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	345000	A. BUILDING _____ B. WING _____	C 06/13/2019

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AUTUMN CARE OF BISCOE	401 LAMBERT ROAD BISCOE, NC 27209

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E 000	Initial Comments An unannounced Recertification survey was conducted on 6/10/19 through 6/13/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #JR3Z11.	E 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		7/3/19

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

Electronically Signed | 06/29/2019

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, the facility failed to treat residents in a dignified manner by not answering call lights related to a request for incontinent care/toileting need which resulted in feeling ignored and disgusted for 3 of 3 sampled cognitively intact residents reviewed for dignity (Residents # 61, #71 & #32). Findings included: 1. Resident #61 was admitted to the facility on 3/26/19 with multiple diagnoses including fracture of the left humerus. The significant change in status Minimum Data Set (MDS) assessment dated 5/8/19 indicated that Resident #61's cognition was intact with the brief interview for mental status (BIMS) score of 15. The assessment further indicated that Resident #61 needed extensive assistance with transfer, toilet use and personal hygiene. The assessment revealed that Resident #61 was always incontinent of bladder and frequently incontinent of bowel. Resident #61's care plan updated on 5/8/19 was reviewed. One of the care plan problem was	F 550	Preparation and submission of this Plan of Correction is required by state and federal law. This Plan of Correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F550 Resident 71 received care on 5/11/19. Resident 61 received care on 5/31/19. Resident 32 without specified date of concern, upon interview by administrator on 6/27/19 resident reports currently receiving assistance without issue. Residents 71, 61 and 32 have been educated on reporting any concerns immediately and to whom to report by facility administrator on 6/28/19. All residents residing at the facility have the potential to be affected by alleged deficiency. A random sampling of 25 residents were interviewed by various department managers between June 17 and June 27, 2019 related to respect and dignity and	

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F 550	Continued From page 2 Resident #61 had a self-care deficit and the approaches included to assist the resident with activities of daily living, dressing, grooming, toileting, feeding, oral care as needed and weight bearing as tolerated to right lower extremity. The grievances were reviewed and there was a grievance filed on 5/11/19 regarding leaving a resident soiled in wheelchair and sitting in the bathroom commode for extended period of time. Call bell audit was conducted for 2 days (5/27-5/28/19). Additional information provided by the Administrator on 6/12/19. A Quality Assurance and Performance Improvement (QAPI) was created related to complaints from residents that staff were not responding to call lights quickly enough. Education regarding call lights was provided to all staff on 2/20/19 and an audit was conducted from 3/18/19 until 4/22/19. The nurse's note dated 5/31/19 (Friday) at 2:28 PM revealed that Resident #61 had been to her orthopedic appointment that morning and had returned to the facility. On 6/10/19 at 10:05 AM, Resident #61 was interviewed. She stated that it was a Friday when she had a doctor's appointment. She had soiled herself on her way to the appointment and when she got back to the facility she informed a staff member that she needed to be cleaned. The staff member (didn't know the name) had told the resident that she would tell the nurse aide (NA) assigned to her to come to her room. Resident #61 reported that the assigned NA never came and she waited more than 3 hours and she had pushed her call light multiple times before a staff member (didn't know her name) came and cleaned her up. The resident further stated that	F 550	wait time with no issues. All current licensed and non-licensed staff and upon hire during orientation will be educated on residents rights by department manager or administrative nurse as assigned by 7/3/19 or prior to working on the floor. In order to monitor compliance, a random sampling of 5 residents per week will be interviewed by various department managers related to respect and dignity and wait time x 8 weeks. Findings will be reported to the Quality Assessment and Assurance committee by the DON monthly x 3 for further review and recommendations.	

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she was so disgusted and feeling ignored, she reported it to the nurse (didn't know the name).

On 6/11/19 at 4:26 PM, Nurse #2 was interviewed. Nurse #2 stated that she worked 7A-7P. She reported that the facility was pretty short of NAs. Nurse #1 verified that residents had been complaining of call bells not being answered and had to wait a long time for request for incontinent care. Nurse #2 stated that the administration was aware of short staffing and they tried to hire NAs but they didn't stay.

On 6/11/19 at 4:48 PM, Nurse Aide (NA) #1 was interviewed. NA #1 stated that she worked 3-11 shift and at times 11-7 shift. She stated that she had been a NA for 27 years and this was the worst staffing she had ever experienced. The facility was "really really short of NAs". A NA was assigned 16-17 residents and most of the residents were needy and were total care. NA #1 stated that when a resident called for help, the resident had to wait until the assigned NA was available. When the assigned NA was in another resident's room providing care, the resident had to wait a long time. The NA reported that the facility had hired NAs but they had quit due to too many assigned residents and some NAs had quit due to being burned out. NA #1 verified that several residents had complained that they had to wait a long time for the call bell to be answered or had to wait a long time for the NA to provide the care. She stated that she just told the residents that they were short of staff and she tried the best she could.

On 6/12/19 at 9:00 AM, Nurse #3 was interviewed. She stated that she worked 7A-7P shift. She reported that the facility expected a lot

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from the staff with little or less staff and she felt over-whelmed.

On 6/12/19 at 10:50 AM, NA #2 was interviewed. NA #2 indicated that she worked 7-3 shift and worked over at times. NA #2 stated that she remembered one day (unable to remember the exact date), she went to Resident #61's room and the resident had mentioned that she sat in her wheelchair in her room soiled for a long time waiting to get cleaned. The NA reported that a staff member (didn't know who the staff member was) had already cleaned the resident before she got to her room. NA #2 reported that the facility was very short of NAs. A NA was assigned 14-17 residents and most of the residents were needy and total care. NA #2 verified that residents had to wait a long time for the call bells to be answered especially when the assigned NA was providing care in a resident's room. The NA also verified that she had received a lot of complaints from the residents regarding waiting for a long time for the call bell to be answered and for the care to be provided. She had been telling the residents that she was alone on the hall and was trying her best.

On 6/13/19 at 10:50 AM, the Administrator was interviewed. She stated that she expected residents to be treated with dignity and respect.

2. Resident #71 was admitted to the facility on 2/17/17 with multiple diagnoses including hypertension. The quarterly Minimum Data Set (MDS) assessment dated 5/22/19 indicated that Resident #71's cognition was intact with the brief interview for mental status (BIMS) score of 15. The assessment further indicated that Resident #71 needed extensive assistance with transfer,

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toilet use and personal hygiene. The assessment revealed that Resident #71 was frequently incontinent of bladder and bowel.

The weekly skin assessments dated 5/2/19 and 6/7/19 revealed that Resident #71 had open areas on the right upper inner thighs.

The grievances were reviewed and there was a grievance filed on 5/11/19 regarding leaving a resident soiled in wheelchair and sitting in the bathroom commode for extended period of time. Call bell audit was conducted for 2 days (5/27-5/28/19). Additional information provided by the Administrator on 6/12/19. A Quality Assurance and Performance Improvement (QAPI) was created related to complaints from residents that staff were not responding to call lights quickly enough. Education regarding call lights was provided to all staff on 2/20/19 and an audit was conducted from 3/18/19 until 4/22/19.

On 6/11/19 at 9:11 AM, Resident #71 was interviewed. She stated that her bottom and both thighs were raw for staying soiled/wet for a long time. Resident #71 reported that recently she was assisted to the bathroom by a NA and was left there with the door closed. The NA did not come back, she rang the call bell but nobody had answered. She sat at the commode for more than 45 minutes and she had to scream for help. Resident #71 indicated that she reported it and had filed a grievance about it and she was told that the staff were educated regarding answering of the call lights. The resident reported that waiting for a long time for the call light to be answered and the care to be provided was still an issue and she felt that the staff was just ignoring her concerns. Resident #71 indicated that her

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room (201) was assigned to a NA who had 300 hall. Room 201 including the call light outside the door was not in view when you were on the 300 hall. The resident indicated that when she turned her call light, she had to wait a long time (more than 45 minutes) before somebody would answer it. If the light was answered by a staff member other than the assigned NA, the staff member would let you know that she/he would get the assigned NA to come. That would take another hour or so for the assigned NA to come and to provide the care. Resident #71 stated that she could tell how long she waited by looking at the clock in her room.

On 6/11/19 at 4:26 PM, Nurse #2 was interviewed. Nurse #2 stated that she worked 7A-7P. She reported that the facility was pretty short of NAs. Nurse #1 verified that residents had been complaining of call bells not being answered and had to wait a long time for request for incontinent care. Nurse #2 stated that the administration was aware of short staffing and they tried to hire NAs but they didn't stay.

On 6/11/19 at 4:48 PM, Nurse Aide (NA) #1 was interviewed. NA #1 stated that she worked 3-11 shift and at times 11-7 shift. She stated that she had been a NA for 27 years and this was the worst staffing she had ever experienced. The facility was "really really short of NAs". A NA was assigned 16-17 residents and most of the residents were needy and were total care. NA #1 stated that when a resident called for help, the resident had to wait until the assigned NA was available. When the assigned NA was in another resident's room providing care, the resident had to wait a long time. The NA reported that the facility had hired NAs but they had quit due to too

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many assigned residents and some NAs had quit due to being burned out. NA #1 verified that several residents had complained that they had to wait a long time for the call bell to be answered or had to wait a long time for the NA to provide the care. She stated that she just told the residents that they were short of staff and she tried the best she could.

On 6/12/19 at 9:00 AM, Nurse #3 was interviewed. She stated that she worked 7A-7P shift. She reported that the facility expected a lot from the staff with little or less staff and she felt over-whelmed.

On 6/12/19 at 10:50 AM, NA #2 was interviewed. NA #2 indicated that she worked 7-3 shift and worked over at times. NA #2 stated that she remembered one day (unable to remember the exact date), she went to Resident #61's room and the resident had mentioned that she sat in her wheelchair in her room soiled for a long time waiting to get cleaned. The NA reported that a staff member (didn't know who the staff member was) had already cleaned the resident before she got to her room. NA #2 reported that the facility was very short of NAs. A NA was assigned 14-17 residents and most of the residents were needy and total care. NA #2 verified that residents had to wait a long time for the call bells to be answered especially when the assigned NA was providing care in a resident's room. The NA also verified that she had received a lot of complaints from the residents regarding waiting for a long time for the call bell to be answered and for the care to be provided. She had been telling the residents that she was alone on the hall and was trying her best.

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On 6/13/19 at 10:50 AM, the Administrator was interviewed. She stated that she expected residents to be treated with dignity and respect.

3. Resident #32 was admitted to the facility on 12/14/08 with multiple diagnoses including insomnia. The significant change in status Minimum Data Set (MDS) assessment dated 4/6/19 indicated that Resident #32's cognition was intact with brief interview for mental status (BIMS) score of 15. The assessment further indicated that Resident #32 needed limited assistance with one person physical assist with toiler use and personal hygiene. The assessment also indicated that Resident #32 was occasionally incontinent of bowel and bladder.

The grievances were reviewed and there was a grievance filed on 5/11/19 regarding leaving a resident soiled in wheelchair and sitting in the bathroom commode for extended period of time. Call bell audit was conducted for 2 days (5/27-5/28/19). Additional information provided by the Administrator on 6/12/19. A Quality Assurance and Performance Improvement (QAPI) was created related to complaints from residents that staff were not responding to call lights quickly enough. Education regarding call lights was provided to all staff on 2/20/19 and an audit was conducted from 3/18/19 until 4/22/19.

On 6/10/19 at 3:55 PM, Resident #32 was interviewed. The resident stated that she was able to ambulate with the use of the walker but at times she needed help to go to the bathroom because her legs were too weak. Resident #32 further stated that she had to wait for as long as 2 hours for the call light to be answered. The

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resident reported that she had discussed this issue with the Administrator and she was told that she was working on it. Resident #32 stated that she could tell how long she waited by looking at the clock in her room.

On 6/11/19 at 4:26 PM, Nurse #2 was interviewed. Nurse #2 stated that she worked 7A-7P. She reported that the facility was pretty short of NAs. Nurse #1 verified that residents had been complaining of call bells not being answered and had to wait a long time for request for incontinent care. Nurse #2 stated that the administration was aware of short staffing and they tried to hire NAs but they didn't stay.

On 6/11/19 at 4:48 PM, Nurse Aide (NA) #1 was interviewed. NA #1 stated that she worked 3-11 shift and at times 11-7 shift. She stated that she had been a NA for 27 years and this was the worst staffing she had ever experienced. The facility was "really really short of NAs". A NA was assigned 16-17 residents and most of the residents were needy and were total care. NA #1 stated that when a resident called for help, the resident had to wait until the assigned NA was available. When the assigned NA was in another resident's room providing care, the resident had to wait a long time. The NA reported that the facility had hired NAs but they had quit due to too many assigned residents and some NAs had quit due to being burned out. NA #1 verified that several residents had complained that they had to wait a long time for the call bell to be answered or had to wait a long time for the NA to provide the care. She stated that she just told the residents that they were short of staff and she tried the best she could.

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F 550	Continued From page 10 On 6/12/19 at 9:00 AM, Nurse #3 was interviewed. She stated that she worked 7A-7P shift. She reported that the facility expected a lot from the staff with little or less staff and she felt over-whelmed. On 6/12/19 at 10:50 AM, NA #2 was interviewed. NA #2 indicated that she worked 7-3 shift and worked over at times. NA #2 stated that she remembered one day (unable to remember the exact date), she went to Resident #61's room and the resident had mentioned that she sat in her wheelchair in her room soiled for a long time waiting to get cleaned. The NA reported that a staff member (didn't know who the staff member was) had already cleaned the resident before she got to her room. NA #2 reported that the facility was very short of NAs. A NA was assigned 14-17 residents and most of the residents were needy and total care. NA #2 verified that residents had to wait a long time for the call bells to be answered especially when the assigned NA was providing care in a resident's room. The NA also verified that she had received a lot of complaints from the residents regarding waiting for a long time for the call bell to be answered and for the care to be provided. She had been telling the residents that she was alone on the hall and was trying her best. On 6/13/19 at 10:50 AM, the Administrator was interviewed. She stated that she expected residents to be treated with dignity and respect.	F 550		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice	F 585		7/3/19

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grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of

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independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in

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F 585	Continued From page 13 accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, the facility failed to provide a written grievance summary with resolution to the person filing the grievance for 4 of 4 sampled residents reviewed (Residents # 61, #71, #32 & #4). Findings included: 1. Resident #61 was admitted to the facility on 3/26/19 with multiple diagnoses including fracture of the left humerus. The significant change in status Minimum Data Set (MDS) assessment dated 5/8/19 indicated that Resident #61's cognition was intact with the brief interview for mental status (BIMS) score of 15. The grievances were reviewed. Resident #61 had filed a grievance dated 5/17/19. The grievance indicated that Resident #61 had reported that a nurse aide (NA) had checked her at 2 and 5 AM. The NA came and uncovered her completely, left her uncovered while the NA went out the room to get washcloths. The resident also reported that the NA was always on the cell phone. The grievance form did not indicate whether the grievance was confirmed or not. The	F 585	F585 Residents 71, 61, 32 and 4 provided with copy of written grievance summary on 6/28/19 by facility administrator. Audit of June concern log by administrator on June 28, 2019 shows copy of written grievance summary not provided as previous facility practice had been upon request. Residents or resident representatives completing grievance form June 28, 2019 forward will be provided with written grievance summary by facility administrator or manager as assigned. Facility administrator to review each grievance form for completion to include written summary of grievance provided to resident or representative, weekly x 4 then monthly x 2. Review findings to be presented to Quality Assurance and Assurance committee by administrator monthly x 3 for further review and recommendations.	

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form revealed that the alleged NA was educated and she was placed on a different assignment. The form also revealed that the resolution was discussed with the resident by the Administrator. The form did not indicate that a written grievance summary was provided to the resident.

On 6/12/19 at 9:13 AM, Resident #61 was interviewed. She verified that she had filed a grievance regarding a NA who left her uncovered. The resident reported that she was told that the NA was educated and was reassigned. Resident #61 indicated that she had not received information in writing about her grievance.

On 6/12/19 at 11:20 AM, the Administrator was interviewed. She stated that she normally discussed the grievance resolution to the person filing the grievance in person or over the phone. The Administrator reported that the facility policy was to provide the written grievance summary to the person filing the grievance only upon request and the resident did not request for it.

2. Resident #71 was admitted to the facility on 2/17/17 with multiple diagnoses including hypertension. The quarterly Minimum Data Set (MDS) assessment dated 5/22/19 indicated that Resident #71's cognition was intact with the brief interview for mental status (BIMS) score of 15.

The grievances were reviewed. Resident #71 had filed written grievances on following dates:

2/18/19 - Resident #71 reported that the 3-11 shift nurse aides (NAs) had bad attitude, the way they treated and talked to her. The grievance form did not indicate whether the grievance was confirmed

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or not. The form revealed that the alleged NAs were educated on 2/26/19. The form did not indicate that a written grievance summary was provided to the resident.

3/14/19 - Resident #71 reported that that the 11-7 shift put her back to bed. The grievance form did not indicate whether the grievance was confirmed or not. The form revealed that the NA was educated. The form did not indicate that a written grievance summary was provided to the resident.

3/20/19 - A visitor reported that the dietary staff were rude to residents. The grievance form did not indicate whether the grievance was confirmed or not. The form revealed that the dietary staff were educated. The form did not indicate that a written grievance summary was provided to the visitor.

5/11/19 - Resident #71 reported that she was left in the wheelchair for extended period of time and had a bowel movement on herself and then a NA put her on the toilet and again left her there for extended period of time. The grievance form did not indicate whether the grievance was confirmed or not. The form revealed that call bell response was monitored on 5/27 and 5/28/19. The form did not indicate that a written grievance summary was provided to the resident.

On 6/12/19 at 10:05 AM, Resident #71 was interviewed. The resident verified that she had filed grievances in the past months. The resident stated that the Administrator had discussed the resolution of her grievances and would let her sign the grievance form but she was not provided a copy of the grievance summary.

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On 6/12/19 at 11:20 AM, the Administrator was interviewed. She stated that she normally discussed the grievance resolution to the person filing the grievance in person or over the phone. The Administrator reported that the facility policy was to provide the written grievance summary to the person filing the grievance only upon request and the resident did not request for it.

3. Resident #32 was admitted to the facility on 12/14/08 with multiple diagnoses including insomnia. The significant change in status Minimum Data Set (MDS) assessment dated 4/6/19 indicated that Resident #32's cognition was intact with brief interview for mental status (BIMS) score of 15.

The grievances were reviewed. Resident #32 reported on 5/27/19 that it was loud at night and she was not able to sleep due to housekeeping carts. The grievance form did not indicate whether the grievance was confirmed or not. The form did not indicate that a written grievance summary was provided to the resident.

On 6/12/19 at 11:20 AM, the Administrator was interviewed. She stated that she normally discussed the grievance resolution to the person filing the grievance in person or over the phone. The Administrator reported that the facility policy was to provide the written grievance summary to the person filing the grievance only upon request and the resident did not request for it.

On 6/12/19 at 1:40 AM, Resident #32 was interviewed. The resident stated that the Administrator had talked with her regarding her grievances. The resident stated that she had not

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F 585	Continued From page 17 received any information in writing regarding her grievance. 4. Resident #4 was admitted to the facility on 3/4/19 with diagnoses that included heart failure and breast cancer. The quarterly Minimum Data Set (MDS) assessment dated 3/11/19 indicated Resident #4 ' s cognition was fully intact. A Facility Concern/Grievance Form had been filed by Resident #4 on 4/3/19. This form indicated that a one on one discussion was had with Resident #4 on 4/5/19 related to the resolution of the grievance. This form indicated the written grievance summary was not given to Resident #4 as the resident had not requested a copy. An interview was conducted with Resident #4 on 6/10/19 at 2:16 PM. She stated that she had filed a facility grievance in the past, but she had not recalled receiving a copy of the written grievance summary reporting the findings of the investigation. An interview was conducted with the Administrator on 6/12/19 at 11:16 AM. She indicated that written grievance summaries were only provided upon request. She stated that she was unaware of the regulation that indicated a written grievance summary was to be provided to the reporting party for all grievances. The Administrator indicated that she expected the regulations related to grievances to be followed.	F 585		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		7/3/19

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§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

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F 623	Continued From page 19 (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 20 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 notify the resident and/or Responsible Party in writing of the reason for hospital discharge for 5 of 5 sampled residents reviewed for hospitalization (Residents #4, #63, #79, #85, #184). The findings included: 1. Resident #4 was admitted to the facility on 1/2/16 with diagnoses that included heart failure. The quarterly Minimum Data Set (MDS) assessment dated 7/14/18 indicated Resident #4' s cognition was intact. A medical record review revealed Resident #4 was transferred to the hospital on 8/8/18 (readmitted on 8/9/18), on 8/11/18 (readmitted on 8/30/18), on 10/30/18 (readmitted on 10/31/18)	F 623	F623 Residents 79, 63 and 4 provided with written notification of transfer on 6/28/19 by facility administrator. Residents 184 and 85, no longer in facility. An review of resident transfers June 1 to current month with written notification of transfer provided by facility administrator with completion date of 6/28/19. All licensed nursing with staff education completed on 7/2/19 by the Director of Nursing on transfer process to include proper transfer/discharge documentation. Written notice that includes the reason for transfer to be given to resident and/or responsible party as soon as practicable,	

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F 623	Continued From page 21 and on 2/27/19 (readmitted on 3/4/19). There was no documentation that written notice that included the reason for the hospital discharge was provided to Resident #4 and/or to her Responsible Party (RP) for any of these hospital discharges. On 6/13/19 at 8:45 AM Nurse #1 was interviewed. She reported that written notice that included the reason for the hospital discharge was not given to the resident and/or RP when a resident was transferred to the hospital. She stated that the RP was notified by phone when a resident was discharged to the hospital. On 6/13/19 at 9:25 AM the Assistant Director of Nursing (ADON) was interviewed. She reported that written notice that included the reason for the hospital discharge was not given to the resident and/or RP when a resident was transferred to the hospital. She stated that the RP was notified by phone when a resident was discharged to the hospital. The ADON revealed she was not aware of the regulation that indicated the facility had to notify the resident and/or RP in writing of the reason for the hospital discharge. On 6/13/19 at 9:50 AM, the Administrator was interviewed. The Administrator also revealed she was not aware of the regulation that indicated the facility had to notify the resident and/or RP in writing of the reason for the hospital discharge. The Administrator reported that she expected the regulation for notification to be followed. 2. Resident #63 was admitted to the facility on 7/20/17 with diagnoses that included end stage renal disease.	F 623	nurse may provide to resident and/or responsible party if available at time of transfer, otherwise medical records and/or administrator may provide via hand delivery or mail. Administrator or Director of Nursing will audit for proper distribution of the Notice of Transfer or Discharge to resident/resident representative, weekly x 2 months then monthly x 2. Audit findings to be reported to QAPI committee by Administrator monthly x 4 for any further review and recommendations.	

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The quarterly Minimum Data Set (MDS) assessment dated 1/4/19 indicated Resident #63 ' s cognition was intact

A medical record review revealed Resident #63 was transferred to the hospital on 1/12/19 and readmitted to the facility on 1/15/19. There was no documentation that a written notice that included the reason for the hospital discharge was provided to Resident #63 and/or to his Responsible Party (RP) for this hospital discharge.

On 6/13/19 at 8:45 AM Nurse #1 was interviewed. She reported that written notice that included the reason for the hospital discharge was not given to the resident and/or RP when a resident was transferred to the hospital. She stated that the RP was notified by phone when a resident was discharged to the hospital.

On 6/13/19 at 9:25 AM the Assistant Director of Nursing (ADON) was interviewed. She reported that written notice that included the reason for the hospital discharge was not given to the resident and/or RP when a resident was transferred to the hospital. She stated that the RP was notified by phone when a resident was discharged to the hospital. The ADON revealed she was not aware of the regulation that indicated the facility had to notify the resident and/or RP in writing of the reason for the hospital discharge.

On 6/13/19 at 9:50 AM, the Administrator was interviewed. The Administrator also revealed she was not aware of the regulation that indicated the facility had to notify the resident and/or RP in writing of the reason for the hospital discharge.

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The Administrator reported that she expected the regulation for notification to be followed.

3. Resident #184 was admitted on 3/18/19 with cumulative diagnoses of Dysphagia, Congestive Heart Failure, Adult Failure to Thrive and Alzheimer's Disease.

Resident #184 was transferred to the hospital on 6/2/19 due to a change in his level of consciousness.

Resident #184 was readmitted to the facility on 6/5/19 on hospice services.

Interview on 6/13/19 at 8:50 AM, Nurse #1 stated she did not provide Resident #184's Responsible Party (RP) a written reason he was being transferred to the hospital She stated when he went out his RP was not present, but she spoke with the RP on the phone.

Interview with the Assistant Director of Nursing (ADON) on 6/13/19 at 9:20 am stated the facility does not provide the written reason for a hospital transfer too either the resident or RP because they were unaware they had too.

Interview on 6/13/19 at 9:25 am the Director of Nursing and Administrator stated it was their expectation that the resident or RP receive a written reason for a hospital transfer.

4. Resident #79 was admitted 5/2/19 with a diagnosis of Urinary Tract Infection.

Resident #79 was transferred to the hospital on

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5/14/19 due to a significant change in his condition.

Resident #79 was readmitted to the facility on 5/24/19 with a diagnosis of Sepsis.

Interview with the Assistant Director of Nursing (ADON) on 6/13/19 at 9:20 am stated the facility does not provide the written reason for a hospital transfer too either the resident or RP because they were unaware they had too.

Interview on 6/13/19 at 9:25 am the Director of Nursing and Administrator stated it was their expectation that the resident or RP receive a written reason for a hospital transfer.

5. Resident #85 was admitted to the facility on 4/23/19.

Review of Resident #85's nurse's note dated 5/7/19 at 9:24 AM, revealed that the resident was having trouble breathing and her oxygen saturation was 87%, on 4 liters of oxygen via nasal cannula. An order was received from the physician to send the resident to the hospital. The note further revealed that the responsible party (RP) was informed that the resident was discharged to the hospital.

On 6/12/19 at 3:28 PM, the Social Worker (SW) was interviewed. The SW indicated that Resident #85 was discharged to the hospital on 5/7/19 and did not come back to the facility. The SW reported that prior to hospitalization, the family had planned to take the resident to home.

On 6/13/19 at 8:49 AM, Nurse #1 was

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F 623	Continued From page 25 interviewed. The nurse stated that she normally notified the resident's responsible party (RP) by phone or in person when at the facility when a resident was discharged to the hospital but not in writing. On 6/13/19 at 9:20 AM, the Unit Manager (UM) was interviewed. The UM stated that when a resident had an order for discharge to the hospital, the resident's information including demographics, list of medications, code status and interact form were sent to the hospital with the resident and the nurse normally notified the RP of the discharge by phone when not in the building. The UM reported that she had not notified the RP in writing of any discharges. On 6/13/19 at 10:50 AM, the Administrator was interviewed. She stated that she expected the regulation be followed when a resident was discharged to the hospital. The Administrator reported that the facility had been notifying the resident and or the RP of hospital discharge but not in writing.	F 623		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the	F 636		7/3/19

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resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.

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F 636	Continued From page 27 (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to comprehensively assess residents on the Minimum Data Set (MDS) assessment in the areas of cognition and mood (Residents #39, #63, and #66) and behaviors (Resident #63) for 3 of 19 sampled residents whose MDS assessments were reviewed. The findings included: 1. Resident #63 was admitted to the facility on 7/20/17 and most recently readmitted on 1/15/19 with diagnoses that included end stage renal disease. The quarterly Minimum Data Set (MDS) assessment dated 5/1/19 indicated Resident #63 ' s cognition was intact. The quarterly MDS assessment dated 5/12/19 indicated Resident #63 had clear speech, was understood by others, and understood others. Section C, the Cognitive Patterns section, was not assessed for Resident #63. Section D, the Mood section, was also not assessed for Resident #63. Section E, the Behavior Section was not fully assessed for Resident #63 as	F 636	F636 Resident 66, 63 and 39 were interviewed related to the areas of mood and cognition, with notation of said interviews, by social worker on 6/27/19 and modification of each on 6/28/19 related to C0100 Should Brief Interview for Mental Status be conducted? Resident 63 with chart review and modification by Minimum Data Set nurse on 6/28/19 to reflect assessment of Section E questions E0100, E0800 and E0900. All residents with any verbal ability with scheduled MDS assessment have the potential to be affected by alleged deficiency. An audit of all current residents with resident interview for cognition completed since June 1 to ensure not interviewed was not selected on the MDS was conducted by facility administrator on 6/16/19. For the one individual identified on audit, social work completed interview related to the areas of mood and cognition on 6/28/19. Modification completed on 6/28/19 by MDS nurse. An audit of all residents with MDS within	

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F 636	Continued From page 28 questions E0100 (indicators of psychosis), E0800 (rejection of care), and E0900 (wandering) were not assessed. Sections C, D, and E of Resident #63 ' s 5/12/19 MDS were completed by MDS Nurse #1. An interview was conducted with Resident #63 on 6/11/19 at 11:20 AM. Resident #63 was alert and oriented times three. An interview was conducted with MDS Nurse #1 on 6/13/19 at 8:30 AM. She stated that Resident #63 was cognitively intact. She reported that the resident interviews for the 5/12/19 quarterly MDS assessment were not completed with Resident #63 prior to the Assessment Reference Date (ARD) so she had to code these sections as not assessed. She was unable to explain why Section E was not fully completed. An interview was conducted with the Director of Nursing (DON) on 6/13/19 at 9:45 AM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS. 2. Resident #66 was admitted to the facility on 8/22/06 and most recently readmitted on 8/17/18 with diagnoses that included chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated 2/12/19 indicated Resident #66 ' s cognition was intact. The quarterly MDS assessment dated 5/15/19 indicated Resident #66 had clear speech, was understood by others, and understood others.	F 636	the last 30 days, completed by Director of Nursing on 6/28/19 that section E was fully assessed without issue. Educational instruction of licensed social worker and MDS nurses completing sections of MDS in absence of social work on 6/26/19 by Regional Clinical Reimbursement Specialist related to completion within assessment reference look back window, of resident interview in the area of cognition and mood for residents with any verbal ability to be interviewed, in event resident is unable to answer 3 or more interview questions then proceed to staff interview. MDS nurse to provide copy of MDS calendar, to individuals completing sections of MDS monthly, to serve as manual communication of MDS schedule in the event of technical/computer issues. June and July calendars provided to interdisciplinary team on 6/17/19 by MDS nurse. MDS nurse/s to review resident interviews and sections of cognition and mood sections completed per schedule monthly x 3. Findings will be reported by MDS nurse to QAPI committee for further review and recommendations.	

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The resident interview portion (C0100 - C0500) of Section C, the Cognitive Patterns section, was not assessed for Resident #66. The resident interview portion (D0100 - D0300) of Section D, the Mood section, was also not assessed for Resident #66. Sections C and D of Resident #66 ' s 5/15/19 MDS were completed by the SW.

An interview was conducted with Resident #66 on 6/10/19 at 3:00 PM. Resident #66 was alert and oriented times three.

An interview was conducted with the SW on 6/12/19 at 3:30 PM. Sections C and D of the 5/15/19 quarterly MDS for Resident #66 that indicated the resident interview portions of these sections were not assessed was reviewed with the SW. The SW stated that Resident #66 was interviewable. She was unable to explain why the resident interviews were not completed with Resident #66 for the 5/15/19 MDS.

An interview was conducted with the Director of Nursing (DON) on 6/13/19 at 9:45 AM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS.

3. Resident #39 was admitted to the facility on 10/31/16 with diagnoses that included Alzheimer ' s disease.

A Social Worker (SW) note dated 4/11/19 indicated Resident #39 was verbal but very difficult to understand at times. The SW indicated Resident #39 ' s words could be jumbled or unintelligible at times.

The quarterly Minimum Data Set (MDS)

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assessment dated 4/11/19 indicated Resident #39 was not in a persistent vegetative state and she had unclear speech. Section C, the Cognitive Patterns section, was not comprehensively assessed for Resident #39. Question C0100 was coded to indicate Resident #39 was rarely/never understood and a Brief Interview for Mental Status (BIMS) was not conducted. Section D, the Mood section, was not comprehensively assessed for Resident #39. Question D0100 was coded to indicate Resident #39 was rarely/never understood and the resident mood interview was not conducted. Sections C and D of Resident #39 ' s 4/11/19 MDS were completed by the Social Worker (SW).

An interview was conducted with Resident #39 and her family member on 6/11/19 at 11:42 AM. Resident #39 was able to state "hi" and "bye", but she was unable to answer questions with logical answers. Resident #39 ' s family member stated that she was verbal at times, but that her speech was not normally sensical.

An interview was conducted with the SW on 6/12/19 at 3:30 PM. The SW indicated she completed Sections C and D of Resident #39 ' s quarterly MDS assessment dated 4/11/19. Sections C and D of the 4/11/19 MDS for Resident #39 were reviewed with the SW. She reported that Resident #39 ' s speech was normally non-sensical, so she had not attempted the resident interviews with her. The SW indicated she was unaware of the coding instructions specified in the Resident Assessment Instrument (RAI) manual for the completion of the resident interviews in Sections C and D.

An interview was conducted with the Director of

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F 636	Continued From page 31 Nursing (DON) on 6/13/19 at 9:45 AM. She indicated her expectation was for all residents to be comprehensively assessed in all areas of the MDS.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to code the Minimum Data Set Assessment accurately in the area of cognition for 1 of 19 residents (Resident #51) reviewed. The findings included: Resident #51 was most recently readmitted to the facility on 8/9/18 with diagnoses that included cerebral infarction, heart failure, and chronic obstructive pulmonary disease. A Social Worker (SW) note dated 4/30/19 indicated Resident #51 was alert and verbal. The SW indicated she attempted the Minimum Data Set (MDS) assessment interviews with Resident #51 and she was unable to repeat three words or answer direct questions, but that she had appeared to know the answers. The SW wrote that Resident #51 was unable to say what she meant at times. The quarterly MDS assessment dated 4/30/19 indicated Resident #51 was not in a persistent vegetative state. Section C, the Cognitive	F 641	F641 Resident 51 with MDS modification on 6/28/19 by MDS nurse to reflect correction for accurate coding of cognition. All residents interviewed for cognition have the potential to be affected by alleged deficiency. An audit of all current residents with resident interview for cognition completed from June 1 to ensure areas of mood and cognition were completed without coding discrepancy was completed by administrator on 6/16/19 with no issues noted. Licensed social worker and MDS nurses completing sections of MDS in absence of social work with education by regional clinical reimbursement nurse on accurate coding of cognition on 6/26/19. MDS nurse/s to review cognition coding by social worker to ensure accurate coding with each completed MDS x 30 days then 5 random monthly x 2.	7/3/19

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F 641	Continued From page 32 Patterns section, was coded to indicate Resident #51 was rarely/never understood and that a Brief Interview for Mental Status (BIMS) was not conducted. Section D, the Mood Section, indicated a resident interview had been completed for Resident #51. Sections C and D were completed by the SW. An interview was conducted with Resident #51 on 6/10/19 at 12:25 PM. Resident #51 was slow to respond to questions but was able to answer questions with logical answers when she was given time to respond. An interview was conducted with the SW on 6/12/19 at 3:30 PM. The Section C of the 4/30/19 MDS for Resident #51 that indicated she was rarely/never understood and that the BIMS was not conducted was reviewed with the SW. The SW revealed that she had attempted the BIMS with Resident #51, but that Resident #51 was not able to answer the questions with correct answers. She stated that Resident #51 was able to answer the resident interview questions for Section D. The SW acknowledged that Section C of Resident #51 ' s 4/30/19 MDS was coded inaccurately as Resident #51 was not rarely/never understood. An interview was conducted with the Director of Nursing (DON) on 6/3/19 at 9:45 AM. She indicated she expected the MDS to be coded accurately.	F 641	Audit findings to be reported to QAPI by MDS nurse monthly x 3 for further review and recommendations.	
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	F 657		7/3/19

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F 657	Continued From page 33 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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and revise a care plan in the area of skin breakdown for 1 of 3 residents sampled for skin conditions. The findings included: Resident #4 was initially admitted to the facility on 1/2/16 most recently readmitted on 3/4/19 with diagnoses that included heart failure and breast cancer.	F 657	F657 Care plan for resident 4 was updated 6/12/19 by MDS nurse with resolution of skin alterations. All residents with care plan for alterations in skin have the potential to be affected by alleged deficiency. An audit of all current skin alteration care plans for resolution updates needed was completed by administrator on 6/17/19 with resolution updates completion on 6/20/19 by MDS nurse/s for six identified	

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F 657	Continued From page 34 The quarterly Minimum Data Set (MDS) assessment dated 3/11/19 indicated Resident #4' s cognition was intact. A medical record review revealed Resident #4 had a wound to the top of her right foot initially identified 3/5/19 and resolved on 3/16/19 and an open area to her left groin initially identified on 3/27/19 and resolved on 5/1/19. The active care plan for Resident #4 was reviewed on 6/12/19. This care plan included the focus area of the risk for skin breakdown initiated on 1/3/17 and last revised on 3/28/19. This focus area indicated Resident #4 had an area to the top of her right foot and an open area to her left groin. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 6/12/19 at 12:10 PM. Both MDS Nurses indicated that it was their shared responsibility to review and revise care plans related to skin breakdown. They indicated that new orders and discontinued orders were reviewed in the morning meetings that were held every Monday through Friday. MDS Nurse #1 and MDS Nurse #2 indicated that it was during this morning meeting that new skin issues and resolved skin issues were to be identified and reviewed and this was how they were supposed to be informed to revise the care plans. They revealed that sometimes, skin issues such as skin tears or lacerations may have been missed or overlooked causing the care plan to not be revised. They explained that other skin issues, such as pressure ulcers, were reviewed more thoroughly. The care plan related to skin breakdown for Resident #4 was reviewed with MDS Nurse #1 and MDS Nurse #2. The medical record that indicated Resident #4 ' s area to the	F 657	residents. Education of licensed nurses, by DON to document resolution of skin alterations in progress notes with completion on 7/2/19. DON or administrative nurse as assigned to report in am clinical meeting, resolution of skin alterations for MDS to update care plan accordingly. DON or administrative nurse as assigned to audit alterations in skin resolutions updated on care plan weekly x 8 weeks. Findings to be reported to QAPI by DON for further review and recommendations monthly x 2.	

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F 657	Continued From page 35 top of her right foot and the open area to her left groin were resolved was reviewed with MDS Nurse #1 and MDS Nurse #2. Both MDS Nurse ' s acknowledged this care plan was not accurate. They reported that they either were not informed that these skin issues were resolved for Resident #4, or that they missed this information during the morning meeting. An interview was conducted with the Director of Nursing on 6/13/19 at 9:45 AM. She indicated that she expected care plans to be reviewed and revised to reflect the current status of the resident.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to administer prescribed continuous oxygen at the ordered rate for 2 (Resident #30 and Resident #38) of 2 residents reviewed for oxygen therapy. The facility also failed to change a Nasal Cannula (NC) tubing weekly as ordered and failed to obtain orders to change the sterile water for humidification of continuous oxygen for 1 (Resident #30) of 2 reviewed for oxygen therapy.	F 695	F695 Oxygen delivery method adjusted by nurse to provide MD ordered rate for resident 38 and 30 on 6/12 by nurse. Resident 30 oxygen tubing and sterile water changed on 6/12/19 by nurse. Audit of all residents currently receiving oxygen delivery via concentrator or tank for visual validation of MD ordered rate completed as assigned by Director of	7/3/19

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F 695	Continued From page 36 1. Resident #30 was admitted 4/2/19 with cumulative diagnoses of Chronic Respiratory Failure and Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #30 admission Minimum Data Set (MDS) dated 4/9/19 indicated she was cognitively intact and exhibited no behaviors. She was coded for oxygen therapy. Review of Resident #30's revised care plan dated 4/15/19 read she was on oxygen therapy and staff were to administer her oxygen as ordered and oxygen per facility protocol. Review of Resident #30's June 2019 physician orders read as follows: Change oxygen cannula every week and as needed (prn) on night shift every 7 days and date NC tubing when changed. The June 2019 physician orders also read Resident #30 was to have oxygen at 2 Liters Per Minute (LPM) via NC every shift for COPD. In an observation on 6/10/19 at 1:55 PM Resident #30 was sitting up in bed. She was wearing her NC tubing that was connected to an electric oxygen concentrator. The oxygen was running at 3/LPM. The NC tubing was dated last changed 6/4/19 and the sterile water humidifying the oxygen was dated as last changed 6/4/19. Resident #30 stated she always wore oxygen and when she was not in bed, she had a portable oxygen tank secured to the back of her wheelchair. In an observation on 6/11/19 at 1:50 PM, an activity staff member was propelling Resident #30	F 695	Nursing on 6/13/19 with no issues. All residents receiving oxygen with orders updated to include humidifier bottle use on 6/14/19 by nurse as assigned by DON. Education of all licensed nurses regarding oxygen administration by Director of Nursing with completion on 7/2/19. Licensed nurse to audit alternate assignment as assigned by DON every shift x 3 days then daily x 7 days then weekly x 3 months by unit manager. Audit findings to be reported to QAPI committee by DON monthly x 3.	

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to go play bingo. She was connected to her portable oxygen running at the rate of 3/LPM.

In another observation on 6/11/19 at 4:35 PM, Resident #30 was sitting up in bed and connected to her electric oxygen concentrator. It was running at 3/LPM. The NC tubing and sterile water were both still dated 6/4/19.

In an interview on 6/11/19 at 5:10 PM Nurse #1 stated she checked on Resident #30's oxygen frequently because she required so much of it and required frequent portable oxygen tank changes. Nurse #1 stated Resident #30 was not known to adjust her own oxygen flow rate.

In an observation on 6/12/19 at 10:15 AM, Resident #30 stated she recently returned from an appointment. Her oxygen concentrator was running at 2.5/LPM. The NC tubing was still dated 6/4/19 and the sterile water was still dated as 6/4/19. Resident #30 stated the nurse came in last night and changed her nebulizer mask but that was all she changed.

A review of Resident #30's Treatment Administration Record (TAR) indicated Nurse #4 had signed out that she changed Resident #30's NC tubing on 6/11/19.

In an interview on 6/12/19 at 12:00 PM, Nurse #5 stated Resident #30 was very independent with her activities of daily living. She stated Resident #30 was known to turn the power back on to her electric oxygen concentrator once she returned to her room after an activity and returned to bed. She stated Resident #30 had never been observed changing or adjusting her oxygen flow

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rate on either her portable oxygen tank or the electric oxygen concentrator. Nurse #5 stated setting the oxygen rate was the responsibly of the nurse and the aides were not allowed to adjust oxygen settings.

In an observation on 6/12/19 at 3:00 PM, Resident #30's oxygen was running at 2.5/LPM. The NC tubing was still dated 6/4/19 and the sterile water was still dated as 6/4/19.

In an interview on 6/12/19 at 3:10 PM, the Administrator stated the facility did not have an oxygen protocol as mentioned in Resident #30's care plan and that when a resident was admitted with oxygen, the nurse had to contact the physician for orders for the oxygen rate unless it was already listed on their admission orders. The Administrator stated the nurse had to contact the physician for orders to change the NC tubing, nebulizer mask, clean filters and replace the sterile water every time a resident was admitted with oxygen.

In a telephone interview on 6/12/19 at 4:00 PM, Nurse #4 confirmed she worked with Resident #30 third shift on 6/11/19. She stated she cleaned the electric oxygen concentrator filter and changed her nebulizer mask and dated it changed on 6/11/19. When asked why she did not change the NC tubing but had signed out that she did, she stated she must have gotten confused and signed out twice for changing the nebulizer mask in the wrong place on the TAR. Nurse #4 confirmed she did not change Resident #30's NC tubing on 6/11/19. When questioned about the sterile water on the electric oxygen concentrator Nurse #4 stated she did not change it because there were no orders as to how often it

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was to be changed so she left the one dated 6/4/19 on the concentrator. She stated she did not report to anyone that Resident #30 needed orders to change her sterile water on the electric oxygen concentrator.

In an interview and observation on 6/12/19 at 4:15 PM, the Director of Nursing (DON) was asked to assess the date on the NC tubing and the sterile water. Resident #30 was not in her room and her electric oxygen concentrator was powered off. Both the NC tubing and sterile water were still dated 6/4/19. She stated it was her expectation that the NC tubing be changed on the 7th day on night shift as ordered. The DON further stated it was her expectation that the sterile water be change every 7 days on night shift as well and if there were no orders to change, it was her expectation that the nurse contact the physician for orders to change the sterile water. Regarding the multiple observations of Resident #30's oxygen not running at the ordered rate, she stated it was her expectation that Resident #30 receive her oxygen as ordered and that the nurses should assess the concentrator and tank at eye level to ensure it was running at 2/LPM continuously.

In an interview on 6/13/19 at 8:15 AM, Nursing Assistant (NA) #3 stated she had been assigned Resident #30 all week. She stated Resident #30 never adjusted her oxygen flow rate to her knowledge. NA #3 stated when Resident #30 went to Bingo on 6/12/19, she turned on Resident #30's oxygen to her portable tank at her ordered rate. NA #3 stated Resident #30's ordered oxygen rate was 3/LPM.

In an observation on 6/13/19 at 8:30 AM,

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Resident #30 was lying in bed. She stated the nurse changed her NC tubing and her sterile water on 6/12/19.

In an interview on 6/13/19 at 9:45 AM, the Administrator and DON stated it was their expectation that Resident #30's NC tubing be changed every 7 days, her sterile water for humidification of the oxygen be changed every 7 days and for her oxygen rate to be maintained by the nurse at 2/LPM as ordered.

2. Resident #38 was admitted 5/22/18 with cumulative diagnoses of lung cancer, vascular dementia and respiratory failure.

Review of Resident #38's quarterly Minimum Data Set (MDS) dated 4/10/19 indicated moderate cognitive impairment and she exhibited no behaviors. She was coded as receiving oxygen therapy.

Review of Resident #38's care plan last revised 1/21/19 read she was receiving oxygen for Chronic Obstructive Pulmonary Disease (COPD) and interventions included providing her oxygen as ordered.

Resident #38's care plan was also revised on 6/10/19 to include the following: Resident #38 was at risk by not wanting her oxygen tubing to be changed and unplugging her electric oxygen concentrator. There was no new care planned interventions related to the revision on 6/10/19 regarding her new behaviors.

Review of Resident #38's June 2019 physician

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orders read she was to receive oxygen at 4 at liters per minute (LPM) via Nasal Cannula every shift related to COPD.

In an observation on 6/12/19 at 12:00 PM, Resident #38 was sitting in a wheelchair in the main dining room eating lunch. Her portable oxygen tank was running at 2/LPM.

In an observation on 6/12/19 at 3:25 PM, Resident #38 was sitting in her wheelchair at the Nursing Station on the 100 hall. Her portable oxygen tank was observed running at 2/LPM and appeared to be empty. She did not appear in any distress.

In an interview on 6/12/19 at 3:27 PM, Nurse #6 assessed the oxygen and noted it to be empty and running at 2/LPM. Nurse #6 reviewed the oxygen orders and noted Resident #38 was to receive 4/LPM. Nurse #6 stated she changed Resident #38's portable oxygen tank earlier around 10:30 AM this morning and when she changed it, she was certain she sat it a 4/LPM. Nurse #6 stated Resident #38 was known to remove her NC tubing and unplug her electric oxygen concentrator in her room. When asked if she thought Resident #38 had the dexterity and ability to change the rate on the portable oxygen tank strapped to the back of her wheelchair, Nurse #6 stated it was possible Resident #38 changed the flow rate accidently.

In an interview on 6/12/19 at 3:40 PM, Nursing Assistant (NA) #4 stated she was assigned Resident #38 and got her up out of bed this morning. She stated when she helped Resident #38 to her wheelchair, she noticed her portable oxygen tank was empty and she rolled Resident

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F 695	Continued From page 42 #38 to the nursing station and told Nurse #6 that Resident #38 needed oxygen. NA #4 stated Resident #38 went to the dining room and lunch and she did not notice if Nurse #6 ever changed her oxygen tank. NA #4 stated the aides were not allowed to touch resident's portable tanks or electric oxygen concentrators. She stated it was the responsibility of the nurse. NA #4 stated Resident #38 was not known to tamper with her oxygen flow rate, but she was known to remove her oxygen tubing. In an interview on 6/13/19 at 9:45 AM, the Director of Nursing (DON) stated Resident #38's care plan was updated 6/10/19 because she was unplugging her oxygen concentrator and it was suspected this behavior was due to a recently diagnosed urinary tract infection. The Administrator and Director of Nursing (DON) stated it was their expectation that Resident #38's oxygen rate to be maintained by the nurse at 4/LPM as ordered.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		7/3/19

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F 725	Continued From page 43 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interview, the facility failed to provide sufficient nursing staff to ensure residents were treated with dignity and respect for 3 of 3 sampled residents reviewed for dignity (Resident #71, #61 & #32). Findings included: This tag was cross referred to: F550 - Based on record review, resident and staff interview, the facility failed to treat residents in a dignified manner by not answering call lights related to a request for incontinent care/toileting need which resulted in feeling ignored and disgusted for 3 of 3 sampled cognitively intact residents reviewed for dignity (Residents # 61, #71 & #32). On 6/13/19 at 10:50 AM, the Administrator was interviewed. She stated that the facility had a low census and she didn ' t think the facility was short	F 725	F0725 This tag was cross referred to F550: Resident 71 received care on 5/11/19. Resident 61 received care on 5/31/19. Resident 32 without specified date of concern, upon interview by administrator on 6/27/19 resident reports currently receiving assistance without issue. Residents 71, 61 and 32 have been educated on reporting concerns immediately and to whom to report by facility administrator on 6/28/19. All residents residing at the facility have the potential to be affected by alleged deficiency. A random sampling of 25 residents were interviewed by various department managers between June 17 and June 27, 2019 related to respect and dignity and wait time with no issues.	

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F 725	Continued From page 44 of staff.	F 725	Random sampling of call lights were monitored by nurse as assigned on 6/15 to include date, time to answer light and resident response to do you feel your needs were met with majority of responses within one to five minutes and all residents reporting felt needs were met. All current licensed and non-licensed staff and upon hire during orientation will be educated on residents rights by department manager or administrative nurse as assigned by 7/3/19, prior to working on the floor or upon hire. All current licensed and non-licensed staff to complete Call Bell pledge by 7/3/19, prior to working the floor or upon hire with their respective department manager or administrative nurse as assigned to facilitate understanding of each individual employee's responsibility to respond to the resident's call light to assist with or seek assistance for resident's needs. A call light competency will be completed by Director of Nursing or other administrative nurse as assigned with all current licensed nurses and certified nursing assistants by 7/3/19, prior to working the floor or upon hire during orientation to evaluate competence related to answering of/response to a call bell. In order to monitor compliance, a random sampling of 5 residents per week will be interviewed by various department	

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F 725	Continued From page 45	F 725	managers related to respect and dignity and wait time x 8 weeks. A call light monitor to include date, time to answer light and resident response to do you feel your needs were met will be completed for 3-5 random call lights daily x 7 by nurse as assigned by DON then weekly x 2 months by unit manager. Findings will be reported to the Quality Assessment and Assurance committee by the DON monthly x 3 for further review and recommendations.	
F 730 SS=B	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure nurse's aides (NAs) had documented training on the care and needs of residents with dementia for 3 of 5 sampled NAs reviewed (NAs #1, #5 & #6). Findings included: NA #1 was hired on 4/1/7. She did not have a documented training on dementia care/needs as of 6/13/19.	F 730	F730 The 3 of 5 sampled nursing assistants received dementia training from DON with completion date of 6/20/19. An audit of all current nursing assistants by Director of Nursing on 7/2/19 for prior year dementia training with eleven without documented training. All nursing assistants on staff to receive dementia training from DON or administrative nurse as assigned with completion date of 7/3/19, prior to working	7/3/19

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F 730	Continued From page 46 NA #5 was hired on 4/1/17. She did not have a documented training on dementia care/needs as of 6/13/19. NA #6 was hired on 4/1/17. She did not have a documented training on dementia care/needs as of 6/13/19. On 6/11/19 at 4:48 PM, NA #1 was interviewed. She stated that she could not recall having a dementia training. Tried to interview NA #5 and NA #6 but were not available. On 6/12/19 at 4:45 PM, the Director of Nursing (DON) was interviewed. The DON stated she could not find documentation that NAs #1, #5 and #6 were trained on dementia care/needs since their hire date. She indicated that she expected all NAs to be trained on care and needs of residents with dementia,	F 730	the floor or upon hire during orientation. DON or as assigned by DON to track dementia training completed annually for each nursing assistant on staff. DON or administrative nurse as assigned to assess monthly x 2 then quarterly x 3 all currently employed nursing assistants compliance with dementia training. Assessment findings to be reported to QAPI monthly, by DON or as assigned, x 2 then quarterly x 3 for further review and recommendations.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that	F 867	F0867 Oxygen delivery method adjusted by nurse to provide MD ordered rate for resident 38 and 30 on 6/12 by nurse. Resident 30 oxygen tubing and sterile	7/3/19

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F 867	Continued From page 47 the committee put into place following the 4/12/18 recertification survey. This was for a recited deficiency in the area of Respiratory Care (F695). This deficiency was cited again on the current recertification survey of 6/13/19. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F695 Respiratory Care: Based on observations, resident and staff interviews and record review, the facility failed to administer prescribed continuous oxygen at the ordered rate for 2 (Resident #30 and Resident #38) of 2 residents reviewed for oxygen therapy. The facility also failed to change a Nasal Cannula (NC) tubing weekly as ordered and failed to obtain orders to change the sterile water for humidification of continuous oxygen for 1 (Resident #30) of 2 reviewed for oxygen therapy. During the recertification survey of 4/12/18 the facility was cited at F695 for failing to administer prescribed continuous oxygen at the ordered rate. An interview was conducted with the Administrator on 6/13/19 at 9:05M. The Administrator indicated she was the head of the facility ' s Quality Assessment and Assurance (QAA) Committee. She stated she was aware that F695 was a repeat citation from the previous recertification survey. She indicated the Plan of Correction for the previous deficiency included education on how to properly set oxygen concentrator rates and observational monitoring to ensure that oxygen was being administered at	F 867	water changed on 6/12/19 by nurse. Audit of all residents currently receiving oxygen delivery via concentrator or tank for visual validation of MD ordered rate completed by Director of Nursing on 6/13/19 with no issues. All residents receiving oxygen with orders updated to include humidifier bottle use on 6/14/19 by nurse as assigned by DON. Education of all licensed nurses regarding oxygen administration by DON with completion on 7/2/19. Licensed nurse to verify by audit, audit to include but not limited to the oxygen delivery method in use, be it concentrator or tank, is set for administration of prescribed continuous oxygen rate, treatment record reflects weekly cleaning, oxygen sign by door, tubing change out on designated day of the week, as assigned by DON every shift x 3 days then daily x 7 days then weekly x 5 months by unit manager. Findings from audit to be presented to QAPI committee by DON monthly x 6 months for further review, root cause analysis and recommendations.	

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F 867	Continued From page 48 the ordered rate. The Administrator stated that this observational monitoring was ongoing and there had been no identified issues with oxygen being administered at the ordered rate over the past several months. She was unable to explain why this was a repeat citation.	F 867		