STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigaion survey. Event ID #2ZTF11.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		6/15/18

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

Electronically Signed | 06/08/2018

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F 623	Continued From page 1 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual 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	F 623		

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F 623	Continued From page 2 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide the resident and resident representative a written notification for the reason for discharge to the hospital and failed to provide a copy of the notice to the Ombudsman for 2 of 2 sampled residents (Resident #251 and Resident #35) reviewed for hospitalization. The findings included: 1. Resident #251 was originally admitted to the facility on 2/17/18 and was readmitted on 5/17/18 with diagnoses including Urinary Tract Infection, Cerebral Infarction, Muscle Weakness (generalized), Aphasia following Cerebral	F 623	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. The ombudsman and legal representative for Residents #251 was notified in writing of the reason for	

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F 623	Continued From page 3 Infarction, Glaucoma, Pneumonia, Hypertension, and Type 2 Diabetes Mellitus without complications. During an interview on 5/23/18 at 4:28 PM, the facility Social Worker revealed she did not provide written notification to the resident or resident representative or a copy to the Ombudsman of the reason a resident was sent to the hospital. During an interview on 5/24/18 at 8:45 AM the Admissions Coordinator revealed she did not provide written notification to the resident or resident representative or a copy to the Ombudsman of the reason a resident was sent to the hospital. During an interview with the Director of Nursing and the Administrator on 5/24/18 at 8:52 AM the Administrator revealed when a resident was discharged to the hospital, they notified the family right away by a telephone call. She stated the Admission's Director would call families and make a note. The Administrator revealed that discharges were sent to the Ombudsman monthly via e-mail. She stated her expectation for notifying the resident or resident representative and Ombudsman about a resident's discharge to the hospital was to do whatever was required. 2. Resident # 35 was admitted to the facility on 5/22/2008 and readmitted on 3/3/18 with diagnoses Cerebrovascular Accident with Hemiplegia, Dementia, Atherosclerosis, Depression, Anxiety, Anemia and Aphasia.	F 623	discharge on 5/31/18 and for Resident #35 the legal representative was notified on 6/4/18 and the Ombudsman on 6/5/18 by the Administrator. Root cause: Lack of understanding by the facility staff regarding the regulation for written notification of the reasons for discharge or transfers. 2. A review of residents transferred from the facility within the past 30 days was conducted by the Administrator on 6/1/2018 and notifications were sent to residents□ responsible parties and Ombudsman on 6/1/2018. 3. The Social Worker, Business Office Staff, and the Licensed Nurses were in-serviced by the Administrator regarding notification of transfer and discharges to the responsible party and ombudsman on 6/14/2018. When the resident is sent to the ER, the discharge notice will be sent in the resident□s discharge envelope packet by the discharging nurse. The following business day the social worker or designee will call the resident/responsible party, notify and complete the notice of discharge and mail to the representative or resident and the Ombudsman. They will keep a copy in the medical file and log on the transitional care log. 4. The administrator will audit all transfers and discharges weekly for three months to ensure written notification has been	

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F 623	Continued From page 4 A review of the quarterly Minimum Data Set (MDS) completed on 4/4/18 revealed Resident # 35 as having short term and long term memory problems and moderately impaired for daily decision making skills. Review of Resident ' s # 35 record revealed on 2/16/18 he was transferred to the hospital for breathing difficulties. No written notice of transfer was documented to have been provided to the resident or resident representative. During an interview on 5/23/18 at 4:28 PM, the facility Social Worker revealed she did not provide written notification to the resident or resident representative or a copy to the Ombudsman of the reason a resident was sent to the hospital. During an interview on 5/24/18 at 8:45 AM the Admissions Coordinator revealed she did not provide written notification to the resident or resident representative or a copy to the Ombudsman of the reason a resident was sent to the hospital. During an interview with the Director of Nursing and the Administrator on 5/24/18 at 8:52 AM the Administrator revealed when a resident was discharged to the hospital, they notified the family right away by a telephone call. She stated the Admission's Director would call families and make a note. The Administrator revealed that discharges were sent to the Ombudsman monthly via e-mail. She stated her expectation for notifying the resident or resident representative and Ombudsman about the reason for a resident's discharge to the hospital was to do	F 623	made to the ombudsman and responsible party. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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F 623	Continued From page 5 whatever was required.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide a bed hold policy upon a resident's discharge to the hospital for 2 of 2 sampled residents (Resident #251, and Resident	F 625	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set	6/15/18

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F 625	Continued From page 6 #35) reviewed for hospitalization. The findings included: 1. Resident #251 was originally admitted to the facility on 2/17/18 and was readmitted on 5/17/18 with diagnoses including Urinary Tract Infection, Cerebral Infarction, Muscle Weakness (generalized), Aphasia following Cerebral Infarction, Glaucoma, Pneumonia, Hypertension, and Type 2 Diabetes Mellitus without complications. During an interview on 05/23/18 at 02:38 PM, Staff Nurse #3, revealed Resident #251 was readmitted to the hospital this morning for hypoxia, pneumonia and acute kidney injury. She stated the first time Resident #251 was admitted to the hospital was on 5/7/18 and she returned on 5/17/18. Staff Nurse #3 said Resident #251 was admitted to the hospital for a urinary tract infection. Staff Nurse #3 revealed Resident #251 was not on oxygen before she was discharged to the hospital. She revealed when a resident was discharged to the hospital, she sent the face sheet, medication administration record, labs and history and physical. She revealed she did not deal with the bed hold policy. She revealed she did not have a standard package of information she sent to the hospital with the resident. She revealed she made up the packet herself from copies of information in the resident's chart. During an interview on 5/23/18 at 3:00 PM, Staff Nurse #4 revealed when a resident was discharged to the hospital, she sent labs, vital signs , blood sugars, medication administration record and history and physical. When asked about the bed hold policy, Staff Nurse #4	F 625	forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. The legal representative for Residents #251 and #35 notified of the bed hold policy on 6/6/18 by the Administrator. Root cause: Lack of understanding by the facility staff regarding the regulation for written notification of the bed hold policy. 2. A review of residents transferred from the facility within the past 30 days was conducted by the social worker and written copies of the bed hold policy were sent to residents□ responsible parties on 6/6/18. 3. The Social Worker, Business Office Staff and the Licensed Nurses were in-serviced by Administrator or designee regarding notification of the bed hold policy to the resident and to the resident□s responsible party on 6/14/2018. When the resident is sent to the ER, the discharge notice Bed Hold Policy will be sent in the resident□s discharge envelope packet by the discharging nurse. The following business day the social worker or designee will call the resident/responsible party, notify and complete the bed hold notice and mail to the representative or resident, they will keep a copy in the medical file and log on the transitional	

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F 625	Continued From page 7 revealed she did not have anything to do with the bed hold policy. She stated the facility never ran into a problem with bed holds because the resident usually came back as a readmission on the long term hall. During an interview on 5/23/18 at 4:28 PM, the facility Social Worker revealed she did not have anything to do with the bed hold policy. She stated Admissions might handle that. During an interview on 5/24/18 at 8:45 AM the Admissions Coordinator revealed when Medicare residents were discharged to the hospital she would call the family to see if the wanted to hold the bed. She stated she did not deal with Medicaid residents too much because the facility has to take them back or hold the room open for them. She stated they normally hold the Medicaid resident's bed open for at least 30 days. During an interview with the Director of Nursing and the Administrator on 5/24/18 at 8:52 AM, the Administrator revealed she did not know who sent the bed hold policy to the hospital with the resident. The Administrator revealed her expectation for when a resident was discharged to the hospital was for the bed hold policy to be sent wth the resident to the hospital. 2. Resident # 35 was admitted to the facility on 5/22/2008 and readmitted on 3/3/18 with diagnoses Cerebrovascular Accident with Hemiplegia, Dementia, Atherosclerosis, Depression, Anxiety, Anemia and Aphasia. A review of the quarterly Minimum Data Set	F 625	care log. 4. The administrator will audit all transfers and discharges weekly for three months to ensure notification has been made to the ombudsman and responsible party. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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F 625	Continued From page 8	F 625		

(MDS) completed on 4/4/18 revealed Resident # 35 as having short term and long term memory problems and moderately impaired for daily decision making skills.
Review of Resident ' s # 35 record revealed on 2/16/18 he was transferred to the hospital for breathing difficulties. No written notice of transfer was documented to have been provided to the resident or resident representative.

A review of Resident ' s # 35 medical record indicated Resident # 35 ' s responsible party was a family member.
During a family interview on 5/24/18 at the family member stated that she had not received any type of bed hold notice when Resident # 35 was transferred to the hospital on 2/16/18.

During an interview with the Director of Nursing and the Administrator on 5/24/18 at 8:52 AM, the Administrator revealed she did not know who sent the bed hold policy to the hospital with the resident. The Administrator revealed her expectation for when a resident was discharged to the hospital was for the bed hold policy to be sent with the resident to the hospital.

During an interview with the Director of Nursing and the Administrator on 5/24/18 at 8:52 AM the Administrator revealed when a resident was discharged to the hospital, they notified the family right away by a telephone call. She stated the Admission's Director would call families and make a note. She revealed she did not know who sent the bed hold policy to the hospital with the resident. The Administrator revealed her expectation for when a resident was discharged to the hospital was for the bed hold to be sent with the resident to the hospital.

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F 625	Continued From page 9 During an interview on 5/24/18 at 1:44 PM staff Nurse # 2 she stated when a resident was sent out to the hospital she sent a copy of the medication list, face sheet, any recent lab work, transfer form and a copy of the Physician ' s orders. She stated she did not think she would need to send a copy of the bed hold policy.	F 625		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		6/15/18

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F 761	Continued From page 10 Based on observation and staff interviews the facility failed to dispose/discard out of date medications and supplements for 2 of 5 medication carts reviewed for medication storage. The findings included: The facility policy provided by the Director of Nursing (DON) for Storage and Expiration of Medications and Biologicals, revised on 1/1/13, read in part 4. Facility should ensure that medications and biologicals: 4.1 have an expiration date on the label; 4.2 have not been retained longer than recommended by manufacturer or supplier guidelines. 17. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis. 18. Facility should request pharmacy perform a routine nursing unit inspection for each nursing station in facility to assist facility in complying with its obligations pursuant to applicable law relating to the proper storage . . . of medications and biologicals. An inspection of the north wing medication cart was conducted on 5/22/2018 at 2:39 PM with Nurse #3 standing beside the medication cart. A bottle labeled as glucosamine sulfate 500 milligrams (mg) had as an expiration date 11/2017. A bottle labeled as cranberry supplement 450 mg had as an expiration date 1/2018. A bottle labeled as multiple vitamin with iron supplement had as an expiration date 12/2017. An interview was conducted with Nurse #3 immediately following the inspection at 2:41 PM on 5/22/2018. The nurse stated the pharmacy representative checked the medication carts, but	F 761	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. No residents were found to be affected by the expired or undated medications located on the north and east wings medication carts. The medications were removed upon notification from surveyor. Root cause: Lack of expectation for the nurses to be checking the medication carts prior to beginning their medication pass for expired and undated medication and a lack of a system for routinely checking the medication carts. 2. Any resident receiving medication has the potential to be affected. A thorough inspection of all facility medication carts was conducted by the Administrative Nursing Team to ensure there were no expired or undated medications noted on the on the medication carts 3. The licensed nurses were in-serviced by the Staff Development Coordinator or designee regarding checking the medication cart prior to the start of their medication pass for expired and undated medications on 6/14/2018 and will be added to the orientation agenda. The medication carts will be checked every Wednesday by the licensed nurses for	

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F 761	Continued From page 11 was unsure how often that occurred, and the unit manager also checked the carts. The nurse stated whoever had the medication cart should check daily, and she had done a fast check that morning, but did not see the expired medications. An inspection of the east wing medication cart was conducted on 5/22/2018 at 2:47 PM with Nurse #4 standing beside the medication cart. A box labeled sore throat lozenges was observed with no expiration date. The box was examined by Nurse #4 who stated she was unable to see an expiration date, and she should have removed the box from the cart and discarded it. An interview was conducted on 5/24/2018 at 1:16 PM with the DON. The DON stated it was the responsibility of the night shift nurse to inspect the medication cart every night, and the unit manager's responsibility to audit the medication carts weekly. The DON stated she expected an expired over the counter medication to be discarded from the medication cart.	F 761	expired medications as part of the medication reorder review. 4. The Director of Nursing or designee will complete audits of all medication carts weekly to check for expired or undated mediations until 100% compliance is maintained for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	
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. (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	F 812		6/15/18

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ROCKY MOUNT REHABILITATION CENTER	160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804

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F 812	Continued From page 12 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 maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean the steam table under shelf for one of one steam tables observed and failed to clean the double oven. The findings included: Review of the Kitchen Sanitation: Dietary Operations manual revised on 7/26/2016. Reads as follows: "Procedure 1. List daily cleaning duties on individual job tasks and on a Cleaning Schedule. Use the Dietary Cleaning Tasks & Frequencies as the guideline for equipment cleaning. 2. Post cleaning assignments for each position at least weekly." The Monthly Cleaning Schedule listed "ingredient bins, walk in freezer floor, walk in cooler floor, delime steamer, tray delivery carts, walls and the conventional oven. Review of the undated weekly cleaning schedule under Cook #1 on Tuesday listed the steam table hood. Cook # 2 on Friday listed the 4 oven doors. During an observation on 5/21/18 at 6:13 PM the 6 well steam table was observed. The 6 foot underside of the steam table shelf was observed to be covered with dark dried food particles. A second observation on 5/22/18 at 11:07 AM the 6 foot underside of the steam table shelf was	F 812	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. No residents were identified to be affected by the unclean underside of the shelf of the steam table and the unclean oven, under the shelf of the steam table and the double oven were cleaned upon notification by the surveyor. Root Cause: Lack of expectation for the dietary staff to be checking the equipment due to Dietary Manager unexpectedly resigning her position without notice and a lack of a system for routinely checking the kitchen equipment for appropriate cleaning per schedule. 2. The Administrator and the Dietary Manager conducted sanitation rounds on 6/6/2018 to ensure there were no other areas not meeting sanitation standards. If	

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F 812	Continued From page 13 observed to be covered with dark dried food particles. A third observation on 5/24/18 9:24 AM revealed the underside of the steam table shelf was in the same condition. During the initial kitchen tour on 5/21/18 at 6:16 PM the double oven was observed. Inside the oven on the right was observed with a dark dried sticky substance and three, 2 inch pieces of foil on the bottom of the oven. A second observation on 5/24/18 at 9:26 AM revealed the oven was in the same condition. In an interview on 5/24/18 at 9:31 AM the cook stated that the new cleaning schedule had not been posted yet, so staff would clean as they worked. In an interview on 5/24/18 at 9:35 AM the Certified Dietary Manger stated she would expect staff to wipe down the oven at the end of each day to avoid any buildup of debris. She indicated the oven and steam table undershelf would be cleaned that day.	F 812	sanitation standards were not met in any area, it was corrected at that time. 3. The Dietary Staff was in-serviced by the Dietary Manager on 6/11/2018 regarding sanitation cleaning schedule and the importance of checking the equipment on a daily basis for need of cleaning. The Dietitian will complete weekly sanitation rounds in the kitchen to ensure sanitation standards are maintained. 4. The Administrator will audit by conducting random sanitation inspections in the kitchen at least 3 times weekly until 100% compliance regarding the oven and under the shelf of the steam table is maintained for at least two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services	F 849		6/15/18

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when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes

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responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

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(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.

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F 849	Continued From page 17 (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview, the facility failed to coordinate care with the hospice provider for 1 of 1 residents (Resident #73) reviewed for hospice care. The findings included: Resident #73 was admitted to the facility on 3/17/16 and most recently readmitted on 1/23/18 with multiple diagnoses that included Alzheimer's, Dementia, Anxiety and Hypothyroidism.	F 849	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. The Administrator called and discussed with the hospice provider to set	

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F 849	Continued From page 18 A review of Resident #73's records revealed hospice had been ordered on 1/25/18. A consent for Hospice care from the Hospice provider signed and dated 1/25/18 was in the chart. A significant change care plan was completed in the Minimum Data Set (MDS) on 2/3/18 and was coded for hospice. The most recent MDS assessment dated 5/2/18 indicated Resident #73 had a short term memory impairment, long term memory impairment and impaired decision making. The MDS revealed Resident #73 had unclear speech. Resident #73's plan of care dated 2/9/18 included an area for Advanced Directives and stated Resident had received hospice. The care plan had a focus area of hospice care dated 4/24/18. A written agreement between the hospice provider and the facility signed on 6/10/15 was reviewed. It revealed that hospice would establish and maintain a plan of care in consultation with the nursing facility representatives. It further stated the interdisciplinary group in consultation with the nursing facility representatives shall review, revise and document the individualized plan of care. On 5/23/18 at 10:05 a.m. the medical record was reviewed and revealed the hospice current plan of care and the hospice progress notes were not in Resident #73's medical record. On 5/23/18 at 10:00 am an interview was conducted with Nurse #2. She stated Resident #73 received hospice care once a week and the hospice notes were located on the chart. On 5/23/18 interview with the Director of Nursing	F 849	the expectation regarding collaboration, communication with the facility, providing a written copy of the plan of care, and attending the scheduled care plan meeting An interdisciplinary care plan meeting to include the hospice nurse for Resident #73 has been scheduled for 6/12/18. The hospice plan of care has been placed in the medical record for Resident #73 on 5/25/18. Root Cause: Lack of training of the facility staff regarding the regulation for collaboration of care and lack of communication with the hospice provider. 2. There was one other resident in the facility receiving hospice services. The medical record of the resident was reviewed during the survey with no deficient practice noted. 3. The Interdisciplinary Care Plan Team was in-serviced by the Administrator regarding the requirement of coordination of care between the hospice providers and the facility and the requirement of establishing and maintaining a plan of care that is individualized, reviewed, revised, and documented. When a resident is placed on hospice, the Social Worker will review the chart to ensure the plan of care is placed on the chart and will schedule a care plan meeting with the Interdisciplinary Team, the resident and responsible party, and the hospice provider. The Social Worker will be responsible for inviting the hospice	

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F 849	Continued From page 19 (DON) revealed the hospice office had been contacted and medical records had been requested to be faxed to the facility. The DON stated the Social Worker #1 (SW #1) had been involved with hospice management for Resident #73. On 5/23/18 at 2:45 pm an interview was conducted with SW#1 that revealed she had an assistant SW (SW #2). She stated she took care of short term care plans and SW#2 managed hospice care plans. An interview with SW #2 revealed she had not participated in meetings with the hospice provider for Resident #73. An interview was conducted with the MDS Nurse #1 on 5/23/18 at 3:11 pm. MDS Nurse #1 indicated the facility care plan was followed for Resident #73. She further indicated if hospice wanted to change the facility care plan then an order would be placed from hospice. She revealed she had not participated in a care plan meeting with the hospice provider for Resident #73. She stated, "I never have to look at notes from hospice but if I did, I would expect to see the notes on the chart." An interview with a marketing representative from the hospice provider was conducted on 5/23/18 at 3:44 pm at the facility. He provided copies of the medical records for Resident #73. He indicated care plan meetings were conducted at the hospice office and he stated he was unaware of how the hospice care plan was communicated to the facility for Resident #73. A phone call was received from the hospice Nurse on 5/23/18 at 4:04 pm. The call revealed Resident #73 had been visited by hospice once a	F 849	provider for scheduled care plan meetings. 4. The Social Worker will audit the chart to ensure the plan of care is placed on the chart. The Social Worker will audit the chart weekly for three months to ensure visits by the hospice disciplines are recorded in the chart and ensure a representative from the hospice provider is attending the interdisciplinary care plans. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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F 849	Continued From page 20 week. The visits had occurred on different days and times due to scheduling. The hospice Nurse revealed after her assessment was complete, a verbal report was conducted to the floor nurse for Resident #73. On 5/24/18 at 9:40 a.m. the DON stated, "From my understanding, the SW works with hospice providers. I am not sure if our MDS Care Plan Nurse is involved with hospice." On 5/24/18 at 1:40 p.m. the MDS Nurse #2 was interviewed. She revealed she could not provide documentation which showed the care plan for Resident #73 had been collaborated with the hospice care planning staff. On 5/23/18 at 12:40 pm the Administrator provided the hospice Interdisciplinary current plan of care for Resident #73. These documents were indicated to have been faxed to the facility on 3/23/18 in the a.m. The Administrator stated "It is my expectation for these notes to be on the chart." On 5/24/18 at 1:55 p.m. the Administrator was interviewed. She stated, "My expectation is coordination of care plans between our facility and hospice to take place."	F 849		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information.	F 865		6/15/18

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F 865	Continued From page 21 A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility ' s Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain implemented procedures to monitor the interventions the committee put into place in October 2016. This was for a recited deficiency which was originally cited on 10/13/17 (F431, now 761). The continued failure of the facility during the two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance and Performance Improvement Program. The findings included: This tag is cross referred to: F431 (now F761). Based on observations and staff interviews the facility failed to keep an unattended medication cart locked for 1 of 4 medication carts reviewed (North wing medication cart). During the complaint survey of 10/13/17, F431 (761) was cited for failure of the facility to lock an unattended medication cart. During a recertification/complaint survey on 5/24/18, F431 (761) was cited due to expired medications found	F 865	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Facility held an ad hoc QAPI meeting on 6/11/2018 to review previous citations regarding assuring professional standards of practice are followed and having an effective QA program. Root Cause: There were transitions in multiple facility department managers which led to the facility inability to perform quality monitoring and comprehensive review of previously cited deficiencies. 2. The QA meeting has been revised and changes are being made so that previous citations will be reviewed as needed and followed up on with documentation being recorded in the QA minutes. 3. QAPI team members were in-serviced by the	

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F 865	Continued From page 22 on 2 of 5 medications carts observed. The medications included the following: one bottle of Glucosamine with the expiration date of 11/17, a multiple vitamin with iron with the expiration date of 12/17 and a cranberry supplement with the expiration date of 1/18. On 5/24/18 at 1:16 PM the Director of Nursing (DON) stated in an interview the night shift nurse checked the medication carts every night and the unit managers audit the carts weekly and she expected expired over the counter medications to be discarded. On 5/24/18 at 3:28 PM an interview was conducted with the Administrator and the Vice President (VP) of Operations who stated on 5/21/18, the facility ' s consulting pharmacist checked all the medication carts for expired medications and the nurse went behind the pharmacist and checked the cart and the expired medications were not on the cart. The VP stated they did not know how the medications got on the cart and felt it was not likely the medications had been missed for the last 6 months.	F 865	Administrator on 6/11/2018. The education included the QA program review of previous survey citations and the inclusion of on-going monitoring to maintain compliance. The QA meeting has been revised and changes are being made so that previous citations will be reviewed as needed and followed up on with documentation being recorded in the QA minutes. 4. The Administrator will document in the QA minutes the monthly review of on-going QAPI plans with the QA team for three months and as needed. The Administrator will be responsible for implementing the POC. The QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		6/15/18

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	345260	A. BUILDING _____ B. WING _____	C 05/24/2018

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F 880	Continued From page 23 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 24 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to wear a gown and gloves when in the room of a resident on contact precautions for 1 of 2 residents reviewed on contact precautions (Resident #220). The findings included: The facility policy dated 11/2016 under Contact Precautions read: "Contact Precautions are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient ' s environment. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient ' s environment. Donning PPE (Personal Protective Equipment) upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through	F 880	1. Nurse #1 and NA #1 that entered the room of Resident #220□s room without proper personal protective equipment (PPE) were in-serviced by the Staff Development Coordinator regarding isolation, what PPE is required for each type of isolation, and using only soap and water for hand sanitation with residents identified with special enteric precautions. Root Cause: Lack of routine training of the facility staff regarding isolation precautions. 2. There was one other resident in the facility on isolation and it was determined that no deficient practice regarding isolation precautions was noted at the time of survey. 3. The facility staff was in-serviced by the Staff Development Coordinator regarding	

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F 880	Continued From page 25 environmental contamination such as C. Difficile (C-Diff)." C-Diff is a bacterial infection that causes mild to life-threatening forms of diarrhea and colitis. The infection is very easily spread from one person to another. 1. Resident #220 was admitted to the facility on 5/21/18 with a diagnosis of Clostridium Difficile (C-Diff). Review of the nursing assistant ' s documentation since admission revealed the resident required extensive assistance with toileting and was incontinent of bowel. On 5/24/18 at 7:55 AM Nurse #1 was observed to prepare a medication for Resident #220. The nurse was observed to walk to the door of the resident ' s room and stated the resident was on contact precautions. There was a sign on the door that read: "CONTACT PRECAUTIONS" along with a metal rack hanging on the door containing gowns and gloves. The C ONTACT PRECAUTIONS sign read: "Wear gloves when entering room and whenever touching the patient ' s intact skin, surfaces or articles in close proximity. Wear gown when entering room and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces. The nurse was observed to enter the room without putting on a gown or gloves and went to the resident ' s bedside and with her hands moved the over bed table and the nurse ' s clothing was observed to brush the edge of the over bed table. The nurse was observed to administer the resident ' s medication and then replaced the over bed table next to the bed and	F 880	isolation, what PPE is required for each type of isolation, and using only soap and water for hand sanitation with residents identified with special enteric precautions on 6/14/2018. The facility staff will be in-serviced at least quarterly regarding what PPE is required for each type of isolation, and using only soap and water for hand sanitation with residents identified with special enteric precautions. 4. Three isolation room observations per week on each shift will be conducted by the supervisory nursing staff to ensure the facility staff are utilizing proper PPE and hand sanitation with isolation rooms. They will follow up with staff as necessary. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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F 880	Continued From page 26	F 880		

exited the room. The Nurse walked down the hall to a hand sanitizer dispenser and sanitized her hands. The Nurse was then observed to go back into the resident ' s room without a gown or gloves and placed both hands on the over bed table and leaned toward the resident to speak with the resident. The nurse was observed to go to the sink and wash her hands with soap and water and exited the room.

On 5/24/18 at 8:10 AM, the Nurse stated in an interview if she anticipated contact with body fluids she would put on a gown and gloves prior to going into the room of a resident on contact precautions.

On 5/24/18 at 9:15 AM an interview was conducted with the infection control nurse. The Nurse stated when staff entered the room of a resident on contact precautions, it did not matter what the staff member was going to do while in the room and the staff needed to put on a gown and gloves prior to entering the room.

On 5/24/18 at 11:01 AM an interview was conducted with the administrator and the director of nursing (DON). The Administrator and the DON stated the nurse should have put on a gown and gloves prior to entering the resident ' s room.

2. An interview was conducted with the infection control nurse on 5/24/18 at 9:15 AM and the Nurse stated when staff went in the room of a resident on contact precautions she would expect the staff to put on a gown and gloves prior to entering the room regardless of what the staff member was going to do while in the room.

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F 880	Continued From page 27 On 5/24/18 at 10:26 AM an observation of the room of Resident #220 revealed a sign on the door that read: "CONTACT PRECAUTIONS" along with a metal rack hanging on the door containing gowns and gloves. The contact precautions sign read: "Wear gloves when entering room and whenever touching the patient ' s intact skin, surfaces or articles in close proximity. Wear gown when entering room and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces." Nursing Assistant (NA) #1 was observed to be in the room of Resident #220. The resident was sitting in a wheelchair and the NA was brushing the resident ' s hair. The NA did not have on a gown or gloves. On 5/24/18 at 10:30 AM, NA #1 stated in an interview she had been in the room with a gown and gloves on and removed them and was leaving the room when she remembered she had not brushed the resident ' s hair. The NA stated she went back to brush the resident ' s hair and forgot to put on a gown and gloves. On 5/24/18 at 11:01 AM an interview was conducted with the administrator and the director of nursing (DON). The Administrator and the DON stated NA #1 should have on gown and gloves when in the resident ' s room.	F 880		