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L 201	Continued From page 20 significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (l)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (o)The plan of care; (p)Consent forms and advance directives; and (q)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 63 sampled residents, the charge nurse failed to provide treatment and care in accordance with professional standards of practice for Resident #44 with Glaucoma and to obtain an order for use of a hand splint to	L 201	**Corrective action for the residents affected:** 1. The resident #89 was reassessed on 4/30/19. The care plan of resident #89 was revised and updated to include goals and approaches for the resident #89 use of eye glasses. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Medical records of all the residents' use of eye glasses were audited if a corresponding care plan is included for the resident use of eye glasses. No other resident was affected. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service the IDT team on care plan with goals and approaches for resident that uses eye glasses. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 4/30/19 6/10/19 ongoing

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L 201	Continued From page 21 Resident #50's right hand. The findings included . . . 1. Resident #44 was admitted to the facility on 4/24/01 (initial admission date) with diagnoses to include: Rheumatoid Arthritis, Unspecified, Unspecified Dementia with Behavioral Disturbance, Unspecified Open-Angle Glaucoma, Stage Unspecified, Hypotension Unspecified, other Iron Deficiency Anemias. Review of the Comprehensive Minimum Data Set [MDS] dated 7/19/18 showed, Section B [Hearing, Speech and Vision] Vision is not coded. Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "2" which indicates severe cognitive impairment. Section G [Functional Status] resident is coded as "3" for dressing, eating, toileting and personal hygiene which indicates extensive assistance (resident involved in activity, staff provide weight bearing support). Review of the medical record on 4/25/19 at 10:00 AM showed a care plan dated 7/27/18 (revision date, 1/27/19) Focus: Resident has impaired visual function related to Glaucoma. Further review of the medical record showed a consult request dated 6/10/17 "Exam requested by nursing home, Glaucoma." Assessment/Plan "the disc appear cupped, I recommend follow up Intraocular Pressure check in 6 months." Physician Progress note dated 4/10/19 showed "patient has baseline confusion, but verbally communicative, no blurry vision or eye pain ...Glaucoma stable: continue current treatment	L 201		

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L 201	Continued From page 22 plan, follow up with ophthalmologist." During an interview on 4/25/19 at 1:00 PM Employee #3 stated, "I will check with the scheduler to see if the resident had the ophthalmology appointment for the eye pressure check." Employee #3 returned at approximately 2:00 PM and stated "the scheduler could not find that the appointment was scheduled, I will tell the doctor." During an interview on 4/25/19 at 2:30 PM with Employee #20, (Physician) states "the resident is on eye treatment, his vision is stable, he did not have the eye appointment, but did you see the order, I asked staff to schedule the eye appointment right away." Facility staff failed to schedule an ophthalmology appointment for Intraocular Pressure check as per ophthalmologist's recommendation (at the resident's appointment on 6/10/17). During a face-to-face interview on 4/25/19 at 3:00 PM Employee # 3 acknowledged the finding. 2. Resident #50 was admitted to the facility on July 10, 2008 with diagnoses which included Hypertension, Cerebrovascular Accident (CVA), Non-Alzheimer's Dementia, Hemiplegia/Hemiparesis, Seizure Disorder and Depression. Review of section C0500 of the Quarterly Minimum Data Set (MDS) with a completion date of October 26, 2018 showed the resident with a Brief Interview for Mental Status (BIMS) score of	L 201	**Corrective action for the residents affected:** 1. The resident #50 was reassessed on 4/30/19. A hand splint was put in place for resident #50 on 4/30/19. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Audit of all residents with prescribed splints was conducted by an occupational therapist to ensure compliance with therapy (4/30/19) No other resident was affected.	4/30/19 4/30/19

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L 201	Continued From page 23 four (4) which is an indication that the resident was severely cognitively impaired. G 0110 Activities of Daily Living (ADL) Assistance showed that the resident was totally dependent on two or more staff for all ADL activities (mobility, transfer, dressing, toileting, personal hygiene and bathing. The resident receives nutrition via tube feeding. Resident #50 was observed lying in bed on April 17, 2019 at approximately 3:00 PM and at 4:00 PM on April 18, 2019. The fingers on the resident's right hand were clasped to his palm. The resident was unable to open his fingers or lift his hand. No splint was noted on either one the resident's hands. Resident #50 was also observed on April 23, 2019 at 2:34 PM and April 24, 2019 at 12:00 PM without a splint on his right hand. A face-to-face interview was conducted with Employee #15 at approximately 10 AM on April 26, 2019. The employee was asked whether Resident #50 wears a hand splint. The employee said he would find out but never returned to this writer with a response. Review of the physician's orders and the Treatment Administration Record (TAR) on April 26, 2019 showed no order for the use of the splint or for application of the splint. However, review of a care plan with an initiation date of August 15, 2018 and a revision date of April 20, 2018 specified the following, "Resident has an alteration in musculoskeletal status r/t (related to)	L 201	**Measures to prevent reoccurrence:** 3. Staff Development Director will in-service licensed nursing staff on obtaining orders for hand splint, and using it as ordered. Unit managers will conduct a weekly audit X4, monthly X3. Audit findings will be given to the DON. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months	6/10/19 ONGOING

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L 201	Continued From page 24 right hand contracture and use splint." Two of the interventions for the use of the splint were; to educate staff on application of splints and monitor skin integrity before applying and after removal of splint. At approximately 11:30 AM on April 26, 2019 the resident was observed wearing a splint to the right hand. A face-to-face interview was conducted with Employee #7 at approximately 11:45 AM on April 26, 2019. The employee was asked for the order for use of the splint to the resident's hand and the schedule for the application of the splint. Employee #7 stated that the resident did not have an order for use of a splint and added that he did not know why someone applied the splint to the resident's hand. Facility staff failed to obtain an order for use of a hand splint to Resident #50's right hand. Employee #7 acknowledged the finding during a face-to-face interview at approximately 11:45 AM on April 26, 2019.	L 201		
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a)The date, time, and description of the incident;	L 204	**Corrective action for the residents affected:** 1. The resident #DG1 was assessed on 4/29.2019. Resident was not harmed by the deficient practice. The clinical manager of the unit was counseled for the absence of documentation in resident #DGI and resident #90 medical record that showed failure that the incident was thoroughly investigated.	4/30/19

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L 204	Continued From page 25 (b)The name of the witnesses; (c)The statement of the victim; (d)A statement indicating whether there is a pattern of occurrence; and (e)A description of the corrective action taken. This Statute is not met as evidenced by: Based on record review and staff interviews, the facility failed to thoroughly investigate an allegation of resident -to-resident abuse for four (4) of 63 sampled Resident #'s, 90, 177, 180 and DG1. Findings included ... A review of the facility's allegations of abuse was conducted on April 24, 2019, at 3:00 PM with Employee #1 review included the following incidents: A. An incident report dated March 15, 2019. "Titled, Abusive Resident ... incident description [Resident # 90] denies slapping his roommate [Resident #DG1] There was no evidence (such as, a documented interview with the resident or the witness interviews or statements and results of the investigation) to show that the incident was thoroughly investigated. B. An incident report dated March 15, 2019. "Titled, Abusive Resident ... incident description [Resident # DG1] denies slapping his roommate [Resident #90] There was no evidence (such as, a documented	L 204	**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. Medical records of all residents with allegations of resident to resident abuse were audited to ensure that the facility thoroughly investigated an allegation of resident to resident abuse/altercation. No other resident was affected. **Measures to prevent reoccurrence:** 3. Staff Development Director will in-service licensed nursing staff regarding the facility policy when there is an allegation of abuse identified. Unit managers will conduct weekly audits X4, than monthly X3. Au8dit results will be forwarded to the DON **Monitoring corrective action:** 4. Abuse, abuse identification, prevention and reporting will be added as a nursing quality indicator for review during the daily stand-up meetings to ensure sustained compliance until 3 months of greater than or equal to 95 % compliance is achieved. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 6/10/19 ongoing

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L 204	Continued From page 26 interview with the resident or the witness interviews or statements and results of the investigation) to show that the incident was thoroughly investigated. C. An incident report dated January 12, 2019. "Titled, Abusive Resident ... incident description [Resident # 180 denies being hit with Resident's walker [Resident #177] There was no evidence (such as, a documented interview with the resident or the witness interviews or statements and results of the investigation) to show that the incident was thoroughly investigated. D. An incident report dated January 12, 2019. "Titled, Abusive Resident ... incident description [Resident # 177] denies purposely hitting Resident with her walker [Resident #180] There was no evidence (such as, a documented interview with the resident or the witness interviews or statements and results of the investigation) to show that the incident was thoroughly investigated. On March 24, 2019, approximately at 5:30 PM, Employee #1 acknowledged the findings.	L 204		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by:	L 214	**Corrective action for the residents affected:** 1. The resident in room #212A and #221A was no negative outcome. Remote bed controller cords that were frayed was repaired by facility operations Director. (4/30/19)	4/30/19

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L 214	Continued From page 27 Based on observations and interview, the facility failed to provide an environment free from accident hazards as evidenced by remote bed controllers cords that were frayed in two (2) of 53 resident's rooms. Findings included ... During observations throughout the facility on April 18, 2019, between 10:45 AM and 3:40 PM, and on April 25, 2019, at approximately 10:40 AM, remote bed controller electrical cords were frayed in resident room #212A and #221A, two (2) of 53 resident's rooms surveyed. The uncovered electrical wires created a potential electrical shock hazard to residents, staff and the public. During a face-to-face interview on April 25, 2019, at approximately 11:30 AM, Employee #14 acknowledged the findings.	L 214	**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. All remote bed controller cards in all resident's room were checked and corrected as needed by facility operations Director. **Measures to prevent reoccurrence:** 3. Building Services and clinical staff will be educated by facility operations Director on safety issues and requirements of functional remote bed controllers. Staff will be educated on a repair request process by facility operations director to ensure timely repairs are completed. Environmental Service supervisor will conduct weekly audits X4, monthly X3. Audit results will be forwarded to the Facility Operations Director. **Monitoring corrective action:** 4. Remote beds controller cords will be added as an indicator for the building service department to be monitored during weekly scheduled surveillance rounds. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 6/10/19 ongoing
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of	L 306	**Corrective action for the residents affected:** 1. The residents in room #212A, #221A, and #115B had no negative outcome. The remote bed controller electrical cords in room #212A, #221A that were frayed and the call bell cords that were frayed in #115B was repaired by facility operations director.	4/30/19

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L 306	Continued From page 28 installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the call bell system in good working condition as evidenced by a call bell in one (1) of 53 resident's rooms that failed to alarm when tested. Findings included... During observations throughout the facility on April 18, 2019, between 10:45 AM and 3:40 PM, the call bell in one (1) of 53 resident's room (#115B) did not alarm when activated. This breakdown could prevent or delay the resident, staff or the public from alerting staff in an emergency. During a face-to-face interview, on April 18, 2019, at approximately 3:30 PM, Employee #13 acknowledged the finding.	L 306	**Identification of others with potential to be affected:** 2. All residents have the potential to be affected. All remote bed controller cords and call bed cords in all resident room were checked and corrected as needed by facility operations Director. **Measures to prevent reoccurrence:** 3. Building Services and clinical staff will be educated by facility operation Director on safety issues and requirements of functional remote bed controllers and call bells. Staff will be educated on the repair request process by facility operation Director to ensure timely repairs are completed. Environmental supervisor will complete audit weekly X4, monthly X3. Audit finding will be forwarded to the facility Operations Director. **Monitoring corrective action:** 4. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	4/30/19 6/10/19 ongoing
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by 16 of 16	L 410	**Corrective action for the residents affected:** 1. The Therapeutic Nutrition drinks that were stored beyond their expiration date cited during the survey period was discarded immediately. **Identification of others with potential to be affected:** 2. All residents have to potential to be affected. All storage shelves were checked by housekeeping staff. No other expired therapeutic nutrition drinks were found.	4/29/19 4/29/19

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L 410	Continued From page 29 Therapeutic Nutrition drinks that were stored beyond their expiration date. Findings included ... During an environmental tour of the facility on April 18, 2019, between 10:45 AM and 3:40 PM, 16 of 16 eight fluid ounce cartons of Ensure Clear Therapeutic Nutrition, stored on a shelf in the Clean room on unit 4 north, were expired as of February 1, 2019. During a face-to-face interview on April 18, 2019, at approximately 10:50 AM, Employee #4 acknowledged the findings.	L 410	**Measures to prevent reoccurrence:** 3. Staff Development Director will educate housekeeping staff and nursing staff on checking all therapeutic nutrition drinks and other items for their expiration dates, how and when to discard these items. Environmental Director will complete audits of storage shelves weekly X4, than monthly X3. **Monitoring corrective action:** 4. Environmental Director will present to the Quality Assurance Improvement Committee monthly for the next 3 months.	6/10/19 ONGOING
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain mechanical and electrical equipment in safe operating condition as evidenced by two (2) remote bed controllers and a call bell cord that were frayed in three (3) of 53 resident's rooms. Findings included ... 1. During observations throughout the facility on April 18, 2019, between 10:45 AM and 3:40 PM, and on April 25, 2019, at approximately 10:40 AM, remote bed controller electrical cords were frayed in resident room #212A and #221A, two (2) of 53 resident's rooms surveyed.	L 442	**Corrective action for the residents affected:** 1. The resident in room #212A and #221A was no negative outcome. Remote bed controller cords that were frayed was repaired by facility operations Director. (4/30/19) **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. All remote bed controller cards in all resident's room were checked and corrected as needed by facility operations Director.	4/30/19 4/30/19

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L 442	Continued From page 30 2. The call bell cord was frayed and its electrical wires were visible and accessible in one (1) of 53 resident's rooms (#115B). The uncovered electrical wires created a potential electrical shock hazard to residents, staff and the public. During a face-to-face interview on April 25, 2019, at approximately 11:30 AM, Employee #14 acknowledged the findings.	L 442	**Measures to prevent reoccurrence:** 3. Building Services and clinical staff will be educated by facility operations Director on safety issues and requirements of functional remote bed controllers. Staff will be educated on a repair request process by facility operations director to ensure timely repairs are completed. Environmental Service supervisor will conduct weekly audits X4, monthly X3. Audit results will be forwarded to the Facility Operations Director. **Monitoring corrective action:** 4. Remote beds controller cords will be added as an indicator for the building service department to be monitored during weekly scheduled surveillance rounds. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	6/10/19 ongoing
L 538	3270.3 Nursing Facilities Upon oral and written notification of discharge, the nursing facility shall provide to the resident and his or her representative: This Statute is not met as evidenced by: Based on record review and staff interview for six (6) of 63 sampled residents, the facility failed to document the transfer information communicated to the receiving health care institution in six (6) residents medical record. Residents' #74, #129, #175, #204, #225 and #474. Findings included... 1. The facility staff failed to document the transfer information communicated to the receiving health care institution in Resident #74's medical record. Resident #74 initial admission to the facility is on January 22, 2019, with diagnoses to include Anemia, Hypertension, Diabetes Mellitus, Malignant Neoplasm of Bladder, Atrial Fibrillation,	L 538	**Corrective action for the residents affected:** 1. The resident #74, #129, #175, #204, #225, and #474. The facility cannot retroactively correct the deficiency. **Identification of others with potential to be affected:** 2. All residents have the potential to be affected. No other resident was affected by this deficient practice and evidenced by a review of residents who were discharged to other health care institutions from the facility in the past 90 days. A transfer/discharge checklist has been created.	4/30/19 4/30/19

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L 538	Continued From page 31 Generalized Muscle Weakness, and Dementia without Behavioral Disturbance. A review of the Admission Minimum Data Set [MDS] dated February 9, 2019. Section C0500 [BIMS Summary Score] of "11" moderately impaired cognition which indicates, "Resident decisions poor: cues/supervision required". A review of the Physician's order dated January 25, 2019, directed "Send resident out to the nearest ER for Hematuria and Hypotension." A review of the Patient Transfer notes dated January 25, 2019, showed a lack of the following documented information: "contact information of the practitioner responsible for the care of the resident, the resident's representative contact information, the comprehensive care plan goals, detailed information on resident's diagnosis at time of transfer, vital signs (temperature, pulse, respirations and blood pressure) at the time of transfer, advance directives, code status, and all pertinent information necessary to address the resident's behavioral needs and mental status." The facility staff failed to ensure all information mentioned above was communicated to the receiving healthcare facility as evidenced by the medical record's lack of documented evidence to show that the information was sent with Resident #74 to the emergency room on January 25, 2019. A face-to-face interview was conducted on April 25, 2019, at approximately 10:00 AM with Employee#6. The employee acknowledged the finding. 2. The facility staff failed to document the transfer information communicated to the receiving health	L 538	**Measures to prevent reoccurrence:** 3. Staff Development Director will provide in-service to the nursing staff to follow the required resident transfer/discharge guidelines and utilize the transfer/discharge checklist. The interdisciplinary team will be re-educated on the discharge planning process, required documented discussion with the resident and their representative, a transfer/discharge checklist will be completed and reviewed for all residents with discharge potential, prior to finalizing the discharge. Audits of discharged residents will be conducted by the Social Service staff weekly X4, monthly X3. **Monitoring corrective action:** 4. Audits of the discharge/transfer process will be added as a social work quality indicator to ensure compliance until 3 consecutive months of greater than or equal to 95% compliance is achieved. Result of the findings will be reported to the Quality Assurance Improvement Committee monthly for the next 3 months.	6/10/19 ongoing

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	HFD02-0010	A. BUILDING: _____ B. WING _____	04/29/2019

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L 538	Continued From page 32 care institution in Resident #129's medical record. Resident #129 was initially admitted to the facility on November 2, 2018, with diagnoses which include Hyperlipidemia, Hypertension, Chronic Obstructive Pulmonary Disease, Gastro-Esophageal Reflux Disease, Parkinsonism, Generalized Muscle Weakness, Major Depressive Disorder, Bipolar Disorder, and Schizophrenia. A review of the Significant Change Minimum Data Set [MDS] dated January 31, 2019. Section C0500 [BIMS Summary Score] of "7" severely impaired cognition which indicates, "Never/rarely make decisions". A review of the Physician's order dated February 18, 2019, directed "Send resident out 911 to nearest ER secondary to multiple seizures even after taking seizure medication and limited physical activities." The medical record lacked documentation to support the facility communicated the name of the practitioner who is responsible for the care of the resident, resident's representative contact information, advance directive information, special instructions and precautions, and comprehensive care plan goals to the receiving health care institution for the transfer that occurred February 18, 2019. A face-to-face interview conducted on April 25, 2019, at approximately 10:00 AM with Employee#5. The employee acknowledged the finding. 3. The facility staff failed to document the transfer	L 538		

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L 538	Continued From page 33 information communicated to the receiving health care institution in Resident #175's medical record. Resident #175 was admitted to the facility on 1/13/17 with diagnoses which include Hypothyroidism, Types II Diabetes Mellitus without Complications, Major Depressive Disorders, Unspecified Glaucoma and Vascular Dementia with Behavioral Disturbance. Review of the medical record on 4/24/19 at 10:00 AM showed a Comprehensive Minimum Data Set dated 3/20/19, Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "7" which indicates severe cognitive impairment. Review of the physician's order dated 2/28/19 "Transfer resident to the nearest emergency room Altered Mental Status and Lethargy." Review of the resident's medical record failed to show information given to the receiving health care institution to include the following: contact information of the practitioner responsible for the care of the resident, resident representative including contact information, advance directive information, special instructions, and comprehensive goals. Facility staff failed to provide evidence that all pertinent information (contact information of the practitioner, advance directive information, special instructions and comprehensive goals) was communicated to the receiving facility. During a face-to-face interview on 4/24/19 at 10:00 AM Employee #3 acknowledged the finding.	L 538		

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L 538	Continued From page 34 4.The facility staff failed to document the transfer information communicated to the receiving health care institution in Resident #204's medical record. Resident #204 was admitted to the facility on June 19, 2018, with diagnoses that included Hyperkalemia, Diabetes Mellitus, Hypertension, Parkinson's Disease, Dysarthria and Anarthria, Cerebrovascular Disease, Chronic Kidney Disease, Generalized Muscle Weakness, Disorientation and Dementia with Behavioral Disturbances. A review of the Significant Change Minimum Data Set [MDS] dated March 26, 2019. Section C1000 [Cognitive Skills for daily Decision Making] coded as "3" which indicates resident is Severely Impaired -never/rarely made decisions. Physician's Order dated January 25, 2019, directed " Transfer resident to nearest ER for evaluation of head injury s/p [status/post] fall." A review of the Patient Transfer notes dated January 25, 2019, lacked the following documented information: "Contact information of the practitioner responsible for the care of the resident, the resident's representative contact information, the comprehensive care plan goals, detailed information on resident diagnosis at time of transfer, vital signs (temperature, pulse, respirations and blood pressure) at the time of transfer, advance directives, code status, and all pertinent information necessary to address the resident's behavioral needs and mental status." The facility staff failed to ensure all information mentioned above was communicated to the	L 538		

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L 538	Continued From page 35 receiving healthcare facility as evidenced by the medical record's lack of documented evidence to show that the information was sent with Resident #204 to the emergency room on January 25, 2019. A face-to-face interview conducted on April 25, 2019, at approximately 10:00 AM with Employee#5. The employee acknowledged the finding. 5. The facility staff failed to document the transfer information communicated to the receiving health care institution in Resident #225's medical record. Resident #225 was admitted to the facility on February 4, 2019, with diagnoses to include Anemia, Hyperlipidemia, Osteoporosis, Anxiety Disorder, Depression, and Schizophrenia. A review of the Admission Minimum Data Set [MDS] dated February 11, 2019. Section C [Cognition Patterns] Brief Interview for Mental Status [BIMS] was recorded as "15" which indicates resident is cognitively intact. A review of the physicians' order dated March 25, 2019 showed, "Resident transfer to [name of facility]." A review of the progress notes dated March 20, 2019 showed a lack of the following documented information: contact information of the practitioner responsible for the care of the resident, the resident's representative contact information, the comprehensive care plan goals, detailed information on resident's diagnosis at time of	L 538		

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L 538	Continued From page 36 transfer, vital signs (temperature, pulse, respirations and blood pressure) at the time of transfer, advance directives, code status, and all pertinent information necessary to address the resident's behavioral needs and mental status. The facility staff failed to ensure all information mentioned above was communicated to the receiving healthcare facility as evidenced by the medical records' lack of documented evidence to show that the information was sent with Resident #225 to the receiving facility on March 25, 2019. Employee #2 acknowledged the finding during a face-to-face interview conducted on April 25, 2019, at approximately 10:00 AM. 6. The facility staff failed to document the transfer information communicated to the receiving health care institution in Resident #474's medical record. Resident #474 was admitted to the facility on 1/13/17 with diagnoses which include Encephalopathy, Unspecified, Essential (Primary) Hypertension, End Stage on Renal Dialysis, Pressure Ulcer of Sacral Region (Unspecified Stage), Unspecified Dementia without Behavioral Disturbance. Review of the medical record on 4/24/19 at 11:00 AM showed a Comprehensive Minimum Data Set (MDS) dated 3/12/19. Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] was recorded as "11" which indicates moderate cognitive impairment. Review of the physician's order dated 3/26/19 "Transfer resident to the nearest emergency room (ER) via 911." Further review of the	L 538		

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L 538	Continued From page 37 progress note dated 3/26/19 showed "resident transferred to [hospital name] and left message for responsible party to call back." Review of the resident's medical record failed to show information given to the receiving health care institution to include the following: contact information of the practitioner responsible for the care of the resident, resident representative including contact information, advance directive information, special instructions, and comprehensive goals. Facility staff failed to provide evidence that all pertinent information (contact information of the practitioner, advance directive information, special instructions and comprehensive goals) was communicated to the receiving facility. During a face-to-face interview on 4/24/19 at 11:00 AM Employee #3 acknowledged the finding.	L 538		