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	345269	A. BUILDING _____ B. WING _____	11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALISBURY	1505 BRINGLE FERRY ROAD SALISBURY, NC 28146

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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 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	F 623		12/6/18

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

Electronically Signed | 12/06/2018

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F 623	Continued From page 1 (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 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.	F 623		

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F 623	Continued From page 2 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 review and staff and family interviews the facility failed to provide a written discharge notice which included the reason for discharge to the resident or resident representative for 4 of 4 sampled residents who were discharged to the hospital (Resident #1, Resident #11, Resident #12, and Resident #71). 1. A review of Resident #1's medical record revealed he admitted to the facility on 7/26/18 with diagnoses of weakness, heart disease, respiratory disease, and blood clots to his upper extremities. His most recent Admission Minimum Data Set assessment dated 8/2/18 revealed he was severely cognitively impaired and required extensive to total assistance with turning in bed, transferring in and out of bed, eating, and toileting. Nurses note dated 11/5/18 at 3:15 pm written by Nurse #4 revealed Resident #1's oxygen	F 623	THE PREPARATION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUDION STATED ON THE STATEMENET OF DEFIENC. THIS PKAN OF CORRECTIOEN IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAW. 1. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED: 1a. Resident #1's daughter was with resident when resident was sent to the hospital; documentation was not noted in chart. Late entry note was placed in the chart and the daughter was called on 12/4/2018 at 5:25pm about the resident	

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F 623	Continued From page 3 saturation was below 90% consistently, the physician was notified, and the resident was sent to the emergency room. The note did not document if the family member was notified of the discharge to the hospital. The Emergency Department Note dated 11/5/18 revealed Resident #5 was admitted to the hospital with Pneumonia of Right Lung and Congestive Heart Failure. An interview with Nurse #4 on 11/8/18 at 9:27 am revealed Resident #1's oxygen level had dropped even though he was on continuous oxygen on 11/5/18 and he was sent back to the emergency room for evaluation and was admitted to the hospital. She stated she called the family member when the resident was discharged to the hospital but she did not notify the resident or family member in writing of the reason for discharge. An Interview with the Director of Nursing on 11/8/18 at 11:35 am revealed she did not have written notification of the reason for discharge for Resident #1 on 11/5/18. A phone interview 11/8/18 at 1:30 pm with Resident #1's family member revealed she had not received a written explanation of the reason Resident #1 was sent to the hospital on 11/5/18. An interview with the Administrator on 11/8/18 at 2:15 pm revealed his expectation was the resident and/or family member would be notified of the reason for a resident being transferred at the time of the transfer. 2. Resident #11 was admitted to the facility on	F 623	being sent to hospital on 11/5/2018 due to low partial pressure of oxygen (PO2) was less than 90%. 1b. Resident 11's granddaughter was not notified when sent to the hospital and documentation was not noted. Late entry note placed in resident's chart that granddaughter was notified on 12/4/2018 at 5:30pm-regarding resident being sent to the hospital on 9/21/2018 with tachycardia, fever and urinary tract infection. 1c. Resident #12's son was not notified on 9/11/2018 that resident was being sent to hospital for increased shortness of breath, low PO2 saturations at 88% with oxygen and abnormal lung sounds. Late entry note was placed in resident's chart on 12/4/2018 that the son was notified at 5:32pm regarding sending resident to hospital; son replied that he was notified and made aware of situation. 1d. Resident #71's son and grandson were with resident when resident was at the cardiologist appointment and was aware resident was being sent to the hospital. Facility medical doctor (MD) was not notified. Late entry note was placed in resident's chart that resident was being admitted to the hospital from the cardiologist's office on 8/17/2018 and grandson and son were notified via telephone at 5:42pm on 12/4/2018. MD notified on 12/5/2018 that resident was admitted to the hospital from the cardiologist office.	

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F 623	Continued From page 4 8/9/2017 with diagnoses that included dysphagia, unspecified convulsions and essential hypertension. A review of the Minimum Data Set (MDS) assessment dated 8/17/2018 revealed Resident #11 was rarely understood, had short and long-term memory problems, recognized staff names and faces and knew she was in a nursing home. Additionally, the MDS revealed Resident #11 had severely impaired cognitive skills. A review of hospital records revealed Resident #11 was hospitalized on 9/21/2018 with tachycardia, fever and urinary tract infection. A review of a nurse's note dated 9/21/2018 at 3:37 PM revealed Resident #11 was sent to the emergency room for evaluation and treatment. Further review did not reveal any documentation that the resident or the resident's representative received prior notification of the transfer. An interview on 11/8/2018 at 2:34 PM with Nurse #1 revealed she wrote the nurse's note on the date of transfer to the hospital. Nurse #1 disclosed that she did not provide prior notification of the transfer to the resident or her granddaughter. An interview on 11/8/2018 at 4:17 PM with the Administrator revealed he expected staff to provide notification to the resident and or the resident's representative prior to transfer out of the facility. 3. A review of Resident #12's medical record revealed she was originally admitted to the facility on 3/6/17 and was most recently admitted on 9/17/18. Resident #12's diagnoses included:	F 623	For each resident and RP the transfer and discharge notices sent were in a manner in which they could easily understand using CMS guidelines and facility policy. 2. CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED: 2a. The Director of Nursing (DON)/designee will audit all medical records for changes in condition of residents including transfers to the hospital in the last 30 days and ensure that MD and resident's responsible party (RP) were notified in a manner easily understood using CMS guidelines and facility policy information. 3. MEASURES AND SYSTEMATIC CHANGES TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR: 3a. All licensed staff will be educated on Responsible Party (RP) being notified per transfer/discharge letter regarding any change in condition including hospitalizations or transfers to hospital from ancillary appointments. This will be documented in the individual's medical record by Social Worker/designee This will include notification of the resident's medical doctor. 3b. During Clinical Morning Meeting, the DON/designee will review changes including emergency room visits, hospitalizations and incidents to verify	

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F 623	Continued From page 5 Generalized weakness, diabetes, chronic kidney disease, heart failure, anxiety, depression, and dementia. A review of Resident #12's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 8/19/18. Review of the assessment revealed the following: The resident was coded as having been cognitively intact. The resident was not coded as having had behaviors during the assessment period. The resident was coded as having had required extensive assistance of one or more people for all Activities of Daily Living (ADLs) except for eating where she was coded as having been independent with supervision. Review of Resident #12's progress notes revealed a nursing note dated 9/11/18 and timed 12:39 AM. The note documented the resident had an oxygen saturation percentage of 87% with supplemental oxygen. The note further documented the resident had been observed to have been short of breath, labored breathing, and had abnormal lung sounds. The resident was also documented as having had swelling and the resident was complaining of nausea. Further review of the progress notes revealed another note dated 9/11/18 documenting the resident had been sent out to the hospital and was admitted to the hospital with a diagnosis of acute congestive heart failure. Review of the notes did not provide evidence of documentation if the family member was notified of the discharge to the hospital. Review of Resident of Resident #12's Readmit History and Physical dated 9/18/18 revealed the resident was documented as being readmitted to the facility after having been hospitalized for	F 623	documentation of notification of RP and that MD was notified of events along with receiving written Transfer and Discharge letter if resident is discharged from the facility. 3c. All new hired nurses will be educated regarding notifying the RP and MD along with ensuring that the RP receives the Transfer/Discharge letter. 4. FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: 4a. Monitoring will be done 5 times per week X 4 weeks; then 3 times per week for 4 weeks; then once a week for 4 weks. 4b. Results of audits will be taken to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months for review and revision as needed. The Administrator is responsible for this Plan of Correction	

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hypoxia (lack of oxygen) and a Congestive Heart Failure (CHF) exacerbation.

An interview was conducted with the Social Worker (SW) on 11/7/18 at 10:01 AM. The SW stated she did not provide a written discharge notice to the family member of Resident #12.

An interview was conducted with the Admissions Director (AD) on 11/7/18 at 2:34 PM. The SW stated she did not provide written discharge notice to the family member of Resident #12. The AD stated it was made clear to family members of residents at the time of admission it was the family member's responsibility to contact the facility if the resident was hospitalized.

An interview was conducted with Nurse #7 on 11/7/18 at approximately 3:00 PM. The nurse sated Resident #12 was sent out to the hospital because the resident had become swollen and was short of breath. The nurse further stated she had called the resident's family to notify them but had not notified the family member in writing at the time of discharge. The nurse stated she sent a packet with the resident which had the resident's face sheet, physician's orders, and the bed hold policy.

A phone interview was conducted with the family member for Resident #12 on 11/7/18 at 3:44 PM. The family member stated he had been notified through a phone call when the resident was discharged to the hospital back in September, but he had received not received written notification of the discharge and the reason for the discharge.

An interview with the Administrator on 11/8/18 at

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2:15 pm revealed his expectation was the resident and/or family member would be notified of the reason for a resident being transferred at the time of the transfer.

4. A review of Resident #71's medical record revealed she was originally admitted to the facility on 8/2/18 and was most recently admitted on 8/31/18. Resident #71's diagnoses included: Generalized weakness, anxiety, abnormal heart beat, heart disease, diabetes, difficulty swallowing, chronic kidney disease, and congestive heart failure (CHF).

A review of Resident #71's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 10/18/18. Review of the assessment revealed the following: The resident was coded as having had moderately impaired cognition. The resident was not coded as having had behaviors during the assessment period. The resident was coded as having required extensive assistance of one or more people for all Activities of Daily Living (ADLs).

Review of Resident #71's progress notes revealed a nursing note dated 8/17/18 and timed 5:40 PM. The note by Nurse #1 documented the resident had been seen at a cardiologist appointment and was triaged to the Emergency Room (ER) at the local hospital.

Review of Resident #71's progress notes revealed a Social Services note dated 8/20/18 which documented staff reported resident was sent to the hospital after a doctor appointment due to health status.

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Review of Resident #71's progress notes revealed a nursing note dated 8/17/18 and timed 6:38 PM. The note by Nurse #1 documented the resident had been admitted to the local hospital with an acute on chronic Congestive Heart Failure (CHF) exacerbation. Review of the note did not provide evidence of documentation if the family member was notified of the discharge to the hospital.

Further review of Resident #71's medical record did not reveal a discharge assessment or physician's orders to discharge the resident to the hospital.

A review was completed of Resident #71's hospital discharge summary dated 8/31/18. The discharge summary the resident had received treatment during hospitalization for the following diagnoses: urinary tract infection, acute on chronic congestive heart failure, and chronic kidney disease. The documented main complaint at the time of admission to the hospital was shortness of breath and right leg pain.

An interview was conducted with the Social Worker (SW) on 11/8/18 at 11:53 AM. The SW stated she did not talk to a family member of Resident #71 regarding her discharge to the hospital.

An interview was conducted with Nurse #1 on 11/8/18 at 11:55 AM. Nurse #1 stated Resident #71 had a scheduled cardiologist appointment on 8/17/18. The nurse stated the resident would have had to have been transported either by the facility wheelchair transportation van or a contracted wheelchair transportation van. The nurse stated the resident was admitted to the

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hospital after the cardiologist appointment on Friday, 8/17/18. The nurse stated she did not contact the resident's family when she was made aware the resident had been admitted to the hospital because she said the resident's family would have had to have been with the resident at the cardiologist appointment. The nurse stated she did not forward any written notification to the resident or the resident's family regarding the discharge from the facility. The nurse further stated the facility Social Worker (SW) or the Admissions Coordinator would have been responsible for following up with the resident or family on Monday because the resident was discharged on a Friday.

An interview was conducted with Nurse # 4 on 11/8/18 at 12:01 PM. Nurse #4 stated Resident #71's family would have been with the resident at her doctor appointment because residents were not allowed to go to doctor appointments unaccompanied. The nurse stated she had not contacted the resident's family regarding the resident had having been sent to the emergency room or the resident having had been admitted to the hospital. The nurse stated usually with a normal discharge to the hospital or the emergency room a packet would have been sent along with the resident. The packet would have contained a physician's order for being sent to the ER, bed hold information, and a face sheet. Nurse #4 stated in this instance regarding Resident #71 there would have been no packet, bed hold information, or notification provided to the resident or family from nursing.

An interview was conducted with the Director of Nursing (DON) on 11/8/18 at 12:10 PM. The DON stated the Admission Coordinator was

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F 623	Continued From page 10 usually the person who would notify resident's families about discharge. A second interview was conducted with the Social Worker (SW) on 11/8/18 at 12:15 PM. The SW stated she did not contact Resident #71's family regarding her discharge to the hospital. An interview was conducted with the Admissions Director (AD) on 11/8/18 at 12:31 PM. The AD stated she did not provide written discharge notice to the family member of Resident #71. The AD stated she may have talked to the resident's family on Monday, 8/20/18, if the family came in to pick up the resident's belongings but she would not have documented that conversation. An interview with the Administrator on 11/8/18 at 2:15 pm revealed his expectation was the resident and/or family member would be notified of the reason for a resident being transferred at the time of the transfer.	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;	F 625		12/6/18

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F 625	Continued From page 11 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews the facility failed to provide residents or their representative a written explanation of the facility's Bed Hold Policy to 4 of 4 residents reviewed for discharge from the facility (Resident #1, Resident #11, Resident #12, and Resident #71). 1. A review of Resident #1's medical record revealed he admitted to the facility on 7/26/18 with diagnoses of weakness, heart disease, respiratory disease, and blood clots to his upper extremities. His most recent Admission Minimum Data Set assessment dated 8/2/18 revealed he was severely cognitively impaired and required extensive to total assistance with turning in bed, transferring in and out of bed, eating, and toileting. Nurses note dated 11/5/18 at 3:15 pm written by Nurse #4 revealed Resident #1's oxygen	F 625	1. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY DEFICIENT PRACTICE: 1a. Resident #1's RP received a bed hold policy and a copy of the discharge/transfer letter on 12/5/2018, which was discussed with individual for 11/5/2018 when resident was discharged to the hospital 1b. Resident #11's responsible party (RP) received a bed hold policy and a copy of the discharge/transfer letter on 12/5/2018, which was discussed with individual for 9/21/2018 when resident was discharged to the hospital. 1c. Resident #12's RP received a bed hold policy and a copy of the discharged transfer letter on 12/5/2018, which was discussed with the individual for 8/9/2018 when resident was discharged to the	

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	345269	A. BUILDING _____ B. WING _____	11/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 12 saturation was below 90% consistently, the physician was notified, and the resident was sent to the emergency room. The Emergency Department Note dated 11/5/18 revealed Resident #1 was admitted to the hospital with Pneumonia of Right Lung and Congestive Heart Failure. An interview with the Social Worker on 11/7/18 at 10:01 am revealed the Admission Coordinator is responsible for calling the family member after a resident is discharged to let them know about the Bed Hold Policy. On 11/7/18 at 2:34 pm an interview with the Admissions Coordinator revealed she contacts the family when a resident is discharged to the hospital. She also stated she does not keep a record of calling families to notify them of the Bed Hold Policy when a resident is discharged. The Admission Coordinator stated the nurses send a copy of the Bed Hold Policy in the discharge packet to the hospital when a resident is discharged. An interview with Nurse #4 on 11/8/18 at 9:27 am revealed Resident #1's oxygen level had dropped even though he was on continuous oxygen on 11/5/18 and he was sent back to the emergency room for evaluation and was admitted to the hospital. Nurse #4 stated the discharge packet that is sent with discharged residents to the hospital included a copy of the Bed Hold Policy. She stated she called the family member when the resident was discharged to the facility but did not give her a copy of the Bed Hold Policy or discuss the Bed Hold Policy.	F 625	hospital from the Cardiologist appointment. 1d. Resident #71's RP received a bed hold policy and a copy of the discharge/transfer letter on 12/5/2018 which was discussed with the individual for the 8/17/2018 discharge to the hospital. 2. HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY SAME DEFICIENT PRACTICE: 2a. The Director of Nursing (DON)/designee will re-educate all licensed staff and Admissions Coordinator on the bed hold policy and the discharge/transfer letter. 2b. Admissions Coordinator/Designee will audit all current residents in facility to ensure that RPs have been given and have been educated on the Bed Hold policy and the transfer/discharge letter. 3.MEASURES TO BE PUT IN PLACE/SYSTEMIC CHANGES TO ENSURE DEFICIENT PRACTICE WILL NOT RECUR: 3a. DON/designee will re-educate all clinical nursing staff on Bed Hold policy and discharge/transfer letter and elements of what is needed for any resident sent out of facility to hospital and/or information that should be sent to a Specialty Physician with documentation in the	

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F 625	Continued From page 13 An interview with the Director of Nursing on 11/8/18 at 1:00 pm revealed the facility notified residents when they are admitted to the facility of the Bed Hold Policy and a copy of the bed hold policy is sent in the hospital packet when residents are discharged to the hospital by the nurse. A phone interview with Resident #1's family member on 11/8/18 at 1:30 pm revealed she had not received a written explanation of the facility's Bed Hold Policy when Resident #1 was sent to the hospital on 11/5/18. An interview with the Administrator on 11/8/18 at 2:15 pm revealed his expectation was the resident and/or family member would be notified of the Bed Hold Policy when the resident is discharged to the hospital. 2. Resident #11 was admitted to the facility on 8/9/2017 with diagnoses that included dysphagia, unspecified convulsions and essential hypertension. A review of the Minimum Data Set (MDS) assessment dated 8/17/2018 revealed Resident #11 was rarely understood, had short and long-term memory problems, recognized staff names and faces and knew she was in a nursing home. Additionally, the MDS revealed Resident #11 had severely impaired cognitive skills. A review of hospital records revealed Resident #11 was hospitalized on 9/21/2018 with tachycardia, fever and urinary tract infection. A review of a nurse's note dated 9/21/2018 at	F 625	resident's medical record. 3b. DON/designee will re-educate all clinical nursing staff on documentation of the items required to be sent with each resident when leaving the facility to include but not limited to the medical doctor (MD)/RP notification. 3c. Admissions Coordinator will be re-educated on discussion of facility Bed Hold policy upon admission with copy given to that individual and regarding the Discharge/Transfer letter. 4. FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED: 4a. DON/designee will audit clinical records of residents that have been sent to the hospital and/or MD appointments and will be audited and discussed in Clinical Morning Meeting 5X/week for 4 weeks; then 3X/week for 4 weeks and once a week for 4 weeks. This audit will include Situation, Background, Assessment and Recommedation (SBAR), admission record and transfer/discharge report in Point Click Care (PCC), Medication Administration Record (MAR), Treatment Administration Record (TAR), Care Plan, Physician Order/Notification, Pertinent Notes, Labs, Do Not Resuscitate (DNR), RP notification and placing bed hold/leave of absence policy and Notice of Discharge in the Social Worker's mailbox.	

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F 625	Continued From page 14 3:37 PM revealed Resident #11 was sent to the emergency room for evaluation and treatment. Further review did not reveal any documentation that the resident or the resident's representative received a bed hold. During an interview on 11/7/2018 at 10:01 AM the Social Worker (SW) revealed the nursing department was required to send a packet with residents who transferred out. The SW further revealed the packet included information regarding the bed hold policy. During an interview on 11/7/2018 at 2:34 PM the Admissions Coordinator (AC) revealed the resident's representative/family is to follow up with facility regarding the bed hold. The AC reported the resident's representative/family would call the facility if the resident was in the hospital and they will state they can't hold the bed. She further reported that she did not keep a record of the calls discussing the bed hold. Additionally, the AC revealed the bed hold paperwork is sent out by nursing. An interview on 11/8/2018 at 2:34 PM with Nurse #1 revealed she wrote the nurse's note on the date of transfer to the hospital. Nurse #1 disclosed that she did not provide any information to the resident or the resident's representative related to a bed hold. Additionally, Nurse #1 revealed she thought the social worker or someone in the front office handled the bed hold notification. An interview on 11/8/2018 at 4:17 PM with the Administrator revealed he expected staff to provide bed hold notification to resident's and or resident's responsible party prior to transfer.	F 625	4b. Results of audits will be taken to Quality Assurance Performance Improvement committee meeting monthly X 3 months for review and revision as needed. 4c. All newly hired clinical nursing staff will be educated on the Bed Hold Policy, Discharge/Transfer letter, documentation in the medical record and discharges to the hospital and/or specialty physician. The Administrator is responsible for this Plan of Correction	

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3. A review of Resident #12's medical record revealed she was originally admitted to the facility on 3/6/17 and was most recently admitted on 9/17/18. Resident #12's diagnoses included: Generalized weakness, diabetes, chronic kidney disease, heart failure, anxiety, depression, and dementia.

A review of Resident #12's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 8/19/18. Review of the assessment revealed the following: The resident was coded as having been cognitively intact. The resident was not coded as having had behaviors during the assessment period. The resident was coded as having had required extensive assistance of one or more people for all Activities of Daily Living (ADLs) except for eating where she was coded as having been independent with supervision.

Review of Resident #12's progress notes revealed a nursing note dated 9/11/18 and timed 12:39 AM. The note documented the resident had an oxygen saturation percentage of 87% with supplemental oxygen. The note further documented the resident had been observed to have been short of breath, labored breathing, and had abnormal lung sounds. The resident was also documented as having had swelling and the resident was complaining of nausea. Further review of the progress notes revealed another note dated 9/11/18 documenting the resident had been sent out to the hospital and was admitted to the hospital with a diagnosis of acute congestive heart failure. Review of the notes did not provide evidence of documentation if the family member was notified of the facility bed hold policy.

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Review of Resident of Resident #12's Readmit History and Physical dated 9/18/18 revealed the resident was documented as being readmitted to the facility after having been hospitalized for hypoxia (lack of oxygen) and a Congestive Heart Failure (CHF) exacerbation.

An interview was conducted with the Social Worker (SW) on 11/7/18 at 10:01 AM. The SW stated she did not provide bed hold information to the resident or the family member of Resident #12. The SW stated the Admissions Director (AD) was the person who would call the resident or the resident's family about the bed hold. The SW stated the nursing department was required to send a packet with the resident at the time of discharge and the packet included the bed hold policy.

An interview was conducted with the Admissions Director (AD) on 11/7/18 at 2:34 PM. The SW stated she did not provide bed hold information to the resident or family member of Resident #12. The AD stated it was made clear to family members of residents at the time of admission it was the family member's responsibility to contact the facility if the resident was hospitalized. The AD stated she did not keep a record of who she had called to discuss the bed hold policy. The AD further stated the bed hold policy was something nursing sent out with the resident. The AD stated she did not know if the nurse asked the resident or the resident's family about a bed hold when the resident was being discharged.

An interview was conducted with Nurse #7 on 11/7/18 at approximately 3:00 PM. The nurse sated Resident #12 was sent out to the hospital

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because the resident had become swollen and was short of breath. The nurse further stated she had called the resident's family to notify them but had not discussed bed hold with the family or the resident at the time of discharge. The nurse stated she sent a packet with the resident which had the resident's face sheet, physician's orders, and the bed hold policy.

A phone interview was conducted with the family member for Resident #12 on 11/7/18 at 3:44 PM. The family member stated he had been notified through a phone call when the resident was discharged to the hospital back in September, but he had not received information nor was he informed about a bed hold or bed hold policy.

An interview with the Administrator on 11/8/18 at 2:15 pm revealed his expectation was the resident and/or family member would be notified of the bed hold policy when a resident was being discharged to the hospital.

4. A review of Resident #71's medical record revealed she was originally admitted to the facility on 8/2/18 and was most recently admitted on 8/31/18. Resident #71's diagnoses included: Generalized weakness, anxiety, abnormal heart beat, heart disease, diabetes, difficulty swallowing, chronic kidney disease, and congestive heart failure (CHF).

A review of Resident #71's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 10/18/18. Review of the assessment revealed the following: The resident was coded as having had moderately impaired cognition. The resident was not coded as having had behaviors during

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the assessment period. The resident was coded as having required extensive assistance of one or more people for all Activities of Daily Living (ADLs).

Review of Resident #71's progress notes revealed a nursing note dated 8/17/18 and timed 5:40 PM. The note by Nurse #1 documented the resident had been seen at a cardiologist appointment and was triaged to the Emergency Room (ER) at the local hospital. Review of the note did not provide evidence of documentation if the family member was notified regarding the bed hold policy.

Review of Resident #71's progress notes revealed a Social Services note dated 8/20/18 which documented staff reported resident was sent to the hospital after a doctor appointment due to health status. Review of the note did not provide evidence of documentation if the family member was notified regarding the bed hold policy.

Review of Resident #71's progress notes revealed a nursing note dated 8/17/18 and timed 6:38 PM. The note by Nurse #1 documented the resident had been admitted to the local hospital with an acute on chronic Congestive Heart Failure (CHF) exacerbation. Review of the note did not provide evidence of documentation if the family member was notified regarding the bed hold policy.

Further review of Resident #71's medical record did not reveal a discharge assessment or physician's orders to discharge the resident to the hospital.

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A review was completed of Resident #71's hospital discharge summary dated 8/31/18. The discharge summary the resident had received treatment during hospitalization for the following diagnoses: urinary tract infection, acute on chronic congestive heart failure, and chronic kidney disease. The documented main complaint at the time of admission to the hospital was shortness of breath and right leg pain.

An interview was conducted with the Social Worker (SW) on 11/8/18 at 11:53 AM. The SW stated she did not talk to Resident #71 nor her family regarding a bed hold after her discharge to the hospital.

An interview was conducted with Nurse #1 on 11/8/18 at 11:55 AM. Nurse #1 stated Resident #71 had a scheduled cardiologist appointment on 8/17/18. The nurse stated the resident would have had to have been transported either by the facility wheelchair transportation van or a contracted wheelchair transportation van. The nurse stated the resident was admitted to the hospital directly from a cardiologist appointment on Friday, 8/17/18. The nurse stated she did not contact the resident's family when she was made aware the resident had been admitted to the hospital because she said the resident's family would have had to have been with the resident at the cardiologist appointment. The nurse stated she did not forward bed hold information to the resident or the resident's family regarding the discharge from the facility. The nurse further stated the facility Social Worker (SW) or the Admissions Coordinator would have been responsible for following up with the resident or family on Monday because the resident was discharged on a Friday.

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An interview was conducted with Nurse # 4 on 11/8/18 at 12:01 PM. Nurse #4 stated Resident #71's family would have been with the resident at her doctor appointment because residents were not allowed to go to doctor appointments unaccompanied. The nurse stated she had not contacted the resident's family regarding the resident had having been sent to the emergency room, the resident having had been admitted to the hospital, or bed hold information. The nurse stated usually with a normal discharge to the hospital or the emergency room a packet would have been sent along with the resident. The packet would have contained a physician's order for being sent to the ER, bed hold information, and a face sheet. Nurse #4 stated in this instance regarding Resident #71 there would have been no packet, no bed hold information, or notification provided to the resident or family from nursing.

An interview was conducted with the Director of Nursing (DON) on 11/8/18 at 12:10 PM. The DON stated the Admission Coordinator was usually the person who would notify resident's families about the bed hold.

A second interview was conducted with the Social Worker (SW) on 11/8/18 at 12:15 PM. The SW stated she was not the one who normally contacted a resident or a resident's family about a bed hold and she had not contacted Resident #71 nor her family regarding a bed hold.

An interview was conducted with the Admissions Director (AD) on 11/8/18 at 12:31 PM. The AD stated she did not recall discussing the bed hold policy with Resident #71's family after her

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F 625	Continued From page 21 discharge to the hospital. The AD further stated if the family came in to pick up some of the resident's belongings she may have talked to them, but that would have been on Monday because the resident was discharged to the hospital on Friday. The SW stated she would not have documented she had talked to the resident's family about the bed hold if she had talked with them. An interview with the Administrator on 11/8/18 at 2:15 pm revealed his expectation was the resident and/or family member would be notified of the bed hold policy when a resident was being discharged to the hospital.	F 625		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interview the facility failed to follow a physician's order for 1 of 4 resident reviewed, Resident #1, for hospitalization. Resident #1 returned from the hospital on 11/2/18 with an order to be given nothing by mouth. He received a breakfast tray on 11/3/18 and drank 120 milliliters of orange juice.	F 684	1. HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED: 1a. Resident #1- diet has been changed to Nothing By Mouth (NPO) secondary to resident receiving all nutritional value via tube feedings.	12/6/18

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F 684	Continued From page 22 A review of Resident #1's medical record revealed he admitted to the facility on 7/26/18 with diagnoses of pneumonitis due to inhalation of food, heart disease, respiratory disease, and blood clots to his upper extremities. His most recent Admission Minimum Data Set assessment dated 8/2/18 revealed he was severely cognitively impaired and required extensive to total assistance with turning in bed, transferring in and out of bed, eating, and toileting. The assessment further revealed Resident #1 had difficulty swallowing and received enteral feedings that provided 51% or more of his caloric intake. Nurse's Note dated 10/28/18 at 4:45 pm revealed Resident #1 was discharged to the hospital after being found unresponsive with oxygen saturation of 54% on 3 liters of oxygen by nasal canula. Admission Note dated 11/2/18 at 3:55 pm revealed Resident #1 returned to the facility from the hospital with diagnoses of respiratory failure, heart failure, and pneumonia. The Physician's Orders for 11/2/18 included an order for nothing by mouth and enteral feedings every shift for nutrition. A review of Resident #1's care plan dated 11/2/18 revealed he required administration of feeding and hydration via feeding tube. The Dietary Order & Communication form dated 11/2/18 for readmission stated the resident was to have nothing by mouth. A Nursing Note dated 11/3/18 at 3:57 pm written by Nurse #4 stated it was reported to the nurse Resident #1 drank 120 cc of orange juice this am. The note further revealed the Physician's	F 684	1b. Certified Nursing Assistant was re-educated on confirming diets for any resident that receives a tray and is noted to be NPO secondary to having tube feeding. 2. HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY SAME DEFICIENT PRACTICE: 2a. 100% of current resident's diet orders were audited on 12/5/2018 and corrections made for specific diets and/or changes per medical doctor (MD) orders 3. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: 3a. All new residents admitted and readmitted will be audited per the Admission/Readmission audit check sheet to ensure that all orders have been approved per the MD. 3b. Orientation will be provided to all new employees during orientation regarding following MD orders. 4. FACILITY PLANS FOR MONITORING ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED: 4a. The Director of Nursing (DON)/designee will audit all new admissions regarding MD orders 5X/week	

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F 684	Continued From page 23 Assistant was notified and gave orders for a chest x-ray and to report any fever or shortness of breath. Review of chest x-ray dated 11/3/18 stated the x-ray suggested the resident had congestive heart failure. Nurses note dated 11/5/18 at 3:15 pm written by Nurse #4 revealed Resident #1's oxygen saturation was below 90% consistently, the physician was notified, and the resident was sent to the emergency room. The Emergency Department Note dated 11/5/18 revealed Resident #5 was admitted to the hospital with Pneumonia of Right Lung and Congestive Heart Failure. An interview with Nurse #4 on 11/8/18 at 9:27 am revealed Resident #1's oxygen level had dropped even though he was on continuous oxygen on 11/5/18 and he was sent back to the emergency room for evaluation and was admitted to the hospital. An interview with the Family Member on 11/8/18 at 1:30 pm revealed she was notified on 11/3/18 Resident #1 was given a breakfast tray and he ate and drank from the tray. She stated she visited on Sunday and Resident #1 was lethargic. The Family Member stated on 11/5/18 he was sent back to the hospital with pneumonia. An interview with Nurse #5 on 11/8/18 at 2:15 pm revealed she was the Charge Nurse on 11/3/18 when Resident #1 received a meal tray that was not ordered. She stated she did not see the tray, but it was reported to her Resident #1 drank 240	F 684	for 4 weeks; then 3X/week for 4 weeks; then 1X/week for 4 weeks. 4b. Results of the audits will be reviewed by the Quality Assurance Performance Committee committee monthly for 3 months for review and revision as needed. The Administrator is responsible for this Plan of Correction	

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F 684	Continued From page 24	F 684		

milliliters of orange juice from the tray. Nurse #5 stated Nurse #6 was Resident #1's Nurse that day. Nurse #5 stated she had called the Physician's Assistant and received an order for a chest x-ray.

A phone interview with Nurse #6 on 11/8/18 at 2:27 pm revealed she was notified by NA #1 that Resident #1 had received a breakfast tray on 11/3/18 and had drank orange juice from the tray. Nurse #6 stated she was concerned because Resident #1 had always had had an order for nothing by mouth. She stated she notified the Charge Nurse, Nurse #5, and the Charge Nurse notified the physician and the family and notified dietary of Resident #1's orders for nothing by mouth.

An interview with Nurse Aide #1 on 11/8/18 at 2:40 pm revealed she had passed trays at breakfast on 11/3/18 and thought Resident #1 had a new order to eat food since a tray was delivered. Nurse Aide #1 stated she picked up the tray Resident #1 was given at 9:30 am and he drank the orange juice from the tray. She stated Resident #1 did not have any choking or coughing after drinking the orange juice and she notified Nurse #6 after picking up the tray Resident #1 drank orange juice.

An interview with the Director of Nursing on 11/8/18 at 2:56 pm revealed it was not reported to her Resident #1 had been given a tray on 11/3/18 at breakfast or that he had drank orange juice from the tray. She stated her expectation was that the physician's diet orders should be followed and Resident #1 should not have received a tray.

On 11/8/18 at 4:09 pm a phone interview with the

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F 684	Continued From page 25 Physician revealed he was not aware Resident #1 drank orange juice on 11/3/18. He stated it would be hard to know if the orange juice had anything to do with Resident #1 having aspiration. He stated his expectation would be the physician's orders would be followed and Resident #1 would not have received anything by mouth.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to secure three of four doors entering the laundry room which contained potentially hazardous chemicals and equipment. The findings included: An observation conducted on 11/6/18 at 3:24 PM revealed the entrance door to the laundry room from the 400 hall, a resident hallway, was not locked. Upon entering the laundry room there were no staff members observed in the laundry room there were two commercial sized washing machines running, two commercial sized dryers, and hazardous chemical storage. Further observation revealed a door to an employee entrance hallway was unlocked, this door was also resident accessible. Observation of the door	F 689	1. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED: 1a. Laundry aide was re-educated on leaving laundry door propped open when not in laundry room. Laundry aide received disciplinary action on 11/8/18. 2. HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENT HAVING POTENTIAL TO BE AFFFECTED BY SAME DEFICIENT PRACTICE: 2a. Laundry room will be locked at all times when employee(s) are not in the laundry room. Laundry employees have	12/6/18

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F 689	Continued From page 26 from the laundry room to the soiled linen revealed it was unlocked and the door which provided access from the 400 hall to the laundry room was also unlocked. Observation of a 4th entrance door to the laundry room revealed the door was locked and would not allow entry from the dining room to the laundry room. There was a posting on the door in the dining room which read, "This door must be kept closed and locked at all times when not in use," and was signed by the Administrator. At least one resident was observed in the 400 hall at the time of the observation. An observation conducted on 11/7/18 at 10:33 AM revealed the entrance door to the laundry room across from the employee entrance, a resident accessible door, was propped open with a 5 gallon bucket which was visibly marked "corrosive" with the hazard sign for corrosive. Upon entrance to the laundry room there were no staff members observed in the laundry room. Further observation revealed the entrance door to the laundry room from the 400 hall, a resident hallway, was not locked. Further observation of the laundry room revealed there were two commercial sized washing machines running, two commercial sized dryers, and more hazardous chemical being stored. Observation of the door from the laundry room to the soiled linen revealed it was unlocked and the door which provided access from the 400 hall to the laundry room was also unlocked. Observation of a 4th entrance door to the laundry room revealed the door was locked and would not allow entry from the dining room to the laundry room. There was a posting on the door in the dining room which read, "This door must be kept closed and locked at all times when not in use," and was signed by the	F 689	been re-educated on keeping all laundry doors locked to ensure that no resident can enter laundry room where chemicals and heavy duty machinery is being utilized. 3. MEASURES PUT IN PLACE/SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILLO NOT RECUR: 3a. Administrator/designee re-educated staff on November 8, 2018 ensuring that all laundry doors are locked at all times, that no laundry door may be propped open at anytime especially doors with automatic closures. Only employees are to have access to the laundry room. 3b. Push button key pad locks have been placed on laundry room doors. Inservices were provided by the Staff Development Coordinator for all facility employees on 12/5/2018 on the process and use of the new key pad locks and that the laundry room door must remain closed and locked when employees are not in the room. 4. FACILITY PLANS FOR MONITORING ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED: 4a. Maintenance Director/designee will audit laundry room doors for 5x/week for 4 weeks; then 3X/week for 4 weeks then 1X/week for 4 weeks. All new employees will be inserviced on this new procedure during orientation. The Administrator is responsible for this	

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F 689	Continued From page 27 Administrator. During the observation the Laundry Aide (LA) was observed to return to the laundry room. The LA was pushing a wheeled clothing rack. The LA stated she needed to prop the door open because she was coming back with the wheeled clothing rack. The LA stated the 5 gallon bucket she had used to prop the door open with was full and contained chlorine destaining concentrate, a kind of liquid bleach. At least one resident was observed in the 400 hall at the time of the observation. An observation conducted on 11/8/18 at 10:03 AM revealed the entrance door to the laundry room from the 400 hall, a resident hallway, was not locked. Upon entering the laundry room there were no staff members observed in the laundry room there were two commercial sized washing machines running, two commercial sized dryers, and hazardous chemical storage. Further observation revealed a door to an employee entrance hallway was propped open with a 5 gallon bucket. The 5 gallon bucket was visibly marked "corrosive" with the hazard sign for corrosive. Observation of the listed contents of the bucker revealed the bucket contained chlorine destaining concentrate. Observation of the door from the laundry room to the soiled linen revealed it was unlocked and the door which provided access from the 400 hall to the laundry room was also unlocked. Observation of a 4th entrance door to the laundry room revealed the door was locked and would not allow entry from the dining room to the laundry room. There was a posting on the door in the dining room which read, "This door must be kept closed and locked at all times when not in use," and was signed by the Administrator. While conducting the observation	F 689	plan of correction.	

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a Nursing Assistant (NA) #2 entered the laundry room then exited the laundry room. The LA came into the laundry room through the soiled linen room entrance door. The LA stated she had been out delivering personal clothes to the residents. The LA stated she had been to the 400 hall, the 200 hall, the 800 hall, and the 600 hall. The LA stated it took her about 25 minutes to deliver personal clothes to the residents on her round and she delivers the clothes after breakfast between 9:00 AM and 10:00 AM, once a shift, and her shift was from 7:00 AM till either 2:30 PM or 3:00 PM. The LA stated she would usually leave the washer and dryer equipment running when she left the laundry room when she was delivering clothes. The LA stated the only door she had to lock was the entrance door to the laundry room from the dining room. The LA stated there was no one assigned to monitor or observe the entrances to the laundry room when she was delivering clothes. The LA further stated the entrance doors to the laundry from the 400 hall, through the soiled linen room, and the entrance by the employee entrance stayed unlocked. The LA stated the main entrance to the laundry room from the 400 hall remained unlocked all of the time, which allowed third shift to be able to access the laundry room. At least one resident was observed in the 400 hall at the time of the observation. At least one resident was observed in the 400 hall at the time of the observation.

An interview was conducted with NA #2 on 11/8/18 at 10:20 AM. The NA stated the laundry room entrance, either the one by the employee entrance or the 400 hall entrance, were usually open. The NA stated there was a door between the 400 hall and the employee hall, that door was

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F 689	Continued From page 29 usually closed, but it did not lock. The NA stated the door from the dining room to the laundry room was kept locked. The NA stated sometimes she would go into the laundry room and the LA was not in the laundry room and the laundry room was not locked. The NA stated she had observed the laundry room to be unlocked without the LA in the laundry room during second shift also when the LA was delivering clothing. During an interview conducted with the Administrator on 11/8/18 at 10:31 AM, the Administrator stated it was his expectation for the laundry room, which contained potentially harmful chemicals and equipment, to either be monitored or locked and secured.	F 689		
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	F 732		12/6/18

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F 732	Continued From page 30 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. §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 review and staff interviews, the facility failed to correctly update daily nursing staff posting records for 15 of 15 staffing records reviewed. Findings included: The facility ' s daily staff posting was observed on 11/5/2018 at 9:49 AM. The posted staffing was completed for all shifts with the total number of nurses and nursing assistants documented on the form and total hours were calculated for each shift. No adjustments were made for changes in staffing. Daily staff posting was observed on 11/6/2018 at 10:36 AM. The posted staffing was completed for all shifts with the total number of nurses and nursing assistants documented on the form and total hours were calculated for each shift. No	F 732	1. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED: 1a. Staffing posting was corrected immediately to reflect the actual staff working. 2.CORRECTIVE ACTION FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: 2a. No residents are affected by this practice at this time 3. MEASURES PUT INTO PLACE/SYSTEMIC CHANGES TO ENSURE DEFICIENT PRACTICES DO NOT OCCUR:	

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F 732	Continued From page 31 adjustments were made for changes in staffing. A total of 15 daily staff posting records dated from 9/1/2018 until 10/14/2018 were reviewed. All posted nurse staffing did not match the employee schedule and no adjustments were made to the posted staffing to reflect staff call-outs or changes in staffing. An interview was conducted with the Director of Nursing (DON) on 11/7/2018 at 10:48 AM. The DON reported the Assistant DON completed the posted nursing staffing forms, but she was unavailable for interview. The DON went on to explain the posted nursing staffing sheets were completed by the charge nurses when the Assistant DON was not available, and Human Resources would correct the forms to reflect call-outs or staffing changes the next day. The DON went on to explain she was not aware the staffing should be updated for each shift to reflect call-outs, staffing changes or adjustments. The Administrator was interviewed on 11/8/2018 at 2:58 PM and he stated it was his expectation each nursing shift would update the posted nurse staffing with accurate staffing information and adjust the hours due to call-outs or other schedule changes.	F 732	3a. Interim Regional Director of Clinical Services (IRDCS) re-educated the Director of Nursing (DON) and charge nurse on the proper guidelines on posting daily nursing hours on November 7, 2018. 3b. The Staff Development Coordinator (SDC)/designee will re-educate all charge nurses on the proper process of posting daily nursing staffing on November 6, 2018. 3c. New form has been initiated to meet requirements as specified by Data Regulations. 4.FACILITY PLANS FOR MONITORING ITS PERFORMANCE TO MAKE SURE THAT THE SOLUTIONS ARE SUSTAINED: 4a. DON/designee will audit Posting Daily Nursing Staff form daily for 4 weeks; then 3X/week; then weekly X 4 weeks. 4b. Results of audits will be taken to Quality Assurance Performance Improvement meeting monthly X3 months for review and revision as needed. The Administrator is responsible for this Plan of Correction.	