VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

DEC 27 2013

In Reply Refer To: 515/012GR

Ms. Sara Dunne, Commandant
Grand Rapids State Home for Veterans
3000 Monroe Avenue NW
Grand Rapids, MI 49505

Dear Ms. Dunne:

The Battle Creek VA Medical Center (VAMC) Survey Team conducted the For Cause Survey of the Grand Rapids State Home for Veterans (SHV) on September 24-27, 2013. During the survey, several deficiencies were cited and a letter was sent to you on October 21, 2013, listing them.

On November 8, 2013, you responded with the Grand Rapids SHV Corrective Action Plan (CAP) and again on December 9, 2013, after the survey team presented several questions. After the survey team reviewed the evidence of implementation of the corrective action plan, it was determined that your facility, the Grand Rapids SHV is in compliance with all VA domiciliary standards and I have granted the Grand Rapids SHV full certification for the 2013 For Cause Survey.

In reviewing the evidence of implementation of the CAP for the nursing home, it was determined that your facility, the Grand Rapids SHV, is provisionally in compliance with all VA nursing home standards and have been granted the provisional certification for the 2013 For Cause Survey. Until the in-service training is fully completed, standards 26, 64, 67 and 93 will continue to be partially met. Upon completion of all in-service training standards, the Grand Rapids SHV provisional certification can then be changed to full certification.

If you have any questions regarding the Grand Rapids SHV certifications or the information provided to you, please contact Mr. Greg Harris at (616) 365-7573. Thank you.

Sincerely,

MARY BETH SKUPIEN, Ph.D.
Medical Center Director

cc: Chief Consultant, Geriatrics and Extended Care (10P4G)

Department of Veterans Affairs Medical Center
5500 Armstrong Road
Battle Creek, MI 49037-7314

Department of Veterans Affairs - (Standards - Nursing Home Care)

SURVEY CLASS	SURVEY YEAR	COMPLETION DATE
Cause Survey	2013	9/27/2013

NAME OF FACILITY	STREET ADDRESS	CITY	STATE	ZIP CODE
Grand RapidsD	3000 Monroe Ave. N.E.	Grand Rapids	MI	49505

SURVEYED BY (VHA Field Activity of Jurisdiction)

Carrie Storms2 Eric George Greg Harris FU_GR Greg Harris TL_GRD Jackie Muir515 Kathy Cummins515 Marilyn Klotz515 Susan Honaker Vincent Williams515

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
1	§ 51.210 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical, physical, mental, and psychological well being of each resident. A. Governing body: 1. The State must have a governing body, or designated person functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility, and 2. The governing body or State official with oversight for the facility appoints the administrator who is: i. Licensed by the State where licensing is required; and ii. Responsible for operations and management of the facility.	(M) Met					
2	b. Disclosure of State agency and individual responsible for oversight of facility. The State must give written notice to the Chief Consultant, Geriatrics and Extended Care Strategic Healthcare Group (114), VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420, at the time of the change, if any of the following change: 1. The State agency and individual responsible for oversight of a State home facility. 2. The State home administrator; 3. The State employee responsible for oversight of the State home facility if a contractor operates the State home.	(M) Met					

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3	C 7. Annual State Fire Marshall's report. c. State official must sign four certificates	(M) Met					
4	8. Annual certification from the responsible State agency showing compliance with Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112) (VA Form 10-0143A set forth at § 51.224);	(M) Met					
5	9. Annual certification for Drug-free Workplace Act of 1988 (VA Form 10-0143 set forth at § 51.225);	(M) Met					
6	10. Annual certification regarding lobbying in compliance with Public Law 101-121 (VA Form 10-0144 set forth at § 51.226);	(M) Met					
7	11. Annual certification of compliance with Title VI of the Civil Rights Act of 1964 as incorporated in Title 38 CFR 18.1-18.3 (VA Form 27-10-0144A located at § 51.227);	(M) Met					
8	d. Percentage of Veterans. The percent of the facility residents eligible for VA nursing home care must be at least 75 percent veterans except that the veteran percentage need only be more than 50 percent if the facility was constructed or renovated solely with State funds. All non-veterans residents must be spouses of veterans or parents all of whose children died while serving in the armed forces of the Unites States.	(M) Met					
9	e. Management Contract Facility. If a facility is operated by an entity contracting with the State, the State must assign a State employee to monitor the operations of the facility on a full-time onsite basis.	(NA) Not Applicable	Facility is ran by State of Michigan.				
10	f. Licensure. The facility and facility management must comply with applicable State and local licensure laws.	(M) Met					
11	g. Staffing qualifications: 1. The facility management must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. 2. Professional staff must be licensed, certified, or registered in accordance with applicable State laws.	(M) Met					

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12	h. Use of Outside Resources: 1. If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h) (2) of this section. 2. Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for: i. Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and ii. The timeliness of the service.	(M) Met					
13	i. Medical Director: 1. The facility management must designate a primary care physician to serve as medical director. 2. The medical director is responsible for: i. Participating in establishing policies, procedures, and guidelines to ensure adequate, comprehensive services; ii. Directing and coordinating medical care in the facility; iii. Helping to arrange for continuous physician coverage to handle medial emergencies; iv. Reviewing the credentialing and privileging process; v. Participating in managing the environment by reviewing and evaluating incident reports or summarizes of incident reports, identifying hazards to health and safety, and making recommendations to the administrator; and vi. Monitoring employees' health status and advising the administrator on employee health policies.	(M) Met					

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14	j. Credentialing and privileging. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologist, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance. 1. The facility management must uniformly apply Credentialing criteria to licensed independent practitioners applying to provide resident care or treatment under the facility's care. 2. The facility management must verify and uniformly apply the following core criteria: Current licensures; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide. 3. The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credential's file must indicate that these criteria are uniformly and individually applied. 4. The facility management must maintain documentation of current credentials for each licensed independent practitioner practicing within the facility. 5. When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience. 6. The facility management systemically must asses whether individuals with clinical privileges act within the scope of privileges granted.	(M) Met					

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15	k. Required training of nursing aides. 1. Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or a volunteer who provide such services without pay. 2. The facility management must not use any individual working in the facility as a nurse aide whether permanent or not unless: i. That individual is competent to provide nursing and nursing related services; and ii. That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State.	(N) Not Met	Based on interviews and reviewing the training records for the contract nursing assistants, 6 out of 59 did not have records indicating training on abuse and neglect, and aggressive behaviors. Training should be conducted for All nursing assistants on all topics to included the training identified above before staff is released to work on a unit. The specific training i.e. abuse and neglect, and aggressive behaviors should be more interactive with instructor than reading a policy as identified by interviews with staff. It is recommended that training be conduct annually and documented in the employees record.	GRHV's annual mandatory annual inservice does include a section on abuse and neglect. Nursing employees also are in-serviced on abuse and neglect annually through Silverchair Learing system. GRHV will continue with these trainings, and will add another mandatory in-service on abuse and neglect for all staff working within the Home, including Housekeeping and Laundry staff. All future employees will receive this training during their orientation to the Home. GRHV policy 01-02-A4 (attached) has been revised to provide additional instructions on how to report suspected incidents of abuse, neglect, and exploitation within the Home, and when to report incidents to the VISN and to the State of Michigan for review.	2-1-2014 11/08/2013		
16	3. Registry verification. Before allowing an individual to serve as a nurse aide, facility management must receive registry verification that the individual has met competency evaluation requirements unless the individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. 4. Multi-State registry verification. Before allowing an individual to serve as a nurse aide, facility management must seek information from every State registry established under HHS regulations at 42 CFR 483.156 which the facility believes will include information on the individual.	(M) Met					

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17	5. Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monitary compensation. The individual must complete a new training and competency evaluation program. 6. Regular in-service education. The facility management must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must; i. Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; ii. Address areas of weakness as determined in nurse aide's performance reviews and may address the special needs of residents as determined by the facility staff; and iii. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	(M) Met					
18	I. Proficiency of nurse aides. The facility management must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	(M) Met					

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19	m. Level B Requirement Laboratory services. 1. The facility management must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services: i. If the facility provides its own laboratory services, the services must meet all applicable certification standards, statutes, and regulations for laboratory services. ii. If the facility provides blood bank and transfusion services, it must meet all applicable certification standards, statutes and regulations. iii. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialities and subspecialities of services and meet certification standards, statutes, and regulations. iv. The laboratory performing the testing must have a current, valid CLIA number (Clinical Laboratory Improvement Amendments of 1988). The facility management must provide VA surveyors with the CLIA number and a copy of the results of the last CLIA inspection. v. Such services must be available to the resident seven days a week, 24 hours a day. 2. The facility management must: i. Provide or obtain laboratory services only when ordered by the primary physician; ii. Promptly notify the primary physician of the findings; iii. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and iv. File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.	(M) Met					

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20	n. Radiology and other diagnostic services. 1. The facility management must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. i. If the facility provides its own diagnostic services, the services must meet all applicable certification standards, statutes, and regulations. ii. If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services. The services must meet all applicable certification standards, statutes, and regulations. iii. Radiologic and other diagnostic services must be available 24 hours a day, seven days a week. 2. The facility management must: i. Provide or obtain radiology and other diagnostic services only when ordered by the primary physician; ii. Promptly notify the primary physician of the findings; iii. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and iv. File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.	(M) Met					

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21	o. Clinical Records. 1. The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are: i. Complete; ii. Accurately documented; iii. Readily accessible; and	(M) Met					
22	2. Clinical records must be retained for: i. The period of time required by State law; or ii. Five years from the date of discharge when there is no requirement in the State law.	(M) Met					
23	3. The facility management must safeguard clinical record information against loss, destruction, or unauthorized use;	(M) Met					
24	4. The facility management must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by: i. Transfer to another health care institution; ii. Law; iii. Third party payment contract; or iv. The resident.	(M) Met					
25	5. The Clinical record must contain: i. Sufficient information to identify the residents; v. Progress notes. iv. The results of any pre-admission screening conducted by the State; and iii. The plan of care and services provided;	(M) Met					

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26	p. Quality assessment and assurance. 1. Facility management must maintain a quality assessment and assurance committee consisting of: i. The director of nursing services; ii. A primary physician designated by the facility; and iii. At least three other members of the facility's staff.	(N) Not Met	Based on interviews and record reviews it was determined the facility does not have a consistent way to ensure orientation and annual training is being conducted and completed for contract staff, i.e., housekeeping, physical therapy, dental, etc. There is specific concerns toward orientation and annual training when dealing with abuse and neglect along with aggressive behavior training.	The Home will ensure that all current employees are in-serviced on abuse, neglect, and exploitation, and all future employees will receive training during their orientation and annually.	2-1-2014		
27	2. The quality assessment and assurance committee: i. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and ii. Develops and implements appropriate plans of action to correct identified quality deficiencies; and	(M) Met					
28	3. Identified quality deficiencies are corrected within an established time period.	(M) Met					
29	q. Disaster and emergency preparedness. 1. The facility management must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.	(M) Met					
30	2. The facility management must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.	(M) Met					

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31	r. Transfer agreement. 1. The facility management must have in effect a written transfer agreement with one or more hospitals that reasonably assures that: i. Residents will be transferred from the nursing home to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the primary physician; and ii. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the nursing home or the hospital, will be exchanged between the institutions. 2. The facility is considered to have a transfer agreement in effect if the facility has an agreement with a hospital sufficiently close to the facility to make transfer feasible.	(M) Met					
32	u. Intermingling. A building housing a facility recognized as a State home for providing nursing home care may only provide nursing home care in the areas of the building recognized as a State home for providing nursing home care.	(M) Met					
33	§ 51.40 Basic per diem. (b) During Fiscal Year 2009 and during each subsequent Fiscal Year, VA will pay a facility recognized as a State home for nursing home care the lesser of the following for nursing home care provided to an eligible veteran in such facility: (1) One-half of the cost of the care for each day the veteran is in the facility; or (2) The basic per diem rate for the Fiscal Year established by VA in accordance with 38 U.S.C. 1741(c).	(M) Met					

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34	§ 51.41 Per diem for certain veterans based on service-connected disabilities. (a) VA will pay a facility recognized as a State home for nursing home care at the per diem rate determined under paragraph (b) of this section for nursing home care provided to an eligible veteran in such facility, if the veteran: (1) Is in need of nursing home care for a VA adjudicated service-connected disability, or (2) Has a singular or combined rating of 70 percent or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability and is in need of nursing home care. (b) For purposes of paragraph (a) of this section, the rate is the lesser of the amount calculated under the paragraph (b)(1) or (b)(2) of this section. (1) For each of the 53 case-mix levels, the daily rate for each State home will be determined by multiplying the labor component by the nursing home wage index and then adding to such amount the non-labor component and an amount based on the CMS payment schedule for physician services. The amount for physician services, based on information published by CMS, is the average hourly rate for all physicians, with the rate modified by the applicable urban or rural geographic index for physician work, and then with the modified rate multiplied by 12 and then divided by the number of days in the year. Note to paragraph(b)(1): The amount calculated under this formula reflects the applicable or prevailing rate payable in the geographic area in which the State home is located for nursing home care furnished in a non-Department nursing home (a public or private institution not under the direct jurisdiction of VA which furnishes nursing home care). Further, the formula for establishing these rates includes CMS information that is published in theFederal Registerevery summer and is effective beginning October 1 for the entire fiscal year. Accordingly, VA will adjust the rates annually. (2) A rate not to exceed the daily cost of care for the month in the State home facility, as determined by the Chief Consultant, Office of Geriatrics and Extended Care, following a report to the Chief Consultant, Office of Geriatrics and Extended Care under the provisions of	(M) Met				

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	§51.43(b) of this part by the director of the State home. (c) Payment under this section to a State home for nursing home care provided to a veteran constitutes payment in full to the State home by VA for such care furnished to that veteran. Also, as a condition of receiving payments under this section, the State home must agree not to accept drugs and medicines from VA on behalf of veterans provided under 38 U.S.C. 1712(d) and corresponding VA regulations (payment under this section includes payment for drugs and medicines).						
35	§ 51.43 Per diem and drugs and medicines—principles. (a) VA will pay per diem under this part from the date of receipt of the completed forms. (b) VA pays per diem on a monthly basis. To receive payment, the State must submit to the VA medical center of jurisdiction a completed VA Form 10–5588, State Home Report and Statement of Federal Aid Claimed. This form is set forth in full at §58.11 of this chapter. (c) Per diem will be paid under §§51.40 and 51.41 for each day that the veteran is receiving care and has an overnight stay. Per diem also will be paid when there is no overnight stay if the veteran has resided in the facility for 30 consecutive days (including overnight stays) and the facility has an occupancy rate of 90 percent or greater. However, these payments will be made only for the first 10 consecutive days during which the veteran is admitted as a patient for any stay in a VA or other hospital (a hospital stay could occur more than once in a calendar year) and only for the first 12 days in a calendar year during which the veteran is absent for purposes other than receiving hospital care. (e) The daily cost of care for an eligible veteran's nursing home care for purposes of §§51.40(a)(1) and 51.41(b)(2) consists of those direct and indirect costs attributable to nursing home care at the facility divided by the total number of residents at the nursing home.	(M) Met					

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36	§ 51.70 Resident Rights The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility management must protect and promote the rights of each resident, including each of the following rights. a. Exercise of rights. 1. The resident has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. 2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility management in exercising his or her rights. 3. The resident has the right to freedom from chemical or physical restraint. 4. In the case of a resident determined incompetent under the laws of a State by a court of jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. 5. In the case of a resident who has not been determined incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.	(M) Met					

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37	b. Notice of rights and services. 1. The facility management must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Such notifications must be made prior to or upon admission and periodically during the resident's stay. 2. The resident or his or her legal representative has the right: i. Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and ii. After receipt of his or her records for review, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and with 2 working days advance notice to the facility management. 3. The resident has the right to be fully informed in language that he or she can understand of his or her total health status; 4. 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 (b)(7) of this section; and 5. The facility management must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services to be billed to the resident. 6. The facility management must furnish a written description of legal rights which includes: i. A description of the manner of protecting personal funds, under paragraph (c) of this section; ii. A statement that the resident may file a	(M) Met					

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	complaint with the State (agency) concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. 7. The facility management must have written policies and procedures regarding advance directives (e.g., living wills). These requirements include provisions to inform and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. If an individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating conditions) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility management is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 8. The facility management must inform each resident of the name and way of contacting the primary physician responsible for his or her care.						

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38	9. Notification of changes: i. Facility management must immediately inform the resident; consult with the primary physician; and if known, notify the resident's legal representative or an interested family member when there is: A. An accident involving the resident which results in injury and has the potential for requiring physician intervention; B. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); C. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); D. A decision to transfer or discharge the resident from the facility as specified in § 51.80(a) of this part. ii. The facility management must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is: A. A change in room or roommate assignment as specified in § 51.100 (f)(2); or B. A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. iii. The facility management must record and periodically update the address and phone number of the resident's legal representative or interested family member.	(M) Met					

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39	c. Protection of resident funds. 1. The resident has the right to manage his or her financial affairs, and the facility management may not require residents to deposit their personal funds with the facility. 2. Management of personal funds. Upon written authorization of a resident, the facility management must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(6) of this section.	(M) Met					
40	3. Deposit of funds. i. Funds in excess of $100. The facility management must deposit any resident's personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on residents funds to that account. (In pooled accounts, there must be a separate accounting for each residents share.) ii. Funds less than $100. The facility management must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.	(M) Met					
41	4. Accounting and records. The facility management must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. i. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. ii. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	(M) Met					

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42	§ 51.70 Resident rights. (C) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows.	(M) Met					
43	6. Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility.	(M) Met					
44	d. Free Choice. The resident has the right to: 1. Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and 2. Unless determined incompetent or otherwise determined to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.	(M) Met					

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45	e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 1. Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident. 2. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; 3. The resident's right to refuse release of personal and clinical records does not apply when: i. The resident is transferred to another health care institution; or ii. Record release is required by law.	(M) Met					
46	f. Grievances. A resident has the right to: 1. Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and 2. Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	(M) Met					
47	g. Examination of survey results. A resident has the right to: 1. Examine the results of the most recent VA survey with respect to the facility. The facility management must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability; and 2. Receive information from agencies acting as clinical advocates, and be afforded the opportunity to contact these agencies.	(M) Met					

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48	h. Work. The resident has the right to: 1. Refuse to perform services for the facility; 2. Perform services for the facility, if he or she chooses, when: i. The facility has documented the need or desire for work in the plan of care; ii. The plan specifies the nature of the services performed and whether the services are voluntary or paid; iii. Compensation for paid services is at or above prevailing rates; and iv. The resident agrees to the work arrangement described in the plan of care.	(M) Met					
49	i. Mail. The resident has the right to privacy in written communications, including the right to: 1. Send and promptly receive mail that is unopened; and 2. Have access to stationary, postage, and writing implements at the resident's own expense.	(M) Met					

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50	j. Access and visitation rights. 1. The resident has the right and the facility management must provide immediate access to any resident by the following: i. Any representative of the Under Secretary for Health; ii. Any representative of the State; iii. Physicians of the resident's choice; iv. The State long-term care ombudsman; v. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time; and vi. Others who are visiting subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time .2. The facility management must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. 3. The facility management must allow representatives of the State Ombudsman Program, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, subject to State law.	(M) Met					
51	k. Telephone. The resident has the right to reasonable access to use a telephone where calls can be made without being overheard.	(M) Met					
52	l. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other resident	(M) Met					
53	m. Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.	(M) Met					

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54	n. Self-Administration of drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defines by § 51.110(d)(2)(ii) of this part, has determined that this practice is safe.	(M) Met					
55	§ 51.80 Admission, transfer and discharge rights. a. Transfer and discharge: 1. Definition. Transfer and discharge includes movement of a resident to a bed outside of the facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility. 2. Transfer and discharge requirements. The facility management must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: i. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing home; ii. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing home; iii. The safety of individuals in the facility is endangered; iv. The health of individuals in the facility would otherwise be endangered; v. The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility; or vi. The nursing home ceases to operate.	(M) Met					
56	3. Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (a)(2)(vi) of this section, the primary physician must document in the resident's clinical record.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
57	4. Notice before transfer. Before a facility transfers or discharges a resident, the facility must: i. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. ii. Record the reasons in the resident's clinical record; and iii. Include in the notice the items described in paragraph (a)(6) of this section.	(M) Met					
58	5. Timing of the notice. i. The notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged, except when specified in paragraph (a)(5)(ii) of this section; ii. Notice may be made as soon as practicable before transfer or discharge when: A. The safety of individuals in the facility would be endangered; B. The health of individuals in the facility would be otherwise endangered; C. The resident's health improves sufficiently so the resident no longer needs the services provided by the nursing home; D. The resident's needs cannot be met in the nursing home.	(M) Met					

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59	6. Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: i. The reason for transfer or discharge; ii. The effective date of transfer or discharge; iii. The location to which the resident is transferred or discharged; iv. A statement that the resident has the right to appeal the action to the State official designated by the State; and v. The name, address and telephone number of the State long term care ombudsman.	(M) Met					
60	7. Orientation for transfer or discharge. A facility management must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	(M) Met					

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61	b. Notice of bed-hold policy and readmission. 1. Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility management must provide written information to the resident and a family member or legal representative that specifies: i. The duration of the facility's bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; and ii. The facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section permitting a resident to return. 2. Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, facility management must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. 3. Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room. If the resident required the services provided by the facility.	(M) Met					
62	c. Equal access to quality care. The facility management must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment.	(M) Met					
63	d. Admissions policy. The facility management must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individu	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
64	§ 51.90 Resident behavior and facility practices. a. Restraints. 1. The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is applied or used, the purpose of the restraint is reviewed and is justified as a therapeutic intervention. i. Chemical restraint is the inappropriate use of a sedating psychotropic drug to manage or control behavior. ii. Physical restraint is any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints. 2. The facility management uses a system to achieve a restraint-free environment. 3. The facility management collects data about the use of restraints. 4. When alternatives to the use of restraint are ineffective, restraint is safely and appropriately used.	(P) Provisional Met	Based on observation, interview and record review it was determined the facility failed to ensure one (1) resident from a sampled thirty-three (33) residents was free from chemical restraints. Restraint #11 had a physician's order for Ativan as needed for agitation. The resident had refused as needed medications. Documentation in the interdisciplinary progress notes revealed a nurse put Ativan (a chemical restraint) in coffee, and gave the coffee to the resident twice without the resident's knowledge.	The employees responsible have been issued corrective action with explicit instructions to never give medication that a member refuses. All licensed nurses will be re-educated on proper medication administration techniques.	11/4-5/2013 1/01/2014		

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
65	b. Abuse. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion. 1. Mental abuse includes humiliation, harassment, and threats of punishment or deprivation. 2. Physical abuse includes hitting, slapping, pinching or kicking. Also includes controlling behavior through corporal punishment. 3. Sexual abuse includes sexual harassment, sexual coercion, and sexual assault. 4. Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include placing the individual in unsafe or unsupervised conditions. 5. Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative.	(N) Not Met	Based on interview and record review it was determined the facility failed to protect one (1) of thirty-three (33) sampled residents (Resident #31) from neglect. Resident #31incurred two (2) fractures to the lower right leg. The facility's concerns identified in their investigation included the resident's care plan and nursing assistant "cheat sheet" did not give specific instructions for bathing, the resident was transferred in a shower chair which is not a mobility device, the employee did not know how to safely operate the shower chair and furthermore the resident was left alone in the shower room although the resident required total assistance with bathing. The facility's failure to ensure Resident #31 was not placed in an unsafe and unsupervised condition resulted in this standard being cited at the actual harm level.	This particular employee was given an unpaid suspension, and when returned completed another orientation and was specifically tested on the knowledge of all transfer equipment. The member's care plan has been updated and the cheat sheets updated to indicate that the member requires total care with showering, and he is not be left alone in the shower room, even when he insists. Case Managers assessed each member and reviewed the care plans to ensure that the information is updated and accurate.	8/16/2013		

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
66	c. Staff treatment of residents. The facility management must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility management must: i. Not employ individuals who: A. Have been found guilty of abusing, neglecting, or mistreating individuals by a court of law; or B. Have had a finding entered into an applicable State registry or with the applicable licensing authority concerning abuse, neglect, mistreatment of individuals or misappropriation of their property; and ii. Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. 2. The facility management must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures. 3. The facility management must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 4. The results of all investigations must be reported to the administrator or the designated representative and to other officials in accordance with State law within 5 working days of the incident, and appropriate corrective action must be taken if the alleged violation is verified.	(N) Not Met	Based on observation, interview, record review, and review of facility policy it was determined the facility staff failed to immediately report allegations of abuse for three residents, Resident's #10,#32, and #33, and failed to ensure all allegations of abuse were thoroughly investigated for two (2) residents, Resident's # 10 and #32. Resident #10 told a nurse he/she had been assaulted. The nurse did not report the allegation and an investigation of the allegation of abuse was not conducted to ensure further allegations of abuse did not occur. Resident #32 reported to a charge nurse he/she had been treated rough and punched in the stomach. A thorough investigation of this allegation was not conducted. Resident #33 was observed to have tape placed over his mouth by a staff person. Two (2) staff persons witnessed the incident and the incident was not reported immediately, staff did not report the incident until the next day. The facility's failure to ensure allegations of abuse were reported immediately and investigated thoroughly placed these residents and other residents of the facility at risk for potential abuse. The facility's failure to ensure allegations of abuse were thoroughly investigated resulted in this standard being cited at the actual harm level.	GRHV has revised and updated facility policy 01-02-A4: Abuse and Neglect to require staff to report all possible incidents of abuse/neglect, even if the staff believe that the member is delusional or not reporting an incident accurately. All of these incidents were not brought to the attention of the Administration until days after the incident allegedly occurred. We are evaluating a computer program that will assist with our investigations and tracking of incidents. We have also added Daily Report including the Director of Nursing, the Administrator, and all of the Nursing Unit Coordinators and Administration team so that all reports will be brought to the attention of the Administration as soon as possible.	11/08/2013 10/14/2013		

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
67	§ 51.100 Quality of Life. A facility management must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. a. Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. b. Self-determination and participation. The resident has the right to: 1. Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans for care; 2. Interact with members of the community both inside and outside the facility; and 3. Make choices about aspects of his or her life in the facility that are significant to the resident.	(N) Not Met	Based on observation, interview and record review it was determined the facility failed to ensure all residents were treated in a dignified manner by staff, for one (1) of thirty-three (33) residents, Resident #33. Resident #33 was observed to have tape placed over his mouth by a staff person. Two (2) staff persons witnessed the incident and the incident was not reported immediately, staff did not report the incident until the next day.	All GRHV Employees, including all contracted employees, will be in-serviced on Abuse, Neglect, and Exploitation. This subject is covered in our yearly mandatory in-service, and will now be required as a live in-service so staff will have at least two trainings related to abuse & neglect. All new employees in the Nursing Department receive training during orientation, and now all GRHV and contract employees will also receive this training. Two modules on abuse and neglect are also included in the mandatory training through Silver Chair, which is mandatory for all Nursing Employees, and will also be extended to all GRHV employees.	2/01/2014		
68	c. Resident Council. The facility management must establish a council of residents that meet at least quarterly. The facility management must document any concerns submitted to the management of the facility by the council.	(M) Met					

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69	d. Participation in resident and family groups. 1. A resident has the right to organize and participate in resident groups in the facility; 2. A resident's family has the right to meet in the facility with the families of other residents in the facility; 3. The facility management must provide the council and any resident or family group that exists with private space; 4. Staff or visitors may attend meetings at the group's invitation; 5. The facility management must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings; 6. The facility management must listen to the views of any resident or family group, including the council established under paragraph (c) of this section, and act upon the concerns of residents, families, and the council regarding policy and operational decisions affecting resident care and life in the facility.	(M) Met					
70	e. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. The facility management must arrange for religi	(M) Met					
71	f. Accommodation of needs. A resident has the right to: 1. Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and 2. Receive notice before the resident's room or roommate in the facility is changed.	(N) Not Met	Based on observation, interview and record review it was determined the facility failed to ensure the CAP (Corrective Action Plan) they had developed to address the deficient practice identified on the survey of 04/09/13 had been implemented. The TeleHealth services that was to be implemented by September 2013 was not in place.	The connection for TeleHealth was finally established between the two facilities on 10/10/13. A psych consult was conducted between the Home and CBOC on 10/10/13 at 3pm for a resident on the Alzheimer's unit at the Home. Consult was placed in medical records. Follow-up was determined on a prn basis. With the establishment of a contract for psychiatric services on 10/1/13, TeleHealth will be utilized as a back-up for psych services and/or any future programs deemed appropriate.	Oct. 10, 2013		

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72	g. Patient activities. 1. The facility management must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	(M) Met					
73	2. The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who: - Is licensed or registered, if applicable, by the State in which practicing; and - Is certified as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body.	(M) Met					
74	h. Social Services. 1. The facility management must provide medically related social services to attain or maintain the highest practicable mental and psychosocial well being of each resident;	(M) Met					
75	2. For each 120 beds, a nursing home must employ one or more qualified social workers who work for a total period that equals at least the work time of one full-time employee (FTE). A State home that has more or less than 120 beds must provide qualified social worker services on a proportionate basis (for example, a nursing home with 60 beds must employ one or more qualified social workers who work for a total period equaling at least one-half FTE and a nursing home with 180 beds must employ qualified social workers who work for a total period equaling at least one and one-half FTE).	(M) Met					

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76	3. Qualifications of social worker. A qualified social worker is an individual with: i. A bachelor's degree in social work from a school accredited by the Council of Social Work Education; and Note: A master's degree social worker with experience in long-term care is preferred. ii. A social work license from the State in which the State home is located, if offered by the State; and iii. A minimum of one year of supervised social work experience, in a health care setting working directly with individuals.	(M) Met					
77	4. The facility management must have sufficient support staff to meet patient's social services needs.	(M) Met					
78	5. Facilities for social services must ensure privacy for interviews.	(M) Met					
79	i. Environment. The facility management must provide: 1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;	(M) Met					
80	2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	(M) Met					
81	3. Clean bed and bath linens that are in good condition;	(M) Met					
82	4. Private closet space in each resident room, as specified in § 51.200 (d)(2)(iv) of this part;	(M) Met					
83	5. Adequate and comfortable lighting levels in all areas;	(M) Met					
84	6. Comfortable and safe temperature levels. Facilities must maintain a temperature range of 71-81 degrees F.; and	(M) Met					
85	7. For the maintenance of comfortable sound levels.	(M) Met					

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86	§ 51.110 Resident assessment. The facility management must conduct initially, annually and as required by a change in the resident's condition a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. a. Admission orders. At the time each resident is admitted, the facility management must have physician orders for the resident's immediate care and a medial assessment, including a medical history and physical examination, within a time frame appropriate to the resident's condition, not to exceed 72 hours after admission, except when an examination was performed within five days before admission and the findings were recorded in the medical record on admission.	(N) Not Met	Based on observation, interview and record review during the for cause and full survey it was determined the facility failed to ensure the CAP (Corrective Action Plan) that had been developed to address the deficient practice identified on the survey of 04/19/13 had been implemented. Staff working in the secured units had not been trained by Activities staff regarding activities to provide to residents when no activities staff are in the building.	Staff working on all units throughout the Home were inserviced 9/13-10/13 regarding types of activities available on each unit for members when activity staff are not available or when members need diversional activities. The Manager of the Activities Dept. began meeting with all new hires starting 10/1/13 to inform them of the availability of activity items on all units and their location. Lists of activities are posted on all units. Care plans are developed to address activities that members can participate in.	Oct. 30, 2013		
87	b. Comprehensive assessments. (1) The facility management must make a comprehensive assessment of a resident's needs: i. Using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 2.0 --- d. Submission of assessments. Each assessment (initial, annual, change in condition, and quarterly) using the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Minimum Data Set, Version 2.0 must be submitted electronically to VA at the IP address provided by VA to the State within 30 days after completion of the assessment document.	(M) Met					
88	2. Frequency. Assessments must be conducted: i. No later than 14 days after the date of admission; ii. Promptly after a significant change in the resident's physical, mental, or social condition; and iii. In no case less often than once every 12 months.	(M) Met					

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89	3. Review of Assessments. The nursing facility management must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.	(M) Met					
90	4. Use. The results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care, under paragraph (d) of this section.	(M) Met					
91	c. Accuracy of Assessments 1. Coordination. i. Each assessment must be conducted or coordinated with the appropriate participation of health professionals. ii. Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment. 2. Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	(M) Met					

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92	e. Comprehensive care plans. (1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following— (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §51.120; and (ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part.	(N) Not Met	Based on interview and record review it was determined the facility failed to develop an appropriate care plan interventions for four (4) of thirty-three (33) sampled residents (Resident #2, #15, #16, and#31) -. Resident #31 incurred two (2) fractures to the lower right leg. The facility's concerns identified in their investigation included the resident's care plan and nursing assistant "cheat sheet" did not give specific instructions for bathing, the resident was transferred in a shower chair which is not a mobility device, the employee did not know how to safely operate the shower chair and further the resident was left alone in the shower room although the resident required total assistance with bathing. Record review for Resident #2 revealed nursing and social services notes dated 3/12/13 indicated Resident #2 verbalized intentions to leave the facility. Social services notes dated 6/10/13 document Resident #2's intention to leave the facility for Montana. The resident left the facility unsupervised twice on 5/3/13. Continued review revealed the resident left facility again 6/17/13 and 7/4/13. Review of the comprehensive care plan revealed no care plan had been developed for behaviors until 9/26/13, the fourth day of the survey. Resident #15 was admitted to the facility on 7/16/09 with diagnoses including vascular dementia, depression, ETOH use and left hemi-plegia post cerebrovascular accident. Record review revealed Resident #15 left the facility unsupervised on 9/1/13, 9/4/13, and 9/17/13. The care plan was not updated with specific elopements until 9/26/13, the fourth day of the survey. Resident #16 was admitted to the facility on 5/2/04 with diagnoses including dementia with alcoholism, combative behaviors, and COPD. Review of the nursing progress notes dated 6/19/13 revealed the Resident asked a staff from another unit to hold the door for him and another resident; both residents were allowed to leave the unit. Both residents were returned to the	GRHV has contracted with Behavioral Care Solutions to evaluate members and make recommendations for interventions that will address behavioral issues such as members wanting to leave the facility. The Social Workers will work with the Interdisciplinary Team to develop a comprehensive plan of care that is appropriate for each member and will work with the nursing staff to implement the interventions. All GRHV Employees, including all contracted employees, will be in-serviced on Abuse, Neglect, and Exploitation. This subject is covered in our yearly mandatory in-service, and will now be required as a live in-service so staff will have at least two trainings related to abuse & neglect. All new employees in the Nursing Department receive training during orientation, and now all GRHV and contract employees will also receive this training. Two modules on abuse and neglect are also included in the mandatory training through Silver Chair, which is mandatory for all Nursing Employees, and will also be extended to all GRHV employees. The Medical Director and the Social Worker on Main Court Yard, which is a secured unit for members that are not appropriately placed on the Dementia units, are developing criteria for admission and continued stay on that particular unit. Criteria for off unit privileges will be formalized for the Interdisciplinary Team. Members who are not allowed off the unit unattended will be identified so staff will not accidently allow someone off the unit that may not return. Elopement care plans have been developed for those members identified to be an elopement risk.	10/01/2013 and ongoing 2/01/2014 and ongoing 12/20/2013		

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			unit by another staff member. A review of the care plan dated 8/9/13 revealed an elopement care plan was not developed. The facility's failure to ensure Resident #31 care plan had been developed to address his/her bathing need and failure to ensure the resident was not placed in an unsafe and unsupervised condition resulted in this standard being cited at the actual harm level.				
93	2. A comprehensive care plan must be: i. Developed within 7 calendar days after completion of the comprehensive assessment; ii. Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and iii. Periodically reviewed and revised by a team of qualified persons after each assessment.	(N) Not Met	Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure resident care plans were updated to reflect resident care needs for two (2) of thirty-two (32) sampled resident's, Resident #19 and #12. Resident #19 had a history of smoking with oxygen. Staff failed to update the resident's care plan to address this dangerous behavior. The resident was observed smoking with oxygen on the back of his/her wheelchair on 09/2 Resident #12 had a history of falls and a care plan had been developed to address the falls which included bed and chair alarms. Staff documentation and interviews revealed the resident turned the bed and chair alarms off. Although staff had knowledge of the resident's behavior of turning off the alarms no new interventions were developed to address the resident's noncompliance with the alarms. On 09/11/13 the resident was found on the floor yelling and lying on his/her back on the floor in his/her room. No alarms had been sounding. The resident was transferred to an emergency room for an evaluation and was diagnosed with two (2) fractures to the right lower leg. The facility's failure to ensure resident care plans were updated to reflect current resident care need placed this resident's at risk for serious injury, harm, impairment or death. Therefore this standard is being cited at the actual harm level.	GRHV Policy 11-13-S1 was updated immediately during the VA Survey process and all staff have been in-serviced. Members who are not compliant with GRHV Smoking policy will be asked to sign a contract, indicating that they are aware of GRHV smoking policies and will abide by them or be discharged. GRHV will develop a Specialty Nurse position that will work with Nursing staff and PT/OT to find the most effective plan to reduce falls while helping the members maintain their highest level of functioning. This Nurse will also lead a team to review all falls and work directly with the staff and member to find the best solution to reduce falls and keep members safe. Care plans will be reviewed and updated to reflect interventions approved by the Interdisciplinary Team. GRHV will request BCVA to re-educate all staff responsible for completing the MDS assessments on developing care plans based on the MDS assessments.	9/23/ 2013 1/30/ 2014		

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
94	3. The services provided or arranged by the facility must: i. Meet professional standards of quality; and ii. Be provided by qualified persons in accordance with each resident's written plan of care.	(M) Met					
95	f. Discharge summary. Prior to discharging a resident, the facility management must prepare a discharge summary that includes— (1) A recapitulation of the resident's stay; (2) A summary of the resident's status at the time of the discharge to include items in paragraph (b)(2) of this section; and (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
96	§ 51.120 Quality of care. Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. a. Reporting of Sentinel Events: 1. Definition. A sentinel event is an adverse event that results in the loss of life or limb or permanent loss of function. 2. Examples of sentinel events are as follows: i. Any resident death, paralysis, coma or other major permanent loss of function associated with a medication error; or ii. Any suicide of a resident, including suicides following elopement (unauthorized departure) from the facility; or iii. Any elopement of a resident from the facility resulting in a death or a major permanent loss of function; or iv. Any procedure or clinical intervention, including restraints, that result in death or a major permanent loss of function; or v. Assault, homicide or other crime resulting in patient death or major permanent loss of function; or vi. A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall. 3. The facility management must report sentinel events to the director of the VA medical center of jurisdiction within 24 hours of identification.	(M) Met					

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97	4. The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. i. Goal. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility.	(M) Met					
98	b. Activities of daily living. Based on the comprehensive assessment of a resident, the facility management must ensure that: i. Bathe, dress, and groom; 1. A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to: ii. Transfer and ambulate; iii. Toilet; iv. Eat; and	(M) Met					
99	2. A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(1) of this section; and	(M) Met					
100	3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination.	(M) Met					
101	c. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident: 1. In making appointments; and 2. By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	(M) Met					

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102	d. Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that: 1. A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and 2. A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	(M) Met					
103	e. Urinary and Fecal Incontinence. Based on the resident's comprehensive assessment, the facility management must ensure that: 1. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and 2. A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	(M) Met					
104	3. A resident who has persistent fecal incontinence receives appropriate treatment and services to treat reversible causes and to restore as much normal bowel function as possible.	(M) Met					
105	f. Range of motion. Based on the comprehensive assessment of a resident, the facility management must ensure that: 1. A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and 2. A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.	(M) Met					
106	g. Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility management must ensure that a resident, who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and service	(M) Met					

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107	h. Enteral Feedings. Based on the comprehensive assessment of a resident, the facility management must ensure that: 2. A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers and other skin breakdowns, and to restore, if possible, normal eating skills. 1. A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings were unavoidable; and	(M) Met					

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108	i. Accidents. The facility management must ensure that: 1. The resident environment remains as free of accident hazards as is possible; and 2. Each resident receives adequate supervision and assistance devices to prevent accidents.	(N) Not Met	Based on observation, interview, record review and review of facility policy it was determined the facility failed to maintain an environment free of accident hazards for six(6)) of thirty-three (33) sampled residents, Residents #2, #12, #15, #16, #19, and #31). Resident #19 was observed on 09/24/13 smoking a cigarette with oxygen on the back of the wheelchair. Although staff had documented evidence on three (3) occasions the resident had been observed smoking with oxygen, no interventions were put in place to ensure the safety of the resident, other residents, visitors and staff of the facility. The facility's failure to ensure safety measures put resulted in this standard being cited at the Immediate Jeopardy level. The facility's failure to ensure the resident was provided with appropriate supervision and/or assistive devices could cause or is likely to cause serious injury, harm, impairment or death to the resident, other residents, visitors and staff of the facility. Immediate Jeopardy was identified and the facility administrative staff was informed of the Immediate Jeopardy on 09/24/13 at 7:07pm. The facility implemented the following interventions: Resident #19 was reassessed for the ability to smoke independently and was found to be non-compliant with smoking with oxygen. The oxygen was removed from his/her wheelchair. All residents that smoked with oxygen were reassessed for the ability to smoke independently in a safe manner. All other residents who smoke will also be reassessed for the ability to smoke independently or with supervision. The facility smoking policy was revised to include progressive corrective action for residents who do not comply with the facility's smoking policy. All residents who smoke and staff were educated on the revised smoking policy. A Quality Assurance monitor will be developed to check compliance with the revised policy and will be reported to the	GRHV Policy 11-13-S1 was updated immediately during the VA Survey process and all staff have been in-serviced. Members who are not compliant with GRHV Smoking policy will be asked to sign a contract, indicating that they are aware of GRHV smoking policies and will abide by them or be discharged. GRHV Nursing staff also immediately assessed all members who smoked to ensure that if they required assistance with smoking, that it would be care planned, put on the cheat sheets, and staff would be available to assist members when needed. A Quality Assurance Monitor has been developed to monitor members who smoke. Smoking assessments are completed quarterly and as needed for those members who do smoke. Members who smoke will be given a copy of the GRHV Smoking rules (see attached) quarterly during their assessment by the care team and reminded of the smoking rules.	9/23/2013 11/01/2013		

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			Quality Assurance committee quarterly. The Immediate Jeopardy was abated on 09/24/13 at 8:25pm. Resident #12 had a history of falls and care plan interventions to address the resident's falls included bed and chair alarms. Documentation in the resident's record and interviews with staff revealed the resident would turn the bed and chair alarms off. Although staff had knowledge the resident turned off the bed and chair alarms, no additional interventions were put in place to address the resident's risk for falls. On 09/11/13 the resident was found on the floor yelling and lying on his/her back on the floor in his/her room. No alarms had been sounding. The resident was transferred to an emergency room for an evaluation and was diagnosed with two (2) fractures to the right lower leg. Resident #31incurred two (2) fractures to the lower right leg. The facility's concerns identified in their investigation included the resident's care plan and nursing assistant "cheat sheet" did not give specific instructions for bathing, the resident was transferred in a shower chair which is not a mobility device, the employee did not know how to safely operate the shower chair and further the resident was left alone in the shower room although the resident required total assistance with bathing. Record review for Resident #2 revealed nursing and social services notes dated 3/12/13 indicated Resident #2 verbalized intentions to leave the facility. Social services notes dated 6/10/13 document Resident #2's intention to leave the facility for Montana. The resident facility unsupervised twice on 5/3/13. Continued review revealed the resident left facility again 6/17/13 and 7/4/13. Review of the comprehensive care plan revealed no care plan had been developed for behaviors until 9/26/13, the fourth day of the survey. Resident #15 was admitted to the facility on 7/16/09 with diagnoses including vascular dementia, depression, ETOH use and left hemi-plegia post cerebrovascular accident. Record	GRHV will develop a Specialty Nurse position that will work with Nursing staff and PT/OT to find the most effective plan to reduce falls while helping the members maintain their highest level of functioning. This Nurse will also lead a team to review all falls and work directly with the staff and member to find the best solution to reduce falls and keep members safe. Care plans will be reviewed and updated to reflect interventions approved by the Interdisciplinary Team. GRHV will request BCVA to re-educate all staff responsible for completing the MDS assessments on developing care plans based on the MDS assessments. The member's care plan has been updated and the cheat sheets updated to indicate that the member requires total care with showering, and he is not be left alone in the shower room, even when he insists. Case Managers assessed each member and reviewed the care plans to ensure that the information is updated and accurate. GRHV has contracted with Behavioral Care Solutions to evaluate members and make recommendations for interventions that will address behavioral issues such as members wanting to leave the facility and/or an elopement risk. The Social Workers will work with the Interdisciplinary Team to develop a comprehensive plan of care that is appropriate for each member and will work with the nursing staff to implement the interventions. Elopement care plans have been developed for those members identified to be an elopement risk.	1/30/2014 9/23/2013 10/01/2013 and ongoing		

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			review revealed Resident #15 left the facility unsupervised on 9/1/13, 9/4/13, and 9/17/13. The care plan was not updated with specific elopements until 9/26/13, the fourth day of the survey. Resident #16 was admitted to the facility on 5/2/04 with diagnoses including dementia with alcoholism, combative behaviors, and COPD. Review of the nursing progress notes dated 6/19/13 revealed the Resident asked a staff from another unit to hold the door for him and another resident; both residents were allowed to leave the unit. Both residents were returned to the unit by another staff member. A review of the care plan dated 8/9/13 revealed an elopement care plan was not developed. The facility's failure to ensure resident's were provided with appropriate supervision , staff had received appropriate training and instructions on the care needs of residents resulted in this standard being cited at the actual harm level.	The Medical Director and the Social Worker on Main Court Yard, which is a secured unit for members that are not appropriately placed on the Dementia units, are developing criteria for admission and continued stay on that particular unit. Criteria for off unit privileges will be formalized for the Interdisciplinary Team. Members who are not allowed off the unit unattended will be identified so staff will not accidently allow someone off the unit that may not return. Elopement care plans have been developed for those members identified to be an elopement risk.	12/20/2013		
109	j. Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident: 1. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and 2. Receives a therapeutic diet when a nutritional deficiency is identified.	(M) Met					
110	k. Hydration. The facility management must provide each resident with sufficient fluid intake to maintain proper hydration and health.	(M) Met					

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111	l. Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: 1. Injections; 2. Parenteral and enteral fluids; 3. Colostomy, ureterostomy, or ileostomy care 4. Tracheostomy care; 5. Tracheal suctioning; 6. Respiratory care; 7. Foot care; and 8. Prostheses.	(M) Met					
112	m. Unnecessary drugs: 1. General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: i. In excessive dose (including duplicate drug therapy); or ii. For excessive duration; or iii. Without adequate monitoring; or iv. Without adequate indications for its use; or v. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	(N) Not Met	Based on observation, interview and record review during the for cause and full survey it was determined the facility failed to implement the CAP (Corrective Action Plan) developed to address the deficient practice identified on the survey of 04/19/13. TeleHealth services were not being provided to those residents needing psychiatric care.	The connection for TeleHealth was finally established between the two facilities on 10/10/13. A psych consult was conducted between the Home and CBOC on 10/10/13 at 3pm for a resident on the Alzheimer's unit at the Home. Consult was placed in medical records. Follow-up was determined on a prn basis. With the establishment of a contract for psychiatric services on 10/1/13, TeleHealth will be utilized as a back-up for psych services and/or any future programs deemed appropriate.	10/10/ 2013		
113	2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility management must ensure that: ii. Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. i. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and	(M) Met					

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114	n. Medication Errors. The facility management must ensure that: 1. Medication errors are identified and reviewed on a timely basis; and 2. Strategies for preventing medication errors and adverse reactions are implemented.	(M) Met					
115	§ 51.130 Nursing Services. The facility management must provide an organized nursing service with a sufficient number of qualified nursing personnel to meet the total nursing care needs, as determined by resident assessment and individualized comprehensive plans of care, of all patients within the facility 24 hours a day, 7 days a week. a. The nursing service must be under the direction of a full-time registered nurse who is currently licensed by the State and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff.	(M) Met					
116	b. The facility management must provide registered nurses 24 hours per day, 7 days per week.	(M) Met					
117	c. The director of nursing services must designate a registered nurse as a supervising nurse for each tour of duty. 2. Based on the application and results of the case mix and staffing methodology, the evening or night supervising nurse may serve in a dual role as supervising nurse as well as provides direct patient care only when the facility has an average daily occupancy of 60 or fewer residents in nursing homes. 1. Based on the application and results of the case mix and staffing methodology, the director of nursing may serve in a dual role as director and as an onsite-supervising nurse only when the facility has an average daily occupancy of 60 or fewer residents in nursing homes.	(M) Met					
118	d. The facility management must provide nursing services to ensure that there is a minimum direct care nurse staffing per patient per 24 hours, 7 days per week of no less than 2.5 hours.	(M) Met					

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119	e. Nurse staffing must be based on a staffing methodology that applies case mix and is adequate for meeting the standards of this part.	(M) Met					
120	§ 51.140 Dietary Services. The facility management must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. a. Staffing. The facility management must employ a qualified dietitian either full-time, part-time, or on a consultant basis. 1. If a qualified dietitian is not employed full-time, the facility management must designate a person to serve as the director of food service who receives at least a monthly scheduled consultation from a qualified dietitian. 2. A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetic Registration of the American Dietetic Association.	(M) Met					
121	b. Sufficient staff. The facility management must employ sufficient support personnel competent to carry out the functions of the dietary service.	(M) Met					
122	c. Menus and nutritional adequacy. Menus must: 1. Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; 2. Be prepared in advance; and 3. Be followed.	(M) Met					

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123	d. Food. Each resident receives and the facility provides: 1. Food prepared by methods that conserve nutritive value, flavor, and appearance; 2. Food that is palatable, attractive, and at the proper temperature; 3. Food prepared in a form designed to meet individual needs; and 4. Substitutes offered of similar nutritive value to residents who refuse food served.	(M) Met					
124	e. Therapeutic diets. Therapeutic diets must be prescribed by the primary care physician.	(M) Met					
125	f. Frequency of meals. 1. Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. 2. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in paragraph (f)(4) of this section. 3. The facility staff must offer snacks at bedtime daily. 4. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day, if a resident group agrees to this meal span, and a nourishing snack is served.	(M) Met					
126	g. Assistive devices. The facility management must provide special eating equipment and utensils for residents who need them.	(M) Met					
127	h. Sanitary conditions. The facility must: 1. Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; 2. Store, prepare, distribute, and serve food under sanitary conditions; and 3. Dispose of garbage and refuse properly	(M) Met					

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128	§ 51.150 Physician services. A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. a. Physician supervision. The facility management must ensure that: 1. The medical care of each resident is supervised by a primary care physician; 2. Each resident's medical record must list the name of the resident's primary physician; and 3. Another physician supervises the medical care of residents when their primary physician is unavailable.	(M) Met					
129	b. Physician visits. The physician must: 1. Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; 2. Write, sign, and date progress notes at each visit; and 3. Sign and date all orders.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
130	c. Frequency of physician visits. 1. The resident must be seen by the primary physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter, or more frequently based on the condition of the resident. 2. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. 3. Except as provided in paragraphs (c) (4) of this section, all required physician visits must be made by the physician personally. 4. At the option of the physician, required visits in the facility after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.	(M) Met					
131	d. Availability of physicians for emergency care. The facility management must provide or arrange for the provision of physician services 24 hours a day, 7 days per week, in case of an emergency.	(M) Met					
132	e. Physician delegation of tasks. 1. Except as specified in paragraph (e)(2) of this section, a primary physician may delegate tasks to: i. A certified physician assistant or a certified nurse practitioner; or ii. A clinical nurse specialist who: A. Is acting within the scope of practice as defined by State law; and B. Is under the supervision of the physician. Note: A certified clinical nurse specialist with experience in long term care is preferred.	(M) Met					
133	2. The primary physician may not delegate a task when the regulations specify that the primary physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.	(M) Met					

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134	§ 51.160 Specialized rehabilitative services. a. Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the resident's comprehensive plan of care, facility management must: 1. Provide the required services; or 2. Obtain the required services from an outside resource, in accordance with § 51.210(h) of this part, from a provider of specialized rehabilitative services.	(M) Met					
135	b. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	(M) Met					
136	§ 51.170 Dental Services. A facility: a. Must provide or obtain from an outside resource, in accordance with § 51.210 (h) of this part, routine and emergency dental services to meet the needs of each resident; b. May charge a resident an additional amount for routine and emergency dental services; c. Must, if necessary, assist the resident: 1. In making appointments; and 2. By arranging for transportation to and from the dental services; and 3. Promptly refer residents with lost or damaged dentures to a dentist.	(M) Met					
137	§ 51.180 Pharmacy services. The facility management must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in § 51.210 (h) of this part. The facility management must have a system for disseminating drug information to medical and nursing staff.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
138	a. Procedures. The facility management must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. b. Service consultation. The facility management must employ or obtain the services of a pharmacist licensed in a State in which the facility is located who: 1. Provides consultation on all aspects of the provision of pharmacy services in the facility; 2. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and 3. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	(M) Met					
139	b. Service consultation. The facility management must employ or obtain the services of a pharmacist licensed in a State in which the facility is located who: 1. Provides consultation on all aspects of the provision of pharmacy services in the facility; 2. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and 3. Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	(M) Met					
140	c. Drug regimen review. 1. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. 2. The pharmacist must report any irregularities to the primary physician and the director of nursing, and these reports must be acted upon.	(M) Met					

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141	d. Labeling of drugs and biologicals. Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the e	(M) Met					
142	e. Storage of drugs and biologicals. 1. In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	(M) Met					
143	2. The facility management must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse.	(M) Met					
144	§ 51.190 Infection Control. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. a. Infection control program. The facility management must establish an infection control program under which it: 1. Investigates, controls, and prevents infections in the facility; 2. Decides what procedures, such as isolation, should be applied to an individual resident; and 3. Maintains a record of incidents and corrective actions related to infections.	(M) Met					

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145	b. Preventing spread of infection: 1. When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. 2. The facility management must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. 3. The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	(M) Met					
146	c. Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
147	§ 51.200 Physical environment. The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. a. Life safety from fire. The facility must meet the applicable provisions of the 2006 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference).	(N) Not Met	Based on observation and interview, the facility failed to install sprinklers in the elevator hoist way located in the Mann Building. This deficient practice has the potential to affect 4 of 18 smoke compartments, staff and residents in those particular compartments. The facility has the capacity of 618 beds in the nursing home with a census of 417, and a bed capacity of 140 in the DOM with a census of 58 the day of the survey. Findings include: Observation of the facility's elevators on 9/25/2013 at 1:00 p.m. revealed the elevator located in the Mann Building did not have a sprinkler installed in the hoist way. Interview with the Maintenance Manager and Safety Manager on 9/25/2013 at 2:00 p.m. revealed the facility was unaware the elevator hoist way in the Mann Building did not have a sprinkler installed. The census of 417 in the nursing and 58 in the DOM was verified by the Administrator on 9/25/2013. The finding was acknowledge by the Administrator and verified by the Maintenance Manager and Safety Manager at the exit interview conference on 9/25/2013 at 5:30 p.m. Actual Standard: NFPA 13, Standard for the Installation of Sprinkler Systems (2000ed.) Ch. 8.14.5 Sidewall spray sprinklers shall be installed at the bottom of each elevator not more than two feet above the floor of the pit. Upright or pendent spray sprinklers shall be installed at the top of elevator hoist ways. The automatic sprinkler and standpipe system shall be inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and	A purchase order (attached) was written on 10/23/13 to have a sprinkler head installed in the pits of both visitor elevators. A purchase order (attached) was written on 1/29/13 to inspect and test the sprinkler pipes in all three patient care buildings. This inspection/testing was added to the preventive maintenance (PM) program so that the dept. will be notified in the future when this inspection/testing is due.	11/ 29/2013 11/04/ 2013		

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
			Maintenance of Water-Based Fire Protection Systems. A service program shall be provided by a qualified contractor in which all components are inspected and tested at the required times and necessary maintenance is provided. This standard is not met as evidenced by: Based on documentation review and interview, the facility failed to provide documentation for the internal sprinkler pipe inspections as required by NFPA 25. This deficient practice has the potential to affect all compartments, staff and all residents. The facility has the capacity of 618 beds in the nursing home with a census of 417, and a bed capacity of 140 in the DOM with a census of 58 the day of the survey. Findings include: Documentation review of the facility's reports for the 12 month period prior to 9/25/2013 at 2:00 p.m. revealed the facility was unable to provide documentation for the required internal sprinkler pipe inspection. Interview with the facility Maintenance Manager and the Safety Manager on 9/25/2013 at 3:00 p.m. revealed the facility was unaware the internal sprinkler pipe inspection had not been completed. The census of 417 in the nursing and 58 in the DOM was verified by the Administrator on 9/25/2013. The finding was acknowledge by the Administrator and verified by the Maintenance Manager and Safety Manager at the exit interview conference on 9/25/2013 at 5:30 p.m. Actual Standard: NFPA 25, (2002ed.) Ch. 13.2.1 Standards for Inspection and Testing. An investigation of piping and branch line conditions shall be conducted every five years.				

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
148	b. Emergency power. (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of the National Fire Protection Association's NFPA 101, Life Safety Code (2006 edition) and the NFPA 99, Standard for Health Care Facilities (2005 edition). (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Standard for Health Care Facilities (2005 edition). (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with the National Fire Protection Association's NFPA 101, Life Safety Code (2006 edition) and the NFPA 99, Standard for Health Care Facilities (2005 edition).	(N) Not Met	Observation of the emergency generator system on 9/24/2013 at 1:30 p.m. located in the generator /maintenance shop revealed the facility failed to install an emergency generator annunciator panel or remote alarm in an area where it is likely to be heard and monitored by personnel in case of an alarm. Interview with the Maintenance Supervisor and Safety Manager on 9/24/2013 at 2:00 p.m. revealed the facility was equipped with a remote audible alarm for the generator (EPSS system) located at the fire control panel but it did not operate during testing. Actual Standard: NFPA110, Standard for Emergency and Standby Power Systems (2002ed.) Ch5.6. A remote common audible alarm shall be provided that is powered by the storage battery and located outside of the EPS service room at a work site observable by personnel. Actual Standard: NFPA 101, Life Safety Code Ch.9.1 (2009ed.) New Generators controllers shall be monitored by the fire alarm system, where provided, or at an attended location, for the following; 1) generator running, 2)generator fault,3)generator switch in nonautomatic position.	A purchase request (attached) was written on 10/16/13 to have an annunciator panel installed in the Safety Office to be heard and monitored in case of an alarm. The bid request went out on the State of Michigan web site on 10/29/13. Purchase order for project is expected to be submitted by 11/8/13. Notifications are currently being provided thru the fire alarm print out located in the security office which notifies the safety officers of any issues at that time. The remote annunciator panel will be additional light/sound notification in the event issues arise with the emergency generator.	12/20/2013		
149	c. Space and equipment. Facility management must: 1. Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and 2. Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
150	d. Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents: 1. Bedrooms must: i. Accommodates no more than four residents; ii. Measure at least 115 net square feet per resident in multiple resident bedrooms; iii. Measure at least 150 net square feet in single resident bedrooms; iv. Measure at least 245 net square feet in small double resident bedrooms; and v. Measure at least 305 net square feet in large double resident bedrooms used for spinal cord injury residents. It is recommended that the facility have one large double resident bedroom for every 30 resident bedrooms. vi. Have direct access to an exit corridor; vii. Be designed or equipped to assure full visual privacy for each resident; viii. Except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains; ix. Have at least one window to the outside; and x. Have a floor at or above grade level.	(M) Met					
151	2. The facility management must provide each resident with: i. A separate bed of proper size and height for the safety of the resident; ii. A clean, comfortable mattress; iii. Bedding appropriate to the weather and climate; and iv. Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.	(M) Met					

NO.	STANDARD DESCRIPTION	RATING	EXPLANATORY STATEMENTS	STATE CORRECTIVE ACTION PLAN	STATE PROPOSED COMPLETION DATE	VA FOLLOW UP	FINAL RATING DATE
152	e. Toilet facilities. Each resident room must be equipped with or located near toilet and bathing facilities. It is recommended that public toilet facilities be also located near the resident's dining and recreational areas.	(M) Met					
153	f. Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from: 1. Resident rooms; and 2. Toilet and bathing facilities	(M) Met					
154	g. Dining and resident activities. The facility management must provide one or more rooms designated for resident dining and activities. These rooms must: 1. Be well lighted; 2. Be well ventilated; 3. Be adequately furnished; and 4. Have sufficient space to accommodate all	(M) Met					
155	h. Other environmental conditions. The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must: 1. Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;	(M) Met					
156	2. Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;	(M) Met					
157	3. Equip corridors with firmly secured handrails on each side; and	(M) Met					
158	4. Maintain an effective pest control program so that the facility is free of pests and rodents.	(M) Met					

SURVEY CLASS	SURVEY YEAR	COMPLETION_DATE
Cause Survey	2013	9/27/2013

NAME OF FACILITY	STREET ADDRESS	CITY	STATE	ZIP CODE
Grand RapidsD	3000 Monroe Ave. N.E.	Grand Rapids	MI	49505

Carrie Storms2 _____

Eric George _____

Greg Harris FU_GR _____

Greg Harris TL_GRD _____

Jackie Muir515 _____

Kathy Cummins515 _____

Marilyn Klotz515 _____

Susan Honaker _____

Vincent Williams515 _____