she revealed the nurses typically had not sent a written notice of transfer/discharge when a resident went to the hospital and added she was unsure who was responsible to have the notice sent to the resident and resident representative. On 2/12/20 at 3:01 PM an interview was completed with the Director of Nursing (DON). She recalled Resident #19 was transferred to the hospital on 1/21/20 for bleeding and low hemoglobin. She reported there was a check list at the nurse's station of the paperwork that needed to be sent when a resident went to the hospital. She added she was unsure who sent the written notice of transfer/discharge to the resident and resident representative when a resident transferred to the hospital. A transfer check list was provided by Nurse Supervisor #1 on 2/11/20 at 4:30 PM. The transfer/discharge notice was not a form that was included in the check list.	F 623	Administrator is responsible for compliance.	

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F 623	Continued From page 9	F 623		

On 2/13/20 at 10:33 AM an interview with the Administrator revealed that the transfer/discharge notice was supposed to be completed by the nurse and given to the resident prior to being transferred to the hospital. He acknowledged the process was not consistently being followed by nursing staff and staff had just been re-educated about the process.

2. Resident #59 was admitted to the facility on 2/24/16 with diagnoses that included, in part, heart failure and hypertension.

The comprehensive minimum data set assessment dated 1/19/20 revealed Resident #59 had cognitive impairment.

The medical record indicated Resident #59's representative was a family member.

A nurse's note in the medical record reported Resident #59 was transferred to the hospital on 10/15/19 due to shortness of breath, abnormal lung sounds, and low oxygen levels. The medical record demonstrated no evidence that a written notice of transfer/discharge was provided to the resident and resident representative when she was transferred to the hospital.

Resident #59 was readmitted to the facility from the hospital following treatment for aspiration pneumonia on 10/18/19.

On 2/13/20 at 1:56 PM an interview was completed with the Business Office Manager (BOM). The BOM added she typically called a resident's representative and remembered calling

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Resident #59's representative to notify her of the discharge to the hospital. The facility also sent the resident representative a certified letter regarding the resident's discharge from the facility. She stated that she would notify the Administrative Assistant, who would then send a certified letter to the resident representative about the discharge. The BOM reviewed the certified letter signature receipts and stated there was not one for Resident #59's representative.

On 2/13/20 at 2:12 PM a phone call was placed to Resident #59's representative but no interview was obtained.

During an interview with the Assistant Director of Nursing on 2/12/20 at 3:08 PM she revealed the nurses typically had not sent a written notice of transfer/discharge when a resident went to the hospital and added she was unsure who was responsible to have the notice sent to the resident and resident representative.

On 2/12/20 at 3:01 PM an interview was completed with the Director of Nursing (DON). She reported there was a check list at the nurse's station of the paperwork that needed to be sent when a resident went to the hospital. She added she was unsure who sent the written notice of transfer/discharge to the resident and resident representative when a resident transferred to the hospital.

Review of the transfer check list on 2/11/20 at 4:30 PM revealed that the transfer/discharge notice was not a form that was included in the check list.

On 2/13/20 at 10:33 AM an interview with the

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F 623	Continued From page 11 Administrator revealed that the transfer/discharge notice was supposed to be completed by the nurse and given to the resident prior to being transferred to the hospital. He acknowledged the process was not consistently being followed by nursing staff and staff had just been re-educated about the process.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		3/4/20

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F 625	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on resident, resident representative and staff interviews, and record review, the facility failed to provide the resident and resident representative a written notification of the bed hold policy upon a resident's transfer to the hospital for 2 of 3 residents (Resident #19 and Resident #59) reviewed for hospitalization. Findings included: 1. Resident #19 was admitted to the facility on 3/11/19 with diagnoses that included, in part, diabetes and hypertension. The comprehensive minimum data set assessment dated 12/12/19 revealed Resident #19 was cognitively intact. The medical record indicated Resident #19's representative was a family member. A nurse's note in the medical record reported Resident #19 was transferred to the hospital on 1/21/20 due to low hemoglobin and bleeding. The resident returned to the facility on 1/26/20. The medical record demonstrated no evidence that a written notice of the bed hold policy was provided to the resident and resident representative when she was transferred to the hospital. On 2/10/20 at 9:59 AM an interview was completed with Resident #19. She stated approximately three weeks earlier she transferred to the hospital because "I was bleeding." She recalled she had not been contacted by anyone at the facility about bed hold after she transferred to the hospital nor had she received a copy of the	F 625	Resident #19 and resident #59 were admitted back to facility prior to survey exit of 2/13/2020. Both residents received education of the facility bed hold policy and requirement of notifications. Neither resident had any negative outcome from this event. To identify other residents who have the potential to be affected, the facility administrator completed an audit of all residents currently in the hospital as of 2/13/2020, in order to ensure residents had received the proper bedhold policy notifications and proper documentation present in the record. There were no residents in the hospital as of 2/13/2020. Resident rights were also reviewed at resident council on 2/27/2020. To prevent this from recurring, the Business Office Manager and Social Worker were educated by the Corporate Director of Social Services and Activities on the process for providing Bed Hold Policy and proper documentation on 2/27/2020. Education was completed on 02-28-2020 by the Director of Nursing, to the nurses, to provide the discharge packet containing the facility bed hold policy. This education will be provided to any new hired nurses and any agency nurses. The Business Office Manager is responsible for sending a certified letter containing the Bed Hold Policy. The Business Office Manager will also call the resident or responsible party by the day next business day to ensure that this information was received.	

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F 625	Continued From page 13 bed hold policy. During an interview with Resident #19's representative on 2/12/20 at 1:50 PM he expressed he had not received a copy of the bed hold policy when Resident #19 discharged to the hospital. On 2/11/20 at 1:23 PM a phone call was placed to Nurse #1, who was on duty when Resident #19 was sent to the hospital. A message was left for Nurse #1 but the phone call was not returned. An interview was completed with the Admissions Coordinator on 2/11/20 at 9:44 AM during which she stated the facility's bed hold policy was given to residents/families upon admission to the facility. She said the nursing department sent the bed hold policy with the resident when being transferred to the hospital. The Admissions Coordinator added if the bed hold policy was not sent by nursing she thought the business office sent it out. On 2/11/20 at 3:22 PM an interview was completed with the Business Office Manager (BOM). She revealed the bed hold policy was sent with a resident when transferred to the hospital. The BOM added she typically called a resident's representative the day after being transferred to the hospital and inquired if the representative wanted to do a bed hold. The facility also sent the resident representative a certified letter that included a copy of the bed hold policy. The BOM expressed she thought she had called Resident #19's representative after she transferred to the hospital and asked if he wanted to hold Resident #19's bed.	F 625	To monitor and maintain ongoing compliance, Administrator will audit three discharges per week for 12 weeks, to ensure that the Bed Hold Policy was sent and properly documented beginning 2/28/2020. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing. Administrator is responsible for compliance.	

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During interviews with the Administrative Assistant on 2/11/20 at 3:33 PM and 4:20 PM she indicated the BOM usually notified her when a resident went to the hospital and then she immediately sent a certified letter to the resident representative that contained the bed hold policy. She explained she kept the certified letter receipt that was signed by the resident representative when the letter was received. The Administrative Assistant reviewed the certified letter signature receipts and stated there was not one for Resident #19's representative. She added she may not have been notified by the BOM when Resident #19 went to the hospital and so the bed hold policy must have not been sent.

The Director of Nursing was interviewed on 2/12/20 at 3:01 PM. She explained that when a resident transferred to the hospital a copy of the bed hold policy was supposed to be included in the packet of information that was sent with the resident to the hospital.

On 2/13/20 at 10:33 AM an interview with the Administrator revealed that the bed hold policy was to be sent with the resident upon transfer to the hospital and a copy provided to the resident representative in the mail. He acknowledged the process was not consistently being followed and staff had just been re-educated about the process.

2. Resident #59 was admitted to the facility on 2/24/16 with diagnoses that included, in part, heart failure and hypertension.

The comprehensive minimum data set assessment dated 1/19/20 revealed Resident #59

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had cognitive impairment.

The medical record indicated Resident #59's representative was a family member.

A nurse's note in the medical record reported Resident #59 was transferred to the hospital on 10/15/19 due to shortness of breath, abnormal lung sounds, and low oxygen levels. The medical record demonstrated no evidence that a written notice of the bed hold policy was provided to the resident and resident representative when she was transferred to the hospital.

On 2/13/20 at 1:56 PM an interview was completed with the Business Office Manager (BOM). She revealed the bed hold policy was sent with a resident when transferred to the hospital. The BOM added she typically called a resident's representative and remembered calling Resident #59's representative to notify her of the discharge to the hospital. The facility also sent the resident representative a certified letter that included a copy of the bed hold policy. She stated that she would notify the Administrative Assistant, who would then send a certified letter to the resident representative that contained the bed hold policy. The BOM reviewed the certified letter signature receipts and stated there was not one for Resident #59's representative.

Resident #59 was readmitted to the facility from the hospital following treatment for aspiration pneumonia on 10/18/19.

On 2/13/20 at 2:12 PM a phone call was placed to Resident #59's representative but no interview was obtained.

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F 625	Continued From page 16 The Director of Nursing was interviewed on 2/12/20 at 3:01 PM. She explained that when a resident transferred to the hospital a copy of the bed hold policy was supposed to be included in the packet of information that was sent with the resident to the hospital. On 2/13/20 at 10:33 AM an interview with the Administrator revealed that the bed hold policy was to be sent with the resident upon transfer to the hospital and a copy provided to the resident representative in the mail. He acknowledged the process was not consistently being followed and staff had just been re-educated about the process.	F 625		
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 interviews and record review the facility failed to accurately code the active diagnoses section (section I) on the Minimum Data Set (MDS) assessment for 2 of 5 residents (Resident #7 and Resident #19) reviewed for unnecessary medications. Findings included: 1. Resident #7 was admitted to the facility on 8/23/16. Cumulative diagnoses included, in part, anxiety disorder and depression. A psychiatry note dated 10/21/19 stated Resident #7 had a diagnosis of anxiety and major	F 641	Residents #7 and #19 have had their MDS assessment modified and corrected. Neither resident had any negative outcome from this event. To identify other resident who have the potential to be affected, resident assessments beginning 2/9/2020 have been reviewed for accuracy by the MDS coordinators (no coordinator completed their own review). Any noted discrepancies have been corrected based on the guidance from the resident assessment instrument. To prevent this from recurring, the corporate regional resident	3/4/20

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F 641	Continued From page 17 depressive disorder. In a note dated 10/23/19, the facility nurse practitioner indicated Resident #7 had a past medical history of depression. The quarterly MDS assessment dated 11/17/19 revealed Resident #7 received an anti-depressant medication for 7 of 7 days during the lookback period. Additionally, no diagnoses were checked under the psychiatric/mood disorder portion of section I. On 2/12/20 at 11:29 AM an interview was completed with MDS Nurse #1. She said when she coded diagnoses on the MDS assessment she reviewed physician (MD) notes and if the MD note indicated an active psychiatric diagnosis within the past 60 days then she coded it on the MDS assessment. She added that if a resident took a medication for depression or anxiety of if a resident was seen by psychiatric services in the facility then she kept the diagnosis active and coded it on the MDS assessment. She explained that both anxiety and depression diagnoses should have been coded on the MDS based upon the psychiatry note and thought she must have missed coding it when she completed the quarterly MDS assessment. During an interview with the Administrator on 2/13/20 at 10:33 AM, he revealed when a MDS assessment was completed it went through a "triple check process" among the business office, MDS office and therapy office and they made sure everything was appropriately checked. The Administrator said he wasn't sure why the diagnoses coding was missed on the MDS assessment.	F 641	reimbursement specialist re-educated the facility MDS nurse coordinators on the requirement of accurate coding of assessments 2/21/2020 Orders will be reviewed during clinical meeting and changes to the MDS will be made as needed based on the review. To monitor and maintain ongoing compliance, three assessments will be audited weekly for four weeks then two assessments will be audited for four weeks, and then one chart will be audited for four weeks beginning 2/17/2020. Resident assessments are audited by MDS nurses and any additional diagnoses are added to resident charts. The assessments are audited by nurses that did not perform the initial MDS. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing. DON is responsible for compliance.	

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2. Resident #19 was admitted to the facility on 3/11/19. Cumulative diagnoses included, in part, anxiety disorder, depression and post-traumatic stress disorder (PTSD).

A psychiatry note dated 12/2/19 stated Resident #19 had a diagnosis of PTSD.

In a note dated 12/11/19, the facility nurse practitioner included PTSD in the list of diagnoses for Resident #19.

The comprehensive MDS assessment dated 12/12/19 revealed Resident #19 received anti-depressant and anti-psychotic medications for 7 of 7 days during the lookback period. The diagnoses of anxiety and depression were checked under the psychiatric/mood disorder portion of section I, however, PTSD was not checked.

On 2/12/20 at 2:40 PM an interview was completed with MDS Nurse #2. She said when she coded diagnoses on the MDS assessment she reviewed physician (MD) notes and the medical diagnoses list. She explained she typically included all psychiatric diagnoses when she coded section I because, "the resident can fluctuate." She indicated Resident #19 had multiple psychiatric diagnoses and said she missed coding the PTSD diagnosis and thought "it got overlooked."

During an interview with the Administrator on 2/13/20 at 10:33 AM, he revealed when a MDS assessment was completed it went through a "triple check process" among the business office, MDS office and therapy office and they made

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F 641	Continued From page 19 sure everything was appropriately checked. The Administrator said he wasn't sure why the diagnoses coding was missed on the MDS assessment.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to refer a resident, who was hospitalized for a psychiatric condition which resulted in an additional psychiatric diagnosis, for a level II Preadmission Screening and Resident Review (PASARR) for 1 of 1 resident (Resident #19) reviewed for PASARR. Findings included:	F 644	Resident #19 had a new PASRR updated by social worker, there was no change in the PASRR. To identify other residents who have the potential to be affected, all residents in facility as of 2/13/2020 were audited for current/significant change PASRR by the facility social worker. Any identified residents needing an update were acted upon and an update completed.	3/4/20

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F 644	Continued From page 20 Resident #19 was admitted to the facility on 3/11/19 with diagnoses that included, in part, anxiety disorder and major depressive disorder. She had a level I PASARR number upon initial admission. Resident #19 discharged to the hospital on 5/8/19 due to a decline in her psychiatric condition. She was re-admitted to the facility on 5/16/19 with a new diagnosis of suicidal ideations. The medical record revealed a level II PASARR referral (the purpose of the Level II screening is to assure that individuals with serious mental illness entering or residing in Medicaid certified nursing facilities receive appropriate placement and services) was not completed by the facility upon the resident's re-admission. The facility completed a psychiatric evaluation on 5/20/19 which explained Resident #19 was "admitted to the hospital 5/8/19 and was discharged back to facility on 5/16/19 due to suicidal ideations and paranoia." The comprehensive Minimum Data Set (MDS) assessment dated 12/12/19 indicated Resident #19 was cognitively intact. She reported mood symptoms that included having little interest in things and feeling tired/little energy. Resident #19 received antipsychotic and antidepressant medications for 7 of 7 days during the MDS look back period. A care plan for delusional behavior was updated 1/14/20 and an intervention included, "Refer to psychiatrist and/or psychologist as needed." On 2/11/20 at 9:55 AM Resident #19's current PASARR number was provided by the facility social worker (SW) and revealed a level I	F 644	Residents did not have any negative outcome from this event. To prevent this from recurring, the facility Social Worker and Admissions Department were educated by the Corporate Director of Social Services and Activities on the process for applying for PASRRs on 2/27/2020. During clinical review, the IDT will identify any new changes or needs that may require a PASRR referral or update. The social worker will apply for a new PASRR for all residents returning from a hospitalization with a significant change in status. To monitor and maintain ongoing compliance, the facility administrator will audit three residents per week for 12 weeks that return from hospitalization to determine if a Level II PASRR was applied for if needed beginning on 2/28/2020. The facility social worker will review 3 resident charts per week for 12 weeks to ensure that there has not been a significant change that would require a PASRR referral. These results will be documented on an audit tool. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing. Administrator is responsible for compliance.	

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PASARR number.

On 2/11/20 at 9:10 AM an interview was completed with the SW. She reported the Admissions office verified PASARR numbers prior to a resident's admission to the facility. She stated she was unaware that a level II PASARR needed to be completed when a resident was identified with a mental illness diagnosis.

The Admissions Coordinator (AC) was interviewed on 2/11/20 at 9:35 AM. She stated she was the facility's social worker in May 2019 when Resident #19 was transferred to the hospital. She said the resident had received psychiatric services in the facility for about two weeks yet on 5/8/19 was delusional and endorsed suicidal ideation with a plan. The facility immediately sent Resident #19 to the emergency department and the resident was admitted to the hospital for psychiatric care. The AC stated when the resident returned to the facility she had not completed a level II PASARR referral and added she had not done level II referrals when a resident was identified with a mental illness diagnosis. She said, "Honestly, I didn't know I should have done one."

During an interview with Resident #19 on 2/13/20 at 9:31 AM, she recalled in May 2019 she had thoughts of harming herself and was sent to the hospital. While in the hospital Resident #19 stated her psychiatric medications were adjusted and she felt better. She acknowledged that since her return to the facility she had seen a therapist weekly for psychotherapy and had felt well.

On 2/12/20 at 2:15 PM an interview was completed with the Administrator. He reported

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F 644	Continued From page 22 the SW was responsible for completing level 2 PASARR referrals. He said the SW was new to the facility and recently had received education from the corporate office regarding the level 2 PASARR process.	F 644		
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 exceed the community standard.	F 732		3/4/20

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F 732	Continued From page 23 §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 observations, record reviews, and staff interviews, the facility failed to ensure nurse staffing data was posted daily and maintained for 23 of the 46 dates reviewed. The facility also failed to complete and accurately record the nurse staffing data for 20 of the 46 dates reviewed. Findings included: 1. During the initial tour of the facility on 2/9/20 at 9:30 a.m., the daily nursing staff data with the date of 2/7/20 was observed posted in the front lobby. Review of the facility's records dated 12/30/19 through 2/13/20 indicated the following nurse staffing postings were not available: 1/1/20, 1/3/20, 1/4/20, 1/5/20, 1/9/20, 1/10/20, 1/11/20, 1/12/20, 1/13/20, 1/15/20, 1/16/20, 1/17/20, 1/18/19, 1/19/20, 1/20/20, 1/22/20, 1/23/20, 1/24/20, 1/25/20, 1/26/20, 2/1/20, 2/2/20, and 2/8/20. During an interview on 2/13/20 at 2:03 p.m., the Staffing Scheduler confirmed the missing daily nursing staff postings were either not completed and or not maintained. She acknowledged the facility was required to maintain the postings for a minimum of 18 months. The Staffing Scheduler	F 732	The facility staff posting was corrected and reflected accurate census and staffing by the end of the survey exit. No residents suffered any negative outcomes as a result of this event. To identify other residents who have the potential to be affected, the staff scheduler, payroll coordinator, and the facility administrator completed audits from 2-1-2020 to date of exit of staff posting, and corrections made as identified. To prevent this from recurring, the facility scheduler was educated by administrator on accuracy of staff posting requirements on 2/17/2020. Clinical managers received completed education on 3/2/2020, on updating and verifying staff posting by the director of nursing. Any new hired clinical managers will receive this same education. The daily staff posting will be updated to reflect accurate census and staff by the facility scheduler or designee. To monitor and maintain ongoing compliance, staffing sheets will be reviewed in morning meeting for 12 weeks, beginning 3/2/2020 by the facility administrator. Any inaccuracies will be corrected. These results will be documented on an audit tool.	

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F 732	Continued From page 24 revealed she was the facility's only nursing staff scheduler and she completed and posted the daily nurse staffing. She stated most of the missing dated nursing staff postings coincided with the dates she worked at the facility as a nursing assistant or on the dates in which she did not work. During an interview on 2/13/20 at 2:27 p.m., the Administrator stated his expectation was that the facility complied with the regulations with daily posting of nurse staffing data. 2. Review of the facility's daily nurse staffing postings dated 12/30/19 through 2/13/20 revealed incomplete and inaccurate nurse staffing data on 12/30/19, 12/31/19, 1/2/20, 1/6/20, 1/7/20, 1/8/20, 1/14/20, 1/21/20, 1/27/20, 1/28/20, 1/29/20, 1/30/20, 1/31/20, 2/3/20, 2/4/20, 2/5/20, 2/6/20, 2/7/20, and 2/12/20. There was no data recorded during second and third shifts for census, total number of staff by category, and total number of hours worked for each staffing category. Also, the census number recorded on the postings were greater than the number of certified beds in the facility indicating the census number included the assistant living residents. Additionally, the hours posted on the daily nursing staffing sheet for the nursing staff were incorrect because it included the hours the staff worked with the residents who resided in the facility's Assisted Living (AL) rooms as evidenced by review of the daily nursing assignment sheets. During an observation on 2/10/20 at 9:24 a.m., the daily nurse staffing data posted in the lobby of the facility showed a residents' census of 98.	F 732	The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing. DON is responsible for compliance.	

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F 732	Continued From page 25 During an interview on 2/11/20 at 2:30 p.m., the Administrator stated there were a total of 108 beds in the facility of which only 96 beds were certified. He stated that only 89 of the 96 certified beds were currently occupied. He revealed the census number on the daily nurse staffing posted in the facility's lobby included both certified and non-certified beds. During an interview on 2/13/20 at 2:03 p.m., the Staffing Scheduler confirmed she was responsible for entering the data on the facility's daily nurse staffing form and posting the form in the lobby of the facility. The Staffing Scheduler revealed she only worked at the facility during first shift, Monday through Friday and only during the weekend as a nursing assistant if a scheduled nursing assistant was unable to work. She stated she assumed a nurse on duty during the second and third shifts would have completed the data on the posted nurse staffing. She indicated she was unaware that she was to separate the census data of the residents in the skilled beds and Assisted Living (AL) residents on the daily nurse staffing form. She stated the facility did not have a back-up staffing scheduler to complete and post the daily nurse staffing information when she did not work in this role. During an interview on 2/13/20 at 2:27 p.m., the Administrator stated his expectation was that the facility complied with the regulations with daily posting of nurse staffing data.	F 732		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		3/4/20

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F 760	Continued From page 26 medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, nurse practitioner, and physician interviews the facility failed to prevent a significant medication error by not administering a resident's anticoagulant medication (Xarelto) on two consecutive days and failed to notify the on-call nurse practitioner or physician of the missed doses because of the resident's altered mental status for 1 of 3 residents' (Resident #85) closed charts reviewed. Findings included: Resident #85 was admitted to the facility on 11/6/19 following a hospitalization for left radius and left hip open reduction internal fixation (ORIF) after sustaining a fall at home. Review of Resident #85's Admission Minimum Data Set dated 11/20/19, progress notes, and assessments revealed that Resident #85 had cognitive deficit but was alert and able to make needs known and required a one-two-person extensive assistance with activities of daily living. Her diagnoses included, in part, atrial fibrillation, hypertension, and left distal radial and left interotranteric (proximal end of femur) fractures. Review of progress notes, diagnostic results, and physician's orders revealed that Resident #85 had noted left lower leg swelling, the on-call nurse practitioner was notified, and a physician's order was placed on 1/15/20 for a venous ultrasound of her left lower extremity. The ultrasound was completed on 1/16/20, the results of "evidence of a rather extensive left lower extremity deep venous thrombosis (DVT)" was reported to the	F 760	Resident #85 no longer resides in the facility. To identify other residents who have the potential to be affected, medication records for current residents who were receiving anticoagulant medications were audited for the last 7 days since the state exit on 2/13/2020. No discrepancies found. To prevent this from recurring, the facility director of nursing or clinical manager completed education on 2/28/2020 to nurses and medication aides on administering anticoagulant medications per MD order and contacting a provider if anticoagulants are unable to be given as ordered. This education will be provided to any new hired nurses and medication aides and any agency nurses or medication aides. Medication administration of anticoagulation medications will be reviewed for administration at clinical morning meeting. Any identified concerns will be followed up on. To monitor and maintain ongoing compliance, beginning 2/23/2020, the DON will audit 5 residents who receive anticoagulant medications weekly, for 12 weeks, to ensure administration of the medication was completed as ordered. Any negative findings will be addressed immediately. The results of the audit will be documented. The results of the audits will be forwarded to the facility QAPI committee for further	

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F 760	Continued From page 27 on-call provider, and orders were placed for Xarelto Tablet 15 milligrams (MG) (Rivaroxaban) 15 mg by mouth every 12 hours for Left Lower Extremity DVT for 21 Days on 1/16/20. Review of Resident #85's Medication Administration Record and progress notes revealed that the resident was not alert enough to take her ordered medications on 1/18/20 and 1/19/20 and did not receive her Xarelto on either day at 8:00 PM. During an interview with Nurse #2 on 2/11/20 at 05:02 PM she stated that Resident #85 was not alert enough to take her medications on 1/18/20 and 1/19/20 at 8:00 PM, she did not administer her ordered medications, including Xarelto, and did not notify the physician or on-call nurse practitioner of the missed doses. During an interview with Nurse Practitioner #1 on 2/11/20 at 04:02 PM she stated that she had seen Resident #85 daily during the week of 1/13/20 through 1/17/20 due to nausea/vomiting, critical labs reported, and the lower left extremity DVT that was found on 1/16/20 via ultrasound. When asked if she would expect staff to notify a provider of missed doses of Xarelto and mental status changes, she stated that if there was a change in condition where Resident #85 was not alert enough to take her medications and/or missed doses of ordered medications that the on-call provider should have been notified of the change. When asked about Resident #85's missed doses of Xarelto ordered to treat her DVT, she stated that it would increase the risk of a negative outcome for the resident if not taken as ordered.	F 760	review and recommendations for the duration of the auditing. DON is responsible for compliance.	

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F 760	Continued From page 28 During an interview with the Director of Nursing on 2/12/20 at 11:05 AM when asked about Resident #85's missed doses of medications on 1/18/20 and 1/19/20 at 8:00 PM, she stated that she became aware of the situation shortly after and had started/implemented a Quality Assurance plan to address it. She stated that it was her expectation that a nurse practitioner or physician is notified of missed medication doses, especially the high-risk medications like Xarelto. Education was given to all staff to notify and document resident status changes and failure to receive ordered medications for any reason. During an interview with Physician #1 on 2/12/20 at 3:07 PM, when asked if the nursing staff should have contacted the on-call provider regarding Resident #85's cognitive status change and missed doses of Xarelto, she stated yes. When asked what negative outcomes could have occurred due to Resident #85 not receiving her Xarelto as ordered, she stated "possible" worsening of the resident's current blood clot and other blood clots were a possibility.	F 760		
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure the side doors and top lids of 2 of 2 dumpsters remained closed when not in use and the area surrounding the dumpsters remained free from garbage and refuse. Findings included:	F 814	Trash was cleaned up around dumpsters and doors were closed prior to 2/13/2020. The area is clean and free of debris. No resident suffered any negative outcome as a result of this event. All residents have the potential to be affected. Dietary manager and	3/4/20

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F 814	Continued From page 29 During the initial tour of the facility on 2/9/20 at 10:49 a.m., two dumpsters were observed enclosed within a wooden fence. The side door of 1 of 2 of the dumpsters was open. The top lids of both dumpsters were open with bags of trash hanging out of the tops onto the sides of the dumpsters. There were multiple soiled gloves, plastic cup lids, paper, used cigarettes, and plastic spoons on the ground surrounding the dumpsters. During an observation on 2/12/20 at 2:40 p.m., the side doors of 2 of 2 dumpsters were open (bags of trash in each dumpster). There were 2-soiled gloves and 2-used cigarettes on ground surrounding the dumpsters. During an interview on 2/12/20 at 2:43 p.m., the Dietary Manager revealed the facility's housekeeping and maintenance services were responsible for ensuring the dumpster area was clean and free from debris. She stated the dietary staff were instructed to keep the doors to dumpsters closed after discarding bags of trash. During an interview on 2/12/20 at 2:45 p.m., the Environmental Services Supervisor stated the environmental service staff collected and transferred trash from the facility to the dumpsters twice during each shift. He indicated all facility staff used the dumpsters and the environmental staff were instructed to ensure the doors to the dumpsters were closed after discarding bags of trash. During an interview on 2/12/20 at 3:00 p.m., the Administrator stated he expected, and staff	F 814	maintenance director monitored dumpster area through the remainder of survey and any area of concern was corrected. To prevent this from recurring, the dietary and housekeeping staff received completed educated on properly maintaining the dumpster area and keeping dumpster doors and lids closed by the administrator on 2/28/2020. Random review of the dumpster area will be conducted as an ongoing process by the facility housekeeping supervisor and dietary manager. To monitor and maintain ongoing compliance,Dietary Manager or Maintenance Director will audit the dumpsters and dumpster area 5x weekly, for 12 weeks, beginning the week of 2/24/2020. The results of the audit will be documented. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing. Dietary Manager is responsible for compliance.	

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F 814	Continued From page 30 should have been aware to keep the doors to the dumpsters closed after bags of trash were put in them.	F 814		