STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255331	A. BUILDING _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARRINGTON LIVING CENTER	701 SOUTH HOLLY STREET COLLINS, MS 39428

(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 The State Agency (SA) conducted an annual recertification survey at the facility from 07/30/19 through 08/01/19. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid requirements for participation. The SA cited F623, F625, F656, F657, and F812. The facility was licensed for 60 beds, and the census was 53 at the time of survey.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		9/5/19

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

Electronically Signed | 08/29/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to provide written notification of transfer to the resident or the Resident Representative (RR) for two (2) of four (4) hospitalizations reviewed, Resident #32 and Resident #11. Findings include:	F 623	F 623 1.On 8/1/19, the Interdisciplinary Team reviewed policy titled, "Bed Hold Policy Before and Upon Transfer" dated 11/28/17 with Quality Committee and determined all residents transferred from the facility will be provided written notification of transfer	

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F 623	Continued From page 3 Review of the facility's policy titled, "Bed Hold Policy Before and Upon Transfer", dated 11/28/17, revealed: Notice Before a 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 the resident representative that specifies the nursing facility's policies regarding bed hold periods. Notice at Time of Transfer: The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of an emergency transfer, within 24 hours. The notice must provide information to the resident that explains the duration of bed hold, if any, and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed. Resident #32 Review of the Face Sheet revealed the facility admitted Resident #32, on 6/25/19, with the included diagnoses of Unspecified Intellectual Disabilities, Bilateral Osteoarthritis of the knees, Edema, and Falling. Review of the Departmental Notes-Nursing revealed Resident #32 was sent to the hospital on 07/03/19 and returned to the facility on 07/15/19. Review of Nurses Notes, on 07/03/19 at 1:39 PM, revealed Resident #32 was sent out to the Emergency Room (ER) due to an Illuis related to a small bowel obstruction. The Nurses Note, on 07/15/19 at 8:11 PM, revealed Resident #32 returned to the facility. Nurses Note dated 07/17/19 at 8:49 PM revealed Resident #32 was status post a colectomy with formation of an	F 623	to the resident and/or Resident Representative (RR) at the time of transfer to an acute care hospital according to the facility policy coordinated with Federal Regulation Tag 0623 - 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge (LONG TERM CARE FACILITIES). Resident #11 and Resident #32 were not properly notified upon transfer according to Arrington Policy and Federal Regulations. The Facility notified Resident #11 Resident Representative of the deficient practice via mail on 9/4/19 and explained that the facility did not charge Resident #11 insurance as the result of the deficient practice. Copies of this notification were submitted to Emergency Quality Assurance (QA) Committee 9/4/19. The Administrator notified Resident #32 Resident Representative of the deficient practice via mail on 9/4/19 and explained that the facility did not charge Resident #32 insurance as the result of the deficient practice. Copies of this notification were submitted to Emergency QA Committee on 9/4/19. The Minimum Data Set Nurse did properly notify the State Ombudsmen of the both Resident #11 and #32 at the time of transfer. 2. An audit of Facility Transfers from the last 6 months was conducted on 9/4/19 by the Medicare Nurse and determined no other residents in the facility was affected by this deficient practice. All residents transferred are at risk to be affected by	

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F 623	Continued From page 4 ileostomy on 07/11/19. Today had episodes of nausea and vomiting and elevated temp. Order to send to (Name of Hospital) for evaluation by surgeon. Further review of the Nurses Notes revealed Resident #32 returned to the facility, on 07/19/2019, with diagnosis of Pneumonia. On 07/31/19 at 2:40 PM, an interview revealed the Administrator reported there was no written notification to Resident # 32 or the Resident's Representative regarding the hospital transfers. No documentation was located in Resident #32's medical record of any written notifications regarding the resident's transfers to the hospital were provided to Resident #32 or the Resident's Representative. Resident #11 Review of the Face Sheet revealed Resident # 11 was admitted by the facility, on 03/06/19, with the included diagnoses Major Depression Disorder, recurrent, severe with psychiatric symptoms, and Paranoid Schizophrenia. Review of the Department Notes-Nursing, dated 06/17/19 at 9:01 AM, revealed at 8:10 AM Resident #11 was found on the floor on her right side. The resident was assessed and no injuries were found. Resident #11 said she was going over to the roommate's side of the room and tripped on a blanket. Resident. The Department Note-Nursing on 06/17/19 at 9:29 AM revealed Resident #11 was verbalizing suicidal ideation, stated she swallowed hair pins, and she wanted to die. The Nurse Practitioner was notified and Resident #11 was transferred to the hospital for further evaluation. The suicidal ideation was	F 623	this deficient practice. 3. Interdisiciplinary Team has determined that the deficiency resulted from a lack of education of the notification requirements according to the regulation and facility policy. Regional Nurse Consultant in-serviced 8/5/2019 Resident Nurse Supervisors and Minimum Data Set Nurse on Facility "Bed Hold Policy Before and Upon Transfer" and Tag 0623 - 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge (LONG TERM CARE FACILITIES) and role of providing written notification of transfer to the resident or resident representative. Shift Resident Nurse Supervisors will be responsible for providing the written notification of transfer at the time of transfer to all residents leaving the facility for therapeutic leave or hospital stay and maintaining a copy in the resident medical chart. Copies of this written notification will be placed at each nurse station. The Minimum Data Set Nurse will review the list of discharges every morning and determine compliance with facility policy and federal regulation. This review will be reported to the facility interdisciplinary team daily during morning directors meeting. 4.The Quality Assurance Committee will monitor transfer/discharge report monthly to determine compliance with facility policy and regulatory requirements. The QA Committee will make recommendations and/or changes as needed. The Minimum Data Set Nurse will	

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F 623	Continued From page 5 reported to the Emergency Medical staff at the time of the transfer, and the hospital Emergency Room Resident #11 was transferring to. Further review of the Department Notes-Nursing revealed on 07/02/19 at 12:50 PM, Resident #11 returned to the facility. An interview, on 07/31/19 2:40 PM, revealed the Administrator stated there was no written notification to Resident #11 or the Resident's Representative regarding the hospital transfer. No documentation was located in Resident #11's medical record of any written notifications regarding the resident's transfers to the hospital were provided to Resident #32 or the Resident's Representative.	F 623	provide copies of written notifications for all residents transferred or discharged for the reported month along with copies of the notification sent to the State Ombudsmens office. Failure to comply with these requirements will result in Administrator and Director of Nursing notifying families of deficient practice, logging a performance improvement plan, and disciplinary action (if appropriate) for failure to maintain regulatory compliance.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (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	F 625		9/5/19

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F 625	Continued From page 6 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide the bed hold policy/agreement to the resident and/or Resident Representative (RR) at the time of transfer to an acute care hospital for two (2) of four (4) hospitalizations reviewed, Resident #32 and Resident #11. Findings include: Review of the facility's policy titled, "Bed Hold Policy Before and Upon Transfer", with an effective date 11/28/2017, revealed: 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 the resident's representative that specifies 3. The nursing facilities policies regarding bed hold periods. Resident #32 Review of the Face Sheet revealed the facility admitted Resident #32, on 6/25/19, with the included diagnoses of Unspecified Intellectual Disabilities, Bilateral Osteoarthritis of the knees, Edema, and Falling.	F 625	F 625 1.On 8/1/19, the Interdisciplinary Team reviewed policy titled, "Bed Hold Policy Before and Upon Transfer" dated 11/28/17, with the Quality Assurance (QA) Committee and determined all residents transferred from the facility will be provided bed hold policy/agreement to the resident and/or Resident Representative (RR) at the time of transfer to an acute care hospital according to the facility policy coordinated with Federal Regulation Tag 0625 - 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Transfer (LONG TERM CARE FACILITIES). Resident #11 and Resident #32 were not properly notified upon transfer according to Arrington Policy and Federal Regulations. The Facility notified Resident #11 s Resident Representative of the deficient practice via mail on 9/4/19 and explained that the facility did not charge Resident #11 insurance as the result of the deficient practice. Copies of this notification were submitted to Emergency QA Committee on 9/4/19. The Administrator notified Resident #32	

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F 625	Continued From page 7 Review of the Departmental Notes-Nursing revealed Resident #32 was sent to the hospital on 07/03/19 and returned to the facility on 07/15/19. Review of Nurses Notes, on 07/03/19 at 1:39 PM, revealed Resident #32 was sent out to the Emergency Room (ER) due to an Illuis related to a small bowel obstruction. The Nurses Note, on 07/15/19 at 8:11 PM, revealed Resident #32 returned to the facility. Nurses Note dated 07/17/19 at 8:49 PM revealed Resident #32 was status post a colectomy with formation of an ileostomy on 07/11/19. Today had episodes of nausea and vomiting and elevated temp. Order to send to (Name of Hospital) for evaluation by surgeon. Further review of the Nurses Notes revealed Resident #32 returned to the facility, on 07/19/2019, with diagnosis of Pneumonia. An interview, on 07/31/19 at 2:40 PM, revealed the Administrator stated there was no written notification to Resident # 32 or the Resident's Representative regarding the hospital transfers. No documentation was located in Resident #32's medical record of any written notifications regarding the resident's transfers to the hospital were provided to Resident #32 or the Resident's Representative. Resident #11 Review of the Face Sheet revealed Resident # 11 was admitted by the facility, on 03/06/19, with the included diagnoses Major Depression Disorder, recurrent, severe with psychiatric symptoms, and Paranoid Schizophrenia. Review of the Department Notes-Nursing, dated	F 625	Resident Representative of the deficient practice via mail on 9/4/19 and explained that the facility did not charge Resident #32 insurance as the result of the deficient practice. Copies of this notification were submitted to Emergency QA Committee on 9/4/19. The Minimum Data Set Nurse did properly notify the State Ombudsmen of the both Resident #11 and #32 at the time of transfer. 2. An audit of Transfers from the last 6 months conducted on 9/4/19 determined no other residents in the facility was affected by this deficient practice. 3.All residents transferred are at risk to be affected by this deficient practice. Arrington has determined that the deficiency resulted from a lack of education of the notification requirements according to the regulation and facility policy. On 8/5/2019, Regional Nurse Consultant in-serviced Resident Nurse Supervisors and Minimum Data Set Nurse on Facility "Bed Hold Policy Before and Upon Transfer" and Tag 0625 - 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Transfer (LONG TERM CARE FACILITIES) and role of providing bed hold policy/agreement to the resident or resident representative. Shift Resident Nurse Supervisors will be responsible for providing the written notification of transfer at the time of transfer to all residents leaving the facility for therapeutic leave or hospital stay and	

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F 625	Continued From page 8 06/17/19 at 9:01 AM, revealed at 8:10 AM Resident #11 was found on the floor on her right side. The resident was assessed and no injuries were found. Resident #11 said she was going over to the roommate's side of the room and tripped on a blanket. Resident. The Department Note-Nursing on 06/17/19 at 9:29 AM revealed Resident #11 was verbalizing suicidal ideation, stated she swallowed hair pins, and she wanted to die. The Nurse Practitioner was notified and Resident #11 was transferred to the hospital for further evaluation. The suicidal ideation was reported to the Emergency Medical staff at the time of the transfer, and the hospital Emergency Room Resident #11 was transferring to. Further review of the Department Notes-Nursing revealed on 07/02/19 at 12:50 PM, Resident #11 returned to the facility. During an interview, on 07/31/19 2:40 PM, the Administrator revealed there was no written notification to Resident #11 or the Resident's Representative regarding the hospital transfer. No documentation was located in Resident #11's medical record of any written notifications regarding the resident's transfers to the hospital were provided to Resident #32 or the Resident's Representative.	F 625	maintaining a copy in the resident medical chart. Copies of this written notification will be placed at each nurse station. The Minimum Data Set Nurse will review the list of discharges every morning and determine compliance with facility policy and federal regulation. This review will be reported to the facility interdisciplinary team daily during morning directors meeting. 4.The Quality Assurance Committee will monitor transfer/discharge report monthly to determine compliance with facility policy and regulatory requirements. The QA Committee will make recommendations and/or changes as needed. The Minimum Data Set Nurse will provide copies of bed hold policy/agreement for all residents transferred or discharged for the reported month along with copies of the notification sent to the State Ombudsman s office. Failure to comply with these requirements will result in Administrator and Director of Nursing notifying families of deficient practice, logging a performance improvement plan, and disciplinary action (if appropriate) for failure to maintain regulatory compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		9/5/19

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F 656	Continued From page 9 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed	F 656	F656	

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F 656	Continued From page 10 to develop a Care Plan related to a resident's behaviors, for one (1) of 18 Care Plans reviewed, Resident #15. Finding include: A review of the facility's policy titled, "Care Plan", revised 11/28/17, revealed the care plans would be developed by the interdisciplinary team to coordinate and communicate care approaches and goals for the resident related to clinical diagnosis or identified concerns. A review of Resident #15's Current Comprehensive Care Plan, with Goal and Target dates of 09/18/19, revealed no care plan for behavioral concerns. Review of the facility's Resident Incident Report, dated 02/17/19, revealed Resident #15's wheelchair was bumped by another resident's wheelchair at the dining room table and Resident #15 kicked the other resident in the ankle under the table. The incident report revealed after the investigation, the facility concluded no injuries were noted, and the residents were separated without any incident before or after. The facility determined that seating arrangements were to be changed during dining, and both residents agreed to the changes. An interview was attempted, on 07/30/19 at 3:58 PM, with Resident #15. However Resident #15 refused to talk to this surveyor related to the incident. Resident #15 was ambulatory with wheelchair in the hallway with a Certified Nursing Assistant (CNA) at her side. Resident #15 said	F 656	1. Interdisciplinary Team determined the facility did not properly execute an appropriate care plan for Resident #15 s potential for behavior based on evidence collected during the investigation of an incident occurring on 2/17/19. The facility separated both Residents during the incident and the incident has not reoccurred since. It was determined to be isolated. There was no physical harm to any patient as the result of the incident. The facility did not develop a current comprehensive care plan for the behavior noted on 2/17/19 because Resident #15 has not displayed any other behaviors or been involved in any other incidents prior to or in following Minimum Data Set Assessment periods. 2. A complete audit of all other current incidents was conducted on 8/5/2019 by the Director of Nursing determined the facility did not fail to properly care plan potential behaviors from any other resident. All residents have the ability to be affected by this deficient practice. 3. Interdisciplinary Team determined the deficient practice to have occurred as the result of the facility not reviewing the incident report properly with interdisciplinary staff to determine appropriate measures following occurrence. All Registered Nurse (RN) Supervisors were in-serviced on determining proper interventions for any incident occurring on their appropriated	

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F 656	Continued From page 11 "I'm too busy right now". An observation, on 07/31/19 at 9:59 AM, revealed Resident #15 was sitting in the dining room by the TV with other residents without any behaviors noted. A review of the Significant Change Minimum Data Set (MDS) assessment, with an Assessment Reference Dates (ARD) of 04/23/19 and 06/12/19, revealed no behaviors were documented for the review periods. A review of the Resident #15's Nurses Notes revealed no further incidents or behaviors were documented regarding since the incident on 02/17/19. An interview, on 07/31/19 3:57 PM, revealed the Director of Nursing (DON) said Resident #15 had not had any indications of this behavior prior to the incident on 02/17/19. The DON said the resident was very picky as to who she would talk to, but did not show any verbal or physical behaviors towards staff or residents before or after the incident. An interview, on 07/31/19 at 4:42 PM, with Social Service (SS) revealed she would update the care plan for Resident #15 with any behavior issues, but she said that the incident on 02/17/19 was considered a misunderstanding more than a behavior issue, and therefore she would not care plan those. An interview, on 08/01/19 at 9:53 AM, revealed the DON said she thought the facility should have care planned the incident related to behaviors for Resident #15 so staff could be aware of concerns	F 656	shifts on 8/5/19 by Regional Nurse Consultant. The interventions will be reported to the Director of Nursing and a copy of the incident report will be recorded on Facility Software. The Interdisciplinary Team will review all incident reports for the prior day during the morning director meeting to determine compliance and insure proper care plans are in place. The Director of Nursing will submit a monthly report of incidents to Quality Committee for review of compliance. 4. The Quality Committee will review monthly report of incidents and review interventions and care plans to determine all care plans are being updated daily and are individualized. The Quality Committee will approve, correct, or dismiss care plans as needed during this process.	

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F 656	Continued From page 12 or problems for the resident. Review of the Face Sheet revealed the facility admitted Resident #11, on 03/09/12, with the included diagnoses Alzheimer's Disease, Essential Tremor, and Hypertensive Heart Disease. Review of Resident #15's Significant Change MDS, with an ARD of 06/12/19, revealed a Basic Interview for Mental Status (BIMS) score was 12, which indicated moderate cognitive impairment.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		9/5/19

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F 657	Continued From page 13 (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, facility policy review, and staff interview, the facility failed to revise Resident #18's Comprehensive Care Plan for the use of an anti-coagulate medication, for one (1) of 14 care plans reviewed. Findings include: Review of the facility's policy titled, "Comprehensive Plan of Care," dated 11/26/2017, revealed it is the policy of this facility that Plans of Care are developed by the Interdisciplinary Team, to coordinate and communicate care, approaches, and goals for the resident related to clinical diagnosis or identified concerns. The facility policy stated this facility develops a comprehensive plan of care from needs that are identified in the comprehensive assessment. The facility policy stated the plan of care will be reviewed and revised: Quarterly, annually, with significant change of status, and as needed; to enhance the resident's ability to meet his/her objectives. Review of Resident #18's medical record documentation titled, "Care Plan," revealed a Problem/Need, with an onset date of 03/08/2018, for the risk of bleeding/bruising related to (r/t) the use of Aspirin and anti-platelet medications. The Care Plan's Approaches included: The Nursing department is to administer medications as ordered, and the nursing department is to Notify Medical Director (MD) as warranted. The Goal	F 657	F657 1. Administration determined the facility to be in deficient practice as evidenced by Resident #18 s comprehensive care plan for the use of anti-coagulant medications. The Minimum Data Set Nurse updated Resident #18 s care plan on 8/1/2019 for the use of anti-coagulant medications for the medication Eliquis (apixaban) five (5) milligrams (mg) to be given by mouth (PO) twice a day (BID). No harm came to Resident #18 as the result of this practice. 2. All residents receiving anti-coagulant medications are at risk for this deficient practice. The Minimum Data Set Nurse conducted an audit of all anti-coagulant, anti-platelet and thrombolytic medications used throughout the facility and determined all the care plans for these medications were accurate. It was then determined by Quality Committee on 8/5/19 that the use of anti-coagulant, anti-platelet, and thrombolytic medications would be care planned as blood thinning medications for all resident applicable. 3. The Regional Nurse Consultant in-serviced all nursing staff on the use and proper care plan of blood thinning medications on 8/5/2019. All blood thinning medications will be reviewed weekly during the facility High Risk	

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F 657	Continued From page 14 and Target Date was 09/18/2019. During an observation, on 7/30/2019 at 9:30 AM, Resident #18 was sitting in the day room area in her wheel chair. Resident #18 had multiple bruise-like areas to her Bilateral Upper Extremities (BUE). Review of Resident #18's medical record documentation titled, "August 2019 Physician Orders," revealed an order, dated 04/30/18, for the anti-coagulate medication Eliquis (apixaban) five (5) milligrams (mg) to be given by mouth (PO) twice a day (BID). The order also revealed this medication was prescribed for the diagnosis (DX) of Deep Vein Thrombosis (DVT) of the Bilateral Lower Extremities (BLE). Review of Resident #18's medical record documentation titled, "Significant Change Minimum Data Set (MDS)", with an Assessment Reference Date (ARD) of 06/12/2019, revealed section N0410E was coded that Resident #18 had received an anti-coagulate medication for the seven (7) day look back period. During an interview, on 08/01/2019 at 11:30 AM, Registered Nurse (RN) #1/ Care Plan/MDS Coordinator, confirmed the comprehensive Significant Change MDS, for 06/12/2019, was coded to indicate the resident was on an anti-coagulate medication for the seven (7) day look back period. RN #1 stated the Care Plan had not been revised to include the use of the anticoagulant medication. RN #1 stated that was an order for the anti-coagulant medication Eliquis on 04/30/2018, and it should have been added to Resident #18's Care Plan.	F 657	meeting to determine proper care plans. 4. The Quality Assurance Nurse will report and review to the committee to determine appropriate careplans, treatments, and diagnosis. The results of this review will be measured and reported monthly. The Quality Committee will review monthly the weekly reports of blood thinning medications for the prior month. The Quality Committee will make recommendations and/or changes as needed.	

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F 657	Continued From page 15 During an interview, on 08/01/2019 at 2:15 PM, the Director of Nursing (DON), confirmed the anticoagulant should have been added to Resident #18's current care plan. The DON stated the order for the medication had an order date of 04/30/2018, and was on the Physician Orders for August 2019. Review of the Face Sheet revealed the facility admitted Resident #18, on 03/08/2018 and re-admitted Resident #18 on 04/30/2019, with diagnoses to include Atherosclerotic Heart Disease and Type Two (2) Diabetes Mellitus.	F 657		
F 812 SS=F	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 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, staff interview, record	F 812	Tag 812	9/5/19

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F 812	Continued From page 16 review, and facility policy review, the facility failed to ensure dishes, pots and pans were sanitized to prevent the possibility of food borne illnesses, staff failed to wash their hands between contact with clean and dirty dishes for three (3) of three (3) kitchen observations. Findings include: Review of the facility's policy titled, "Ware Washing", dated May 2014, revealed: It is the center policy that all dishware and service ware will be cleaned and sanitized after each use. The Food Services Director insures that the nutrition service staff is knowledgeable in proper technique for processing dirty dish ware to clean through the dish machine and proper handling of sanitized dish ware. The Food Services Director ensures that all the dish machine water temperatures are maintained in accordance with manufacturer recommendations for high temperature or low temperature machines. Review of the facility's policy titled, "Manual Ware Washing", dated May 2014, revealed It is the center policy to ensure all service ware and cook ware that is not processed through the dish machine will be manually washed and sanitized. The Food Service Director ensures that the Dining Service staff is knowledgeable in proper technique for washing, rinsing, and sanitizing. An observation, on 08/01/19 at 8:43 AM, during the dishwashing machine process, two trays full of cups were run through the dish machine, the rinse water got to 140 degrees Fahrenheit (F). The dishwash machine was a hot temp machine. Dietary Department Staff (DDS) Staff # 1 staff doing the dishwashing and was observed to touch	F 812	1. On 8/1/19, the three (3) compartment sink was tested by the Quality Assurance Nurse and determined to be at 400 parts per million (ppm) according to manufacturer s recommendations. On 8/1/19, all dishes mishandled by the Dietary Department Staff (DDS) #1 were rewashed by DDS #2 for appropriate sanitation levels according to regulation standards. DD #1 was inserviced on 8/1/19 on the proper handling of dishware and infection control by Quality Assurance Nurse. On 8/1/19, the heat booster was reconnected to the facility dish machine and determined by Maintenance Director to reach appropriate rinse temperature of 180 degrees Fahrenheit. All dishes in stock were recycled through dish machine for proper sanitation levels. 2. No residents were determined to be negatively affected by this deficiency. All residents receiving meals from dietary have the potential to be affected by this deficiency. 3. On 8/26/19, all dietary employees were in-serviced by the Regional Consultant Nurse on proper handwashing and handling of dishes, Manufacturer's temperature requirements for proper sanitation when using dish machine, and appropriate ppm levels for the three (3)	

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F 812	Continued From page 17 the dirty dishes and then the clean dishes without washing her hands. DDS#1 handled the clean cups without washing her hands. DDS #2 entered the dishwashing area and also observed DDS #1 touching the clean dishes and then the dirty dishes without washing her hands in between the contacts. In an interview, on 8/01/19 at 1:30 PM, DDS #2 revealed the potential harm of the dishwasher temperature not reaching 180 degrees F was bacteria growth and infectious diseases. DDS #2 revealed the manufacturers temperature recommendations for the rinse water for the dish machine was 180 degrees F. DDS #2 also stated the harm of staff not washing their hands after handling dirty dishes and then handling clean dishes was the potential for contamination. An observation, on 07/30/19 at 10:00 AM, revealed the rinse water's chemical sanitizer level, in the three compartment sink, was required to be 200 to 400 parts per million (ppm). However, on 07/30/19 at 10:00 AM, the chemicals in the rinse water only tested at 20 ppm. An observation, on 08/01/19 at 9:00 AM, revealed, the three compartment, sink's chemical level registered at zero (0) ppm. In an interview, on 08/01/19 at 1:30 PM, DDS #2 revealed the three compartment sink chemical level was supposed to register from 150 to 400 ppm.	F 812	compartment sink. 4. On 8/29/2019, Quality Committee determined that the Dietary Director will communicate all ppm and dish machine temperatures to the Interdisciplinary Team during morning stand-up meeting for the past 24 hours. The Quality Assurance Nurse will monitor check both temperatures and ppm levels weekly 8/29/2019. The weekly reports will be reported and recorded to Quality Committee monthly by the Quality Assurance Nurse to determine compliance. Should any ppm level or temperature fluctuate from regulatory standard, it will be immediately reported to Maintenance Director and recorded monthly in Quality Committee minutes. The Quality Committee will make recommendations and/or changes as needed.	

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K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 08/29/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments ********** Survey conducted on 08/01/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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