STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. BUILDING _____ B. WING _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	1403 CONNER DRIVE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were sited as a result of the complaint investigation Event ID BR1511 Intake NC 00138402 & NC 00135030.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		12/14/18

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

Electronically Signed | 12/10/2018

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F 580	Continued From page 1 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to notify the physician and responsible party (RP) of a newly identified pressure ulcer for 1 of 2 residents reviewed for pressure ulcer care. (Resident #304) Findings included: Resident #304 was admitted to the facility on 1/19/18. Her active diagnoses included coronary artery disease, heart failure, hypertension, renal insufficiency, Alzheimer's disease, dementia, and a history of colon cancer. Review of Resident #304's admission minimum data set (MDS) assessment dated 1/26/18 revealed she was assessed as severely cognitively impaired. Resident #304 was assessed to require extensive assistance with personal hygiene and totally dependent on staff for toilet use. She had no pressure ulcers during	F 580	F580 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. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to notify the physician and responsible party of a newly identified pressure ulcer for 1 of 2 residents reviewed for pressure ulcer care.	

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F 580	Continued From page 2 the assessment. Review of Resident #304's care plan initiated 1/23/18 revealed she was care planned to be at risk for pressure ulcer development related to bowel and bladder incontinence and decreased ability to assist with repositioning. The interventions included to observe Resident #304's skin for redness or open areas and inform the nurse if any areas were noted. Review of a nurse's note dated 4/18/18 revealed Nurse #1 performed a skin assessment and noted an old ulcer to the sacrum had reopened and was 0.5 centimeter in diameter. No drainage or odors were noted. A hydrocolloid dressing was placed over the area per standing orders and tolerated well. There was no documentation of the RP or physician being notified. During an interview on 11/14/18 at 11:54 PM MDS Nurse #1 stated she received report from the night nurse that a stage II pressure ulcer had been identified and dressing changes had been initiated according to physician standing orders. She further stated she assumed the physician and RP had been notified which was why she did not contact the physician. During an interview on 11/14/18 at 3:27 PM Nurse #1 stated she was the nurse who discovered Resident #304 had an old, healed wound open to be about 0.5 centimeters with no drainage to her sacrum. She further stated there were standing orders for residents who developed a stage I or II pressure ulcers, so she followed those orders and placed a hydrocolloid dressing on the resident. Nurse #1 stated when old wounds reopened, the nurse's followed the standing	F 580	(Resident#304) On 12/10/18, an LPN Support Nurse completed a 100% review on all residents. 57 current residents audited of which 8 have pressure ulcers. All RP's and Physicians were notified. 2. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - On 12-10-17, The Administrator and Director of Nursing began in servicing all FT, PT, and PRN RN's and LPN's, Admissions and Social Services Assistant on the following procedures: • Notification of Changes- A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority the resident representative(s) when there is (A) and accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) a significant change in the resident's physical, mental, or psychosocial status (that is a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) a decision to transfer or discharge the resident from the facility as specified in 483.15 (c)(1)(ii). The facility must also	

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F 580	Continued From page 3 orders and the nurses took care of reopened wounds themselves. She further stated she then wrote a nurse's note about the dressing documenting how Resident #304 tolerated the treatment, and that was all she needed to do. Nurse #1 further stated she then reported the opened wound to the oncoming day shift nurse during change of shift but did not remember who it was. The nurse stated the facility did not have a wound care nurse, so she did not report it to any wound care nurse, and because it was a reopened wound, it did not need to be reported to the physician or RP. During an interview on 11/14/18 at 4:07 PM the Director of Nursing stated it was her expectation that Nurse #1 notify the Director of Nursing, RP, and physician about the development of new pressure ulcers. She further stated she was not aware of the new area until 4/24/18 during an interdisciplinary team meeting regarding Resident #304. The Director of Nursing concluded the RP and physician were made aware of the new pressure ulcer on 4/24/18 as well. During an interview on 11/15/18 at 8:28 AM Physician #1 stated it was his expectation to be notified by staff if a resident ' s old, healed pressure ulcer reopened. He concluded Nurse #1 should have notified his office after the pressure ulcer was first identified.	F 580	promptly notify the resident and the resident representative, if any, when there is a (A) A change in room or roommate assignment as specified in 483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e) (10) of this section. The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Any in-house staff member who did not receive in-service training by 12-14-2018 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Administrator, Director of Nursing or MDS Coordinator will conduct audits to ensure the Resident, Physician, and the Resident Representative were notified for Resident's with newly identified pressure ulcers. These audits will be conducted weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA	

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F 580	Continued From page 4	F 580	committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F 582		12/14/18

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F 582	Continued From page 5 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review (Residents #13 and #30).	F 582	F582 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	

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F 582	Continued From page 6 The findings included: 1. Resident #13 was admitted to the facility on 5/31/18 with diagnoses including chronic obstructive pulmonary disease, diabetes, heart disease, and spinal stenosis. She was readmitted to Medicare Part A skilled services on 8/24/18. Resident #13's Medicare Part A skilled services ended on 9/6/18. She remained in the facility. Record review revealed that Resident #13 was not given the CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC)or the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). During an interview with the Business Officer on 11/14/18 at 4:50 PM, she stated she was recently hired as the Business Officer. She reported it is her responsibility to inform the resident or the resident representative that Medicare Part A skilled services were ending with benefit days remaining at least three days prior to termination of services. The Business Officer reported an additional responsibility is to advise the resident or resident representative of the cost of services should Part A skilled services continue. She stated she utilizes the CMS-10123 NOMNC and CMS-10555 SNF-ABN to give this written notification. The Business Officer indicated she was not responsible for giving these notifications to Resident #13. During an interview with the Administrator on 11/14/18 at 4:59 PM, she stated it is her expectation the facility follows the CMS Federal guidelines and provide the CMS-10123 NOMNC and the CMS-10555 SNF-ABN to the resident or	F 582	constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review. (Resident #13 and #30). The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - The Regional Business Office Consultant in-serviced the Business Office Manager and the Admissions/Social Worker and Social Worker Assistant on the following procedures: • The facility must inform each Medicaid eligible resident in writing, at time of admission to the nursing facility and when the resident becomes eligible for Medicaid and the facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by	

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F 582	Continued From page 7 resident representative when required. 2. Resident #30 was admitted to the facility on 3/16/18 with diagnoses including anemia, diabetes mellitus, and dementia. She was readmitted to Medicare Part A skilled services on 5/3/18. Resident #30's Medicare Part A skilled services ended on 5/23/18. She remained in the facility. Record review revealed that Resident #30 was not given the CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC)or the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). During an interview with the Business Officer on 11/14/18 at 4:50 PM, she stated she was recently hired as the Business Officer. She reported it is her responsibility to inform the resident or the resident representative that Medicare Part A skilled services were ending with benefit days remaining at least three days prior to termination of services. The Business Officer reported an additional responsibility is to advise the resident or resident representative of the cost of services should Part A skilled services continue. She stated she utilizes the CMS-10123 NOMNC and CMS-10555 SNF-ABN to give this written notification. The Business Officer indicated she was not responsible for giving these notifications to Resident #30. During an interview with the Administrator on 11/14/18 at 4:59 PM, she stated it is her expectation the facility follows the CMS Federal guidelines and provide the CMS-10123 NOMNC and the CMS-10555 SNF-ABN to the resident or resident representative when required.	F 582	the facility's per diem rate, Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to Residents of the change as soon as is reasonably possible. • F582 in its entirety • CMS-10123 Notice of Medicare Non-Coverage Letter (NOMNC) • CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) Any in-house staff member who did not receive in-service training by 12-14-2018 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Administrator will conduct audits to ensure the facility has provided a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) and or the CMS 10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). These audits will be conducted weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by	

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F 582	Continued From page 8	F 582	QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
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		12/14/18

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F 623	Continued From page 9	F 623		

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 10 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 review and staff interview the facility failed to provide written notice of discharge for 2 of 2 residents reviewed for hospitalization (Resident #15 and Resident #14).	F 623	F623 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	

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F 623	Continued From page 11 The findings included: 1. Resident #15 was admitted to the facility on 7/31/18. His diagnoses included: congestive heart failure, chronic kidney disease and atrial fibrillation. Review of a nurse's note dated 10/18/18 revealed Resident # 15 was sent to the hospital for evaluation for major renal failure. A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's transfer to the hospital on 10/18/18. No written notice was forwarded to the ombudsman. During an interview with the Admissions Coordinator on 11/15/18 at 12:31 PM, she stated that she was unaware that written notice of discharge was to be sent to the resident or resident's representative and ombudsman for emergent hospital transfers. She continued she would ensure written notice of discharge is sent to the resident or resident's representative with a copy to the ombudsman for future hospital transfers. An interview was conducted with the Administrator on 11/15/18 at 2:11PM, who indicated it was her expectation written notice of discharge would be sent to the resident or resident's representative with a copy forwarded to the ombudsman as required by regulations for emergent hospital transfers by the Admission Coordinator. 2. Resident #14 was admitted to the facility on 11/17/17. His active diagnoses included dementia, chronic kidney disease, osteoarthritis, and hyperlipidemia. Review of Resident #14's nurses notes revealed on 8/1/18 he was order to be transferred to the	F 623	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. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to provide written notice of discharge for 2 of 2 residents reviewed for hospitalization. (Resident#15 and Resident#14) The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - The Administrator, Director of Nursing, began in servicing all FT, PT, and PRN RN's, LPN's, Admissions and Social Worker Assistant on the following procedures: • Notice before Transfer, before a facility transfers or discharges a resident, the facility must 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. • F623 in its entirety	

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F 623	Continued From page 12 hospital following the report of an abnormal lab. Review of Resident #14's chart revealed no written notice of discharge was provided to the resident or resident ' s representative. No written notice of discharge was forwarded to the ombudsman. During an interview on 11/15/18 at 1:38 PM the Admissions Coordinator stated she was not aware of the regulation requiring the notice of transfer being sent to the ombudsman and resident or family regard emergent hospitalizations. During an interview on 11/15/18 at 2:11 PM the Administrator stated it was her expectation that notification of discharge would be provided to the resident, resident representative, and forwarded to the ombudsman as the regulations required for emergent hospitalizations.	F 623	Any in-house staff member who did not receive in-service training by 12-14-2018 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Administrator or Director of Nursing will conduct audits to ensure the facility has provided Notice before Transfer, Before a facility transfers or discharges a resident, the facility must 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. These audits will be conducted weekly for two weeks and monthly for 3 months. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and	

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F 623	Continued From page 13	F 623	ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		12/14/18

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F 657	Continued From page 14 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, and resident representative interviews the facility failed to perform a quarterly interdisciplinary care plan meeting for 1 of 1 residents reviewed for care plans. (Resident #13) Findings included: Resident #13 was admitted to the facility on 5/31/18. Her active diagnose included chronic obstructive pulmonary disease, diabetes, heart disease, and spinal stenosis. Review of Resident #13's most recent minimum data set assessment dated 8/31/18 revealed she was assessed as cognitively intact. Review of Resident #31's records revealed there had not been an interdisciplinary care plan meeting held for Resident #31 since her admission on 5/31/18. During an interview on 11/13/18 at 10:00 AM Resident #13 stated she had not been invited to a care plan meeting since her admission on 5/31/18. During an interview on 11/15/18 at 9:33 AM Resident #13's Responsible Party stated he had never been invited to a care plan meeting since Resident #13 had been admitted on 5/31/18. During an interview on 11/15/18 at 1:41 PM Admission's Coordinator stated Resident #13 had not had an interdisciplinary care plan meeting since her admission on 5/31/18. She further stated she did not know how or why she had not	F 657	F657 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. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to perform a quarterly interdisciplinary care plan meeting for 1 of 1 residents reviewed for care plans. For resident #13, a corrective action was obtained on 11/16/18. A care plan meeting for resident #13 was conducted on 11/16/18. This meeting was attended by resident, resident's representative/husband, as well as facility Interdisciplinary Team. On 11/15/18 and 12-10-2018, the MDS Coordinator and the Social Worker assistant conducted a 100% audit on all current residents to determine whether or not they and/or their representative have received invitations to their care planning conference during the past 90 days. This audit was completed by interviewing all alert and oriented residents to determine	

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F 657	Continued From page 15 received a care plan meeting invitation or notice since her admission and would schedule one as soon as possible. During an interview on 11/15/18 at 2:10 PM Administrator stated it was her expectation interdisciplinary care plan meetings and updates to the care plan be done upon admission and quarterly and it was not done for Resident #13.	F 657	whether they have received an invitation to their care planning conference during the past 90 days or not. Validation of whether or not resident representatives had received invitations to care planning conference during the past 90 days was done by either interviewing the representative or by locating a copy of mailed invitation (including date mailed). The results of this audit were: 12 residents did recall receiving invitation to care planning conference during the past 90 days. 5 residents did not recall having received invitation to care planning conference during the past 90 days. 25 resident representatives had received invitation to care planning conference during past 90 days. 24 resident representatives had not received invitation to care planning conferencing during past 90 days. Based on the above audit, an invitation to schedule and participate in a care planning conference was extended to all residents and/or representatives who have not been invited to participate in his/her care planning conference within the past 90 days. 2. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - On 12/10/2018, the Minimum Data Set	

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F 657	Continued From page 16	F 657	Nurse Consultant in-serviced the facility Minimum Data Set Nurse and Social Services Director on the importance as well as requirement to invite and involve residents and their representatives in care planning conferences. Each resident should have an initial care planning conference during the first 72 hours of admission and on a quarterly basis. The facility interdisciplinary team should be included in these care planning meetings. The facility should extend invitations to both the resident and their representative, and encourage their involvement, as they are the best resources for coordinating an individualized care plan. Upon admission, a 72 hour care plan conference should be scheduled. Thereafter, either a verbal or written invitation should be extended to the resident on a quarterly basis. In addition, an invitation should be mailed to the resident representative on a quarterly basis. There are times when it is necessary to conduct the care planning meeting either at resident's bedside or via telephone conference call in order to accommodate the resident and/or representative's needs. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators and Social Services Directors. The Director of Nursing or Minimum Data Set Nurse or designee will review 5 current residents to ensure that the resident as well as their representative	

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F 657	Continued From page 17	F 657	have been invited to attend and participate in their care planning conference during the past quarter. They will use the quality assurance tool entitled "Care Plan Conference Invitation Audit Tool." This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 12/14/18	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with	F 661		12/14/18

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F 661	Continued From page 18 the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a recapitulation of stay for 1 of 1 residents reviewed for a planned discharge from the facility to the community (Resident # 52). The findings included: Resident #52 was admitted to the facility on 7/27/18 with diagnoses that included congestive heart failure, atrial fibrillation and hyperlipidemia. Resident #52's admission Minimum Data Set dated 8/3/18 coded him cognitively intact, requiring limited assistance for most activities of daily living and having the expectation to be discharged to the community. Review of Resident #52's closed record revealed he was discharged home on 8/15/18. Further review of closed records revealed the facility	F 661	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 661 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Based on record review and staff	

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F 661	Continued From page 19 failed to complete a recapitulation of Resident #52's stay in the facility. The Director of Nursing (DON) stated during an interview on 11/15/18 at 12:38 PM, the nurse discharging a resident is responsible for completing the discharge recapitulation section of the discharge summary. She stated the discharge recapitulation was not completed on Resident #52's discharge summary. She continued the nurse who discharged Resident #52 is no longer employed with the facility. The DON stated it is her expectation all departments complete the discharge summary prior to a resident's discharge. An interview was completed with the Administrator on 11/15/18 at 2:14 PM. She stated it is her expectation all sections of the discharge summary be complete	F 661	interviews, the facility failed to complete a recapitulation of stay 1of 1 resident review for a planned discharge from facility to the community (Resident #52). The findings included: Resident #52 was admitted to the facility on 7/27/2018 with a diagnosis that included congestive heart failure, atrial fibrillation and hyperlipidemia. Resident #52's admission Minimum Data Set dated 8/3/2018 coded him cognitively intact, requiring limited assistance for most activities of daily living and having the expectation to be discharged to the community. Review of Resident #52"s closed record revealed he was discharged home on 8/15/2018. Further review of closed records revealed the facility failed to complete a recapitulation. An audit was conducted on 12-10-18 by the DON, MDS, and HIMS on 100% of resident discharge summaries for the last 90 days. Any concerns found are being corrected. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 12-10-2018 the Director of Nursing	

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F 661	Continued From page 20	F 661		

began in servicing all FT, PT, and PRN RN's, LPN's on the following procedures:

- The importance of a recapitulation of the resident's stay that includes, but is not limited to diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results.
- Completion of final summary of the resident's status at the time of discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
- Importance of reconciliation of all pre-discharge medications with the resident's post-discharge medications both prescribed and over-the-counter.
- Review with nurses the importance of using planned discharge checklist to ensure all steps are followed.

Any in-house staff member who did not receive in-service training by 12/14/2018 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

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

The Director of Nursing, MDS Coordinator

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F 661	Continued From page 21	F 661	will audit weekly for four weeks then monthly for three months for completion of the discharge summary. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a resident had appointments scheduled every 91 days to have her gall bladder catheter replaced as ordered by the physician for 1 of 1 sampled residents for medically related social services (Resident # 24). The findings included:	F 745	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	12/14/18

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F 745	Continued From page 22 Resident #24 was admitted to the facility on 2/18/09 with diagnoses that included cancer, dementia and cholecystitis (accumulation of bile in the gall bladder). A review of Resident #24's medical record revealed a physician's order dated 9/22/16 which indicated her gall bladder catheter was to be changed every 91 days. The order was discontinued on 11/15/18. The record indicated Resident #24's catheter was changed 12/4/17. Review of an emergency department note dated 8/19/18 indicated Resident #24 went to the hospital due to her catheter not draining. The note further stated she missed a scheduled catheter change February 2018. The note indicated Resident #24 was discharged back to the facility and instructed to schedule an appointment for a gall bladder catheter exchange. Review of a doctor's note dated 8/28/18 revealed Resident #24's gall bladder catheter was changed 8/28/18. Review of Resident #24's most recent Minimum Data Set (MDS) assessment, dated 9/21/18 indicated the resident was cognitively impaired. Resident #24 required extensive assistance with most activities of daily living including bed mobility, locomotion and personal hygiene. During an interview with the facility's health information manager on 11/14/18 at 3:16 PM, she indicated that she is responsible for making outside appointments for residents and scheduling transportation. She stated when a resident returned to the facility from outside	F 745	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 745 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Based on record review and staff interviews, the facility failed to ensure a resident had appointments scheduled every 91 days to have her gall bladder catheter replaced as ordered by the physician for 1of 1 sampled residents for medically related social services (Resident #24). The findings included: Resident #24 was admitted to facility on 2/18/2009 with diagnoses that included cancer, dementia, and cholecystitis (accumulation of bile in the gall bladder). A review of Resident #24's medical record revealed a physician's order dated 9/22/16 which indicated her gall bladder catheter was to be changed 12/4/2017. Review of an emergency department note dated 8/19/2018 indicated Resident #24 went to the hospital due to her catheter not draining. The note further stated she missed a scheduled catheter change	

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F 745	Continued From page 23 appointments she would document the appointment and schedule transportation. She stated that she was unable to locate documentation of an appointment for Resident #24 during the period from December 2017 to August 2018 to have her gall bladder catheter changed every 91 days as ordered by the resident's physician. The health information manager stated she was unsure why an appointment was not scheduled during this period. An interview was conducted on 11/16/18 at 8:30 AM with Resident #24's primary care physician. He stated Resident #24 received comfort care and should not have the gall bladder catheter changed unless it was clogged. An interview was conducted with the Director of Nursing (DON) on 11/16/18 at 9:26 AM. She stated Resident #24 should have had an appointment scheduled prior to August 2018 to have her gall bladder catheter changed. The DON stated it is her expectation that physician orders are followed, and staff should have contacted the provider regarding an appointment to have Resident #24's gall bladder catheter changed. An interview was conducted with the Administrator on 11/16/18 at 10:02 AM. She stated it was her expectation that physician orders are followed, and a staff member should have contacted the physician regarding an appointment for Resident #24's gall bladder catheter to be changed.	F 745	February 2018. The note indicated Resident #24 was discharged back to the facility and instructed to schedule an appointment for a gall bladder catheter exchange. Review of a doctor's note dated 8/28/2018 revealed Resident#24's gallbladder was changed 8/28/2018. Review of Resident #24's most recent Minimum Data Set (MDS) assessment, dated 9/21/2018 indicated the resident was cognitively impaired. Resident #24 required extensive assistance with most activities of daily living including bed mobility, locomotion and personal hygiene. An audit was conducted 12/10/2018 on 100% of residents with a consult in last 90 days by the DON, MDS and HIMS. One issue was identified and corrected. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 12-10-2018 the Director of Nursing began in servicing all FT, PT, and PRN RN's, LPN's, Med Tech's, and Med Aides on the following procedures: • Staff educated on the importance of making 2 copies of follow up consultation	

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	345404	A. BUILDING _____ B. WING _____	C 11/16/2018

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F 745	Continued From page 24	F 745		

report for DON and HIMS.
- Staff will be educated on location of mail tray for follow up consultation reports for HIMS to pick up
- Email to be sent to DON by HIMS of next scheduled appointment,

Any in-house staff member who did not receive in-service training by 12/14/2018 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

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

The Director of Nursing, MDS Coordinator and HIM will audit consults weekly for four weeks then monthly for three months for completion of consultation follow up completion. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.

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F 745	Continued From page 25	F 745	The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or	F 801		12/14/18

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nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and

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F 801	Continued From page 27 (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to employ a clinically qualified nutritional professional on a full time basis while the currently employed dietary manager obtained dietary certification. The findings included: A record review of the facility ' s current full time Dietary Manager's employment record revealed a hire date of 5/8/18. There was no information that she was not a certified dietary manager. During an interview with the Dietary Manager (DM) on 11/15/18 at 11:35 AM she stated she began her employment with the facility in May 2018. The DM stated she was not a certified dietary manager but she had enrolled in an online class to become a certified dietary manager and had received her books. She stated the Registered Dietitian (RD) visited the facility monthly and she was able to call her on the telephone if there were any questions. She stated she was trained by corporate certified dietary managers from other facilities and the RD. During the interview the DM displayed the online course books which were located on the DM ' s desk. During a telephone interview with the Registered Dietitian on 11/16/18 at 10:30 AM she stated she was not a full time employee of the facility. She stated she worked at the facility on a consultant basis. She stated she and the certified dietary managers from other facilities assisted with	F 801	F801 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. Plan for correcting specific deficiency. The process that led to deficiency cited. A record review of the facility's current full time Dietary Manager's employment record revealed a hire date of 5/8/2018. There was no information that she was a certified dietary manager. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - The facility will employ a full-time dietitian or a full-time certified dietary manager. During the interim, an individual has been designated by the Administrator to be interim Kitchen Supervisor. Additional	

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F 801	Continued From page 28 completing the DM duties from the time the previous DM left until the new DM was hired in May. The RD explained that she thought the facility's current dietary manager had one year to complete the course work to become a certified dietary manager to meet the requirement for being a qualified nutritional professional. The Administrator was interviewed on 11/16/18 at 12:25 PM. She stated the facility's RD worked at the facility on a consultation basis and was not a full time employee of the facility. The Administrator stated the facility's current DM was not certified but she thought the facility was allowed one year from the dietary manager's hire date for her to obtain certification to be considered a qualified nutritional professional.	F 801	clinical guidance and production guidance will be provided by the Consultant Dietitian and a Certified Dietary Manager from another facility on a regular basis. Weekly updates on recruitment will be provided by the Administrator. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Position Description for the Dietary Services Director Position is being revised to meet CMS guidance. The facility is actively recruiting a qualified Dietary Manager who meets Position Description requirements. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	