STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185471	A. BUILDING _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAUL E PATTON EASTERN KY VETERANS CENTER	200 VETERANS DRIVE HAZARD, KY 41701

(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 A Standard Health and Life Safety Code Survey was conducted on 01/13/15-01/15/15. Deficient practice was identified at F257, F280, F282, F328, F371, and F441, with the highest Scope and Severity at 'E' level. An acceptable Plan of Correction was received on 03/12/15. A Revisit Survey was conducted on 03/24/15; F257, F280, F328, F371 and F441 were corrected as alleged; however, noncompliance continued at F282. An Abbreviated Standard Survey (KY22881) was initiated on 03/02/15 and concluded on 03/24/15. The complaint was substantiated and Immediate Jeopardy was identified on 03/10/15, and was determined to exist on 12/11/14, at 42 CFR 483.10 Resident Rights (F155 - "K"), 42 CFR 483.15 Quality of Life (F250 - "K"), 42 CFR 483.20 Resident Assessment (F279 - "K"), 42 CFR 483.25 Quality of Care (F309 - "J") and 483.75 Administration (F490 - "K"), with Substandard Quality of Care at 42 CFR 483.15 Quality of Life (F250) and 42 CFR 483.25 Quality of Care (F309). The facility was notified of the Immediate Jeopardy on 03/10/15. Additional deficient practice was identified at F425 at Scope and Severity of a "D" level. Continued non-compliance was identified F282 at a Scope and Severity of a D". The facility failed to ensure that Resident #1's Living Will, which directed that treatment be withheld or withdrawn and that he/she be permitted to die naturally with only the administration of medication or medical treatment deemed necessary to alleviate pain, was transferred to the hospital with the resident on 12/11/14. As a result of the facility's failure,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] LNHA — TITLE: Administrator — (X6) DATE: 5/1/2015

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 000	Continued From page 1 Resident #1 received life-sustaining treatment including intubation with mechanical ventilation during his/her hospitalization from 12/11/14-12/16/14. The resident was transferred back to the facility on 12/16/14. A partial extended survey was conducted on 03/23-24/15. An acceptable Allegation of Compliance was received on 03/24/15, which alleged removal of the Immediate Jeopardy on 03/23/15. The State Survey Agency determined the Immediate Jeopardy was removed on 03/23/15 as alleged, which lowered the Scope and Severity to an "E" at 42 CFR 483.10 Resident Rights (F155), 42 CFR 483.15 Quality of Life (F250), 42 CFR 483.20 Resident Assessment (F279), 42 CFR 483.75 Administration (F490); and, 42 CFR 483.25 Quality of Care (F309) Scope and Severity of a "D", while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000		
F 155 SS=K	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This	F 155	1. ***ADDRESS WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.*** RESIDENT #1 ***On 3/11/15,*** an emergency Interdisciplinary Care Conference was conducted by phone with Resident #1's Health Care Surrogate. The Interdisciplinary Care Conference Team consisting of the Administrator,	***05/15/15***

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F 155	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, hospital record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure that the rights of five (5) of twenty-four (24) sampled residents (Residents #1, #2, #4, #5 and #6) to execute and implement advance directives related to life-sustaining treatment were protected and promoted. On 12/11/14, the facility transferred Resident #1 to the hospital due to shortness of breath and labored respirations. However, the facility failed to ensure Resident #1's Living Will, which directed that no life-sustaining treatments or medications be administered to the resident, was transferred with the resident to the hospital. On 12/12/14, Resident #1 was intubated and placed on mechanical ventilation until he/she was extubated on 12/13/14. Resident #1 returned from the hospital, to the facility on 12/16/14. On 02/17/15, the facility initiated intravenous (IV) fluids for Resident #1; however, the resident's Living Will directed the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids (Refer to F250, F279, F309, and F490). The facility admitted Resident #2 with an Advance Directive that stated the resident's Power of	F 155	Assistant Administrator, DON, ADON, Nurse Manager, Social Worker, MDS Coordinator, Clinical Dietician and Attending Physician reviewed all components of the Living Will with the Health Care Surrogate to ensure it included Resident #1's wishes. ***Changes to Resident #1's code status as directed by the Health Care Surrogate during this call were noted, orders received by the Attending Physician, and care plan and medical record were updated with these changes.*** RESIDENT #2 On 3/11/15 an emergency Interdisciplinary Care team that included the Administrator, Assistant Administrator, DON, ADON, Nurse Manager, Social Worker, MDS Coordinator, Clinical Dietician and ***Attending*** Physician conducted a meeting via telephone with Resident #2's Durable Power of Attorney. The DPOA confirmed the information in the DPOA document provided on admission on 1/20/15 was correct and reflected the current wishes of the resident. ***The care plan team informed DPOA that the resident has the right to refuse treatment and***	

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F 155	Continued From page 3 Attorney (POA) could refuse or withdraw consent to any type of medical care or treatment including but not limited to artificially administered nutrition or hydration. The facility failed to have a system to ensure staff was knowledgeable of residents' advance directive wishes. Staff was not aware Resident #2 had an advance directive. On 01/22/15, staff notified Resident #2's family member that, if after testing the resident could have nothing by mouth, the resident would require "a tube feeding, hospice, or to be discharged from the facility." (Refer to F250, F279, and F309) On 02/25/15, the facility transferred Resident #4 to the Emergency Department for treatment; however, according to the hospital's Emergency Department Chart the facility failed to send the resident's Living Will with the resident (Refer to F250). In addition, review of the medical records for Resident #5 and Resident #6 revealed the residents had Advanced Directives. The facility failed to ensure the Advanced Directives were in the residents' medical record and that staff was knowledgeable of the Advanced Directives (Refer to F250). The facility's failure to have an effective system in place to establish, maintain, and implement policies and procedures regarding the residents' right to execute and implement advance directives was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 12/11/14 at 42 CFR 483.10 Resident Rights (F155), 42 CFR 483.15 Quality of Life (F250), 42 CFR 483.20 Resident Assessment (F279), and 42 CFR 483.25 Quality	F 155	***would not be discharged from the facility.*** RESIDENT # 4 On 3/16/15 Resident #4's medical record was reviewed by the Social Worker to ensure the resident's Advance Directives were in the ***Advance Directive section*** of the medical record. On 3/17/15 the Social Worker talked with Resident #4 and confirmed there were no changes to his Advance Directives. RESIDENT # 5 On 3/11/15 the social worker talked with Resident #5's legal representative to ***request*** copies of the POA papers that were not provided upon admission. ***Family provided Guardianship papers to facility on 3/13/15 and these were placed on the chart in the Advance Directives section of medical record.*** RESIDENT # 6 ***On 3/13/15 Social Services obtained a copy of resident #6's living will and placed it in the Advance Directive section of the resident's medical record. The resident's State Guardian confirmed by phone the***	

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F 155	Continued From page 4 of Care (F309); and, 42 CFR 483.75 Administration (F490). The facility was notified of the Immediate Jeopardy on 03/10/15. An acceptable Allegation of Compliance was received on 03/24/15 which alleged removal of the Immediate Jeopardy on 03/23/15. A Partial Extended Survey was conducted on 03/23-24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 03/23/15, which lowered the Scope and Severity to "E" at 42 CFR 483.10 Resident Rights (F155), 42 CFR 483.15 Quality of Life (F250), 42 CFR 483.20 Resident Assessment (F279), 42 CFR 483.75 Administration (F490); and,42 CFR 483.25 Quality of Care (F309) Scope and Severity of a "D", while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy, Resident Rights, reviewed by the facility on 07/07/08, revealed the policy did not specifically address advance directives. Review of the facility's Advance Directives policy and procedure, reviewed by the facility on 07/24/12, revealed Social Services staff or others designated by the Administrator, would meet with the resident and/or legal representative and explain Advance Directives. Social Services or designees would assist residents to execute an advance directive. The facility would have an Advance Directive Committee consisting of the Administrator/Assistant Administrator, Medical Director, Director of Nursing (DON), Director of Social Services (DSS), Primary Care Nurse, Resident/Resident's Responsible Party, and Concerned Individual/Family Member that would	F 155	***Advance Directive on file was current.*** 2 ***ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE.*** ***The facility determined that all current residents and new admissions have the potential to be affected by the same deficient practice.*** As of 3/26/15 a review of all current residents' charts have been completed by the Director of Social Services or the Social Worker to ensure all Advance Directives, which include DPOA, POA, Health Care Surrogate, Guardianship and Living Wills are correct, on the chart and in the ***advance directive section of the medical record. All residents or their designated representatives were interviewed or contacted to confirm their current advance directives and code status reflect the resident's wishes.*** ***For new admissions, the admissions coordinator will obtain a copy of any advance directive during the***	

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F 155	Continued From page 5 meet and review any situation of concern related to advance directives. The policy also stated that any person may bring a situation of concern to any member of the Advance Directive Committee member, and that member would be responsible for calling a committee meeting. The facility's policy did not address how the facility would ensure that advance directives were transferred with residents to other health care facilities when the resident was transferred from the facility. In addition, the facility's policy did not address how the facility would ensure all staff was knowledgeable of the residents' advance directive wishes. 1. Review of Resident #1's medical record revealed the facility admitted the resident on 02/19/09, with diagnoses which included Dementia, Insomnia, Paranoia, Diabetes Mellitus, and Hypertension. Further review revealed a Living Will Directive and Health Care Surrogate Designation formulated by Resident #1 which had been notarized and filed on 07/14/08. The Living Will specified that Resident #1 chose to have life-prolonging treatment and medication withheld or withdrawn and be permitted to die naturally with only the administration of pain-alleviating medication or treatment. Review of Resident #1's Resident's Rights/Advance Directives form dated 02/19/09, revealed the resident had initialed and signed the form which the DSS witnessed on 02/19/09, indicating that the resident had executed advance directives and had a designated Power of Attorney (POA). However, review of Resident #1's admission Minimum Data Set (MDS) assessment dated 02/28/09 revealed the facility had assessed Resident #1 to have executed no	F 155	***admission process. A copy of the advance directive will then be provided to finance, nursing administration, social services and the respective unit supervisor where the resident will reside. The ward clerk on that unit will then place the unit copy of the residents advance directive on the medical record in the advance directive section.*** ***The Unit Managers or Charge Nurses confirm that the Advance Directives section of each resident's chart is sent with the resident by the licensed staff on duty at the time of transfer.*** ***On 3/23/15 the Dietetic Administrator reviewed all dietary assessments of the active charts for the last 15 months. This was done to ensure all residents 1) had been assessed on a quarterly basis and 2) to ensure nutritional needs of residents' were addressed and updated to include specifically NPO status, need for mechanically altered diets and/or enteral feeding regimens, among other nutrition related needs and 3) to ensure that no other residents wishes were violated or addressed in such a manner as to inform any resident***	

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F 155	Continued From page 6 advance directives. Review of Resident #1's initial Comprehensive Care Plan, dated 03/02/09, and the most recent Comprehensive Care Plan dated 02/25/15, revealed that although Resident #1's cardiopulmonary resuscitation (CPR) designation had been included on both care plans, the resident's Living Will Directive and Health Care Surrogate Designation, had not been included in the resident's Comprehensive Plan of Care. Review of a Nursing Note dated 12/11/14, at 4:42 AM, revealed Registered Nurse (RN) #1 assessed the resident to have audible wheezing throughout his/her lung fields, labored respirations, and pitting edema. RN #1 notified Resident #1's Physician, and the resident was transferred to the hospital for further evaluation and treatment. Interview with RN #1 on 03/09/15, at 3:40 PM, revealed at the time she transferred Resident #1 to the hospital on 12/11/14, she completed a facility transfer form which contained resident specific information such as vital signs at the time of transfer, weight, and diagnoses for Resident #1. This form along with a copy of the resident's "Face Sheet" and medication list was sent to the hospital with the resident. RN #1 stated she did not send a copy of Resident #1's Living Will to the hospital at the time of transfer because the only advance directive information copied and sent with a resident when transferred to another health care facility was their CPR designation. Additionally, RN #1 stated she had been unaware that Resident #1 had a Living Will when she transferred him/her to the hospital on 12/11/14. Review of the resident's hospital medical record	F 155	***they would be discharged if they choose to refuse a medically prescribed diet.*** 3. ***ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR.*** On 3/10/15 the ADON began in-servicing Charge Nurses, Licensed Staff and Ward Clerks of the proper paperwork that is to accompany all residents being transferred to any other facility including emergency care, verification of face sheet information, and proper placement of copies of forwarded forms in the medical record. This information includes documents such as code status, Living Wills, POA, Guardianship, Health Care Surrogate, Fiduciary and any other legal documents in the Advance Directive section of the medical record. Any staff not present during the training was trained before they returned to resident care. ***Any newly hired staff will receive this training during orientation and prior to assuming floor duties.***	

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F 155	Continued From page 7 from 12/11/14-12/16/14, revealed the resident arrived at the Hospital Emergency Room via ambulance on 12/11/14, at 5:10 AM, with a chief complaint of shortness of breath. Review of the "Emergency Department Chart" revealed hospital staff documented that Resident #1 had no Advance Directive based on the documentation sent from the facility. Further review of the Emergency Department Chart revealed after receiving his/her initial evaluation and treatment in the Emergency Department, Resident #1 was admitted to the hospital's medical unit on 12/11/14 at 12:01 PM for further treatment of exacerbation of Chronic Obstructive Pulmonary Disease (COPD). Review of the Physician Orders from Resident #1's hospital medical record revealed on 12/12/14, at 5:35 AM, hospital staff assessed the resident to be in acute respiratory distress, and transferred Resident #1 to the Intensive Care Unit (ICU). At 6:18 AM on 12/12/14, the Hospital Physician intubated (a tube inserted into the trachea for artificial ventilation) Resident #1 and placed the resident on mechanical ventilation. Further review of the hospital's Physician's Orders revealed Resident #1 continued to receive mechanical ventilation, and was placed in bilateral wrist restraints to prevent self-extubation (resident removing his/her tube). Further review revealed Resident #1 also received hemodialysis (a medical procedure to remove fluid and waste from the blood) on 12/12/14. Resident #1 was extubated on 12/13/14 and returned to the facility on 12/16/14. Observations of Resident #1 on 03/02/15, revealed the resident to be in bed, alert but with confusion, and unable to communicate	F 155	***On 3/17/15 the Dietetic Administrator revised the Dysphagia Protocol Policy and Procedure to allow any resident and/or responsible party/POA/Healthcare Surrogate to refuse physician ordered altered diets and/or NPO status. On 3/17/15 the Dietetic Administrator in-serviced the Clinical Dietician on the changes to the Dysphagia Protocol Policy and the Dysphagia Wavier. On 3/22/15 the Clinical Dietician began in-servicing all licensed staff on the revised dysphagia waiver policy, training was completed on 3/27/15. Any newly hired licensed staff will have this policy training during their orientation phase by the ADON or staff development coordinator.*** As of 4/14/15 the Advance Directive Policy (6.14.1) was revised to reflect the responsibilities of the Director of Social Services or Social Worker to confirm that Living Wills/Advance Directives are maintained in the Advance Directive section of the medical record. ***Training on this policy change was done on 4/14/15 by the Administrator and Assistant***	

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F 155	Continued From page 8 effectively. Interviews with the Unit Manager for Resident #1 on 03/03/15, at 5:30 PM and with the Director of Nursing (DON) on 03/09/15, at 10:56 AM, revealed, they both stated the only information related to advance directives sent with a resident when transferred to the hospital or other health care facility was the resident's designation for cardiopulmonary resuscitation. Additionally both staff members stated they were unaware that Resident #1 had a Living Will when he/she was transferred to the hospital on 12/11/14. Continued review of Resident #1's medical record revealed the facility readmitted the resident on 12/16/14. Review of a Hospital Discharge Summary for Resident #1, dictated on 12/22/14, revealed his/her discharge diagnoses included Acute Kidney Injury and Chronic Kidney Disease. Review of Resident #1's Care Plan last reviewed by the facility on 09/12/14, revealed Resident #1 had a history of abnormal laboratory values and was identified to be at risk for continued abnormal laboratory values due to the resident's medical diagnoses and medications. Review of Resident #1's Living Will Directive and Health Care Surrogate Designation, as specified above, revealed Resident #1 authorized the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids. Observation of Resident #1 on 03/02/15 at 1:43 PM, revealed the resident was in bed receiving intravenous (IV) fluids of 5% Dextrose with no added medications, infusing via roller dial with an insertion site in the resident's lower extremity.	F 155	***Administrator for the Social Services Department.*** 4. ***INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED.*** ***Beginning on 3/11/15 the QA Coordinator and Assistant Administrator have been reviewing all hospital transfers daily to assure the proper paperwork was sent with the resident to the receiving facility. On 4/29/15 the Unit Managers or charge nurses will audit all resident transfers daily for proper forwarding to treatment facility of required information including existing advance directive/living will forms. These audits will be verified weekly by the DON or ADON reviewing all resident transfer records. Results will be sent to the QA coordinator for review during the monthly QA meetings.*** ***The Director of Social Services or Social worker will audit bi-weekly for placement of Advance directive/living will documents in the medical record and that admission records and face sheet data relative***	

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F 155	Continued From page 9 Continued observations of Resident #1 on 03/03/15 at 10:20 AM, 12:15 PM, and 3:06 PM; on 03/09/15 at 5:33 PM; and, on 03/10/15 at 3:10 PM revealed Resident #1 continued to receive intravenous fluids via roller clamp. Review of Physician Orders and Nurse's Notes, both dated 02/17/15 at 8:20 AM for Resident #1, revealed the physician ordered staff on 02/17/15, to initiate intravenous fluids for Resident #1 due to the resident's abnormal laboratory test results. Further review of Resident #1's Physician Orders revealed the resident continued to receive the IV fluids as of 03/10/15. Interview with Resident #1's Physician on 03/09/15, at 10:10 AM revealed she initiated intravenous fluids for Resident #1 on 02/17/15, due to the resident having decreased food and fluid intake and abnormal laboratory values. However, Resident #1's Physician stated that the resident's laboratory values had been chronically abnormal and were secondary to the resident's Chronic Kidney Disease, and would likely always be abnormal. The Physician stated she was unaware that Resident #1 had a Living Will until "approximately two weeks ago" when she was told by the facility. The Physician stated she had not read the resident's Living Will, but had been informed that Resident #1 had elected to receive no life-sustaining measures. However, the Physician stated she was not aware that the Living Will also directed the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids. Interview with Resident #1's family member on 03/02/15, at 4:15 PM, revealed she was not aware that Resident #1 was receiving intravenous	F 155	***to advance directives are current and correct. The Assistant Administrator or the Administrative Branch Manager will be responsible for reviewing Social Services bi-weekly audit. This audit will consist of reviewing 10 charts weekly resulting in 100% of residents being reviewed in a quarter. Findings will then be reported to the QA Committee monthly for review.*** ***As of 4/10/15, residents placed in the Nutrition At Risk (NAR) Program (when a resident exhibits weight loss or other clinical issues which may impair appropriate and necessary nutritional/fluid intake) will be reviewed weekly by nursing, MDS coordinators, unit managers and social services. Interventions are made to improve overall nutritional status and weekly monitoring results are reviewed by these disciplines. An audit of NAR residents for condition changes will be completed weekly by the Clinical Dietician. These audits will be reported to the monthly Quality Assurance Committee. Residents who receive enteral nutrition are audited monthly by the Clinical Dietitian and Dietetic Administrator and these audits will***	

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F 155	Continued From page 10 therapy, and had never been consulted or contacted prior to the fluids being implemented for Resident #1. The family member stated that infusion of fluids would be a direct contradiction of Resident #1's wishes as specified in his/her Living Will. Interviews with the Administrator on 03/03/15, at 12:05 PM and 6:00 PM revealed a resident's designated CPR status was transferred with a resident when sent out to the hospital, but no other Advance Directive documents were sent, including the resident's Living Will. The Administrator stated the facility's policy did not direct staff to send a copy of Living Wills or advance directives to other health care facilities upon a resident's transfer, and it had never been a practice of the facility to do so. The Administrator stated he had been unaware that the Living Will in Resident #1's chart contained information detailing Resident #1's wishes related to life-sustaining treatment until he was notified by Resident #1's family member on 02/23/15. Interview with the facility's Administrator on 03/09/15 at 10:53 AM revealed he had "looked" at Resident #1's Living Will when was made aware of the document on 02/23/15, but he had not recognized or considered the initiation of intravenous fluids for Resident #1 on 02/17/15, to be in conflict with the resident's Advance Directive to receive no artificially provided food, water, or fluids. Additional interview with the Administrator on 03/03/15 at 6:00 PM, revealed he was unaware of how many residents in the facility had formulated Advance Directives. He stated the facility did not have a system in place to readily identify this	F 155	***be reported in the monthly QA meeting.***	

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F 155	Continued From page 11 Information. The Administrator stated he was also unaware of what system the facility utilized to ensure that if a resident had executed an Advance Directive, it was on the chart and accessible to staff. 2. Review of Resident #2's medical record revealed the facility admitted the resident on 01/20/15 with diagnoses which included Malignant Neoplasm of the Larynx, Depression, Kidney Failure, and Osteoarthritis. Review of the Resident's Rights/Advance Directives form for Resident #2 dated 01/20/15, revealed the resident had executed a Durable Power of Attorney (DPOA) Advance Directive. Review of Resident #2's DPOA dated 09/21/12, revealed the resident's POA could consent to, refuse, or withdraw consent to any type of medical care, treatment, surgical procedure, diagnostic procedure, medication, and the use of mechanical or other procedures that affect any bodily function, including but not limited to artificial respiration, artificially administered nutrition, or hydration and cardiopulmonary resuscitation. Review of Resident #2's Dietary Progress Note, dated 01/22/15, revealed the Unit Manager (UM) and the Registered Dietitian (RD) had a discussion with Resident #2's family member about the results of a bedside swallow evaluation (BSE). Continued review of the Dietary Progress Notes revealed the recommendation was for the resident to be on a pureed diet with pudding-thick liquids and a Modified Barium Swallow Study (MBSS - swallowing study) was recommended. Further review of the Dietary Progress Notes revealed the family member requested to sign a	F 155		

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F 155	Continued From page 12 waiver that he/she was aware of the risk of aspiration, but requested the resident be allowed to eat and drink other foods. Review of the Dietary Progress Notes revealed the facility's staff informed the family member that a waiver was not an option in the facility and confirmed with the Assistant Administrator that a waiver was not an option in the facility. The RD and UM notified the resident's family member that if after the swallowing study it was recommended the resident could have nothing by mouth (NPO), the options for the resident "would be a tube feeding, hospice, or to be discharged from the facility." Further review of the Dietary Progress Notes revealed Resident #2's family member gave consent for the MBSS and stated if it was recommended that the resident be NPO a Hospice service referral could be made. Review of the Dietary Progress Notes dated 01/23/15, revealed the recommendation from the MBSS was for the resident to have a mechanical soft diet with thin liquids. Continued review revealed staff made Resident #2's family member aware of the recommendations and the family member was agreeable to the diet. Interview on 03/03/15 at 1:55 PM with Resident #2's family member revealed Resident #2 did not eat a pureed diet well and would have lost weight if the facility left the resident on that diet. The interview further revealed the family member had informed the facility that the resident had a Living Will that stated he/she did not want a feeding tube. Continued interview revealed facility staff informed the family member that the Assistant Administrator had told them that if it was recommended the resident be NPO, the resident would have to have tube feedings, be on Hospice	F 155		

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F 155	Continued From page 13 services, or be discharged from the facility. Interviews with Registered Nurse (RN) #5 on 03/03/15, at 4:24 PM; with RN #4 on 03/09/15, at 3:25 PM; and, with RN #1 on 03/09/15, at 3:40 PM revealed the staff was not aware Resident #2 had a Living Will. Interview on 03/03/15 at 3:43 PM with the RD, and on 03/03/15 at 3:50 PM with UM #2 revealed the UM and the RD discussed the BSE results with Resident #2's family member. The resident's family member requested to sign a waiver that he/she was aware of the risk of aspiration, but wanted the resident to be allowed to eat a diet other than a pureed diet. The RD stated that the family member did not want Resident #2 to have a pureed diet because he/she was afraid the resident would not eat well and would lose weight. The interview further revealed the RD and UM confirmed with the Assistant Administrator that the facility did not allow families to sign waivers, and that the options, if the recommendation was for the resident to be NPO, would be to have a tube feeding placed, to be placed on Hospice services, or be discharged from the facility. Continued interview with the RD and UM revealed Resident #2's family member was agreeable to the MBSS, but informed the facility staff that the resident had a Living Will and did not want a tube feeding. The staff revealed prior to the discussion with Resident #2's family member they were not aware the resident had a Living Will. Interview on 03/03/15 at 5:40 PM with the Assistant Administrator revealed he had discussed Resident #2 with the RD because the resident had lost weight; a feeding tube and Hospice were discussed as options. Further	F 155		

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F 155	Continued From page 14 interview revealed staff made the resident's family member aware of the options. The Assistant Administrator stated he never informed a family member or facility staff that a waiver was not an option in the facility. He stated it was the right of the resident and/or their family to make decisions about the care they received. The Assistant Administrator stated he was not aware the resident had a Living Will at the time the discussions about tube feeding placement occurred. Interview on 03/03/15 at 5:58 PM with the Administrator revealed he had a discussion with the family member of Resident #2. The family member informed the Administrator that the resident had an extensive 24-page Advance Directive which stated that the resident did not wish to have a feeding tube placed. The Administrator stated the facility did not have a copy of the Advance Directive and was not aware the resident had an Advance Directive. 3. Review of Resident #4's medical record revealed the facility admitted the resident on 06/26/14 with diagnoses which included Chronic Respiratory Failure, Congestive Heart Failure, and Malignant Neoplasm (tumor) of the Upper Lobe. Review of the Quarterly MDS, dated 03/11/15, revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be thirteen (13), indicating the resident's cognition was intact. Review of the "Resident's Rights/Advance Directives" form, dated 06/26/14, revealed the resident executed an advance directive including a Living Will. Review of the resident's Emergency Department chart, dated 02/25/15 at 12:28 PM, revealed the resident was sent from the facility to the local hospital. Triage	F 155		

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F 155	Continued From page 15 charting revealed the resident was sent without his/her Advance Directive. 4. Review of Resident #5's medical record revealed the facility admitted the resident on 06/10/14 with diagnoses that included Alzheimer's Disease, Dementia, Paranoid Schizophrenia, Depression, and Anxiety. Review of the Quarterly MDS, dated 12/15/14, revealed the facility assessed the resident's BIMS score to be fourteen (14), indicating the resident's cognition was intact. Review of the "Resident's Rights/Advance Directives" form, dated 06/10/14, revealed the resident had executed an advanced directive including a Power of Attorney (POA). Review of the resident's medical record revealed the facility failed to have a copy of the resident's POA information in the chart. Interview with the facility's administrative staff including the Administrator, Assistant Administrator, and DON on 03/11/15 at 5:17 PM revealed they were unaware the resident's POA information was not in the chart. Further interview, with the administrative staff revealed the facility should have been aware of the resident's POA information. 5. Review of Resident #6's medical record revealed the facility admitted the resident on 07/23/09 with diagnoses which included Dementia, Cerebrovascular Accident, Schizophrenia, Chronic Obstructive Pulmonary Disease, and Depression. Review of the Quarterly MDS, dated 02/01/15, revealed the facility assessed the resident's BIMS score to be six (6), indicating the resident's cognition was severely impaired.	F 155		

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F 155	Continued From page 16 Review of the "Resident's Rights/Advance Directives" form, dated 07/23/09, revealed the resident had not executed a Living Will but listed a Health Care Surrogate. However, review of the resident's Physician Orders dated 02/02/15, revealed the resident had a Living Will. The Physician's Order and the resident's Face Sheet stated, "Living Will-please see chart for instructions." However, review of the resident's medical record revealed the facility failed to have a copy of the Living Will in the chart. Interview with the facility's administrative staff including the Administrator, Assistant Administrator, and DON on 03/11/15 at 5:11 PM revealed they were "unsure" if the resident had an advance directive or Living Will. Further interview revealed the facility should have been aware of the Living Will and a copy should have been on the chart. **The facility provided an acceptable Allegation of Compliance (AOC) on 03/24/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) On 03/10/15, licensed nursing staff that was on duty at that time was informed immediately, by the ADON of actions to be taken, and on the proper paperwork that was to accompany Resident #1 and all other residents in the facility when they were transferred to any other facility including appointments and emergency care. This paperwork included Code Status, Living Will, POA, Guardianship papers, Healthcare Surrogate, Fiduciary, and any other legal documents in the Advance Directive section of the resident's medical record.	F 156		

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F 155	Continued From page 17 2) On 03/10/15, the Director of Social Services, Nurse Manager, QA (Quality Assurance) Coordinator, and MDS (Minimum Data Set) Coordinator conducted an immediate review of Resident #1's medical record and confirmed that the resident's Living Will was in the chart and in the correct location. 3) On 03/10/15, the MDS Coordinator immediately developed an Advance Directives Care Plan for Resident #1 after being notified of the Immediate Jeopardy. 4) On 03/11/15, the Nurse Consultant in-serviced the MDS Coordinators on the process for developing an Advance Directive Care Plan. The Advance Directive Care Plan was reviewed by the Nurse Consultant for accuracy and determined to be correct. The Advance Directive Care Plan was then placed in Resident #1's chart. 5) An emergency Interdisciplinary Care Team Conference was conducted by phone with Resident #1's Health Care Surrogate on 03/11/15 at 12:00 PM, and at this time, the Surrogate verified that she was indeed this person's Healthcare Surrogate and the Living Will the facility had on file reflected the resident's wishes. 6) The Interdisciplinary Care Conference Team consisting of the Administrator, Assistant Administrator, DON (Director of Nursing), ADON (Assistant Director of Nursing), Nurse Manager, Social Worker, MDS Coordinator, Clinical Dietician, and Attending Physician reviewed the resident's care plan to confirm that all components of the Living Will were included. 7) The Health Care Surrogate directed that	F 155		

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F 155	Continued From page 18 Resident #1 be changed from "full code" (CPR) status to a "no code" (no CPR) status, which was witnessed by everyone present at the meeting. The Do Not Resuscitate form was completed and signed on 03/11/15 by the Nurse Manager and the Attending Physician. The Attending Physician wrote the new order and nursing staff updated the medical record to reflect the change. 8) Resident #1's care plan was confirmed on 03/11/15 to reflect the no code status and was determined by the Nurse Consultant to be correct. 9) On 03/11/15, the Attending Physician documented participating in the conference call on 03/11/15 with the Health Care Surrogate and discussed the current medical condition of the patient. Resident #1's intravenous (IV) fluids were discontinued on 03/11/15. 10) On 03/10/15, the Director of Social Services, Nurse Manager, QA Coordinator, and MDS Coordinator conducted an immediate review of Resident #2's medical record and confirmed that it included a copy of a Durable Power of Attorney (DPOA) and it was located in the correct location of the medical record. 11) On 03/11/15, an emergency Interdisciplinary Care team that included the Administrator, Assistant Administrator, DON, ADON, Nurse unit Manager Social Worker, MDS coordinator, Clinical Dietician and Physician, conducted a meeting via telephone conference with Resident #2's Durable Power of Attorney (DPOA) and confirmed that the information the DPOA provided on admission on 01/20/15 was in fact correct in reflecting the current wishes of the	F 156		

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F 155	Continued From page 19 resident. 12) On 03/10/15, the MDS Coordinator immediately developed an Advance Directives Care Plan for Resident #2 after being notified of the Immediate Jeopardy. 13) On 03/11/15, the Nurse Consultant in-serviced the MDS Coordinators on the process for developing an Advance Directive Care Plan. The Advance Directive Care Plans were reviewed by the Nurse Consultant for accuracy and determined to be correct. The Advance Directive Care Plan was then placed in Resident #2's chart. 14) As of 03/15/15, all current residents' charts have been reviewed by the Director of Social Services or Social Worker to ensure all Advance Directives, which include: DPOA, POA (Power of Attorney), Healthcare Surrogate, Guardianship, and Living Wills were in the chart and in the proper place. 15) All residents that are their own responsible party were interviewed by Social Services beginning on 03/11/15 to determine their cognitive status, and those with impaired cognition had a legal representative. The residents were also asked about their code status and if they wanted any changes to their Advance Directives at that time. No residents, who were their own responsible party, were found to have changes in their cognitive status. 16) All residents or their designated representatives, except two (2), were called by Social Services, to confirm that their Advance Directive was current and up to date; and the Code Status that the facility had on file was	F 155		

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F 155	Continued From page 20 correct. Social Services and the Assistant Administrator will continue to contact the legal representatives to confirm that the information the facility has on file is current. 17) On 03/15/15, through individual chart reviews, the Assistant Administrator verified that the Social Worker's Progress Notes confirmed the accuracy of the Advance Directives currently on file. The Assistant Administrator documented this in a monitoring log. 18) During this process two (2) residents had code status changes from CPR only to Full Code Status. The Full Code Status form was signed and placed in the resident's chart. The MDS Coordinators then updated the care plans on 03/14/15 and the face sheets were updated. 19) On 03/14/15, the Full Code Status Form was revised by the DON. Options of CPR only and Chemical Code were removed from the Full Code Status Form. The ADON and Charge Nurses (beginning on 03/15/15) completed training on this form change. 20) The MDS Coordinators were trained on 03/11/15 by the Nurse Consultant to ensure proper understanding of Advance Directive Care Plans and what should be included in them. This training included assessing whether the resident had an Advance Directive, Durable Power of Attorney for Healthcare, or a Living Will. 21) Care plans will also include the resident's expressed wishes regarding care and treatment goals as outlined by the Advance Directives. Social Services staff was trained as of 03/11/15 by the MDS Coordinators on how to develop the	F 155		

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F 155	Continued From page 21 Advance Directive Care Plan. 22) All resident care plans were reviewed and revised relating to Advance Directives and Code Status by the MDS Coordinators, and was completed by 03/14/15 23) The MDS Coordinators will initiate the Advance Directives care plan upon admission. The Social Services Department will be responsible for maintaining and updating the Advance Directive Care Plans now and forward on all residents. 24) Beginning on 03/15/15, the Quality Assurance Nurse and Assistant Administrator began monitoring Social Services' care plans daily, to ensure that the residents' wishes related to advance directives were accurately reflected on their care plan and any changes in their Advance Directives had been addressed. This was accomplished by comparing the Social Services' Notes, the Advance Directive, and care plan following any reported changes to the resident's Advance Directives. In conjunction with the care plan audit, they were also monitoring whether the Advance Directives were current and in the Advance Directives section of the resident's chart. 25) On 03/10/15, the Administrator, Assistant Administrator, DON, and ADON, discussed what immediate action needed to be taken. At that time, the ADON began informing Charge Nurses, Licensed Staff, and Ward Clerks on duty, of the proper paperwork that is to accompany all residents being transferred to any other facility including emergency care. This information included documents such as code status, Living	F 155		

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F 155	Continued From page 22 Wills, POA, Guardianship, Healthcare Surrogate, Fiduciary, and any other legal documents in the Advance Directive Section of the resident's chart. 26) On 03/13/15 the Executive Director provided training on the State and Federal requirements. This training was provided to the Admissions Coordinator, Assistant Administrator, Assistant Director of Nursing, Social Worker and Licensed Practical Nurse (LPN) Coordinator and competency was demonstrated by a posttest on 03/13/15. Beginning on 03/13/15, the ADON provided the same training to the Administrator, DON, Director of Social Services, and Charge Nurses, and competency was demonstrated by a posttest. 27) The ADON began training the Administrator, Assistant Administrator, DON, Charge Nurses, Licensed Staff, and Ward Clerks on 03/13/15 regarding additional measures needed to be taken to ensure that all resident's information in the Resident Transfer Packet, which included Advance Directives were being sent to the receiving facility. This training gave direction that all residents' information was sent with him or her when they were transferred out of the facility and will also be faxed to the receiving facility, copied and placed in the miscellaneous section of the chart with the fax transmission confirmation. During this time, staff was also instructed to compare the documents included in the Advance Directive Section to those listed on the resident's Face Sheet, which is generated from Point Click Care, to ensure all current documents were present. 28) Beginning on 03/11/15 the QA Nurse, Unit Manager, or the Assistant Administrator, started	F 155		

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F 155	Continued From page 23 monitoring to ensure that all Advance Directives for a resident that was being transferred out of the facility were accurate and sent. This was accomplished by reviewing the resident's transfer packet that was copied, faxed, and placed in the miscellaneous section of the resident's chart. This process is being documented daily on a monitoring log; no problems have been identified at this time. 29) The facility initiated daily monitoring on 03/13/15 of staff training regarding resident transfer processes, faxing Advance Directives, the State and Federal requirements, Advance Directive Definitions, Sending Advance Directives during transfer, and the Advance Directives policy. The ADON or Charge Nurse was performing the monitoring through interviews with a minimum of three (3) staff per day that were previously trained. All shifts were included in this monitoring, and all shifts were being monitored within a 2-day period. 30) Beginning on 03/13/15, Social Services, MDS Coordinators, Admissions Coordinator, QA Coordinator, Licensed Staff, Ward Clerks, and Finance, were trained by the ADON, DON, or Charge Nurse on the advance directive definitions and the State and Federal requirements; competency was demonstrated by posttest. 31) As of 03/13/15, the Administrator and Assistant Administrator reviewed and revised the Advance Directive Policy to reflect that upon admission the Admission Coordinator would provide a copy of this policy and would discuss and confirm the Advance Directive status with the resident and or responsible party and would	F 155		

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F 155	Continued From page 24 document in the individual medical record with the Resident Rights/Advance Directives form upon admission whether the resident had an Advance Directive. The resident and/or legal representative, DPOA, POA, or Guardian would date and sign a statement attesting that the Advance Directive and facility policy had been explained upon admission. 32) The Admissions Coordinator will provide copies of Advance Directive information obtained on the day of admission to Finance, LPN Supervisor, and Unit Manager or Ward Clerk. 33) LPN Supervisor/Data Entry Specialist entered all orders into the Point Click Care to include code status and advance directives on the day of admission. This information was then generated to the resident's face sheet, which was sent to the resident's nursing unit, and then placed on the resident's chart by the ward clerk, on the day of admission. 34) On 03/14/15, the Assistant Administrator trained the Admissions Coordinator, ADON, and Social Services on the revisions to the Advance Directive Policy, responsibilities, and processes that were in place to ensure that residents' advance directives were executed per the resident's wishes, and competency was demonstrated by a posttest. 35) Together the Assistant Administrator and ADON trained the DON, QA Coordinator, MDS Coordinators, Charge Nurses, Finance, and Unit Managers regarding the Advance Directive Policy and Procedure revision and competency was demonstrated by a post test.	F 155		

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F 155	Continued From page 25 36) Beginning 03/20/15, licensed staff and the ward clerks were trained on the changes to the Advance Directive Policy by the DON, ADON, or Charge Nurse and showed competancy by test. All above-mentioned staff was trained as of 03/22/15 on this policy except eight (8) licensed staff and one ward clerk, who will be trained prior to returning to direct resident care. 37) Beginning on 03/13/15 the initial admissions portion of the Advance Directive procedure as outlined in the Advance Directive Policy was being monitored daily by the Assistant Administrator with each new admission. This will accomplished by reviewing the admissions' paperwork and confirming that any advance directives received during the admission process were in fact listed on the Resident's Rights/Advance Directive Sheet. The findings were then reported on a daily monitoring log with each new admission. No problems were identified at the time. 38) Starting on 03/11/15, the QA Coordinator or the Assistant Administrator checked resident charts daily to confirm that the Advance Directive section of the chart still contained all of the resident's Advance Directives. This was accomplished by comparing the Advance Directives located in the chart to their daily monitoring log. 39) The Administrator and Assistant Administrator revised the Social Services Policy on 03/21/15 to include the procedure for invoking a health care agent or legal representative after the resident was determined not to have decision-making capacity. This policy stated, "The assigned social worker will determine if the resident is	F 155		

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F 155	Continued From page 26 self-responsible or if they have a POA, DPOA, or legal guardian in place. The social worker would contact them to let them know the resident has had a mental status change and can no longer make their own decisions. If the legal representative accepts responsibility, they will begin making decisions for the resident. If the resident does not have a POA, DPOA or legal guardian then social services would contact any family members who may be willing to be the responsible party for the resident. If the family members are not willing, then social services will contact Adult Protective Services (APS) and request the process for obtaining a guardian to be started." 40) Social Services was trained on 03/22/15 by the Assistant Administrator regarding the revised Social Services Policy. 41) During the admission process, the Admissions Coordinator would determine the resident's legal representative based on information provided by the resident at the time of admission. 42) Upon admission, the resident's mental status was assessed by the Licensed Staff assigned to the resident on their unit through the nursing admission assessment form, and by the MDS Coordinators through the Brief Interview Mental Status (BIMS), which is done within seven (7) days of admission and also done quarterly with scheduled care plan meetings and with any significant change. Should any of these assessments indicate the resident was not capable of being their own decision maker, Social Services would be informed by the nursing staff during the daily morning management	F 155		

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F 155	Continued From page 27 administrative meeting of any mental status changes that may require further assessment. 43) If a mental status change and further assessment of a resident indicated the need for a legal representative, then at that point Social Services would seek to invoke the health care agent or legal representative as outlined in the Social Services Policy. 44) The Assistant Administrator checked to ensure that any issues relating to Social Services have been followed-up on during the daily Social Services meeting. This was documented on the Daily Social Services Meeting Minutes. 45) Upon admission, the resident's assigned Social Worker would confirm Advance Directives. Furthermore, the Social Worker would review the advance directive status when requested by the resident or responsible party, upon any re-admission, quarterly with care plan meetings and after any significant change. 46) The Social Worker would assist the resident in developing a living will within twenty-four (24) hours of being requested. The Assistant Administrator would monitor this by comparing the Advance Directives to what was stated on the Resident's Rights/Advance Directive Sheet and documented in the Social Services Progress Note. 47) As of 03/13/15, the Assistant Administrator initiated daily meetings with the Social Worker and Director of Social Services to discuss any residents that were sent out of the facility, returned to facility, or had received any new documents concerning Advance Directives.	F 155		

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F 155	Continued From page 28 48) All Advance Directive care plans will be reviewed immediately upon admission or re-admission by the Social Worker and documentation of the review will be placed in the Social Worker Notes. These would also be reviewed by the MDS Coordinator and Social Worker and the rest of the interdisciplinary care plan team during scheduled care plan meetings, and then documented in the Social Services section of the clinical record as well as the Interdisciplinary Care Plan Sheets. 49) If the resident and/ or their representative were present during this care plan meeting, the Advance Directive and Code Status would be discussed to confirm that the directive continues to reflect the resident's wishes. If there was no representative present, Social Services would contact the legal representative to confirm the Advance Directive was still current. This will be completed with the Quarterly MDS review, and any change in status. 50) The Quality Assurance (QA) Nurse and Assistant Administrator were monitoring care plans relating to advance directives daily to ensure the residents' wishes expressed on the Advance Directives were outlined in the care plans as of 03/15/15. 51) Beginning on 03/20/15, Licensed Staff and Ward Clerks were given re-enforcement training by the ADON, related to information to be included on the shift-to-shift report, and competency was proven by a post test. 52) On 03/16/15, the Administrator instructed the Nurse Managers and DON to begin reporting any	F 155		

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F 155	Continued From page 29 mental status changes reported on the shift-to-shift report during the Morning Administrative Management Meeting. At that time, the team would discuss necessary changes that needed to be addressed, if any. As of 03/22/15, no change in any resident's mental status had been reported. This was documented daily on the Daily Morning Administrative Management Meeting Notes. 53) When a significant change, quarterly or annually assessment is conducted and a brief interview of mental status (BIMS) will be completed on each resident to determine their decision making ability by the MDS Coordinator. This will be reported to the resident's assigned Social Worker, to determine if any changes in legal representative needs to be made. 54) When a resident is admitted, readmitted, or had verbalized their desire to change their code status, the nurse will contact the Doctor and obtain a Doctor's order. At that time, a DNR or full code status form would be completed with two (2) caregiver signatures. If the code status was obtained by telephone, the same process will apply. The nurse will document the code status change in the Nurse's Notes and place the change on the shift-to-shift report. 55) Beginning on 03/20/15, licensed staff and ward clerks were trained on the changes to the Advance Directive Policy by the DON, ADON, or Charge Nurse and showed competency by a post test. The Advance Directive Policy included the process for contacting the legal representative with any changes in the Advance Directives. All above-mentioned staff was trained as of 03/22/15 on this policy, except for eight (8) licensed staff	F 155		

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F 155	Continued From page 30 and one ward clerk, who will be trained prior to returning to direct resident care. 56) Per the revised Advance Directives Policy, Social Services or designated others will assist the residents who elect to execute an Advance Directive. Social Services will ensure all documents that belong in the Advance Directive Section are placed in the medical chart. 57) Social Services was trained on the changes to the Advance Directive Policy on 03/14/15 by the ADON; and competency was demonstrated by a post test. 58) A copy of the Code Status order will be given to the LPN Supervisor, who will input the order into the "Point Click Care System" and the Admission Record will be generated from this information. The Admission Record (Face Sheet) will be sent to the resident's nursing unit and placed in front of the chart by the ward clerk, on the day of the change in code status. 59) On 03/15/15, the Assistant Director of Nursing implemented and trained all Licensed staff and Ward Clerks on the modified existing transfer form to provide an expanded checklist that specifically listed Living Wills, Power of Attorney, Health Care Surrogate or Guardianship documents. 60) As of 03/11/15, compliance with the policies and processes were being verified daily by the facility's Administrative team which consists of the Administrator, Assistant Administrator, Director of Nursing, and Assistant Director of Nursing or QA Coordinator and reviewed daily during the QA Daily meeting. Any notice of non-compliance will	F 155		

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F 155	Continued From page 31 be reported to the Administrator and a plan of action will be developed to prevent reoccurrence. 61) The Executive Adviser and the Nurse Consultant will review the minutes of the management meetings and will attend meetings at least weekly to ensure the Allegation of Compliance is being implemented and that any adjustments to the process are identified, discussed and steps implemented to correct. 62) The Executive Adviser and Nurse Consultant are in daily consultation with the Administrator since 03/11/15. They are reviewing documentation, interviews and training staff to ensure the plan is being carried out as alleged. ***The SSA validated the Immediate Jeopardy was removed as follows: 1) Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM and RN #2 on 03/24/15 at 2:56 PM revealed they were knowledgeable regarding what paper work was to be transferred with residents when sent out of the facility including all Advance Directives formulated by the resident. 2) Review of Resident #1's chart on 03/24/15 revealed the resident's Living Will was in the chart and in the correct location. 3) Review of Resident #1's chart on 03/24/15 at 1:50 PM revealed an Advance Directive Care Plan was present in the medical record. 4) Interviews with MDS Coordinator #2 on	F 155		

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F 155	Continued From page 32 03/24/15 at 3:06 PM revealed the Nurse Consultant had trained her on developing an Advance Directive care plan. Interview with the Nurse Consultant on 03/24/15 at 2:00 PM, revealed she had confirmed the accuracy of Resident #1's Advance Directive Care Plan. 5) Review of the Progress Notes dated 03/11/15, and interview with Resident #1's Health Care Surrogate on 03/13/15 at 3:00 PM revealed a care plan conference was conducted via telephone to discuss Resident #1. During the interview, the Health Care Surrogate stated she was making health care decisions for Resident #1. 6) Interviews on 03/24/15, at 4:44 PM with the Administrator; at 3:32 PM with the Assistant Administrator; and, at 4:37 PM with the DON (Director of Nursing) revealed they had all reviewed Resident #1's care plan and confirmed it contained all the Advance Directives that were included in Resident #1's Living Will. 7) Interview with Resident #1's Health Care Surrogate on 03/13/15 at 3:00 PM revealed she confirmed with the facility that Resident #1 was to be a DNR. Review of Resident #1's medical record on 03/24/15 at 1:50 PM revealed the DNR form was signed on 03/11/15. Resident #1's medical record also contained a signed Physician's Order for the DNR status. 8) Review of Resident #1's chart on 03/24/15 at 1:50 PM revealed the resident's care plan reflected the DNR status. 9) Review of Physician Nots, dated 03/11/15 revealed the physician documented participating	F 155		

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F 155	Continued From page 33 In the conference call on 03/11/15 with the Health Care Surrogate and discussed the current medical condition of the resident. Review of Resident #1's medical record revealed intravenous (IV) fluids were discontinued for Resident #1 on 03/11/15. Observation of Resident #1 on 03/24/15 at 3:09 PM revealed the resident was not receiving IV fluids. 10) Review of Resident #2's medical record on 03/24/15 at 2:20 PM revealed it contained a copy of the resident's Durable Power of Attorney (DPOA) and it was located in the correct section of the medical record. 11) Review of the Progress Notes dated 03/11/15, and interview with Resident #2's DPOA on 03/13/15 at 3:00 PM revealed the facility confirmed the information in Resident #2's DPOA was correct and reflected the wishes of Resident #2. 12) Review of Resident #2's medical record on 03/24/15 at 2:20 PM revealed it contained an Advance Directive Care Plan for Resident #2. 13) Interview with MDS Coordinator #2 on 03/24/15 at 3:06 PM revealed the Nurse Consultant trained her on developing an Advance Directive care plan. Interview with the Nurse Consultant on 03/24/15 at 2:00 PM, revealed she confirmed the accuracy of Resident #2's Advance Directive Care Plan. 14) Review of a Resident Disposition form dated 03/15/15, and interview on 03/24/15 at 4:05 PM with the Director of Social Services revealed that all charts had been reviewed to ensure Advance Directives were on the chart under the designated	F 155		

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F 155	Continued From page 34 tab. 15) Interviews on 03/24/15 at 3:15 PM with Resident #3 and at 3:22 PM with Resident #4 revealed they had been interviewed by the DSS and had not made changes in their code status designations. Review of Social Service Notes for Residents #20 and #23 revealed entries dated 03/11/15, indicating they had a responsible party named, and no changes in their cognitive status had been identified. 16) Review of a facility Resident Roster revealed that all residents or their designated representatives except one had been interviewed to ensure Advance Directives and Code Status were correct for each resident. Review of a copy of a certified letter revealed the facility had attempted to contact the remaining responsible party. 17) Interview with the Assistant Administrator on 03/24/15 at 3:32 PM, and review of the Advance Directive Monitoring Log revealed the Assistant Administrator had reviewed the Social Worker's Progress Notes to ensure they were accurate when compared with the Advance Directive on file for each resident. 18) Review of Residents #9 and #14's medical record revealed their code status designation had been changed to Full Code Status. The medical record revealed a Code Status form was signed and in the medical records. Review of resident's care plans also revealed the update was on the care plans. 19) Review of the facility's Code Status form revealed it had been updated on 03/14/15.	F 155		

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F 155	Continued From page 35 Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM, and RN #2 on 03/24/15 at 2:56 PM revealed they had been trained on the form changes. 20) Interview with MDS Coordinator #2 on 03/24/15 at 3:08 PM revealed she had been trained by the Nurse Consultant related to Advance Directive care plans and was able to verbalize the different types of Advance Directives. 21) Review of Residents #1, #2 and #4's Care Plans revealed they included the resident's expressed wishes that were contained in their Advance Directives. Interview with the DSS on 03/24/15, at 4:05 PM revealed he was trained on how to develop an Advance Directive care plan. 22) Review of Residents #1, #2 and #4's Care Plans revealed they had been revised and included Advance Directives and Code Status. 23) Interview with MDS Coordinator #2 on 03/24/15 at 3:06 PM revealed she was knowledgeable that she would be responsible for maintaining and updating the Advance Directive Care Plans after initial development by the DSS. 24) Review of a Care Plan Monitoring Log and Interviews on 03/24/15 at 1:48 PM and 3:32 PM with the Quality Assurance Nurse and Assistant Administrator revealed the Social Service care plans related to Advance Directives were being reviewed daily to ensure the resident's wishes relating to advance directives were accurately reflected on their care plan and included any changes.	F 155		

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F 155	Continued From page 36 .	F 155		

25) Interview with the DON on 03/24/15 at 4:37 PM revealed she initiated training on 03/10/15 with staff related to sending all Advance Directives with a resident when they were transferred out of the facility.

26) Interviews on 03/24/15 at 2:11 PM with the Admissions Coordinator, at 3:32 PM with the Assistant Administrator, and at 4:05 PM with the DSS; and review of an In-service Sign In Sheet dated 03/13/15, revealed the Executive Director had provided training on the State and Federal requirements. Review of competency testing revealed each of the staff had also completed a competency test.

27) Review of a facility In-service Sign In Sheet dated 03/13/15, revealed the ADON trained the Administrator, Assistant Administrator, DON, Charge Nurses, Licensed Staff, and Ward Clerks regarding ensuring that all resident information related to Advance Directives was being sent to the receiving facility and faxed. Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM, RN #2 on 03/24/15 at 2:58 PM, and Ward Clerk #1 at 3:14 PM, revealed they were knowledgeable regarding the process for sending Advance Directive information with residents when transferred out of the facility.

28) Review of a Transfer Monitoring Log and interviews on 03/24/15 at 1:48 PM with the QA nurse and at 3:54 PM with Unit Manager #1, revealed all resident transfers were being monitored to ensure all Advance Directives for each resident transferred out of our facility had been sent and were accurate.

29) Review of daily questionnaires and interviews

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F 155	Continued From page 37 with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM and RN #2 on 03/24/15 at 2:58 PM revealed staff was being asked questions to ensure competency on the State and Federal requirements daily by the ADON or a Charge Nurse. 30) Review of In-service Sign In Sheets and Interviews on 03/24/15, at 4:05 PM with the DSS, at 3:06 PM with MDS Coordinator #2, at 2:11 PM with the Admissions Coordinator revealed they were trained on Advance Directive definitions and the State and Federal requirements. They completed a competency test. 31) Interviews conducted on 03/24/15 at 4:44 PM with the Administrator and at 3:32 PM with the Assistant Administrator and review of the Advance Directive Policy revealed the Advance Directive Policy had been revised to include the following: upon admission the Admission's Coordinator will provide a copy of this policy and will discuss and confirm the advance directive status with the resident and or responsible party and upon admission, will document in the individual medical record using the Resident Rights/Advance Directives Form whether the resident had an Advance Directive. The resident and/or legal representative will date and sign a statement attesting that the Advance Directive and the facility's policy had been explained upon admission. 32) Interview with the Admissions Coordinator on 03/24/15 at 2:11 PM, revealed she it is her responsible to provide copies of the Advance Directive Information related to each new admission to the Finance Department, the LPN Supervisor, and the Unit Manager or Ward Clerk.	F 155		

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F 155	Continued From page 38 33) Interviews on 03/24/15 at 4:30 PM with the LPN Supervisor/Data Entry Specialist revealed she was knowledgeable on the process to enter code status and advance directive information for residents when they were admitted. Review of a Face Sheet for a resident admitted to the facility on 03/20/15, revealed the resident's Face Sheet contained the appropriate information related to Code Status and Advance Directives. 34) Review of an In-service Sign In Sheet dated 03/14/15, and interviews on 03/24/15 at 2:11 PM with the Admissions Coordinator, and at 4:05 PM with the DSS revealed the Assistant Administrator trained them on the revisions to the Advance Directive Policy and Procedures. 35) Review of an In-service Sign In Sheet dated 03/14/15, revealed the Assistant Administrator and ADON trained the DON, QA Coordinator, MDS Coordinators, Charge Nurses, Finance Staff, and the Unit Managers on the Advance Directive Policy and Procedure revision and staff completed a competency test. 36) Review of a facility In-service Sign In sheet dated 03/20/15, and interviews on 03/24/15, with LPN #2 at 2:28 PM, with LPN #1 at 3:23 PM, and with RN #2 at 2:56 PM, revealed they were trained on the changes to the Advance Directive Policy, and completed a competency test. 37) Review of the Advance Directive Monitoring Log and interview with the Assistant Administrator revealed he conducted daily monitoring of the admission process related to Advance Directives for each new admission. The Assistant Administrator stated he reviewed the admissions	F 155		

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F 155	Continued From page 39 paperwork and confirmed that any advance directive received during the admission process was listed on the Resident Rights/Advance Directive sheet. 38) Interviews on 03/24/15 at 1:48 PM with the QA Coordinator and at 3:32 PM with the Assistant Administrator revealed they were checking resident charts daily to ensure all Advance Directives were on the chart in the appropriate section. 39) Review of the Social Services Policy and interview on 03/24/15 at 4:44 PM with the Administrator; and, at 3:32 PM with the Assistant Administrator revealed they revised the Social Services Policy on 03/21/15 to include the procedure for invoking a health care agent or legal representative after the resident was determined not to have decision-making capacity. 40) Review of an In-service Sign In Sheet and interview with the DSS on 03/24/15 at 4:05 PM revealed the DSS was trained by the Assistant Administrator on the revised Social Services Policy on 03/22/15. 41) Interview on 03/24/15 at 2:11 PM with the Admissions Coordinator revealed she was knowledgeable regarding determining a resident's responsible party, if applicable, at the time of admission. 42) Interviews conducted on 03/24/15 at 4:00 PM with Charge Nurse #1 and at 3:54 PM with Unit Manager #1 revealed they were knowledgeable regarding the procedure for assessing a resident's mental status upon admission. The staff stated if these assessments indicated the	F 155		

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F 155	Continued From page 40 resident was unable to make competent decisions, the DSS would be informed. 43) Interview with the DSS on 03/24/15 at 4:05 PM revealed that if a resident was assessed to have a mental status change and further assessment indicated a need for a responsible party to be identified for decision making the DSS would then attempt to identify a responsible party or involve State Adult Protective Services if indicated. 44) Interview with the Assistant Administrator on 03/24/15 at 3:32 PM revealed he was responsible to ensure any issues relating to Social Services have been addressed during the facility's morning meeting. Any issues identified would be documented in the Social Services meeting minutes. 45) Interview with the DSS on 03/24/15 at 4:05 PM revealed Social Services would confirm the resident's Advance Directives on admission, when requested by a resident or family, or during any MDS assessment. 46) Interview with the DSS on 03/24/15 at 4:05 PM and review of a Living Will formulated on 03/12/15, revealed residents would be assisted within twenty-four hours by the Social Worker in developing an Advance Directive. Interview with the Assistant Administrator on 03/24/15 at 3:32 PM revealed the Assistant Administrator would monitor this by comparing the formulated Advance Directive to what was stated on the Resident Rights/Advance Directive sheet and documented in the Social Services Progress Note.	F 155		

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F 155	Continued From page 41 47) Interviews on 03/24/15 at 3:32 PM with the Assistant Administrator and at 4:05 PM with the DSS, revealed the Assistant Administrator and Social Services were meeting daily to discuss the status of any resident transferring or returning to the facility to review the status of their Advance Directives. 48) Interviews on 03/24/15 at 4:05 PM with the DSS revealed Advance Directive care plans would be reviewed when a resident was re-admitted to the facility, and noted in the Social Services Notes. Interview with MDS Coordinator #2 on 03/24/15, at 2:11 PM revealed the Advance Directive would also be reviewed during scheduled care plan meetings, and documented in the Social Services section of the clinical record as well as the resident's care plan. 49) Interview with MDS Coordinator #2 on 03/24/15, at 2:11 PM revealed if the resident and/or their representative were present during a care plan meeting, the Advance Directive and Code Status would be discussed to confirm the directive continued to reflect the resident's wishes. If the resident or their representative were not present, Social Services would contact the legal representative and confirm the Advance Directive was still current. 50) Interviews on 03/24/15 at 1:48 PM with the Quality Assurance Nurse and at 3:32 PM with Assistant Administrator revealed they monitored care plans related to advance directives daily to ensure the resident's wishes expressed on the Advance Directives were included in the resident's plan of care. 51) Interviews on 03/24/15 at 2:44 PM with Ward	F 155		

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F 155	Continued From page 42 Clerk #3 and at 3:14 PM with Ward Clerk #1, and review of In-service Sign In Sheets revealed they were trained by the ADON on 03/20/15 related to the shift-to-shift report and completed a competency test. 52) Review of the daily administrative meeting documentation and interview on 03/24/15 at 3:54 PM with Unit Manger #1 revealed the Administrator instructed her on 03/16/15 to record any mental status changes of a resident on the shift-to-shift report. The report would be reviewed at the morning administrative meeting where any necessary changes would be discussed. 53) Interview with MDS Coordinator #2 at 3:06 PM on 03/24/15, revealed when an MDS assessment was completed which included a Brief Interview of Mental Status (BIMS) score, it would be reported to the resident's assigned Social Worker, to determine if any changes in legal representative needed to be made. 54) Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM and RN #2 on 03/24/15 at 2:58 PM, revealed they were knowledgeable regarding the steps to be taken to change a resident's code status. 55) Review of In-service Sign In Sheets dated 03/20/15, revealed licensed staff and Ward Clerks were trained on the changes to the Advance Directive Policy and completed competency testing. 56) Interview with the DSS on 03/24/15 at 4:05 PM revealed Social Services or a staff they designated would be responsible to assist residents who wished to execute an Advance	F 155		

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F 155	Continued From page 43 Directive. Social Services would also ensure Advance Directive documents were placed in the resident's chart. 57) Review of an In-service Sign In Sheet dated 03/14/15, revealed Social Services staff was trained on the changes to the Advance Directive Policy by the ADON, and completed a competency test. 58) Interview with LPN #2 at 2:28 PM on 03/24/15, revealed Code Status orders would be entered into the Point Click Care System and then the Admission Record would be generated and sent to the resident's nursing unit. Interview with Ward Clerk #3 at 2:44 PM on 03/24/15 revealed the record would then be placed in the resident's chart. 59) Review of a Resident Transfer Form dated 03/15/15 revealed it had been modified to include a checklist that specifically listed Living Wills, Powers of Attorney, Health Care Surrogate or Guardianship documents which were to be included when a resident was transferred. Review of In-Service sign In Sheets initiated on 03/15/15, revealed licensed staff and Ward Clerks were trained on the revision. 60) Review of daily QA Meeting Minutes revealed the Advance Directive Policies and procedures were being reviewed and verified daily by the facility's Administrative team consisting of the Administrator, Assistant Administrator, Director of Nursing, and Assistant Director of Nursing or QA Coordinator and reviewed daily during the QA Daily meeting. Interview with the Administrator on 03/24/15 at 4:44 PM revealed any non-compliance was to be reported to him and a	F 155		

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F 155	Continued From page 44 plan of action would be developed to prevent reoccurrence. 61) Interviews on 03/24/15 at 2:00 PM with the Executive Adviser and the Nurse Consultant revealed they would review the minutes of the management meetings and attend meetings at least weekly to ensure the Allegation of Compliance was being implemented and any needed adjustments to theprocess were being identified and addressed. 62) Interviews on 03/24/15 at 2:00 PM with the Executive Adviser and Nurse Consultant revealed they were in daily consultation with the Administrator since 03/11/15 to ensure the plan was being carried out as alleged.	F 155		
F 250 SS=K	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, hospital records and review of the facility's policy, it was determined the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for five (5) of twenty-four (24) sampled residents (Residents #1, #2, #4, #5 and #6). The facility failed to provide Resident #1, #2, #4, #5, and #6	F 250	1. ***ADDRESS WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.*** **RESIDENT # 1** ***On 03/10/15, the Director of Social Services verified Resident #1's living will was in the medical record, and listed a secondary health care surrogate (HCS). On 03/11/15 an interdisciplinary care team consisting of the Administrator, Assistant Administrator, DON, ADON, Nurse Manager, Social Worker, MDS***	***05/15/15***

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F 250	Continued From page 45 assistance with implementing advance directives and failed to assist Resident #1 to find an alternate responsible party when the resident's Health Care Surrogate became unable to make decisions. The facility admitted Resident #1 on 02/19/09, and placed a copy of the resident's previously executed Living Will Directive and Health Care Surrogate Designation in his/her medical record. However, the facility failed to assist Resident #1 to implement his/her Advance Directive when it became medically necessary. On 12/11/14, Resident #1 was transferred to the hospital; however, the facility failed to ensure the resident's Living Will was provided to the hospital. On 12/12/14, while admitted to the hospital Resident #1 suffered acute respiratory distress, was intubated, and placed on mechanical ventilation until he/she was extubated on 12/13/14. Additionally, the facility was aware since 10/03/14 that Resident #1's Health Care Surrogate was no longer able to make decisions, but failed to provide Resident #1 with assistance to determine who or how health care decisions would be made for him/her (refer to F155, F279, F309, and F490). The facility's failure to have an effective system in place to ensure resident's received medically related social services, and residents who had executed advance directives were assisted to implement those directives was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 12/11/14 at 42 CFR 483.10 Resident Rights	F 250	*Coordinator, Clinical Dietician, and Attending Physician verified by phone that the identity of the secondary Health Care Surrogate was correct and reviewed the code and living will status of Resident #1 with the HCS. The resident's code status was changed by the HCS to Do Not Resuscitate during this phone call. The attending Physician's orders were noted, and the care plan, face sheet, and medical record were so annotated with this code change. A copy of the living will was sent to the HCS via certified mail, and confirmation of receipt was received on 3/13/15.* **RESIDENT # 2** *On 03/10/15 the Director of Social Services verified the medical record of Resident #2 contained Durable Power of Attorney (DPOA) documentation. On 03/11/15 the interdisciplinary care team consisting of the Social Worker, Attending Physician, Clinical Dietitian, Assistant Administrator, Administrator, DON, ADON, and MDSC verified telephonically with resident #2's DPOA, that the medical record copy of the DPOA for Resident #2 accurately reflected Resident #2's*	

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F 250	Continued From page 46 (F155), 42 CFR 483.15 Quality of Life (F250), 42 CFR 483.20 Resident Assessment (F279),42 CFR 483.25 Quality of Care (F309); and, 42 CFR 483.75 Administration (F490). The facility was notified of the Immediate Jeopardy on 03/10/15. An acceptable Allegation of Compliance was received on 03/24/15, which alleged removal of the Immediate Jeopardy on 03/23/15. A partial extended survey was conducted on 03/23-24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 03/23/15, which lowered the Scope and Severity to "E" at 42 CFR 483.10 Resident Rights (F155), 42 CFR 483.15 Quality of Life (F250), 42 CFR 483.20 Resident Assessment (F279), 42 CFR 483.75 Administration (F490); and, 42 CFR 483.25 Quality of Care (F309) Scope and Severity of a "D", while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: An interview with the Administrator on 03/09/15 at 10:53 AM revealed the facility did not have a specific policy and procedure that addressed medically related Social Services. Review of the facility's policy, "Advance Directives," reviewed by the facility on 07/24/12, revealed Social Services staff would be responsible to assist residents who elected to formulate or implement an Advance Directive. Review of the Director of Social Services' (DSS) job description revealed the DSS was responsible for overseeing the assessment and documentation of medically related social needs of residents upon admission and throughout	F 250	***wishes. The DPOA was assured during this call that the DPOA had the right to refuse any medical treatment and that the resident would not be discharged from the facility or transferred for making a decision of this nature.*** **RESIDENT # 4** ***On 3/12/13, The Director of Social Services conducted a review of Resident #4's medical record and confirmed that the resident's Living Will was in the Advance Directives section of the medical record*** **RESIDENT # 5** ***On 3/11/15, the Social Worker requested a copy of Guardianship papers from Resident #5's guardian. The requested guardianship papers were received and placed in the resident's medical record on 3/13/15. The Resident Rights form and the face sheet were updated to reflect the information received.*** **RESIDENT # 6** ***On 03/13/15, a copy of resident #6's advance directives were placed in the resident's medical record. On 03/16/15, the social worker verified with Resident #6's guardian that the***	

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F 250	Continued From page 47 residency; acting as a liason between staff, residents, and families on matters concerning resident needs, progress, and medical condition; ensuring social services staffs' compliance with agency policies regulating, and laws governing the agency, and methods of service delivery; and participating as a member of the Admissions Committee and Advance Directive Committee. 1. Review of Resident #1's medical record revealed the facility admitted the resident on 02/19/09, with diagnoses which included Hypertension and Diabetes Mellitus. Review of Resident #1's Minimum Data Set (MDS) assessment dated 12/10/14, revealed the resident had a Brief Interview for Mental Status (BIMS) score of eight (8), indicating the resident had moderately impaired cognition. Resident #1's Comprehensive Care Plan updated 12/04/14, revealed the resident had impaired cognition related to dementia. Further review of the medical record revealed it contained a Living Will Directive and Health Care Surrogate Designation, which Resident #1 formulated and signed on 07/14/08. Review of Resident #1's Advance Directive revealed a Health Care Surrogate was designated for Resident #1; the surrogate's spouse was an alternate Health Care Surrogate, if the original Health Care Surrogate became unable to make decisions for Resident #1. Resident #1's medical record also contained a Resident Rights/Advance Directive form dated 02/19/09, which was signed by the Social Worker acknowledging that Resident #1 had an Advance Directive, and that facility staff would follow the terms of the Advance Directive.	F 250	***medical record contained the correct advance directives.*** 2. ***ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE.*** ***As of 3/16/15, all residents that are their own responsible party were interviewed by the Director of Social Services and the Social Worker to confirm accuracy of these residents' Advance Directives and offered to make any changes. All residents who were their own responsible party were found to be of decisional making capacity based on their most current Brief Interview of Mental Status (BIMS) score.*** ***As of 3/26/15, all residents or designated legal representatives were contacted by Director of Social Services, Social Worker, Assistant Administrator, or trained staff to confirm that all Advance Directives and Code Statuses in the medical record were accurate and if any changes were desired at that time.***	

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(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 250	Continued From page 48 Interviews with the facility's DSS on 03/03/15 at 11:00 AM, 5:15 PM, and 5:50 PM, revealed the DSS was present when Resident #1 was originally admitted to the facility on 02/19/09. After reviewing the Resident's Rights/Advance Directives form, the DSS stated he had witnessed the form on 02/19/09, and was aware that Resident #1 had a Living Will upon admission. However, he stated he had not read the document and was unaware that an alternate Health Care Surrogate had been designated by Resident #1 if the original Health Care Surrogate became incapacitated. The DSS stated his only role in assisting residents with advance directives was to inquire upon admission if they had formulated an advance directive. If the resident had not formulated an advance directive, the DSS would provide the resident or family with written information regarding advance directives. The DSS stated if the resident did have an advance directive, it was placed in the resident's chart, and he had no further involvement in assisting residents with implementing the advance directive. Review of a Nutritionally at Risk Ongoing Report Summary revealed on 10/03/14 the facility's Registered Dietitian (RD) called the telephone number listed on the chart for Resident #1's Health Care Surrogate, and was informed the Health Care Surrogate had a tracheotomy and was unable to speak. The entry indicated the facility's DSS was notified of the Health Care Surrogate's condition, and the DSS stated he would notify State Adult Protective Services. Interviews with the facility's DSS on 03/03/15 at 11:00 AM, 5:15 PM, and 5:50 PM, revealed he notified State Adult Protective Services (APS) "a	F 250	***New admissions/responsible parties will be queried by the Director of Social Services or Social Worker if the incoming resident has an Advance Directive, desire to make any changes to existing Advance Directives, or would like assistance with executing an Advance Directive. Additionally, designation of any Health Care Surrogate or desire to name one will also be confirmed or offered. The Director of Social Services or Social Worker will assist the resident/responsible party in making any desired changes.*** 3. ***ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR.*** ***As of 4/29/15, Social Services staff will audit bi-weekly that Advance Directives are in the Advance Directive Section of the Medical Record for each resident, with audit results entered in the bi-Weekly Advance Directive Log.*** On 3/11/15 The Assistant Administrator in-serviced the Director of Social Services and Social Worker	

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F 250	Continued From page 49 couple of times" related to Resident #1 having no primary decision maker, but made no documentation related to the notifications. The DSS stated he also called the number listed for Resident #1's Health Care Surrogate and spoke to the spouse and daughter of the Health Care Surrogate regarding Resident #1 having no person identified to make health care decisions. However, because the DSS failed to read Resident #1's Living Will, he was unaware the spouse of the Health Care Surrogate was the alternate named in Resident #1's Living Will. The DSS stated he did not document any contact with the family member and did not recall the date the conversations took place. Interviews were conducted with the resident's Alternate Health Care Surrogate and her daughter on 03/03/15 at 12:27 PM and 1:18 PM; on 03/04/15 at 11:25 AM; on 03/05/15 at 4:15 PM; and, on 03/07/15 at 1:00 PM. The Alternate Health Care Surrogate's daughter explained that she was a health care professional with a background in geriatrics and long-term care and had routinely assisted Resident #1's Health Care Surrogate to make decisions related to Resident #1's medical care. The Alternate Health Care Surrogate's daughter stated the facility initially contacted her in November 2014 related to making health care decisions for Resident #1, when the resident's Health Care Surrogate suffered a debilitating stroke and was unable to make decisions for Resident #1. The Alternate Health Care Surrogate's daughter explained that she and the Alternate Health Care Surrogate were unaware at the time that Resident #1 had formulated a Living Will naming him/her (the Health Care Surrogate's spouse) as the alternate decision maker when they were contacted by the	F 250	on Advance Directives definitions and KRS 311. *On 3/13/15, the Executive Director of Office of Kentucky Veterans Centers in-serviced the Assistant Administrator and Social Worker on State and Federal requirements of Advance Directives and Advance Directive definitions, relating to long term care.* *On 3/14/15, the Assistant Administrator in-serviced the Director of Social Services on State and Federal requirements of Advance Directives and Advance Directive definitions, related to long term care.* *On 3/21/15, an in-service regarding the procedure for acquiring a health care agent or legal representative after the resident no longer has decisional capacity was given to the Director of Social Services and Social Worker by the Administrator or Assistant Administrator.* *On 3/22/15 the Director of Social Services and social worker were in-serviced by the Assistant Administrator concerning purpose,*	

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F 250	Continued From page 50 DSS in November 2014. Continued interview with the Alternate Health Care Surrogate's daughter revealed the facility requested she obtain guardianship of Resident #1. She stated she was agreeable to do so and went to the courthouse on 11/18/14, and was instructed that "emergency guardianship" would be the most appropriate and time effective avenue to pursue. The Alternate Health Care Surrogate's daughter stated court officials told her that obtaining "emergency" guardianship would require documentation by Resident #1's physician confirming the resident's need for the emergency order. The Alternate Health Care Surrogate's daughter stated she spoke to the facility's DSS who agreed that pursuit of emergency guardianship for Resident #1 would be the most appropriate action, and would request that Resident #1's physician provide the documentation. However, according to the Alternate Health Care Surrogate's daughter she was never provided the documentation and was therefore unable to proceed with obtaining emergency guardianship of Resident #1. Further interviews with the DSS on 03/03/15 at 11:00 AM, 5:15 PM, and 5:50 PM, revealed he had discussed obtaining guardianship of Resident #1 with the Alternate Health Care Surrogate's daughter over the phone on various occasions, but had made no documentation of the discussions and was unable to provide any information related to dates or times. The DSS stated that the Alternate Health Care Surrogate's daughter had been agreeable to obtaining guardianship but he had not contacted Resident #1's physician and requested the documentation required for the family member to obtain	F 250	***function, accuracy, accomplishing changes to, and filing location of Living Wills, Advance Directives.*** ***On 4/2/15 the Executive Staff Advisor provided in-service to the Director of Social Services, Social Worker and Assistant Administrator regarding the intent of the regulation 483.15g, interpretive guidelines for this regulation, and definition of medically related psychosocial services.*** ***On 4/11/15 the Director of Social Services and Social Worker were in-serviced by the Assistant Administrator on their roles and function of The Advance Directive Committee.*** ***On 4/13/15 the Social Worker, Director of Social Services and Assistant Administrator were in-serviced by the Thomson-Hood Veterans Center (THVC) Director of Social Services regarding assessment and documentation requirements in long term care and included the review of several residents at this facility. New documentation was reviewed by the THVC Director of***	

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F 250	Continued From page 51 emergency guardianship, because he wanted to "meet with her (the Alternate Health Care Surrogate's daughter) in person and discuss it with her." The DSS stated he wanted to ensure the family member was "serious" about obtaining guardianship of Resident #1 before contacting the resident's physician. However, there was no evidence that the DSS took any action to arrange a meeting with the Alternate Health Care Surrogates daughter. Review of the Hospital Discharge Summary for Resident #1 dictated on 12/22/14, revealed the facility transferred Resident #1 to the hospital on 12/11/14, with shortness of breath, wheezing in the lungs, and pitting edema. Review of the Emergency Department (ED) Chart for Resident #1 dated 12/11/14, revealed upon arrival to the ED Resident #1's history was obtained via facility documentation, and the resident had no advance directives. The Summary stated that on 12/12/14, while admitted to the hospital for treatment of Chronic Obstructive Pulmonary Disease exacerbation, Resident #1 went into acute respiratory distress, was intubated, and placed on mechanical ventilation. The Summary stated Resident #1 also underwent hemodialysis (a medical procedure to remove fluid and waste products from the blood) on 12/12/14. Further review of the Summary revealed the hospital physician caring for Resident #1 contacted the Alternate Health Care Surrogate's daughter on 12/12/14, notifying her that Resident #1 had been intubated and was on mechanical ventilation. The Summary indicated that the Alternate Health Care Surrogate's daughter came to the hospital, but was not allowed to make health care decisions for Resident #1 because	F 250	***Social Services for the last 8 EKVC admissions and 22 other residents.*** ***Beginning on 4/10/15, staff received an in-service regarding Resident Rights and Advance Directives presented by the Director of Social Services and Administrative Branch Manager. Any staff member unable to attend this training will receive this in-service upon return to work and prior to performing resident care. Newly-hired staff will receive this training during new staff orientation.*** ***On 4/27/15 the Administrator and Quality Assurance Coordinator trained the Assistant Administrator on the proper use of the Advance Directive Continuous Quality Improvement (CQI) Audit Tool that will begin on 4/29/2015.*** 4. ***INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO ENSURE THAT SOLUTIONS ARE SUSTAINED.*** ***Beginning 3/13/15, audits were conducted by the Director of Social Services, Social Worker, or Assistant Administrator of advance directive***	

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F 250	Continued From page 52 the Alternate Health Care Surrogate's daughter did not have a Power of Attorney or other legal designation for Resident #1. The Summary stated that eventually a "next of kin" for Resident #1 was located and contacted via telephone on 12/13/14. The Next of Kin gave verbal authority to the physician to extubate Resident #1, and provide no further hemodialysis treatment. Resident #1 was extubated on 12/13/14 and readmitted to the facility on 12/16/14. 2. Review of Resident #2's medical record revealed the facility admitted the resident on 01/20/15, with diagnoses which included Malignant Neoplasm of the Larynx, Depression, Kidney Failure, and Osteoarthritis. Review of the Resident's Rights/Advance Directives form for Resident #2 dated 01/20/15, revealed the resident had executed a Durable Power of Attorney (DPOA) Advance Directive. Review of Resident #2's DPOA dated 09/21/12, revealed the resident's POA could consent to, refuse, or withdraw consent to any type of medical care, treatment, surgical procedure, diagnostic procedure, medication, and the use of mechanical or other procedures that affect any bodily function, including but not limited to artificial respiration, artificially administered nutrition, or hydration and cardiopulmonary resuscitation. Review of Resident #2's clinical record revealed a Dietary Progress Note dated 01/22/15, which stated the Unit Manager (UM) and the Registered Dietitian (RD) had spoken with resident's family member about the resident's ability to swallow. The Progress Note stated the family member was	F 250	***documentation sent with residents when going out of the facility for treatment. These audits will be conducted bi-weekly for 6 weeks, weekly for four weeks, and once per month for one month. Audit results will be reviewed by the Quality Assurance Committee during the monthly meeting.*** ***On 4/29/15, the Advance Directive bi-weekly log will be completed by the Director of Social Services and Social Worker, which will compare the Advance Directives currently in the Advance Directive section of the medical record to the Advance Directives listed on the Resident Rights form. The Assistant Administrator or Administrative Branch Manager will perform weekly chart audits. Audits will consist of reviewing 10 charts per week for 1 month, and 5 charts per week for 1 month. Audit results will be reviewed by the Quality Assurance Committee during the monthly meeting.***	

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F 250	Continued From page 53 informed the options for the resident "would be a tube feeding, Hospice, or to be discharged from the facility" if the resident could not have anything by mouth." Interview on 03/03/15 at 1:55 PM with Resident #2's family member revealed the family member had informed the facility that the resident had a Living Will that stated he/she did not want a feeding tube. Continued interview revealed facility staff informed the family member that the Assistant Administrator stated if it was recommended the resident be NPO, the resident would have to have tube feedings, be on Hospice services, or be discharged from the facility. Interview on 03/03/15 at 3:43 PM with the RD, and on 03/03/15 at 3:50 PM with UM #2 revealed they were not aware the resident had a Living Will until the family member informed them. Further interview with the RD and UM #2 revealed they informed the family member that the Assistant Administrator told them that if it was recommended that Resident #2 be NPO, a tube feeding would have to be placed, the resident would have to be placed on Hospice services, or the resident would be discharged from the facility. An interview with the DSS on 03/23/15 at 3:30 PM revealed he was not involved in the discussion regarding Resident #2's weight loss/swallowing difficulties. The DSS stated he thought the resident already had a feeding tube. Interview on 03/03/15 at 5:40 PM with the Assistant Administrator revealed he had discussed Resident #2's care with the RD because the resident had lost weight. He stated a feeding tube and Hospice were discussed as	F 250		

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F 250	Continued From page 54 options. The Assistant Administrator stated he was not aware the resident had a Living Will when the discussions occurred. 3. Review of Resident #4's medical record revealed the facility admitted the resident on 06/26/14 with diagnoses that included Chronic Respiratory Failure, Congestive Heart Failure, and Malignant Neoplasm of the Upper Lobe. Review of Resident #4's "Resident's Rights/Advance Directives" form, dated 06/26/14, revealed the resident executed a Living Will. However, review of the resident's Emergency Department Chart, dated 02/25/15 at 12:28 PM, revealed the facility transferred the resident to the local hospital and did not send the resident's Advance Directive. 4. Review of Resident #5's medical record revealed the facility admitted the resident on 06/10/14 with diagnoses that included Alzheimer's Disease, Dementia, Paranoid Schizophrenia, Depression, and Anxiety. Review of the "Resident's Rights/Advance Directives" form for Resident #5, dated 06/10/14, revealed the resident had executed a Power of Attorney (POA). Review of the resident's medical record revealed the facility failed to have a copy of the POA information in the chart. 5. Review of Resident #6's medical record revealed the facility admitted the resident on 07/23/09 with diagnoses, which included Dementia, Cerebrovascular Accident, Schizophrenia, Chronic Obstructive Pulmonary Disease, and Depression.	F 250		

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F 250	Continued From page 55 Review of the "Resident's Rights/Advance Directives" form, dated 07/23/09, for Resident #6 revealed the resident had a Health Care Surrogate. Review of the resident's Physician Orders dated 02/02/15, revealed the resident had a Living Will. The Physician's Order and the resident's Face Sheet stated, "Living Will-please see chart for instructions." However, review of the resident's medical record revealed the facility failed to have a copy of the Living Will in the chart. During an interview with the facility's Director of Social Services (DSS) on 03/03/15 at 11:00 AM, 5:15 PM, and 5:50 PM, the DSS stated his only role with advance directives was to inquire upon admission if they had formulated an advance directive. He stated if the resident did have an advance directive, it was placed in the resident's chart, and he had no further involvement in assisting residents with implementing the advance directive. Interviews with the facility's Administrator on 03/03/15 at 12:05 PM and 6:00 PM revealed that the DSS was responsible to oversee and ensure that residents were assisted to execute and/or implement their Advance Directives after admission to the facility. The Administrator stated he conducted no oversight or monitoring of Advance Directives in the facility. **The facility provided an acceptable Allegation of Compliance (AOC) on 03/24/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) On 03/10/15, licensed nursing staff that was on	F 250		

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F 250	Continued From page 56 duty at that time was informed immediately, by the ADON of actions to be taken, and on the proper paperwork that was to accompany Resident #1 and all other residents in the facility when they were transferred to any other facility including appointments and emergency care. This paperwork included Code Status, Living Will, POA, Guardianship papers, Healthcare Surrogate, Fiduciary, and any other legal documents in the Advance Directive section of the resident's medical record. 2) On 03/10/15, the Director of Social Services, Nurse Manager, QA (Quality Assurance) Coordinator, and MDS (Minimum Data Set) Coordinator conducted an immediate review of Resident #1's medical record and confirmed that the resident's Living Will was in the chart and in the correct location. 3) On 03/10/15, the MDS Coordinator immediately developed an Advance Directives Care Plan for Resident #1 after being notified of the immediate Jeopardy. 4) On 03/11/15, the Nurse Consultant in-serviced the MDS Coordinators on the process for developing an Advance Directive Care Plan. The Advance Directive Care Plan was reviewed by the Nurse Consultant for accuracy and determined to be correct. The Advance Directive Care Plan was then placed in Resident #1's chart. 5) An emergency Interdisciplinary Care Team Conference was conducted by phone with Resident #1's Health Care Surrogate on 03/11/15 at 12:00 PM, and at this time, the Surrogate verified that she was indeed this person's Healthcare Surrogate and the Living Will the	F 250		

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F 250	Continued From page 57 facility had on file reflected the resident's wishes. 6) The Interdisciplinary Care Conference Team consisting of the Administrator, Assistant Administrator, DON (Director of Nursing), ADON (Assistant Director of Nursing), Nurse Manager, Social Worker, MDS Coordinator, Clinical Dietician, and Attending Physician reviewed the resident's care plan to confirm that all components of the Living Will were included. 7) The Health Care Surrogate directed that Resident #1 be changed from "full code" (CPR) status to a "no code" (no CPR) status, which was witnessed by everyone present at the meeting. The Do Not Resuscitate form was completed and signed on 03/11/15 by the Nurse Manager and the Attending Physician. The Attending Physician wrote the new order and nursing staff updated the medical record to reflect the change. 8) Resident #1's care plan was confirmed on 03/11/15 to reflect the no code status and was determined by the Nurse Consultant to be correct. 9) On 03/11/15, the Attending Physician documented participating in the conference call on 03/11/15 with the Health Care Surrogate and discussed the current medical condition of the patient. Resident #1's intravenous (IV) fluids were discontinued on 03/11/15. 10) On 03/10/15, the Director of Social Services, Nurse Manager, QA Coordinator, and MDS Coordinator conducted an immediate review of Resident #2's medical record and confirmed that it included a copy of a Durable Power of Attorney (DPOA) and it was located in the correct location	F 250		

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F 250	Continued From page 58 of the medical record. 11) On 03/11/15, an emergency Interdisciplinary Care team that included the Administrator, Assistant Administrator, DON, ADON, Nurse unit Manager Social Worker, MDS coordinator, Clinical Dietician and Physician, conducted a meeting via telephone conference with Resident #2's Durable Power of Attorney (DPOA) and confirmed that the information the DPOA provided on admission on 01/20/15 was in fact correct in reflecting the current wishes of the resident. 12) On 03/10/15, the MDS Coordinator immediately developed an Advance Directives Care Plan for Resident #2 after being notified of the Immediate Jeopardy. 13) On 03/11/15, the Nurse Consultant in-serviced the MDS Coordinators on the process for developing an Advance Directive Care Plan. The Advance Directive Care Plans were reviewed by the Nurse Consultant for accuracy and determined to be correct. The Advance Directive Care Plan was then placed in Resident #2's chart. 14) As of 03/15/15, all current residents' charts have been reviewed by the Director of Social Services or Social Worker to ensure all Advance Directives, which include: DPOA, POA (Power of Attorney), Healthcare Surrogate, Guardianship, and Living Wills were in the chart and in the proper place. 15) All residents that are their own responsible party were interviewed by Social Services beginning on 03/11/15 to determine their cognitive status, and those with impaired cognition had a	F 250		

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F 250	Continued From page 59 legal representative. The residents were also asked about their code status and if they wanted any changes to their Advance Directives at that time. No residents, who were their own responsible party, were found to have changes in their cognitive status. 16) All residents or their designated representatives, except two (2), were called by Social Services, to confirm that their Advance Directive was current and up to date; and the Code Status that the facility had on file was correct. Social Services and the Assistant Administrator will continue to contact the legal representatives to confirm that the information the facility has on file is current. 17) On 03/15/15, through individual chart reviews, the Assistant Administrator verified that the Social Worker's Progress Notes confirmed the accuracy of the Advance Directives currently on file. The Assistant Administrator documented this in a monitoring log. 18) During this process two (2) residents had code status changes from CPR only to Full Code Status. The Full Code Status form was signed and placed in the resident's chart. The MDS Coordinators then updated the care plans on 03/14/15 and the face sheets were updated. 19) On 03/14/15, the Full Code Status Form was revised by the DON. Options of CPR only and Chemical Code were removed from the Full Code Status Form. The ADON and Charge Nurses (beginning on 03/15/15) completed training on this form change. 20) The MDS Coordinators were trained on	F 250		

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F 250	Continued From page 60 03/11/15 by the Nurse Consultant to ensure proper understanding of Advance Directive Care Plans and what should be included in them. This training included assessing whether the resident had an Advance Directive, Durable Power of Attorney for Healthcare, or a Living Will. 21) Care plans will also include the resident's expressed wishes regarding care and treatment goals as outlined by the Advance Directives. Social Services staff was trained as of 03/11/15 by the MDS Coordinators on how to develop the Advance Directive Care Plan. 22) All resident care plans were reviewed and revised relating to Advance Directives and Code Status by the MDS Coordinators, and was completed by 03/14/15 23) The MDS Coordinators will initiate the Advance Directives care plan upon admission. The Social Services Department will be responsible for maintaining and updating the Advance Directive Care Plans now and forward on all residents. 24) Beginning on 03/15/15, the Quality Assurance Nurse and Assistant Administrator began monitoring Social Services' care plans daily, to ensure that the residents' wishes related to advance directives were accurately reflected on their care plan and any changes in their Advance Directives had been addressed. This was accomplished by comparing the Social Services' Notes, the Advance Directive, and care plan following any reported changes to the resident's Advance Directives. In conjunction with the care plan audit, they were also monitoring whether the Advance Directives were current and in the	F 250		

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F 250	Continued From page 61 Advance Directives section of the resident's chart. 25) On 03/10/15, the Administrator, Assistant Administrator, DON, and ADON, discussed what immediate action needed to be taken. At that time, the ADON began informing Charge Nurses, Licensed Staff, and Ward Clerks on duty, of the proper paperwork that is to accompany all residents being transferred to any other facility including emergency care. This information included documents such as code status, Living Wills, POA, Guardianship, Healthcare Surrogate, Fiduciary, and any other legal documents in the Advance Directive Section of the resident's chart. 26) On 03/13/15 the Executive Director provided training on the State and Federal requirements. This training was provided to the Admissions Coordinator, Assistant Administrator, Assistant Director of Nursing, Social Worker and Licensed Practical Nurse (LPN) Coordinator and competency was demonstrated by a posttest on 03/13/15. Beginning on 03/13/15, the ADON provided the same training to the Administrator, DON, Director of Social Services, and Charge Nurses, and competency was demonstrated by a posttest. 27) The ADON began training the Administrator, Assistant Administrator, DON, Charge Nurses, Licensed Staff, and Ward Clerks on 03/13/15 regarding additional measures needed to be taken to ensure that all resident's information in the Resident Transfer Packet, which included Advance Directives were being sent to the receiving facility. This training gave direction that all residents' information was sent with him or her when they were transferred out of the facility and	F 250		

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F 250	Continued From page 62 will also be faxed to the receiving facility, copied and placed in the miscellaneous section of the chart with the fax transmission confirmation. During this time, staff was also instructed to compare the documents included in the Advance Directive Section to those listed on the resident's Face Sheet, which is generated from Point Click Care, to ensure all current documents were present. 28) Beginning on 03/11/15 the QA Nurse, Unit Manager, or the Assistant Administrator, started monitoring to ensure that all Advance Directives for a resident that was being transferred out of the facility were accurate and sent. This was accomplished by reviewing the resident's transfer packet that was copied, faxed, and placed in the miscellaneous section of the resident's chart. This process is being documented daily on a monitoring log; no problems have been identified at this time. 29) The facility initiated daily monitoring on 03/13/15 of staff training regarding resident transfer processes, faxing Advance Directives, the State and Federal requirements, Advance Directive Definitions, Sending Advance Directives during transfer, and the Advance Directives policy. The ADON or Charge Nurse was performing the monitoring through interviews with a minimum of three (3) staff per day that were previously trained. All shifts were included in this monitoring, and all shifts were being monitored within a 2-day period. 30) Beginning on 03/13/15, Social Services, MDS Coordinators, Admissions Coordinator, QA Coordinator, Licensed Staff, Ward Clerks, and Finance, were trained by the ADON, DON, or	F 250		

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F 250	Continued From page 63 Charge Nurse on the advance directive definitions and the State and Federal requirements; competency was demonstrated by posttest. 31) As of 03/13/15, the Administrator and Assistant Administrator reviewed and revised the Advance Directive Policy to reflect that upon admission the Admission Coordinator would provide a copy of this policy and would discuss and confirm the Advance Directive status with the resident and or responsible party and would document in the individual medical record with the Resident Rights/Advance Directives form upon admission whether the resident had an Advance Directive. The resident and/or legal representative, DPOA, POA, or Guardian would date and sign a statement attesting that the Advance Directive and facility policy had been explained upon admission. 32) The Admissions Coordinator will provide copies of Advance Directive information obtained on the day of admission to Finance, LPN Supervisor, and Unit Manager or Ward Clerk. 33) LPN Supervisor/Data Entry Specialist entered all orders into the Point Click Care to include code status and advance directives on the day of admission. This information was then generated to the resident's face sheet, which was sent to the resident's nursing unit, and then placed on the resident's chart by the ward clerk, on the day of admission. 34) On 03/14/15, the Assistant Administrator trained the Admissions Coordinator, ADON, and Social Services on the revisions to the Advance Directive Policy, responsibilities, and processes	F 250		

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F 250	Continued From page 64 that were in place to ensure that residents' advance directives were executed per the resident's wishes, and competency was demonstrated by a posttest. 35) Together the Assistant Administrator and ADON trained the DON, QA Coordinator, MDS Coordinators, Charge Nurses, Finance, and Unit Managers regarding the Advance Directive Policy and Procedure revision and competency was demonstrated by a post test. 36) Beginning 03/20/15, licensed staff and the ward clerks were trained on the changes to the Advance Directive Policy by the DON, ADON, or Charge Nurse and showed competency by test. All above-mentioned staff was trained as of 03/22/15 on this policy except eight (8) licensed staff and one ward clerk, who will be trained prior to returning to direct resident care. 37) Beginning on 03/13/15 the initial admissions portion of the Advance Directive procedure as outlined in the Advance Directive Policy was being monitored daily by the Assistant Administrator with each new admission. This will accomplished by reviewing the admissions' paperwork and confirming that any advance directives received during the admission process were in fact listed on the Resident's Rights/Advance Directive Sheet. The findings were then reported on a daily monitoring log with each new admission. No problems were identified at the time. 38) Starting on 03/11/15, the QA Coordinator or the Assistant Administrator checked resident charts daily to confirm that the Advance Directive section of the chart still contained all of the	F 250		

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F 250	Continued From page 65 resident's Advance Directives. This was accomplished by comparing the Advance Directives located in the chart to their daily monitoring log. 39) The Administrator and Assistant Administrator revised the Social Services Policy on 03/21/15 to include the procedure for invoking a health care agent or legal representative after the resident was determined not to have decision-making capacity. This policy stated, "The assigned social worker will determine if the resident is self-responsible or if they have a POA, DPOA, or legal guardian in place. The social worker would contact them to let them know the resident has had a mental status change and can no longer make their own decisions. If the legal representative accepts responsibility, they will begin making decisions for the resident. If the resident does not have a POA, DPOA or legal guardian then social services would contact any family members who may be willing to be the responsible party for the resident. If the family members are not willing, then social services will contact Adult Protective Services (APS) and request the process for obtaining a guardian to be started." 40) Social Services was trained on 03/22/15 by the Assistant Administrator regarding the revised Social Services Policy. 41) During the admission process, the Admissions Coordinator would determine the resident's legal representative based on information provided by the resident at the time of admission. 42) Upon admission, the resident's mental status	F 250		

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F 250	Continued From page 66 was assessed by the Licensed Staff assigned to the resident on their unit through the nursing admission assessment form, and by the MDS Coordinators through the Brief Interview Mental Status (BIMS), which is done within seven (7) days of admission and also done quarterly with scheduled care plan meetings and with any significant change. Should any of these assessments indicate the resident was not capable of being their own decision maker, Social Services would be informed by the nursing staff during the daily morning management administrative meeting of any mental status changes that may require further assessment. 43) If a mental status change and further assessment of a resident indicated the need for a legal representative, then at that point Social Services would seek to invoke the health care agent or legal representative as outlined in the Social Services Policy. 44) The Assistant Administrator checked to ensure that any issues relating to Social Services have been followed-up on during the daily Social Services meeting. This was documented on the Daily Social Services Meeting Minutes. 45) Upon admission, the resident's assigned Social Worker would confirm Advance Directives. Furthermore, the Social Worker would review the advance directive status when requested by the resident or responsible party, upon any re-admission, quarterly with care plan meetings and after any significant change. 46) The Social Worker would assist the resident in developing a living will within twenty-four (24) hours of being requested. The Assistant	F 250		

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F 250	Continued From page 67 Administrator would monitor this by comparing the Advance Directives to what was stated on the Resident's Rights/Advance Directive Sheet and documented in the Social Services Progress Note. 47) As of 03/13/15, the Assistant Administrator initiated daily meetings with the Social Worker and Director of Social Services to discuss any residents that were sent out of the facility, returned to facility, or had received any new documents concerning Advance Directives. 48) All Advance Directive care plans will be reviewed immediately upon admission or re-admission by the Social Worker and documentation of the review will be placed in the Social Worker Notes. These would also be reviewed by the MDS Coordinator and Social Worker and the rest of the interdisciplinary care plan team during scheduled care plan meetings, and then documented in the Social Services section of the clinical record as well as the Interdisciplinary Care Plan Sheets. 49) If the resident and/ or their representative were present during this care plan meeting, the Advance Directive and Code Status would be discussed to confirm that the directive continues to reflect the resident's wishes. If there was no representative present, Social Services would contact the legal representative to confirm the Advance Directive was still current. This will be completed with the Quarterly MDS review, and any change in status. 50) The Quality Assurance (QA) Nurse and Assistant Administrator were monitoring care plans relating to advance directives daily to	F 250		

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F 250	Continued From page 68 ensure the residents' wishes expressed on the Advance Directives were outlined in the care plans as of 03/15/15. 51) Beginning on 03/20/15, Licensed Staff and Ward Clerks were given re-enforcement training by the ADON, related to information to be included on the shift-to-shift report, and competency was proven by a post test. 52) On 03/16/15, the Administrator instructed the Nurse Managers and DON to begin reporting any mental status changes reported on the shift-to-shift report during the Morning Administrative Management Meeting. At that time, the team would discuss necessary changes that needed to be addressed, if any. As of 03/22/15, no change in any resident's mental status had been reported. This was documented daily on the Daily Morning Administrative Management Meeting Notes. 53) When a significant change, quarterly or annually assessment is conducted and a brief interview of mental status (BIMS) will be completed on each resident to determine their decision making ability by the MDS Coordinator. This will be reported to the resident's assigned Social Worker, to determine if any changes in legal representative needs to be made. 54) When a resident is admitted, readmitted, or had verbalized their desire to change their code status, the nurse will contact the Doctor and obtain a Doctor's order. At that time, a DNR or full code status form would be completed with two (2) caregiver signatures. If the code status was obtained by telephone, the same process will apply. The nurse will document the code status	F 250		

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F 250	Continued From page 69 change in the Nurse's Notes and place the change on the shift-to-shift report. 55) Beginning on 03/20/15, licensed staff and ward clerks were trained on the changes to the Advance Directive Policy by the DON, ADON, or Charge Nurse and showed competency by a post test. The Advance Directive Policy included the process for contacting the legal representative with any changes in the Advance Directives. All above-mentioned staff was trained as of 03/22/15 on this policy, except for eight (8) licensed staff and one ward clerk, who will be trained prior to returning to direct resident care. 56) Per the revised Advance Directives Policy, Social Services or designated others will assist the residents who elect to execute an Advance Directive. Social Services will ensure all documents that belong in the Advance Directive Section are placed in the medical chart. 57) Social Services was trained on the changes to the Advance Directive Policy on 03/14/15 by the ADON; and competency was demonstrated by a post test. 58) A copy of the Code Status order will be given to the LPN Supervisor, who will input the order into the "Point Click Care System" and the Admission Record will be generated from this information. The Admission Record (Face Sheet) will be sent to the resident's nursing unit and placed in front of the chart by the ward clerk, on the day of the change in code status. 59) On 03/15/15, the Assistant Director of Nursing implemented and trained all Licensed staff and Ward Clerks on the modified existing transfer	F 250		

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F 250	Continued From page 70 form to provide an expanded checklist that specifically listed Living Wills, Power of Attorney, Health Care Surrogate or Guardianship documents. 60) As of 03/11/15, compliance with the policies and processes were being verified daily by the facility's Administrative team which consists of the Administrator, Assistant Administrator, Director of Nursing, and Assistant Director of Nursing or QA Coordinator and reviewed daily during the QA Daily meeting. Any notice of non-compliance will be reported to the Administrator and a plan of action will be developed to prevent reoccurrence. 61) The Executive Adviser and the Nurse Consultant will review the minutes of the management meetings and will attend meetings at least weekly to ensure the Allegation of Compliance is being implemented and that any adjustments to the process are identified, discussed and steps implemented to correct. 62) The Executive Adviser and Nurse Consultant are in daily consultation with the Administrator since 03/11/15. They are reviewing documentation, interviews and training staff to ensure the plan is being carried out as alleged. ***The SSA validated the Immediate Jeopardy was removed as follows: 1) Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM and RN #2 on 03/24/15 at 2:56 PM revealed they were knowledgeable regarding what paper work was to be transferred with residents when sent out of the	F 250		

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F 250	Continued From page 71 facility including all Advance Directives formulated by the resident. 2) Review of Resident #1's chart on 03/24/15 revealed the resident's Living Will was in the chart and in the correct location. 3) Review of Resident #1's chart on 03/24/15 at 1:50 PM revealed an Advance Directive Care Plan was present in the medical record. 4) Interviews with MDS Coordinator #2 on 03/24/15 at 3:06 PM revealed the Nurse Consultant had trained her on developing an Advance Directive care plan. Interview with the Nurse Consultant on 03/24/15 at 2:00 PM, revealed she had confirmed the accuracy of Resident #1's Advance Directive Care Plan. 5) Review of the Progress Notes dated 03/11/15, and interview with Resident #1's Health Care Surrogate on 03/13/15 at 3:00 PM revealed a care plan conference was conducted via telephone to discuss Resident #1. During the interview, the Health Care Surrogate stated she was making health care decisions for Resident #1. 6) Interviews on 03/24/15, at 4:44 PM with the Administrator; at 3:32 PM with the Assistant Administrator; and, at 4:37 PM with the DON (Director of Nursing) revealed they had all reviewed Resident #1's care plan and confirmed it contained all the Advance Directives that were included in Resident #1's Living Will. 7) Interview with Resident #1's Health Care Surrogate on 03/13/15 at 3:00 PM revealed she confirmed with the facility that Resident #1 was to	F 250		

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F 250	Continued From page 72 be a DNR. Review of Resident #1's medical record on 03/24/15 at 1:50 PM revealed the DNR form was signed on 03/11/15. Resident #1's medical record also contained a signed Physician's Order for the DNR status. 8) Review of Resident #1's chart on 03/24/15 at 1:50 PM revealed the resident's care plan reflected the DNR status. 9) Review of Physician Nots, dated 03/11/15 revealed the physician documented participating in the conference call on 03/11/15 with the Health Care Surrogate and discussed the current medical condition of the resident. Review of Resident #1's medical record revealed Intravenous (IV) fluids were discontinued for Resident #1 on 03/11/15. Observation of Resident #1 on 03/24/15 at 3:09 PM revealed the resident was not receiving IV fluids. 10) Review of Resident #2's medical record on 03/24/15 at 2:20 PM revealed it contained a copy of the resident's Durable Power of Attorney (DPOA) and it was located in the correct section of the medical record. 11) Review of the Progress Notes dated 03/11/15, and Interview with Resident #2's DPOA on 03/13/15 at 3:00 PM revealed the facility confirmed the information in Resident #2's DPOA was correct and reflected the wishes of Resident #2. 12) Review of Resident #2's medical record on 03/24/15 at 2:20 PM revealed it contained an Advance Directive Care Plan for Resident #2. 13) Interview with MDS Coordinator #2 on	F 250		

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F 250	Continued From page 73 03/24/15 at 3:08 PM revealed the Nurse Consultant trained her on developing an Advance Directive care plan. Interview with the Nurse Consultant on 03/24/15 at 2:00 PM, revealed she confirmed the accuracy of Resident #2's Advance Directive Care Plan. 14) Review of a Resident Disposition form dated 03/15/15, and interview on 03/24/15 at 4:05 PM with the Director of Social Services revealed that all charts had been reviewed to ensure Advance Directives were on the chart under the designated tab. 15) Interviews on 03/24/15 at 3:15 PM with Resident #3 and at 3:22 PM with Resident #4 revealed they had been interviewed by the DSS and had not made changes in their code status designations. Review of Social Service Notes for Residents #20 and #23 revealed entries dated 03/11/15, indicating they had a responsible party named, and no changes in their cognitive status had been identified. 16) Review of a facility Resident Roster revealed that all residents or their designated representatives except one had been interviewed to ensure Advance Directives and Code Status were correct for each resident. Review of a copy of a certified letter revealed the facility had attempted to contact the remaining responsible party. 17) Interview with the Assistant Administrator on 03/24/15 at 3:32 PM, and review of the Advance Directive Monitoring Log revealed the Assistant Administrator had reviewed the Social Worker's Progress Notes to ensure they were accurate when compared with the Advance Directive on file	F 250		

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F 250	Continued From page 74 for each resident. 18) Review of Residents #9 and #14's medical record revealed their code status designation had been changed to Full Code Status. The medical record revealed a Code Status form was signed and in the medical records. Review of resident's care plans also revealed the update was on the care plans. 19) Review of the facility's Code Status form revealed it had been updated on 03/14/15. Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM, and RN #2 on 03/24/15 at 2:56 PM revealed they had been trained on the form changes. 20) Interview with MDS Coordinator #2 on 03/24/15 at 3:08 PM revealed she had been trained by the Nurse Consultant related to Advance Directive care plans and was able to verbalize the different types of Advance Directives. 21) Review of Residents #1, #2 and #4's Care Plans revealed they included the resident's expressed wishes that were contained in their Advance Directives. Interview with the DSS on 03/24/15, at 4:05 PM revealed he was trained on how to develop an Advance Directive care plan. 22) Review of Residents #1, #2 and #4's Care Plans revealed they had been revised and included Advance Directives and Code Status. 23) Interview with MDS Coordinator #2 on 03/24/15 at 3:06 PM revealed she was knowledgeable that she would be responsible for maintaining and updating the Advance Directive	F 250		

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F 250	Continued From page 75 Care Plans after initial development by the DSS. 24) Review of a Care Plan Monitoring Log and interviews on 03/24/15 at 1:48 PM and 3:32 PM with the Quality Assurance Nurse and Assistant Administrator revealed the Social Service care plans related to Advance Directives were being reviewed daily to ensure the resident's wishes relating to advance directives were accurately reflected on their care plan and included any changes. 25) Interview with the DON on 03/24/15 at 4:37 PM revealed she initiated training on 03/10/15 with staff related to sending all Advance Directives with a resident when they were transferred out of the facility. 26) Interviews on 03/24/15 at 2:11 PM with the Admissions Coordinator, at 3:32 PM with the Assistant Administrator, and at 4:05 PM with the DSS; and review of an In-service Sign In Sheet dated 03/13/15, revealed the Executive Director had provided training on the State and Federal requirements. Review of competency testing revealed each of the staff had also completed a competency test. 27) Review of a facility In-service Sign In Sheet dated 03/13/15, revealed the ADON trained the Administrator, Assistant Administrator, DON, Charge Nurses, Licensed Staff, and Ward Clerks regarding ensuring that all resident information related to Advance Directives was being sent to the receiving facility and faxed. Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM, RN #2 on 03/24/15 at 2:56 PM, and Ward Clerk #1 at 3:14 PM, revealed they were knowledgeable regarding the process for	F 250		

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F 250	Continued From page 76 sending Advance Directive information with residents when transferred out of the facility. 28) Review of a Transfer Monitoring Log and interviews on 03/24/15 at 1:48 PM with the QA nurse and at 3:54 PM with Unit Manager #1, revealed all resident transfers were being monitored to ensure all Advance Directives for each resident transferred out of our facility had been sent and were accurate. 29) Review of daily questionnaires and interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM and RN #2 on 03/24/15 at 2:56 PM revealed staff was being asked questions to ensure competency on the State and Federal requirements daily by the ADON or a Charge Nurse. 30) Review of In-service Sign In Sheets and interviews on 03/24/15, at 4:05 PM with the DSS, at 3:06 PM with MDS Coordinator #2, at 2:11 PM with the Admissions Coordinator revealed they were trained on Advance Directive definitions and the State and Federal requirements. They completed a competency test. 31) Interviews conducted on 03/24/15 at 4:44 PM with the Administrator and at 3:32 PM with the Assistant Administrator and review of the Advance Directive Policy revealed the Advance Directive Policy had been revised to include the following: upon admission the Admission's Coordinator will provide a copy of this policy and will discuss and confirm the advance directive status with the resident and or responsible party and upon admission, will document in the individual medical record using the Resident Rights/Advance Directives Form whether the	F 250		

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F 250	Continued From page 77 resident had an Advance Directive. The resident and/or legal representative will date and sign a statement attesting that the Advance Directive and the facility's policy had been explained upon admission. 32) Interview with the Admissions Coordinator on 03/24/15 at 2:11 PM, revealed she it is her responsible to provide copies of the Advance Directive information related to each new admission to the Finance Department, the LPN Supervisor, and the Unit Manager or Ward Clerk. 33) Interviews on 03/24/15 at 4:30 PM with the LPN Supervisor/Data Entry Specialist revealed she was knowledgeable on the process to enter code status and advance directive information for residents when they were admitted. Review of a Face Sheet for a resident admitted to the facility on 03/20/15, revealed the resident's Face Sheet contained the appropriate information related to Code Status and Advance Directives. 34) Review of an In-service Sign In Sheet dated 03/14/15, and interviews on 03/24/15 at 2:11 PM with the Admissions Coordinator, and at 4:05 PM with the DSS revealed the Assistant Administrator trained them on the revisions to the Advance Directive Policy and Procedures. 35) Review of an In-service Sign In Sheet dated 03/14/15, revealed the Assistant Administrator and ADON trained the DON, QA Coordinator, MDS Coordinators, Charge Nurses, Finance Staff, and the Unit Managers on the Advance Directive Policy and Procedure revision and staff completed a competency test. 36) Review of a facility In-service Sign In sheet	F 250		

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F 250	Continued From page 78 dated 03/20/15, and interviews on 03/24/15, with LPN #2 at 2:28 PM, with LPN #1 at 3:23 PM, and with RN #2 at 2:56 PM, revealed they were trained on the changes to the Advance Directive Policy, and completed a competency test. 37) Review of the Advance Directive Monitoring Log and interview with the Assistant Administrator revealed he conducted daily monitoring of the admission process related to Advance Directives for each new admission. The Assistant Administrator stated he reviewed the admissions paperwork and confirmed that any advance directive received during the admission process was listed on the Resident Rights/Advance Directive sheet. 38) Interviews on 03/24/15 at 1:48 PM with the QA Coordinator and at 3:32 PM with the Assistant Administrator revealed they were checking resident charts daily to ensure all Advance Directives were on the chart in the appropriate section. 39) Review of the Social Services Policy and interview on 03/24/15 at 4:44 PM with the Administrator; and, at 3:32 PM with the Assistant Administrator revealed they revised the Social Services Policy on 03/21/15 to include the procedure for invoking a health care agent or legal representative after the resident was determined not to have decision-making capacity. 40) Review of an In-service Sign In Sheet and interview with the DSS on 03/24/15 at 4:05 PM revealed the DSS was trained by the Assistant Administrator on the revised Social Services Policy on 03/22/15.	F 250		

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F 250	Continued From page 79 41) Interview on 03/24/15 at 2:11 PM with the Admissions Coordinator revealed she was knowledgeable regarding determining a resident's responsible party, if applicable, at the time of admission. 42) Interviews conducted on 03/24/15 at 4:00 PM with Charge Nurse #1 and at 3:54 PM with Unit Manager #1 revealed they were knowledgeable regarding the procedure for assessing a resident's mental status upon admission. The staff stated if these assessments indicated the resident was unable to make competent decisions, the DSS would be informed. 43) Interview with the DSS on 03/24/15 at 4:05 PM revealed that if a resident was assessed to have a mental status change and further assessment indicated a need for a responsible party to be identified for decision making the DSS would then attempt to identify a responsible party or involve State Adult Protective Services if indicated. 44) Interview with the Assistant Administrator on 03/24/15 at 3:32 PM revealed he was responsible to ensure any issues relating to Social Services have been addressed during the facility's morning meeting. Any issues identified would be documented in the Social Services meeting minutes. 45) Interview with the DSS on 03/24/15 at 4:05 PM revealed Social Services would confirm the resident's Advance Directives on admission, when requested by a resident or family, or during any MDS assessment. 46) Interview with the DSS on 03/24/15 at 4:05	F 250		

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F 250	Continued From page 80 PM and review of a Living Will formulated on 03/12/15, revealed residents would be assisted within twenty-four hours by the Social Worker in developing an Advance Directive. Interview with the Assistant Administrator on 03/24/15 at 3:32 PM revealed the Assistant Administrator would monitor this by comparing the formulated Advance Directive to what was stated on the Resident Rights/Advance Directive sheet and documented in the Social Services Progress Note. 47) Interviews on 03/24/15 at 3:32 PM with the Assistant Administrator and at 4:05 PM with the DSS, revealed the Assistant Administrator and Social Services were meeting daily to discuss the status of any resident transferring or returning to the facility to review the status of their Advance Directives. 48) Interviews on 03/24/15 at 4:05 PM with the DSS revealed Advance Directive care plans would be reviewed when a resident was re-admitted to the facility, and noted in the Social Services Notes. Interview with MDS Coordinator #2 on 03/24/15, at 2:11 PM revealed the Advance Directive would also be reviewed during scheduled care plan meetings, and documented in the Social Services section of the clinical record as well as the resident's care plan. 49) Interview with MDS Coordinator #2 on 03/24/15, at 2:11 PM revealed if the resident and/or their representative were present during a care plan meeting, the Advance Directive and Code Status would be discussed to confirm the directive continued to reflect the resident's wishes. If the resident or their representative were not present, Social Services would contact	F 250		

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F 250	Continued From page 81 the legal representative and confirm the Advance Directive was still current. 50) Interviews on 03/24/15 at 1:48 PM with the Quality Assurance Nurse and at 3:32 PM with Assistant Administrator revealed they monitored care plans related to advance directives daily to ensure the resident's wishes expressed on the Advance Directives were included in the resident's plan of care. 51) Interviews on 03/24/15 at 2:44 PM with Ward Clerk #3 and at 3:14 PM with Ward Clerk #1, and review of in-service Sign In Sheets revealed they were trained by the ADON on 03/20/15 related to the shift-to-shift report and completed a competency test. 52) Review of the daily administrative meeting documentation and interview on 03/24/15 at 3:54 PM with Unit Manger #1 revealed the Administrator instructed her on 03/16/15 to record any mental status changes of a resident on the shift-to-shift report. The report would be reviewed at the morning administrative meeting where any necessary changes would be discussed. 53) Interview with MDS Coordinator #2 at 3:06 PM on 03/24/15, revealed when an MDS assessment was completed which included a Brief Interview of Mental Status (BIMS) score, it would be reported to the resident's assigned Social Worker, to determine if any changes in legal representative needed to be made. 54) Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM and RN #2 on 03/24/15 at 2:56 PM, revealed they were knowledgeable regarding the steps to be taken to	F 250		

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F 250	Continued From page 82 change a resident's code status. 55) Review of In-service Sign In Sheets dated 03/20/15, revealed licensed staff and Ward Clerks were trained on the changes to the Advance Directive Policy and completed competency testing. 56) Interview with the DSS on 03/24/15 at 4:05 PM revealed Social Services or a staff they designated would be responsible to assist residents who wished to execute an Advance Directive. Social Services would also ensure Advance Directive documents were placed in the resident's chart. 57) Review of an In-service Sign In Sheet dated 03/14/15, revealed Social Services staff was trained on the changes to the Advance Directive Policy by the ADON, and completed a competency test. 58) Interview with LPN #2 at 2:28 PM on 03/24/15, revealed Code Status orders would be entered into the Point Click Care System and then the Admission Record would be generated and sent to the resident's nursing unit. Interview with Ward Clerk #3 at 2:44 PM on 03/24/15 revealed the record would then be placed in the resident's chart. 59) Review of a Resident Transfer Form dated 03/15/15 revealed it had been modified to include a checklist that specifically listed Living Wills, Powers of Attorney, Health Care Surrogate or Guardianship documents which were to be included when a resident was transferred. Review of In-Service sign in Sheets initiated on 03/15/15, revealed licensed staff and Ward	F 250		

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F 250	Continued From page 83 Clerks were trained on the revision. 60) Review of daily QA Meeting Minutes revealed the Advance Directive Policies and procedures were being reviewed and verified daily by the facility's Administrative team consisting of the Administrator, Assistant Administrator, Director of Nursing, and Assistant Director of Nursing or QA Coordinator and reviewed daily during the QA Daily meeting. Interview with the Administrator on 03/24/15 at 4:44 PM revealed any non-compliance was to be reported to him and a plan of action would be developed to prevent reoccurrence. 61) Interviews on 03/24/15 at 2:00 PM with the Executive Adviser and the Nurse Consultant revealed they would review the minutes of the management meetings and attend meetings at least weekly to ensure the Allegation of Compliance was being implemented and any needed adjustments to the process were being identified and addressed. 62) Interviews on 03/24/15 at 2:00 PM with the Executive Adviser and Nurse Consultant revealed they were in daily consultation with the Administrator since 03/11/15 to ensure the plan was being carried out as alleged.	F 250		
F 279 SS=K	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	1. ***ADDRESS WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.***	***05/15/15***

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F 279	Continued From page 84 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to develop a care plan for nineteen (19) of twenty-four (24) sampled residents (Residents #1, #2, #4, #5, #6, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21) that identified the resident's preferences regarding Advance Directives which dictated the resident's care and treatment wishes at a time when/if the resident lacked the ability to do so to ensure the resident's highest practicable psychosocial well-being. Resident #1 was admitted to the facility with an executed Advance Directive, which dictated the resident's wishes regarding life-prolonging treatment and artificially provided food, water, and fluids, to be implemented when the resident became incapacitated and unable to make decisions. However, the facility failed to develop	F 279	*On 3/11/15, MDS Coordinators began developing Advance Directive Care Plans for the following residents: 1,2,4,5,6,8,9,10,11,12,13,14,15,16,17,18, 19,20,21. Prior to completing these care plans the resident or their legal representative was contacted by Social Services to ensure the information in the Advance Directive reflected the resident's preferences.* *On 3/11/15, the Interdisciplinary Care Team which included the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Manager, Social Worker, MDS Coordinator, Clinical Dietician and Attending Physician conducted a telephone conference with Resident #1's Health Care Surrogate (HCS) and Resident #2's Durable Power of Attorney (DPOA). This individual confirmed their role for both residents and confirmed the advance directive documents on file represented the wishes of each resident respectively. Additionally, the DPOA of Resident #2 confirmed that all components of the DPOA were addressed in the care plan.* • On 3/11/15 the social worker talked with Resident #9 about his code status of CPR only. After the discussion with Social Services the resident expressed wishes that he be a Full Code. *Appropriate orders were written and face sheet revised accordingly. Care plan was*	

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F 279	Continued From page 85 an initial care plan which recognized or addressed the Advance Directive, and failed to periodically reassess the resident's plan of care related to Advance Directives (refer to F155, F250, F309, and F490). Medical record review of Residents #2, #4, #5, #6, #8, #10, #11, #12, #13, #15, #16, #17, #18, #19, #20, and #21 revealed the residents all had Advance Directives (Living Will, Power of Attorney, or Health Care Surrogate Designation). The facility failed to develop a care plan that included advance care planning to address residents' advance directives. Interviews with Minimum Data Set (MDS) Coordinators #1 and #2 revealed the only advance directive incorporated into a resident's plan of care was the resident's designated cardiopulmonary resuscitation status (CPR). Resident #9 and Resident #14 chose "CPR only" code status upon admission to the facility. The facility failed to ensure the residents' code status was accurately reflected on the residents' care plans. Review of the residents' care plans revealed the facility identified the residents were classified as "full code" (refer to F309). The facility's failure to have an effective system in place to ensure the process of Advance Directive care planning was ongoing; and failure to afford the resident/family the ability to implement an advance directive was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 12/11/14 at 42 CFR 483.10 Resident Rights (F155), 42 CFR 483.15 Quality of Life (F250), 42 CFR 483.20 Resident Assessment (F279), 42 CFR 483.25 Quality of Care (F309), and 42 CFR 483.75	F 279	***updated to reflect full code status on 3/16/15.*** • On 3/13/15 the social worker talked with Resident #5's legal representative to confirm the Advance Directives on record reflect the resident's wishes and no changes were made. • On 3/13/15 the social worker contacted Resident #14's responsible party about his code status of CPR only. After the discussion with the social worker, Resident #14's responsible party expressed wishes for the resident to be a full code. On 3/13/15 the resident's face sheet was updated to include the Full Code status. On 3/13/15 the resident's care plan was also updated to include the Full Code Status by the MDS Coordinator. • ***On 3/14/15 the social worker talked with Residents #11, #12, #13, #19, and #20 and confirmed there were no changes to their Advance Directives.*** • ***On 3/15/15 the social worker talked with Residents #10, #15, #17, #18, and #21 and confirmed there were no changes to their Advance Directives.*** • ***On 3/16/15 the social worker talked with Residents #4 and #6 and confirmed there were no changes to their Advance Directives.*** • On 3/21/15 the social worker talked with Resident #8 and confirmed there were no changes to his Advance Directives. • On 3/26/15 the social worker talked with Resident #16 and confirmed there	

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F 279	Continued From page 86 Administration (F490). The facility was notified of the Immediate Jeopardy on 03/10/15. An acceptable Allegation of Compliance was received on 03/24/15 which alleged removal of the Immediate Jeopardy on 03/23/15. A Partial Extended Survey was conducted on 03/23/15-03/24/15. The State Survey Agency determined the Immediate Jeopardy was removed on 03/23/15, which lowered the Scope and Severity to "E" at 42 CFR 483.10 Resident Rights (F155), 42 CFR 483.15 Quality of Life (F250), 42 CFR 483.20 Resident Assessment (F279), 42 CFR 483.75 Administration (F490); and, 42 CFR 483.25 Quality of Care (F309) Scope and Severity of a "D", while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy and procedure, "Care Plans-Comprehensive," undated, revealed the resident's comprehensive care plan was designed to reflect the resident's expressed wishes regarding care and treatment goals. The policy also stated interventions would be implemented that were targeted and meaningful to the resident. Additionally, the policy stated the interdisciplinary process would require careful data gathering, proper sequencing of events, and complex clinical decision-making. Further review of the facility's policy revealed it was the responsibility of the "Care Planning/Interdisciplinary Team" to develop a comprehensive care plan and no single person was responsible. However, an interview on 03/09/15 at 11:45 AM with MDS Coordinators #1 and #2 revealed they were responsible for	F 279	were no changes to his Advance Directives. 2. *ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE.* Beginning 3/11/15 the *MDS Coordinators began updating all resident care plans to reflect verified advance directive preferences, and was completed on 3/26/15.* *Upon admission, the Admissions Coordinator will confirm the Advance Directives* of the resident or legal representative and the MDS Coordinator will create a Preliminary Advance Directive Care Plan as required *Upon Re-admission, the resident's assigned social worker will confirm the resident's advance directive preferences and make appropriate medical record updates if any changes are requested by the resident or legal representative.* 3. *ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR* *On 3/11/15, the MDS Coordinators were in-serviced by the KDVA Nurse Consultant regarding the Advance Directive Care Planning process and*	

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F 279	Continued From page 87 completing MDS assessments and completing care plans in the facility. 1. Review of Resident #1's medical record revealed the facility admitted the resident on 02/19/09, and acknowledged upon admission that Resident #1 had executed an advance directive related to life-prolonging treatment and artificially provided food, fluids, and nutrition. Review of Resident #1's Admission Minimum Data Set (MDS) assessment dated 02/19/09, revealed the facility assessed Resident #1 to be moderately cognitively impaired. However, the facility failed to identify on the assessment that Resident #1 had formulated an Advance Directive, and had named a Health Care Surrogate designated to make decisions if he/she became unable to do so himself/herself. Review of Resident #1's Initial Comprehensive Care Plan dated 03/02/09, revealed Resident #1 had impairment with both long and short-term memory, but was able to make most decisions for himself/herself. The Care Plan did not address Resident #1's Advance Directive related to life-prolonging treatment or the administration of artificially provided food, water, or fluids. Review of Resident #1's MDS assessment completed on 02/25/15, revealed the facility assessed Resident #1 to be severely cognitively impaired and rarely or never able to make decisions. Review of Resident #1's Comprehensive Care Plan updated on 02/25/15 revealed the resident was dependent on staff related to cognitive impairment. However, the Care Plan failed to identify that Resident #1 had formulated a Living Will and would be dependent on facility staff to assist the resident with	F 279	*documentation requirements, including assessing whether the resident has Advance Directives, Durable Power of Attorney for Health Care, and Living Wills. Also, care plans are to include the resident's expressed wishes regarding care and treatment goals as outlined in the documents the resident provides.* *On 3/11/15 the MDS Coordinators trained the Social Service staff to ensure proper understanding of components to be included in the Advance Directive Care Plans as well as maintaining and updating the care plans for all residents.* *As of 4/14/15 the Advance Directive Policy (6.14.1) revisions relative to creating and implementing Advance Directives Preliminary Care Plan were in-serviced to MDS Coordinators and Social Services by the Administrator.* 4. *INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED.* *On 4/6/15, audits were conducted by Unit Managers/Charge Nurse of advance directives in the medical record with developed care plan, each of these audits will be conducted with 10 care plans/advance directives weekly for four weeks and 5 care plans/advance directives per week for four weeks.*	

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F 279	Continued From page 88 executing the Advance Directive. Review of the clinical record revealed documentation from a hospital "Emergency Department Chart" dated 12/11/14, which stated the facility transferred Resident #1 to the Emergency Department (ED) on 12/11/14, but failed to send the resident's Advance Directive. Resident #1 was admitted to the hospital. On 12/12/14, when the resident's health condition deteriorated, Resident #1 was intubated, placed on mechanical ventilation, and received hemodialysis, which was against the resident's expressed wishes in his/her Advance Directive. Resident #1 was extubated on 12/13/14, and readmitted to the facility on 12/16/14. Additionally, the facility infused Resident #1 intravenously (IV) with artificial fluids, from 02/17/15 until 03/11/5, which was against the resident's expressed wishes in the Advance Directive. The facility did not consult or obtain consent from Resident #1's Alternate Health Care Surrogate. Interview with Registered Nurse (RN) #1, who completed Resident #1's Initial Admission MDS assessment and Comprehensive Care Plan, stated she did not recall doing the details of Resident #1's admission documentation. She stated she had never been trained or instructed to care plan any Advance Directive other than the resident's designated cardiopulmonary resuscitation (CPR) designation. 2. Review of Resident #2's medical record revealed the facility admitted the resident on 01/20/15 with diagnoses which included Malignant Neoplasm of the Larynx, Depression, Kidney Failure, and Osteoarthritis.	F 279	*Audit results will be reviewed by the Quality Assurance Committee monthly.* *As of 4/29/15 the Director of Social Services and Social Worker began bi-weekly audits of all resident advance directive care plans. The Assistant Administrator and Administrative Branch Manager will be auditing 10 resident advance directive care plans weekly for 4 weeks, and then 5 resident's Advance Directive Care Plans per week for 4 weeks. Audit results will be reviewed by the QA Committee monthly. Any inaccuracies will be reported to the Administrator immediately and re-education and/or disciplinary action will result. The Administrator will ensure compliance and the results will be presented to the Quality Assurance Committee for further review monthly.*	

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F 279	Continued From page 89 Review of Resident #2's Admission Minimum Data Set (MDS) assessment, dated 01/27/15, revealed the resident was cognitively impaired. Review of the Resident's Rights/Advance Directives form dated 01/20/15 for Resident #2 revealed the resident had executed a Durable Power of Attorney (DPOA) Advance Directive. Review of Resident #2's DPOA dated 09/21/12, revealed the resident's POA could consent to, refuse, or withdraw consent to any type of medical care, treatment, surgical procedure, diagnostic procedure, medication, and the use of mechanical or other procedures that affect any bodily function including but not limited to artificial respiration, artificially administered nutrition or hydration, and cardiopulmonary resuscitation. Review of Resident #2's Plan of Care dated 01/28/15, revealed the facility developed a care plan related to the resident's Do Not Resuscitate (DNR) status; however, the facility failed to develop a care plan regarding the DPOA and the resident's wishes regarding health care decisions. Continued review of the resident's Plan of Care revealed the plan of care had been revised on 02/06/15, related to the resident not wanting to have a feeding tube placed (see F155). However, the Care Plan did not include Advance Directive care planning information to address the resident's wishes regarding health care decisions. 3. Review of Resident #4's medical record revealed the facility admitted the resident on 08/26/14 with diagnoses which included Chronic Respiratory Failure, Congestive Heart Failure, and Malignant Neoplasm of the Upper Lobe.	F 279		

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F 279	Continued From page 90 Review of the Quarterly MDS, dated 03/11/15, revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be 13, indicating the resident's cognition was intact. Review of the "Resident's Rights/Advance Directives" form, dated 08/28/14, revealed the resident had executed a Living Will. Review of the Care Plan last reviewed on 12/11/14, revealed the resident had a "full code" status. However, the Care Plan did not include Advance Directive care planning to address the resident's Living Will information. 4. Review of Resident #5's medical record revealed the facility admitted the resident on 08/10/14 with diagnoses which included Alzheimer's disease, Dementia, Paranoid Schizophrenia, Depression, and Anxiety. Review of the Quarterly MDS, dated 12/15/14, revealed the facility assessed the resident's BIMS score to be 14, indicating the resident's cognition was intact. Review of the "Resident's Rights/Advance Directives" form, dated 08/10/14, revealed the resident had executed an Advanced Directive including a Power of Attorney (POA). Review of the Care Plan reviewed by the facility on 12/16/14 revealed the resident had chosen a "full code" status; however, the care plan did not include Advance Directive care planning containing the resident's POA information and Advance Directives. 5. Review of Resident #6's medical record revealed the facility admitted the resident on 07/23/09 with diagnoses which included Dementia, Cerebrovascular Accident, Schizophrenia, Chronic Obstructive Pulmonary Disease, and Depression. Review of the Quarterly MDS, dated 02/01/15, revealed the	F 279		

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F 279	Continued From page 91 facility assessed the resident's BIMS score to be six (6), indicating the resident's cognition was severely impaired. Review of the "Resident's Rights/Advance Directives" form, dated 07/23/09, revealed the resident listed a Health Care Surrogate. Review of the resident's Physician Orders dated 02/02/15, revealed an order for "Living Will-please see chart for instructions." Review of Resident #6's Care Plan reviewed by the facility on 02/03/15, revealed the facility identified the resident requested DNR code status. The Care Plan stated, "If hospitalized, send copy of the written DNR order with resident." However, the Care Plan did not include Advance Directive care planning regarding the resident's Health Care Surrogate or the resident's Living Will. 6. Review of Resident #8's medical record revealed the facility admitted the resident on 05/28/13 with diagnoses which included Alzheimer's disease, Cerebrovascular Accident, and Psychosis. Review of the Significant Change MDS, dated 02/09/15, revealed the facility assessed the resident's BIMS score to be one (1), indicating the resident's cognition was severely impaired. Review of the "Resident's Rights/Advance Directives" form, dated 05/28/13, revealed the resident had executed an Advance Directive which included a Health Care Surrogate. Medical record review revealed a Living Will located in the resident's chart. Review of the Care Plan reviewed by the facility on 02/17/15 revealed a DNR code status, stating, "If hospitalized, send copy of the written DNR order	F 279		

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F 279	Continued From page 92 with resident." The Care Plan did not include Advance Directive care planning regarding the resident's Living Will information. 7. Review of Resident #10's medical record revealed the facility admitted the resident on 12/04/12 with diagnoses which included End Stage Renal Disease (ESRD), Malignant Neoplasm of Bladder, Alzheimer's Disease, Anorexia, and Parkinson's disease. Review of the Quarterly MDS, dated 01/28/15, revealed the facility assessed the resident's BIMS score to be five (5), indicating the resident's cognition was severely impaired. Review of the "Resident's Rights/Advance Directives" form, dated 12/04/12, revealed the resident had executed a Living Will. Review of the resident's Care Plan, reviewed by the facility on 01/29/15, revealed the resident chose "Do Not Resuscitate" (DNR) for his/her code status. However, the facility failed to provide Advance Directive care planning regarding the resident's Living Will. 8. Review of Resident #11's medical record revealed the facility admitted the resident on 10/13/14 with diagnoses which included Dementia, Alzheimer's disease, Depression, and Hypertension. Review of the Quarterly MDS, dated 01/09/15, revealed the facility assessed the resident's BIMS score to be five (5), indicating the resident's cognition was severely impaired. Review of the "Resident Rights/Advance Directives" form, dated 10/13/14, revealed the resident had executed an Advance Directive including a Living Will and POA. Review of the care plan, which was reviewed by the facility on 01/13/15, revealed the resident's DNR code status, but the facility failed to provide advance care planning information regarding the Living	F 279		

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F 279	Continued From page 93 Will or POA information. 9. Review of Resident #12's medical record revealed the facility admitted the resident on 09/04/13 with diagnoses which included Alzheimer's disease, Dementia with Behaviors, Depression, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease. Review of the Significant Change MDS, dated 02/24/15, revealed the facility assessed the resident's BIMS score to be 99, indicating the resident was unable to complete the interview. Review of the "Resident's Rights/Advance Directives" form, dated 09/04/13, revealed the resident had executed an Advance Directive including a Living Will. Review of the Care Plan, which was reviewed by the facility on 03/03/15, revealed no Advance Directive care planning regarding the Living Will information. 10. Review of Resident #13's medical record revealed the facility admitted the resident on 12/10/13, with diagnoses which included Dementia, Anxiety, Bipolar Disorder, and Depression. Review of the Quarterly MDS, dated 03/02/15, revealed the facility assessed the resident's BIMS score to be 15, indicating the resident was assessed to be cognitively intact. Review of the "Resident's Rights/Advance Directives" form, dated 12/10/13, revealed the resident had executed an Advance Directive which included a Living Will and POA. Review of the Care Plan, last reviewed by the facility on 03/03/15, revealed the resident's DNR code status was included on the care plan; however, the facility failed to include the Advance Directive care planning regarding the resident's Living Will or POA information.	F 279		

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F 279	Continued From page 94 11. Review of Resident #15's medical record revealed the facility admitted the resident on 03/14/13, with diagnoses which included Altered Mental Status, Dementia, Paranoid Personality Disorder, Depression, Morbid Obesity, and Anxiety. Review of the Quarterly MDS, dated 02/17/15, revealed the facility assessed the resident's BIMS score to be 15, indicating the resident was cognitively intact. Review of the "Resident's Rights/Advance Directives" form, dated 03/14/13, revealed the resident had executed his/her Advance Directive which included a Living Will and Power of Attorney. Review of the resident's Care Plan, last reviewed by the facility on 02/17/15, revealed there was no advance care planning regarding the resident's Living Will or POA. 12. Review of Resident #16's medical record revealed the facility admitted the resident on 02/21/14 with diagnoses which included Senile Dementia, Hypertension, and Cerebral Artery Occlusion. Review of the Significant Change MDS, dated 02/16/15, revealed the facility had assessed the resident's BIMS score to be 99, indicating the resident was unable to complete the interview. Review of the "Resident's Rights/Advance Directives" form, dated 02/21/14, revealed the resident had executed an Advance Directive which included a Living Will and POA. Review of the resident's Care Plan, last reviewed by the facility on 02/20/15, revealed no advance care planning to include information about the resident's Living Will and POA. 13. Review of Resident #17's medical record revealed the facility admitted the resident on 09/27/13, with diagnoses which include Dementia, Hypertension, and Psychosis. Review	F 279		

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F 279	Continued From page 95 of the Quarterly MDS, dated 12/29/14, revealed the facility assessed the resident's BIMS score to be 15, indicating the resident was cognitively intact. Review of the "Resident's Rights/Advance Directives" form, dated 09/27/13, revealed the resident had executed an Advance Directive which included a Living Will and designation of a Health Care Surrogate. Review of the Care Plan, last reviewed by the facility on 12/30/14, revealed no advance care planning to include information regarding the resident's Living Will and Health Care Surrogate. 14. Review of Resident #18's medical record revealed the facility admitted the resident on 04/25/13 with diagnoses which included Dementia with Behaviors, Anxiety, Depression, Epilepsy, and Malignant Neoplasm of Prostate. Review of the Quarterly MDS, dated 02/17/15, revealed the facility assessed the resident's BIMS score to be 99, indicating the resident was unable to complete the interview. Review of the "Resident's Rights/Advance Directives" form, dated 04/25/13, revealed the resident had executed an Advance Directive including a Living Will and Durable Power of Attorney (DPOA). Review of the Care Plan, last reviewed by the facility on 02/17/15, revealed the resident had a "full code" status, but the facility failed to provide the Advance Directive care planning containing the resident's Living Will or DPOA information. 15. Review of Resident #19's medical record revealed the facility admitted the resident on 08/27/13, with diagnoses which included Alzheimer's Disease, Dementia, and Malignant Neoplasm. Review of the Quarterly MDS, dated 01/07/15, revealed the facility had assessed the resident's BIMS score to be three (3), indicating	F 279		

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F 279	Continued From page 96 the resident's cognition was severely impaired. Review of the "Resident's Rights/Advance Directives" form, dated 07/23/13, revealed the resident had executed an Advance Directive which included a Living Will. Review of the Care Plan dated 01/08/15, revealed the DNR code status, stating, "If hospitalized, send copy of the written DNR order with resident." However, the facility failed to provide advance care planning regarding the resident's Living Will information. 16. Review of Resident #20's medical record revealed the facility admitted the resident on 05/15/13 with diagnoses which included Alzheimer's disease, Dementia, and Psychosis. Review of the Quarterly MDS, dated 01/26/15, revealed the facility assessed the resident's cognitive skills for daily decision-making to be severely impaired. Review of the "Resident's Rights/Advance Directives" form, dated 05/15/13, revealed the resident had executed an Advance Directive including a Living Will and POA. Review of the Care Plan reviewed on 01/27/15, revealed the resident's DNR code status, but the facility failed to provide Advance Directive care planning regarding the resident's Living Will and POA. 17. Review of Resident #21's medical record revealed the facility admitted the resident on 11/15/10 with diagnoses which included Alzheimer's disease, Weight Loss, Anxiety, Depression, and Congestive Heart Failure. Review of the Quarterly MDS, dated 03/09/15, revealed the facility assessed the resident's BIMS score to be seven (7), indicating the resident's cognition was severely impaired. Review of the "Resident's Rights/Advance Directives" form, dated 11/15/10, revealed the resident had	F 279		

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F 279	Continued From page 97 executed an Advance Directive including a Living Will and Power of Attorney. Review of the resident's Care Plan, last reviewed by the facility on 03/10/15, revealed the resident's DNR code status. However, the care plan did not include advance care planning regarding the resident's Living Will or POA information. 18. Review of Resident #9's medical record revealed the facility admitted the resident on 12/27/13, with diagnoses which included Parkinson's disease, Psychosis, Chronic Obstructive Pulmonary Disease, and Depression. Review of the Annual MDS, dated 12/15/14, revealed the facility assessed the resident's BIMS score to be 15, indicating the resident was cognitively intact. Review of the resident's code status form, dated 12/27/13, revealed the resident had chosen "CPR only" as his/her code status. Review of the resident's Admission Physician Orders, dated 12/27/13, revealed a Physician's Order for "CPR only." However, further review of the Physician Orders revealed the resident was classified as "Full Code" status as of 01/09/14. Review of the resident's care plan, which the facility last reviewed on 12/18/14, revealed the resident was classified as "Full Code" status. Review of the clinical record revealed no documented evidence the resident's responsible party had changed the resident's code status. 19. Review of Resident #14's medical record revealed the facility admitted the resident on 12/20/13, with diagnoses which included Parkinson's Disease, Acute Kidney Failure, and Systolic Heart Failure. Review of the Quarterly MDS, dated 03/02/15, revealed the facility assessed the resident's BIMS score to be three (3), indicating the resident's cognition was	F 279		

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F 279	Continued From page 98 severely impaired. Review of the resident's code status form, dated 03/20/14, revealed the resident chose "CPR only" for his/her code status. However, review of the Physician Orders dated 02/24/15, the resident's Face Sheet, as well as the resident's Care Plan, last reviewed by the facility on 03/03/15, revealed the resident was classified as "Full Code" status. An interview on 03/09/15 at 11:45 AM with MDS Coordinators #1 and #2, who were responsible for completing MDS assessments and completing care plans in the facility, revealed they did not care plan Advance Directives other than cardiopulmonary resuscitation (CPR) status for any resident in the facility. The MDS Coordinators stated it was not a facility practice to incorporate the resident choices regarding Advance Directives into the resident's current or future plan of care. **The facility provided an acceptable Allegation of Compliance (AOC) on 03/24/15. The facility implemented the following actions to remove the Immediate Jeopardy: 1) On 03/10/15, licensed nursing staff that was on duty at that time was informed immediately, by the ADON of actions to be taken, and on the proper paperwork that was to accompany Resident #1 and all other residents in the facility when they were transferred to any other facility including appointments and emergency care. This paperwork included Code Status, Living Will, POA, Guardianship papers, Healthcare Surrogate, Fiduciary, and any other legal documents in the Advance Directive section of the resident's medical record.	F 279		

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F 279	Continued From page 99 2) On 03/10/15, the Director of Social Services, Nurse Manager, QA (Quality Assurance) Coordinator, and MDS (Minimum Data Set) Coordinator conducted an immediate review of Resident #1's medical record and confirmed that the resident's Living Will was in the chart and in the correct location. 3) On 03/10/15, the MDS Coordinator immediately developed an Advance Directives Care Plan for Resident #1 after being notified of the Immediate Jeopardy. 4) On 03/11/15, the Nurse Consultant in-serviced the MDS Coordinators on the process for developing an Advance Directive Care Plan. The Advance Directive Care Plan was reviewed by the Nurse Consultant for accuracy and determined to be correct. The Advance Directive Care Plan was then placed in Resident #1's chart. 5) An emergency Interdisciplinary Care Team Conference was conducted by phone with Resident #1's Health Care Surrogate on 03/11/15 at 12:00 PM, and at this time, the Surrogate verified that she was indeed this person's Healthcare Surrogate and the Living Will the facility had on file reflected the resident's wishes. 6) The Interdisciplinary Care Conference Team consisting of the Administrator, Assistant Administrator, DON (Director of Nursing), ADON (Assistant Director of Nursing), Nurse Manager, Social Worker, MDS Coordinator, Clinical Dietician, and Attending Physician reviewed the resident's care plan to confirm that all components of the Living Will were included. 7) The Health Care Surrogate directed that	F 279		

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F 279	Continued From page 100 Resident #1 be changed from "full code" (CPR) status to a "no code" (no CPR) status, which was witnessed by everyone present at the meeting. The Do Not Resuscitate form was completed and signed on 03/11/15 by the Nurse Manager and the Attending Physician. The Attending Physician wrote the new order and nursing staff updated the medical record to reflect the change. 8) Resident #1's care plan was confirmed on 03/11/15 to reflect the no code status and was determined by the Nurse Consultant to be correct. 9) On 03/11/15, the Attending Physician documented participating in the conference call on 03/11/15 with the Health Care Surrogate and discussed the current medical condition of the patient. Resident #1's intravenous (IV) fluids were discontinued on 03/11/15. 10) On 03/10/15, the Director of Social Services, Nurse Manager, QA Coordinator, and MDS Coordinator conducted an immediate review of Resident #2's medical record and confirmed that it included a copy of a Durable Power of Attorney (DPOA) and it was located in the correct location of the medical record. 11) On 03/11/15, an emergency Interdisciplinary Care team that included the Administrator, Assistant Administrator, DON, ADON, Nurse unit Manager Social Worker, MDS coordinator, Clinical Dietician and Physician, conducted a meeting via telephone conference with Resident #2's Durable Power of Attorney (DPOA) and confirmed that the information the DPOA provided on admission on 01/20/15 was in fact correct in reflecting the current wishes of the	F 279		

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F 279	Continued From page 101 resident. 12) On 03/10/15, the MDS Coordinator immediately developed an Advance Directives Care Plan for Resident #2 after being notified of the Immediate Jeopardy. 13) On 03/11/15, the Nurse Consultant in-serviced the MDS Coordinators on the process for developing an Advance Directive Care Plan. The Advance Directive Care Plans were reviewed by the Nurse Consultant for accuracy and determined to be correct. The Advance Directive Care Plan was then placed in Resident #2's chart. 14) As of 03/15/15, all current residents' charts have been reviewed by the Director of Social Services or Social Worker to ensure all Advance Directives, which include: DPOA, POA (Power of Attorney), Healthcare Surrogate, Guardianship, and Living Wills were in the chart and in the proper place. 15) All residents that are their own responsible party were interviewed by Social Services beginning on 03/11/15 to determine their cognitive status, and those with impaired cognition had a legal representative. The residents were also asked about their code status and if they wanted any changes to their Advance Directives at that time. No residents, who were their own responsible party, were found to have changes in their cognitive status. 16) All residents or their designated representatives, except two (2), were called by Social Services, to confirm that their Advance Directive was current and up to date; and the Code Status that the facility had on file was	F 279		

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F 279	Continued From page 102 correct. Social Services and the Assistant Administrator will continue to contact the legal representatives to confirm that the information the facility has on file is current. 17) On 03/15/15, through individual chart reviews, the Assistant Administrator verified that the Social Worker's Progress Notes confirmed the accuracy of the Advance Directives currently on file. The Assistant Administrator documented this in a monitoring log. 18) During this process two (2) residents had code status changes from CPR only to Full Code Status. The Full Code Status form was signed and placed in the resident's chart. The MDS Coordinators then updated the care plans on 03/14/15 and the face sheets were updated. 19) On 03/14/15, the Full Code Status Form was revised by the DON. Options of CPR only and Chemical Code were removed from the Full Code Status Form. The ADON and Charge Nurses (beginning on 03/15/15) completed training on this form change. 20) The MDS Coordinators were trained on 03/11/15 by the Nurse Consultant to ensure proper understanding of Advance Directive Care Plans and what should be included in them. This training included assessing whether the resident had an Advance Directive, Durable Power of Attorney for Healthcare, or a Living Will. 21) Care plans will also include the resident's expressed wishes regarding care and treatment goals as outlined by the Advance Directives. Social Services staff was trained as of 03/11/15 by the MDS Coordinators on how to develop the	F 279		

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F 279	Continued From page 103 Advance Directive Care Plan. 22) All resident care plans were reviewed and revised relating to Advance Directives and Code Status by the MDS Coordinators, and was completed by 03/14/15 23) The MDS Coordinators will initiate the Advance Directives care plan upon admission. The Social Services Department will be responsible for maintaining and updating the Advance Directive Care Plans now and forward on all residents. 24) Beginning on 03/15/15, the Quality Assurance Nurse and Assistant Administrator began monitoring Social Services' care plans daily, to ensure that the residents' wishes related to advance directives were accurately reflected on their care plan and any changes in their Advance Directives had been addressed. This was accomplished by comparing the Social Services' Notes, the Advance Directive, and care plan following any reported changes to the resident's Advance Directives. In conjunction with the care plan audit, they were also monitoring whether the Advance Directives were current and in the Advance Directives section of the resident's chart. 25) On 03/10/15, the Administrator, Assistant Administrator, DON, and ADON, discussed what immediate action needed to be taken. At that time, the ADON began informing Charge Nurses, Licensed Staff, and Ward Clerks on duty, of the proper paperwork that is to accompany all residents being transferred to any other facility including emergency care. This information included documents such as code status, Living	F 279		

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F 279	Continued From page 104 Wills, POA, Guardianship, Healthcare Surrogate, Fiduciary, and any other legal documents in the Advance Directive Section of the resident's chart. 28) On 03/13/15 the Executive Director provided training on the State and Federal requirements. This training was provided to the Admissions Coordinator, Assistant Administrator, Assistant Director of Nursing, Social Worker and Licensed Practical Nurse (LPN) Coordinator and competency was demonstrated by a posttest on 03/13/15. Beginning on 03/13/15, the ADON provided the same training to the Administrator, DON, Director of Social Services, and Charge Nurses, and competency was demonstrated by a posttest. 27) The ADON began training the Administrator, Assistant Administrator, DON, Charge Nurses, Licensed Staff, and Ward Clerks on 03/13/15 regarding additional measures needed to be taken to ensure that all resident's information in the Resident Transfer Packet, which included Advance Directives were being sent to the receiving facility. This training gave direction that all residents' information was sent with him or her when they were transferred out of the facility and will also be faxed to the receiving facility, copied and placed in the miscellaneous section of the chart with the fax transmission confirmation. During this time, staff was also instructed to compare the documents included in the Advance Directive Section to those listed on the resident's Face Sheet, which is generated from Point Click Care, to ensure all current documents were present. 28) Beginning on 03/11/15 the QA Nurse, Unit Manager, or the Assistant Administrator, started	F 279		

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F 279	Continued From page 105 monitoring to ensure that all Advance Directives for a resident that was being transferred out of the facility were accurate and sent. This was accomplished by reviewing the resident's transfer packet that was copied, faxed, and placed in the miscellaneous section of the resident's chart. This process is being documented daily on a monitoring log; no problems have been identified at this time. 29) The facility initiated daily monitoring on 03/13/15 of staff training regarding resident transfer processes, faxing Advance Directives, the State and Federal requirements, Advance Directive Definitions, Sending Advance Directives during transfer, and the Advance Directives policy. The ADON or Charge Nurse was performing the monitoring through interviews with a minimum of three (3) staff per day that were previously trained. All shifts were included in this monitoring, and all shifts were being monitored within a 2-day period. 30) Beginning on 03/13/15, Social Services, MDS Coordinators, Admissions Coordinator, QA Coordinator, Licensed Staff, Ward Clerks, and Finance, were trained by the ADON, DON, or Charge Nurse on the advance directive definitions and the State and Federal requirements; competency was demonstrated by posttest. 31) As of 03/13/15, the Administrator and Assistant Administrator reviewed and revised the Advance Directive Policy to reflect that upon admission the Admission Coordinator would provide a copy of this policy and would discuss and confirm the Advance Directive status with the resident and or responsible party and would	F 279		

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F 279	Continued From page 106 document in the individual medical record with the Resident Rights/Advance Directives form upon admission whether the resident had an Advance Directive. The resident and/or legal representative, DPOA, POA, or Guardian would date and sign a statement attesting that the Advance Directive and facility policy had been explained upon admission. 32) The Admissions Coordinator will provide copies of Advance Directive information obtained on the day of admission to Finance, LPN Supervisor, and Unit Manager or Ward Clerk. 33) LPN Supervisor/Data Entry Specialist entered all orders into the Point Click Care to include code status and advance directives on the day of admission. This information was then generated to the resident's face sheet, which was sent to the resident's nursing unit, and then placed on the resident's chart by the ward clerk, on the day of admission. 34) On 03/14/15, the Assistant Administrator trained the Admissions Coordinator, ADON, and Social Services on the revisions to the Advance Directive Policy, responsibilities, and processes that were in place to ensure that residents' advance directives were executed per the resident's wishes, and competency was demonstrated by a posttest. 35) Together the Assistant Administrator and ADON trained the DON, QA Coordinator, MDS Coordinators, Charge Nurses, Finance, and Unit Managers regarding the Advance Directive Policy and Procedure revision and competency was demonstrated by a post test.	F 279		

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F 279	Continued From page 107 36) Beginning 03/20/15, licensed staff and the ward clerks were trained on the changes to the Advance Directive Policy by the DON, ADON, or Charge Nurse and showed competency by test. All above-mentioned staff was trained as of 03/22/15 on this policy except eight (8) licensed staff and one ward clerk, who will be trained prior to returning to direct resident care. 37) Beginning on 03/13/15 the initial admissions portion of the Advance Directive procedure as outlined in the Advance Directive Policy was being monitored daily by the Assistant Administrator with each new admission. This will accomplished by reviewing the admissions' paperwork and confirming that any advance directives received during the admission process were in fact listed on the Resident's Rights/Advance Directive Sheet. The findings were then reported on a daily monitoring log with each new admission. No problems were identified at the time. 38) Starting on 03/11/15, the QA Coordinator or the Assistant Administrator checked resident charts daily to confirm that the Advance Directive section of the chart still contained all of the resident's Advance Directives. This was accomplished by comparing the Advance Directives located in the chart to their daily monitoring log. 39) The Administrator and Assistant Administrator revised the Social Services Policy on 03/21/15 to include the procedure for invoking a health care agent or legal representative after the resident was determined not to have decision-making capacity. This policy stated, "The assigned social worker will determine if the resident is	F 279		

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F 279	Continued From page 108 self-responsible or if they have a POA, DPOA, or legal guardian in place. The social worker would contact them to let them know the resident has had a mental status change and can no longer make their own decisions. If the legal representative accepts responsibility, they will begin making decisions for the resident. If the resident does not have a POA, DPOA or legal guardian then social services would contact any family members who may be willing to be the responsible party for the resident. If the family members are not willing, then social services will contact Adult Protective Services (APS) and request the process for obtaining a guardian to be started." 40) Social Services was trained on 03/22/15 by the Assistant Administrator regarding the revised Social Services Policy. 41) During the admission process, the Admissions Coordinator would determine the resident's legal representative based on information provided by the resident at the time of admission. 42) Upon admission, the resident's mental status was assessed by the Licensed Staff assigned to the resident on their unit through the nursing admission assessment form, and by the MDS Coordinators through the Brief Interview Mental Status (BIMS), which is done within seven (7) days of admission and also done quarterly with scheduled care plan meetings and with any significant change. Should any of these assessments indicate the resident was not capable of being their own decision maker, Social Services would be informed by the nursing staff during the daily morning management	F 279		

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F 279	Continued From page 109 administrative meeting of any mental status changes that may require further assessment. 43) If a mental status change and further assessment of a resident indicated the need for a legal representative, then at that point Social Services would seek to invoke the health care agent or legal representative as outlined in the Social Services Policy. 44) The Assistant Administrator checked to ensure that any issues relating to Social Services have been followed-up on during the daily Social Services meeting. This was documented on the Daily Social Services Meeting Minutes. 45) Upon admission, the resident's assigned Social Worker would confirm Advance Directives. Furthermore, the Social Worker would review the advance directive status when requested by the resident or responsible party, upon any re-admission, quarterly with care plan meetings and after any significant change. 46) The Social Worker would assist the resident in developing a living will within twenty-four (24) hours of being requested. The Assistant Administrator would monitor this by comparing the Advance Directives to what was stated on the Resident's Rights/Advance Directive Sheet and documented in the Social Services Progress Note. 47) As of 03/13/15, the Assistant Administrator initiated daily meetings with the Social Worker and Director of Social Services to discuss any residents that were sent out of the facility, returned to facility, or had received any new documents concerning Advance Directives.	F 279		

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F 279	Continued From page 110 48) All Advance Directive care plans will be reviewed immediately upon admission or re-admission by the Social Worker and documentation of the review will be placed in the Social Worker Notes. These would also be reviewed by the MDS Coordinator and Social Worker and the rest of the interdisciplinary care plan team during scheduled care plan meetings, and then documented in the Social Services section of the clinical record as well as the Interdisciplinary Care Plan Sheets. 49) If the resident and/ or their representative were present during this care plan meeting, the Advance Directive and Code Status would be discussed to confirm that the directive continues to reflect the resident's wishes. If there was no representative present, Social Services would contact the legal representative to confirm the Advance Directive was still current. This will be completed with the Quarterly MDS review, and any change in status. 50) The Quality Assurance (QA) Nurse and Assistant Administrator were monitoring care plans relating to advance directives daily to ensure the residents' wishes expressed on the Advance Directives were outlined in the care plans as of 03/15/15. 51) Beginning on 03/20/15, Licensed Staff and Ward Clerks were given re-enforcement training by the ADON, related to information to be included on the shift-to-shift report, and competency was proven by a post test. 52) On 03/16/15, the Administrator instructed the Nurse Managers and DON to begin reporting any	F 279		

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F 279	Continued From page 111 mental status changes reported on the shift-to-shift report during the Morning Administrative Management Meeting. At that time, the team would discuss necessary changes that needed to be addressed, if any. As of 03/22/15, no change in any resident's mental status had been reported. This was documented daily on the Daily Morning Administrative Management Meeting Notes. 53) When a significant change, quarterly or annually assessment is conducted and a brief interview of mental status (BIMS) will be completed on each resident to determine their decision making ability by the MDS Coordinator. This will be reported to the resident's assigned Social Worker, to determine if any changes in legal representative needs to be made. 54) When a resident is admitted, readmitted, or had verbalized their desire to change their code status, the nurse will contact the Doctor and obtain a Doctor's order. At that time, a DNR or full code status form would be completed with two (2) caregiver signatures. If the code status was obtained by telephone, the same process will apply. The nurse will document the code status change in the Nurse's Notes and place the change on the shift-to-shift report. 55) Beginning on 03/20/15, licensed staff and ward clerks were trained on the changes to the Advance Directive Policy by the DON, ADON, or Charge Nurse and showed competency by a post test. The Advance Directive Policy included the process for contacting the legal representative with any changes in the Advance Directives. All above-mentioned staff was trained as of 03/22/15 on this policy, except for eight (8) licensed staff	F 279		

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F 279	Continued From page 112 and one ward clerk, who will be trained prior to returning to direct resident care. 56) Per the revised Advance Directives Policy, Social Services or designated others will assist the residents who elect to execute an Advance Directive. Social Services will ensure all documents that belong in the Advance Directive Section are placed in the medical chart. 57) Social Services was trained on the changes to the Advance Directive Policy on 03/14/15 by the ADON; and competency was demonstrated by a post test. 58) A copy of the Code Status order will be given to the LPN Supervisor, who will input the order into the "Point Click Care System" and the Admission Record will be generated from this information. The Admission Record (Face Sheet) will be sent to the resident's nursing unit and placed in front of the chart by the ward clerk, on the day of the change in code status. 59) On 03/15/15, the Assistant Director of Nursing implemented and trained all Licensed staff and Ward Clerks on the modified existing transfer form to provide an expanded checklist that specifically listed Living Wills, Power of Attorney, Health Care Surrogate or Guardianship documents. 60) As of 03/11/15, compliance with the policies and processes were being verified daily by the facility's Administrative team which consists of the Administrator, Assistant Administrator, Director of Nursing, and Assistant Director of Nursing or QA Coordinator and reviewed daily during the QA Daily meeting. Any notice of non-compliance will	F 279		

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F 279	Continued From page 113 be reported to the Administrator and a plan of action will be developed to prevent reoccurrence. 61) The Executive Adviser and the Nurse Consultant will review the minutes of the management meetings and will attend meetings at least weekly to ensure the Allegation of Compliance is being implemented and that any adjustments to the process are identified, discussed and steps implemented to correct. 62) The Executive Adviser and Nurse Consultant are in daily consultation with the Administrator since 03/11/15. They are reviewing documentation, interviews and training staff to ensure the plan is being carried out as alleged. ***The SSA validated the Immediate Jeopardy was removed as follows: 1) Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM and RN #2 on 03/24/15 at 2:56 PM revealed they were knowledgeable regarding what paper work was to be transferred with residents when sent out of the facility including all Advance Directives formulated by the resident. 2) Review of Resident #1's chart on 03/24/15 revealed the resident's Living Will was in the chart and in the correct location. 3) Review of Resident #1's chart on 03/24/15 at 1:50 PM revealed an Advance Directive Care Plan was present in the medical record. 4) Interviews with MDS Coordinator #2 on	F 279		

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F 279	Continued From page 114 03/24/15 at 3:06 PM revealed the Nurse Consultant had trained her on developing an Advance Directive care plan. Interview with the Nurse Consultant on 03/24/15 at 2:00 PM, revealed she had confirmed the accuracy of Resident #1's Advance Directive Care Plan. 5) Review of the Progress Notes dated 03/11/15, and Interview with Resident #1's Health Care Surrogate on 03/13/15 at 3:00 PM revealed a care plan conference was conducted via telephone to discuss Resident #1. During the interview, the Health Care Surrogate stated she was making health care decisions for Resident #1. 6) Interviews on 03/24/15, at 4:44 PM with the Administrator; at 3:32 PM with the Assistant Administrator; and, at 4:37 PM with the DON (Director of Nursing) revealed they had all reviewed Resident #1's care plan and confirmed it contained all the Advance Directives that were included in Resident #1's Living Will. 7) Interview with Resident #1's Health Care Surrogate on 03/13/15 at 3:00 PM revealed she confirmed with the facility that Resident #1 was to be a DNR. Review of Resident #1's medical record on 03/24/15 at 1:50 PM revealed the DNR form was signed on 03/11/15. Resident #1's medical record also contained a signed Physician's Order for the DNR status. 8) Review of Resident #1's chart on 03/24/15 at 1:50 PM revealed the resident's care plan reflected the DNR status. 9) Review of Physician Nots, dated 03/11/15 revealed the physician documented participating	F 279		

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F 279	Continued From page 115 in the conference call on 03/11/15 with the Health Care Surrogate and discussed the current medical condition of the resident. Review of Resident #1's medical record revealed intravenous (IV) fluids were discontinued for Resident #1 on 03/11/15. Observation of Resident #1 on 03/24/15 at 3:09 PM revealed the resident was not receiving IV fluids. 10) Review of Resident #2's medical record on 03/24/15 at 2:20 PM revealed it contained a copy of the resident's Durable Power of Attorney (DPOA) and it was located in the correct section of the medical record. 11) Review of the Progress Notes dated 03/11/15, and interview with Resident #2's DPOA on 03/13/15 at 3:00 PM revealed the facility confirmed the information in Resident #2's DPOA was correct and reflected the wishes of Resident #2. 12) Review of Resident #2's medical record on 03/24/15 at 2:20 PM revealed it contained an Advance Directive Care Plan for Resident #2. 13) Interview with MDS Coordinator #2 on 03/24/15 at 3:06 PM revealed the Nurse Consultant trained her on developing an Advance Directive care plan. Interview with the Nurse Consultant on 03/24/15 at 2:00 PM, revealed she confirmed the accuracy of Resident #2's Advance Directive Care Plan. 14) Review of a Resident Disposition form dated 03/15/15, and interview on 03/24/15 at 4:05 PM with the Director of Social Services revealed that all charts had been reviewed to ensure Advance Directives were on the chart under the designated	F 279		

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F 279	Continued From page 116 tab. 15) Interviews on 03/24/15 at 3:15 PM with Resident #3 and at 3:22 PM with Resident #4 revealed they had been interviewed by the DSS and had not made changes in their code status designations. Review of Social Service Notes for Residents #20 and #23 revealed entries dated 03/11/15, indicating they had a responsible party named, and no changes in their cognitive status had been identified. 16) Review of a facility Resident Roster revealed that all residents or their designated representatives except one had been interviewed to ensure Advance Directives and Code Status were correct for each resident. Review of a copy of a certified letter revealed the facility had attempted to contact the remaining responsible party. 17) Interview with the Assistant Administrator on 03/24/15 at 3:32 PM, and review of the Advance Directive Monitoring Log revealed the Assistant Administrator had reviewed the Social Worker's Progress Notes to ensure they were accurate when compared with the Advance Directive on file for each resident. 18) Review of Residents #9 and #14's medical record revealed their code status designation had been changed to Full Code Status. The medical record revealed a Code Status form was signed and in the medical records. Review of resident's care plans also revealed the update was on the care plans. 19) Review of the facility's Code Status form revealed it had been updated on 03/14/15.	F 279		

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F 279	Continued From page 117 Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM, and RN #2 on 03/24/15 at 2:58 PM revealed they had been trained on the form changes. 20) Interview with MDS Coordinator #2 on 03/24/15 at 3:06 PM revealed she had been trained by the Nurse Consultant related to Advance Directive care plans and was able to verbalize the different types of Advance Directives. 21) Review of Residents #1, #2 and #4's Care Plans revealed they included the resident's expressed wishes that were contained in their Advance Directives. Interview with the DSS on 03/24/15, at 4:05 PM revealed he was trained on how to develop an Advance Directive care plan. 22) Review of Residents #1, #2 and #4's Care Plans revealed they had been revised and included Advance Directives and Code Status. 23) Interview with MDS Coordinator #2 on 03/24/15 at 3:06 PM revealed she was knowledgeable that she would be responsible for maintaining and updating the Advance Directive Care Plans after initial development by the DSS. 24) Review of a Care Plan Monitoring Log and Interviews on 03/24/15 at 1:48 PM and 3:32 PM with the Quality Assurance Nurse and Assistant Administrator revealed the Social Service care plans related to Advance Directives were being reviewed daily to ensure the resident's wishes relating to advance directives were accurately reflected on their care plan and included any changes.	F 279		

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F 279	Continued From page 118 25) Interview with the DON on 03/24/15 at 4:37 PM revealed she initiated training on 03/10/15 with staff related to sending all Advance Directives with a resident when they were transferred out of the facility. 26) Interviews on 03/24/15 at 2:11 PM with the Admissions Coordinator, at 3:32 PM with the Assistant Administrator, and at 4:05 PM with the DSS; and review of an In-service Sign In Sheet dated 03/13/15, revealed the Executive Director had provided training on the State and Federal requirements. Review of competency testing revealed each of the staff had also completed a competency test. 27) Review of a facility In-service Sign In Sheet dated 03/13/15, revealed the ADON trained the Administrator, Assistant Administrator, DON, Charge Nurses, Licensed Staff, and Ward Clerks regarding ensuring that all resident information related to Advance Directives was being sent to the receiving facility and faxed. Interviews with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM, RN #2 on 03/24/15 at 2:58 PM, and Ward Clerk #1 at 3:14 PM, revealed they were knowledgeable regarding the process for sending Advance Directive information with residents when transferred out of the facility. 28) Review of a Transfer Monitoring Log and interviews on 03/24/15 at 1:48 PM with the QA nurse and at 3:54 PM with Unit Manager #1, revealed all resident transfers were being monitored to ensure all Advance Directives for each resident transferred out of our facility had been sent and were accurate. 29) Review of daily questionnaires and interviews	F 279		

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F 279	Continued From page 119 with LPN #2 on 03/24/15 at 2:28 PM, LPN #1 on 03/24/15 at 3:23 PM and RN #2 on 03/24/15 at 2:56 PM revealed staff was being asked questions to ensure competency on the State and Federal requirements daily by the ADON or a Charge Nurse. 30) Review of In-service Sign In Sheets and interviews on 03/24/15, at 4:05 PM with the DSS, at 3:06 PM with MDS Coordinator #2, at 2:11 PM with the Admissions Coordinator revealed they were trained on Advance Directive definitions and the State and Federal requirements. They completed a competency test. 31) Interviews conducted on 03/24/15 at 4:44 PM with the Administrator and at 3:32 PM with the Assistant Administrator and review of the Advance Directive Policy revealed the Advance Directive Policy had been revised to include the following: upon admission the Admission's Coordinator will provide a copy of this policy and will discuss and confirm the advance directive status with the resident and or responsible party and upon admission, will document in the individual medical record using the Resident Rights/Advance Directives Form whether the resident had an Advance Directive. The resident and/or legal representative will date and sign a statement attesting that the Advance Directive and the facility's policy had been explained upon admission. 32) Interview with the Admissions Coordinator on 03/24/15 at 2:11 PM, revealed she it is her responsible to provide copies of the Advance Directive information related to each new admission to the Finance Department, the LPN Supervisor, and the Unit Manager or Ward Clerk.	F 279		