STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. BUILDING _____ B. WING _____	C 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		10/8/21

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

Electronically Signed | 09/25/2021

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E 039	Continued From page 1	E 039		

a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using

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E 039	Continued From page 2	E 039		

a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

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E 039	Continued From page 3 *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E 039		

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E 039	Continued From page 4 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that

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E 039	Continued From page 6 is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.	E 039		

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E 039	Continued From page 7 (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

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E 039	Continued From page 8 questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to participate in a full-scale, community-based exercise, or an individual facility-based exercise or a table top exercise as part of their Emergency Preparedness (EP) plan. Findings included: The facility's EP plan was reviewed and revealed the facility had not conducted either a full-scale exercise that was community-based, an individual	E 039	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. E039	

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E 039	Continued From page 9 facility-based exercise or a table top exercise in the past 12 months. During an interview with the Administrator on 8/26/21 at 1:03 PM, he stated the facility had not conducted any emergency preparedness exercises in the last 12 months and was unaware if the facility activated their EP plan in the past 12 months. The Administrator said he was new to the facility and explained the Facility Services Manager was responsible to conduct emergency preparedness exercises and did not know why they had not been completed in the last year. An attempt to interview the Facility Services Manager was unsuccessful. The Executive Director was interviewed on 8/26/21 at 2:00 PM. He shared the facility had completed some emergency drills over the past year but was unable to locate any documentation of the drills.	E 039	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Provide annual full scale community based Disaster Drills to test the emergency plan on all shifts. This will be scheduled October 5 2021 and all shifts will be participating. 2. How facility will identify other residents having the potential to be affected by the same alleged deficient practice: Full scale community based disaster drills to test the emergency plan will be scheduled annually on all shifts and documented. During an actual or man-made emergency that requires activation of the emergency plan, the activation of the plan will be documented and revisions provided as needed. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not reoccur: All new hires will be educated on where to find the disaster plan, color codes, meanings of alarms for disasters as well as in-servicing on what the fire panel displays. Full scale community based disaster drills to test the emergency plan will be scheduled annually on all shifts and documented and revised as needed.	

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E 039	Continued From page 10	E 039	4. Monitoring of procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Facility Services or designee will conduct all monthly fire required drills and annual Disaster Drills. These full scale exercises will documented and revised as needed. Monthly audits/observations will be documented and taken to QAPI committee for the next six (6) months. A Disaster protocol was instituted on 9-21-21 due to a power outage and was documented; all went well.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/23/21 through 08/26/21. Event ID#B16Q11. 4 of the 4 complaint allegations were not substantiated.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents,	F 577		10/15/21

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F 577	Continued From page 11 and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post the results of the most recent survey of the facility. Findings included: The Aspen Central Office database system was reviewed and revealed the most recent survey at the facility was a focused infection control survey completed on 11/24/20. During a tour of the facility on 8/24/21 at 9:07 AM and 8/25/21 at 1:30 PM, observations were made of survey results located in a three ring binder notebook on a credenza in the entryway of the facility. The most recent survey results in the notebook were from 8/8/19. During the Resident Council group meeting on 8/25/21 at 2:03 PM, the residents indicated they were aware of the location of the survey results in the entryway of the facility.	F 577	The facility will post in a place readily accessible to residents, family members and legal representatives of residents, the results of the most recent survey of the facility, and have those reports during the 3 preceding years available for any individual to review upon request in areas of the facility that are prominent and accessible to the public, without identifying information about complaints or residents. 1. Actions taken for residents affected by the alleged deficient practice: - Administrator or designee will update and be responsible for ensuring that survey results preceding three years prior and most recent results are in the notebook located in the entryway of the facility. To ensure that the notebook is updated, notebook will be audited weekly for 1 month, two times a month for one month, and then monthly for four months. The review of the notebook will be added	

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F 577	Continued From page 12 An interview was completed with the Administrator on 8/26/21 at 10:25 AM. The survey results notebook was reviewed with the Administrator and revealed the most recent survey results in the notebook were from 8/8/19. The Administrator said he was new to the facility and was set up to receive the statement of deficiencies when a survey was completed by the State Agency. He added it was his responsibility to ensure the survey results were placed in the notebook. He said the most recent survey dated 11/24/20 should have been included in the survey results notebook and was unsure why the previous administration had not placed them in the notebook.	F 577	to the monthly QAPI meetings for six (6) months and/or until compliance is met starting October 2021.	
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	F 623		10/15/21

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

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

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F 623	Continued From page 14	F 623		

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

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility failed to provide written notifications to the residents and the resident representatives of the reason for the transfers of 2 of 2 sampled

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.

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F 623	Continued From page 15 residents (Residents #4 and #21) to the hospital. The facility failed to provide written notification to the ombudsman of the transfer of 1 of 2 sampled residents (Resident #4) to the hospital. Findings included: 1. Resident #4 was admitted to the facility on 5/2/18. The quarterly minimum data set assessment dated 6/7/21 indicated Resident #4 was moderately, cognitively impaired. The medical record revealed Resident #4 was transferred to the hospital on 7/14/21 due to a critically low hemoglobin laboratory result. The record indicated the resident's family member was notified. The resident was re-admitted to the facility on 7/16/21. No written notice of transfer was documented to have been provided to the resident, the resident's representative, or the ombudsman. A clinical note in the medical record on revealed Resident #4 was transferred to the hospital on 7/29/21 due to complaints of abdominal pain and abnormal laboratory values. The resident was re-admitted to the facility on 7/31/21. There was no documentation indicating a written notice of transfer was provided to the resident, the resident's representative, or the ombudsman. During an interview on 8/26/21 at 1:03 p.m., the Administrator acknowledged the facility did not provide a transfer/discharge notice to the resident, the resident's representative or to the ombudsman.	F 623	To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. What corrective action will be accomplished for those residents found to be affected by the deficient practice? Notice of Transfer/Discharge was provided to the office of the State Long-Term Care for Residents # 4 and # 21. Resident #4 was provided notice of transfer 10/1/21 for discharge on 7/14/21 and for discharge on 7/29/21. Resident # 21 expired 8/15/21, notice of transfer was sent 10/1/21 to resident representative for discharge 8/14/21. The notice of transfer was documented as being sent. All discharge/transfers for the months of August and September have been sent to the Ombudsman. 2. How will other residents having the potential to be affected by the same deficient practice be identified? All residents have the potential to be affected. By 10/08/21 SDC will provide education to all nurses, Administrator, and Social Worker on written notification of any transfers/discharges to the office of the Long-Term Care Ombudsman. Written	

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F 623	Continued From page 16 During an interview on 8/26/21 at 1:25 p.m., the Assistant Director of Nursing (ADON) revealed that during the interim of the facility's social worker's replacement, she was responsible for notifying ombudsman of the transfer/discharge of residents. She indicated she would submit a list of resident transfers/discharges to the ombudsman by the 15th of the following month. She stated Resident #4 was mistakenly left from the August 2021 list sent to the ombudsman. The ADON also revealed she was not aware a written notification of a resident's discharge/transfer was to be sent to the resident's representative. 2. Resident #21 was admitted to the facility on 8/2/21. The admission minimum data set assessment dated 8/9/21 indicated Resident #21 was moderately, cognitively impaired. The medical record revealed Resident #21 was transferred to the hospital on 8/14/21 for evaluation and treatment due to labored breathing, low oxygen saturation and low blood pressure. The resident passed away at the hospital on 8/15/21 due to metastatic lung cancer. No written notice of transfer was documented to have been provided to the resident or the resident's representative. During an interview on 8/26/21 at 1:03 p.m., the Administrator acknowledged the facility did not provide a transfer/discharge notice to the resident or the resident's representative. During an interview on 8/26/21 at 1:25 p.m., the	F 623	notification of transfers/discharges started on 8/27/21 and continues to be compliant. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? The Social Worker has contacted the office of the Long-Term Care Ombudsman. The office would like transfers/discharges written notification to be provided to them monthly. The Social Worker will provide proof of notification to CSA (Care Services Administrator) monthly. This will be an ongoing practice. A.D.O.N./SDC to reeducate all nurses on notification of transfer and discharge to responsible party and sufficient documentation of the notification. A letter of notification has been developed to be given or mailed to responsible party of transfers out of facility and reason. This education will begin on 10/4/21 and will be on-going for any new nursing staff. All current nurses will be educated before 10/15/21. D.O.N./Delegate will audit clinical notes daily for nursing documentation of notification. Audits will begin on 10/11/2021 for 3 months and will be ongoing to ensure compliance. Results of all audits will be taken to QAPI meeting for 3 consecutive months beginning October 2021.	

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F 623	Continued From page 17 Assistant Director of Nursing (ADON) revealed that during the interim of the facility's social worker's replacement, she was responsible for notifying ombudsman of the transfer/discharge of residents. She indicated she would submit a list of resident transfers/discharges to the ombudsman by the 15th of the following month. She stated Resident #21 would be included on the August 2021's discharge/transfer notification list which would be sent to the ombudsman by 15th of September 2021. The ADON revealed she was not aware a written notification of a resident's discharge/transfer was to be sent to the resident's representative.	F 623	4. How will the corrective action be monitored to ensure the continued effectiveness of the system changes? The CSA/designee will audit the transfers/discharges monthly to ensure that the office of Long-Term Care Ombudsman and Responsibly party if applicable, is notified in writing of all transfers/discharges. Audits by the CSA/designee will begin week of 10/4/21 for 3 months and will continue until substantial compliance is met. Findings of the audits are to be taken to QAPI meeting for 3 consecutive months beginning October 2021	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the	F 756		10/15/21

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F 756	Continued From page 18 attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to follow-up on the pharmacist's recommendation for the rationale for the use of Seroquel (antipsychotic medication) or to consider discontinuing its use for 1 of 5 residents (Resident #8) reviewed for unnecessary medications. Findings included: Resident #8 was originally admitted to the facility on 4/29/21 and re-admitted on 5/26/21 with diagnoses which included dementia without behavioral disturbance. Resident #8's clinical records and medication administration records revealed that on 4/29/21,	F 756	1. How corrective action will be accomplished for those residents found to have been affected by the deficit practice? The facility will ensure the monthly drug regimen review are followed and provide the pharmacist recommendations to the physician by: The DON/designee will exit with the pharmacist upon the facility audit. The pharmacist will send the recommendations to the DON, ADON, ADM, and NP. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? The facility will conduct an audit by 10/15	

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F 756	Continued From page 19 the physician ordered Seroquel 12.5 mg (milligrams) which was administered every morning. On 4/30/21, the physician ordered Seroquel 25mg every 12 hours which was administered then discontinued on 5/1/21. On 5/1/21, the physician ordered Seroquel 25mg every evening at 5:00 p.m. which was administered. The pharmacist's recommendation to the physician/prescriber on 5/7/21 included the request for the diagnosis for the administration of Seroquel 12.5mg every day and 25mg in the evening or to consider discontinuing the medication if unnecessary. There was no documented response from the physician/prescriber. The clinical records revealed Resident #8 was hospitalized on 5/18/21 and was re-admitted to the facility on 5/26/21 with orders for Seroquel 50mg every evening and 12.5mg every morning. The dosages were administered as ordered. The significant change minimum data set assessment dated 6/10/21 indicated Resident #8 was severely, cognitively impaired and was receiving an antipsychotic medication. Review of the undated pharmacist's recommendation to the physician/prescriber included the request for the diagnosis for the administration of Seroquel 12.5mg every day and Seroquel 50mg in the evening or to consider discontinuing the medication if unnecessary. There was also a statement indicating this recommendation was made in May 2021 but was not addressed by the physician/prescriber. This recent written recommendation was responded to	F 756	to identify all residents on psychotropic medications in order to determine if GDR is needed. This audit will include all residents from 5/2021 to present. In addition, the facility will conduct an audit from 5/2021 to present to ensure all residents on psychotropic medications have an appropriate diagnosis. This audit will be conducted by the DON, MDS, and nursing staff in conjunction with the administrator. All findings will be addressed with the Medical Director and Nurse Practitioner immediately. Once the audit is completed all findings will be presented to the QAPI committee in October for further action. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The facility's communication procedure will be reviewed and updated if necessary to ensure that all pharmacy recommendations are communicated to the physician. The facility will conduct an audit from 5/2021 to present to ensure all residents on psychotropic medications have an appropriate diagnosis. This audit will be conducted by the DON, MDS, and nursing staff in conjunction with the administrator. All findings will be addressed with the Medical Director and Nurse Practitioner immediately. Once the audit is completed all findings will be presented to the QAPI committee in October for further action. The facility will conduct an audit every month for 6 months and report to QAPI and to the	

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F 756	Continued From page 20 and signed by the nurse practitioner on 7/1/21. The nurse practitioner's response to the Seroquel recommendation was "will GDR" (gradual dose reduction). The care plan updated 8/1/21 revealed Resident #8 was at risk for side effects from psychotropic medications. Interventions included the pharmacist was to review the medications monthly with recommendations to the physician as needed. Review of the physician's orders and the August 2021 medication administration record revealed Resident continued to receive Seroquel 12.5mg every day through 8/24/21 and 50mg every evening through 8/23/21. There was no documentation of a physician's order for the reduction in the dosage of Seroquel for Resident #8. During an interview on 8/26/21 at 9:56 a.m., the Assistant Director of Nursing (ADON) revealed that part of the facility's communication procedure with the physician included the pharmacist would email any recommendations to the Director of Nursing who was responsible for ensuring the recommendations were placed in the Physician Communication book. The ADON stated she was unsure if the physician or the nurse practitioner reviewed the pharmacist's recommendation of 5/7/21 for a Seroquel dose reduction. After review of facility records, the ADON stated there was no GDR of Seroquel for Resident #8 in July 2021 or Aug 2021 because the nurse practitioner did not write the order. She stated there was no documentation indicating an order was given (written or verbally) for a GDR of Seroquel for Resident #8.	F 756	medical director and correct as needed. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not occur? A monthly audit of all drug regimen recommendations will be completed by the DON/designee for every month for 6 months and report to QAPI and to the medical director and correct as needed. The QAPI committee in conjunction with the administrator will monitor audits to ensure compliance and completion.	

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F 756	Continued From page 21 During an interview on 8/26/21 at 2:51 p.m., the Nurse Practitioner recalled visiting Resident #8 on 7/1/21 but was unable to recall why she did not document about the Seroquel or write the order for the GDR of Seroquel or if she verbally instructed the nurse to write the order. When asked about the no response and no signature to the 5/7/21 pharmacist's recommendation, the Nurse Practitioner stated if she had seen the recommendation, she would have signed it.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 757		10/15/21

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F 757	Continued From page 22 Based on record reviews and staff interviews, the facility failed to provide medical justification for the use of Seroquel (antipsychotic medication) for 1 of 5 residents (Resident #8) reviewed for unnecessary medications. Findings included: Resident #8 was originally admitted to the facility on 4/29/21 and re-admitted on 5/26/21 with diagnoses which included dementia without behavioral disturbance. Resident #8's clinical records and medication administration records revealed that on 4/29/21, the physician ordered Seroquel 12.5 mg (milligrams) which was administered every morning. On 4/30/21, the physician ordered Seroquel 25mg every 12 hours which was administered then discontinued on 5/1/21. On 5/1/21, the physician ordered Seroquel 25mg every evening at 5:00 p.m. which was administered. There was no diagnosis for the administration of an antipsychotic medication for Resident #8 in the medical records. The clinical records revealed Resident #8 was hospitalized on 5/18/21 and was re-admitted to the facility on 5/26/21 with orders for Seroquel 50mg every evening and 12.5mg every morning. The dosages were administered as ordered. There was no diagnosis for the administration of an antipsychotic medication for Resident #8 in the medical records. The significant change minimum data set assessment dated 6/10/21 indicated Resident #8 was severely, cognitively impaired and was	F 757	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. How corrective action will be accomplished for those residents found to have been affected by the deficit practice? Resident #8 passed away 8/29/21, 2567 received on 9/15/21. Facility is unable to institute POC for this resident. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? The facility will conduct an audit by 10/15 for medical justification for the use of antipsychotic medication. This audit will include all residents from 5/2021 to present. In addition, the facility will conduct an audit from 5/2021 to present to ensure all residents on psychotropic medications have an appropriate diagnosis. This audit will be conducted by the DON, MDS, and nursing staff in conjunction with the administrator. All	

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F 757	Continued From page 23 receiving an antipsychotic medication. The care plan updated 8/1/21 revealed Resident #8 was at risk for side effects from psychotropic medications. Interventions included for staff to observe and report any side effects of the medication, report sudden change in mood or behaviors, and the pharmacist was to review the medications monthly with recommendations to the physician as needed. Review of the physician's orders and the August 2021 medication administration record revealed Resident continued to receive Seroquel 12.5mg every day through 8/24/21 and 50mg every evening through 8/23/21. There was no documentation of a diagnosis in the medical record for the administration of Seroquel for Resident #8. During an interview on 8/26/21 at 9:56 a.m., the Assistant Director of Nursing (ADON) revealed that part of the facility's communication procedure with the physician included emails from the pharmacist with medication recommendations. The Director of Nursing was responsible for ensuring the recommendations were placed in the Physician Communication book. The ADON indicated she was unsure if the physician or the nurse practitioner reviewed the pharmacist's recommendation of 5/7/21 which requested a diagnosis to support the administration of Seroquel or to consider discontinuing the antipsychotic medication if unnecessary, for Resident #8. During an interview on 8/26/21 at 2:51 p.m., the Nurse Practitioner recalled visiting Resident #8 on 7/1/21 but did not specify medical justification	F 757	findings will be addressed with the Medical Director and Nurse Practitioner immediately. Once the audit is completed all findings will be presented to the QAPI committee in October for further action. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The facility will conduct an audit from 5/2021 to present to ensure all residents on psychotropic medications have an appropriate diagnosis. This audit will be conducted by the DON, MDS, and nursing staff in conjunction with the administrator. All findings will be addressed with the Medical Director and Nurse Practitioner immediately. Once the audit is completed all findings will be presented to the QAPI committee in October for further action. The facility will conduct an audit every month for 6 months and report to QAPI and to the medical director and correct as needed. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not occur? The facility will conduct an audit from 5/2021 to present to and all findings will be addressed with the Medical Director and Nurse Practitioner immediately. Once the audit is completed all findings will be presented to the QAPI committee in October for further action. The facility will conduct an audit every month for 6 months and report to QAPI and to the	

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F 757	Continued From page 24 for the administration of Seroquel to the resident.	F 757	medical director and correct as needed. The QAPI committee in conjunction with the administrator will monitor audits to ensure compliance and completion.	
F 814 SS=F	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 lid of 1 of 1 trash dumpster remained closed when not in use, the area surrounding the dumpster remained free from garbage, refuse and foul odors. The facility also failed to ensure 1 of 1 cardboard dumpster was not used to maintain the facility's trash overflow. Findings included: During an observation from the parking lot of the facility on 8/23/21 at 9:00 a.m., large bags of trash were protruding from the opened top of a dumpster which was surrounded by a fence. On 8/23/21 at 11:00 a.m., during an observation of the fenced dumpster area with the Assistant Director of Dining Services (ADDS) there was a foul odor emitting from 1 of 1 trash dumpster and 1 of 1 cardboard dumpster within the fenced area. There were three large trash filled bags observed on the ground next to the trash dumpster and one bag of trash protruding from the opened side door of the cardboard dumpster. One of the two top lids of the dumpster was	F 814	Based on Observation large bags of trash were protruding from opened top of dumpster. Trash was picked up by trash removal service and top closed when identified on 8/23/21. Assistant Dining Director provided in-service to all staff to ensure side door and lid of dumpster are closed, areas surrounding dumpster remain free from garbage, refuse, foul odors, and ensure that cardboard dumpster was not used to maintain the facility's trash overflow. All employees completed in-service on 9/28/21. Based on Observation the facility failed to close the side door of the dumpster. The dumpster side door was closed when identified on 8/24/21. The Assistant Dining Director/designee will implement dumpster monitoring tool to be used 5 x weekly for 30 days, 3 x weekly for 30 days and 2 x weekly for 30 days, 1 x monthly for 3 months. The results of monitoring tool will be presented in the monthly QAPI Committee meetings on a monthly basis for 6 months to determine compliance and revise as needed.	9/28/21

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F 814	Continued From page 25 buckled at an upward angle with bags of trash protruding from the top of the dumpster. During an interview on 8/23/21 at 11:10 a.m., the ADDS indicated the waste management contractor was scheduled to empty the trash dumpster twice each week. He revealed the dumpster was used by the skilled nursing unit and the assisted living unit of the facility. The ADDS stated he reported the constant problem of the overflow of the trash and the cardboard dumpsters to administration and made suggestions, such as a trash compactor, larger dumpsters, or separate dumpsters for each unit of the facility; but had not received any response. On 8/24/21 at 8:10 a.m., there was an observation of an opened side door of the trash dumpster with trash bags inside. On 8/25/21 at 3:30 p.m., one of the side doors of the trash dumpster was observed open. There was trash bags inside the dumpster.	F 814	Based on Observation the side door of trash dumpster was observed opened. The dumpster side door was closed when identified on 8/25/21. The Assistant Dining Director/designee will implement dumpster monitoring tool to be used 5 x weekly for 30 days, 3 x weekly for 30 days and 2 x weekly for 30 days, 1 x monthly for 3 months. The results of monitoring tool will be presented in the monthly QAPI Committee meetings on a monthly basis for 6 months to determine compliance and revise as needed.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		9/25/21

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F 880	Continued From page 26 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 27 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to implement contact isolation signage for 1 of 3 residents (Resident #11) that had symptoms of Clostridium Difficile (C-Diff) and required transmission-based precautions. The findings included: A facility policy titled "Isolation - Initiating Transmission Based Precautions," revised August 2019 stated if a resident was suspected of, or identified as, having a communicable infectious disease, the nurse notifies the facility infection preventionist and the resident's attending physician for evaluation of appropriate transmission-based precautions. In the event the attending physician fails to take appropriate action, the infection preventionist has the authority to implement appropriate transmission-based precautions. The personal protective equipment (PPE) required for enteric contact precautions was a gown and gloves.	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 880 1. How corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident #11 was not affected by the alleged deficient practice. Facility provided contact isolation signage that identified contact isolation information and	

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F 880	Continued From page 28 Resident #11 was admitted to the facility on 10/30/2018 with diagnoses that included an intracerebral hemorrhage. A review of Resident #11's most recent quarterly Minimum Data Set (MDS), dated 7/4/2021, assessed the Resident had moderate cognitive impairment and required extensive assistance of two staff members for toileting. An interview was conducted on 8/25/2021 at 8:45 AM with Nursing Assistant (NA) #1 in the dining room. NA #1 revealed that Resident #11 was not eating in the dining room because she had two loose stools during the night and was placed on isolation precautions for suspected C-Diff. An observation was completed of Resident #11's private room on 8/25/2021 at 9:20 AM with an isolation cart containing personal protective equipment (PPE) sitting beside the doorway and no signage to indicate if isolation precautions were in place. An interview was completed with Resident #11 on 8/25/2021 at 9:21 AM with an unknown visitor sitting on Resident #11's bed with only a face mask for PPE. The Resident stated she was in her room because she was told she had a bug and was to remain in her room. The visitor denied knowing why the cart was outside of the door. An interview occurred on 8/25/2021 at 9:45 AM with Nurse #1 and she stated she was the nurse on the assignment for Resident #11. She revealed that Resident #11 had two loose stools during the night and a neighboring room had confirmed C-Diff. She added the isolation cart was placed outside of the Resident's room and a	F 880	what PPE is required to enter room; gown and gloves. Other residents in the surrounding area were assessed and found to have no signs or symptoms of C-Diff or any other GI issues, with the exception of the 2 residents placed on Transmission Based Precautions previously for C-Diff. Appropriate signage, equipment and PPE were available and at their room door. Nurse and DON both spoke with the Medical Director regarding resident #11. Medical Director did assess resident #11 and said it was fine to place resident #11 on Transmission Based Precautions and obtain a stool specimen for C-Diff. However, she did not feel like it was C-Diff, said it did not smell like nor look like C-Diff. 2. How facility will identify other residents having the potential to be affected by the same alleged deficient practice: Education: All Nursing Staff will be educated on or by end of day 9/24/21 on Policy and Procedures relating to Infection Control as it relates to Isolation, PPE requirements, donning and doffing of PPE, and Hand Hygiene. This education is also introduced to all new hires in orientation. Other residents were assessed for like or similar GI symptoms and none were noted on 8/25/21. Going forward, the Infection Prevention Nurse or designee will be notified of any sign or symptom which	

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F 880	Continued From page 29	F 880		

stool sample was collected in preparation for the Medical Director's (MD) visit on 8/25/2021. She stated an MD/doctor's order was required to place isolation precautions on a resident, even if the resident had a suspected communicable disease that required transmission-based precautions. She added staff were utilizing the PPE to be safe.

An observation occurred on 8/25/2021 at 11:22 AM with the Director of Nursing of Resident #11's room. Nurse #1 was in the room providing personal care assistance to Resident #11 with only a face mask for PPE. When Nurse #1 exited the room, she performed hand hygiene with hand sanitizer. A PPE cart was observed beside the door to Resident #11's room and no isolation signage was present.

An interview was conducted with the Director of Nursing on 8/25/2021 at 11:26 AM and she revealed Resident #11 had two loose stools during the night shift. She added that the nursing staff felt transmission-based precautions should be implemented until the Medical director could assess Resident #11 and provide orders. She stated a stool sample had been collected. She added that it was her expectation that an order for enteric contact precautions be obtained and implemented at the time C-Diff was suspected by a nurse and isolation precaution signage was to be placed on the doorway immediately. She added that she expected PPE to be worn into a room that had a suspected case of C-Diff.

An interview was conducted on 8/25/2021 at 1:31 PM with the Assistant Director of Nursing (ADON)/Infection Preventionist for the facility. She revealed that on the morning of 8/25/2021 would warrant the need for any type of Isolation. The IP Nurse or designee will give further direction at that time.

3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not reoccur:

Education:
All Nursing Staff will be educated on or by end of day 9/24/21 on Policy and Procedures relating to Infection Control as it relates to Isolation, PPE requirements, donning and doffing of PPE, and Hand Hygiene. This education is also introduced to all new hires in orientation.

Observations/Audits:
Will be performed as resident/s are placed on any form of Isolation, including donning and doffing of PPE.
Hand hygiene will be observed and audited as indicated in 4.

4. Monitoring of procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements:

The Director of Nursing or designee will conduct audits for all residents placed on Isolation five times weekly for one month, then three times weekly for one month, then one time a week for one month and finally, one time per month for three months. This audit will include proper signage and equipment placement.

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F 880	Continued From page 30 she received a report that Resident #11 had two loose stools and she provided instructions to Nurse #1 to implement enteric contact precautions for the Resident. She stated her expectation was for a hall nurse to carry out the instructions that included placing an isolation precaution sign on the door and a PPE cart beside the room.	F 880	Donning and doffing will be audited as well when resident/s are place on Isolation. Observation/auditing of staff performing hand hygiene will be completed on random staff members five times a week for one month, then three times a week for one month, then one time a week for one month, and finally one time a month for three months. All audits/observations will be taken to QAPI for the next six months. All audits/observations will begin 9/23/21	