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E 000	Initial Comments An unannounced Recertification survey was conducted on 02/24/20 through 02/27/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# OTZ111.	E 000		
F 641 SS=E	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 and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of appliances, diagnoses, hospice, prognosis, Preadmission Screening and Resident Review (PASRR), urinary continence, and weight loss for 7 of 13 residents reviewed for hospice, PASRR, resident assessments, unnecessary medications, and urinary catheter (Residents #2, #6, #21, #32, #33, #36, and #51). Findings included: 1. Resident #21 was admitted to the facility on 07/19/16 with multiple diagnoses that included chronic pain, major depression, anxiety disorder, and a progressive disease that affects the central nervous system. Review of a PASRR Level II determination letter indicated Resident #21 had a Level II PASRR effective as of 09/06/16 with no expiration date. Review of the Hospice Recertification Statement,	F 641		

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

Electronically Signed

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with an effective date of 09/18/19, indicated Resident #21 was certified to receive Hospice services for end of life care.

The significant change MDS assessment dated 10/01/19 indicated under Section A1500 for PASRR that Resident #21 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability.

The quarterly MDS assessment dated 01/01/20 indicated under Section J1400 for Prognosis, Resident #21 had a condition or chronic disease that may result in a life expectancy of less than 6 months; however, under Section O for Special Treatments and Programs, it was not marked to indicate Resident #21 received hospice care.

During an interview on 02/25/20 at 3:06 PM, the MDS Coordinator #1 confirmed Resident #21 was admitted under hospice care on 09/18/19 which was why the significant change MDS was completed on 10/01/19. He confirmed section O was coded incorrectly and should have reflected Resident #21 received hospice care. He explained it was an oversight and a modification would be submitted.

During an interview on 02/26/20 at 3:30 PM the Social Worker (SW) shared he kept track of all residents who had a Level II PASRR but did not code section A of the MDS. He added the MDS Coordinator coded section A1500 for PASRR.

During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of MDS Coordinator #1 not

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having consistent help with completing MDS assessments the majority of the year. The DON stated she would expect for MDS assessments to be accurately coded.

During an interview on 02/26/20 at 1:08 PM, the Administrator stated she would expect for MDS assessments to be accurately coded.

During a follow-up interview on 02/27/20, the MDS Coordinator #1 confirmed Resident #21 had a PASRR Level II and the significant change MDS dated 10/01/19 was miscoded in error. He added a modification would be submitted to accurately reflect Resident #21's Level II PASRR status.

2. Resident #32 was admitted to the facility on 05/27/13 with multiple diagnoses that included hemiplegia (paralysis on one side of the body), diabetes, and obstructive uropathy (condition in which the flow of urine is blocked).

Review of Resident #32's medial record revealed a physician's order dated 02/09/18 that read in part, "Foley catheter (flexible tube inserted into the bladder to allow urinary drainage) with 16 french (catheter size) 10 cubic centimeters balloon. Change as needed for leakage or occlusion (blockage)."

The quarterly MDS assessment dated 04/17/19 indicated under Section H for Bladder and Bowel that Resident #32 had an indwelling catheter. It was further noted urinary continence was marked as "always incontinent."

The quarterly MDS assessment dated 11/18/19 indicated under Section H for Bladder and Bowel that Resident #32 had an external (condom)

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catheter.

The annual MDS assessment dated 01/09/20 indicated under Section H for Bladder and Bowel that Resident #32 had an indwelling catheter. It was further noted urinary continence was marked as "always incontinent."

During an interview on 02/26/20 at 9:24 AM, the MDS Coordinator #1 confirmed Resident #32 had an indwelling catheter. He reviewed the MDS assessments dated 04/17/19, 11/18/19 and 01/09/20 and verbalized Section H Bladder and Bowel were incorrectly coded on each assessment. He explained bowel incontinence should have been marked as "not rated" instead of "always incontinent" on the MDS dated 04/17/19 and 01/09/20. He added appliances should have been marked as "indwelling catheter" instead of "external" on the MDS dated 11/18/19. The MDS Coordinator #1 stated the errors in coding were an oversight and modifications for the MDS assessments dated 04/17/19, 11/18/19 and 01/09/20 for Resident #32 would be submitted.

During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of MDS Coordinator #1 not having consistent help with completing MDS assessments the majority of the year. The DON stated she would expect for MDS assessments to be accuracy coded.

During an interview on 02/26/20 at 1:08 PM, the Administrator stated she would expect for MDS assessments to be accurately coded.

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3. Resident #36 was admitted to the facility 06/04/15 with multiple diagnoses that included hepatic (liver) failure, major depression, and anxiety disorder.

Review of the Hospice Certification Statement, with an effective date of 01/03/20, indicated Resident #36 was certified to receive Hospice services for end of life care.

The significant change MDS assessment dated 01/13/20 indicated under Section O for Special Treatments and Programs that Resident #36 received hospice care; however, under Section J1400 for Prognosis, Resident #36 was not coded as having a condition or chronic disease that might result in a life expectancy of less than 6 months.

During an interview on 02/25/20 at 3:06 PM, the MDS Coordinator #1 confirmed Resident #36 was admitted under hospice care on 01/03/20 and explained he had been confused with the interpretation of the Resident Assessment Instrument (RAI) manual on how to code prognosis under Section J for MDS assessments. He confirmed the MDS assessment dated 01/13/20 should have been coded to reflect Resident #36 had a life expectancy of less than 6 months and verified a modification would be submitted to accurately reflect Resident #36's prognosis.

During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of MDS Coordinator #1 not having consistent help with completing MDS assessments the majority of the year. The DON

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stated she would expect for MDS assessments to be accuracy coded.

During an interview on 02/26/20 at 1:08 PM, the Administrator stated she would expect for MDS assessments to be accurately coded.

4. Resident #51 was admitted to the facility on 01/05/10 with multiple diagnoses that included diabetes, dysphagia (difficulty swallowing), epilepsy (seizures), and a condition that affects movement, muscle tone, balance, and posture.

Review of Resident #51's medical record revealed the following recorded weights:
98 pounds on 08/27/19.
95 pounds on 09/24/19.
98 pounds on 10/15/19.
96 pounds on 11/26/19.
95 pounds on 12/24/19.
94 pounds on 01/21/20.

The quarterly MDS assessment dated 01/21/20 indicated Resident #51 had a weight loss of 5% (percent) or more in the last month or 10% or more in the last 6 months and was not on a physician-prescribed weight loss regimen.

During an interview on 02/25/20 at 3:06 PM, the MDS Coordinator #1 stated either he or the Certified Dietary Manager (CDM) typically coded Section K, Nutritional Status on the MDS. He reviewed Resident #51's recorded weights and verbalized it was incorrectly coded to indicate weight loss. He added a modification would be submitted to accurately reflect Resident #51 did not have a weight loss during the MDS assessment period.

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During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of MDS Coordinator #1 not having consistent help with completing MDS assessments the majority of the year. The DON stated she would expect for MDS assessments to be accuracy coded.

During an interview on 02/26/20 at 1:08 PM, the Administrator stated she would expect for MDS assessments to be accurately coded.

During an interview on 02/26/20 at 2:40 PM, the CDM confirmed she completed Section K, Nutritional Status on the MDS assessment dated 01/21/20 for Resident #51. The CDM recalled she initially checked weight loss on the MDS assessment for Resident #51 but after clarifying his recorded weights, she realized his weight had actually remained stable during the assessment period. She explained she forgot to change the MDS assessment and weight loss was coded in error.

5. Resident #6 was admitted to the facility on 05/14/07. Her diagnoses included vascular dementia with behavioral disturbance, schizoaffective disorder and depressive disorder.

Medical record review for Resident #6 revealed the Resident's PASARR number ended in "B" indicative of PASARR Level II status. Resident #6's PASARR Level II determination letter was dated 05/21/09.

The significant change minimum data set assessment dated 11/25/19 for Resident #6 revealed the resident was severely cognitively

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impaired and exhibited verbal behaviors directed towards others on 4-6 days of the look back period. It was coded that Resident #6's behaviors put her at risk for physical injury and significantly impacted her care. The assessment indicated under Section A1500 for PASRR that Resident #6 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability.

Resident #6's care plan reviewed and continued on 12/15/19 revealed that Resident #6 had a behavior problem which included refusal of care, throwing briefs on the floor and cursing. Interventions noted that Resident #6 was a level II PASARR elated to a schizoaffective disorder.

During an interview on 02/25/20 at 3:02 PM the MDS Coordinator #1 confirmed Resident #6 had a PASRR Level II and the significant change MDS dated 11/25/19 was miscoded in error. He added a modification would be submitted to accurately reflect Resident #6's Level II PASARR status.

During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of MDS Coordinator #1 not having consistent help with completing MDS assessments the majority of the year. The DON stated she would expect for MDS assessments to be accuracy coded.

During an interview on 02/26/20 at 1:08 PM, the Administrator stated she would expect for MDS assessments to be accurately coded.

6. Resident #2 was admitted to the facility on 06/28/19 with multiple diagnoses that included

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heart failure, Alzheimer's disease, dementia, anxiety, and depression.

Review of the Hospice Recertification Statement indicated Resident #2 was certified to receive Hospice services for end of life care with an effective date of 10/18/19.

Review of progress notes dated 10/18/19 revealed Resident #2 started to receive Hospice services on the same day.

Review of the significant change in status assessment Minimum Data Set (MDS) dated 11/01/19 indicated under Section J-1400 for Prognosis, Resident #2 was not coded with a condition or chronic disease that may result in a life expectancy of less than 6 months. In addition, under Section O for Special Treatments and Programs, it was not coded to indicate Resident #2 received hospice care.

During an interview on 02/25/20 at 2:57 PM, the MDS Coordinator #1 stated the significant change MDS dated 11/01/19 was completed for Resident #2 due to her admission to Hospice on 10/18/19. He confirmed the coding for section J-1400 and section O-0100 of the significant change MDS dated 11/01/19 were incorrect. MDS Coordinator #1 explained he was confused about section J as he thought he had to have physician's documentation to indicate Resident #2 had less than 6 months of life expectancy. For section O, MDS Coordinator #1 stated it was miscoded due to his carelessness. He further stated he would modify the MDS to reflect Resident #2's actual care needs and re-submit the correction as soon as possible.

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During an interview on 02/27/20 at 9:01 am, the Director of Nursing (DON) acknowledged that she was aware of the issues identified with MDS accuracy. She stated MDS Coordinator #1 was working by himself without consistent staffing support most of the year. The DON would expect the MDS Coordinator to correct the errors and re-submit the correction as soon as possible. It was her expectation for all the MDS assessments to be coded accurately.

During an interview on 02/27/20 at 11:40 AM, the Administrator stated it was her expectation for all the MDS to be coded accurately.

7. Resident #33 was admitted to the facility on 06/29/19 with diagnosis of fractures and other multiple trauma.

A signed physician's order dated 09/20/19 indicated Resident #33 was to receive Zoloft (antidepressant) 50 milligrams (mg) 1 tablet one time a day for depression.

A review of psychiatric practitioner progress note dated 12/03/19 indicated Resident #33 had diagnoses of adjustment disorder with depressed mood and goal of treatment was to improve depression.

The quarterly Minimum Data Set (MDS) assessment dated 01/09/20 indicated Resident #33 had not been coded under Section I Active Diagnoses as having a diagnosis of depression.

A review of the Medication Administration Record (MAR) for the month of January 2020 indicated per staff documentation on the MAR that Resident #33 received Zoloft 50 mg 1 tablet one

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time a day for depression during the 7 day look back period.

On 02/26/20 at 11:00 AM an interview was conducted with the MDS Coordinator Assistant who stated she was responsible for coding Section I on Resident #33's quarterly MDS assessment dated 01/09/20. The MDS Coordinator Assistant verified that Resident #33 had a physician's order that indicated a diagnosis of depression which she did not code under Section I on the quarterly MDS assessment. The MDS Coordinator Assistant verbalized that she would need to submit a modification to the quarterly MDS assessment dated 01/09/20 to accurately reflect Resident #33 had a diagnosis of depression.

On 02/26/20 at 12:13 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the quarterly MDS assessment dated 01/09/20 would have been accurately coded to reflect Resident #33 had a diagnosis of depression. The DON shared her expectation was that the quarterly MDS dated 01/09/20 would be modified and submitted to indicate Resident #33 had diagnosis of depression.

On 02/26/20 at 1:15 PM an interview was conducted with the Administrator who stated her expectation was that the quarterly MDS assessment dated 01/09/20 would have been accurately coded to reflect Resident #33 had diagnosis of depression. She verbalized her expectation was that the quarterly MDS assessment dated 01/09/20 would be modified and submitted to accurately reflect Resident #33 had diagnosis of depression.

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F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the state mental health authority when residents with a Level II Preadmission Screening and Resident Review (PASRR) had a significant change in condition for 3 of 4 residents (Residents #6, #21 and #36) reviewed for PASRR and resident assessments. Findings included: 1. Resident #21 was admitted to the facility on 07/19/16 with multiple diagnoses that included dysphagia (difficulty swallowing), chronic pain, major depression, and anxiety disorder. Review of a PASRR Level II determination letter indicated Resident #21 had a Level II PASRR effective as of 09/06/16 with no expiration date. The significant change Minimum Data Set (MDS) assessment dated 10/01/19 revealed Resident #21 had severe impairment in cognition, required extensive to total staff assistance with activities of daily living and displayed verbal behaviors directed toward others 4 to 6 days during the MDS assessment period. It was noted under Section A1500 for PASRR that Resident #21 had not been evaluated by Level II PASRR and determined to have a serious mental illness	F 646		

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and/or intellectual disability.

During an interview on 02/25/20 at 3:06 PM, the MDS Coordinator #1 confirmed Resident #21 had a Level II PASRR and was admitted under hospice care on 09/18/19 which was why the significant change MDS was completed on 10/01/19. The MDS Coordinator #1 explained he completed Section A of the MDS but it was the Social Worker (SW) who would have notified the state mental health authority of Resident #21's change in condition.

During an interview on 02/26/20 at 3:30 PM the Social Worker (SW) shared he notified the state mental health authority whenever a resident with a Level II PASRR had a significant change in their mental condition but was unaware they also needed to be notified when there was a significant change in the resident's physical condition. He confirmed he did not notify the state mental health authority of Resident #21's significant change in physical condition when the MDS assessment dated 10/01/19 was completed.

During an interview on 02/26/20 at 1:08 PM, the Administrator explained they had not known the state mental health authority needed to be notified when a resident with a Level II PASRR had a significant change in physical condition. She added moving forward, she would expect for the state mental health authority to be notified any time a resident with a Level II PASRR had a significant change in mental or physical condition.

2. Resident #36 was admitted to the facility 06/04/15 with multiple diagnoses that included hepatic (liver) failure, schizophrenia, bipolar disorder, major depression, and anxiety disorder.

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Review of Resident #36's medical record revealed she had a Level II PASRR with an effective date of 11/03/11.

The significant change Minimum Data Set (MDS) assessment dated 01/13/20 revealed Resident #36 had severe impairment in cognition, required extensive to total staff assistance with activities of daily living and displayed no behaviors during the MDS assessment period. It was noted under Section A1500 for PASRR that Resident #36 was evaluated by Level II PASRR and determined to have a serious mental illness.

During an interview on 02/25/20 at 3:06 PM, the MDS Coordinator #1 confirmed Resident #36 had a Level II PASRR and was admitted under hospice care on 01/03/20 which was why the significant change MDS was completed on 01/13/20. The MDS Coordinator #1 explained he completed Section A of the MDS but it was the Social Worker (SW) who would have notified the state mental health authority of Resident #36's change in condition.

During an interview on 02/26/20 at 3:30 PM the Social Worker (SW) shared he notified the state mental health authority whenever a resident with a Level II PASRR had a significant change in their mental condition but was unaware they also needed to be notified when there was a significant change in the resident's physical condition. He confirmed he did not notify the state mental health authority of Resident #36's significant change in physical condition when the MDS assessment dated 01/13/20 was completed.

During an interview on 02/26/20 at 1:08 PM, the

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Administrator explained they had not known the state mental health authority needed to be notified when a resident with a Level II PASRR had a significant change in physical condition. She added moving forward, she would expect for the state mental health authority to be notified any time a resident with a Level II PASRR had a significant change in mental or physical condition.

3. Resident #6 was admitted to the facility on 05/14/07. Her diagnoses included vascular dementia with behavioral disturbance, schizoaffective disorder and depressive disorder.

Medical record review for Resident #6 revealed the Resident's PASARR number ended in "B" indicative of PASARR Level II status. Resident #6's PASARR Level II determination letter was dated 05/21/09.

The quarterly minimum data set assessment dated 11/04/19 for Resident #6 revealed the resident was severely cognitively impaired and had not exhibited any behaviors. Resident #6 required extensive assistance with bed mobility and toileting, limited assistance with personal hygiene and was independent with transferring.

The significant change minimum data set assessment dated 11/25/19 for Resident #6 revealed the resident was severely cognitively impaired and exhibited verbal behaviors directed towards others on 4-6 days of the look back period. It was coded that Resident #6's behaviors put her at risk for physical injury and significantly impacted her care. Resident #6 required extensive assistance with bed mobility, toileting, personal hygiene and transferring.

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F 646	Continued From page 15 Resident #6's care plan reviewed and continued on 12/15/19 revealed that Resident #6 had a behavior problem which included refusal of care, throwing briefs on the floor and cursing. Interventions noted that Resident #6 was a level II PASARR related to a schizoaffective disorder. During an interview on 02/26/20 at 1:53 PM the Social Worker (SW) stated he was responsible for PASARR referrals. He stated he had not notified PASARR that Resident #6 had experienced a significant change. The SW indicated he was not aware PASARR needed to be notified when a physical significant change had occurred in addition to psychological changes in condition. He stated because the resident's significant change was related to a physical decline and did not include psychological changes, he did not know it was necessary to perform a PASARR referral. During an interview on 02/27/20 at 12:23 PM the Administrator stated that it was not in the forefront of her mind that needed to be notified with all significant changes in condition. The Administrator further reported that moving forward she expected to be notified of all significant changes in condition for all residents with a level II PASARR.	F 646		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		

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(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews the facility failed to remove expired food from 1 of 1 kitchen walk-in refrigerators.

The findings included:

On 02/24/20 at 9:05 AM during the initial tour of the kitchen with the Food Service Director (FSD) observations were made of the facility's walk-in refrigerator. The walk-in refrigerator was observed to contain a five-pound container of ricotta cheese, with one quarter remaining, with an expiration date of 12/04/19. No additional containers of Ricotta cheese were observed in the walk-in refrigerator.

Review of facility menus revealed ricotta cheese was used to make lasagna and lasagna had been served on 12/31/19 and 01/28/20.

An interview was conducted with the FSD on 02/26/20 at 2:31 PM who reported that the expired container of ricotta cheese should not have been in the walk-in refrigerator, it should

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F 812	Continued From page 17 have been discarded. The FSD stated that she had ordered fresh ricotta cheese for the lasagna served on 12/31/10 and 01/28/20 and therefore the expired product would not have been used. The FSD further indicated that facility cooks were responsible for monitoring the walk-in refrigerator and discarding expired items. An interview was completed with Cook #1 on 02/27/20 at 12:27 PM who indicated that he checked the walk-in refrigerator daily for expired products. Cook #1 further reported he had seen the ricotta cheese in the refrigerator but did not see the expiration date located on the bottom of the container. Cook #1 stated that if he had seen the expiration date he would have discarded the item. The Administrator was interviewed at 12:19 PM on 02/27/20 who explained that food items that have expired should have been thrown out and should not remain in the walk-in refrigerator.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		

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must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to document in the medical record the actual date and time of a resident's discharge from the facility for 1 of 1 resident reviewed for discharge (Resident #74).

Findings included:

Resident #74 was admitted to the facility on 11/01/19 with multiple diagnoses that included displaced fracture of base of neck of left femur (thigh bone), osteoarthritis, and dementia.

The admission Minimum Data Set (MDS) dated 11/07/19 indicated Resident #74 had severe impairment in cognition and required limited to total staff assistance with all activities of daily living. Further review revealed an active discharge plan was in place for Resident #74 to return to the community.

Review of the physician's orders for Resident #74 revealed an order dated 12/12/19 that read in part, discharge to assisted living facility on 12/16/19.

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Review of Resident #74's discharge summary, signed as complete on 12/13/19, revealed plans for her to discharge to an assisted living facility on 12/16/19 at 8:00 AM.

The discharge MDS assessment dated 12/16/19 indicated Resident #74 discharged to the community.

Review of the nurse progress notes for Resident #74 revealed the last entry was a daily nursing note dated 12/15/19. There was no entry on the day of her discharge, 12/16/19, that indicated what time she left the facility, her disposition at the time of her discharge, mode of transportation, or paperwork provided to her upon discharge.

During an interview on 02/25/20 at 2:50 PM, Nurse #1 confirmed she was the nurse who was assigned to work with Resident #74 on the day of her discharge. Nurse #1 explained when a resident discharged from the facility, she typically made herself a note of what was discussed with the resident and/or their family, the resident's disposition, and the time they left the facility for her to enter a nurse note when she completed her charting for the day. Nurse #1 could not recall the time but stated she provided Resident #74's family member with her discharge paperwork when they arrived to transport her to another facility on 12/16/19 and she left without incident. Nurse #1 added she should have written a nurse progress note on the day of Resident #74's discharge but she must have forgotten.

During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) explained when a

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F 842	Continued From page 21 resident discharged from the facility, the nurse completing the discharge was expected to write a nurse progress note in the resident's medical record that included information such as the resident's disposition, date and time the resident left the facility, and who transported the resident. The DON confirmed there was no nurse progress note dated 12/16/19 for Resident #74 and stated she would have expected Nurse #1 to have documented in the medical record when Resident #74 discharged from the facility on 12/16/19.	F 842		
F 867 SS=E	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 record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain and implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification survey of 02/14/19. This was for one recited deficiency that was originally cited in February 2019 and subsequently recited on the current recertification of 02/27/20. The recited deficiency was in the area of accuracy of assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 867		

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F 867	Continued From page 22 Findings included: This tag is cross referenced to: F-641: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Sets (MDS) in the areas of appliances, diagnoses, hospice, prognosis, Preadmission Screening and Resident Review (PASRR), urinary continence, and weight loss for 7 of 13 residents reviewed for hospice, PASRR, resident assessments, unnecessary medications, and urinary catheter (Residents #2, #6, #21, #32, #33, #36, and #51). During the annual recertification survey of 02/14/19 the facility was cited for failure to code the MDS assessment to accurately reflect diagnosis for a resident reviewed for unnecessary medication. On 02/27/20 at 12:26 PM an interview was conducted with the Administrator who stated the average daily census increased and the MDS Coordinator was trying to keep up with the work load of completing MDS assessments without assistance. The Administrator shared that the facility recently added a part time MDS nurse to assist the MDS Coordinator with MDS assessments.	F 867		