NORTHAMPTON MANOR CARE HEALTH CENTER

CERTIFICATE OF NEED APPLICATION

May 5, 2016

For internal staff use:

MARYLAND HEALTH CARE COMMISSION

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

COMPREHENSIVE CARE FACILITY (NURSING HOME) APPLICATION FOR CERTIFICATE OF NEED

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

Required Format:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively. **The Table of Contents must include:**

- **Responses to PARTS I, II, III, and IV of the COMPREHENSIVE CARE FACILITY (NURSING HOME) application form**

- **Responses to PART IV must include responses to the standards in the State Health Plan chapter, COMAR 10.24.08*, applicable to the type of nursing home project proposed*.**
    - All Applicants must respond to the general standards, COMAR 10.24.08.05A.
    - Applicants proposing *new construction or expansion* of comprehensive care facility beds, including replacement of an existing facility or existing beds, if new outside walls are proposed must also respond to all the standards in COMAR 10.24.08.05B.
    - Applicants only proposing *renovations within existing facility* walls using beds currently shown in the Commission's inventory as authorized to the facility must respond to all the standards in COMAR 10.24.08.05C in addition to the standards in .05A. Applicants for such renovations should not respond to the standards in .05B.
    - All Applicants must respond to the Review Criteria listed at 10.24.01.08G(3)(b) through 10.24.01.08G(3)(f) as detailed in the application form.

- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

SUBMISSION FORMATS:

We require submission of application materials and the applicant's responses to completeness questions in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.

- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

A pre-application conference will be scheduled by Commission Staff to cover this and other topics. Applicants are encouraged to contact Staff with any questions regarding an application.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

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PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Northampton Manor Care Health Center

Address:

Street	City	Zip	County
200 East 16th Street	Frederick	21701	Frederick

2. Name of Owner: Northampton Manor Nursing and Rehabilitation Center, LLC

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

All of the entities listed are owned by MAHC Holdings, LLC, a Maryland limited liability company, which is in turn owned by Scott Rifkin, Scott Potter, Howard Friner, and Alaris USA, Inc.

Northampton Manor Nursing and Rehabilitation Center, LLC is the operating entity that: (1) holds the license for the facility; (2) employs the employees of the facility; (3) provides care to the residents of the facility; (4) enters into contracts with residents, suppliers / vendors of the facilities; and (5) seeks payment / reimbursement for care.

Northampton Manor Realty, LLC, is the real estate holding company that owns the land and improvements thereon. It is only a holding company and will not conduct any operations or own any assets other than the land and improvements. Its only activity is to lease the facility to Northampton Manor Nursing and Rehabilitation Center, LLC through a written lease agreement.

Mid-Atlantic Health Care, LLC is a management company used by the owners, (Scott Rifkin, Scott Potter, and Howard Friner), to manage the financial, accounting, tax, human resources, and legal functions of the various facilities that are owned by the owners. This entity provides those services to all of the facilities owned by the owners, including Northampton Manor Nursing and Rehabilitation Center, LLC, through a Management Agreement between this entity and each operating entity.

For additional Ownership Information, please see **Exhibit A**, attached hereto.

3. APPLICANT. ***If the application has a co-applicant, provide the following information in an attachment.***

Legal Name of Project Applicant (Licensee or Proposed Licensee): Northampton Manor Nursing and Rehabilitation Center, LLC

Address:

200 East 16th Street	Frederick	21701	MD	Fred.
Street	City	Zip	State	County
Telephone:	(301) 662-8700			

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:

Same as Applicant.

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental		
B.	Corporation		
	(1) Non-profit		
	(2) For-profit		
	(3) Close		State & date of incorporation
C.	Partnership		
	General		
	Limited		
	Limited liability partnership		
	Limited liability limited partnership		
	Other (Specify):		
D.	Limited Liability Company	X	Maryland (02/18/2015)
E.	Other (Specify):		

To be formed:

Existing:

See **Exhibit A** for an Organizational Chart showing the owners of the Applicant.

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: George Watson
VP Corporate Development

Company Name Mid-Atlantic Health Care, LLC

Mailing Address:

1922 Greenspring Drive, Suite 6	Timonium	21093	MD
Street	City	Zip	State

Telephone: 410-308-2300

E-mail Address (required): gwatson@mid-atlanticltc.com

Fax: 410-308-4999

If company name See explanation under Part I, Question # 2.

is different than applicant briefly describe the relationship

B-1. Additional or alternate contacts:

Name and Title: Peter Parvis, Esq.

Company Name Miles & Stockbridge P.C.

Mailing Address:

One West Pennsylvania Ave., Suite 900	Towson	21204	MD
Street	City	Zip	State

Telephone: 410-823-8165
E-mail Address (required): pparvis@milesstockbridge.com
Fax: 410-823-8123

If company name is different than applicant briefly describe the relationship

Mr. Parvis is legal counsel to the Applicant.

B-2. Additional or alternate contacts:

Name and Title: Andrew Solberg

Company Name A.L.S. Healthcare Consultant Services

Mailing Address:

5612 Thicket Lane	Columbia	21044	MD
Street	City	Zip	State

Telephone: 410-730-2664
E-mail Address (required): asolberg@earthlink.net
Fax: 410-730-6775

If company name is different than applicant briefly describe the relationship

Mr. Solberg is a consultant to the Applicant.

7. NAME OF THE OWNER OR PROPOSED OWNER OF THE REAL PROPERTY and Improve (if different from the licensee or proposed licensee)

Legal Name of the Owner of the Real Property
Northampton Manor Realty, LLC

Address:

1922 Greenspring Drive, Suite 6	Timonium	21093	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

If Owner is a Corporation, Partnership, or Limited Liability Company attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share the in the real property and any related parent entities. Attach a chart that completely delineates th ownership structure.

For Ownership Information, please *see* **Exhibit A**, attached hereto.

8. NAME OF THE Owner of the Bed Rights (i.e., the person/entity that could sell the beds included in this application to a 3rd party):

For Ownership Information, please see **Exhibit A**, attached hereto.

Legal Name of the Owner of the Rights to Sell the CCF Beds

See above, Part I, question #2.

If the Legal Entity that has or will have the right to sell the CCF beds is other than the Licensee or the Owner of the Real Property Identified Above Provide the Following Information.

Address:

1922 Greenspring Drive, Suite 6	Timonium	21093	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

Name of Management Company Mid-Atlantic Health Care, LLC

Address:

1922 Greenspring Drive, Suite 6	Timonium	21093	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

For Ownership Information, please see **Exhibit A**, attached hereto.

9. If a management company or companies is or will be involved in the clinical or financial management of the facility or will provide oversight of any construction or renovations proposed as part of this APPLICATION, identify each company or individual that will provide the services and describe the services that will be provided. Identify any ownership relationship between the management company and the owner of the facility and/or the real property or any related entity.

Name of Management Company: Mid-Atlantic Health Care, LLC

Address:

1922 Greenspring Drive, Suite 6	Timonium	21093	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

For Ownership Information, please see Exhibit A, attached hereto.

10. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

(1)	A new health care facility built, developed, or established	
(2)	An existing health care facility moved to another site	
(3)	A change in the bed capacity of a health care facility	X
(4)	A change in the type or scope of any health care service offered by a health care facility	
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	X

11. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is, why you need to do it, and what it will cost. A one-page response will suffice. Please include:

(1) Brief Description of the project – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

(1) and (2) – Description and Rationale of Project:

Mid-Atlantic Health Care, LLC ("MAHC" or "Mid-Atlantic") is seeking to bring its Restore Health concept to its newly acquired, five-star CMS rated Northampton Manor Nursing and Rehabilitation, LLC ("Northampton") located in the City of Frederick. The MHCC has already identified a need for 66 additional comprehensive care beds in Frederick County. MAHC plans to build on the success it has seen since opening its inaugural 67-bed Restore Health facility in Waldorf, MD and also the proposed Restore Health Baltimore City facility under consideration by the MHCC. This new wing will be branded Restore Health at Northampton ("RNH") and will add 66 additional private rooms and a new 1,900 square foot state of the art rehabilitation gym all in a hotel-like setting creating a new option for County residents that further supports the restorative care provided. MAHC's facilities (owned at least one year) average a 4.4 star rating under CMS's care quality measures with 70% of its facilities rating five stars (including Northampton). MAHC will use this care model to expand its relationships with its hospital partners in Western Maryland that will

provide enhanced clinical programming based on the needs of its hospital partners. MAHC believes these types of relationships are growing in importance given the changing needs of hospitals under the Maryland Medicare Waiver.

Upon completion of RNH, the project will also include a renovation of two floors of Northampton to improve the look and feel of these nursing units and create an enhanced resident experience for long term care residents. The renovation is largely cosmetic, and does not involve any construction activity in the existing nursing units. The other half of Northampton was renovated in 2009-2010.

RNH is designed explicitly to serve some patients who are currently served in the hospital, thereby shifting volume from the hospital setting to the nursing home setting. It will be equipped to serve a broader patient population and will provide higher skilled staff/service capabilities to reduce reliance on the higher cost hospital setting. Its purposes and its distinct features are defined by the following:

- RNH will provide a higher level of care in the nursing home and accommodate patients who require the higher skill set, facility accommodations, specialized equipment, and/or support services to provide additional care options to residents of Frederick County. These services will permit hospitals to discharge patients earlier from the hospital, provide rehabilitative/restorative care in a lower cost setting, and reduce readmissions to the hospital.

- RNH will be designed to work in close partnership with hospitals and physicians in episode management and bundled payment models. MAHC is exploring integrated treatment protocols that support lower cost episode management, and allow it to participate in bundled pricing and shared savings models with hospitals and physicians. The HSCRC has explicitly identified bundled payments as one of the strategies supporting the goals of the waiver. MAHC is prepared to coordinate with Maryland hospitals and with the HSCRC to develop bundling arrangements that support the Maryland Demonstration Model.

- Together, RNH and Northampton will provide a lower cost

alternative setting to the hospital by providing a safe, high quality, well-resourced inpatient setting for low acuity patients who are currently admitted to the hospital for cardiac monitoring, fluid management, IV antibiotics, complex wound care, or palliative care. RNH will serve as a lower cost setting to which these patients may be admitted directly. Patients may be admitted directly from the emergency room or from the hospital observation unit or admitted directly from home and thereby avoid hospitalization altogether.[2] RNH will function to reduce unnecessary hospital admissions (PAUs) by providing an alternative setting, and will reduce readmission rates for patients discharged from the hospital. Given the already identified need, RNH will have minimal impact on existing nursing homes because its census will be built on the increasing demand in Frederick County.

This new model for a nursing home responds directly to the initiatives established by The Affordable Care Act:

- The Affordable Care Act created the Center for Medicare and Medicaid Innovations (CMMI) which then introduced several initiatives aimed at reducing Medicare and Medicaid expenditures while enhancing the quality of care. One of the payment initiatives developed and implemented by CMMI was the "Bundled Payments for Care Improvement Initiative," designed to align incentives for providers (hospitals, post-acute care providers, physicians and other practitioners), and encourage these provider networks to work more closely across specialties and across settings. *See* https://www.cms.gov.

  Under the Bundled Payments Model, profitability is tied to reducing the costs of care, achieved largely by minimizing hospital length of stay and reducing hospital re-admissions. In part, this is achieved by shifting more care to the lower cost sub-acute or home setting, improving continuity of care across settings, and elevating the level of services and quality of care provided in the sub-acute setting. Across the country, bundled

[2] We recognize that Medicare reimbursement is not currently available for these services, but the facility will not open until CY2018 at the earliest, and commercial payors are increasingly paying for this type of service elsewhere now.

payment models are operating, and the HSCRC has explicitly identified bundled payment models as one of the approaches it aims to expand in Maryland. *See* HSCRC Payment Models Workgroup, 6/2/15 http://www.hscrc.state.md.us/hscrc-workgroup-payment-models.cfm ("Encourage . . . [and] enable population-based approaches . . . look to broaden authority for gainsharing, bundled payments, and shared savings for Medicare FFS").

- The Affordable Care Act of 2010 required the establishment of a readmission reduction program. The Hospital Readmissions Reduction Program, made effective in 2012, established a methodology to calculate the expected 30 day readmission ratio for three conditions and allowed CMS to reduce payments to hospitals with excess readmissions. The program was designed to provide incentives for hospitals to reduce the number of unnecessary hospitals readmissions. One of the strategies that hospitals have adopted is to strengthen medical services in nursing homes to better manage patients in the post-acute stage. Restore Health has a strong track record in achieving lower than average readmission rates from the nursing home to the hospital by providing a high caliber of medical services, care management protocols, and effective communications between nursing and medical staff.[3] Finally, readmission rates may be

[3] Evidence from Mid-Atlantic's nursing homes documents the following readmission rates:

Overall readmission rates CY2015
- Maryland nursing homes (9 facilities) = 14%
- Pennsylvania nursing homes (8 facilities) = 14%

Mid-Atlantic defines its readmission rate as all MHAC residence that have an unplanned readmission to a hospital within 30 days of discharge from a hospital divided by all admissions to MAHC nursing facilities that had a hospital stay within the last 30 days prior to admission.

The DelMarva Foundation of Maryland issued a report titled "ICPC Quarterly Scorecard, 2009-2012" that includes performance indicators related to readmissions across various settings. Included in this report is the 30-day readmission rate of all patients discharged to skilled nursing facilities. The 30-day readmission rate for skilled nursing facilities in Maryland in CY2012 is reported as 23.2%. (Source: *DelMarva Foundation*, *"ICP Quarterly Scorecard, 2009-2012"*, Appendix 2, page 141). For additional information, see **Exhibit B**, which contains selected portions of ICPC Quarterly Scorecard, January 1, 2009 to December 31, 2012, Maryland, published by Delmarva Foundation, QIO (June 1, 2013).

Also worth noting is the steady decline in readmission rates that Mid-Atlantic has achieved after taking ownership of facilities.

lowered by providing more extended inpatient care for recuperative care after an acute episode. This recuperative care, however, can be provided at lower cost in the nursing home setting. The new wing will allow Northampton to better respond directly to this objective.

Maryland adopted its own readmissions program to incentivize hospitals to reduce readmissions. The Maryland model is much more inclusive than the Medicare model discussed above since it applies to many more conditions and to all patients, not just Medicare.

In addition to the penalties and potential gains under the readmission program, all Maryland acute hospitals currently are under some form of population health program (either the Guaranteed Budgeted Revenue or the Total Patient Revenue program), which is designed to not pay hospitals for any increase in potentially avoidable utilization, including readmissions. In addition, the HSCRC penalizes hospitals if individual hospital and statewide readmission reduction targets are not met. Since the amount of hospital revenue is basically fixed (with limited adjustments for 50% of the age cohort adjusted population increase and market shift), hospitals continue to have incentives to reduce length of stay. However, given that hospitals' revenue is not increased for increased for potentially avoidable readmissions (some readmissions are planned and therefore permissible), the old problem of inappropriately quick discharges (the "quicker and sicker" syndrome) is avoided. Unless a hospital has a medically appropriate discharge option (which this application is intended to provide), the hospital may keep patients in the inpatient setting longer to ensure a lack of readmission. Hospitals need an alternative which this Project is designed to provide.

Overall readmission rates CY2012-2015
Maryland nursing homes, 2012 = 17%
Maryland nursing homes, 2015 = 14%

Pennsylvania nursing homes, 2012 = 22%
Pennsylvania nursing homes, 2015 = 14%

Although Maryland does not currently publish readmission rates from Maryland CCFs, **Exhibit C** contains a study prepared by The Maryland Hospital Association which cites a 21.3% readmission rate for Maryland nursing home patients and an average readmission rate of 17.7% for Frederick County. Mid-Atlantic's readmission rate of 14% or lower compares favorably and represents a very substantial potential for reduction in avoidable hospital utilization.

By locating RNH at a pre-existing MAHC facility, MAHC can leverage the strong management and support infrastructure already in place at Northampton and create a more cost effective strategy for the roll out of the Restore Health model.

(3) Cost of Project:

The Budget for the total cost of the Project is estimated at $ 10.2 million. *See* **Table C** for additional information.

B. Comprehensive Project Description: The description should include details regarding:

(1) Construction, renovation, and demolition plans
(2) Changes in square footage of departments and units
(3) Physical plant or location changes
(4) Changes to affected services following completion of the project
(5) Outline the project schedule.

Northampton proposes to construct a new state-of-the art 40,357 square foot addition to the existing 76,195 square foot facility. This new wing will be located on southwestern side of the facility. The original building design included this wing, but was never built as the original owners only secured the 196 CCF beds currently in use at the facility. The site is ready for the addition, and will include the expansion of the current kitchen to provide for the necessary space to prepare food for these new residents.

In the new wing, Northampton will construct 66 private rooms, each with its own private bathroom. This will expand the number of private rooms from two to 68 in the facility. Northampton will add a new 1,927 square foot rehabilitation gym dedicated for to the residents in this wing. The addition will also include a new, neighborhood-style, dining and multi-purpose room to be used by these residents and by residents in the adjoining, existing nursing unit which enhances the home-like feel of the facility for all residents. This wing will become the facility's designated wing for short term rehab residents. Northampton will, over time, move its existing short stay residents over to RNH creating an enhanced, "hotel-like" experience for these residents consistent with the quality and feel of Mid-Atlantic's Restore Health facility in Waldorf, MD and proposed Restore Health Baltimore facility under review by the MHCC. We have

included pictures of the Waldorf facility in **Exhibit D.** The new wing will include a separate entrance for families to visit their loved-ones.

Northampton also plans to renovate the adjoining two nursing units to the north of the new wing to enhance the resident experience. The renovation is largely cosmetic, and does not involve any construction activity in the existing nursing units. The previous owners had renovated the east wings in 2009-10 and this will allow Northampton to create an enhanced, home-like setting for all its long-term residents.

12. Complete Table A of the CON Table Package for Nursing Home (CCF) Applications

Table A is attached, see page 63.

13. Identify any community based services that are or will be offered at the facility and explain how each one will be affected by the project.

The Facility offers and will continue to offer respite services to the citizens in Frederick City and surrounding areas. No other community-based services are contemplated at this time.

14. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: _11___ acres

B. Have all necessary State and local land use and environmental approvals, including zoning and site plan, for the project as proposed been obtained? YES_____ NO ___X__ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

All required City Permits for the Project will be applied for and prosecuted by the Owner at the appropriate times consistent with the Project schedule.

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: Northampton Manor Realty, LLC

(2) Options to purchase held by: N/A
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: N/A
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: N/A
Please provide a copy of the option to lease as an attachment.

(5) Other: N/A
Explain and provide legal documents as an attachment.

15. PROJECT SCHEDULE

In completing this section, please note applicable performance requirements time frames set forth in Commission regulations, COMAR 10.24.01.12. Ensure that the information presented in the following table reflects information presented in Application Item 11 (Project Description).

Project Schedule Table – Phase I (New Construction)
Table J-1

	Proposed Project Timeline	
Obligation of 51% of capital expenditure from approval date	**4**	Months**
Initiation of Construction within 4 months of the effective date of a binding construction contract	**2**	Months**
Time to Completion of Construction from date of capital obligation	**18**	Months**

***** Assumes Grant of CON by November, 2016***

Project Schedule Table – Phase II (Renovation)
Table J-2

	Proposed Project Timeline	
Obligation of 51% of capital expenditure from approval date from completion of Phase I	**4**	Months**
Initiation of Construction within 4 months of the effective date of a binding construction contract	**2**	Months**
Time to Completion of Construction from date of capital obligation	**12**	Months**

***** Assumes Grant of CON by November, 2016***

16. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bath rooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. Specify dimensions and square footage of patient rooms.

See **Exhibit E**. A large scale of each drawing will be submitted with this Application.

17. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction and Renovation Square Footage worksheet in the CON Table Package (Table B)

Table B is attached, see page 64.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

The site is already served by public utilities for all essential utilities, including water, electricity, sewage and natural gas.

PART II - PROJECT BUDGET

Complete the Project Budget worksheet in the CON Table Package (Table C).

Table C is attached, see page 65.

Note: Applicant should include a list of all assumptions and specify what is included in each budget line, as well the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.)

Budget Assumptions are attached hereto as **Exhibit F**.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project and its implementation.

   For ownership information, please see **Exhibit A**, attached hereto.

2. Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

   Yes. MAHC owns and operates a total of 21 skilled nursing facilities comprising over 3,600 beds in Maryland and Pennsylvania. Please see **Exhibit G**.

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Question 2, above, been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   Villa Rosa Nursing and Rehabilitation, LLC –
   On 11/06/2014, based upon a Life and Safety Code Survey revisit, conducted by the Office of Health Care Quality, it was found that this facility was not in compliance with the requirements of participation and received an imposition of denial of payments for new admissions. Specifically, based upon observation and discussion with the maintenance supervisory, it was determined that the facility failed to ensure that the sprinkler system had been upgraded to full coverage of all areas of the facility. In addition, the State Fire Marshal observed that ground fault protection was to be installed in all bathrooms and shower rooms where electrical devices were in

close proximity to a water source. Proposals for the work had been acquired, but no contract was signed and no work had been started. No harm occurred. All corrections were made. Substantial compliance was regained. Please see **Exhibit H** for relevant materials associated with this survey.

Attached as **Exhibit I** is a letter dated December 15, 2014 demonstrating that Villa Rosa Nursing And Rehabilitation, LLC had regained substantial compliance with Medicare requirements as of December 10, 2014.

Mid-Atlantic of Delmar, LLC –

On May 10, 2013, an abbreviated survey was conducted by the Delaware Department of Health and Social Services and determined that the facility was not in substantial compliance with the participation agreement requirements. No harm occurred. All corrections were made. Substantial compliance was regained.

On May 2, 2013 through May 10, 2013 an unannounced visit and complete facility census was conducted by the Delaware Department of Health and Social Services. The nature of the deficiencies at Mid-Atlantic of Delmar involved the following: a) failing to consult with a physician and/or immediately notify a responsible party for six of 17 sampled residents who had a significant change in condition requiring physical intervention; b) failing to ensure three of 17 residents were free from neglect; c) failing to immediately report thoroughly investigate allegations of neglect for two of the 17 residents; f) for two of 17 sampled residents, the facility failed to provide medically-related social services to enable the residents to attain their highest practicable physical, mental, and psychosocial well-being; g) for one of the 17 sampled residents, the facility failed to ensure that the care plan was updated to reflect identified care needs; h) for six out of 17 sampled residents, the facility failed to ensure that the residents received 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; i) for two out of 17 sampled residents, the facility failed to ensure that two residents with pressure ulcers received the treatment and services necessary to promote healing and prevent new sores from developing; j) for one of the 17 sampled residents, the facility failed to follow established policy/procedure by replacing the gastrostomy tube via the PEG method; k) for one of 17 residents reviewed and three sub-sample residents, the facility failed to ensure that the resident environment was as free of accident hazards as possible; l) for one of the 17 sampled residents, the facility failed to provide proper treatment of care; m) for one of 17 sampled residents, the facility failed to provide or obtain mental health rehabilitative services for a resident admitted with a mental illness diagnosis; n) for seven of the 17 sampled residents,

the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain the highest practicable well-being of each resident; o) for seven sampled residents, the facility failed to ensure that the medical director was enabled to perform the role of ensuring implementation of policies and procedures as well as coordinating medical care in the facility; for two of the sampled residents, the facility failed to ensure accurately documented and systematically organized clinical records. See **Exhibit J**.

Also attached within **Exhibit J** is a letter dated September 19, 2013 demonstrating that the Delmar Nursing and Rehabilitation Center regained substantial compliance with Federal participation requirements as of September 18, 2013.

We note that this facility, (Mid-Atlantic of Delmar, Inc.), has been sold and is no longer part of Mid-Atlantic.

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4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

Northampton Manor Nursing and Rehabilitation Center –
On 03/30/2016, based upon a QIS Medicare/Medicaid recertification survey conducted by the Office of Health Care Quality, it was found that this facility was not in compliance with the requirements of participation. There were no level G deficiencies. A plan of correction was requested within 10 days after the facility received its form CMS 2567. A plan of correction was submitted and Northampton received oral notice of substantial compliance. Written notice will be forwarded upon receipt. Substantial compliance with the recommendations is requested by June 10, 2016. Please see **Exhibit K** for relevant materials associated with this survey.

Mid-Atlantic of Delmar, LLC - On June 7, 2014, Mid-Atlantic of Delmar, LLC (herein “Delmar”) made a submission pursuant to OIG’s Self Disclosure Protocol. The OIG accepted Delmar into the Protocol on July 23, 2014. This case involved an employee who was hired as a nurse for the provision of nursing services for which

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payment was made under a Federal health care program from October 18, 2013 through May 30, 2014. Unbeknownst to Delmar, at the time of hiring, the employee had been listed on the OIG List of Excluded Individuals and Entities at the time of hiring. Upon discovery of the employees excluded status, the employee was immediately terminated. Delmar followed the law and self-reported the incident to the OIG. Delmar agreed to pay to OIG $92,344.60 dollars. In consideration of the obligations of Delmar, the OIG released Delmar from any claims or causes of action it had against Delmar under 42 U.S.C. §§ 1320a-7a and 1320a-7(b) (7). It should be noted, that the OIG recognized that Mid-Atlantic Health Care, LLC and it facilities had the integrity to self-report recognized reportable events. As a result, Delmar received the lowest penalty multiplier under the Civil Monetary Penalty formula. Please see **Exhibit J** for relevant materials associated with this matter.

Again, note that this facility, (Mid-Atlantic of Delmar, Inc.), has been sold and is no longer part of Mid-Atlantic.

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5. Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the proposed or existing facility.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

5/4/16
Date

Signature of Owner or Board-designated Official

VP Corporate Development, Mid-Atlantic Health Care, LLC
Position/Title

George Watson
Printed Name

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). The State Health Plan.

Every Comprehensive Care Facility ("CCF" -- more commonly known as a nursing home) applicant must address each applicable standard from **COMAR 10.24.08: State Health Plan for Facilities and Services -- Nursing Home and Home Health Services.**[4] Those standards follow immediately under ***10.24.08.05 Nursing Home Standards*.**

Please provide a direct, concise response explaining the project's consistency with each standard. In cases where demonstrating compliance with a standard requires the provision of specific documentation, please include the documentation as a part of the application.

10.24.08.05 Nursing Home Standards.

A. General Standards. The Commission will use the following standards for review of all nursing home projects.

(1) Bed Need. The bed need in effect when the Commission receives a letter of intent for the application will be the need projection applicable to the review.

RESPONSE:

COMAR 10.24.08, "State Health Plan for Facilities and Services: Nursing Home and Home Health Agency Services" (published in the *Maryland Register* on April 29, 2016) identifies a need for 66 Comprehensive Care beds in Frederick County in 2016.

[4] [1] Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

Jurisdiction	Bed Inventory as of January 31, 2016					2016 Projected Bed Need			
	Licensed Beds	CON Approved Beds	Waiver Beds	Temporarily Delicensed Beds	Total Bed Inventory	Gross Bed Need Projection	Unadjusted Net Bed Need	Community-Based Services Adjustment	2016 Net Bed Need
WESTERN MARYLAND									
Allegany	901	0	22	8	931	784	-147	40	0
Carroll	933	0	10	0	943	750	-193	45	0
Frederick	1,080	0	0	0	1,080	1,235	155	89	66
Garrett	316	0	0	0	316	262	-54	12	0
Washington	1,136	0	6	5	1,147	1,003	-144	54	0

Jurisdiction	Bed Inventory as of January 31, 2016					2016 Projected Bed Need			
	Licensed Beds	CON Approved Beds	Waiver Beds	Temporarily Delicensed Beds	Total Bed Inventory	Gross Bed Need Projection	Unadjusted Net Bed Need	Community-Based Services Adjustment	2016 Net Bed Need
WESTERN MARYLAND									
Allegany	900	0	22	8	930	784	-146	40	0
Carroll	921	0	10	0	931	750	-181	45	0
Frederick	1,080	0	0	0	1,080	1,235	155	89	66
Garrett	316	0	0	0	316	262	-54	12	0
Washington	1,138	0	4	0	1,142	1,003	-139	54	0

This application proposes to add 66 beds. Thus, it is consistent with the need projection applicable in this review.

(2) Medical Assistance Participation.

(a) Except for short-stay, hospital-based skilled nursing facilities required to meet .06B of this Chapter, the Commission may approve a Certificate of Need for a nursing home only for an applicant that participates, or proposes to participate, in the Medical Assistance Program, and only if the applicant submits documentation or agrees to submit documentation of a written Memorandum of Understanding with Medicaid to maintain the proportion of Medicaid patient days required by .05A 2(b) of this Chapter.

RESPONSE:

Northampton participates, and will continue to participate, in the Medical Assistance Program. Prior to licensure, Northampton will execute a written Memorandum of Understanding with the Medical Assistance Program of the Department of Health and Mental Hygiene to (i) achieve or maintain the level of participation required by .05A 2(b) of this Chapter; and (ii) admit residents whose primary source of payment on admission is Medicaid. On March 20, 2015, the MHCC published the Required Maryland Medical Assistance Participation Rates for Nursing Homes by Region and Jurisdiction: Fiscal Year 2013 in the *Maryland Register*, requiring a Medicaid percentage of 37.59 percent.

REQUIRED MARYLAND MEDICAL ASSISTANCE PARTICIPATION RATES FOR NURSING HOMES BY REGION AND JURISDICTION: FISCAL YEAR 2013

Region/Jurisdiction		Required Medicaid Participation Rate*
Western Maryland		46.17
	Allegany County	54.70
	Carroll County	44.64
	Frederick County	37.59
	Garrett County	61.70
	Washington County	44.36

In FY 2014 (based on the MHCC's Public Use data, downloaded from the MHCC website), Northampton's Medicaid percentage was 63.5%. This was higher than the countywide average.

Table K
Total Patient Days, MD Medical Assistance Days, and Percent Medical Assistance
Frederick County Comprehensive Care Facilities
FY 2014

	Total Comprehensive Care Patient Days	Pat Days_Comp_ MD Med Asst	% Med Asst
Genesis College View Center	37,356	27,402	73.4%
Vindobona Nursing and Rehabilitation Center	16,543	10,566	63.9%
Citizens Care and Rehabilitation Center of Frederi	57,449	31,839	55.4%
Homewood at Crumland Farms	42,021	12,420	29.6%
Northampton Manor Health Care Center	62,839	39,930	63.5%
Golden LivingCenter Frederick	41,142	30,590	74.4%
Genesis Glade Valley Center	43,197	18,809	43.5%
Buckingham's Choice, Inc.	14,505	1,237	8.5%
St. Joseph Ministries	34,126	13,370	39.2%
Total	349,178	186,163	53.3%

Source: MHCC Public Use Data for 2014

While the percentage of total patient days at Northampton that will be Medicaid are projected to decline from the 63.5% in 2014 to 62%, the number of Medicaid days is projected to increase (from 39,930 in 2014 to 54,886 once stabilized). The projected percentage decline is due to at least two factors:

- Historically, there has been a decline in Medicaid days at nursing homes in Frederick County. Data from the MHCC's Public Use Databases show that the Medicaid percentage in Frederick County facilities declined from 56.1% in 2010 to 53.3% in 2014.

Table L
Average Medicaid Percentage
Frederick County Nursing Homes
2010-2014

Year	% Medicaid
2010	56.10%
2011	54.51%
2012	54.67%
2013	53.09%
2014	53.31%

Source: MHCC Public Use Databases

- Northampton anticipates an overall projected increase in the Medicare and other (non-Medicaid) payors' percentage due to the role that post-acute facilities are increasingly playing in rehabilitation. Since Medicaid is the largest payor for residents at Northampton, it would follow that the Medicaid percentage would decline.

Notwithstanding this decline, Northampton will continue to meet this standard.

(b) Each applicant shall agree to serve a proportion of Medicaid patient days that is at least equal to the proportion of Medicaid patient days in all other nursing homes in the jurisdiction or region, whichever is lower, calculated as the weighted mean minus 15.5% based on the most recent Maryland Long Term Care Survey data and Medicaid Cost Reports available to the Commission as shown in the *Supplement to COMAR 10.24.08: Statistical Data Tables*, or in subsequent updates published in the *Maryland Register*.

RESPONSE:

Northampton agrees to abide by 10.24.08.05A(2)(b).

(c) An applicant shall agree to continue to admit Medicaid residents to maintain its required level of participation when attained and have a written policy to this effect.

RESPONSE:

Northampton agrees to abide by 10.24.08.05A(2)(c).

(d) Prior to licensure, an applicant shall execute a written Memorandum of Understanding with the Medical Assistance Program of the Department of Health and Mental Hygiene to:

(i) Achieve or maintain the level of participation required by .05A 2(b) of this Chapter; and

(ii) Admit residents whose primary source of payment on admission is Medicaid.

(iii) An applicant may show evidence why this rule should not apply.

RESPONSE:

Northampton agrees to serve the Medicaid patient population as required, and shall execute the required MOU with the Medical Assistance Program of the Department of Health and Mental Hygiene prior to licensure.

(3) Community-Based Services. An applicant shall demonstrate commitment to providing community-based services and to minimizing the length of stay as appropriate for each resident by:

(a) Providing information to every prospective resident about the existence of alternative community-based services, including, but not limited to, Medicaid home and community-based waiver programs and other initiatives to promote care in the most appropriate settings;

(b) Initiating discharge planning on admission; and

(c) Permitting access to the facility for all "Olmstead" efforts approved by the Department of Health and Mental Hygiene and the Department of Disabilities to provide education and outreach for residents and their families regarding home and community-based alternatives.

RESPONSE:

Northampton provides information to all prospective residents about the existence of alternative community-based services, including but not limited to Medicaid home and community-based waiver programs, home care, medical day care, assisted living and other initiatives to promote care in the most appropriate settings. Please see **Exhibit L** for examples of such material distributed to prospective residents at Northampton.

The Applicant initiates discharge planning on admission as part of its development of a care plan. Mid-Atlantic has a strong track record of getting residents out of the facility and back into the community safely as demonstrated by its hospital readmission rate of 14% across its facilities. Upon admission and twice every day, an interdisciplinary group that includes the Director of Nursing, the medical directors, and department

directors, reviews all patients demonstrating a change in status, abnormal lab values, unstable status or patient/family concerns. These practices have earned 70% of MAHC's facilities a five star rating form CMS for quality measures. Further, Mid-Atlantic continues to follow residents after they leave the facility to insure they are getting the community based services they require to remain healthy and independent.

Northampton will permit access to all residents for the Olmstead efforts approved by the Department of Health and Mental Hygiene to provide education and outreach for residents and their families.

(4) Nonelderly Residents. An applicant shall address the needs of its nonelderly (<65 year old) residents by:

(a) Training in the psychosocial problems facing nonelderly disabled residents; and

(b) Initiating discharge planning immediately following admission with the goal of limiting each nonelderly resident's stay to 90 days or less, whenever feasible, and voluntary transfer to a more appropriate setting.

RESPONSE:

MAHC serves nonelderly disabled residents at Northampton as well as at all of its facilities. All employees of MAHC facilities are required to complete 30 hours of online training each year. One of the training modules specifically focuses on age specific care. We have included the course description in **Exhibit M**.

Northampton attempts to locate non-elderly patients in rooms as proximate to one another as possible and consistent with its sister facilities will provide staff with appropriate training. Northampton focuses on developing discharge plans immediately upon admission to help manage stays to less than 90 days. As described above, each of MAHC's facilities holds two care planning meetings a day (in morning and late afternoon to identify changes in condition of any residents (older and younger residents) and to begin discharge planning. As detailed in **Exhibit N**, greater than 35% of skilled nursing centers fail to conduct proper care planning.

In addition, Northampton has wireless Internet available to its residents and also has a café available to residents and their families.

***(5) Appropriate Living Environment*.** An applicant shall provide to each resident an appropriate living environment, including, but not limited to:

(a) In a **new construction** project:

(i) Develop rooms with no more than two beds for each patient room;

(ii) Provide individual temperature controls for each patient room; and

(iii) Assure that no more than two residents share a toilet.

(b) In a **renovation** project:

(i) Reduce the number of patient rooms with more than two residents per room;

(ii) Provide individual temperature controls in renovated rooms; and

(iii) Reduce the number of patient rooms where more than two residents share a toilet.

(c) An applicant may show evidence as to why this standard should not be applied to the applicant.

RESPONSE:

The new wing will include 66 private rooms, all with private bathrooms showers and temperature controls. No patient room will have more than two residents in the new wing. This will increase the percentage of private rooms at Northampton from approximately 1% to 41%. There also will be eight specially designed rooms for bariatric patients where currently there are none. The finishes will help create a bright, "hotel-like" experience that will enhance the overall resident experience. The project will also include café-style dining where residents have more choice over what and how much food they eat.

The project also includes a renovation of the current nursing unit located to the north of the new wing to similar finishes as those used in the new wing. All these rooms already have their own temperature controls. The renovations are largely cosmetic in nature and are intended to brighten the atmosphere and make the facility more "home-like". There are not sufficient funds to re-design the existing semi-private rooms to reduce the number of patient rooms where more than two residents share a toilet.

(6) Public Water. Unless otherwise approved by the Commission and the Office of Health Care Quality in accordance with COMAR 10.07.02.26, an applicant for a nursing home shall demonstrate that its facility is, or will be, served by a public water system.

RESPONSE:

The location of the facility is within Frederick City limits and is served by public water and sewer systems.

(7) Facility and Unit Design. An applicant must identify the special care needs of the resident population it serves or intends to serve and demonstrate that its proposed facility and unit design features will best meet the needs of that population. This includes, but is not limited to:

(a) Identification of the types of residents it proposes to serve and their diagnostic groups;

(b) Citation from the long term care literature, if available, on what types of design features have been shown to best serve those types of residents;

(c) An applicant may show evidence as to how its proposed model, which is not otherwise documented in the literature, will best serve the needs of the proposed resident population.

RESPONSE:

The RNH design is oriented toward increasing both the capacity for treating an increased number of short stay patients as well as more typical comprehensive care residents. RNH will have a strong emphasis on rehabilitation and creating a restorative environment unlike any other in the City of Frederick; its design will create a hotel-like look and feel as opposed to a typical, more institutional, nursing home environment. A working example of this type of facility is MAHC's newly constructed Restore Health Facility (opened in March 2015) in Charles County. This application includes pictures of that facility to provide a sense of the "look and feel" we are seeking in this facility as well, (see **Exhibit D**).

The first floor of RNH will include a dedicated entrance for the families to enter the wing. This floor will also include a new, 1,927 square foot rehabilitation gym and 1,410 square foot dining/multipurpose room. There will be two sets of elevators in RNH to allow easy access to the gym.

Both floors will have 33 private rooms. The private rooms vary in size, but are all larger than 260 square feet providing ample space for the residents. Each room contains its own bathroom and shower meaning no residents will share a bathroom with shower. Four rooms on each floor are designed for bariatric patients with larger doorways for the entry and in the bathrooms. Currently the facility has no specially designed bariatric rooms.

As stated the design will add 66 much needed private patient rooms. The advantages of private rooms are well accepted, but we have attached an article as **Exhibit O** which discusses the psychological and clinical advantages to private rooms. The article cites the positive resident experience and the psychological effect associated with privacy, and highlights several studies that document lower rates of infection associated with private rooms. The article also mentions greater family satisfaction and privacy when visiting their loved ones in facilities with private rooms which helps both long term and short stay resident families. Finally, it also suggests that greater privacy enabled better adherence to HIPAA regulations.

From a regulatory standpoint, the facility's rooms are designed to be at least double the required square footage by COMAR for a private or semi-private room. According to COMAR 10.07.02, a private room must be at least 100 square feet per bed and a semi-private room must be at least 80 square feet per bed. The average private room in the facility is almost 300 square feet which is over three times the required size. These rooms range in size from 262 square feet to 339 square feet.

Larger room sizes enable the facility to serve specific patient populations. For example, bariatric patients require larger beds. RNH includes eight bariatric rooms Specifically, Northampton will use Invacare BAR750 beds which measure 48 in x 88 in versus MAHC's normal Invacare Carroll CS Series CS7 bed which measures 36 in x 80 in. The footprint of a bariatric bed alone therefore requires as much as 10 square feet of additional floor space. Rooms designated for bariatric residents also require larger bathrooms and space for additional equipment to be rolled in including lifts to aid the care staff to remove the resident from his/her bed. In addition, these rooms will include wider, double doors to allow easier access. Other patient populations will enjoy similar benefits, such as ventilator and dialysis patients who require space for bulky medical equipment by the bedside for their care.

The design of the facility also promotes a "neighborhood model" as discussed in **Exhibit P.** Neighborhood models attempt to create a more home-like setting and promote greater interaction among residents and increased patient satisfaction. Each of the two floors has 33 rooms creating its own neighborhood which includes a central activity/dining space that features café style dining. Northampton uses this design feature in the east side of the facility and also at its Waldorf facility, pictures of which were included in **Exhibit D**. This style of food preparation includes a central kitchen which makes all the food which is then delivered to the cafes where it is served individually to each resident from hot warming stations. At both facilities, feedback has been very strong from our residents as it allows residents to see their options and pick and choose their own meals. Again, these features enhance the experience for both short stay and long term care residents of the facility.

RNH, like the rest of Northampton, will be equipped with a WanderGuard monitoring system so that residents who wander will not be able to leave the building without setting off an alarm. Mid-Atlantic is prepared to equip the facility with the specialized equipment for dialysis (potentially at the bedside) and also a vent unit. We will make the final determination based on discussions with our hospital partners, but each has currently expressed a need for these services.

Consistent with the rest of Northampton, specific attention has been made to resident safety. RNH has been designed to provide a safe environment for the residents, including the following:

- **Proximity of Staff to residents**
  The nursing stations (one per floor) are located central to all the rooms in RNH so that nurses and other staff can see all the resident rooms from each station. The activity and dining areas are also located nearby the nursing stations so that nurses can observe residents while there as well.

- **Standardization**
  While the rooms may be slightly different in shape each room will have common equipment.

- **Automation and Technology**
  MAHC is dedicated to using technology to make our nurses and other care staff more proactive and productive. The RNH wing will include a wireless infrastructure to enable the use of PointClickCare, Northampton's chosen electronic medical record system allowing nurses to get information efficiently at the point of care. Furthermore, the EMR will interface with Real Time Medical Systems, which is a data mining tool used in conjunction with the EMR to identify at risk patents and alerts our nurses when they should intervene before a resident may have an adverse event. These technologies allow for greater accuracy, efficiency and care for our residents.

- **Noise Reduction**
  The materials in RNH and the renovation will be designed to reduce noise as much as possible to create a safer, more restful and enjoyable resident experience.

- **Resident Involvement in Care**
  Consistent with our philosophy, RNH will promote Resident and family involvement in care whenever possible. RNH will have a separate entrance and readily accessible parking to allow resident families to visit their loved one easily and safely. RNH will hold routine care planning meetings with resident and/or family participation. It will also create a resident council to solicit feedback from the residents.

- **Precarious Events**
  RNH, like the rest of Northampton, will have sprinklers and the staff will be

trained how to react quickly and safely to all potential precarious events.

(8) Disclosure. An applicant shall disclose whether any of its principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.

RESPONSE:

None of Northampton's principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.

(9) Collaborative Relationships. An applicant shall demonstrate that it has established collaborative relationships with other types of long term care providers to assure that each resident has access to the entire long term care continuum.

RESPONSE:

As an existing facility, Northampton has established relationships with many providers and organizations to assure that residents have access to different aspects of the long term care continuum. These include:

Home Health Care
Spiritrust Lutheran Home Care & Hospice
FMH Home Health
Visiting Angels
Home Instead
Home Call
Bayada
Amada HHC

Hospice Contacts
Hospice of Frederick County
Carroll County Hospice

ALF's
Tranquility at Fredericktowne
Country Meadows
Somerford
Heartfields Assisted Living of Frederick
Edenton

B. **New Construction or Expansion of Beds or Services.** The Commission will review proposals involving new construction or expansion of comprehensive care facility beds, including replacement of an existing facility or existing beds, if new outside walls are proposed, using the following standards in addition to .05A(1)-(9):

(1) Bed Need.

(a) An applicant for a facility involving new construction or expansion of beds or services, using beds currently in the Commission's inventory, must address in detail the need for the beds to be developed in the proposed project by submitting data including, but not limited to: demographic changes in the target population; utilization trends for the past five years and expected changes in the next five years; and demonstrated unmet needs of the target population.

(b) For a relocation of existing comprehensive care facility beds, an applicant must demonstrate need for the beds at the new site, including, but not limited to: demonstrated unmet needs; utilization trends for the past five years and expected changes in the next five years; and how access to, and/or quality of, needed services will be improved.

RESPONSE:

The population of Frederick County has experienced considerable growth since the year 2000. Maryland Department of Planning projections show that the county wide population grew by 19.5% between 2000-2010, by 5.2% between 2010 and 2015, and is projected to grow by another 8.2% between 2015 and 2020. Furthermore, the population age 65 and over grew disproportionately to the other age groups. That age cohort grew by 37.6% between 2000-2010, by 28.1% between 2010 and 2015, and is projected to grow by another 27.52% between 2015-2020. It will have more than doubled in just 20 years. This data was used to calculate the need for 66 additional beds in the County, which need will continue to grow.

Table M
Population
Frederick County - 2000-2020

	2000	2010	% Change '00-'10	2015	% Change '10-'15	2020	% Change '15-'20
0-4	14,056	14,862	5.7%	14,160	-4.7%	16,730	18.1%
5-19	44,629	50,293	12.7%	50,010	-0.6%	49,200	-1.6%
20-44	73,545	75,528	2.7%	76,070	0.7%	83,900	10.3%
45-64	44,211	66,788	51.1%	72,160	8.0%	73,480	1.8%
65+	18,836	25,914	37.6%	33,200	28.1%	42,340	27.5%
Total	195,277	233,385	19.5%	245,600	5.2%	265,650	8.2%

Source: Maryland Department of Planning website, http://planning.maryland.gov/MSDC/County/fred.pdf, accessed on 3/29/16

Table N shows the occupancy rates at the Comprehensive Care facilities in Frederick County 2010-2014, based on MHCC Public Use Data. Of note is that the average occupancy rate in the county exceeded 90% for every year except 2014, when it was 89.5%.

Table N
Occupancy Rates
Comprehensive Care Facilities in Frederick County
2010-2014

	2014	2013	2012	2011	2010
Genesis College View Center	86.0%	83.5%	90.9%	86.6%	84.4%
Vindobona Nursing and Rehabilitation Center	69.7%	89.7%	73.0%	72.9%	87.3%
Citizens Care and Rehabilitation Center of Frederi	92.6%	90.0%	92.6%	91.2%	85.2%
Homewood at Crumland Farms	95.9%	93.5%	95.4%	96.5%	96.4%
Northampton Manor Health Care Center	87.8%	88.5%	93.1%	92.3%	92.4%
Golden LivingCenter Frederick	93.9%	90.4%	96.5%	95.0%	95.7%
St. Catherine's Nursing Center	N/A	N/A	N/A	94.3%	95.2%
Genesis Glade Valley Center	95.4%	95.1%	96.2%	108.5%	86.9%
Buckingham's Choice, Inc.	94.6%	90.0%	87.5%	83.8%	84.2%
St. Vincent Care Center LLC	82.7%	90.7%	87.7%	95.0%	142.3%
Total	89.5%	90.1%	91.8%	93.1%	91.1%

Source: MHCC Public Use Data

The difference between 89.5% occupancy and 90% occupancy is 1,951 patient days, the equivalent of only 16 admissions. Hence, if there had just been 16 more people admitted to the nursing homes in Frederick County in 2014, the occupancy would have equaled 90%. This is shown in **Table O**.

Table O
Admissions, Patient Days, Average Length of Stay, Potential Bed Days and Number of Admissions Which Would Result in 90% Average Occupancy Comprehensive Care Facilities in Frederick County 2014

	No Adm Year 2014_ Comp	Total Comprehensive Care Patient Days	ALOS (Days/Admits)	Total Potential Bed Days	.005 X Potential Bed Days	Effective # Patients @ALOS
Genesis College View Center	446	37,356	84	43,435		
Vindobona Nursing and Rehabilitation Center	163	16,543	101	23,725		
Citizens Care and Rehabilitation Center of Frederi	374	57,449	154	62,050		
Homewood at Crumland Farms	159	42,021	264	43,800		
Northampton Manor Health Care Center	612	62,839	103	71,540		
Golden LivingCenter Frederick	215	41,142	191	43,800		
Genesis Glade Valley Center	560	43,197	77	45,260		
Buckingham's Choice, Inc.	123	14,505	118	15,330		
St. Joseph Ministries	192	34,126	178	41,245		
Total	2,844	349,178	123	390,185	1,951	15.89

Source: MHCC Public Use Data

As to future utilization, the MHCC has projected a net bed need for 66 additional beds in 2016, as discussed supra.

(2) Facility Occupancy.

(a) The Commission may approve a nursing home for expansion only if all of its beds are licensed and available for use, and it has been operating at 90 percent or higher, average occupancy for the most recent consecutive 24 months.

(b) An applicant may show evidence why this rule should not apply.

RESPONSE:

Northampton respectfully requests that this rule should not apply. **Table P** shows the occupancy for the 24 month period January 1, 2014 through December 28, 2015.

Table P
Percent Occupancy
Northampton Manor
January 1, 2014 through December 28, 2015

Month	Year	Days	Beds	Potential Pt. Days	Pt. Days	% Occup.
Jan	2014	31	196	6,076	5,306	87.3%
Feb	2014	28	196	5,488	4,924	89.7%
Mar	2014	31	196	6,076	5,348	88.0%
Apr	2014	30	196	5,880	4,929	83.8%
May	2014	31	196	6,076	5,216	85.8%
Jun	2014	30	196	5,880	5,054	86.0%
Jul	2014	31	196	6,076	5,397	88.8%
Aug	2014	31	196	6,076	5,408	89.0%
Sep	2014	30	196	5,880	5,198	88.4%
Oct	2014	31	196	6,076	5,454	89.8%
Nov	2014	30	196	5,880	5,362	91.2%
Dec	2014	31	196	6,076	5,243	86.3%
Jan	2015	31	196	6,076	5,517	90.8%
Feb	2015	28	196	5,488	4,972	90.6%
Mar	2015	31	196	6,076	5,060	83.3%
Apr	2015	30	196	5,880	4,903	83.4%
May	2015	31	196	6,076	5,477	90.1%
Jun	2015	30	196	5,880	5,290	90.0%
Jul	2015	31	196	6,076	5,461	89.9%
Aug	2015	31	196	6,076	5,567	91.6%
Sep	2015	30	196	5,880	4,974	84.6%
Oct	2015	31	196	6,076	5,583	91.9%
Nov	2015	30	196	5,880	5,314	90.4%
Dec	2015	28	196	5,488	4,742	86.4%
Total		727	4,704	142,492	125,699	88.21%

Source: Northampton Manor

During this 24 month period, Northampton's occupancy was 88.21%. This is only 1.79% lower than the 90% standard. This calculates to 2,544 patient days (.0179 x 142,492 Potential Days = 2,544). As shown in **Table O**, Northampton Manor's average length of stay (ALOS) was 103 days. This means that if just 25 more patients had entered Northampton Manor over the two year period, Northampton would have been at 90% occupancy.

Mid-Atlantic took over management of Northampton on January 1, 2016. Therefore, Northampton was under the management of the predecessor owner for the entire 24 months shown above. However, in eight months of 2015, the occupancy exceeded 90%. From February 21 through March 21, 2015, there was a ban on admissions at Northampton Manor as a result of influenza. One can see that during March and April 2015, the occupancy fell to 83% but recovered in May 2015.

Northampton Manor is also impeded by a lack of Private Rooms with Private Toilets. **Table Q** shows that Northampton has the lowest percentage of Private Rooms with Private Toilets of all of the facilities in Frederick County. This has put Northampton at a competitive disadvantage, and this project is, in part, intended to address that problem.

Table Q
Patient Rooms by Type
Nursing Homes in Frederick County
FY 2014

	Total Licensed Beds (EDO2014)	Private Room_ Private Toilet	Semi Private Room_ Private Toilet	Triple Room_ Private Toilet	Quad Room_ Private Toilet	Private Room_ Shared Toilet	Semi Private Room_ Shared Toilet	Triple Room_ Shared Toilet	Quad Room_ Shared Toilet	Physical Capacity	% Private Room_ Private Toilet
Genesis College View Center	119	10	9	1	0	11	31	0	0	119	8.4%
Vindobona Nursing and Rehabilitation Center	65	1	8	0	0	7	7	7	7	65	1.5%
Citizens Care and Rehabilitation Center of Frederick	170	74	0	0	0	0	48	0	0	170	43.5%
Homewood at Crumland Farms	120	56	0	0	0	0	32	0	0	120	46.7%
Northampton Manor Health Care Center	196	2	15	0	0	0	41	0	0	196	1.0%
Golden LivingCenter Frederick	120	12	0	0	0	0	54	0	0	120	10.0%
Genesis Glade Valley Center	124	8	0	0	0	0	58	0	0	124	6.5%
Buckingham's Choice, Inc.	42	42	0	0	0	0	0	0	0	42	100.0%
St. Joseph Ministries	113	49	0	0	0	0	32	0	0	113	43.4%
Total	1069	254	32	1	0	18	303	7	7	1,069	23.8%

Source: MHCC 2014 Public Use Data

For these reasons, Northampton believes that the rule should not apply.

(3) Jurisdictional Occupancy.

(a) The Commission may approve a CON application for a new nursing home only if the average jurisdictional occupancy for all nursing homes in that jurisdiction equals or exceeds a 90 percent occupancy level for at least the most recent 12 month period, as shown in the Medicaid Cost Reports for the latest fiscal year, or the latest Maryland Long Term Care Survey, if no Medicaid Cost Report is filed. Each December, the Commission will issue a report on nursing home occupancy.

(b) An applicant may show evidence why this rule should not apply.

RESPONSE:

N/A

(4) Medical Assistance Program Participation.

(a) An applicant for a new nursing home must agree in writing to serve a proportion of Medicaid residents consistent with .05A 2(b) of this Chapter.

(b) An applicant for new comprehensive care facility beds has three years during which to achieve the applicable proportion of Medicaid participation from the time the facility is licensed, and must show a good faith effort and reasonable progress toward achieving this goal in years one and two of its operation.

RESPONSE:

As demonstrated in Northampton's above response to COMAR 10.24.08.02A(2) - Medical Assistance Participation, Northampton already exceeds the required Medicaid minimal proportion. Northampton projects that it will continue to exceed it. See **Table F**.

(c) An applicant for nursing home expansion must demonstrate either that it has a current Memorandum of Understanding (MOU) with the Medical Assistance Program or that it will sign an MOU as a condition of its Certificate of Need.

RESPONSE:

Northampton does not currently have an MOU. Northampton commits that, prior to filing for First Use Review, it will sign an MOU that reflects the most recent Medicaid participation rate and submit it to the MHCC as part of its request for First Use Review.

(d) An applicant for nursing home expansion or replacement of an existing facility must modify its MOU upon expansion or replacement of its facility to encompass all of the nursing home beds in the expanded facility, and to include a Medicaid percentage that reflects the most recent Medicaid participation rate.

RESPONSE:

Please see prior response.

(e) An applicant may show evidence as to why this standard should not be applied to the applicant.

(5) Quality. An applicant for expansion of an existing facility must demonstrate that it has no outstanding Level G or higher deficiencies, and that it maintains a demonstrated program of quality assurance.

RESPONSE:

MAHC is dedicated to providing to the highest quality, resident-centered care to each resident. MAHC's facilities owned more than a year have average a 4.4 star rating for

quality measures as determined by CMS. Northampton itself has a five star rating for quality measures.

Northampton completed its last survey on in March 2016 and had no Level G or higher deficiencies. A copy of the latest survey is attached as **Exhibit K**. Northampton, like all Mid-Atlantic facilities, has a robust Quality Assurance and Performance Improvement (QAPI) program that complies with all CMS regulations.

(6) Location. An applicant for the relocation of a facility shall quantitatively demonstrate how the new site will allow the applicant to better serve residents than its present location.

RESPONSE:

N/A

C. Renovation of Facility. The Commission will review projects involving renovation of comprehensive care facilities using the following standards in addition to .05A(1)-(9).

(1) Bed Status. The number of beds authorized to the facility is the current number of beds shown in the Commission's inventory as authorized to the facility, provided:

(a) That the right to operate the facility, or the beds authorized to the facility, remains in good standing; and

(b) That the facility provides documentation that it has no outstanding Level G or higher deficiency reported by the Office of Health Care Quality.

RESPONSE:

Northampton has a license to operate 196 beds as per the inventory. A copy of the license is attached in **Exhibit Q**. Northampton has no Level G or higher deficiencies as per its latest survey in March 2016 by the Office of Health Care Quality attached as **Exhibit K.**

(2) Medical Assistance Program Participation. An applicant for a Certificate of Need for renovation of an existing facility:

(a) Shall participate in the Medicaid Program;

(b) May show evidence as to why its level of participation should be lower than that required in .05A2(b) of this Chapter because the facility has programs that focus on discharging residents to community-based programs or an innovative nursing home model of care;

(c) Shall present a plan that details how the facility will increase its level of participation if its current and proposed levels of participation are below those required in .05A2(b) of this Chapter; and

(d) Shall agree to accept residents who are Medicaid-eligible upon admission.

RESPONSE:

Northampton already participates in the Medicaid program and will continue to do so after completion of the addition and renovation at a level in compliance with required participation rates for Frederick and Western Maryland.

(3) Physical Plant. An applicant must demonstrate how the renovation of the facility will improve the quality of care for residents in the renovated facility, and, if applicable will eliminate or reduce life safety code waivers from the Office of Health Care Quality and the State Fire Marshall's Office.

RESPONSE:

Northampton does not operate under any waivers from life safety codes. The renovation will improve the quality of care for residents by creating a more "hotel-like" environment for the residents and also by creating a new café-style, neighborhood dining concept that is currently in use in the other wing of Northampton and also in MAHC's Restore-Waldorf facility. This style of dining has gotten strong reviews from residents as it promotes more of a home-like setting and allows residents to have greater choice than the current, more institutional-like, tray service.

10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Fully address the way in which the proposed project is consistent with any specific applicable need standard or need projection methodology in the State Health Plan.
If the current bed need projection published by the MHCC based on the need formula in the State Health Plan does not project a need for all of the beds proposed, the applicant should identify the need that will be addressed by the proposed project by quantifying the need for all facility and service capacity proposed for development, relocation or renovation in the project.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the nursing home. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified and identify all the assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), and the relevant population considered in the analysis with information that supports the validity of these assumptions. The existing and/or intended service area population of the applicant should be clearly defined.

Complete the Statistical Projection (Tables D and E, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Table D must be completed if the applicant is an existing facility. Table E must be completed if the application is for a new facility or service or if it is requested by MHCC staff.

RESPONSE:

As stated previously, the applicable need analysis in the State Health Plan projects a need for 66 additional beds in Frederick County.

The population of Frederick County has experienced considerable growth since the year 2000. Maryland Department of Planning projections show that the county wide population grew by 19.5% between 2000-2010, by 5.2% between 2010 and 2015, and is projected to grow by another 8.2% between 2015 and 2020. Furthermore, the population age 65 and over grew disproportionately to the other age groups. That age cohort grew by 37.6% between 2000-2010, by 28.1% between 2010 and 2015, and is projected to grow by another 27.52% between 2015 to 2020. It will have more than doubled in just 20 years.

Table R
Population
Frederick County - 2000-2020

	2000	2010	% Change '00-'10	2015	% Change '10-'15	2020	% Change '15-'20
0-4	14,056	14,862	5.7%	14,160	-4.7%	16,730	18.1%
5-19	44,629	50,293	12.7%	50,010	-0.6%	49,200	-1.6%
20-44	73,545	75,528	2.7%	76,070	0.7%	83,900	10.3%
45-64	44,211	66,788	51.1%	72,160	8.0%	73,480	1.8%
65+	18,836	25,914	37.6%	33,200	28.1%	42,340	27.5%
Total	195,277	233,385	19.5%	245,600	5.2%	265,650	8.2%

Source: Maryland Department of Planning website, http://planning.maryland.gov/MSDC/County/fred.pdf, accessed on 3/29/16

Table S shows the occupancy rates at the Comprehensive Care facilities in Frederick County 2010-2014, based on MHCC Public Use Data. Of note is that the average occupancy rate in the county exceeded 90% for every year except 2014, when it was 89.5%.

Table S
Occupancy Rates
Comprehensive Care Facilities in Frederick County
2010-2014

	2014	2013	2012	2011	2010
Genesis College View Center	86.0%	83.5%	90.9%	86.6%	84.4%
Vindobona Nursing and Rehabilitation Center	*69.7%*	*89.7%*	*73.0%*	*72.9%*	*87.3%*
Citizens Care and Rehabilitation Center of Frederi	92.6%	90.0%	92.6%	91.2%	85.2%
Homewood at Crumland Farms	95.9%	93.5%	95.4%	96.5%	96.4%
Northampton Manor Health Care Center	87.8%	88.5%	93.1%	92.3%	92.4%
Golden LivingCenter Frederick	93.9%	90.4%	96.5%	95.0%	95.7%
St. Catherine's Nursing Center	N/A	N/A	N/A	94.3%	95.2%
Genesis Glade Valley Center	95.4%	95.1%	96.2%	108.5%	86.9%
Buckingham's Choice, Inc.	94.6%	90.0%	87.5%	83.8%	84.2%
St. Vincent Care Center LLC	82.7%	90.7%	87.7%	95.0%	142.3%
Total	89.5%	90.1%	91.8%	93.1%	91.1%

Source: MHCC Public Use Data

The difference between 89.5% occupancy and 90% occupancy is 1,951 patient days, the equivalent of only 16 admissions. Hence, if there had just been 16 more people admitted to the nursing homes in Frederick County in 2014, the occupancy would have equaled 90%. This is shown in **Table T**.

Table T
Admissions, Patient Days, Average Length of Stay, Potential Bed Days and Number of Admissions Which Would Result in 90% Average Occupancy Comprehensive Care Facilities in Frederick County 2014

	No Adm Year 2014_ Comp	Total Comprehensive Care Patient Days	ALOS (Days/Admits)	Total Potential Bed Days	.005 X Potential Bed Days	Effective # Patients @ALOS
Genesis College View Center	446	37,356	84	43,435		
Vindobona Nursing and Rehabilitation Center	163	16,543	101	23,725		
Citizens Care and Rehabilitation Center of Frederick	374	57,449	154	62,050		
Homewood at Crumland Farms	159	42,021	264	43,800		
Northampton Manor Health Care Center	612	62,839	103	71,540		
Golden LivingCenter Frederick	215	41,142	191	43,800		
Genesis Glade Valley Center	560	43,197	77	45,260		
Buckingham's Choice, Inc.	123	14,505	118	15,330		
St. Joseph Ministries	192	34,126	178	41,245		
Total	2,844	349,178	123	390,185	1,951	15.89

Source: MHCC Public Use Data

Northampton has the lowest percentage of private rooms with private toilets of any facility in Frederick County. This project will address this issue, as all the 66 additional beds will be in private rooms with private toilets.

Table U
Room Type
Comprehensive Care Facilities in Frederick County - 2014

	Private Room_ Private Toilet	Semi Private Room_ Private Toilet	Triple Room_ Private Toilet	Quad Room_ Private Toilet	Private Room_ Shared Toilet	Semi Private Room_ Shared Toilet	Triple Room_ Shared Toilet	Quad Room_ Shared Toilet	Total Licensed Beds (EDO 2014)	% Private Room_ Private Toilet
Genesis College View Center	10	9	1	0	11	31	0	0	119	8.4%
Vindobona Nursing and Rehabilitation Center	1	8	0	0	7	7	7	7	65	1.5%
Citizens Care and Rehabilitation Center of Frederi	74	0	0	0	0	48	0	0	170	43.5%
Homewood at Crumland Farms	56	0	0	0	0	32	0	0	120	46.7%
Northampton Manor Health Care Center	2	15	0	0	0	41	0	0	196	1.0%
Golden LivingCenter Frederick	12	0	0	0	0	54	0	0	120	10.0%
Genesis Glade Valley Center	8	0	0	0	0	58	0	0	124	6.5%
Buckingham's Choice, Inc.	42	0	0	0	0	0	0	0	42	100.0%
St. Joseph Ministries	49	0	0	0	0	32	0	0	113	43.4%
Total	254	32	1	0	18	303	7	7	1069	23.8%

Source: 2014 MHCC Public Use Data

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of

providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

RESPONSE:

MAHC analyzed a few different scenarios before settling on this option. Given that only 1% of the facility's rooms are private today, Northampton also focused on options that expanded the amount of private room options. MAHC analyzed the following options:

- **Maintain Status Quo –No change**
  Give the identified need for additional services, MAHC dismissed this option. Further, MAHC understood the need to expand the facility's private room options and to introduce dedicated space and clinical programs for short stay patients delivered in a hotel-like setting.

- **Complete renovation of Facility**
  Given the strong history of census at the Facility, MAHC dismissed this option as it would take many of its beds offline during a renovation. The facility was designed to include this wing, but the previous owner delayed its construction. The other side of the facility was renovated in 2009/2010 and the cost of renovation and lost income during an extensive project were deemed too costly.

- **Demolish existing center and rebuild**
  Given its recent purchase of the facility in January 2016, MAHC quickly dismissed this option. MAHC has not identified any ideal spots for a new skilled nursing center and the additional costs associated with a new facility prohibited this option.

Northampton is being cost effectively constructed. The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

TABLE V
I. Marshall Valuation Service
Calculation

Type		Convalescent Hospital
Construction Quality/Class		C/Good
Stories		2
Perimeter		851
Height of Ceiling		11.65
Square Feet		40,357
f.1	Average floor Area	20,179

A. Base Costs		
Basic Structure	$185.03	11/15
Elimination of HVAC cost for adjustment	0	
HVAC Add-on for Mild Climate	0	
HVAC Add-on for Extreme Climate	0	
Total Base Cost	$185.03	
B. Additions		
Elevator (If not in base)	$1.56	
Other	$0.00	
Subtotal	$1.56	
Total	$186.59	
C. Multipliers		
Perimeter Multiplier	0.954825679	
Product	$178.16	
Height Multiplier (plus/minus from 12')	0.991846908	
Product	$176.71	
Multi-story Multiplier (0.5%/story above 3)	1	
Product	$176.71	
D. Sprinklers		
Sprinkler Amount	$3.43	
Subtotal	$180.14	
E. Update/Location Multipliers		
Update Multiplier	1.03	4/16
Product	$185.54	
Location Multiplier	1.02	4/16
Product	$189.25	
Final Square Foot Cost Benchmark	**$189.25**	

II. Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
New Construction	$4,113,696	$101.93
Fixed Equipment	$2,090,077	$51.79
Site Preparation	$757,736	$18.78
Architectual Fees	$539,500	$13.37
Capitalized Construction Interest + Loan Placement Fee	$242,859	$6.02
Permits	$125,000	$3.10
Subtotal	$7,868,868	$194.98

However, this project includes a considerable amount of costs for facets of the project that would not be included in the MVS average, such as demolition, canopies, etc. Each of these are listed below:

B. Extraordinary Cost Adjustments

	Project Costs	Associated A&E Fees	Associated Cap Interest	Total	
Storm Drains	$100,000	$11,075		**$111,075**	Site
Rough Grading	$10,000	$1,107		**$11,107**	Site
Site Demolition Costs	$10,000	$1,107		**$11,107**	Site
Sediment & Erosion Control		$0		**$0**	Site
Site Improvements		$0		**$0**	Site
Landscaping	$50,000	$5,537		**$55,537**	Site
Paving	$150,000	$16,612		**$166,612**	Site
Lighting	$15,000	$1,661		**$16,661**	Site
Utilities		$0		**$0**	Permits
Jurisdictional Hook-up Fees		$0		**$0**	Permits
Signs	$3,000	$332	$132	**$3,464**	Building
Canopy		$0	$0	**$0**	Building
Total Cost Adjustments	$338,000	$37,433	$132	**$375,564**	
Per Square Foot				**$9.31**	

C. Adjusted Project Cost	$7,493,303
Per square foot	$185.68

Explanation of Extraordinary Costs

To better explain the extraordinary costs Northampton offers the following expanded explanation of the extraordinary costs:

- Storm Drains, Rough Grading, Demolition, Landscaping, Paving, Lighting, and Signs - MVS specifically states that these costs are not included in the MVS estimate per Section 1, page 3 of the Marshall Valuation Service.

- A&E Fees and Capitalized Interest – Both Architectural and Engineering Fees and Capitalized Interest are based on project costs including Building, Site Preparation, and Fixed Equipment. Consequently, if individual components of these categories are not included in the MVS comparison, their related A&E Fees and Capitalized Interest should also be removed from the comparison. Since only the Capitalized Interest associated with the "Building" costs are included in the comparison, only those items in "Building" (and not, for example, the items in "Site Preparation") have had their Capitalized Interest removed from the comparison.

These costs should fairly be eliminated from the costs that are compared to the MVS Estimate in order to obtain and "apples to apples" comparison. Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS estimate from $194.98 to $185.68.

III. Comparison

A. Adjusted Project Cost/Sq. Ft.	$185.68
B. Marshall ValuationService Benchmark	$189.25

One can see that Northampton estimates that the costs in the apples to apples comparison to the MVS estimate are reasonable and below the MVS comparison.

Table W

Northampton Manor

New Construction

M&S Method for Interpolating Area and Perimeter Factor

To use this, substitute the perimeter and average floor area measures that apply. Then substitute the M&S multipliers from the table on page 15-37 for the sizes just above and below the actual measures.

Perimeter		Below	Actual	Above		Calculated:	Below	Actual	Above
Area		800	851.0	1,000			800	851	1,000
Below	20,000	0.949			0.975	Below	0.949		0.975
Actual	20,179					Actual	0.9482503	**0.9548257**	0.9740361
Above	25,000	0.928			0.948	Above	0.928		0.948

Area Interpolation

1	0.949	-	0.928	=	0.021
2	20178.5	-	20000	=	178.5
3	25000	-	20000	=	5000
4	178.5	/	5000	=	0.0357
5	0.021	*	0.0357	=	0.0007497
6	0.949	-	0.0007497	=	0.9482503
7	0.975	-	0.948	=	0.027
8	0.027	*	0.0357	=	0.0009639
9	0.975	-	0.0009639	=	0.9740361

Perimeter Interpolation

10	1000	-	800	=	200
11	851	-	800	=	51
12	51	/	200	=	0.255
13	0.9740361	-	0.9482503	=	0.0257858
14	0.0257858	*	0.255	=	0.0065754
15	0.9482503	+	0.0065754	=	0.9548257

	Perimeter	Area	
1	930.0	21,352	Elevators
2	772.0	19,005	$63,000
Total	1,702.0	40,357	1.5610675
Avg	851.0	20,179	

	Height								
1		11.33	241918.16		Wall Height Interpolation				
2		12	228060				11	0.977	
			469978.16				11.65	0.9918469	
		11.65	**0.992**				12	1	

1	0.977	-	1	=	-0.023
2	12	-	11	=	0.645517
3	12	-	11	=	1
4	0.6455178	/	1	=	0.645517
5	-0.023	*	0.6455178	=	-0.014847
6	0.977	-	-0.0148469	=	**0.991846**

Capitalized Construction Allocation

	New	Renovation	Total				
Building Cost	$ 4,113,696						
Subtotal Cost	$5,535,932		$5,535,932	Cap	Fin Fees		
Cap Interest	$ 326,823			$290,510	$36,314		
Building/Subtotal	74.3%						
Building Cap Interest	$ 242,859						

		Sprinkler	Interpolation		
			30,000	3.58	
			40,357	3.4298235	
			50,000	3.29	

1	3.58	-	3.29	=	0.29
2	40,357	-	30000	=	10357
3	50000	-	30000	=	20000
4	10357	/	20000	=	0.51785
5	0.29	*	0.51785	=	0.150176
6	3.58	-	0.1501765	=	**3.429823**

10.24.01.08G(3)(d). Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required (Tables H and I for all applicants and Table F for existing facilities and/or Table G, for new facilities, new services, and when requested by MHCC staff). Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the nursing home exists or is proposed, explain why the projected Medicare percentages are reasonable.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project (see Part I question 15) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

RESPONSE:

Each of MAHC's facilities are legally organized and financed separately. Some entities do have audited financial statements (as required by financing sources) and some are reviewed, but we do not have an audited set of statements that consolidates all entities. Given this, we submit a letter from Hertzbach as they perform all our independent reviews and audits and therefore could best provide the support requested in the application, please see **Exhibit Q.**

MAHC has several relationships with banking institutions and is confident it can source the debt financing contemplated by the application.

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

RESPONSE:

Mid-Atlantic Health Care has been issued one Certificate of Need to build a 67-bed facility in Waldorf, Maryland in Charles County. The initial CON (Docket No. 11-08-2325) was issued September 10, 2010, but was modified in 2012 to change the location due to issues with the seller completing certain storm water improvements for the location. Mid-Atlantic has since completed the construction of the Facility in 2015 and opened in March 2015. The project was completed on time and within the budgeted cost.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any

expected increase in patients by payer.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

d) On costs to the health care delivery system.

If the applicant is an existing nursing home, provide a summary description of the impact of the proposed project on costs and charges of the applicant nursing home, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

RESPONSE:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project:

This project should not have any impact on other facilities. The additional 66 beds that the Commission has projected to be needed in 2016 is calculated at a county-wide percent occupancy of 90%. There should be enough volume of patient days to accommodate the addition of these beds without affecting existing facilities.

As demonstrated previously, the facilities in Frederick County have operated at approximately 90% for each of the last five years.

With the 8.2% population growth projected by the Maryland Department of Planning for Frederick County between 2015 and 2020 and, in particular, the 27.5% projected population growth in the 65 and older age cohort, it is reasonable to project that the additional population will generate additional Comprehensive Care days.

Hospitals are increasingly collaborating with Comprehensive Care facilities to provide post-acute care, as they attempt to discharge patients sooner and try to reduce readmissions and avoidable hospital admissions.

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer:

The Project should not have any impact on the payor mix of existing facilities. The Medicare age population has a very high growth rate, and the new unit is designed to treat patients in need of short stay, higher acuity services. Those facilities that currently treat larger numbers of Medicare patients (as a payor) should not be affected given the large growth of this category of patients in the county.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access):

See the answer to (a) above. The addition of a dedicated short stay wing with all of the needed ancillary services should increase access to the unique type of health care needed by those residents in the County. As you know, hospital consortiums are engaged in studies of how to reduce the cost per capita of health care while improving quality. The Facility is engaged in those discussions with the Trivergent Health Alliance and fully intends to participate in those joint efforts (across the Frederick, Washington and Allegany county areas) following approval.

d) On costs to the health care delivery system:

RNH's care programs and facility design are specifically geared toward lowering the overall costs to the health care delivery system. First, MAHC has an outstanding record of managing hospital readmissions from its facilities. MAHC's Maryland skilled nursing facilities average a 14% readmission rate 30 days after discharge. As detailed in **Exhibit S**, according to a study by Avalere Health commissioned by the Maryland Hospital Association, all Maryland-based skilled nursing centers average a 30-day readmission rate of 21.7%. A closer look at the facilities in Frederick County illustrates the opportunity in that county as well. MAHC is already working on instituting its best practices and care models on Northampton to lower its readmission rate. For the county, the average readmission rate was 17.9% with only one facility at MAHC's average rate of 14%.

Table X

Frederick County Skilled Nursing Facilities 2013 Readmission Rates

Facility	2013 Readmission Rate
Buckingham's Choice	17.7%
Citizen's Care & Rehab Center of Frederick	15.7%
College View Center	22.4%
Glade Valley Center	18.9%
Golden Living Center - Frederick	14.0%
Northampton Manor (1)	18.7%
St. Joseph's Ministries	16.4%
Vindobona Nursing & Rehab Center	19.1%
Average - Frederick County (2)	**17.9%**
MAHC 2015 Maryland Average	**14.0%**

(1) Readmission data before MAHC's ownership of facility
(2) Excludes CCRCs.

Source: Maryland Hospital Association Skilled Nursing Facility Partnership Development Guide

Lower readmission rates drive lower costs to the health care delivery system.

As mentioned above, MAHC is Trivergent Health Alliance's exclusive skilled nursing provider in Trivergent's application for a care management grant from the HSCRC focused on lowering the cost per capita of health care. Trivergent and MAHC are exploring gain sharing and bundled care models that incent each provider to lower costs to the health care delivery system.

TABLE OF TABLES

TABLE OF EXHIBITS

Exhibit	Description	Application Page Number Reference
A	Ownership Information and Organizational Chart	5, 6, 8, 9, 19
B	Selected portions of ICPC Quarterly Scorecard, January 1, 2009 to December 31, 2012, Maryland, published by Delmarva Foundation, QIO (June 1, 2013).	13
C	Study prepared by the Office of Inspector General dated November 2013	14
D	Samples of Planned Interior Look – Photographs of Restore Health Facility in Waldorf, Maryland	16, 32
E	Facility Drawings (Large Scale Drawings provided separately)	18
F	Budget Assumptions	19
G	Listing of Other Facilities Managed by Mid-Atlantic Health Care, LLC	19
H	Communications from DHMH Health Facilities Survey Coordinator concerning Villa Rosa Nursing and Rehab, LLC	20
I	Substantial Compliance letter concerning Villa Rosa Nursing and Rehab, LLC	20
J	Communications Concerning Delmar Nursing & Rehabilitation Center	21, 22
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L	Sample of Handouts to Residents	28
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N	OIG Study “Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements”	29
O	Article: “Envisioning your future in a nursing home” by Margaret P. calkins, Ph.D.	31, 39
P	Article: Discussion of Neighborhood Model for Nursing Facilities	32
Q	Northampton State CCF License	42
R	Letter from CPA dated April 28, 2016	54
S	Study by Avalere Health commissioned by the Maryland Hospital Association	57
T	Affirmations	

CON TABLE PACKAGE FOR NURSING HOME (CCFs) APPLICATIONS

Name of Applicant: Northampton Manor Care Health Center

Date of Submission: 5-May-16

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

Table	Table Title	Instructions
Table A	**Bed and Room Inventory**	All Comprehensive Care facility applicants must complete Table A regardless of the project type and scope.
Table B	**Construction and Renovation Square Footage**	All applicants proposing new construction or renovation must complete Table B.
Table C	**Project Budget**	All applicants, regardless of project type or scope, must complete Table C.
Table D	**Utilization - Entire Facility**	Existing facility applicants must complete Table D. All applicants who complete this table must also complete Table F.
Table E	**Utilization - New Facility or Service**	Applicants who propose to: establish a new facility; a new service; or are directed by MHCC staff must complete Table E. All applicants who complete this table must also complete Table G.
Table F	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table F. The projected revenues and expenses in Table F should be consistent with the volume projections in Table D.
Table G	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to: establish a new facility; a new service and any other applicant who completes a Table D must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table E.
Table H	**Workforce**	All applicants, regardless of project type or scope, must complete Table H.
Table I	**Bedside Care Staffing**	All applicants, regardless of project type or scope, must complete Table I.

TABLE A. BED CAPACITY BY FLOOR AND NURSING UNIT BEFORE AND AFTER PROJECT

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project.
Applicants should add columns and recalculate formulas to address any rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.

Before the Project						After Project Completion				
		Based on Physical Capacity					Based on Physical Capacity			
		Room Count			Physical		Room Count			Physical
Service Location (Floor/Wing)	Current Licensed Beds	Private	Semi-Private	Total Rooms	Bed Capacity	Service Location (Floor/Wing)	Private	Semi-Private	Total Rooms	Bed Capacity
COMPREHENSIVE CARE						**COMPREHENSIVE CARE**				
Floor 1 - Unit 1	59	1	29	30	59	Floor 1 - Unit 1	1	29	30	59
Floor 2 - Unit 2	59	1	29	30	59	Floor 2 - Unit 2	1	29	30	59
Floor 1 - Unit 3	38	0	19	19	38	Floor 1 - Unit 3	0	19	19	38
Floor 2 - Unit 4	40	0	20	20	40	Floor 2 - Unit 4	0	20	20	40
				0	0	Floor 1 - Unit 5	33	0	33	33
				0	0	Floor 2 - Unit 4	33	0	33	33
				0	0				0	0
SUBTOTAL Comprehensive Care	**196**	**2**	**97**	**99**	**196**	**SUBTOTAL**	**68**	**97**	**165**	**262**
ASSISTED LIVING						**ASSISTED LIVING**				
TOTAL ASSISTED LIVING						**TOTAL ASSISTED LIVING**				
Other *(Specify/add rows as needed)*				0	0	**Other** *(Specify/add rows as needed)*			0	0
TOTAL OTHER						**TOTAL OTHER**				
FACILITY TOTAL	**196**	**2**	**97**	**99**	**196**	**FACILITY TOTAL**	**68**	**97**	**165**	**262**

TABLE B. PROPOSED NEW CONSTRUCTION AND RENOVATION SQUARE FOOTAGE

INSTRUCTION: Account for all existing and proposed square footage by floor. Further breakdown by nursing unit and building wing are at Applicants discretion and should be used by applicants if it adds valuable information to the description of the existing and proposed facilities. Add or delete rows if necessary. See additional instruction in the column to the right of the table.

Gross Square Footage by Floor/Nursing Unit/Wing	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
BASEMENT	4,020			4,020	4,020
FIRST FLOOR	38,240	21,352	10,815	27,425	59,592
SECOND FLOOR	33,935	19,005	10,815	23,120	52,940
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total	76,195	40,357	21,630	54,565	116,552

TABLE C. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. If the project involves services other than CCF such as assisted living explain the allocation of costs between the CCF and the other service(s). See additional instruction in the column to the right of the table.

NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds

	CCF Nursing Home	Cost of Other Service Areas	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. Land Purchased/Donated	**$0**		**$0**
b. New Construction			
(1) Building	$4,113,696		$4,113,696
(2) Fixed Equipment	$2,090,077		$2,090,077
(3) Site and Infrastructure	$757,736		$757,736
(4) Architect/Engineering Fees	$539,500		$539,500
(5) Permits (Building, Utilities, Etc.)	$125,000		$125,000
SUBTOTAL New Construction	**$7,626,009**	**$0**	**$7,626,009**
c. Renovations			
(1) Building	$662,600		$662,600
(2) Fixed Equipment (not included in construction)	$0		$0
(3) Architect/Engineering Fees	$0		$0
(4) Permits (Building, Utilities, Etc.)	$0		$0
SUBTOTAL Renovations	**$662,600**	**$0**	**$662,600**
d. Other Capital Costs			
(1) Movable Equipment	$981,000		$981,000
(2) Contingency Allowance	$250,000		$250,000
(3) Gross interest during construction period	$290,510		$290,510
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL Other Capital Costs	***$1,521,510***		**$1,521,510**
TOTAL CURRENT CAPITAL COSTS	**$9,810,118**	**$0**	**$9,810,118**
e. Inflation Allowance	$249,304		$249,304
TOTAL CAPITAL COSTS	**$10,059,423**	**$0**	**$10,059,423**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	**$36,314**		$36,314
b. Bond Discount			$0
c. Legal Fees	**$80,000**		$80,000
d. Non-Legal Consultant Fees	**$20,000**		$20,000
e. Liquidation of Existing Debt			$0
f. Debt Service Reserve Fund			$0
g. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$136,314***		$136,314
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$10,195,736***	***$0***	***$10,195,736***
B. Sources of Funds			
1. Cash	**$2,932,998**		$2,932,998
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage	**$7,262,738**		$7,262,738
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$10,195,736***		**$10,195,736**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

TABLE D. UTILIZATION PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	
1. ADMISSIONS										
a. Comprehensive Care (public)	612	501	645	695	738	995	1,079	1,076	1,076	
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care	**612**	**501**	**645**	**695**	**738**	**995**	**1,079**	**1,076**	**1,076**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL ADMISSIONS	***612***	***501***	***645***	***695***	***738***	***995***	***1,079***	***1,076***	***1,076***	
2. PATIENT DAYS										
a. Comprehensive Care (public)	62,839	63,357	66,053	67,229	69,588	85,333	89,373	89,129	89,129	
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care	**62,839**	**63,357**	**66,053**	**67,229**	**69,588**	**85,333**	**89,373**	**89,129**	**89,129**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***62,839***	***63,357***	***66,053***	***67,229***	***69,588***	***85,333***	***89,373***	***89,129***	***89,129***	
3. NUMBER OF BEDS										
a. Comprehensive Care (public)	196	196	196	196	262	262	262	262	262	
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care Beds	**196**	**196**	**196**	**196**	**262**	**262**	**262**	**262**	**262**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL BEDS	***196***	***196***	***196***	***196***	***262***	***262***	***262***	***262***	***262***	***0***
4. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Comprehensive Care (public)	87.8%	88.6%	92.3%	94.0%	72.8%	89.2%	93.5%	93.2%	93.2%	
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care Beds	**87.8%**	**88.6%**	**92.3%**	**94.0%**	**72.8%**	**89.2%**	**93.5%**	**93.2%**	**93.2%**	
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %	**87.8%**	**88.6%**	**92.3%**	**94.0%**	**72.8%**	**89.2%**	**93.5%**	**93.2%**	**93.2%**	
5. OUTPATIENT (specify units used for charging and recording revenues)										
a. Adult Day Care										
b. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE E. UTILIZATION PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of proposed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**		
1. ADMISSIONS							
a. Comprehensive Care (public)	43	305	353	357	357		
b. Comprehensive Care (CCRC Restricted	0	0	0	0	0		
Total Comprehensive Care	**43**	**305**	**353**	**357**	**357**	**0**	**0**
c. Assisted Living	0	0	0	0	0		
d. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL ADMISSIONS	***43***	***305***	***353***	***357***	***357***		
2. PATIENT DAYS							
a. Comprehensive Care (public)	2,359	18,104	21,960	21,900	21,900		
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care	**2,359**	**18,104**	**21,960**	**21,900**	**21,900**	**0**	**0**
c. Assisted Living							
TOTAL PATIENT DAYS	***2,359***	***18,104***	***21,960***	***21,900***	***21,900***		
3. NUMBER OF BEDS							
a. Comprehensive Care (public)	66	66	66	66	66		
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care Beds	**66**	**66**	**66**	**66**	**66**	**0**	**0**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL BEDS	***66***	***66***	***66***	***66***	***66***	***0***	***0***
4. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. Comprehensive Care (public)	9.8%	75.2%	90.9%	90.9%	90.9%		
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care Beds	**9.8%**	**75.2%**	**90.9%**	**90.9%**	**90.9%**	**#DIV/0!**	**#DIV/0!**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL OCCUPANCY %	**9.8%**	**75.2%**	**91.2%**	**90.9%**	**90.9%**	**#DIV/0!**	**#DIV/0!**
5. OUTPATIENT (specify units used for charging and recording revenues)							
a. Adult Day Care							
b. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. The table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table D reflecting changes in volume and with the costs of the Workforce identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projected revenue and expenses specifying all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with calculations detailed in the attachment and Contractual Allowance should not be included if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
1. REVENUE										
a. Inpatient Services	$ 19,562,481	$ 18,710,157	$ 19,211,529	$ 20,532,723	$ 21,375,243	$ 26,818,336	$ 28,128,506	$ 28,051,653	$ 28,051,653	
b. Outpatient Services			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 19,562,481***	***$ 18,710,157***	***$ 19,211,529***	***$ 20,532,723***	***$ 21,375,243***	***$ 26,818,336***	***$ 28,128,506***	***$ 28,051,653***	***$ 28,051,653***	***$ -***
c. Allowance For Bad Debt	$ 421,976	$ 262,065	$ 284,183	$ 303,708	$ 316,159	$ 396,599	$ 415,961	$ 414,825	$ 414,825	$ -
d. Contractual Allowance										
e. Charity Care										
Net Patient Services Revenue	***$ 19,140,505***	***$ 18,448,092***	***$ 18,927,346***	***$ 20,229,015***	***$ 21,059,084***	***$ 26,421,737***	***$ 27,712,545***	***$ 27,636,828***	***$ 27,636,828***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 34,738	$ 47,643	$ 18,180	$ 18,180	$ 18,180	$ 18,180	$ 18,180	$ 18,180	$ 18,180	
NET OPERATING REVENUE	***$ 19,175,243***	***$ 18,495,735***	***$ 18,945,526***	***$ 20,247,195***	***$ 21,077,264***	***$ 26,439,917***	***$ 27,730,725***	***$ 27,655,008***	***$ 27,655,008***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 8,581,022	$ 8,961,130	$ 8,717,676	$ 9,153,560	$ 10,502,091	$ 12,296,385	$ 12,333,804	$ 12,304,322	$ 12,304,322	
b. Contractual Services	$ 1,762,417	$ 1,491,324	$ 1,862,347	$ 1,955,464	$ 2,105,335	$ 2,994,480	$ 3,163,449	$ 3,160,148	$ 3,160,148	
c. Interest on Current Debt	$ 425,130	$ 416,948	$ 1,286,589	$ 1,286,589	$ 1,286,589	$ 1,286,589	$ 1,286,589	$ 1,286,589	$ 1,286,589	
d. Interest on Project Debt					$ 146,449	$ 290,510	$ 291,305	$ 290,510	$ 290,510	
e. Current Depreciation	$ 473,445	$ 485,618	$ 474,492	$ 474,492	$ 474,492	$ 474,492	$ 474,492	$ 474,492	$ 474,492	
f. Project Depreciation					$ 125,542	$ 251,083	$ 251,083	$ 251,083	$ 251,083	
g. Current Amortization	$ 8,829	$ 8,829	$ 740,861	$ 740,861	$ 740,861	$ 740,861	$ 740,861	$ 740,861	$ 740,861	
h. Project Amortization					$ -	$ -	$ -	$ -	$ -	
i. Supplies	$ 1,317,552	$ 1,348,252	$ 1,312,882	$ 1,378,526	$ 1,511,713	$ 2,233,756	$ 2,410,332	$ 2,399,774	$ 2,399,774	
j. Other Expenses (Specify/add rows if needed)	$ 5,540,847	$ 5,523,042	$ 4,248,744	$ 4,256,560	$ 4,298,063	$ 4,566,196	$ 4,627,965	$ 4,626,950	$ 4,626,950	
TOTAL OPERATING EXPENSES	***$ 18,109,242***	***$ 18,235,143***	***$ 18,643,591***	***$ 19,246,052***	***$ 21,191,135***	***$ 25,134,352***	***$ 25,579,880***	***$ 25,534,730***	***$ 25,534,730***	***$ -***
3. INCOME										
a. Income From Operation	**$ 1,066,001**	**$ 260,592**	**$ 301,935**	**$ 1,001,143**	**$ (113,871)**	**$ 1,305,565**	**$ 2,150,845**	**$ 2,120,278**	**$ 2,120,278**	**$ -**
b. Non-Operating Income										
SUBTOTAL	***$ 1,066,001***	***$ 260,592***	***$ 301,935***	***$ 1,001,143***	***$ (113,871)***	***$ 1,305,565***	***$ 2,150,845***	***$ 2,120,278***	***$ 2,120,278***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 1,066,001***	***$ 260,592***	***$ 301,935***	***$ 1,001,143***	***$ (113,871)***	***$ 1,305,565***	***$ 2,150,845***	***$ 2,120,278***	***$ 2,120,278***	***$ -***

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. The table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table D reflecting changes in volume and with the costs of the Workforce identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projected revenue and expenses specifying all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with calculations detailed in the attachment and Contractual Allowance should not be included if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	32.9%	27.2%	31.2%	33.5%	34.6%	38.8%	39.0%	39.0%	39.0%	
2) Medicaid	49.6%	51.6%	52.6%	51.6%	50.8%	47.5%	47.3%	47.3%	47.3%	
3) Blue Cross			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
4) Commercial Insurance	5.2%	7.2%	5.0%	5.1%	5.0%	4.7%	4.7%	4.7%	4.7%	
5) Self-pay	12.0%	13.7%	10.3%	8.9%	8.8%	8.2%	8.2%	8.2%	8.2%	
6) Other - Hospice	0.3%	0.3%	1.0%	0.9%	0.8%	0.8%	0.8%	0.8%	0.8%	
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*
b. Percent of Inpatient Days										
1) Medicare	20.1%	16.9%	18.7%	20.6%	21.4%	24.8%	25.0%	25.0%	25.0%	
2) Medicaid	64.2%	64.8%	66.2%	65.2%	64.5%	61.8%	61.6%	61.6%	61.6%	
3) Blue Cross			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
4) Commercial Insurance	3.5%	4.8%	4.2%	4.4%	4.3%	4.2%	4.2%	4.2%	4.2%	
5) Self-pay	12.2%	13.5%	9.6%	8.7%	8.6%	8.2%	8.2%	8.2%	8.2%	
6) Other - Hospice			1.2%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*

TABLE G. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). This table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table E and with the Workforce costs identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with detailed calculation by payer in the attachment. The contractual allowance should not be reported if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instructions in the column to right of the table.

	Projected Years (ending five years after completion) Add columns of needed.						
Indicate CY or FY	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**		
1. REVENUE							
a. Inpatient Services	$ 842,520	$ 6,285,613	$ 7,539,530	$ 7,518,930	$ 7,518,930		
b. Outpatient Services							
Gross Patient Service Revenues	***$ 842,520***	***$ 6,285,613***	***$ 7,539,530***	***$ 7,518,930***	***$ 7,518,930***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 12,451	$ 92,891	$ 111,422	$ 111,117	$ 111,117		
d. Contractual Allowance							
e. Charity Care							
Net Patient Services Revenue	***$ 830,069***	***$ 6,192,722***	***$ 7,428,108***	***$ 7,407,813***	***$ 7,407,813***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)	$ -	$ -	$ -	$ -	$ -		
NET OPERATING REVENUE	***$ 830,069***	***$ 6,192,722***	***$ 7,428,108***	***$ 7,407,813***	***$ 7,407,813***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 1,348,532	$ 3,142,825	$ 3,180,244	$ 3,150,762	$ 3,150,762		
b. Contractual Services	$ 149,871	$ 1,039,016	$ 1,207,984	$ 1,204,684	$ 1,204,684		
c. Interest on Current Debt							
d. Interest on Project Debt	$ 146,449	$ 290,510	$ 291,305	$ 290,510	$ 290,510		
e. Current Depreciation							
f. Project Depreciation	$ 125,542	$ 251,083	$ 251,083	$ 251,083	$ 251,083		
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 133,188	$ 855,231	$ 1,031,806	$ 1,021,249	$ 1,021,249		
j. Other Expenses Management Fee	$ 41,503	$ 309,636	$ 371,405	$ 370,391	$ 370,391		
TOTAL OPERATING EXPENSES	***$ 1,945,084***	***$ 5,888,300***	***$ 6,333,828***	***$ 6,288,678***	***$ 6,288,678***	***$ -***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). This table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table E and with the Workforce costs identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with detailed calculation by payer in the attachment. The contractual allowance should not be reported if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instructions in the column to right of the table.

	Projected Years (ending five years after completion) Add columns of needed.						
Indicate CY or FY	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**		
3. INCOME							
a. Income From Operation	**$ (1,115,015)**	**$ 304,422**	**$ 1,094,280**	**$ 1,119,135**	**$ 1,119,135**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (1,115,015)***	***$ 304,422***	***$ 1,094,280***	***$ 1,119,135***	***$ 1,119,135***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (1,115,015)***	***$ 304,422***	***$ 1,094,280***	***$ 1,119,135***	***$ 1,119,135***	***$ -***	***$ -***
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	59.9%	55.3%	53.5%	53.5%	53.5%		
2) Medicaid	30.3%	33.8%	35.2%	35.2%	35.2%		
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%		
4) Commercial Insurance	4.1%	4.5%	4.6%	4.6%	4.6%		
5) Self-pay	5.2%	5.8%	6.1%	6.1%	6.1%		
6) Other - Hospice	0.5%	0.6%	0.6%	0.6%	0.6%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***
b. Percent of Inpatient Days							
1) Medicare	44.8%	40.1%	38.3%	38.3%	38.3%		
2) Medicaid	45.3%	49.1%	50.6%	50.6%	50.6%		
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%		
4) Commercial Insurance	3.1%	3.3%	3.4%	3.4%	3.4%		
5) Self-pay	6.0%	6.6%	6.7%	6.7%	6.7%		
6) Other - Hospice	0.8%	0.9%	0.9%	0.9%	0.9%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

TABLE H. WORKFORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table H if submitted)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Administrator	1.0	$168,022	$168,022			$0			$0	1.0	$168,022
Office Manager	1.0	$65,645	$65,645			$0			$0	1.0	$65,645
Human Resources	1.0	$55,640	$55,640	1.0	$55,650	$55,650			$0	2.0	$111,290
Receptionists	3.1	$27,560	$84,885			$0			$0	3.1	$84,885
Admission Coordinator	2.0	$38,626	$77,251			$0			$0	2.0	$77,251
Business Officer Clerk	1.0	$38,626	$38,626	1.0	$38,634	$38,634			$0	2.0	$77,260
Central Intake	1.0	$38,626	$38,626			$0			$0	1.0	$38,626
Medical Records	1.0	$31,200	$31,200			$0			$0	1.0	$31,200
Assistant Administrator	0.0	$0	$0	1.0	$97,760	$97,760			$0	1.0	$97,760
Total Administration	11.1	$50,532	$559,894	3.0	$64,015	$192,044			$0	14.1	$751,938
Direct Care Staff *(List general categories, add rows if needed)*											
Director Of Nursing	1.0	$130,270	$130,270			$0			$0	1.0	$130,270
RN Assessment Coordinator	3.0	$65,148	$195,437			$0			$0	3.0	$195,437
Staffing Coord	1.0	$35,714	$35,714			$0			$0	1.0	$35,714
Unit Clerk - Nurse Admin	2.0	$31,200	$62,400			$0			$0	2.0	$62,400
Q/A Services	1.0	$55,141	$55,141			$0			$0	1.0	$55,141
Nurse Educator	0.5	$67,683	$33,842			$0			$0	0.5	$33,842
ADN	1.0	$92,040	$92,040			$0			$0	1.0	$92,040
Central Supply	1.0	$31,200	$31,200			$0			$0	1.0	$31,200
EMR Nurse	1.0	$54,787	$54,787			$0			$0	1.0	$54,787
Care Plan	1.0	$82,014	$82,014			$0			$0	1.0	$82,014
Unit Manager	4.0	$79,206	$316,826	2.0	$79,200	$158,400			$0	6.0	$475,226
RNs	17.0	$67,038	$1,139,641	8.3	$67,038	$559,066			$0	25.3	$1,698,727
LPNs	20.7	$51,792	$1,070,063	9.3	$51,792	$483,873			$0	30.0	$1,553,936
CNAs	76.0	$30,326	$2,305,457	31.2	$30,326	$946,105			$0	107.2	$3,251,562
Asst. Director Of Nursing			$0	1.0	$99,986	$99,986			$0	1.0	$99,986
			$0			$0			$0	0.0	$0
Total Direct Care	130.2	$43,054	$5,604,832	51.9	$45,320	$2,247,450			$0	182.1	$7,852,281
Support Staff *(List general categories, add rows if needed)*											
Activities - Director	1.0	$50,502	$50,502			$0			$0	1.0	$50,502
Recreation Aide	6.6	$24,918	$163,963			$0			$0	6.6	$163,963
Social Services - Super	1.0	$50,502	$50,502			$0			$0	1.0	$50,502
Social Services - Staff	1.0	$32,490	$32,490			$0			$0	1.0	$32,490
Nurse Liaison	0.5	$74,589	$37,294			$0			$0	0.5	$37,294
Director of Food Service	1.0	$60,590	$60,590			$0			$0	1.0	$60,590
Dietician	2.0	$78,125	$156,250			$0			$0	2.0	$156,250
Cook/Supervisors	1.4	$38,022	$53,231			$0			$0	1.4	$53,231
Cooks/Helpers	2.5	$29,058	$72,644	5.3	$29,349	$156,463			$0	7.8	$229,107
Dietary Services	16.4	$23,379	$382,951			$0			$0	16.4	$382,951
Laundry Services	2.0	$25,979	$52,020			$0			$0	2.0	$52,020
Housekeeper Director	1.0	$38,022	$38,022			$0			$0	1.0	$38,022
Housekeeping Floor Techs	2.0	$24,440	$48,880	7.5	$24,690	$184,953			$0	9.5	$232,932
Housekeepers	6.1	$22,880	$140,175			$0			$0	6.1	$140,175
Maintenance Director	1.0	$61,131	$61,131			$0			$0	1.0	$61,131
Maintenance	2.1	$33,821	$69,984			$0			$0	2.1	$69,984
Driver	1.0	$29,411	$29,411			$0			$0	1.0	$29,411
			$0			$0			$0	0.0	$0
Total Support	48.6	$30,892	$1,500,042	12.8	$26,632	$340,515			$0	61.3	$1,840,557
REGULAR EMPLOYEES TOTAL	***189.8***	***$40,379***	$7,664,768	***67.7***	***$41,085***	$2,780,009			$0	257.5	$10,444,777
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
						$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff	0.0	#DIV/0!	$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL	***0.0***		$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below):*			1,488,792			379,753					1,859,545.3
Based on budgeted/historical levels											
TOTAL COST	***189.8***		***$9,153,560***	***67.7***		***$3,159,762***	***0.0***		***$0***		***$12,304,322***

TABLE I. Scheduled Staff for Typical Work Week

INSTRUCTION: Quantify the staff that will provide bedside care that would be counted toward the current minimum staffing as required by COMAR 10.07.02.12

	Weekday Hours Per Day					Weekend Hours Per Day			
Staff Category	**Day**	**Evening**	**Night**	**Total**		**Day**	**Evening**	**Night**	**Total**
Registered Nurses	69	52	43	165		69	52	43	165
L. P. N. s	69	52	43	165		69	52	43	165
Aides				-					-
C. N. A.s	208	173	139	520		208	173	139	520
Medicine Aides				-					-
Total	347	277	225	849		347	277	225	849
Licensed Beds at Project Completion				262		**Licensed Beds at Project Completion**			**262**
Hours of Bedside Care per Licensed Bed Per Day				3.24		**Hours of Bedside Care per Licensed Bed Per Day**			3.24
Ward Clerks (bedside care time calculated at 50%	26	0	0	26		26	0	0	26
Total Including 50% of Ward Clerks Time	373	277	225	875		373	277	225	875
Total Hours of Bedside Care per Licensed Bed Per Day				3.34		**Total Hours of Bedside Care per Licensed Bed Per Day**			3.34

CON TABLE PACKAGE FOR NURSING HOME (CCFs) APPLICATIONS

Name of Applicant: Northampton Manor Care Health Center

Date of Submission: 5-May-16

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

Table	Table Title	Instructions
Table A	**Bed and Room Inventory**	All Comprehensive Care facility applicants must complete Table A regardless of the project type and scope.
Table B	**Construction and Renovation Square Footage**	All applicants proposing new construction or renovation must complete Table B.
Table C	**Project Budget**	All applicants, regardless of project type or scope, must complete Table C.
Table D	**Utilization - Entire Facility**	Existing facility applicants must complete Table D. All applicants who complete this table must also complete Table F.
Table E	**Utilization - New Facility or Service**	Applicants who propose to: establish a new facility; a new service; or are directed by MHCC staff must complete Table E. All applicants who complete this table must also complete Table G.
Table F	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table F. The projected revenues and expenses in Table F should be consistent with the volume projections in Table D.
Table G	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to: establish a new facility; a new service and any other applicant who completes a Table D must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table E.
Table H	**Workforce**	All applicants, regardless of project type or scope, must complete Table H.
Table I	**Bedside Care Staffing**	All applicants, regardless of project type or scope, must complete Table I.

TABLE A. BED CAPACITY BY FLOOR AND NURSING UNIT BEFORE AND AFTER PROJECT

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project.
Applicants should add columns and recalculate formulas to address any rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.

Before the Project						After Project Completion					
		Based on Physical Capacity					Based on Physical Capacity				
		Room Count			Physical		Room Count			Physical
Service Location (Floor/Wing)	Current Licensed Beds	Private	Semi-Private	Total Rooms	Bed Capacity	Service Location (Floor/Wing)	Private	Semi-Private	Total Rooms	Bed Capacity
COMPREHENSIVE CARE						**COMPREHENSIVE CARE**				
Floor 1 - Unit 1	59	1	29	30	59	Floor 1 - Unit 1	1	29	30	59
Floor 2 - Unit 2	59	1	29	30	59	Floor 2 - Unit 2	1	29	30	59
Floor 1 - Unit 3	38	0	19	19	38	Floor 1 - Unit 3	0	19	19	38
Floor 2 - Unit 4	40	0	20	20	40	Floor 2 - Unit 4	0	20	20	40
				0	0	Floor 1 - Unit 5	33	0	33	33
				0	0	Floor 2 - Unit 4	33	0	33	33
				0	0				0	0
SUBTOTAL Comprehensive Care	**196**	**2**	**97**	**99**	**196**	**SUBTOTAL**	**68**	**97**	**165**	**262**
ASSISTED LIVING						**ASSISTED LIVING**				
TOTAL ASSISTED LIVING						**TOTAL ASSISTED LIVING**				
Other *(Specify/add rows as needed)*				0	0	**Other** *(Specify/add rows as needed)*			0	0
TOTAL OTHER						**TOTAL OTHER**				
FACILITY TOTAL	**196**	**2**	**97**	**99**	**196**	**FACILITY TOTAL**	**68**	**97**	**165**	**262**

TABLE B. PROPOSED NEW CONSTRUCTION AND RENOVATION SQUARE FOOTAGE

INSTRUCTION: Account for all existing and proposed square footage by floor. Further breakdown by nursing unit and building wing are at Applicants discretion and should be used by applicants if it adds valuable information to the description of the existing and proposed facilities. Add or delete rows if necessary. See additional instruction in the column to the right of the table.

Gross Square Footage by Floor/Nursing Unit/Wing	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
BASEMENT	4,020			4,020	4,020
FIRST FLOOR	38,240	21,352	10,815	27,425	59,592
SECOND FLOOR	33,935	19,005	10,815	23,120	52,940
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total	76,195	40,357	21,630	54,565	116,552

TABLE C. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. If the project involves services other than CCF such as assisted living explain the allocation of costs between the CCF and the other service(s). See additional instruction in the column to the right of the table.

NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds

	CCF Nursing Home	Cost of Other Service Areas	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. Land Purchased/Donated	**$0**		**$0**
b. New Construction			
(1) Building	$4,113,696		$4,113,696
(2) Fixed Equipment	$2,090,077		$2,090,077
(3) Site and Infrastructure	$757,736		$757,736
(4) Architect/Engineering Fees	$539,500		$539,500
(5) Permits (Building, Utilities, Etc.)	$125,000		$125,000
SUBTOTAL New Construction	**$7,626,009**	**$0**	**$7,626,009**
c. Renovations			
(1) Building	$662,600		$662,600
(2) Fixed Equipment (not included in construction)	$0		$0
(3) Architect/Engineering Fees	$0		$0
(4) Permits (Building, Utilities, Etc.)	$0		$0
SUBTOTAL Renovations	**$662,600**	**$0**	**$662,600**
d. Other Capital Costs			
(1) Movable Equipment	$981,000		$981,000
(2) Contingency Allowance	$250,000		$250,000
(3) Gross interest during construction period	$290,510		$290,510
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL Other Capital Costs	***$1,521,510***		**$1,521,510**
TOTAL CURRENT CAPITAL COSTS	**$9,810,118**	**$0**	**$9,810,118**
e. Inflation Allowance	$249,304		$249,304
TOTAL CAPITAL COSTS	**$10,059,423**	**$0**	**$10,059,423**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	**$36,314**		$36,314
b. Bond Discount			$0
c. Legal Fees	**$80,000**		$80,000
d. Non-Legal Consultant Fees	**$20,000**		$20,000
e. Liquidation of Existing Debt			$0
f. Debt Service Reserve Fund			$0
g. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$136,314***		**$136,314**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$10,195,736***	***$0***	***$10,195,736***
B. Sources of Funds			
1. Cash	**$2,932,998**		$2,932,998
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage	**$7,262,738**		$7,262,738
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$10,195,736***		**$10,195,736**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

TABLE D. UTILIZATION PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	
1. ADMISSIONS										
a. Comprehensive Care (public)	612	501	645	695	738	995	1,079	1,076	1,076	
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care	**612**	**501**	**645**	**695**	**738**	**995**	**1,079**	**1,076**	**1,076**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL ADMISSIONS	***612***	***501***	***645***	***695***	***738***	***995***	***1,079***	***1,076***	***1,076***	
2. PATIENT DAYS										
a. Comprehensive Care (public)	62,839	63,357	66,053	67,229	69,588	85,333	89,373	89,129	89,129	
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care	**62,839**	**63,357**	**66,053**	**67,229**	**69,588**	**85,333**	**89,373**	**89,129**	**89,129**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***62,839***	***63,357***	***66,053***	***67,229***	***69,588***	***85,333***	***89,373***	***89,129***	***89,129***	
3. NUMBER OF BEDS										
a. Comprehensive Care (public)	196	196	196	196	262	262	262	262	262	
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care Beds	**196**	**196**	**196**	**196**	**262**	**262**	**262**	**262**	**262**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL BEDS	***196***	***196***	***196***	***196***	***262***	***262***	***262***	***262***	***262***	***0***
4. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Comprehensive Care (public)	87.8%	88.6%	92.3%	94.0%	72.8%	89.2%	93.5%	93.2%	93.2%	
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care Beds	**87.8%**	**88.6%**	**92.3%**	**94.0%**	**72.8%**	**89.2%**	**93.5%**	**93.2%**	**93.2%**	
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %	**87.8%**	**88.6%**	**92.3%**	**94.0%**	**72.8%**	**89.2%**	**93.5%**	**93.2%**	**93.2%**	
5. OUTPATIENT (specify units used for charging and recording revenues)										
a. Adult Day Care										
b. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE E. UTILIZATION PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of proposed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**		
1. ADMISSIONS							
a. Comprehensive Care (public)	43	305	353	357	357		
b. Comprehensive Care (CCRC Restricted)	0	0	0	0	0		
Total Comprehensive Care	**43**	**305**	**353**	**357**	**357**	**0**	**0**
c. Assisted Living	0	0	0	0	0		
d. Other (Specify/add rows of needed)	0	0	0	0	0		
TOTAL ADMISSIONS	***43***	***305***	***353***	***357***	***357***		
2. PATIENT DAYS							
a. Comprehensive Care (public)	2,359	18,104	21,960	21,900	21,900		
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care	**2,359**	**18,104**	**21,960**	**21,900**	**21,900**	**0**	**0**
c. Assisted Living							
TOTAL PATIENT DAYS	***2,359***	***18,104***	***21,960***	***21,900***	***21,900***		
3. NUMBER OF BEDS							
a. Comprehensive Care (public)	66	66	66	66	66		
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care Beds	**66**	**66**	**66**	**66**	**66**	**0**	**0**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL BEDS	***66***	***66***	***66***	***66***	***66***	***0***	***0***
4. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. Comprehensive Care (public)	9.8%	75.2%	90.9%	90.9%	90.9%		
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care Beds	**9.8%**	**75.2%**	**90.9%**	**90.9%**	**90.9%**	**#DIV/0!**	**#DIV/0!**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL OCCUPANCY %	**9.8%**	**75.2%**	**91.2%**	**90.9%**	**90.9%**	**#DIV/0!**	**#DIV/0!**
5. OUTPATIENT (specify units used for charging and recording revenues)							
a. Adult Day Care							
b. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. The table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table D reflecting changes in volume and with the costs of the Workforce identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projected revenue and expenses specifying all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with calculations detailed in the attachment and Contractual Allowance should not be included if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
1. REVENUE										
a. Inpatient Services	$ 19,562,481	$ 18,710,157	$ 19,211,529	$ 20,532,723	$ 21,375,243	$ 26,818,336	$ 28,128,506	$ 28,051,653	$ 28,051,653	
b. Outpatient Services			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Gross Patient Service Revenues	***$ 19,562,481***	***$ 18,710,157***	***$ 19,211,529***	***$ 20,532,723***	***$ 21,375,243***	***$ 26,818,336***	***$ 28,128,506***	***$ 28,051,653***	***$ 28,051,653***	***$ -***
c. Allowance For Bad Debt	$ 421,976	$ 262,065	$ 284,183	$ 303,708	$ 316,159	$ 396,599	$ 415,961	$ 414,825	$ 414,825	$ -
d. Contractual Allowance										
e. Charity Care										
Net Patient Services Revenue	***$ 19,140,505***	***$ 18,448,092***	***$ 18,927,346***	***$ 20,229,015***	***$ 21,059,084***	***$ 26,421,737***	***$ 27,712,545***	***$ 27,636,828***	***$ 27,636,828***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 34,738	$ 47,643	$ 18,180	$ 18,180	$ 18,180	$ 18,180	$ 18,180	$ 18,180	$ 18,180	
NET OPERATING REVENUE	***$ 19,175,243***	***$ 18,495,735***	***$ 18,945,526***	***$ 20,247,195***	***$ 21,077,264***	***$ 26,439,917***	***$ 27,730,725***	***$ 27,655,008***	***$ 27,655,008***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 8,581,022	$ 8,961,130	$ 8,717,676	$ 9,153,560	$ 10,502,091	$ 12,296,385	$ 12,333,804	$ 12,304,322	$ 12,304,322	
b. Contractual Services	$ 1,762,417	$ 1,491,324	$ 1,862,347	$ 1,955,464	$ 2,105,335	$ 2,994,480	$ 3,163,449	$ 3,160,148	$ 3,160,148	
c. Interest on Current Debt	$ 425,130	$ 416,948	$ 1,286,589	$ 1,286,589	$ 1,286,589	$ 1,286,589	$ 1,286,589	$ 1,286,589	$ 1,286,589	
d. Interest on Project Debt					$ 146,449	$ 290,510	$ 291,305	$ 290,510	$ 290,510	
e. Current Depreciation	$ 473,445	$ 485,618	$ 474,492	$ 474,492	$ 474,492	$ 474,492	$ 474,492	$ 474,492	$ 474,492	
f. Project Depreciation					$ 125,542	$ 251,083	$ 251,083	$ 251,083	$ 251,083	
g. Current Amortization	$ 8,829	$ 8,829	$ 740,861	$ 740,861	$ 740,861	$ 740,861	$ 740,861	$ 740,861	$ 740,861	
h. Project Amortization					$ -	$ -	$ -	$ -	$ -	
i. Supplies	$ 1,317,552	$ 1,348,252	$ 1,312,882	$ 1,378,526	$ 1,511,713	$ 2,233,756	$ 2,410,332	$ 2,399,774	$ 2,399,774	
j. Other Expenses (Specify/add rows if needed)	$ 5,540,847	$ 5,523,042	$ 4,248,744	$ 4,256,560	$ 4,298,063	$ 4,566,196	$ 4,627,965	$ 4,626,950	$ 4,626,950	
TOTAL OPERATING EXPENSES	***$ 18,109,242***	***$ 18,235,143***	***$ 18,643,591***	***$ 19,246,052***	***$ 21,191,135***	***$ 25,134,352***	***$ 25,579,880***	***$ 25,534,730***	***$ 25,534,730***	***$ -***
3. INCOME										
a. Income From Operation	**$ 1,066,001**	**$ 260,592**	**$ 301,935**	**$ 1,001,143**	**$ (113,871)**	**$ 1,305,565**	**$ 2,150,845**	**$ 2,120,278**	**$ 2,120,278**	**$ -**
b. Non-Operating Income										
SUBTOTAL	***$ 1,066,001***	***$ 260,592***	***$ 301,935***	***$ 1,001,143***	***$ (113,871)***	***$ 1,305,565***	***$ 2,150,845***	***$ 2,120,278***	***$ 2,120,278***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 1,066,001***	***$ 260,592***	***$ 301,935***	***$ 1,001,143***	***$ (113,871)***	***$ 1,305,565***	***$ 2,150,845***	***$ 2,120,278***	***$ 2,120,278***	***$ -***

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. The table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table D reflecting changes in volume and with the costs of the Workforce identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projected revenue and expenses specifying all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with calculations detailed in the attachment and Contractual Allowance should not be included if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**	**CY 2023**
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	32.9%	27.2%	31.2%	33.5%	34.6%	38.8%	39.0%	39.0%	39.0%	
2) Medicaid	49.6%	51.6%	52.6%	51.6%	50.8%	47.5%	47.3%	47.3%	47.3%	
3) Blue Cross			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
4) Commercial Insurance	5.2%	7.2%	5.0%	5.1%	5.0%	4.7%	4.7%	4.7%	4.7%	
5) Self-pay	12.0%	13.7%	10.3%	8.9%	8.8%	8.2%	8.2%	8.2%	8.2%	
6) Other - Hospice	0.3%	0.3%	1.0%	0.9%	0.8%	0.8%	0.8%	0.8%	0.8%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***
b. Percent of Inpatient Days										
1) Medicare	20.1%	16.9%	18.7%	20.6%	21.4%	24.8%	25.0%	25.0%	25.0%	
2) Medicaid	64.2%	64.8%	66.2%	65.2%	64.5%	61.8%	61.6%	61.6%	61.6%	
3) Blue Cross			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
4) Commercial Insurance	3.5%	4.8%	4.2%	4.4%	4.3%	4.2%	4.2%	4.2%	4.2%	
5) Self-pay	12.2%	13.5%	9.6%	8.7%	8.6%	8.2%	8.2%	8.2%	8.2%	
6) Other - Hospice			1.2%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***

TABLE G. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). This table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table E and with the Workforce costs identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with detailed calculation by payer in the attachment. The contractual allowance should not be reported if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instructions in the column to right of the table.

	Projected Years (ending five years after completion) Add columns of needed.						
Indicate CY or FY	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**		
1. REVENUE							
a. Inpatient Services	$ 842,520	$ 6,285,613	$ 7,539,530	$ 7,518,930	$ 7,518,930		
b. Outpatient Services							
Gross Patient Service Revenues	***$ 842,520***	***$ 6,285,613***	***$ 7,539,530***	***$ 7,518,930***	***$ 7,518,930***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 12,451	$ 92,891	$ 111,422	$ 111,117	$ 111,117		
d. Contractual Allowance							
e. Charity Care							
Net Patient Services Revenue	***$ 830,069***	***$ 6,192,722***	***$ 7,428,108***	***$ 7,407,813***	***$ 7,407,813***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)	$ -	$ -	$ -	$ -	$ -		
NET OPERATING REVENUE	***$ 830,069***	***$ 6,192,722***	***$ 7,428,108***	***$ 7,407,813***	***$ 7,407,813***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 1,348,532	$ 3,142,825	$ 3,180,244	$ 3,150,762	$ 3,150,762		
b. Contractual Services	$ 149,871	$ 1,039,016	$ 1,207,984	$ 1,204,684	$ 1,204,684		
c. Interest on Current Debt							
d. Interest on Project Debt	$ 146,449	$ 290,510	$ 291,305	$ 290,510	$ 290,510		
e. Current Depreciation							
f. Project Depreciation	$ 125,542	$ 251,083	$ 251,083	$ 251,083	$ 251,083		
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 133,188	$ 855,231	$ 1,031,806	$ 1,021,249	$ 1,021,249		
j. Other Expenses Management Fee	$ 41,503	$ 309,636	$ 371,405	$ 370,391	$ 370,391		
TOTAL OPERATING EXPENSES	***$ 1,945,084***	***$ 5,888,300***	***$ 6,333,828***	***$ 6,288,678***	***$ 6,288,678***	***$ -***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). This table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table E and with the Workforce costs identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with detailed calculation by payer in the attachment. The contractual allowance should not be reported if it is a positive adjustment to gross revenue. Specify the sources of non-operating income. See additional instructions in the column to right of the table.

	Projected Years (ending five years after completion) Add columns of needed.						
Indicate CY or FY	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**		
3. INCOME							
a. Income From Operation	**$ (1,115,015)**	**$ 304,422**	**$ 1,094,280**	**$ 1,119,135**	**$ 1,119,135**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (1,115,015)***	***$ 304,422***	***$ 1,094,280***	***$ 1,119,135***	***$ 1,119,135***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (1,115,015)***	***$ 304,422***	***$ 1,094,280***	***$ 1,119,135***	***$ 1,119,135***	***$ -***	***$ -***
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	59.9%	55.3%	53.5%	53.5%	53.5%		
2) Medicaid	30.3%	33.8%	35.2%	35.2%	35.2%		
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%		
4) Commercial Insurance	4.1%	4.5%	4.6%	4.6%	4.6%		
5) Self-pay	5.2%	5.8%	6.1%	6.1%	6.1%		
6) Other - Hospice	0.5%	0.6%	0.6%	0.6%	0.6%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***
b. Percent of Inpatient Days							
1) Medicare	44.8%	40.1%	38.3%	38.3%	38.3%		
2) Medicaid	45.3%	49.1%	50.6%	50.6%	50.6%		
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%		
4) Commercial Insurance	3.1%	3.3%	3.4%	3.4%	3.4%		
5) Self-pay	6.0%	6.6%	6.7%	6.7%	6.7%		
6) Other - Hospice	0.8%	0.9%	0.9%	0.9%	0.9%		
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***

TABLE H. WORKFORCE INFORMATION

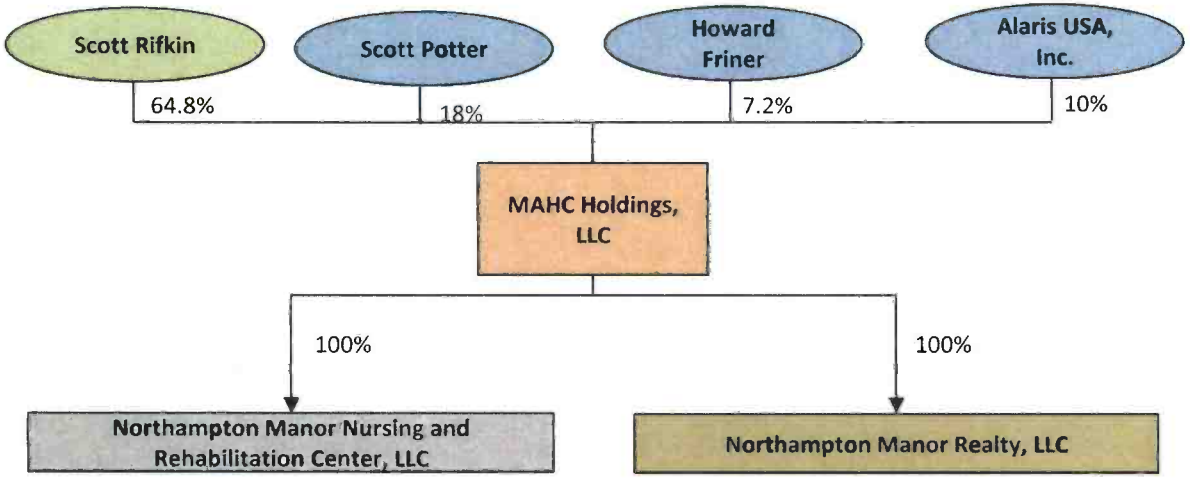
INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table H if submitted)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Administrator	1.0	$168,022	$168,022			$0			$0	1.0	$168,022
Office Manager	1.0	$65,645	$65,645			$0			$0	1.0	$65,645
Human Resources	1.0	$55,640	$55,640	1.0	$55,650	$55,650			$0	2.0	$111,290
Receptionists	3.1	$27,560	$84,885			$0			$0	3.1	$84,885
Admission Coordinator	2.0	$38,626	$77,251			$0			$0	2.0	$77,251
Business Officer Clerk	1.0	$38,626	$38,626	1.0	$38,634	$38,634			$0	2.0	$77,260
Central Intake	1.0	$38,626	$38,626			$0			$0	1.0	$38,626
Medical Records	1.0	$31,200	$31,200			$0			$0	1.0	$31,200
Assistant Administrator	0.0	$0	$0	1.0	$97,760	$97,760			$0	1.0	$97,760
Total Administration	11.1	$50,532	$559,894	3.0	$64,015	$192,044			$0	14.1	$751,938
Direct Care Staff *(List general categories, add rows if needed)*											
Director Of Nursing	1.0	$130,270	$130,270			$0			$0	1.0	$130,270
RN Assessment Coordinator	3.0	$65,146	$195,437			$0			$0	3.0	$195,437
Staffing Coord	1.0	$35,714	$35,714			$0			$0	1.0	$35,714
Unit Clerk - Nurse Admin	2.0	$31,200	$62,400			$0			$0	2.0	$62,400
Q/A Services	1.0	$55,141	$55,141			$0			$0	1.0	$55,141
Nurse Educator	0.5	$67,683	$33,842			$0			$0	0.5	$33,842
ADN	1.0	$92,040	$92,040			$0			$0	1.0	$92,040
Central Supply	1.0	$31,200	$31,200			$0			$0	1.0	$31,200
EMR Nurse	1.0	$54,787	$54,787			$0			$0	1.0	$54,787
Care Plan	1.0	$82,014	$82,014			$0			$0	1.0	$82,014
Unit Manager	4.0	$79,206	$316,826	2.0	$79,200	$158,400			$0	6.0	$475,226
RNs	17.0	$67,038	$1,139,641	8.3	$67,038	$559,086			$0	25.3	$1,698,727
LPNs	20.7	$51,792	$1,070,063	9.3	$51,792	$483,873			$0	30.0	$1,553,936
CNAs	76.0	$30,326	$2,305,457	31.2	$30,326	$946,105			$0	107.2	$3,251,562
Asst. Director Of Nursing			$0	1.0	$99,986	$99,986			$0	1.0	$99,986
			$0			$0			$0	0.0	$0
Total Direct Care	130.2	$43,054	$5,604,832	51.9	$43,320	$2,247,450			$0	182.1	$7,852,281
Support Staff *(List general categories, add rows if needed)*											
Activities - Director	1.0	$50,502	$50,502			$0			$0	1.0	$50,502
Recreation Aide	6.6	$24,918	$163,963			$0			$0	6.6	$163,963
Socal Services - Super	1.0	$50,502	$50,502			$0			$0	1.0	$50,502
Socal Services - Staff	1.0	$32,490	$32,490			$0			$0	1.0	$32,490
Nurse Liaison	0.5	$74,589	$37,294			$0			$0	0.5	$37,294
Director of Food Service	1.0	$60,590	$60,590			$0			$0	1.0	$60,590
Dietician	2.0	$78,125	$156,250			$0			$0	2.0	$156,250
Cook/Supervisors	1.4	$38,022	$53,231			$0			$0	1.4	$53,231
Cooks/Helpers	2.5	$29,058	$72,644	5.3	$29,349	$156,463			$0	7.8	$229,107
Dietary Services	16.4	$23,379	$382,951			$0			$0	16.4	$382,951
Laundry Services	2.0	$25,979	$52,020			$0			$0	2.0	$52,020
Housekeeper Director	1.0	$38,022	$38,022			$0			$0	1.0	$38,022
Housekeeping Floor Techs	2.0	$24,440	$48,880	7.5	$24,690	$184,052			$0	9.5	$232,932
Housekeepers	6.1	$22,880	$140,175			$0			$0	6.1	$140,175
Maintenance Director	1.0	$61,131	$61,131			$0			$0	1.0	$61,131
Maintenance	2.1	$33,821	$69,984			$0			$0	2.1	$69,984
Driver	1.0	$29,411	$29,411			$0			$0	1.0	$29,411
			$0			$0			$0	0.0	$0
Total Support	48.6	$30,892	$1,500,042	12.8	$26,632	$340,515			$0	61.3	$1,840,557
REGULAR EMPLOYEES TOTAL	***189.8***	***$40,379***	$7,664,768	***67.7***	***$41,085***	$2,780,009			$0	257.5	$10,444,777
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
						$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff	0.0	#DIV/0!	$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL	***0.0***		$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below):*			1,488,792			370,753					1,859,545.3
Based on budgeted/historical levels											
TOTAL COST	***189.8***		***$9,153,560***	***67.7***		***$3,150,762***	***0.0***		***$0***		***$12,304,322***

TABLE I. Scheduled Staff for Typical Work Week

INSTRUCTION: Quantify the staff that will provide bedside care that would be counted toward the current minimum staffing as required by COMAR 10.07.02.12

	Weekday Hours Per Day					Weekend Hours Per Day			
Staff Category	**Day**	**Evening**	**Night**	**Total**		**Day**	**Evening**	**Night**	**Total**
Registered Nurses	69	52	43	165		69	52	43	165
L. P. N. s	69	52	43	165		69	52	43	165
Aides				-					-
C. N. A.s	208	173	139	520		208	173	139	520
Medicine Aides				-					-
Total	347	277	225	849		347	277	225	849
Licensed Beds at Project Completion				262		**Licensed Beds at Project Completion**			**262**
Hours of Bedside Care per Licensed Bed Per Day				3.24		**Hours of Bedside Care per Licensed Bed Per Day**			3.24
Ward Clerks (bedside care time calculated at 50%	26	0	0	26		26	0	0	26
Total Including 50% of Ward Clerks Time	373	277	225	875		373	277	225	875
Total Hours of Bedside Care per Licensed Bed Per Day				3.34		**Total Hours of Bedside Care per Licensed Bed Per Day**			3.34



Key

Operating Company

Owner

Realty Company

Holding Company

Controlling Owner

MILES & STOCKBRIDGE

Mid-Atlantic Health Care
Northampton Ownership Structure
Updated: April 29,, 2016

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

DFMC
DELMARVA FOUNDATION
Maryland

ICPC Quarterly Scorecard

January 1, 2009 to December 31, 2012

Maryland

Report Date: June 1, 2013

This material provided by Delmarva Foundation for Medical Care (DFMC), the Medicare Quality Improvement Organization (QIO) for Maryland, was prepared by Colorado Foundation for Medical Care (CFMC), the Integrating Care for Populations & Communities National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-MD-CT-071713-353.

Introduction

The Integrate Care for Populations and Communities (ICPC) Quarterly Scorecard is a report designed to help Quality Improvement Organizations (QIOs) monitor and evaluate the progress of the nation, states, US territories, and communities involved in the 10th Scope of Work (SOW) ICPC Aim. QIOs will receive an updated Scorecard following submission of the QIO Quarterly Deliverables. The Scorecard is based on the most recent C.3 Monthly Community/Provider Log and the most current ASAT data file to which the NCC has access. Note that the most recent quarter of data may not be fully mature.

Changes and Updates

Additions

- Map showing ZIP Code level percent of hospitalizations that are out of state (Nation and State section)
- Table showing ZIP Code level percent of hospitalizations that are out of state. Only those ZIP Codes for which the out-of-state percentage is in the top decile of the nation are shown. (Appendix 2)

Deletions

- Community metrics and maps for previously reported communities whose ZIP Codes and hospitals remain unchanged. This affects the following tables and maps:
  - ZIP Code level admissions per 1,000 benes maps
  - ZIP Code level 30-day readmissions per 1,000 benes maps
  - Admissions/Readmissions by Hospital
  - Admissions/Readmissions by ZIP Code
- All state maps (IC-7 and IC-8) and statewide coalition maps (IC-5a, IC-5b, IC-6a, and IC-6b) if all community ZIP Codes and hospitals remain unchanged

Of Note

Several QIOs have requested that the Scorecard include tables for the proportionate readmission rate (readmissions/live discharges). This information is included in the "Post-Acute Care Setting Readmission Rates" table in the Appendix. The next to last column reported as (G=D/A) calculates the rate of readmissions per live discharges.

Navigating the Scorecard

The Quarterly Scorecard includes a Table of Contents listing the numerous tables, figures, and maps. To navigate to any of these elements, hover your mouse over the title or page number, press and hold the Ctrl key, and left click your mouse simultaneously. To return to the title page, press Ctrl+Home.

Interpreting the Scorecard

The Quarterly Scorecard is divided into five sections: 1) National; 2) State; 3) Statewide Coalition; 4) Statewide Engaged Communities; and 5) Community. Each section contains a set of summary tables and figures reflecting population-based admission and readmission metric trends, admission and readmission metrics pertaining to specific diagnoses, post-acute care settings, and emergency department visits and observation stays. Each Quarterly Scorecard also highlights a variety of maps that visually display admission and readmission metrics. Note that the maps and table depicting ZIP Code level percent of hospitalizations that are out of state are claims-based and not population-based which means that a beneficiary who is hospitalized multiple times will be counted multiple times.

Because the Scorecard relies on the exact data reported in the C.3 Monthly Community/Provider Log, QIOs must resolve potential errors found in this report on subsequent C.3 Monthly Community/Provider Logs for the changes to be reflected within future Quarterly Scorecards.

Community Designations

Engaged QIO Community: Any community reported in the QIO's most recent C.3 Monthly Community/Provider Log. This is analogous to the QIO Community designation used for maps.
Recruited QIO Community: Any community marked as formally recruited in the C.3 Monthly Community/Provider Log regardless of recruitment date. Recruited QIO communities are designated by an asterisk (*) in the Table of Contents and Community section of the Scorecard.
CCTP Partner: Community-based Care Transitions Program (CCTP) Partners officially announced by the Centers for Medicare & Medicaid Services (CMS). CCTP Partners are designated by a double dagger (‡) in the Table of Contents and Community section of the Scorecard.
Formal CT Program (Non-CCTP): Any community accepted into a formal Care Transitions (CT) program (other than CCTP) as determined by CMS. Formal CT Program (Non-CCTP) communities are designated by a dagger (†) in the Table of Contents and Community section of the Scorecard.
ADRC Option D Communities: Any community that has been awarded a CT Option D grant from the Aging and Disability Resource Centers (ADRC) as determined by CMS. These communities are displayed on the national maps.

Cohort Designations

National: All Medicare fee-for-service (FFS) beneficiaries residing in any valid ZIP Code in the 50 States, District of Columbia, Puerto Rico, and the United States (US) Virgin Islands.
State: All Medicare FFS beneficiaries residing in any valid ZIP Code in the state. ZIP Codes that cross state lines are assigned based on the SAS zipstate function.
Statewide Coalition: All Medicare FFS beneficiaries residing in the ZIP Codes associated with recruited QIO communities in the IC-5 and IC-6 metrics. This section includes both the Coalition A and Coalition B designations of the IC-5 and IC-6 metrics. If ZIP Codes are the same for both the 'A' and 'B' designations, the Scorecard will not display results for the 'B' statewide coalition cohort. For all other metrics, only Coalition 'A' is displayed.

Statewide Engaged Communities: All Medicare FFS beneficiaries residing in the ZIP Codes associated with all QIO communities as reported in the QIO's most recent C.3 Monthly Community/Provider Log. All communities with associated ZIP Codes, regardless of recruitment status, are included in these aggregate metrics.
Community: All Medicare FFS beneficiaries residing in the ZIP Codes associated with each engaged QIO community as reported in the most recent C.3 Monthly Community/Provider Log. Communities in the log, but without associated ZIP Codes, are not included. These tables and figures include beneficiaries residing in out-of-state ZIP Codes associated with the engaged community.

Note: The 'baseline' time period is included in this report. However, the rates presented here do not reflect official baseline rates to be used for evaluation. Also note that the addition of the cohorts used for IC-5a, IC-5b, IC-6a, and IC-6b are based on the most recent C.3 Monthly Community/Provider Log. They do not represent official baseline or interim results. These additional metrics use the exact ZIP Codes as entered in the most recent C.3 Monthly Community/Provider Log, not the 'locked down' ZIP Codes entered in the July 31, 2012 C.3 Monthly Community/Provider Log. These metrics use the most recent ASAT data pull. For these reasons, the Scorecard metrics may not match the baseline numbers you received nor can they be used for official evaluation purposes.

Figures (see glossary for definitions)

Quarterly Admissions and Readmissions: Each of the five cohort sections displays graphs of admissions and readmissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort. The graphs display both observed and seasonally adjusted values.

Seasonally Adjusted Quarterly Admissions by Cohort: The state section displays seasonally adjusted admissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the nation, state, statewide coalition (both 'A' and 'B' designations, where applicable), and each engaged community with associated ZIP Codes in the QIO's C.3 Monthly Community/Provider Log. The community section displays seasonally adjusted admissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the nation, state, statewide coalition, and the designated community.

Seasonally Adjusted Quarterly Readmissions by Cohort: The state section displays seasonally adjusted readmissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the nation, state, statewide coalition (both 'A' and 'B' designations, where applicable), and each engaged community with associated ZIP Codes in the QIO's C.3 Monthly Community/Provider Log. The community section displays seasonally adjusted readmissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the nation, state, statewide coalition, and the designated community.

Quarterly Emergency Department Visits/Observation Stays: Each of the five cohort sections includes a graph displaying Emergency Department Visits, Observation Stays, and Admissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort. Please note that these metrics are not seasonally adjusted and may show seasonal effects.

Quarterly Diagnosis-Specific Admissions: Each of the five cohort sections includes a graph displaying Diagnosis-Specific Admissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort. Please note that these metrics are not seasonally adjusted and may show seasonal effects.

Quarterly Diagnosis-Specific Readmissions: Each of the five cohort sections includes a graph displaying Diagnosis-Specific Readmissions per 1,000, by quarter, for the Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort. Please note that these metrics are not seasonally adjusted and may show seasonal effects.

Annual Post-Acute Care Setting Readmissions: Each of the five cohort sections includes a pie chart displaying discharges to various post-acute care settings for calendar year 2011. The outer circle represents setting-specific discharges while the inner circle displays discharges with and without associated 30-day readmissions within the specified setting.

Tables (see glossary for definitions)

Admissions and Readmissions by Hospital: The community section includes tables displaying admissions and readmissions by hospital among Medicare FFS beneficiaries residing in the ZIP Codes associated with the community. Hospitals with no associated claims within the time period of interest are not displayed. These tables will only be displayed for new communities or communities with associated ZIP Code or hospital changes.

Admissions and Readmissions by ZIP Code: The community section includes tables displaying admissions and readmissions by ZIP Code among Medicare FFS beneficiaries residing in the ZIP Codes associated with the community. These tables will only be displayed for new communities or communities with associated ZIP Code or hospital changes.

Appendix Tables (see glossary for definitions)

The following tables are included for each of the five cohorts and display quarterly, semi-annual, and annual metrics.

Admissions and Readmissions: These tables show the admissions and 30-day readmissions for eligible beneficiaries residing in the ZIP Codes associated with the designated cohort.

For the admissions and readmissions per 1,000 quarterly metrics, the *Observed* column represents the total number of admissions and readmissions per 1,000 beneficiaries while the *Seasonally Adjusted* column represents the number of admissions and readmissions per 1,000 beneficiaries after adjusting for seasonal effects.

The quarterly denominator (eligible beneficiaries) for the observed measure is consistent across the quarters. However, admissions and readmissions show seasonal effects. These effects could be due to a variety of issues, including more hospitalizations in winter months, number of days in the quarter, and major holidays in the quarter (lower 'elective' admissions). Therefore, comparisons using the observed measure should be made using the same quarter of the year (e.g., Q1 2009 to Q1 2010). To compare other quarters or consider trends, the seasonally adjusted metrics should be used.

To determine the seasonal effects, we computed quarterly rates for each of the 20 quarters from Q1 2006 through Q4 2010 using a national inpatient file. We then calculated the average rate of all 20 quarters (Overall Mean). Next, we calculated a residual for each of the 20 quarters (difference between each of the 20 quarterly rates and the Overall Mean). The seasonal adjustments reflect the mean of the residuals at each of the four quarters (e.g., Q1 is the average of all 5 Q1s - Q1 2006, Q1 2007, Q1 2008, Q1 2009, Q1 2010). Finally, we computed the seasonally adjusted rates as the observed minus the quarterly adjustment.

ZIP Code Level Percent of Hospitalizations that are Out of State: Provided for each state, this table shows the number of in-state, out-of-state, and total hospitalizations as well as the percent of total hospitalizations that are at out-of-state hospitals. Only those ZIP Codes for which the out-of-state percentage is in the top decile of the nation are shown. It should be noted that point ZIPs and ZIP Codes with ten or less hospitalizations might be included in the table, but are not included in the maps.

Emergency Department (ED) Visits and Observation Stays (Obs): Medicare often disperses payments for inpatient admissions, observation stays, and emergency department visits based on hierarchical rules since each claim can only count as one of these three types. The related tables show the breakdown of claims in each category: ED visits, Obs stays, and inpatient admissions. For a further explanation of the hierarchical rules used to assign a claim into one of these categories refer to the webex "ED Visits/Observation Stays per 1000 Beneficiaries" located on the ICPC National Coordinating Center (NCC) website (http://www.cfmc.org/integratingcare/qios_reference.htm).

Diagnosis-Specific Admissions and Readmissions: These tables show admissions and readmissions among beneficiaries for the following six disease categories: acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), chronic renal failure, congestive heart failure, diabetes mellitus, and pneumonia.

Post-Acute Care Setting Readmission Rates: These tables show the number and percent of patients discharged to each of four post-acute care settings: Home Health Agency (HHA), Home, Hospice, and Skilled Nursing Facility (SNF). Also included are the number and percent of those patients readmitted within 30 days.

Note: The post-acute care settings are determined by the discharge status code on the index claim (HSE_CLM_STUS_CD). As such, readmission measures do not necessarily reflect the patient setting immediately prior to readmission but rather the intended setting immediately following the index discharge.

Maps

The National (section 1), State (section 2), Statewide Coalition (section 3) and Community (section 5) sections contain a series of maps intended to depict visual information about beneficiary hospital utilization as well as communities involved in care transitions efforts at the national, state, and community levels.

The maps display calendar year 2011 admissions and readmissions per 1,000 beneficiaries by ZIP Code for the following cohorts:

- National (all valid ZIP Codes in the 50 states, District of Columbia, Puerto Rico and the US Virgin Islands).
- State (all ZIP Codes in the state).
- Statewide Coalition (both 'A' and 'B' designations, where applicable).
- Community (all ZIP Codes in the community).

The majority of the maps display the admissions and readmissions per 1,000 beneficiaries metrics by ZIP Code which enables the viewer to visualize potential areas of higher admissions or readmissions within the cohort. Generally, the ZIP Codes for the national and state (IC-7 and IC-8) maps are sorted into deciles of admissions or readmissions per 1,000, with each decile representing approximately 1/10 of the cohort's associated ZIP Codes. The ZIP Codes for the statewide coalition (both 'A' and 'B' designations, where applicable) and the community maps are sorted into quintiles of admissions or readmissions per 1,000, with each quintile representing approximately 1/5 of the cohort's associated ZIP Codes. Legend values are based solely on ZIP Codes that contain area; therefore, point ZIP Codes are not represented in these maps. Admission and readmission metrics for ZIP Codes with 10 or fewer beneficiaries are not displayed on any of the maps due to confidentiality restraints. These areas do not have any red, yellow, or green shading but are symbolized using a black hatch pattern on a white background. If these areas are within a community, they will also be displayed beneath a community designation layer. These designation layers are symbolized with either a black, blue, or turquoise border with a black, blue, or turquoise stipple (evenly distributed dot pattern) interior.

National and state maps each include an overlay of the following community designations:

- Engaged QIO communities, designated as 'QIO Communities' with associated ZIP Codes entered into the QIO's C.3 Monthly Community/Provider Log. These communities are symbolized with a black border and a black stipple (evenly distributed dot pattern) interior. The border is based on contiguous ZIP Codes. If a community has noncontiguous ZIP Codes, it may appear as multiple communities on the map. In addition, some ZIP Codes that appear to be contiguous do not actually touch (e.g., a river is between them). If a community has this phenomenon, it may look like more than one community on the map.
- CCTP Partners, as reported by CMS, with associated ZIP Codes entered into the QIO's C.3 Monthly Community/Provider Log. These communities are symbolized with a royal blue border and a royal blue stipple (evenly distributed dot pattern) interior.
- CCTP Partners, as reported by CMS, without associated ZIP Codes entered into the QIO's C.3 Monthly Community/Provider Log. These communities are symbolized with a royal blue circular border and royal blue stipple (evenly distributed dot pattern) interior. The circles surround arbitrary community epicenters.
- Formal CT Program (Non-CCTP), as reported by CMS, with associated ZIP Codes entered into the QIO's C.3 Monthly Community/Provider Log. These communities are symbolized with a turquoise border and a turquoise stipple (evenly distributed dot pattern) interior.
- ADRC Option D Communities. These communities are symbolized with a fuchsia border and a fuchsia stipple (evenly distributed dot pattern) interior. ADRC communities are defined by counties rather than ZIP Codes. These communities are included for those who might wish to work collaboratively to improve care transitions. These communities are only represented on the National maps.

The Statewide Coalition section of the Quarterly Scorecard includes maps for both the 'A' and 'B' designations, where applicable. If the ZIP Codes for the 'A' and 'B' designations are identical, only Coalition 'A' is displayed. The Statewide Coalition 'A' designation consists of communities recruited by 7/31/12 that were not accepted into a formal CT program by 7/31/12. The Statewide Coalition 'B' designation consists of communities recruited by 7/31/12 that were not accepted into a formal CT program by 7/31/12 or any time thereafter. Maps in the Community section of the Quarterly Scorecard are only displayed for new or modified communities with associated ZIP Codes in the QIO's C.3 Monthly Community/Provider Log.

The National and State sections also contain a map visually depicting the percent of hospitalizations that are out of state for calendar year 2011 data at the ZIP Code level. The ZIP Codes are sorted into deciles, with each decile representing approximately 1/10 of the ZIP Codes in the nation. Legend values are based solely on ZIP Codes that contain area; therefore, point ZIP Codes are not represented in these maps. Percentages for ZIP Codes with 10 or fewer hospitalizations are not displayed on any of the maps due to confidentiality restraints. These areas do not have any shading, but are symbolized using a black hatch pattern on a white background. The state map is a zoomed-in view from the national map, providing a higher level of detail due to the larger scale. Acute Care and Critical Access Hospitals appear on the state map to help the viewer better understand out-of-state hospitalization patterns.

Glossary

Admissions per 1,000 Benes: Number of hospitalizations among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort per 1,000 eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Admissions (Percent): Number of hospitalizations among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort, within the designated group (hospital or ZIP Code), divided by the total number of hospitalizations among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort, multiplied by 100.

Admissions (Number): Number of hospitalizations among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Beneficiaries (Eligible): Number of Medicare FFS beneficiaries at risk for hospitalization who reside in the ZIP Codes associated with the designated cohort.

Beneficiaries (Percent): Number of Medicare FFS beneficiaries at risk for hospitalization who reside in the specified ZIP Code divided by the total number of Medicare FFS beneficiaries at risk for hospitalization who reside in any ZIP Code associated with the designated community, multiplied by 100.

Coalition A: A cohort designation for the statewide coalition consisting of ZIP Codes associated with communities recruited as of 7/31/12 including those accepted into a formal Care Transitions Program after July 31, 2012.

Coalition B: A cohort designation for the statewide coalition consisting of ZIP Codes associated with communities recruited as of 7/31/12 **excluding** those accepted into a formal Care Transitions Program after July 31, 2012.

Description: Description of the Clinical Classification Software (CCS) diagnosis category.

Discharges: Discharges among eligible Medicare FFS beneficiaries at risk for hospitalization who reside in the ZIP Codes associated with the designated cohort.

Emergency Department (ED) Visits: The number of emergency department visits among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

End Date: End date for the time period of interest.

Hospital Name: The hospital name associated with the hospital ID as indicated in the HLTH_SERV_PROVIDER table in Complex 1.

IC-5a: Readmissions per 1,000 beneficiaries metric based on ZIP Codes associated with communities in the statewide coalition (recruited as of 7/31/12) **including** those accepted into a formal Care Transitions Program after July 31, 2012.

IC-5b: Readmissions per 1,000 beneficiaries metric based on ZIP Codes associated with communities in the statewide coalition (recruited as of 7/31/12) **excluding** those accepted into a formal Care Transitions Program after July 31, 2012.

IC-6a: Admissions per 1,000 beneficiaries metric based on ZIP Codes associated with communities in the statewide coalition (recruited as of 7/31/12) **including** those accepted into a formal Care Transitions Program after July 31, 2012.

IC-6b: Admissions per 1,000 beneficiaries metric based on ZIP Codes associated with communities in the statewide coalition (recruited as of 7/31/12) **excluding** those accepted into a formal Care Transitions Program after July 31, 2012.

ID: The identification number of the hospital as listed in the QIO's C.3 Monthly Community/Provider Log. 'Other' indicates aggregate metrics for hospitals not listed in the C.3 Monthly Community/Provider Log.

Observations (Obs) stays: The number of observation stays among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Observed: The total number of admissions or readmissions per 1,000 beneficiaries.

Point ZIPs: ZIP Codes that do not contain area such as post offices or military bases.

Readmissions per 1,000 Benes: Number of readmissions within 30 days of hospital discharge among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort per 1,000 eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Readmissions (Number): Number of readmissions within 30 days of a hospital discharge among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Readmissions (Percent): Number of readmissions within 30 days of a hospital discharge among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort, within the designated group (hospital or ZIP Code), divided by the total number of readmissions among eligible Medicare FFS beneficiaries residing in the ZIP Codes associated with the designated cohort, multiplied by 100.

Seasonally Adjusted: The number of admissions and readmissions per 1,000 beneficiaries after adjusting for seasonal effects.

Start Date: Start date for the time period of interest.

Stays: Number of observation stays among eligible FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

Visits: Number of Emergency Department visits among eligible FFS beneficiaries residing in the ZIP Codes associated with the designated cohort.

ZIP Code: The US Post Office ZIP (Zone Improvement Plan) Code of the postal region of interest.

Appendix 2: Maryland

Table 2.22: Annual Post-Acute Care Setting Readmission Rates

Skilled Nursing Facility (SNF)

		Discharges			30 Day Readmissions			Rates	
Start Date	End Date	Total (A)	To SNF (B)	% To SNF (C=B/A)	Total (D)	From SNF (E)	% From SNF (F=E/D)	% of All Discharges Readmitted (G=D/A)	% of Discharges to SNF Readmitted (H=E/B)
01/01/2009	12/31/2009	248,139	47,339	19.08%	55,735	12,865	23.08%	22.46%	27.18%
04/01/2009	03/31/2010	245,786	47,050	19.14%	54,621	12,606	23.08%	22.22%	26.79%
07/01/2009	06/30/2010	245,014	46,824	19.11%	54,003	12,337	22.85%	22.04%	26.35%
10/01/2009	09/30/2010	243,670	46,552	19.10%	53,434	12,177	22.79%	21.93%	26.16%
01/01/2010	12/31/2010	242,691	46,748	19.26%	52,932	11,905	22.49%	21.81%	25.47%
04/01/2010	03/31/2011	243,270	47,355	19.47%	52,871	12,012	22.72%	21.73%	25.37%
07/01/2010	06/30/2011	240,853	47,106	19.56%	52,040	11,781	22.64%	21.61%	25.01%
10/01/2010	09/30/2011	239,193	46,597	19.48%	51,221	11,533	22.52%	21.41%	24.75%
01/01/2011	12/31/2011	238,538	46,375	19.44%	50,923	11,490	22.56%	21.35%	24.78%
04/01/2011	03/31/2012	235,989	45,238	19.17%	49,745	11,029	22.17%	21.08%	24.38%
07/01/2011	06/30/2012	233,984	44,639	19.08%	49,048	10,737	21.89%	20.96%	24.05%
10/01/2011	09/30/2012	232,214	44,195	19.03%	48,330	10,487	21.70%	20.81%	23.73%
01/01/2012	12/31/2012	229,241	43,306	18.89%	46,917	10,038	21.40%	20.47%	23.18%

Figure 2.7: Annual Post-Acute Care Setting Readmissions

Appendix 3: Maryland Statewide Coalition

Table 3.24: Annual Post-Acute Care Setting Readmission Rates

Skilled Nursing Facility (SNF)

		Discharges			30 Day Readmissions			Rates	
Start Date	End Date	Total (A)	To SNF (B)	% To SNF (C=B/A)	Total (D)	From SNF (E)	% From SNF (F=E/D)	% of All Discharges Readmitted (G=D/A)	% of Discharges to SNF Readmitted (H=E/B)
01/01/2009	12/31/2009	96,479	17,535	18.17%	23,286	5,237	22.49%	24.14%	29.87%
04/01/2009	03/31/2010	96,191	17,327	18.01%	23,006	5,093	22.14%	23.92%	29.39%
07/01/2009	06/30/2010	95,984	17,265	17.99%	22,630	4,958	21.91%	23.58%	28.72%
10/01/2009	09/30/2010	96,007	17,398	18.12%	22,605	4,983	22.04%	23.55%	28.64%
01/01/2010	12/31/2010	95,296	17,532	18.40%	22,271	4,834	21.71%	23.37%	27.57%
04/01/2010	03/31/2011	95,957	17,907	18.66%	22,300	4,876	21.87%	23.24%	27.23%
07/01/2010	06/30/2011	95,221	17,724	18.61%	22,071	4,775	21.63%	23.18%	26.94%
10/01/2010	09/30/2011	94,449	17,434	18.46%	21,654	4,594	21.22%	22.93%	26.35%
01/01/2011	12/31/2011	94,769	17,262	18.21%	21,795	4,618	21.19%	23.00%	26.75%
04/01/2011	03/31/2012	93,885	16,982	18.09%	21,363	4,487	21.00%	22.75%	26.42%
07/01/2011	06/30/2012	93,232	16,986	18.22%	21,106	4,413	20.91%	22.64%	25.98%
10/01/2011	09/30/2012	92,743	17,155	18.50%	20,831	4,406	21.15%	22.46%	25.68%
01/01/2012	12/31/2012	91,450	17,109	18.71%	20,196	4,258	21.08%	22.08%	24.89%

Figure 3.5: Annual Post-Acute Care Setting Readmissions

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICARE NURSING HOME RESIDENT HOSPITALIZATION RATES MERIT ADDITIONAL MONITORING

Daniel R. Levinson
Inspector General

November 2013
OEI-06-11-00040

EXECUTIVE SUMMARY: MEDICARE NURSING HOME RESIDENT HOSPITALIZATION RATES MERIT ADDITIONAL MONITORING
OEI-06-11-00040

WHY WE DID THIS STUDY

Nursing homes hospitalize residents when physicians and nursing staff determine that residents require acute-level care. Such transfers to hospitals provide residents with access to needed acute-care services. However, hospitalizations are costly to Medicare, and research indicates that transfers between settings increase the risk of residents' experiencing harm and other negative care outcomes. High rates of hospitalizations by individual nursing homes could signal quality problems within those homes.

HOW WE DID THIS STUDY

We used administrative and billing data both for nursing homes and hospitals to identify all Medicare residents in Medicare- or Medicaid-certified nursing homes who experienced hospitalizations—i.e., transfers to hospitals for inpatient stays—in fiscal year (FY) 2011. We included all Medicare nursing home residents—those in Medicare-paid skilled nursing and rehabilitative (referred to as "SNF") stays and those in nursing home stays not paid for by Medicare, which include long-term care (LTC) stays)—in our analysis. We calculated the percentage of Medicare nursing home residents that each nursing home hospitalized. We identified the diagnoses associated with these hospitalizations, calculated Medicare reimbursements for the hospital stays, and calculated the rates and costs of hospitalizations of nursing home residents. We also examined the extent to which annual rates of resident hospitalizations varied among individual nursing homes.

WHAT WE FOUND

In FY 2011, nursing homes transferred one quarter of their Medicare residents to hospitals for inpatient admissions, and Medicare spent $14.3 billion on these hospitalizations. Nursing home residents went to hospitals for a wide range of conditions, with septicemia the most common. Annual rates of Medicare resident hospitalizations varied widely across nursing homes. Nursing homes with the following characteristics had the highest annual rates of resident hospitalizations: homes located in Arkansas, Louisiana, Mississippi, or Oklahoma and homes with one, two, or three stars in the Centers for Medicare & Medicaid Services' (CMS) Five-Star Quality Rating System.

WHAT WE RECOMMEND

In its comments on the draft report, CMS concurred with both of our recommendations to: (1) develop a quality measure that describes nursing home resident hospitalization rates and (2) instruct State survey agencies to review the proposed quality measure as part of the survey and certification process.

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OBJECTIVES

1. To determine the percentage of Medicare nursing home residents hospitalized in fiscal year (FY) 2011 and the associated costs to Medicare.
2. To identify the medical conditions most commonly associated with these hospitalizations.
3. To determine the extent to which these hospitalization rates varied across nursing homes.
4. To determine the extent to which these hospitalization rates varied according to select nursing home characteristics.

BACKGROUND

Nursing homes send residents to hospitals when physicians or nursing staff determine that residents require acute-level care. These transfers to hospitals provide residents with access to needed acute-care services.[1]

However, research indicates that transfers between health care facilities increase the risk of residents' experiencing harm and other negative care outcomes and that these hospitalizations are costly to Medicare.[2] The harm that residents experience during hospitalizations can include disruption of their care plans, disorientation, stress, and iatrogenic illness (e.g., adverse events).[3,4,5] The Centers for Medicare & Medicaid Services (CMS), in its *2012 Nursing Home Action Plan*, suggests that negative outcomes associated with hospitalizations are further complicated because health care providers often do not communicate critical information when transferring the residents.[6] Financial costs associated with hospitalizations of nursing home residents include, but are not limited to, Medicare

[1] D. Saliba, "Appropriateness of the Decision to Transfer Nursing Facility Residents to the Hospital," *Journal of the American Geriatrics Society*, 48, 2, 2000, p. 155.

[2] Assistant Secretary for Planning and Evaluation (ASPE), *Hospitalizations of Nursing Home Residents: Background and Options*, June 2011, p. 1.

[3] D. Saliba, op. cit., pp. 154–155.

[4] J.G. Ouslander, "Reducing Potentially Avoidable Hospitalizations of Nursing Home Residents: Results of a Pilot Quality Improvement Project," *Journal of the American Medical Directors Association*, 2009, p. 645.

[5] E. Hutt, "Precipitants of Emergency Room Visits and Acute Hospitalization in Short-Stay Medicare Nursing Home Residents," *Journal of the American Geriatrics Society*, 50, 2, 2002, pp. 223–224.

[6] CMS, *2012 Nursing Home Action Plan*, 2012. Accessed at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/2012-Nursing-Home-Action-Plan.pdf on February 5, 2013.

reimbursements for hospital stays, physician services during these stays, and applicable copayments.

Although nursing homes may hospitalize residents primarily for clinical reasons, research indicates that several nonclinical factors can also influence homes' decisions to hospitalize residents. These factors include the availability and training of nursing staff in the home, resident and family member preferences, and physician availability and preferences.[7] Additionally, research suggests that aspects of Medicare payment policies and other economic factors can influence hospitalization rates.[8, 9]

Payment for Hospitalizations. Medicare pays for hospitalizations of nursing home residents primarily by reimbursing acute-care hospitals according to the Inpatient Prospective Payment System (IPPS).[10] Under IPPS, hospitals may submit Medicare claims with codes from the Internal Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM codes) representing resident conditions and procedures for each hospital stay.[11] Payment for most Medicare resident hospitalizations is determined largely by grouping the diagnosis and procedure codes into Diagnosis-Related Groups based on the average cost of care for residents with similar conditions.

Nursing Homes

There are two primary types of care for Medicare beneficiaries in nursing homes: skilled nursing and rehabilitative care (referred to as "SNF")[12] and long-term care (LTC). Over 90 percent of nursing homes can admit residents into either type of care, depending on their clinical needs.[13]

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[7] ASPE, *Hospitalizations of Nursing Home Residents: Background and Options*, June 2011, pp. 6–7.

[8] Ibid., pp. 8–14.

[9] Congressional Research Service (CRS), *Medicare Hospital Readmissions: Issues, Policy Options and PPACA [the Patient Protection and Affordable Care Act]*, September 21, 2010, pp. 11–17.

[10] CMS does not pay all hospitals for resident stays through the IPPS. CMS pays several types of hospitals (e.g., critical access hospitals, inpatient psychiatric hospitals) and most hospitals in Maryland through alternate payment methodologies. CMS, *Pub. No. 100-04 Medicare Claims Processing,* April 2004. Accessed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R156CP.pdf on March 18, 2013.

[11] The ICD-9-CM system assigns diagnoses and procedure codes associated with hospital stays and is maintained jointly by CMS and the National Center for Health Statistics. CMS, *Acute Inpatient PPS Overview*, last modified February 22, 2010. Accessed at http://www.cms.gov/AcuteInpatientPPS/01_overview.asp on March 18, 2013.

[12] In this report, we use the commonly used acronym for skilled nursing facility ("SNF") to describe residents in skilled nursing and rehabilitative stays covered under Medicare Part A (i.e., "SNF residents").

[13] Medicare Payment Advisory Committee (MedPAC), *Report to the Congress: Medicare Payment Policy, Skilled Nursing Facility Services*, March 2013, p. 161.

Federal law requires all nursing homes to provide residents with care that enables them to attain or maintain the highest practicable physical, mental, and psychosocial well-being.[14] (In this report, we refer to all Medicare beneficiaries in nursing homes as "residents" or "nursing home residents.")

SNF Care in Nursing Homes. In 2011, about 20 percent of all hospitalized Medicare beneficiaries went to 1 of the 15,207 nursing homes for SNF care following their hospital stays.[15] Examples of nursing home residents in SNF stays include those recovering from surgical procedures performed in hospitals (e.g., hip or knee replacements) or recovering from acute medical conditions (e.g., septicemia, urinary tract infection, heart failure).[16] In 2009, the Medicare Standard Analytical Files (SAF) categorized over 50 percent of residents in Medicare Part A SNF care as having illnesses of major or extreme severity.[17]

Medicare beneficiaries have access to SNF care benefits through Medicare Part A. Medicare coverage of SNF care is typically limited to 100 days per benefit period.[18] Examples of services provided to SNF residents include the development, management, and evaluation of resident care plans; physical therapy; administration of intravenous feedings; insertion of suprapubic catheters; medication management; and wound care. CMS pays for SNF care when residents have preceding hospital stays of at least 3 days and a medical professional verifies the need for nursing and rehabilitative care related to the hospitalizations.[19] In 2011, Medicare Part A paid $32 billion for SNF stays for Medicare beneficiaries.[20]

LTC in Nursing Homes. Nursing home residents in LTC stays typically need assistance accomplishing two or more activities of daily living (e.g., eating, bathing, dressing, walking). This group includes, but is not limited to, Medicare beneficiaries who are also enrolled in a State Medicaid program (known as dual eligibles).

State Medicaid requirements specify that nursing home residents in LTC stays must have access to several services including basic nursing care,

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[14] Social Security Act § 1819 (b)(2) and §1919 (b)(2).

[15] MedPAC, *Report to the Congress: Medicare Payment Policy, Skilled Nursing Facility Services*, March 2013, p. 161.

[16] Ibid.

[17] Avalere Publishing, *Medicare SAF Data Book*, 2009, p. 27.

[18] CMS, *Medicare Benefit Policy Manual: Duration of Covered Inpatient Services, Chapter 3,* October 1, 2003.

[19] CMS, *Medicare Benefit Policy Manual: Coverage of Extended Care (SNF) Services Under Hospital Insurance*, Chapter 8, April 4, 2012.

[20] MedPAC, *Report to the Congress: Medicare Payment Policy, Skilled Nursing Facility Services*, March 2012, p. 171.

medical-related social services, pharmaceutical services, specialized rehabilitative services, individualized dietary services, emergency dental services, and other quality-of-life services.[21] Medicare Part A does not pay for LTC stays in nursing homes, but Medicare Part B may pay for certain LTC services (e.g., enteral nutrition) for these nursing home residents.[22, 23] Payment for Medicare beneficiaries' nursing home LTC comes from sources other than Medicaid, including personal resources, LTC insurance, or (if beneficiaries are dual eligibles) Medicaid.

Medicare Oversight of Nursing Homes

CMS verifies that Medicare- and Medicaid-certified nursing homes comply with Federal requirements.[24] It enters into agreements with State survey agencies to conduct onsite reviews of each nursing home to certify compliance with Federal requirements.[25] When surveyors identify noncompliance, CMS requires nursing homes to submit plans of correction and to correct the problems. If nursing homes do not correct the problems, CMS may take enforcement actions. These actions include imposing civil monetary penalties, denying payment for new admissions of Medicare residents, or terminating the nursing home from participation in Medicare and Medicaid.[26]

Nursing Home Quality Measures. Nursing homes routinely collect resident assessment data at specific intervals during a nursing home stay, and CMS stores the assessment results in the Minimum Data Set (MDS).[27] CMS converts MDS data into 18 Quality Measures (QM).[28, 29] The QMs

[21] CMS, *Nursing Facilities*. Accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html on January 22, 2013.

[22] CMS. *What is Long-Term Care?,* August 3, 2012. Accessed at http://www.medicare.gov/longtermcare/static/home.asp on May 15, 2013

[23] Office of Inspector General (OIG), *Medicare Part B Services During Non-Part A Nursing Home Stays: Enteral Nutrient Pricing*, January 2010, pp. 2-4.

[24] Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act of 1987; 42 CFR Part 483.

[25] 42 CFR §§ 488.308(a), 488.330(a)(1)(i), and CMS, *Survey and Certification: General Information*, April, 11, 2013. Accessed at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/index.html?redirect=/surveycertificationgeninfo/ on May 15, 2013.

[26] 42 CFR §§ 488.402(d), 488.408, and 488.456.

[27] CMS, *MDS 3.0 for Nursing Homes and Swing Bed Providers.* Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html on March 4, 2013.

[28] CMS, *Nursing Home Quality Initiative: Quality Measures.* Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html on April 16, 2013.

[29] See Appendix A for a complete listing of the 18 QMs.

indicate how well a nursing home provides care to its residents. Examples of QMs include the percentage of residents who report moderate to severe pain, the percentage of residents who were appropriately given the seasonal influenza vaccine, and the percentage of residents who have lost significant amounts of weight.[30] CMS provides QMs to nursing homes for them to use in quality improvement efforts. Currently, the QMs do not include a measure of how often nursing homes hospitalize residents.

Public Reporting of QMs and Other Data Through the Five-Star Quality Rating System. CMS publicly reports nursing home QMs through the Five-Star Quality Rating System. CMS gives each Medicare- and Medicaid-certified nursing home an overall rating between one and five stars. A rating of one star indicates that a nursing home is "much below average" in terms of quality, and a rating of five stars indicates that a nursing home is "much above average."[31]

CMS bases the overall five-star rating on the nursing homes' ratings in three areas: performance on inspection surveys (survey metric), QMs (quality metric), and staffing (staffing metric). CMS calculates these three metrics as follows:

- The survey metric is based on points assigned to the results of nursing home surveys, complaint surveys, and survey revisits conducted within the last 3 years.
- The quality metric is based on nursing homes' performance on 10 QMs. Seven of the QMs relate to LTC residents (e.g., mobility decline, use of physical restraints), and the three remaining QMs relate to SNF residents (e.g., delirium, level of pain).
- The staffing metric is based on registered nurse (RN) hours per resident day and total staffing hours (hours by RNs, licensed practical nurses, and nurse aides).

Efforts To Monitor and Reduce Rates of Hospitalization and Other Types of Transfers

Rates of hospitalizations and other types of resident transfers have received increased attention from government agencies and key stakeholders because of the resident risk and high associated cost.

[30] RTI [Research Triangle Institute] International, *MDS 3.0 Quality Measures User's Manual*. Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V60.pdf on February 19, 2013.

[31] CMS, *Consumer Fact Sheet*, December 2008. Accessed at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/consumerfactsheet.pdf on October 4, 2013.

Congress, through the Affordable Care Act, established several initiatives designed to reduce hospital resident readmissions.[32, 33] CMS publicly reports hospital readmission rates, has requested that Quality Improvement Organizations examine resident transfers, and is developing nursing home surveyor guidance related to the evaluation of hospitalizations of nursing home residents.[34, 35, 36] The National Quality Forum (NQF) adopted measures of hospital performance based on hospital resident readmission rates.[37] MedPAC made recommendations to CMS to limit payment policies that incentivize unnecessary hospitalizations of nursing home residents.[38] Researchers have suggested changes to Medicare payment policies that can reduce hospitalization rates for the benefit of both the program and beneficiaries.[39, 40] The provider community has also focused attention on developing best practices to reduce hospitalizations of nursing home residents.[41]

METHODOLOGY

To determine the percentage of Medicare residents transferred to hospitals for acute inpatient stays in FY 2011, we collected nursing home resident assessment data from the MDS, beneficiary information from the Enrollment Database (EDB), and hospital claims data from the National Claims History (NCH). We combined these data sources to identify all transfers of Medicare nursing home residents to hospitals for inpatient stays. For this report, we defined a Medicare nursing home resident as any Medicare beneficiary who stayed in a Medicare- or Medicaid-certified

[32] Patient Protection and Affordable Care Act of 2010, P.L. 111-148 § 3025.

[33] CMS, *Community-Based Care Transitions Program Fact Sheet.* Accessed at http://innovations.cms.gov/Files/fact-sheet/Community-based-Care-Transitions-Program-Fact-Sheet-.pdf on February 5, 2013.

[34] CMS, *Hospital Quality Initiatives: Outcome Measures.* Accessed at https://www.cms.gov/HospitalQualityInits/20_OutcomeMeasures.asp on January 12, 2012.

[35] CMS, *Medicare Quality Improvement Organization 9th Scope of Work*, p. 69. Accessed at http://www.cms.gov/QualityImprovementOrgs/Downloads/9thSOWBaseContract_C_08-01-2008_2_.pdf on September 13, 2011.

[36] CMS, *2012 Nursing Home Action Plan*, 2012, pp. 25–26 and 37–39.

[37] NQF, *Candidate Hospital Care Additional Priorities: 2007 Performance Measure.* Washington, DC, 2007.

[38] MedPAC, *Report to the Congress: Reforming the Delivery System*, June 2008, p. 87.

[39] ASPE, *Hospitalizations of Nursing Home Residents: Background and Options*, June 2011, pp. 15–23.

[40] CRS, *Medicare Hospital Readmissions: Issues, Policy Options and PPACA*, September 21, 2010, pp. 18–36.

[41] National Transitions of Care Coalition, 2011. Accessed at http://www.ntocc.org/ on September 13, 2011.

nursing home for at least 1 day in FY 2011. We defined a hospitalization as an instance when a Medicare nursing home resident went to a hospital for a Medicare-reimbursed inpatient stay within 1 day of discharge from a nursing home.

Identifying Hospitalizations of Medicare Nursing Home Residents

We identified hospitalizations of Medicare nursing home residents using data from the MDS, the EDB, and the NCH. To identify all Medicare beneficiaries who were nursing home residents in FY 2011, we used the MDS and the EDB. The MDS contains resident Social Security Numbers (SSN), admission and discharge dates, and the related nursing home identification numbers. We matched SSNs in the MDS to those in the EDB to identify Medicare beneficiaries and their associated Medicare Health Insurance Claim Numbers. We excluded from this analysis the small number of beneficiaries in the MDS who had SSNs that did not match their SSNs as listed in the EDB. We used the Medicare Part A claims data in the NCH to determine whether nursing home residents entered hospitals following their nursing home stays and to determine whether the nursing home stays were reimbursed through Medicare Part A.[42]

The resulting data set enabled us to determine when beneficiaries were admitted to nursing homes, whether they were discharged from nursing homes, and whether they were hospitalized following discharge from nursing homes.

Analysis

Using the data set described above, we determined the percentage of Medicare nursing home residents hospitalized in FY 2011, the Medicare costs associated with hospitalizations of nursing home residents, the medical conditions associated with the hospitalizations, each nursing home's rate of resident hospitalization (which we refer to as the "annual hospitalization rate"), and the extent to which annual hospitalization rates varied according to select characteristics. For analysis, we combined all Medicare nursing home residents—those in Medicare-paid SNF stays and

[42] We excluded nursing home stays that occurred in "swing bed" units within hospitals from our analysis. (A swing-bed unit is a hospital unit in which residents receive skilled nursing services.) We excluded these stays because the associated facilities differ substantially from the freestanding nursing homes that are the focus of this report. Excluding these stays removed 111,298 stays and 1,149 hospital swing-bed facilities from our analysis. CMS, *Swing Bed Services,* January 2013. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SwingBedFactsheet.pdf on March 18, 2013.

those in nursing home stays not paid by Medicare—and refer to them as "Medicare nursing home residents" or "nursing home residents."

Calculating the Percentage of Hospitalized Nursing Home Residents. To calculate the percentage of nursing home residents hospitalized, we divided the total number of Medicare nursing home residents hospitalized at least once in FY 2011 by the total number of residents who had nursing home stays of at least 1 day in FY 2011.

Calculating the Medicare Costs Associated With Resident Hospitalizations. We calculated the amount Medicare spent on hospitalizations of nursing home residents by summing the Medicare reimbursements for each hospital stay that we identified as a hospitalization of a Medicare nursing home resident. These costs represent only the amounts that Medicare paid hospitals for the residents' acute-care hospital stays. Our analysis included payments made to IPPS and non-IPPS hospitals. When hospitalized residents were transferred from their initial hospitals to other hospitals, we combined the reimbursements paid by Medicare to each hospital.[43]

We calculated the amount Medicare spent on all hospitalizations of Medicare beneficiaries by summing Part A reimbursements for all hospital stays with admission dates in FY 2011.

Identification of Medical Conditions Associated With Hospitalization. To identify the medical conditions associated with hospitalizations of nursing home residents, we reviewed the primary ICD-9-CM diagnosis codes on the Medicare claims submitted for the hospital stays. To categorize the diagnosis codes, we used the clinical classification system (CCS) of the Agency for Healthcare Research and Quality's (AHRQ) Healthcare Cost and Utilization Project (HCUP). The CCS enables researchers to collapse ICD-9-CM codes into clinically meaningful categories for analysis and comparison between studies.[44]

Calculating Annual Hospitalization Rates for Nursing Homes. To calculate the annual hospitalization rate for each nursing home in FY 2011, we divided the number of nursing home stays that ended in hospitalization in a given home by the total number of nursing home stays

[43] Under CMS's transfer policy, CMS reduces reimbursements for hospitalizations under several scenarios, including instances when residents are transferred to other hospitals covered by the IPPS. CMS, *Acute Care Hospital Inpatient Prospective Payment System,* February 2012. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctsht.pdf on March 18, 2013.

[44] See Appendix B for a detailed description of the methodology we used to describe the ICD-9-CM codes on the hospital claims using the HCUP CCS.

of at least 1 day in the home. We calculated annual hospitalization rates only for homes that provided care to 30 or more Medicare residents in FY 2011.

Analysis of Characteristics Associated With Variation in Annual Hospitalization Rates. To determine whether annual hospitalization rates varied according to select nursing characteristics, we divided homes into subgroups based on characteristics and then calculated average annual hospitalization rates for the subgroups. To determine how much annual hospitalization rates varied by geographic location, we divided homes into groups by the State code in their billing addresses and then calculated the average annual hospitalization rate for nursing homes in each State and the District of Columbia. To determine how much annual hospitalization rates varied by scores on the four CMS Five-Star Quality Rating System metrics, we divided nursing homes into two groups—one group consisting of those with one, two, or three stars and the other consisting of those with four or five stars—for each metric and calculated the rates for each group. To determine how much annual hospitalization rates varied by nursing home size, we divided nursing homes into three categories based on the number of beds within each home and then calculated the rate for each group. To determine how much annual hospitalization rates varied by ownership type, we divided nursing homes into three groups based on ownership type and then calculated the rate for each group.

We collected information on nursing homes' locations, bed counts, and ownership categories from CMS's Certification and Survey Provider Enhanced Reports (CASPER) database. CMS provided five-star ratings data applicable to our observation period.

Limitations. The annual hospitalization rates are not adjusted to account for "case mix"—in this instance, the physical and mental health of residents in a given nursing home—or other factors. Additionally, the cost figures associated with the hospitalizations of nursing home residents do not include copayments for the hospital stays, physician reimbursements for the hospital stays, or payments made by the Medicare program or other payers for post-hospitalization services (e.g., followup physician office visits). Therefore, we likely underestimate the costs associated with hospitalizations of nursing home residents to the Medicare program and beneficiaries.

Standards

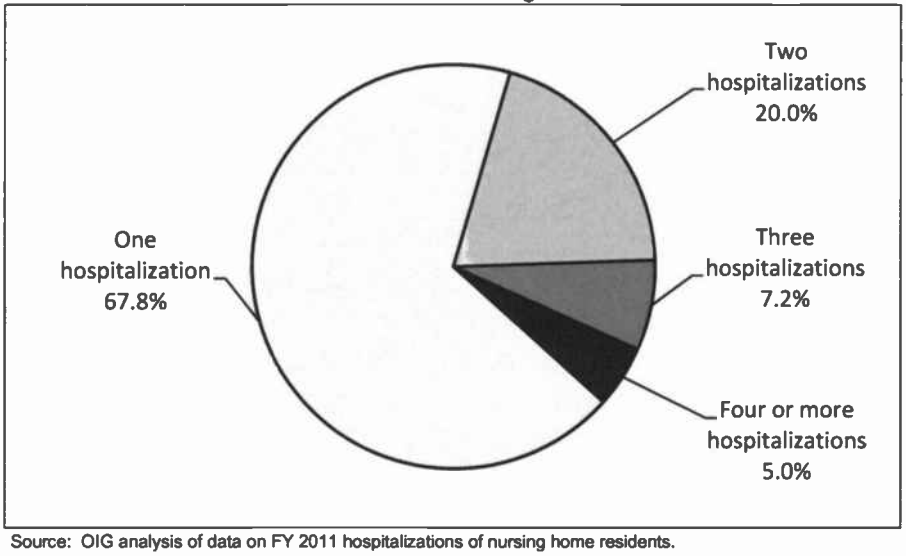
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

One-quarter of Medicare nursing home residents experienced hospitalizations in FY 2011, and Medicare spent $14.3 billion on these hospitalizations

Of the 3.3 million Medicare residents who stayed in nursing homes for at least 1 day in FY 2011, 825,765 (24.8 percent) experienced hospitalizations. The majority of hospitalized residents (67.8 percent) transferred from nursing homes to hospitals only once. Twenty percent transferred two times, 7.2 percent transferred three times, and the remaining 5 percent transferred four or more times (see Figure 1).

Figure 1: Number of Hospitalizations Experienced by Hospitalized Medicare Residents Who Resided in Nursing Homes in FY 2011



Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Medicare spent $14.3 billion in FY 2011 on hospital stays for nursing home residents, spending 33 percent more per stay than for the average Medicare hospitalization

Medicare spent $14.3 billion on 1.3 million hospital stays associated with hospitalizations of nursing home residents. These costs represent 11.4 percent of Medicare Part A spending on all hospital admissions ($126 billion) in the same year.[45] Medicare spent an average of $11,255 on each hospitalization of a nursing home resident, which was 33.2 percent above the average cost ($8,447) of hospitalizations for all Medicare residents.

[45] Cost estimates presented in this report are based only on reimbursements paid by Medicare Part A for the initial hospitalizations. They do not include any other costs paid by Medicare or by other payers for further medical care—such as physician office visits or additional nursing home stays—needed as a result of the hospitalizations.

Nursing home residents went to hospitals most commonly for septicemia, pneumonia, and congestive heart failure

Medicare nursing home residents went to hospitals for a wide range of conditions—236 of the possible 285 primary diagnosis categories described in the HCUP CCS. The primary diagnosis describes the most significant medical condition found during an inpatient admission.[46] The 15 most frequent CCS diagnosis categories accounted for 60.9 percent of all resident hospitalizations (see Table 1).

Table 1: Primary Diagnoses on Claims of All Hospitalized Medicare Nursing Home Residents in FY 2011

CCS Primary Diagnosis Category	Percentage of Hospitalizations
Fifteen Most Frequent CCS Categories	**60.9%**
Septicemia	13.4%
Pneumonia	7.0%
Congestive heart failure, nonhypertensive	5.8%
Urinary tract infections	5.3%
Aspiration pneumonitis, food/vomitus	4.0%
Acute renal failure	3.9%
Complication of device, implant, or graft	3.3%
Respiratory failure, insufficiency, or arrest	2.7%
Gastrointestinal hemorrhage	2.4%
Complications of surgical procedures or medical care	2.4%
Chronic obstructive pulmonary disease (COPD) and bronchiectasis	2.4%
Delirium, dementia, and amnestic and other cognitive disorders	2.2%
Acute cerebrovascular disease	2.1%
Fluid and electrolyte disorders	2.0%
Fracture of neck of femur (hip)	2.0%
Remaining 221 CCS Categories on Nursing Home Claims	**39.1%**
All CCS Diagnosis Categories on Nursing Home Claims	**100%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Hospitalizations for septicemia accounted for 21 percent of Medicare spending on nursing home resident hospitalizations

Septicemia led to the most hospitalizations among all CCS categories (13.4 percent). Septicemia and sepsis (a related condition) are serious bloodstream infections that can rapidly become life threatening.[47]

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[46] CMS, *Medicare Claims Processing Manual*, Chapter 23, "Fee Schedule Administration and Coding Requirements."

[47] Centers for Disease Control and Prevention (CDC), *Inpatient Care of Septicemia or Sepsis: A Challenge for Patients and Hospitals*, National Center for Health Statistics Data Brief, 2011. In the data brief, CDC found that the rate of nursing home resident hospitalizations for septicemia more than doubled from 2000 to 2008 and that hospitalizations for septicemia ended in death much more often than hospitalizations for all other conditions.

Medicare spent almost $3 billion on nursing home resident hospitalizations associated with septicemia, more than the next three most expensive conditions combined. The high total reimbursement amount for septicemia is the result of both its frequency as a primary diagnosis on hospital claims and its above-average reimbursement rate. Table 2 shows the costs associated with the 15 most costly CCS diagnosis categories.

Table 2: Medicare Costs Associated With Medicare Nursing Home Resident Hospitalizations in FY 2011 by Sum of Reimbursement

CCS Primary Diagnosis Category	Sum of All Hospital Reimbursements	Percentage of All Hospital Reimbursements	Average Reimbursement
Fifteen Most Costly CCS Categories	**$9,268,066,011**	**65.2%**	**$11,554**
Septicemia	$2,963,329,522	20.8%	$17,430
Pneumonia	$844,817,051	5.9%	$9,464
Congestive heart failure, nonhypertensive	$643,386,174	4.5%	$8,731
Respiratory failure, insufficiency, or arrest	$637,201,272	4.5%	$18,438
Complication of device, implant, or graft	$619,241,745	4.3%	$14,629
Aspiration pneumonitis, food/vomitus	$618,310,799	4.3%	$12,223
Complications of surgical procedures or medical care	$449,236,625	3.2%	$14,731
Acute renal failure	$425,965,874	3.0%	$8,679
Urinary tract infections	$422,251,024	3.0%	$6,296
Delirium, dementia, and amnestic and other cognitive disorders	$321,003,626	2.3%	$11,515
Fracture of neck of femur (hip)	$311,417,099	2.2%	$12,578
Acute cerebrovascular disease	$285,667,898	2.0%	$10,847
Gastrointestinal hemorrhage	$264,867,028	1.9%	$8,544
COPD and bronchiectasis	$238,845,320	1.7%	$7,727
Acute myocardial infarction	$222,524,954	1.6%	$11,475
Remaining 221 CCS Categories	**$4,991,830,494**	**34.4%**	**$11,188**
All CCS Diagnosis Categories on Nursing Home Claims	**$14,259,896,509**	**100%**	**$11,211**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Nursing homes' annual rate of resident hospitalization varied according to select characteristics, including geographic location and rating on CMS's Five-Star Quality Rating System

Nursing homes' individual annual hospitalization rates varied widely, ranging from less than 1 percent to 69.7 percent. The annual hospitalization rate averaged 25 percent. Additionally, 1,059 nursing homes (7 percent) had annual hospitalization rates greater than 40 percent. Table 5 shows the distribution of annual hospitalization rates among Medicare- and Medicaid-certified nursing homes.

Table 5: Percentages of Nursing Homes by Annual Hospitalization Rate in FY 2011

Annual Hospitalization Rate	Percentage of Homes
Above 50 percent	0.6%
40 percent to 49.9 percent	6.2%
30 percent to 39.9 percent	22.1%
20 percent to 29.9 percent	39.9%
10 percent to 19.9 percent	26.9%
Less than 9.9 percent	4.3%
All Homes	**100.0%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Nursing homes' annual hospitalization rates varied by the four characteristics that we examined: the nursing home's geographic location, its size, its rating on CMS' Five-Star Quality Rating System, and the category of its ownership.[48]

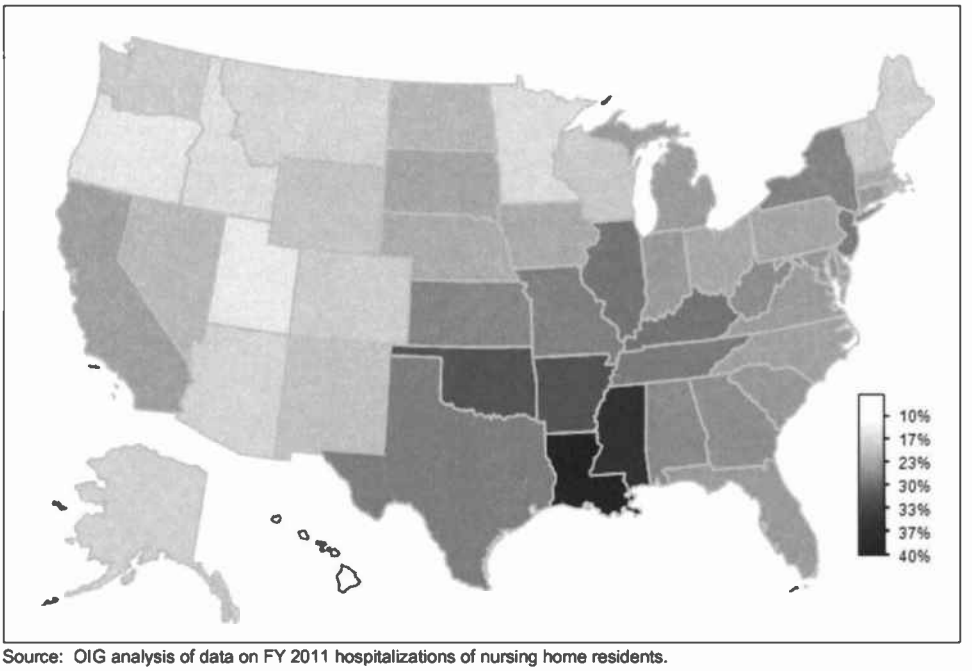
Homes with high annual hospitalization rates were not evenly distributed across the country

Nursing homes in Arkansas, Louisiana, Mississippi, and Oklahoma had the highest annual hospitalization rates when averaged at the State level. The average hospitalization rate for nursing homes in Louisiana (38.3 percent) was 14 percentage points higher than the national average (24.3 percent). Generally, nursing homes in States in the upper Pacific West, Mountain West, upper North Central Midwest, and New England

[48] The extent of identified variations suggests that average annual rates of hospitalization differed by the reviewed characteristics, but we do not try to explain these variations. Other factors—such as State bed hold policies—have been shown to influence hospitalization rates. D.C. Grabowski, "Medicaid bed-hold policy and Medicare skilled nursing facility rehospitalizations," *Health Services Research*, 45, 6, 2010, pp. 1963–1980.

regions had the lowest average annual hospitalization rates (see Figure 2).[49]

Figure 2: Geographic Distribution of Average Annual Hospitalization Rate in FY 2011



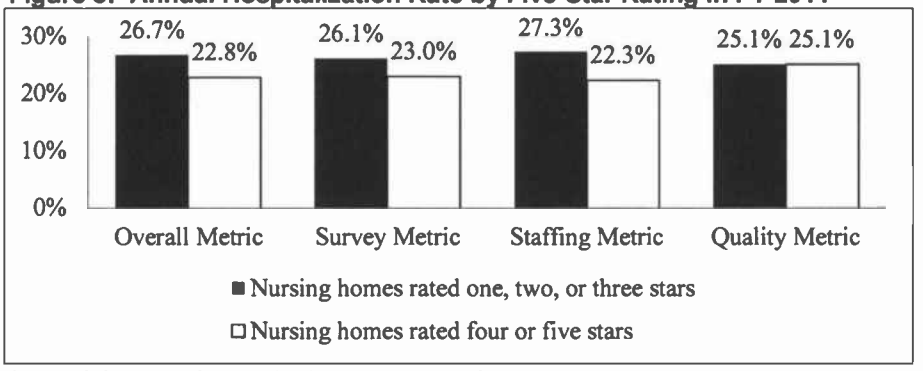
Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

In general, nursing homes rated one, two, or three stars on the Nursing Home Compare Five-Star Quality Rating System had higher annual hospitalization rates than those rated as four or five stars

Nursing homes rated one, two, or three stars (the lowest five-star ratings) on three of the four metrics (the overall, survey, and staffing metrics) had higher annual hospitalization rates than those rated four or five stars (the highest five-star ratings). The biggest difference between annual hospitalization rates appears in the staffing metric, where nursing homes rated one, two, or three stars had hospitalization rates that were 5 percentage points higher than that of those rated four or five stars. The exception is the quality metric, where nursing homes rated one, two, or three stars had the same hospitalization rate as those rated four or five stars (see Figure 3).

[49] Appendix C lists the average annual hospitalization rates for nursing homes in all States. Regions are defined by the Census Bureau.

Figure 3: Annual Hospitalization Rate by Five-Star Rating in FY 2011



Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.

Large and medium-sized nursing homes had higher annual hospitalization rates than small nursing homes

Small nursing homes had annual hospitalization rates 2.4 percentage points lower than the national average. Large and medium-sized nursing homes had annual hospitalization rates 1.6 and 0.9 percentage points higher than the national average, respectively (see Table 6).

Table 6: Annual Hospitalization Rate by Nursing Home Size in FY 2011

Size of Home	Number of Homes	Average Annual Hospitalization Rate	Percentage Point Difference From National Rate
Nationwide	15,497*	25.0%	n/a
• Large nursing homes (more than 120 beds)	4,749	26.6%	**1.6%**
• Medium-sized nursing homes (80–120 beds)	5,539	25.9%	**0.9%**
• Small nursing homes (fewer than 80 beds)	5,209	22.6%	**-2.4%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.
*CASPER did not contain bed count information for one home.

As a group, for-profit nursing homes had the highest annual hospitalization rate compared to the rate for government-owned and nonprofit nursing homes

As shown in Table 7, for-profit homes had an annual hospitalization rate 1.5 percentage points higher than the national average. Government-owned and nonprofit homes had annual hospitalization rates about 1.5 and 3.8 percentage points lower than the national average, respectively.

Table 7: Average Annual Hospitalization Rate by Ownership Category in FY 2011

Ownership Category	Number of Homes	Percentage of Medicare Population Served Annually	Average Annual Hospitalization Rate	Percentage Point Difference From National Rate
Nationwide	15,497*	109.0%**	25.0%	n/a
• For-profit nursing homes	10,761	76.4%	26.5%	**1.5%**
• Government-owned public nursing homes	850	4.8%	23.5%	**-1.5%**
• Nonprofit nursing homes	3,886	27.8%	21.2%	**-3.8%**

Source: OIG analysis of data on FY 2011 hospitalizations of nursing home residents.
*CASPER did not contain ownership information for one home.
**Percentage exceeds 100 percent because some residents received care in multiple nursing homes.

CONCLUSION AND RECOMMENDATIONS

We found that nursing homes hospitalized one-quarter of nursing home residents in FY 2011, that these hospitalizations cost Medicare $14.3 billion, and that a small number of medical conditions (e.g., septicemia) accounted for the majority of hospitalizations and costs. We also identified wide variation in rates of hospitalization among individual nursing homes. Among 1,059 nursing homes, more than 40 percent of stays ended in hospitalization. Nursing homes in certain States (Arkansas, Louisiana, Mississippi, and Oklahoma) and nursing homes rated as one, two, or three stars on CMS's Five-Star Quality Rating System had the highest average annual hospitalization rates.

Hospitalizations of nursing home residents are necessary when physicians and nursing staff determine that residents require acute-level care. However, the higher-than-average resident hospitalization rates of some nursing homes in FY 2011 suggest that some hospitalizations could have been avoided through better nursing home care.

We recommend that CMS:

Develop a QM That Describes Nursing Home Rates of Resident Hospitalization

CMS should develop a QM of nursing home rates of resident hospitalization and consider publicly reporting this measure on the Nursing Home Compare Web site. One possible QM could be a measure of each home's overall hospitalization rate. Alternatively, CMS could develop more discrete measures that would identify nursing homes that hospitalize residents more frequently than other homes for certain conditions. Adding a measure of hospitalization rates to the existing QMs not only would enable nursing homes and the public to compare these rates across nursing homes, but also would provide greater incentive for nursing homes to reduce avoidable hospitalizations.

Instruct State Agency Surveyors To Review Nursing Home Rates of Resident Hospitalization as Part of the Survey and Certification Process

After developing the QM recommended above, CMS should instruct State survey agencies to use the QM in preparing to survey homes and provide the agencies with guidance for interpreting and using the QM. Examining these data could help surveyors identify areas of concern—such as infection control practices in homes with high rates of hospitalizations for septicemia—within individual nursing homes.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with both of our recommendations.

CMS concurred with the recommendation to develop a QM that describes nursing home rates of resident hospitalization. CMS stated that it is taking steps to develop and implement a nursing home hospitalization QM in accordance with the rulemaking process. Further, CMS indicated that it is developing a skilled nursing facility readmission measure, which it intends to submit to the National Quality Forum for endorsement in late 2013.

CMS also concurred with the recommendation to instruct State survey agency surveyors to review rates of hospitalization for nursing home residents as part of the survey and certification process. CMS indicated that surveyors should consider measures of hospitalization during their nursing home reviews. CMS stated that reducing hospitalizations is a major public health goal and that hospitalization measures can be used to assess the quality of care that nursing home residents receive.

For the full text of the CMS's comments, see Appendix D. We made minor changes to the report based on technical comments.

APPENDIX A

Nursing Home Quality Measures

Nursing homes routinely collect resident assessment data at specific intervals during a nursing home stay, and CMS stores the assessment results in the MDS. CMS converts MDS data into the 18 QMs described in Table A-1.[50]

Table A-1: Nursing Home Quality Measures

Short Stay Quality Measures
1. Percent of Residents Who Self-Report Moderate to Severe Pain
2. Percent of Residents With Pressure Ulcers That Are New or Worsened
3. Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine
4. Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine
5. Percent of Short-Stay Residents Who Newly Received Antipsychotic Medications
Long-Stay Quality Measures
6. Percent of Residents Experiencing One or More Falls With Major Injury
7. Percent of Residents Who Self-Report Moderate to Severe Pain
8. Percent of High-Risk Residents With Pressure Ulcers
9. Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine
10. Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine
11. Percent of Residents With Urinary Tract Infections
12. Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder
13. Percent of Residents Who Have/Had Catheters Inserted and Left in Their Bladders
14. Percent of Residents Who Were Physically Restrained
15. Percent of Residents Whose Need for Help With Activities of Daily Living Has Increased
16. Percent of Residents Who Lose Too Much Weight
17. Percent of Residents Who Have Depressive Symptoms
18. Percent of Long-Stay Residents Who Received Antipsychotic Medications

Source: CMS, *MDS 3.0 QM User's Manual V8.0.*

[50] CMS, *Nursing Home Quality Initiative: Quality Measures.* Accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html on April 16, 2013.

APPENDIX B

Detailed Methodology for Categorizing the Primary Diagnosis Codes on Hospital Claims

To describe the ICD-9-CM codes on the hospitalized residents' inpatient claims, we used the CCS established by AHRQ's HCUP.[51] The HCUP CCS enables researchers to identify patterns of diagnosis and procedure codes. Researchers use the CCS to collapse the ICD-9-CM system's 14,000 diagnosis codes and 3,900 procedure codes into a smaller number of clinically meaningful categories for presentation and analysis. AHRQ used the CCS in its 2012 review of data on hospitalizations of nursing home residents.[52]

For this review, we used the CCS "single-level" categorization. The single-level categorization system is designed for ranking diagnoses and procedures. We matched the primary diagnosis codes on the hospital claims associated with the hospitalizations to the appropriate CCS single-level category. See Table B-1 for an example of how the CCS collapses individual ICD-9-CM codes into clinically meaningful groups.

Table B-1: Examples of Single-Level CCS Matching

General Description of Condition	ICD-9-CM Diagnosis Codes Used	CCS Category
Septicemia	0031 0202 0223 0362 0380 0381 03810 03811 03812 03819 0382 0383 03840 03841 03842 03843 03844 03849 0388 0389 0545 449 77181 7907	2
Pneumonia	00322 0203 0204 0205 0212 0221 0310 0391 0521 0551 0730 0830 1124 1140 1144 1145 11505 11515 11595 1304 1363 4800 4801 4802 4803 4808 4809 481 4820 4821 4822 4823 48230 48231 48232 48239 4824 48240 48241 48242 48249 4828 48281 48282 48283 48284 48289 4829 483 4830 4831 4838 4841 4843 4845 4846 4847 4848 485 486 5130 5171	122
Congestive heart failure, nonhypertensive	39891 4280 4281 42820 42821 42822 42823 42830 42831 42832 42833 42840 42841 42842 42843 4289	108

Source: HCUP, *Clinical Classifications Software (CCS) 2013 User Guide.*

[51] A. Elixhauser, C. Steiner, and L. Palmer, *Clinical Classifications Software (CCS)*, AHRQ, 2013. Accessed at http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp on February 5, 2013.

[52] AHRQ, *Transitions between Nursing Homes and Hospitals in the Elderly Population, 2009*, September 2012. Accessed at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb141.pdf on February 5, 2013.

APPENDIX C

Average Annual Rate of Hospitalization of Nursing Home Residents by State

Table C-1 reports the average annual rates of resident hospitalization in FY 2011 for nursing homes in all States. We did not include in this analysis homes with fewer than 30 admissions in FY 2011 or facilities designated as "swing bed" providers.

Table C-1: Average Annual Hospitalization Rates by State in FY 2011

State	Rate	State	Rate	State	Rate
Louisiana	38.3%	Maryland	25.3%	Nevada	20.9%
Mississippi	35.7%	Indiana	24.9%	New Mexico	19.5%
Arkansas	31.7%	Florida	24.9%	Wyoming	19.1%
Oklahoma	31.6%	Michigan	24.8%	New Hampshire	19.0%
Kentucky	29.2%	Virginia	24.8%	Washington	18.6%
Illinois	29.0%	Connecticut	24.7%	Wisconsin	18.3%
Tennessee	28.4%	California	24.2%	Vermont	17.9%
New Jersey	28.2%	North Carolina	24.2%	Colorado	17.8%
Texas	28.2%	Delaware	24.2%	Maine	17.2%
Missouri	27.9%	Pennsylvania	23.4%	Montana	17.0%
Kansas	27.5%	South Dakota	23.4%	Alaska	16.9%
New York	27.4%	Ohio	23.0%	Arizona	16.7%
Alabama	26.9%	Iowa	22.9%	Minnesota	16.0%
West Virginia	26.5%	Nebraska	22.7%	Idaho	15.9%
District Of Columbia	26.5%	Massachusetts	22.5%	Oregon	14.9%
Georgia	26.3%	Rhode Island	21.6%	Utah	14.2%
South Carolina	25.3%	North Dakota	21.4%	Hawaii	10.6%

Source: Office of Inspector General analysis of data on FY 2011 hospitalizations of nursing home residents.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 19 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring (OEI-06-11-00040)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above subject OIG draft report. Nursing home quality measurement and oversight is of critical importance to us, including addressing unnecessary hospital admissions and readmissions. One example, focusing on dual eligible beneficiaries, is the CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. In this initiative, which was launched in 2012, CMS selected organizations to partner with nursing facilities and deploy interventions aimed at reducing avoidable hospitalizations, improving transitions and outcomes, and reducing costs among Medicare-Medicaid enrollees. Lessons learned from this initiative will help inform future policy decisions.[1]

In addition, the Fiscal Year (FY) 2014 President's Budget includes a proposal addressing high rates of hospital readmissions in skilled nursing facilities (SNFs). Currently, there is a Hospital Readmission Reduction program that reduces payments for hospitals with high rates of readmission, many of which could have been avoided with better care. To promote similar high-quality care in SNFs, the President's Budget proposal would reduce payments by up to three percent for SNFs with high rates of care-sensitive, preventable hospital readmissions.

The purpose of this OIG study was to (1) Determine the proportion of Medicare nursing home residents hospitalized in FY 2011 and the associated costs to Medicare; (2) Identify the medical conditions most commonly associated with these hospitalizations; (3) Describe the extent to which these hospitalization rates varied across nursing homes; and (4) Describe the extent to which these hospitalization rates varied according to select nursing home characteristics.

The OIG recommendations and CMS's responses to those recommendations are discussed below.

OIG Recommendation

The OIG recommends that CMS develop a quality measure that describes hospitalization rates for residents of nursing homes.

[1] Additional information on this initiative is available at http://innovation.cms.gov/initiatives/rahnft

CMS Response

The CMS concurs. The rate of nursing home resident hospitalization measure concept was included in CMS's Measures under Consideration (MUC) list that we made public on December 1, 2012, in accordance with the pre-rulemaking process established by section 1890A(a)(2) of the Affordable Care Act. This MUC list was posted for CMS on the website of the National Quality Forum (NQF), and NQF's stakeholder group, the Measure Applications Partnership supported this measure concept for future development. Making this list public is one step in CMS's obligation to establish a pre-rulemaking process prior to adopting certain categories of measures. CMS must include potential measures on the MUC list if it is considering adopting them through rulemaking at any time in the future. Development of this proposed hospitalization outcome measure is commencing later this year and is intended to measure the percent of long-stay residents who are hospitalized during a specific reporting period.

In addition, CMS is developing a Skilled Nursing Facility 30-Day All-Cause Readmission Measure and intends to submit this measure to the NQF for endorsement in late 2013. The specifications for this measure will be designed to harmonize, to the extent possible, with CMS's hospital-wide all-cause unplanned readmission measure endorsed by the NQF for the Hospital Readmission Reduction Program.

OIG Recommendation

The OIG recommends that CMS instruct state agency surveyors to review rates of hospitalization for nursing home residents as part of the survey and certification process.

CMS Response

The CMS concurs. Reducing re-hospitalizations is a major public health goal of CMS and the Department of Health and Human Services, as well as a goal that has been widely embraced by health care providers. As noted above, CMS is actively developing a hospitalization measure for all nursing home residents and a re-hospitalization measure for Medicare SNF residents. We concur that evidence suggests these types of measures are important to assess the quality of care that residents receive. We concur that adding measures of hospitalization and/or re-hospitalization to the list of quality measures that nursing home surveyors review is a logical and useful outcome of CMS's quality measure development efforts.

The CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Kevin K. Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office; Blaine Collins, Deputy Regional Inspector General; and Ruth Ann Dorrill, Deputy Regional Inspector General.

Jeremy Moore served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Dallas regional office who contributed to the report include Maria Balderas, Nathan Dong, and Chetra Yean. Central office staff who provided support include Kevin Farber, Heather Barton, Sandy Khoury, Starr Kidda, and Christine Moritz.

Office of Inspector General

http://oig.hhs.gov

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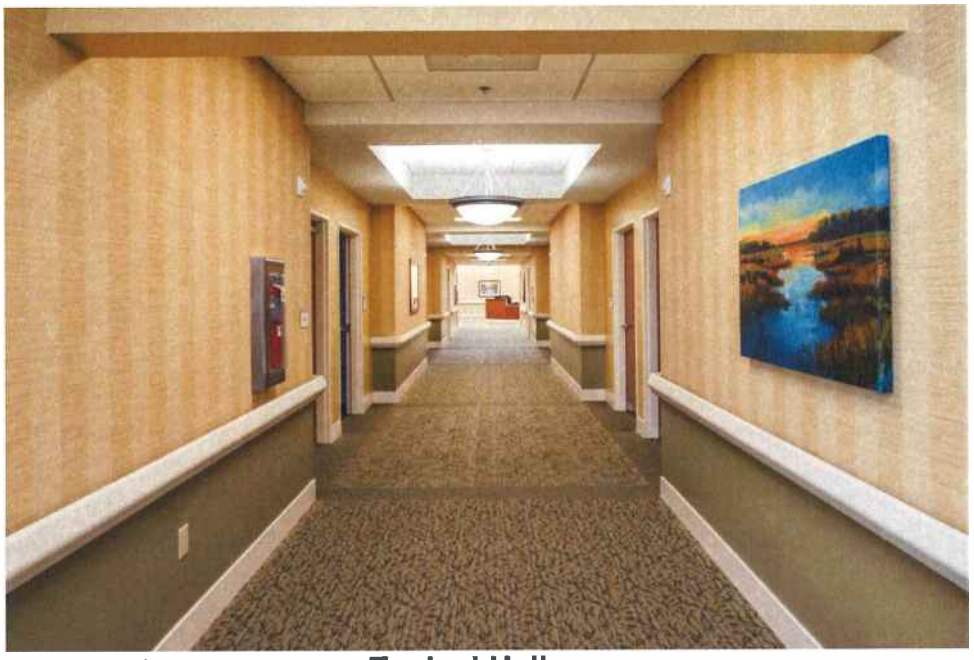
Samples of Planned Interior Look from Restore Health - Waldorf

Entrance Lobby

Dining Room



Typical Hallway

Nurse's Station

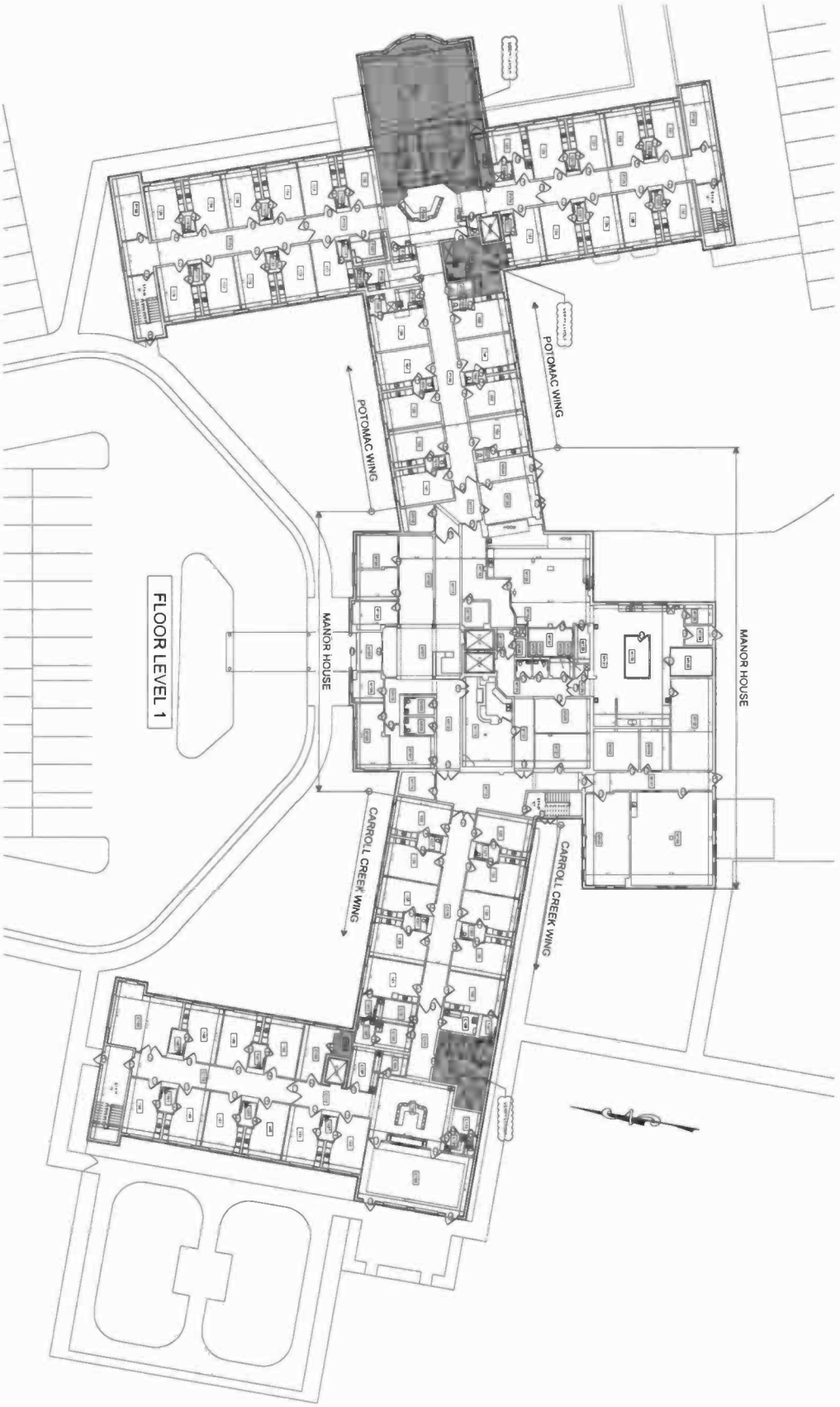
Rehab Gym

Salon

Resident Room

Resident Bathroom

AREA OF RENOVATION
10,814 SF
EXISTING
FIRST FLOOR
38,236 SF



A1.1

EXISTING CONDITIONS

NORTHAMPTON MANOR

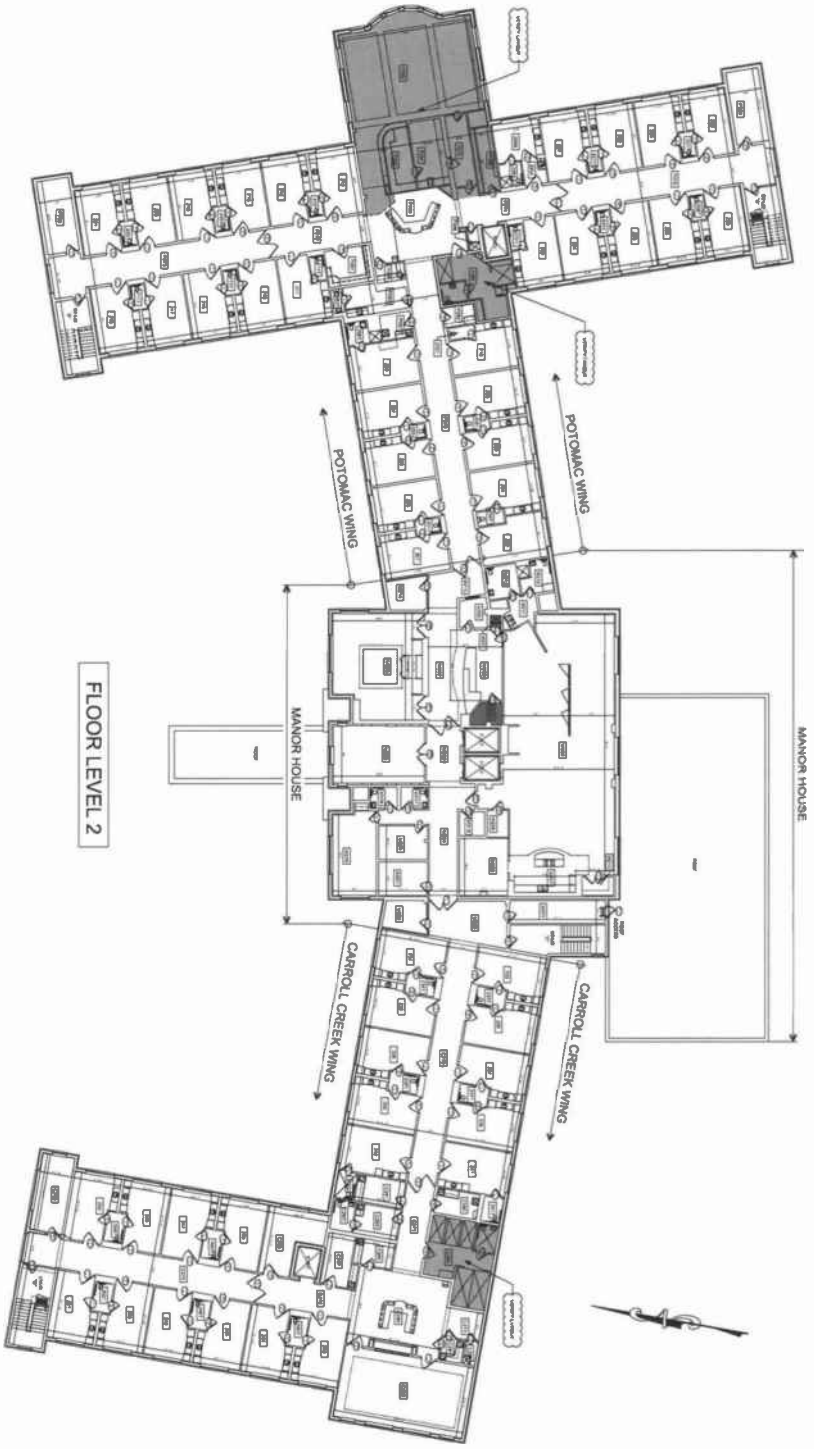
200 E. 16th STREET
FREDERICK, MARYLAND 21701

MAGNOLIA MANAGEMENT INCORPORATED

Northampton Manor
HEALTH CARE CENTER

REVISIONS

ISSUE DATE	DRAWN BY	REMARKS



FLOOR LEVEL 2

EXISTING CONDITIONS

NORTHAMPTON MANOR

200 E. 16th STREET
FREDERICK, MARYLAND 21701

MAGNOLIA MANAGEMENT INCORPORATED

Northampton Manor
HEALTH CARE CENTER

REVISIONS

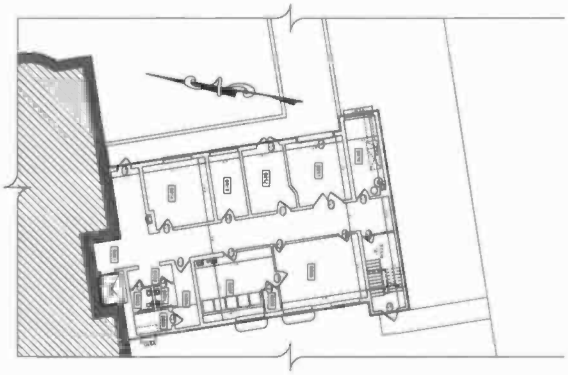
ISSUE DATE	DRAWN BY	REMARKS

A1.2

ROOM LIST: STAIRWELL

STAIR ID	LOCATION
STAIRWELL "A"	STAIRWELL ON SOUTH POTOMAC WING
STAIRWELL "B"	STAIRWELL ON NORTH POTOMAC WING
STAIRWELL "C"	STAIRWELL ON SOUTHWEST MANOR HOUSE AT CARROLL CREEK WING
STAIRWELL "D"	STAIRWELL ON NORTH CARROLL CREEK WING

BASEMENT
(UNDER POTOMAC WING)



ROOM LIST: "POTOMAC WING" BASEMENT

ROOM #	ROOM NAME
B001	CORRIDOR
B002	RESTROOM HALL
B003	WOMEN'S RESTROOM
B004	MEN'S RESTROOM
B005	HOLDING ROOM
B006	ELEVATOR MACHINE ROOM
B007	SOILED LAUNDRY
B008	CHEMICAL STORAGE
B009	CLEAN LAUNDRY
B010	STORAGE
B011	MAINTENANCE & RECEIVING
B012	MAINTENANCE DEPARTMENT
B013	ENVIRONMENTAL SERVICES
B014	FOLDING ROOM

ROOM LIST: "POTOMAC WING" FLOOR LEVEL 1

ROOM #	ROOM NAME
101	PATIENT ROOM A&B
101T	PATIENT TOILET ROOM
102	PATIENT ROOM A&B
102T	PATIENT TOILET ROOM
103	PATIENT ROOM A&B
104	PATIENT ROOM A&B
104T	PATIENT TOILET ROOM
105	PATIENT ROOM A&B
105T	PATIENT TOILET ROOM
106	PATIENT ROOM A&B
107	PATIENT ROOM A&B
108	PATIENT ROOM A&B
108T	PATIENT TOILET ROOM
109	PATIENT ROOM A&B
109T	PATIENT TOILET ROOM
110	PATIENT ROOM A&B
110T	PATIENT TOILET ROOM
111	PATIENT ROOM A&B
111T	PATIENT TOILET ROOM
112	PATIENT ROOM A&B
113	PATIENT ROOM A&B
113T	PATIENT TOILET ROOM
114	PATIENT ROOM A&B
114T	PATIENT TOILET ROOM
115	PATIENT ROOM A&B
116	PATIENT ROOM A&B
117	PATIENT ROOM A&B
117T	PATIENT TOILET ROOM
118	PATIENT ROOM A&B
118T	PATIENT TOILET ROOM
119	PATIENT ROOM A&B
120	PATIENT ROOM A&B
122	PATIENT ROOM A&B
122T	PATIENT TOILET ROOM
123	PATIENT ROOM
123T	PATIENT TOILET ROOM
124	PATIENT ROOM A&B
124T	PATIENT TOILET ROOM
125	PATIENT ROOM A&B
125T	PATIENT TOILET ROOM
126	PATIENT ROOM A&B
127	PATIENT ROOM A&B
128	PATIENT ROOM A&B
128T	PATIENT TOILET ROOM
129	PATIENT ROOM A&B
129T	PATIENT TOILET ROOM
130	PATIENT ROOM A&B
131	PATIENT ROOM A&B
P110	CORRIDOR
P112	CORRIDOR
P113	CORRIDOR
P114	CORRIDOR
P115	CORRIDOR
P116	CORRIDOR
P180	NURSE STATION
P181	SOILED UTILITY
P182	CLEAN UTILITY
P183	EMPLOYEE BREAK ROOM
P183T	EMPLOYEE TOILET ROOM
P184	SHOWER ROOM
P185	MEDICINE PREP ROOM
P186	JANITOR CLOSET
P187	TREATMENT ROOM
P188	FILE STORAGE
P190	DINING/DAY ROOM
P191	PLATING
P192	PLATING
P196	STORAGE ROOM
P199	STORAGE ROOM

ROOM LIST: "POTOMAC WING" FLOOR LEVEL 2

ROOM #	ROOM NAME
201	PATIENT ROOM A&B
201T	PATIENT TOILET ROOM
202	BEAUTY SALON
203	PATIENT ROOM A&B
204	PATIENT ROOM A&B
204T	PATIENT TOILET ROOM
205	PATIENT ROOM A&B
205T	PATIENT TOILET ROOM
206	PATIENT ROOM A&B
206T	PATIENT TOILET ROOM
207	PATIENT ROOM A&B
208	PATIENT ROOM A&B
209	PATIENT ROOM A&B
209T	PATIENT TOILET ROOM
210	PATIENT ROOM A&B
210T	PATIENT TOILET ROOM
211	PATIENT ROOM A&B
211T	PATIENT TOILET ROOM
212	PATIENT ROOM A&B
212T	PATIENT TOILET ROOM
213	PATIENT ROOM A&B
213T	PATIENT TOILET ROOM
214	PATIENT ROOM A&B
215	PATIENT ROOM A&B
216	PATIENT ROOM A&B
216T	PATIENT TOILET ROOM
217	PATIENT ROOM A&B
217T	PATIENT TOILET ROOM
218	PATIENT ROOM A&B
219	PATIENT ROOM A&B
220	PATIENT ROOM A&B
220T	PATIENT TOILET ROOM
221	PATIENT ROOM A&B
222	PATIENT ROOM A&B
222T	PATIENT TOILET ROOM
224	PATIENT ROOM A&B
224T	PATIENT TOILET ROOM
225	PATIENT ROOM
225T	PATIENT TOILET ROOM
226	PATIENT ROOM A&B
227	PATIENT ROOM A&B
227T	PATIENT TOILET ROOM
228	PATIENT ROOM A&B
228T	PATIENT TOILET ROOM
229	PATIENT ROOM A&B
230	PATIENT ROOM A&B
231	PATIENT ROOM A&B
231T	PATIENT TOILET ROOM
232	PATIENT ROOM A&B
P210	CORRIDOR
P212	CORRIDOR
P213	CORRIDOR
P214	CORRIDOR
P215	CORRIDOR
P216	CORRIDOR
P280	NURSE STATION
P281	SOILED UTILITY
P282	CLEAN UTILITY
P283	EMPLOYEE BREAK ROOM
P283T	EMPLOYEE TOILET ROOM
P284	SHOWER ROOM
P285	MEDICINE PREP ROOM
P286	JANITOR CLOSET
P287	TREATMENT ROOM
P288	FILE STORAGE
P290	DINING/DAY ROOM
P291	PLATING
P292	PLATING
P296	STORAGE ROOM
P299	OXYGEN STORAGE ROOM

ROOM LIST: "MANOR HOUSE" FLOOR LEVEL 1

ROOM #	ROOM NAME
M100	VESTIBULE
M101	LOBBY
M102	FAMILY ROOM
M103-A	CONFERENCE ROOM
M103-B	BUSINESS OFFICE
M104	ADMISSIONS OFFICE
M105	PHYSICIAN
M106	ADMINISTRATION OFFICE
M107	HUMAN RESOURCES/SUPPORT
M108	WOMEN'S RESTROOM
M109	MEN'S RESTROOM
M110	CORRIDOR
M111	CORRIDOR
M112	CORRIDOR
M113	EXPRESSIONS CAFE
M114	CORRIDOR
M115	CLEAN UTILITY
M116	TELECOMMUNICATIONS
M117	CORRIDOR
M118	CORRIDOR
M119	ELEVATOR MACHINE ROOM
M120	CORRIDOR
M121	CORRIDOR
M122	CORRIDOR
M123	TOILET
M124	LOCKED TOILET ROOM
M125	OFFICE
M126	QA - OFFICE
M127	OFFICE SUPPORT
M128	JANITOR CLOSET
M129	KITCHEN ENTRANCE
M130	KITCHEN OFFICE
M131	KITCHEN
M132	DRY STORAGE
M133	FREEZER
M134	VESTIBULE
M135	STORAGE CLOSET
M136	STORAGE CLOSET
M137	REFRIGERATOR
M138	PREP-KITCHEN
M139	BOILER
M140	ELECTRIC
M141	CORRIDOR
M142	MEDICAL STORAGE
M143	CONFERENCE ROOM
M144	MEDICAL OFFICE
M145	EMPLOYEE LOUNGE
M146	STORAGE CLOSET
M147	JANITOR CLOSET

ROOM LIST: "MANOR HOUSE" FLOOR LEVEL 2

ROOM #	ROOM NAME
M200	MAIN CORRIDOR
M201	CORRIDOR
M202	LOBBY
M203	RECEPTION
M204	STORAGE
M205	PHYSICIAN EXTENDER
M206	REHAB THERAPY
M207	REHAB KITCHEN
M208	THERAPY DOCUMENTATION
M209	SPEECH THERAPY
M210	STORAGE
M211	BATHROOM CORRIDOR
M212	RESTROOM
M213	RESTROOM
M214	ELECTRICAL
M215	POTOMAC CORRIDOR
M216	PROGRAM MANAGER
M217	MEN'S RESTROOM
M218	WOMEN'S RESTROOM
M219	CAREPLAN CONFERENCE
M220	MDS COORDINATOR
M221	SOCIAL SERVICES
M222	CLEAN LINEN
M223	CARROLL CREEK CORRIDOR
M224	STORAGE/ROOF ACCESS
M225	EXPRESSIONS LOUNGE
M226	CHAPEL
M227	JANITOR CLOSET

ROOM LIST: "CARROLL CREEK WING" FLOOR LEVEL 1

ROOM #	ROOM NAME
152	PATIENT ROOM A&B
152T	PATIENT TOILET ROOM
153	PATIENT ROOM A&B
153T	PATIENT TOILET ROOM
154	PATIENT ROOM A&B
155	PATIENT ROOM A&B
156	PATIENT ROOM A&B
156T	PATIENT TOILET ROOM
157	PATIENT ROOM A&B
157T	PATIENT TOILET ROOM
158	PATIENT ROOM A&B
159	PATIENT ROOM A&B
140	PATIENT ROOM A&B
140T	PATIENT TOILET ROOM
141	PATIENT ROOM A&B
141T	PATIENT TOILET ROOM
142	PATIENT ROOM A&B
142T	PATIENT TOILET ROOM
143	PATIENT ROOM A&B
144	PATIENT ROOM A&B
144T	PATIENT TOILET ROOM
145	PATIENT ROOM A&B
145T	PATIENT TOILET ROOM
146	PATIENT ROOM A&B
147	PATIENT ROOM A&B
148	PATIENT ROOM A&B
148T	PATIENT TOILET ROOM
149	PATIENT ROOM A&B
149T	PATIENT TOILET ROOM
150	PATIENT ROOM A&B
C110	CORRIDOR
C111	CORRIDOR
C112	CORRIDOR
C113	CORRIDOR
C114	CORRIDOR
C180	NURSE STATION
C181	CLEAN UTILITY
C182	SOILED UTILITY
C183	EMPLOYEE BREAK ROOM
C183T	EMPLOYEE TOILET ROOM
C184	SHOWER ROOM
C185	MEDICINE PREP ROOM
C186	JANITOR CLOSET
C187	TREATMENT ROOM
C188	OFFICE
C188M	ELEV MECH ROOM
C190	DAY ROOM/DINING
C191	NOURISHMENT CENTER
C198	MULTI-PURPOSE ROOM

ROOM LIST: "CARROLL CREEK WING" FLOOR LEVEL 2

ROOM #	ROOM NAME
252	PATIENT ROOM A&B
252T	PATIENT TOILET ROOM
254	PATIENT ROOM A&B
254T	PATIENT TOILET ROOM
255	PATIENT ROOM A&B
256	PATIENT ROOM A&B
257	PATIENT ROOM A&B
257T	PATIENT TOILET ROOM
258	PATIENT ROOM A&B
258T	PATIENT TOILET ROOM
259	PATIENT ROOM A&B
240	PATIENT ROOM A&B
241	PATIENT ROOM A&B
241T	PATIENT TOILET ROOM
242	PATIENT ROOM A&B
242T	PATIENT TOILET ROOM
243	PATIENT ROOM A&B
243T	PATIENT TOILET ROOM
244	PATIENT ROOM A&B
245	PATIENT ROOM A&B
245T	PATIENT TOILET ROOM
246	PATIENT ROOM A&B
246T	PATIENT TOILET ROOM
247	PATIENT ROOM A&B
248	PATIENT ROOM A&B
249	PATIENT ROOM A&B
249T	PATIENT TOILET ROOM
250	PATIENT ROOM A&B
250T	PATIENT TOILET ROOM
251	PATIENT ROOM A&B
253	PATIENT ROOM A&B
C210	CORRIDOR
C211	CORRIDOR
C212	CORRIDOR
C213	CORRIDOR
C214	CORRIDOR
C280	NURSE STATION
C281	CLEAN UTILITY
C282	SOILED UTILITY
C283	EMPLOYEE BREAK ROOM
C283T	EMPLOYEE TOILET ROOM
C284	SHOWER ROOM
C285	MEDICINE PREP ROOM
C286	JANITOR CLOSET
C287	TREATMENT ROOM
C288	DIRECTOR OF NURSING
C290	DAY ROOM/DINING
C291	NOURISHMENT CENTER
C298	OFFICE

A1.3
SHEET NO.
SCALE 1/16" = 1'-0"

EXISTING CONDITIONS
NORTHAMPTON MANOR
200 E. 16th STREET
FREDERICK, MARYLAND 21701

MAGNOLIA MANAGEMENT INCORPORATED
Northampton Manor HEALTH CARE CENTER

SUBMITTALS

ISSUE DATE	DRAWN BY	REMARKS
[illegible]	[illegible]	[illegible]

Northampton: Projection Assumptions

The Applicant used the current performance of Northampton and actual expenses as the basis for the projections. As a reminder, MAHC acquired the facility as of January 1, 2016 and we are overlaying our operating model and cost structure on the building throughout 2016. We have assumed the new wing opens July 1, 2018.

Census / Volume Growth

The projections assume the new wing opens July 1, 2018. To drive our census assumptions we have split admissions between short stay and long stay residents. We have assumed that the new wing will house the existing short stay residents plus additional residents based on the expansion. This will allow Northampton to backfill those existing beds with new long term care residents.

We have assumed that the short stay wing will take 13 months to reach stabilization at 61 residents or 92% occupancy. This is a net increase of 23 short stay residents from the expected census level of 38 by year end 2017. We have also assumed that the facility reaches a total average daily census of 244 or 93% occupancy at a similar payor mix at the facility today. The 93% occupancy level is consistent with where we anticipate the facility to be by the end of 2016.

Projected Reimbursement Rates

The Applicant has assumed rates based on calculations of its Reimbursement Director and base don actual reimbursement rates at the facility. MAHC's reimbursement director has established the expected Medicaid reimbursement rate by assuming a case mix index and then applying the Maryland pricing methodology. Given the Company's and this specific facilities focus on higher acuity patients, the Applicant used a CMI of 1.15. These compare to the state average of 1.07 and a Mid-Atlantic average of 1.23. Furthermore, in 2017 we have assumed a total change in reimbursement methodology to CMI-based rates (consistent with state guidance). With these assumptions, the Applicant estimates its Medicaid reimbursement to be $235.42.

Other rates are consistent with those already seen at the facility:

Medicare Part A	$460.00
Private	$305.00
Managed Care	$345.00

Expense Assumptions

Expense assumptions have been built on a detailed line item basis based on per diem rates at Northampton. The facility is able to spread many of its fixed costs across these new beds thereby lowering the overall cost PPD. We have created some new administrative positions give the nccrease in the size of the facility. These include:

- Assistant Administrator
- Assistant Director Of Nursing

- Human Resources
- Back office clerk

Beyond these additions, we have also added over 60 additional FTEs including:

- Unit Managers
- RNs
- LPNs
- CNAs
- Housekeeping staff
- Dietary staff

The projections also include other variable non-labor expenses at levels consistent with those the facility today, such as:

- Nursing and other supplies
- Therapy expenses
- Pharmacy expenses
- Lab & Radiology
- Transportation
- Raw food expenses
- HR expenses
- Telephone
- Utilities

Mid-Alantic Health Care

Facility Listing

Facility Name	Date Acq'd	Beds	Address	City	State
Maryland					
Berlin Nursing and Rehabilitation Center	May-03	153	9715 Healthway Drive	Berlin	MD
Oakland Nursing & Rehabilitation Center	Jul-05	100	706 East Alder Street	Oakland	MD
Fairfield Nursing & Rehabilitation Center	Dec-06	96	1454 Fairfield Loop Road	Crownsville	MD
Mid-Atlantic Of Chapel Hill, LLC	Jul-08	63	4511 Robosson Road	Randallstown	MD
Allegany Health Nursing and Rehab	Jul-09	153	730 Furnace Street	Cumberland	MD
Villa Rosa Nursing and Rehabilitation	Mar-13	107	3800 Lottsford Vista Road	Mitchellville	MD
Forest Haven Nursing	Feb-15	167	701 Edmondson Ave	Catonsville	MD
Restore Health Rehabilitation Center	Feb-15	67	4615 Einstein Place	White Plains	MD
Northampton Manor	Dec-15	196	200 E. 16th Street	Frederick	MD
Julia Manor	Dec-15	131	333 Mill Street	Hagerstown	MD
Devlin Manor	Dec-15	124	10301 Christie Rd. NE	Cumberland	MD
Moran Manor	Dec-15	120	25701 Shady Lane SW	Westernport	MD
Subtotal Maryland		**1,477**			
REIT Portoflio					
Care Pavilion Nursing and Rehabilitation Center	Jul-11	396	6212 Walnut Street	Philadelphia	PA
York Nursing Home	Jul-11	240	7101 Old York Road	Oak Lane	PA
Cliveden Nursing and Rehabilitation Center	Jul-11	180	6400 Greene Street	Philadelphia	PA
Maplewood Nursing and Rehab Center	Jul-11	180	125 W Schoolhouse Lane	Philadelphia	PA
Tucker House Nursing and Rehabilitation Center	Jul-11	180	1001-11 Wallace Street	Philadelphia	PA
Milton Nursing and Rehabilitation Center	May-13	138	743 Mahoning Street	Milton	PA
Watsontown Nursing and Rehabilitation Center	May-13	115	245 East Eight Street	Watsontown	PA
Falling Spring Nursing and Rehab	Jan-14	187	201 Franklin Farm Lane	Chambersburg	PA
Parkhouse Nursing and Rehabilitation Center	Mar-14	467	1600 Black Rock Road	Royersford	PA
Subtotal Pennsylvania		**2,083**			
Total MD Facilities	12	1,477			
Total PAFacilities	9	2,083			
Total All Facilities	**21**	**3,560**			

Mid-Alantic Health Care

Facility Listing

Facility Name	Date Acq'd	Previous Owner Type	Owned / Leased	Beds	Address	City	State
Owned							
Berlin Nursing and Rehabilitation Center [1]	May-03	For Profit	Own	145	9715 Healthway Drive	Berlin	MD
Oakland Nursing & Rehabilitation Center [1]	Jul-05	For Profit	Own	100	706 East Alder Street	Oakland	MD
Fairfield Nursing & Rehabilitation Center [1]	Dec-06	Non-Profit	Own	92	1454 Fairfield Loop Road	Crownsville	MD
Mid-Atlantic Of Chapel Hill, LLC	Jul-08	For Profit	Own	63	4511 Robosson Road	Randallstown	MD
Allegany Health Nursing and Rehab	Jul-09	Non-Profit	Own	143	730 Furnace Street	Cumberland	MD
Villa Rosa Nursing and Rehabilitation [2]	Mar-13	Non-Profit	Lease	107	3800 Lottsford Vista Road	Mitchellville	MD
Forest Haven Nursing	Feb-15	For Profit	Own	167	701 Edmondson Ave	Catonsville	MD
Restore Health Rehabilitation Center	Feb-15	NA	Own	67	4615 Einstein Place	White Plains	MD
Falling Spring Nursing and Rehab	Jan-14	Non-Profit	Own	187	201 Franklin Farm Lane	Chambersburg	PA
Northampton Manor	Dec-15	For Profit	Own	196	200 E. 16th Street	Frederick	MD
Julia Manor	Dec-15	For Profit	Own	131	333 Mill Street	Hagerstown	MD
Devlin Manor	Dec-15	For Profit	Own	124	10301 Christie Rd. NE	Cumberland	MD
Moran Manor	Dec-15	For Profit	Own	120	25701 Shady Lane SW	Westernport	MD
Subtotal Owned/Non-REIT				**1,642**			
REIT Portoflio							
Care Pavilion Nursing and Rehabilitation Center	Jul-11	Non-Profit	Lease	396	6212 Walnut Street	Philadelphia	PA
York Nursing Home	Jul-11	Non-Profit	Lease	240	7101 Old York Road	Oak Lane	PA
Cliveden Nursing and Rehabilitation Center	Jul-11	Non-Profit	Lease	180	6400 Greene Street	Philadelphia	PA
Maplewood Nursing and Rehab Center	Jul-11	Non-Profit	Lease	180	125 W Schoolhouse Lane	Philadelphia	PA
Tucker House Nursing and Rehabilitation Center	Jul-11	Non-Profit	Lease	180	1001-11 Wallace Street	Philadelphia	PA
Milton Nursing and Rehabilitation Center	May-13	For Profit	Lease	138	743 Mahoning Street	Milton	PA
Watsontown Nursing and Rehabilitation Center [1]	May-13	For Profit	Lease	115	245 East Eight Street	Watsontown	PA
Parkhouse Nursing and Rehabilitation Center	Mar-14	Non-Profit	Lease	467	1600 Black Rock Road	Royersford	PA
Subtotal REIT				**1,896**			
Magnolia Acquisition Under APA							
Shippensburg Health Care Center	Jun-16	Non-Profit	Own		121 Walnut Bottom Road	Shippensburg	PA
Subtotal Margnolia				-			
Total Owned Facilities			13	1,642			
Total REIT Facilities			9	1,896			
Total All Facilities			**22**	**3,538**			

(1) Represents operational beds -- ability to increase to licensed amount (Berlin - 165, Oakland - 153, Fairfield - 96, Watsontown - 125)

(2) Villa Rosa is subject to a long term lease from a religious organization.

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Hospital Center • Bland Bryant Building
55 Wade Avenue • Baltimore, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor –Joshua M. Sharfstein, M.D., Secretary

LONG TERM CARE UNIT

FACSIMILE TRANSMITTAL SHEET

To:	Villa Rosa Nursing and Rehab, LLC Attn: Steven Wynn, Administrator	From:	OHCQ/Long Term Care Unit Ranada Cooper
Fax:	301-429-2731	Pages:	4
Phone:	301-459-4700	Date:	11/13/2014
Re:	2567 for 11/06/14 survey	CC:	

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

• Mr. Wynn:

Attached please find the CMS-2567 for the life safety code survey completed by OHCQ at your facility on 11/06/14. A hard copy has also been sent to your facility via standard mail. Please feel free to contact me if you have any questions.

Thank you,

Ranada Cooper
Health Facilities Survey Coordinator
410-402-8017
410-402-8234-fax

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

November 12, 2014

Mr. Steven Wynn, Administrator
Villa Rosa Nursing And Rehabilitation, LLC
3800 Lottsford Vista Road
Mitchellville, MD 20721

RE: 215350
Notice of Deficiencies as a Result of Revisit, Imposition of Denial of Payments for New Admissions under Federal Regulations

Dear Mr. Wynn:

On November 6, 2014, a revisit Life Safety Code survey was conducted at your facility by the Office of Health Care Quality, to verify that your facility had achieved and maintained compliance for those deficiencies cited during the survey completed on August 21, 2014.

We had presumed, that based on your allegation of compliance that your facility was in substantial compliance as of 10/31/2014. However, based on our revisit we found that your facility is not in substantial compliance with the requirements for participation.

All references to regulatory requirement(s) contained in this letter are found in Title 42, Code of Federal Regulations.

I. IMPOSITION OF REMEDIES

As a result of our finding that your facility is not in substantial compliance, the following remedy (ies) will be imposed:

Imposition of denial of payment for new admissions, effective November 21, 2014.

If substantial compliance is not achieved by February 21, 2015, the CMS Regional Office and/or the State Medicaid Agency may terminate your provider agreement on that date.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

II. AUTOMATIC CONSEQUENCES AS A RESULT OF IMPOSITION OF DENIAL OF PAYMENT FOR NEW ADMISSIONS

If you disagree with this determination, you or your legal representative may request a hearing before an Administrative Law Judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR 498.40, et seq. A written request for a hearing must be filed no later that 60 days from the date of receipt of this letter. Such a request may be made to:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver A. Potts, Chief
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Should you choose to exercise your right to appeal, please forward a copy that appeal to:

Mr. James C. Newman, Chief Counsel
Office of the General Counsel
Public Ledger Building, Suite 418
150 South Independence Mall West
Philadelphia, PA 19106

III. PLAN OF CORRECTION (POC)

A Poc for the deficiencies identified in the attached CMS 2567 must be submitted within 10 days of your receipt of this notice. Failure to submit an acceptable PoC by this date may result in the imposition of remedies.

Your PoC must contain the following:

- What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Specific date when the corrective action will be completed.
- References to a resident(s) by Resident # only as noted in the previously supplied Resident Roster. This applies to the PoC as well as any attachments to the PoC. It is unacceptable to include a resident(s) name in these documents since the documents are released to the public.

The enclosed CMS-2567 form, Statement of Deficiencies and Plan of Correction, shall be returned to the attention of the Health Facilities Survey Coordinator at the following address:

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY
55 Wade Avenue Bland Bryant Building
Catonsville, Maryland 21228
410.402.8249
Fax: 410.402.8234

IV. ALLEGATION OF COMPLIANCE

If you believe that the deficiencies identified in the form CMS 2567 have been corrected, you may contact your Survey Coordinator, Ranada Cooper, at the Office of Health Care Quality, Spring Grove Hospital Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228 with your written credible allegation of compliance (*i.e. attached lists of attendance at provided training and/or revised statements of policies/ procedures and/or staffing patterns with revisions or additions*). If you choose, and so indicate, the PoC may constitute your allegation of compliance.

If upon a subsequent revisit or by other means, we verify that the facility is in substantial compliance, we will recommend to CMS that the remedy (ies) be terminated. However, if the seriousness of noncompliance changes from the survey findings, the remedies selected may change. If this occurs, you will be advised of any change.

V. INFORMAL DISPUTE RESOLUTION

In accordance with §488.331, you have one opportunity to question cited deficiencies through

an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency being disputed, and an explanation of why you are disputing the deficiency, to me, Patricia Tomsko Nay, M.D., Executive Director, Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228. This request must be sent within 10 days of your receipt of the CMS 2567.

An informal dispute resolution for the cited deficiencies will not delay the imposition of any enforcement action

VI. LICENSURE ACTION

In the event a revisit determines that substantial compliance has not been achieved, appropriate administrative action may be taken against your State license.

If you have any questions concerning the instructions contained in this letter, please contact me at (410) 402-8201 or by fax at (410) 402-8234.

Sincerely,

Patricia Tomsko Nay, M.D.
Executive Director
Office of Health Care Quality

NG/lm

Enclosures: CMS 2567

cc: Health Facilities Survey Coordinator
Jane Sacco
Ruby Potter
Patricia A. Hannigan
File II

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. BUILDING A1 B. WING _____	R 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	2880 LOTTSPORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 000)	INITIAL COMMENTS The following deficiencies are the result of a revisit Life Safety Code Survey conducted on November 6, 2014 to determine the status of the facility's compliance with the plan of correction submitted for deficiencies cited during the Life Safey Code survey that concluded on August 21, 2014. As a result of the revisit survey, Villa Rosa Nursing Home was not found to be in substantial compliance with the requirements for participation in Medicare and Medicaid. Survey activities included observation of the physical environment, review of records, review of evacuation policies, observation of staff practices, and interviews with the staff members. This is a two story building built on a concrete slab with a partial basement. It has a brick siding exterior. The roof system consists of a flat roof on steel with a membrane and built up covering. The interior walls are drywall supported by steel studs, and masonry painted walls. The facility is partially sprinklered, with a new fire pump, and an updated partial sprinkler system. The upgrading of the facility to full sprinkler coverage has not been achieved as of this date.	(K 000)		
(K 056) SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the	(K 056)	---	

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. BUILDING A1 B. WING	R 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	3800 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 056)	Continued From page 1 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and discussion with the maintenance supervisor, it was determined that the facility failed to ensure that the sprinkler system had been upgraded to full coverage of all areas of the facility as required. The findings include: On November 6, 2014, between the hours of 11:50 AM and 1:00 PM the State Fire Marshal observed that the deficiencies noted during the State survey done on June 25, 2014 and the Federal survey done on August 21, 2014 had not been completed. All bathrooms are now sprinklered but the renovations have not passed local jurisdiction acceptance inspections. It is uncertain when the sprinkler system will be passed for acceptance. In addition several bathrooms are missing large sections of the ceiling where it was removed to facilitate the sprinkler installation of the bathroom. This is a health and safety hazard that must be corrected as soon as possible. These findings were noted and affirmed by the maintenance supervisor during the survey.	(K 056)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215360	A. BUILDING A1 B. WING	R 11/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	3800 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 056)	Continued From page 2 This could affect 100 percent of the occupants.	(K 056)		
(K 147) SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and discussion with the maintenance supervisor, it was determined that the facility failed to ensure that the ground fault protection systems that were ordered to be installed in certain areas on the previously cited surveys had not been installed as required. The findings include: On November 6, 2014, between the hours of 11:50 AM and 1:00 PM the State Fire Marshal observed that the State survey done on June 25, 2014; and the Federal survey conducted on August 21, 2014, that required ground fault protection be installed in all bath rooms and shower rooms where electrical devices were in close proximity to a water source; had not been completed for any designated area. Proposals for the work had been acquired, but no contract was signed, and no work had been started. These findings were noted and affirmed by the maintenance supervisor during the survey. This could affect 100 percent of the occupants.	(K 147)		

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Hospital Center • Bland Bryant Building
55 Wade Avenue • Baltimore, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor –Joshua M. Sharfstein, M.D., Secretary

LONG TERM CARE UNIT

FACSIMILE TRANSMITTAL SHEET

To:	Villa Rosa Nursing and Rehab	**From:**	OHCQ/Long Term Care Unit
	Attn: Steven Wynn		Ranada Cooper
Fax:	301-429-2731	**Pages:**	7
Phone:	301-459-4700	**Date:**	12/05/2014
Re:	2567 for 12/1/14 revisit survey	**CC:**	

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

• Mr. Wynn:

Attached please find the CMS-2567 for the second revisit LSC survey completed by OHCQ at your facility on 12/1/14. A hard copy has also been sent to your facility via standard mail. Please feel free to contact me if you have any questions.

Thank you,

Ranada Cooper
Health Facilities Survey Coordinator
410-402-8017
410-402-8234-fax

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 4, 2014

Mr. Steven Wynn, Administrator
Villa Rosa Nursing and Rehabilitation, LLC
3800 Lottsford Vista Road
Mitchellville, MD 20721

RE: 215350
Notice of Deficiencies as a Result of Second Revisit, Imposition of Denial of Payments for New Admissions under Federal Regulations

Dear Mr. Wynn:

On December 1, 2014, a second revisit Life Safety Code survey was conducted at your facility by the Office of Health Care Quality, to verify that your facility had achieved and maintained compliance for those deficiencies cited during the survey completed on August 21, 2014.

We had presumed, that based on your allegation of compliance that your facility was in substantial compliance as of November 18, 2014.

However, based on our revisit we found that your facility is not in substantial compliance with the requirements for participation.

All references to regulatory requirement(s) contained in this letter are found in Title 42, Code of Federal Regulations.

I. IMPOSITION OF REMEDIES

As a result of our finding that your facility is not in substantial compliance, the following remedy(ies) will remain in effect:

Imposition of denial of payment for new admissions, effective November 21, 2014.

If substantial compliance is not achieved by February 21, 2014, the CMS Regional Office and/or the State Medicaid Agency may terminate your provider agreement on that date.

Please note that this notice does not constitute formal notice of imposition of alternative

remedies or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

II. AUTOMATIC CONSEQUENCES AS A RESULT OF IMPOSITION OF DENIAL OF PAYMENT FOR NEW ADMISSIONS

If you disagree with this determination, you or your legal representative may request a hearing before an Administrative Law Judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR 498.40, et seq. A written request for a hearing must be filed no later that 60 days from the date of receipt of this letter. Such a request may be made to:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver A. Potts, Chief
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Should you choose to exercise your right to appeal, please forward a copy that appeal to:

Mr. James C. Newman, Chief Counsel
Office of the General Counsel
Public Ledger Building, Suite 418
150 South Independence Mall West
Philadelphia, PA 19106

III. PLAN OF CORRECTION (POC)

A Poc for the deficiencies identified in the attached CMS 2567 must be submitted within 10 days of your receipt of this notice. Failure to submit an acceptable PoC by this date may result in the imposition of remedies.

Your PoC must contain the following:

- What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Specific date when the corrective action will be completed.
- References to a resident(s) by Resident # only as noted in the previously provided Resident Roster. This applies to the PoC as well as any attachments to the PoC. It is unacceptable to include a resident(s) name in these documents since the documents are released to the public.

The enclosed CMS-2567 form, Statement of Deficiencies and Plan of Correction, shall be returned to the attention of the Health Facilities Survey Coordinator at the following address:

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY
55 Wade Avenue Bland Bryant Building
Catonsville, Maryland 21228
410.402.8249
Fax: 410.402.8234

IV. ALLEGATION OF COMPLIANCE

If you believe that the deficiencies identified in the form CMS 2567 have been corrected, you may contact your Survey Coordinator, Ranada Cooper, at the Office of Health Care Quality, Spring Grove Hospital Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228 with your written credible allegation of compliance (***i.e. attached lists of attendance at provided training and/or revised statements of policies/ procedures and/or staffing patterns with revisions or additions***). If you choose, and so indicate, the PoC may constitute your allegation of compliance.

If upon a subsequent revisit or by other means, we verify that the facility is in substantial compliance, we will recommend to CMS that the remedy (ies) be terminated. However, if the seriousness of noncompliance changes from the survey findings, the remedies selected may change. If this occurs, you will be advised of any change.

V. INFORMAL DISPUTE RESOLUTION

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency being disputed, and an explanation of why you are disputing the deficiency, to me, Dr. Patricia Tomsko Nay, M.D., Executive Director, Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228. This request must be sent within 10 days of your receipt of the CMS 2567.

An informal dispute resolution for the cited deficiencies will not delay the imposition of any enforcement action.

VI. LICENSURE ACTION

In the event a revisit determines that substantial compliance has not been achieved, appropriate administrative action may be taken against your State license.

If you have any questions concerning the instructions contained in this letter, please contact me at (410) 402-8201 or by fax at (410) 402-8234.

Sincerely,

Patricia Tomsko Nay, M.D.
Executive Director
Office of Health Care Quality

NG/lm

Enclosures: CMS 2567

cc: Health Facilities Survey Coordinator
Jane Sacco
Ruby Potter
Patricia A. Hannigan
File II

PRINTED: 12/04/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. BUILDING A1 B. WING _____	R 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	3500 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(K 000)	INITIAL COMMENTS The following deficiencies are the result of a second revisit Life Safety Code Survey that was conducted on December 1, 2014 to determine the status of the facility's compliance with the plan of correction submitted for deficiencies cited during the first revisit Life Safey Code survey that concluded on November 6, 2014. This is a two story building built on a concrete slab with a partial basement. It has a brick siding exterior. The roof system consists of a flat roof on steel with a membrane and built up covering. The interior walls are drywall supported by steel studs, and masonry painted walls. The facility is now fully sprinklered, with a new fire pump.	(K 000)		
(K 147) SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and discussion with the maintenance supervisor, it was determined that the facility failed to ensure that the electrical system for the shower rooms was compliant with NFPA 70; the Electrical Code. The findings include: On December 1, 2014, between the hours of 11:40 AM and 12:25 PM the State Fire Marshal observed that the ground fault receptacles in rooms 102 and 229 did not function properly when tested by the surveyor and the maintenance supervisor. These receptacles could cause a fatal	(K 147)		

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

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

PRINTED: 12/04/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	216350	A. BUILDING A1 B. WING _____	R 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	3800 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 147}	Continued From page 1 electrical shock to a resident or a staff person. The receptacle in room 229 was being used by an electrical scale for weighing residents in the shower room. These findings were noted and affirmed by the maintenance supervisor during the survey. This could affect 100 percent of the occupants.	{K 147}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215350	A. BUILDING A1 B. WING	R 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA NURSING AND REHABILITATION, LLC	3800 LOTTSFORD VISTA ROAD MITCHELLVILLE, MD 20721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS The following deficiencies are the result of a second revisit Life Safety Code Survey that was conducted on December 1, 2014 to determine the status of the facility's compliance with the plan of correction submitted for deficiencies cited during the first revisit Life Safey Code survey that concluded on November 6, 2014. This is a two story building built on a concrete slab with a partial basement. It has a brick siding exterior. The roof system consists of a flat roof on steel with a membrane and built up covering. The interior walls are drywall supported by steel studs, and masonry painted walls. The facility is now fully sprinklered, with a new fire pump.	{K 000}		
{K 147} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and discussion with the maintenance supervisor, it was determined that the facility failed to ensure that the electrical system for the shower rooms was compliant with NFPA 70; the Electrical Code. The findings include: On December 1, 2014, between the hours of 11:40 AM and 12:25 PM the State Fire Marshal observed that the ground fault receptacles in rooms 102 and 229 did not function properly when tested by the surveyor and the maintenance supervisor. These receptacles could cause a fatal	{K 147}	The ground fault circuit interrupters were repaired and/or replaced. An audit was completed of the building to ensure ground fault circuit interrupters are functioning properly and that they are located in appropriate locations through out the building. This audit was conducted by an independent third party auditor, a licensed electrician. (See Enclosed) The ground fault circuit interrupters will be tested on a regular basis by the director of maintenance or designee. This testing audit will be done weekly for the first four weeks and if 100% compliance it will be done on a monthly basis moving forward. Findings will be reported to the facility's safety and quality assurance committee. The committees will take appropriate action if needed. Corrective actions will be completed by December 5, 2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 12/5/14

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

Wynn, Steven

From:	Fisher, Wayne
Sent:	Monday, December 08, 2014 7:02 AM
To:	Wynn, Steven; Bob Lanza; McGuire, Paul; Skinner, Castro; Robertson, Edward
Cc:	Grillo, Jeff
Subject:	FW: Villa Rosa; Electrical Modifications
Attachments:	doc41806720141202173938.pdf
Importance:	High

Here is the letter from Tomey Electric.

From: David Tomey [mailto:dtomey@tomeyelectric.com]
Sent: Monday, December 08, 2014 6:56 AM
To: Fisher, Wayne
Cc: Chad Hardin; Adam Tomey; Amy Albert
Subject: Villa Rosa; Electrical Modifications
Importance: High

Wayne,

Per your request, Chad and Tyler spent a long day at the Villa Rosa Nursing and Rehabilitation Center at 3800 Lottsford Vista Road in Mitchellville, Maryland 20721 with the directive to test, verify, repair/replace any electrical outlets that are required to be GFCI protected by the 2011 NEC. In addition, the Fire Marshal recommended the light switches located in the shower rooms be GFCI protected. In a phone conversation between David Tomey and Bill Routson (Fire Marshal), it was agreed to replace the stainless steel switch plates to a non-conductive nylon with nylon screws in lieu of installing GFCI breakers since ground fault detection is not required by NEC for the lights and/or associated switches.

Listed below are the tasks preformed which we assume to bring the entire facility into compliance with the code:

Basement Area:

1. Men's & Women's Lockers; Change Stainless Steel plates to nylon with nylon screws for switches in showers (one each locker).
2. Laundry Room; tested one (1) GFCI by sink, tested OK.
3. Elevator equipment room; two (2) GFCI tested OK.
4. Storage closet; replaced one receptacle with GFCI and installed raised receptacle cover

1st Floor A Wing:

1. Social Services Administration; tested OK
2. Business office; replace one receptacle with GFCI
3. Cloyster; two (2) counter receptacles replaced with GFCI receptacles.
4. Shower 113; replaced switch screws with nylon screws for three switches
5. Patient room 101; tested OK
6. Patient room 103; tested OK
7. Patient room 105; tested OK
8. Patient room 109, 110, 111, 112, 115, and 117; tested OK
9. Patient room 106; replaced GFCI by bathroom door and changed switch cover to nylon with nylon screws
10. Patient room 108; replaced receptacle with GFCI outside bathroom door.

1st Floor B Wing:

1. Kitchen/dinning; tested five (5) GFCI receptacles all good
2. Shower 126; replaced switch covers and nylon screws for two switches
3. Rehabilitation; tested one GFCI, OK
4. Inspected the gym; OK

5. Patient room 118; tested one GFCI OK and replaced one receptacle with GFCI which tested OK
6. Patient room 120; OK
7. Patient room 122, 124, 128, and 130; tested and OK

1st Floor C Wing:

1. Men's & Women's Bathrooms; replaced two (2) stainless plates and screws to nylon in each bath
2. Nurses station; tested two (2) GFCI, OK
3. Bathroom 118; tested two (2) GFCI, OK
4. Patient room 119, 120 121, 122, 123, 124 , 125, 126; tested OK

1st Floor D Wing:

1. Bathroom; checked one GFCI OK
2. Solarium; OK
3. Patient room 105-114; GFCI tested OK
4. Patient room 105-114 vanity light receptacles; disconnected
5. Bathroom 101 was currently under construction; Bopat Electric was installing GFCI to the circuit

2nd Floor A Wing:

1. Patient room 200, 202, 203, 204, 206-211 , 215 and 217; tested OK
2. Patient room 205 (Janitor's Closet); replaced receptacle with GFCI

2nd Floor B Wing:

1. Rooms 216, 218, 219, 220, 221, 222, 223, 224, 225, 227, 228, 232, 233, 235, 237 and 239; tested OK
2. Room 229 missing a plate on the GFCI; replaced plate and tested OK

2nd Floor C Wing:

1. Men's & Women's bathrooms; tested OK
2. Oxygen Room; tested OK
3. Patient room 213, 214, 215, 217, 218, 219, 220 , 222 and 224; tested OK
4. Patient room 216; replaced receptacle with GFCI tested two (2) GFCI both OK
5. Patient room 221; replaced receptacle with GFCI tested two (2) GFCI both OK

2nd Floor D Wing:

1. Bathroom 201; changed screws to nylon on two (2) switches
2. Beauty Parlor; replaced one receptacle with GFCI, checked three (3) additional, all OK
3. Solarium; tested OK
4. Patient room 203-209 and 211; tested OK

Exterior of the Building:

1. Outside patio; GFCI tested OK
2. Outside yard by auditorium; No ground on circuit. Disconnected receptacle and installed blank plate.
3. Receptacle by basement door; tested OK
4. Receptacle inside generator enclosure; tested OK

To the best of our knowledge we are complete as of last Friday. Tyler also assisted the onsite maintenance personal ("Ed") to develop a list of the GFCI protected devices to facilitate monthly testing in the future. Please advise if there is anything else that we can be of service to provide.

David A. Tomey
TOMEY ELECTRIC, INC.
5430 Handley Road
Cambridge, MD 21613-3483
410-228-8130 Voice

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Philadelphia Regional Office
Suite 216, The Public Ledger Building
150 S. Independence Mall, West
Philadelphia, PA 19106-3413

Northeast Division of Survey & Certification

December 15, 2014

Mr. Steven Wynn, Administrator
Villa Rosa Nursing And Rehabilitation, LLC
3800 Lottsford Vista Road
Mitchellville, MD 20721

CMS Certification Number: 215350

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Dear Mr. Wynn:

Our letter of November 4, 2014 indicated that a denial of payments for new admissions was being imposed on your facility effective November 21, 2014.

The Maryland Office of Health Care Quality State survey agency conducted a revisit of your facility on December 10, 2014, and has determined that your facility is once again in substantial compliance with Medicare requirements. Your facility continues to participate in the Medicare and Medicaid programs. The denial of payments for new admissions was in effect November 21, 2014 through December 5, 2014.

If you have any questions, please contact Pat McNeal of my staff at (215) 861-4662.

Sincerely,

Dale Van Wieren

Dale Van Wieren, Manager
Certification and Enforcement Branch

DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF
LONG TERM CARE RESIDENTS PROTECTION

September 19, 2013

Ayokunie Ayanleye, Administrator
Delmar Nursing and Rehabilitation Center
101 E. Delaware Avenue
Delmar, DE 19940-1110

RE: Second Follow-up Survey ending – September 18, 2013

Dear Mr. Ayanleye:

I wish to thank your staff for the courtesy shown to the surveyor who conducted the second follow-up Federal Certification Survey ending September 18, 2013 to the two Complaint Surveys that ended May 10, 2013 and June 12, 2013 and the first follow-up survey that ended August 15, 2013. The survey findings show that your facility has regained substantial compliance with Federal participation requirements as of September 18, 2013. Enclosed are copies of the CMS-2567and the CMS-2567B Post-Certification Revisit Report showing corrected deficiencies for your file. Also enclosed is the State Survey Report.

If you have any questions, please contact me at 302-577-6661.

Sincerely,

Robert H. Smith
Licensing and Certification Administrator

RHS/mam

Enclosures

cc: Timothy Hock, CMS, Chief Enforcement Branch
Victor Orija, LTC Ombudsman
Renee Purzycki, MSW, DLTCRP
Richard McKee, DLTCRP
File

3 MILL ROAD, SUITE 308, WILMINGTON, DE 19806
TELEPHONE: (302) 577-6661 • 1-877-453-0012 • FAX: (302) 577-6672

DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF
MEDICAID & MEDICAL ASSISTANCE

OFFICE OF THE DIRECTOR

July 23, 2013

Mr. Robert Lanzo, Administrator
Delmar Nursing & Rehabilitation Center
101 E. Delaware Avenue
Delmar, DE 19940

CMS Certification Number: 085041

DENIAL OF PAYMENT - PLEASE READ CAREFULLY

Dear Mr. Lanzo:

Based on the July 22, 2013 letter sent to you by Mr. Timothy J. Hock, Certification and Enforcement Branch of CMS, the Delaware Division Medicaid & Medical Assistance hereby notifies you that the following two actions will ensue.

- Delaware Medicaid will deny payments for all new Medicaid admissions effective August 10, 2013. This means that Medicaid vendor payments for Delaware Medicaid patients admitted to your facility from August 10, 2013 forward will not be honored.

- Your Delaware Medicaid contract will be terminated no later than November 10, 2013.

These actions are mandated by the Code of Federal Regulations 42, Part 30 to End - Part 442, Subpart B - Provider Agreement, 442.12 which states "... **a Medicaid agency may not execute a provider agreement with a facility for nursing facility services nor make Medicaid payment to a facility for those services unless the Secretary or the State Survey agency has certified the facility under this part to provide those services."**

This notice results from the findings of the Division of Long Term Care Residents Protection that your facility is not in substantial compliance with Federal participation requirements and State regulations. Evidence upon which this decision was based was enclosed in the letter that Mr. Hock sent to you. If an acceptable Plan of Correction is submitted to Mr. Hock within the time frame mandated by him, and if he finds that substantial compliance has been achieved, this action will be stayed.

If this action is not stayed, Delaware Medicaid will either-

- work with your facility to find alternate placements for our Medicaid patients in the case of termination, and/or –
- work with CMS, and/or the Division of Long Term Care Residents Protection in the imposition and implementation of remedies specified by them.

Mr. Hock's letter to you specified the remedy/ies that will be imposed if substantial compliance is not achieved. Note that the enforcement action(s) may be revised if there is a change in the seriousness of noncompliance.

In accordance with 42 CFR 498.40, your facility may request a hearing before an Administrative Law Judge. This request should be made per the procedures outlined in Mr. Hock's letter to you.

If you have any questions, please feel free to call me.

Sincerely,

Stephen Groff
Director
Division of Medicaid & Medical Assistance

pc: Robert Smith

SG: gr

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Philadelphia Regional Office
Suite 216, The Public Ledger Building
150 S. Independence Mall, West
Philadelphia, PA 19106-3413

Northeast Division of Survey & Certification

July 22, 2013

Mr. Robert Lanzo, Administrator
Delmar Nursing & Rehabilitation Center
101 E. Delaware Avenue
Delmar, DE 19940

CMS Certification Number: 085041

DENIAL OF PAYMENT - PLEASE READ CAREFULLY

Dear Mr. Lanzo:

After a careful review of the facts, the Department of Health & Human Services, Centers for Medicare & Medicaid Services (CMS), has determined that Delmar Nursing & Rehabilitation Center no longer meets the requirements for participation as a provider of services in the Health Insurance Program for the Aged and Disabled (Medicare) established under Title XVIII of the Social Security Act (the Act), and Medicaid, Title XIX of the Act.

To participate in the Medicare program as a provider of skilled nursing facility services, a facility must meet all of the provisions of Section 1819 (b), (c), and (d) of the Act. In addition, a skilled nursing facility must be in compliance with the Requirements for Long Term Care Facilities established by the Secretary of Health and Human Services, and be free of hazards to the health and safety of residents. If that facility participates in the Medicaid program, it must also meet all of the provisions of Sections 1919 (b), (c), and (d) of the Act.

On May 10, 2013, an abbreviated survey was completed at your facility by the Delaware Department of Health and Social Services (State survey agency) to determine if your facility was in compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. That survey found that your facility was not in substantial compliance with the participation requirements.

Although a revisit has not been completed at your facility we are denying Medicare and Medicaid payment for all new admissions to your facility effective August 10, 2013. This action is required by sections 1819 (h)(2)(B)(i), 1819 (h)(2)(D), 1919 (h)(3)(B)(ii), and 1919 (h)(3)(C)(i) of the Social Security Act. **If a revisit is completed which finds that your facility regained compliance prior to August 10, 2013 this action will be withdrawn.** In addition, you are advised that, should you remain out of compliance, your provider agreement will be terminated on November 10, 2013. **Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in Medicare managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payments for new admissions.**

If you disagree with this determination, you or your legal representative may request a hearing before an Administrative Law Judge of the Department of Health & Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR 498.40, et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen Robinson, Division Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Should you choose to exercise your right to appeal, please forward a copy of that appeal to:

Mr. James C. Newman, Chief Counsel
Office of the General Counsel
Public Ledger Building, Suite 418
150 South Independence Mall West
Philadelphia, PA 19106

Should we take action to terminate your participation in the Medicare program, we will advise you of your appeal rights as a result of that action. Please note that those appeal rights are separate and distinct from the appeal rights cited above.

You will be notified separately by the Delaware State Medicaid agency regarding their application of the remedies in this letter.

If you have any questions, please contact Pat McNeal of my staff at (215) 861-4662.

Sincerely,

Timothy J. Hock, Manager
Certification and Enforcement Branch

DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF
LONG TERM CARE RESIDENTS PROTECTION

May 23, 2013

Ayokunie Ayanleye, Administrator
Delmar Nursing and Rehabilitation Center
101 E. Delaware Avenue
Delmar, DE 19940

RE: Complaint Survey Ending – May 10, 2013

Dear Mr. Ayanleye;

I wish to thank your staff for the courtesy shown to the surveyor who conducted the complaint survey ending May 10, 2013. The survey findings show that your facility had federal participation requirements and state requirements that were not met. Enclosed is the Statement of Deficiencies (CMS-2567L) which provides specific details concerning federal requirements as well as the State Survey Summary Sheets addressing state licensure requirements.

A Plan of Correction (PoC) for the deficiencies must be submitted on the enclosed forms within ten (10) days of receipt of this letter. Failure to submit a PoC within ten days of receipt of this letter may result in the imposition of remedies in addition to those referred to in this letter, twenty (20) days after your due date for submission of your PoC.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur; and
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Due to the severity and the potential for repeated deficiencies pertaining to F 309 and the associated citations the Division is requiring the completion of a directed plan of correction to include a systematic change for consultation with the physician and notification of family members when residents experience a change in condition, identification of the role of the medical director in the quality assurance committee pertaining to the development of policies and procedures that establish standards of care, a systematic change for identifying and investigating allegations of abuse and neglect. In addition, please include a copy of the documentation of the root cause analysis that you conducted (did conduct) in order to determine how this error occurred. You must address the measurement process that you will put into place to ensure that you are successful in your system change and include any measurement tools that you will utilize.

If you do not achieve substantial compliance within three months after the last day of the survey identifying noncompliance, the Centers for Medicare & Medicaid Services (CMS), must deny payments for new admissions. Also, CMS must terminate your provider agreement no later than six months from the last day of the survey if substantial compliance is not achieved by that time.

In accordance with 42 CFR 488.331 of the federal enforcement regulations, you are entitled to one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. To be given such an opportunity, you must submit a written request which identifies the specific deficiencies being disputed and includes the specific issues relating to the cited deficient practice with which you disagree. This written request must be received within the same ten-calendar day period that you have to submit your PoC. Written request should be submitted to me at the address listed on the letterhead. The IDR process is intended to be a continuous one from the time of survey until ten days after you have received the official CMS-2567L report.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, CMS would not impose its federal remedies. However, if a revisit finds that you have not achieved substantial compliance; CMS has the right to impose federal remedies.

If you have any question please contact me at (302) 577-6661.

Sincerely,

Robert H. Smith
Licensing and Certification Administrator

RHS/jlo

Enclosures

cc: Timothy Hock, CMS, Chief, Certification and Enforcement
Victor Orija, LTC Ombudsman *(w. enclosure)*
Richard McKee, DLTCRP
File

ASPEN

SEVERITY/SCOPE GRID

Name:	DELMAR NURSING & REHABILITATION CENTER 101 E. DELAWARE AVENUE DELMAR, DE 19940	Provider	085041
		Survey Date	05/10/2013
Survey Event ID:	7GRS11	Survey Types	Complaint Investig.

SUMMARY OF DEFICIENCIES

Level 4	**J**	**K**	**L**
Level 3	**G** F0309	**H**	**I**
Level 2	**D** F0224 F0225 F0250 F0280 F0281 F0314 F0322 F0328 F0406	**E** F0157 F0323 F0490 F0501	**F**
Level 1	**A**	**B** F0514	**C**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085041	A. BUILDING _____ B. WING _____	C 05/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	101 E. DELAWARE AVENUE DELMAR, DE 19940

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint visit was conducted at this facility from May 2, 2013 through May 10, 2013. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was eighty-two (82) which included review of seventeen (17) resident records and four (4) sub-sample records.	F 000	F-Tag 157 The center strives that it will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status: a need to alter treatment significantly.	7/30/13
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; 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); 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); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	Corrective action(s) taken accomplished for those residents found to have been affected by the deficient practice: R9 – Resident no longer resides at the facility. R7 – Physician has been made aware of the resident's clogged tube and replacement of the tube. R5– Resident no longer resides at the facility. R12 - Resident no longer resides at the facility. R10 - Resident no longer resides at the facility. R8 - Resident no longer resides at the facility. How we will identify other residents having the potential to be affected by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/6/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085041	A. BUILDING _____ B. WING _____	C 05/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	101 E. DELAWARE AVENUE DELMAR, DE 19940

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews it was determined that the facility failed to immediately consult with the physician and/or notify the responsible party for six (R9, R7, R12, R5,R10, and R8) out of 17 sampled residents who had a significant change in condition which had the potential for requiring physician intervention. Findings include: 1. Cross refer F309, example #1. Review of the facility's incident report dated 4/8/13 documented that R9 experienced a fall on 4/8/13 at approximately 10:10 PM in which R9 reported that he hit his head. The policy and procedure titled "Change of Status Notification" was reviewed. This P & P failed to include the approval date and the effective date. This P & P indicated that resident's attending physician, or designee and Responsible Party will be notified by the Charge Nurse/Nursing Supervisor when: - There is an incident or accident involving a resident. - A sudden or unexpected change or deterioration in resident's physical, mental or emotional status (psychosocial). - Any situation which requires a change in the resident's plan of care, medication or treatment	F 157	**the same deficient practice and what corrective action will be taken:** The following addresses R9, R12 and R10 - Medical Director teaching rounds were conducted by the Medical Director /NP and the nursing team (Attachment #1) to establish baseline and validate condition changes, noncompliance with care and were reported to MD/NP and RP. No other residents affected. Audits were conducted of incident reports (Attachment #2) for the last 30 days to ensure MD/NP and RP's were notified of changes in condition. An audit of the nurses notes (Attachment #3) and 24 hour report (Attachment #4) for 7 days also occurred to verify other condition changes were reported to the MD/NP and RP. R7 - Gastrostomy Tubes were assessed to ensure they are patent and intact. (Attachment #5) No issues identified. A house audit was completed to identify any change in the resident's status/condition (Attachment #1). R9 and R12 - A house audit was completed of falls and neurological assessments for the past 90 days to ensure physician and responsible party have been made aware (Attachment #6)	

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 157	Continued From page 2 regime. Record review lacked evidence that R9's attending physician, E5 was consulted when R9 fell and hit his head. In addition, record review lacked evidence that R9's power of attorney, F1 was notified of the fall on 4/8/13 at 10:10 PM. The facility's P & P titled "Neurological Checks" was reviewed. This P & P failed to include the approval date and the effective date. This P & P indicated: - Neurological checks with complete vital signs are completed every 15 min. (minutes) for the first hour post injury, then every hour for four hours, and then every eight hours for 72 hours unless assessment reveals a more frequent assessment is indicated. Observe for changes from baseline assessment data such as refusal to eat or drink, restlessness, increased confusion, progressive drowsiness or any other progressive deterioration. - Notify physician of any negative changes in assessment status that develop or continue or as neurological status is evaluated over the 72 hours post injury. R9's "Neurological Assessment Flowsheet" dated 4/8/13 was reviewed. The baseline assessment was completed at 10:15 PM on 4/8/13 which documented that R9's level of consciousness (LOC) was alert, pupils equal and reactive to light (PERL), hand grasps equal, appropriate response to pain, blood pressure (BP) 130/60; no temperature (T) obtained; heart rate (HR) per minute 76; respiration rate (RR) per minute of 20 and was signed by E6 (Registered Nurse). For the 10:30 PM and 10:45 PM assessments, the	F 157	as well as completion of the neuro checks. Incomplete audits found. Neuro checks reinitiated. All residents found to be stable. R10 and R5- The medical director will review all residents with a cardiac /respiratory diagnosis to insure they are stable and to be aware of an acute medical condition to include abnormal blood pressures and pulse oxes. Audit conducted of the face sheets to determine accurately assessed cognition. (Attachment #7) Those deemed incapable of making decisions will have face sheets updated to reflect accurate responsible party. For those deemed competent, the resident will be interviewed to determine their point of contact for the notification process. All issues identified corrected and revised copy place on chart. R8- Resident appointments have been reviewed for the last 30 days to insure return consults recommendations have been addressed. (Attachment #8) **What measures will be put in place or what systemic changes made to ensure that the deficient practice does not recur:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085041	A. BUILDING _____ B. WING _____	C 05/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	101 E. DELAWARE AVENUE DELMAR, DE 19940

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F 157	Continued From page 3 neurological assessment was not completed, however, BP decreased to 100/70 and 90/60 respectively. An interview with E6 on 4/8/13 was conducted on 5/3/13 at approximately 2:55 PM confirmed that the attending physician, E5 was not consulted of the decreasing BP from the baseline of 130/60. At 11 PM, R9's LOC documented a change to drowsy and PERL. For hand grasps and pain response, it was documented, "Unable to obtain." BP 98/62; T 97 F (Fahrenheit) ; HR 60; RR 18 and R9 was observed "sleeping" and was signed by the night shift Registered Nurse, E7. At 12 midnight, R9's LOC was drowsy and PERL. For hand grasps and pain response, it was documented, "Unable to obtain." BP decreased to 84/56; no T; HR was 57; RR was 20, R9 was observed sleeping, and signed by E7. Despite the negative changes in BP from baseline of 130/60 to 84/56 at 12 midnight, record review lacked evidence that the physician was consulted of the negative changes in assessment. At the 1 AM assessment, R9 was drowsy with PERL. Hand grasps and pain response were documented as "Unable to obtain." For the vital signs, the staff documented "Ref. BP" or refused BP and signed by E7. At the 2 AM assessment, R9 continued to be drowsy with PERL. Hand grasps and pain response were documented as "Unable to obtain." BP was 108/58; T 98; HR 72; RR 18 and R9 observed sleeping. This assessment was	F 157	**Education:** Nursing staff have been in-serviced by the corporate staff on guidelines of regulation and the center policy on notification of change as well as all in-services below: Staff was in-serviced (Attachment #9) all policies related to change in condition requiring notification MD/NP and as well as documentation: Change of condition – detecting and communicating change in resident condition; and notification of physician and family members – change of status notification In order to identify conditions requiring notification of change, staff has been in-serviced with return competency checks on the following: Policies and procedures related to neurological assessments (Attachment #9): Neurological assessment/vital signs/head injury; Pupil assessment and neurological checks; Motor function assessment; Falls, Accidents and incidents to include incident report investigation checklist; and Neurological observation report and fall investigation report	

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F 157	Continued From page 4 signed by E7. At the 3 AM assessment, R9 remained drowsy with PERL. Hand grasps not assessed, however, R9 moved all his extremities and appropriately responded to pain stimuli. For the vital signs, the staff documented "Ref. BP" or refused BP and signed by E7. Nurse's Note (N.N.) dated 4/9/13 and timed 3:42 AM documented that R9 appeared to be sleeping as evidenced by even respirations and unlabored on oxygen at 2 liters via nasal cannula. R9 opens eyes for neurochecks and then returns to sleep easily. Ambien (brand name for Polypide, a hypnotic medication) from prior shift effective. No new neuro (neurological) symptoms noted, BP was 98/62, HR of 57, and RR of 18. An interview with E7 (Registered Nurse) on 5/7/13 at approximately 10:30 AM confirmed although R9's BPs were decreasing from baseline and R9 was refusing the neurological assessments, E7 confirmed that R9's attending physician was not consulted. N.N. dated 4/9/13 and timed 5:32 AM documented that at 4:45 AM, R9 was found with his feet on the floor lying in his bed with no respiration or pulse and CPR (Cardiopulmonary resuscitation) was initiated. Further review of the facility's incident report dated 4/8/13 documented that the attending physician, E5 was notified of the fall on the following day, 4/9/13 at 8 AM. In addition, R9's legal representative was notified of the fall on 4/9/13 at 2:30 PM. This was after R9's condition	F 157	24 Hour Report Documentation and Follow-up (Attachment #9) Cardiac /respiratory assessment and monitoring (Attachment #9) Medication monitoring (Attachment #9) Competency tests/return demonstrations of neuro assessments, respiratory/cardiac monitoring, and notification of change will be conducted to ensure knowledge base and critical thinking (Attachment #9). Re-education will occur if necessary. New Gastrostomy tube policy was updated and in-serviced at the time of the event. No further issues since the event occurred and continue to reinforce via in-servicing (Attachment #10) Staff and Nursing administrative/Kryterium room team will be in-serviced regarding new policy /procedure on enhancing communication with outside consultants to include contacting the consultants to clarify information as needed (Attachment #11). Staff will be in-serviced on the updated face sheets as well as receiving changes in responsible party information	

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F 157	Continued From page 5 had deteriorated to the point that he required CPR in the facility. An interview with R9's attending physician, E5 on 5/9/13 at approximately 2 PM confirmed that it was his expectation that a complete neurological assessment be conducted per the facility's policy. This included, awakening a resident, such as R9, who was sleeping to complete the assessment. E5 verbalized concerns of the lack of critical thinking by the staff which resulted in the physician not being consulted of the descending BP as well as the nursing staff's inability to consistently complete the neurological assessment. An interview with R9's legal representative, F1 on 5/6/13 at approximately 1 PM confirmed that she was not notified of R9's fall. Findings reviewed with E1, Administrator and E2, Director of Nursing (DON) on 5/10/13 at 2 PM. 2. Cross refer F322. Review of the Nurse's Note (N.N.) dated 1/24/13 at 6:42 PM documented R7's PEG tube was clogged and a Licensed Practical Nurse, E4 replaced the tube with an 18 french catheter with 30 cc (cubic centimeter) balloon. The note documented that the placement was checked and the new tube flushed without difficulty. An interview with E4 (Licensed Practical Nurse) on 5/7/13 at approximately 9 AM revealed that when he replaced the PEG on 1/24/13, he was not aware of the facility's policy that PEG tube replacement should be performed by a physician in the hospital.	F 157	to the 24 hour report and Kryterium room meeting. Audit tool used to identify changes. (Attachment #12) System changes: Charts are audited to ensure that documentation reflects that the physician/NP has been notified. Resident change of status and notification to MD/NP and RP are reviewed in the Kryterium room (Attachment #42) Revised Kryterium room forms implemented to include consults, neuro checks, respiratory/cardiac issues, as well as EMR reports to include pulse oxes, blood pressures/vital signs, G-tube issues and refusal of treatments as well as nurses notes and 24 hour reports (Attachment #13) Currently recruiting for off shift RN Supervisors/ADON's to monitor patient care and assist with critical thinking. Shifts to be monitored by RN include 3-11 and 11-7 during the week and 24 hours on weekends. The responsibilities include frequent rounds and communication with the nursing staff regarding monitoring and follow up of condition changes, nursing interventions and documentation to include	

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F 157	Continued From page 6 Record review lacked evidence that the attending physician/designee was consulted when the PEG tube was clogged on 1/24/13. In addition, record review lacked evidence that the responsible party was notified when the PEG became clogged and had to be replaced. Interview with Clinical Services Consultant, E11 and E2, Director of Nursing on 5/8/13 at 12 noon confirmed the findings. Findings reviewed with E1, Administrator and E2 (DON) 5/10/13 at 2 PM. 3. Cross refer F328. Review of the Nurses Note (N.N.) by E14 (Registered Nurse) dated 11/2/12 and timed 10:32 AM documented when administering the morning medications to R5, E14 observed that the resident seemed very tired and was not eating her breakfast. R5 did minimal verbal conversations and E14 checked her vital signs and they were blood pressure (BP) 110/60, heart rate (HR) of 82 per minute, 12 respiration rate (RR) per minute and temperature (T) of 97.1 Fahrenheit. R5's pulse oximetry (a non-invasive method allowing the monitoring of the oxygen saturation of a resident's hemoglobin in the blood) was initially 88% (low oxygen saturation or hypoxemia) but after a couple deep breathes it rose to 92% therefore E14 decided to continue to monitor the resident. Although R5 had a significant change in condition as evidenced by low pulse oximetry of 88%, record review lacked evidence that R5's attending physician was consulted. Subsequent N.N. dated 11/2/12 and timed 1:55	F 157	notification of change to MD/NP and RP's. During monthly staff meetings, case scenarios will be reviewed and discussed to assist in developing nurses' critical thinking. During weekly rounds, specific cases will be discussed so staffs learn potential outcomes to monitor for. DON or designee on call 24/7 for incident reporting to ensure timely and proper follow up of notification occurs. Audit tool to track nurses (Attachment #14) regarding notification of change. Re-education/disciplinary action up to termination has begun for failure to follow policy and will continue as needed. Consultation recommendations via the Kryterium room consultation form. In the event that a resident returns from a consultation without documented recommendations or follow up, a phone call will be placed to the consultant office to review resident status. Kryterium room consult tool will be reviewed to insure MD/NP and RP have been notified timely. (Attachment #13)	

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F 157	Continued From page 7 PM documented that R5 was sent to the hospital due to decrease in alertness and abnormal vital signs. R5 was flushed, pale in color and unable to obtain BP times two by two additional Registered Nurses, HR of 59, and RR of 10 with two apnea (cessation of breathing) episodes. The resident opened her eyes to painful stimuli but not to basic verbal command. Nurse Practitioner, E32 was contacted and orders were obtained to send the resident to the emergency room. Interviews with E11 (Clinical Services Consultant) and E2 (Director of Nursing) on 5/8/13 at 12 noon confirmed that the facility failed to consult the physician when R5 had a significant change in condition as evidenced by oxygen saturation of 88%. An interview with E3 (Associate Director of Nursing and Unit Manager for units 1 and 3) confirmed that when R5 had oxygen saturation of 88%, the physician should have been consulted and immediately notified. An interview with R5's attending physician, E5 was conducted on 5/9/13 at approximately 2 PM. E5 verbalized the lack of critical thinking by the staff may have resulted in the physician not being consulted when R5 had a oxygen saturation of 88%. Findings reviewed with E1, Administrator and E2, Director of Nursing on 5/10/13 at 2 PM. 4. R12 was admitted to the facility on 9/13/12 for a 5-day hospice respite.	F 157	A new policy has been written and approved by the facility administration and Medical Director - communication with outside physicians (Attachment # 11). Kryterium room process and forms revised to have more inclusive and detailed process. (Attachment #13) New department heads to include QA, social services, activities, unit managers and ADON's will be in-serviced to the Kryterium room revised process and forms. Supervisor checklist implemented to monitor the live time condition changes and communication needs for the off shifts and weekends (Attachment #15). Contact information tracked more aggressively via the social services Kryterium room form that addresses cognition and responsible party contacts and decision making capacity (Attachment #13) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.**	

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F 157	Continued From page 8 The facility's policy and procedure for Change of Status Notification documented the resident's attending physician, or designee and Responsible Party will be notified by the Charge Nurse/Nursing Supervisor when: -A sudden or unexpected change or deterioration in resident's physical, mental or emotional status (psychosocial). -Any situation which requires a change in the resident's plan of care, medication or treatment regime... abnormal lab values .... Review of nurses' notes revealed the following; 9/16/12 1:50 AM blood pressure (BP) 124/64; 9/16/12 6:48 AM pt co of (complaint of) "not feeling well", vs (vital signs) pulse 75 and BP 91/54, skin on back of hand is slightly tenting. I told patient to stay in bed until MD rounded as pt complained of feeling 'messed up' when standing" . There was no evidence that the physician was consulted about this change in condition. An investigative interview on 11/13/12 at 2:50 PM with E5 (attending physician) revealed that he was not made aware of this incident, it was confirmed that the note was written on a Sunday and that the doctor makes rounds on Tuesdays. On 9/16/12 at 2:20 PM R12's BP was 110/74. A nurse's note dated 9/16/12 and timed 9:57 PM documented that R12 had an unwitnessed fall while trying to move from the bed to a chair. There was no observed injury and the resident's BP was 108/58	F 157	QA nurse or designee will review and validate completed Kryterium room documentation as well as the supervisors' checklist/communication form and report findings to the DON. Care review systems which include Kryterium room reviews and tool completion, review of nurses notes (pulled live time from EMR), 24 hour report, pulse oxes, vital signs, (Attachment #16) consultations, accidents/incidents, abuse allegations, g-tube issues face sheet audits and other acute condition changes will be monitored for notification of change to MD/NP and RP by the Administrator or designee and validated by the DON, QA, compliance nurse or designee for occurrence and completion daily until 100% success over 3 consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3 consecutive evaluations and then in one month . Any negative trends will be reported to QA for investigation and follow up.	

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F 157	Continued From page 9 Although the physician (E5) was made aware of the fall there was no evidence that he was made aware of the low BP reading that AM and again at the time of the fall. An interview on 5/8/13 at 10:35 AM with E30 (Licensed Practical Nurse), revealed that the MD should have been consulted about the low blood pressure readings and the resident feeling "messed up". He did state that staff might have told the hospice nurse if they were in so they could look at his medications. Review of the hospice visit note by a registered nurse on 9/16/12 at 3:45 PM revealed no mention of vital signs or R12 feeling messed up. He did tell the nurse that he had some pain. This was reviewed with E1, Administrator and E2, Director of Nursing on 5/10/13 at 2 PM. 5. Cross refer F309, example 3. R10 was admitted to the facility on 10/5/12 with diagnoses including hypertension (high blood pressure) and cerebral vascular accident (stroke) as well as a history of heart problems (infection). On 2/25/13, a physician at a clinic examined R10 and documented that R10 reported the following respiratory issues: shortness of breath on exertion, cough / wheezing, and productive cough. On 3/31/13 at 4:30 PM, a nurse documented that R10's oxygen had dropped abnormally low (88 - 91%) and that R10 refused oxygen and the	F 157	**Measurements of success** 100% compliance with timely physician/NP and RP notification via the audit tools and Kryterium room process which will be determined by the DON, QA and compliance nurse audits.	

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F 157	Continued From page 10	F 157		

physician was notified. On 4/4/13, the physician ordered a chest x-ray. On 4/5/13 at 11:35 AM a nurse documented that R10's oxygen level was 98% and he refused to have the chest x-ray stating that he felt fine. This note further documented that R10 refused to have his breath sounds (lung sounds) listened to by the nurse who notified the nurse practitioner of this. There was no evidence that R10's involved family member (his niece, F4) was notified of this change in condition (abnormal respiratory signs and symptoms) On 4/16/13 at 3:05 AM, a nurse documented that R10 had been short of breath at about 2 AM and had an oxygen level of 91% with a heart rate of 102 beats / minutes and had refused oxygen. R10 became unresponsive soon after this requiring CPR by facility staff and transfer to the hospital via 911.

Interview with F4, the involved family member for R10, revealed that she was never notified that R10 had respiratory issues and had refused a chest x-ray. F4 stated to the surveyor on 5/6/13 at 2:35 PM that if she had been told about the low oxygen levels and the need for a chest x-ray she believed that she would have been able to convince R10 that it was important to have the chest x-ray done. F4 further stated that she had spoken to the facility's Assistant Director of Nursing (E3) on 4/11/13 to get an update on R10's care plan meeting (held on 4/9/13) but E3 never told her about any respiratory issues. E3 confirmed to the surveyor on 5/7/13 at 11:55 AM that she had not discussed R10's respiratory issues on 4/11/13 because she was giving F4 a general update about R10's care plan and didn't get into extensive details. When asked if R10's respiratory issues and refusal of a chest x-ray

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F 157	Continued From page 11 was important information for the family to have, E3 agreed that it was. E3 also stated to the surveyor that she checked the nursing notes for R10 and did not see any indication that the family had been notified of the change in R10's condition although any nurse could have done so. The facility failed to notify an involved family member of R10 of respiratory issues reported by the resident to a physician on 2/25/13 and of low oxygen levels on 3/31/13 followed by refusal to have a chest x-ray done. No notification of the involved family member (F4, niece) occurred despite a phone conversation between F4 and the facility's ADON (E3) within the same week as the chest x-ray being refused. These findings were reviewed with E1 Administrator, E2 Director of Nursing and E11Clinical Services Coordinator on 5/10/13. 6. Cross-refer F309, example 4. On 2/5/13 a consulted physician (E33) told a facility CNA (E19) to take R8 to the emergency room (ER) for evaluation. After hearing this from E19, E2 (Director of Nursing) instructed E19 to bring R8 back to the facility instead. E2 failed to consult with either E33 or E5 (attending physician) about R8's condition and any questions she had about the reason for transfer to the ER. Nurse practitioners E12 and E13 were made aware of E33's instruction for R8 to go to the ER but facility staff failed to communicate to them significant details about E33's reasons for giving this instruction (emesis with bile). The facility failed to comply with its own "Change of Status Notification" policy / procedure which instructed staff to notify the attending physician or designee of "any action of a consultant, which	F 157		

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F 157	Continued From page 12 affects the overall care" of a resident. The facility staff failed to take R8 to the ER as instructed by E33 without consulting with E5 (attending physician) and without providing complete information to nurse practitioners E12 and E13. These findings were reviewed with E1 Administrator, E2 Director of Nursing and E11Clinical Services Coordinator on 5/10/13 at 2 PM.	F 157		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIAT N The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure three (R2, R10, and R9) out of 17 sampled residents were free from neglect. R2 had a debridment (removing unhealthy or dead tissue from a wound) of a right toe corn ulceration and did not receive treatment in the facility for the wound for one month. This resulted in the wound not healing and developing an infection that moved to the bone and blood of the resident. R10 was screened prior to facility admission to need psychiatric services. The facility failed to acquire these services for the resident. For R9 who required neurological assessments after a fall	F 224	**F-Tag 224** The center strives to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** # 2 - Resident no longer resides at the facility #10 - Resident no longer resides at the facility. #9 - Resident no longer resides at the facility. **How we will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** R2 – Chart audits were conducted to insure consult recommendations were addressed and implemented if	7/30/13

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F 224	Continued From page 13 when a change in status (decline on level of consciousness accompanied by a decline in blood pressure) the facility failed to consult the physician. Findings include: The facility's Abuse Prevention and Reporting Policy dated 8/7/12 defined neglect as; The failure to provide goods and services necessary to avoid physical harm or mental anguish. Neglect is the failure to provide the necessary treatment, rehabilitation, care, attention, food, clothing, shelter, supervision or medical services by a caregiver. 1. Cross refer F225 example #1 and F309 example #2. Record review revealed that R2 had seen the podiatrist (foot doctor) on 8/16/12 and returned to the facility with a bandage on her toe, orders for a daily treatment of Neosporin cream dressing and a follow-up visit in one month. Review of the physician orders, treatment record and nurses' notes lacked evidence that the treatment was ever provided. Review of facility documentation included weekly skin assessments done by nursing staff on 8/20, 8/27, 9/3 and 9/10/12 noting each time "no new skin issues", failing to identify and assess the wound to the right second toe. R2 was also scheduled for showers on Mondays and Thursdays on the evening shift. There was no evidence that the wound was identified during any of the showers A nurse's note dated 9/15/12 and timed 12:13 AM	F 224	appropriate (Attachment #8). Skin sweeps have been performed to assess current status of residents' skin (Attachment #17). No unknown areas were identified. R-10 A house audit (Attachment #18) was conducted by the Social worker to review PASAAR tools and to ensure that any PASAAR any resident needing a psych consult was obtained. House audit of all diagnosis/mental health issues was conducted to ensure those residents with a psychiatric related diagnosis/needs were or will be seen by psych services (Attachment #18). R9 - A house audit was completed by the unit managers to identify any change in the resident's status/condition (Attachment #1). The physician was notified of any changes. The responsible party was made aware of any changes in conditions and/or any refusals of physician orders. **What measures will be put in place or what systemic changes we will make to ensure that the deficient practice does not recur:** **Education:**	

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F 224	Continued From page 14 documented that an aide found a dressing on R2's right toe that was thick with dried blood. When the dressing was removed the area measured 1.3 by 1.5 cm, the toe was black and looked like it was going to fall off. The resident was administered Tylenol and sent out to the hospital. Review of hospital records revealed R2 was found to have osteomylitis (an infection of the bone) and sepsis (infection of the blood throughout the body). The facility failed to provide treatment to a wound as ordered by the podiatrist resulting in an infection to the wound, the bone and the blood system of R2. These findings were reviewed on 5/10/13 at 2 PM with E1, Administrator, E2, Director of Nursing, and E11, Clinical Services Consultant. It was confirmed that there was no evidence that the facility provided treatment to the right second toe wound. E1, E2 and E11 could not explain how skin checks and showers could be conducted for a month and no one noticed a bandage or a wound on R2's toe. 2. Cross-refer F406. R10 was admitted to the facility on 10/5/12 with diagnoses including mental illness (schizoaffective bipolar disorder), hypertension (high blood pressure), and cerebral vascular accident (stroke). According to the required Pre-Admission Screening of R10 by a State agency, this resident had a diagnosis of mental illness and had been followed by a psychiatrist in the community and in the hospital prior to admission to the facility. It was recommended	F 224	**Education provided by the corporate clinical nurse consultant to include:** R2 – Staff was in-serviced on head to toe assessment to include CNA bath and skin reports (Attachment #19) and assessments from the knee down following a podiatry consult (Attachment #20). R10 – Nursing, admissions and social services staff educated on identifying psychiatric and psychosocial needs to include review of PASAAR, identifying diagnosis/mental health issues through behavioral documentation; patient and family interview; and review of hospital transfer records. Staff have also been in-serviced on the process for psychiatric and social service referral. Refer to Attachment #46 for a copy of the policy on the referral process. R9 – Nurses have been in-serviced on physical assessment to include neuro checks and blood pressure abnormality/monitoring. Competencies and return demonstration have been conducted to ensure timely notification to the physician/NP when indicated. Neurological assessment/vital signs/head injury; Pupil assessment and	

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F 224	Continued From page 15 that R10 "be followed by psychiatry in nursing home for medication management and for acute changes in psychiatric status". E2, Director of Nursing, confirmed in writing to the surveyor on 5/10/13 at 9:03 AM that R10 "did not receive any psychiatric services" during the 6 months that he was a resident of the facility. Interview with E24, the supervisor of the State's Pre-Admission Screening review team at 10:06 AM on 5/10/13 confirmed that it was expected that R10 would be followed by a psychiatrist while he was in the facility. R10 went to a wellness clinic for medical treatment and monitoring of a medical condition. On 2/25/13, R10 was evaluated by a physician at this clinic who documented "needs psychiatric assessment!!" in his typed report. As confirmed by E2 on 5/10/13 at 9:03 AM, R10 never received any psychiatric services indicating that the facility neglected to meet R10's need for psychiatric care. The clinic physician's typed report had the handwritten initials of a nurse practitioner (E12) and a handwritten notation by a nurse of "no new orders". According to records obtained from the mental health services provider under contract with the facility and provided to the surveyor, between 1/23/13 and 4/9/13 repeated attempts were made (by phone and mail) to contact F2 (the sister who had been the responsible party for R10) to obtain consent for psychological services. F2, however, had died on 12/20/12 and her death was documented in a facility social services note dated 1/7/13 and timed 2:33 PM. The facility failed to communicate F2's death to the mental health services provider and also failed to provide	F 224	neurological checks; Motor function assessment; Falls, Accidents and incidents to include incident report investigation checklist; and Neurological observation report and fall investigation report (Attachment #9). **System Change:** R2 – The daily tracking consultation tool has been revised (Attachment #13) to include assessment of any patient having a podiatry consult to be reviewed by the clinical team to ensure recommendations were received and reported to the physician/NP. Following a podiatry consult, the nurses' responsibility is to assess the feet to identify any skin issues. The Kryterium room consult tool will confirm that the skin assessment occurred. R9- Nurse Supervisor checklist implemented to monitor the live time condition changes and communication needs for the off shifts and weekends (Attachment #15). DON or designee on call 24/7 for incident reporting to ensure timely and proper follow up of notification occurs. R10 - Admission tool (Attachment #13) and social services (Attachment #13) tracking tools have been revised to	

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F 224	Continued From page 16 them with contact information for F3 and F4 (involved family members of R10). This resulted in two and a half months of futile attempts to contact a deceased individual and the neglect of R10's mental health service needs. 3. Cross refer F309, example #1. Review of the facility's incident report dated 4/8/13 documented that R9 experienced a fall on 4/8/13 at approximately 10:10 PM in which R9 reported that he hit his head. The policy and procedure titled "Change of Status Notification" was reviewed. This P & P failed to include the approval date and the effective date. This P & P indicated that resident's attending physician, or designee and Responsible Party will be notified by the Charge Nurse/Nursing Supervisor when: - There is an incident or accident involving a resident. - A sudden or unexpected change or deterioration in resident's physical, mental or emotional status (psychosocial). - Any situation which requires a change in the resident's plan of care, medication or treatment regime. Additional facility's P & P titled "Neurological Checks" was reviewed. This P & P failed to include the approval date and the effective date. This P & P indicated: - Neurological checks with complete vital signs	F 224	include review of PASAAR screening and to identify psychiatric related diagnoses and conditions. This will ensure residents requiring psychiatric consultation or follow up are obtained. Upon admission, nursing reviews the discharge summary for psychiatric meds, diagnoses, psychosocial needs and PASAARs; interviews family members as appropriate to identify potential psychosocial needs. Social Services with in the center and the primary physician are both notified for follow-up. Upon receipt of an order, Deer Oaks will be notified via fax on their current form (Attachment #44) as a condition change is identified warranting psych services.. A new psychiatric group, Med Options is starting in August 29, 2013. The new group will screen all new admissions for psychiatric needs. Nursing will notify the psychiatric group, social services and physician as needed when symptoms identified are indicative of psychiatric or social service intervention. Med options is a provider of psychiatric and psychological services. They will provide a psychiatric nurse practitioner, a psychologist and a psychiatrist. Currently Deer Oaks only provides psychological support. In the interim, if Deer Oaks can't meet the needs of the patient, they will inform staff. At that point, the facility will work with the local hospitals and psychiatrists	

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F 224	Continued From page 17 are completed every 15 min. (minutes) for the first hour post injury, then every hour for four hours, and then every eight hours for 72 hours unless assessment reveals a more frequent assessment is indicated. Observe for changes from baseline assessment data such as refusal to eat or drink, restlessness, increased confusion, progressive drowsiness or any other progressive deterioration. - Notify physician of any negative changes in assessment status that develop or continue or as neurological status is evaluated over the 72 hours post injury. R9's "Neurological Assessment Flowsheet" dated 4/8/13 was reviewed. The baseline assessment was completed at 10:15 PM on 4/8/13 which documented that R9's level of consciousness (LOC) was alert, pupils equal and reactive to light (PERL), hand grasps equal, appropriate response to pain, blood pressure (BP) 130/60; no temperature (T) obtained; heart rate (HR) per minute 76; respiration rate (RR) per minute of 20 and was signed by E6 (Registered Nurse). For the 10:30 PM and 10:45 PM assessments, the neurological assessment was not completed, however, BP decreased to 100/70 and 90/60 respectively. An interview with E6 on 4/8/13 was conducted on 5/3/13 at approximately 2:55 PM confirmed that the facility failed to provide the necessary services by failing to consult the attending physician, E5 of the decreasing BP from the baseline of 130/60. At 11 PM, R9's LOC documented a change to drowsy and PERL. For hand grasps and pain	F 224	in the community to obtain necessary services. R10 – The QA nurse or designee will review the admissions and social services tracking tools to ensure follow through has occurred as documented– The QA nurse will review fall investigations to insure neurological checks have been done thoroughly and completely and physician and responsible party notification appropriately (Attachment #13). Patient care and documentation will be monitored and reviewed live time 24/7 by RN nurse managers and RN supervisors. These RN supervisors are now free floating with no assigned group of residents. This is a change from previous practices. The supervisor checklist has been edited to be more detailed oriented and specific to cited deficiencies. Supervisors has been trained on the new form and the completed are reviewed regularly by the DON or designee to monitor for completeness and accountability. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.**	

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F 224	Continued From page 18 response, it was documented, "Unable to obtain." BP 98/62; T 97 F (Fahrenheit) ; HR 60; RR 18 and R9 was observed "sleeping" and was signed by the night shift Registered Nurse, E7. At 12 midnight, R9's LOC was drowsy and PERL. For hand grasps and pain response, it was documented, "Unable to obtain." BP decreased to 84/56; no T; HR was 57; RR was 20, R9 was observed sleeping, and signed by E7. Despite the negative changes in BP from baseline of 130/60 to 84/56 at 12 midnight, record review lacked evidence that the facility failed to provide the necessary services by failing ton consult E5 of the negative changes in assessment. At the 1 AM assessment, R9 was drowsy with PERL. Hand grasps and pain response were documented as "Unable to obtain." For the vital signs, the staff documented "Ref. BP" or refused BP and signed by E7. At the 2 AM assessment, R9 continued to be drowsy with PERL. Hand grasps and pain response were documented as "Unable to obtain." BP was 108/58; T 98; HR 72; RR 18 and R9 observed sleeping. This assessment was signed by E7. At the 3 AM assessment, R9 remained drowsy with PERL. Hand grasps assessed, however, R9 moved all his extremities and appropriately responded to pain stimuli. For the vital signs, the staff documented "Ref. BP" or refused BP and signed by E7. Nurse's Note (N.N.) dated 4/9/13 and timed 3:42	F 224	QA nurse or designee will review and validate completed documentation on the consult tracking tools weekly until 100% compliance achieved as well as the supervisors' checklist/communication form and report findings to the DON and QA committee. QA nurse or designee will review all fall investigations to insure neurological checks were initiated, completed and physician notified when appropriate. Findings will be reported to the QA committee. Care review systems to include Kryterium room tools, neuro checks, podiatry consults, admissions, social services will be monitored for occurrence and completion daily until 100% success over 3 consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3 consecutive evaluations and then in one month . Any negative trends will be reported to QA for investigation and follow up.	

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		F 224	**Measurement Process:** 100% compliance with live time monitoring of neuro checks and completion and validation of the Kryterium room tools to include neuro checks, podiatry consult follow up, admissions, social services – psych diagnoses/mental health issue monitoring.	

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F 224	Continued From page 19 AM documented that R9 appeared to be sleeping as evidenced by even respirations and unlabored on oxygen at 2 liters via nasal cannula. R9 opens eyes for neurochecks and then returns to sleep easily. Ambien (brand name for Polypide, a hypnotic medication) from prior shift effective. No new neuro (neurological) symptoms noted, BP was 98/62, HR of 57, and RR of 18. An interview with E7 (Registered Nurse) on 5/7/13 at approximately 10:30 AM confirmed although R9's BPs were decreasing from baseline and R9 was refusing the neurological assessments, E7 confirmed that R9's attending physician was not consulted. N.N. dated 4/9/13 and timed 5:32 AM documented that at 4:45 AM, R9 was found with his feet on the floor lying in his bed with no respiration or pulse and CPR (Cardiopulmonary resuscitation) was initiated. An interview with R9's attending physician on 5/9/13 at approximately 2 PM revealed he was not aware of the descending BP as well as the nursing staff's inability to consistently complete the neurological assessment. Findings reviewed with E1, Administrator and E2, Director of Nursing on 5/10/13 at 2 PM.	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225	F-Tag 225 The center strives to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had	7/30/13

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F 225	Continued From page 20 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and 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. The facility 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 (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to immediately report and thoroughly investigate allegations of neglect for two (R2 and R7) out of 17 sampled	F 225	a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriations of their property' and 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 State nurse aide registry or licensing authorities. The center strives to ensure that all alleged violations involving mistreatments, 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. The center strives to ensure that it has evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The center strives to ensure that the results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified	

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F 225	Continued From page 21 residents. Findings include: 1. Cross refer F309 example #2. The facility reported to the state survey agency on 9/15/12 an injury of "unknown source" with the description "Resident has a wound on top of her right foot second toe" : Follow up report dated 9/19/12 documented "Resident had a history of a pre-ulcerative corn on that toe that had been reduced by the podiatrist. Resident sent to [name of hospital] and was diagnosed with osteomylitis (infection of the bone). She has been receiving antibiotics. No other issues" . Record review revealed that R2 had seen the podiatrist (foot doctor) on 8/16/12 and returned to the facility with a bandage on her toe, orders for a daily treatment of Neosporin cream dressing and a follow-up visit in one month. Review of the physician orders, treatment record and nurses' notes lacked evidence that the treatment was ever initiated. A nurse's note dated 9/15/12 documented that an aide found a dressing on R2's right toe that was thick with dried blood. When the dressing was removed the area measured 1.3 by 1.5 cm, the toe was black and looked like it was going to fall off. The resident was administered Tylenol and sent out to the hospital. Review of hospital records revealed R2 was found to have osteomylitis (an infection of the bone) and sepsis (infection of the blood throughout the body). On 5/6/13 E2, Director of Nursing (DON) provided the survey team copies of staff disciplinary action forms for two nurses E17 LPN and E18 LPN dated 9/24/12 and 9/25/12 respectively as well as a plan of correction for skin audits and a	F 225	appropriate corrective action must be taken. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** #2 – Resident no longer resides at the facility. #7 – The appropriate Gastrostomy Tube was inserted and replaced. **How we will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of investigations completed for the previous 10 days was completed to review for trends for educational opportunities on the investigative process (Attachment #2). **What measures will be put in place or what systemic changes we will make to ensure that the deficient practice does not recur:** **Education:** Staff has been in serviced by the corporate staff on timely reporting of injuries, neglect or changes in condition that require investigation and reporting to include classification of injuries/wounds. (Attachment #22)	

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F 225	Continued From page 22 nurse/aide communication book dated 9/14/12. On 5/7/13 at 10:52 AM E2, DON provided copies of staff interviews conducted in 12/2012 when the facility identified that a thorough investigation had not been conducted. E2 stated that due to the amount of time between the incident and the interview staff could not remember specific information so they stopped the investigation due to the lack of information to go on. Despite the fact the facility identified failures in their system they failed to identify that an allegation of neglect related to lack of care and treatment for R2's wound that led to the osteomylitis and sepsis. This resulted in the failure to immediately report and thoroughly investigate an allegation of neglect. 2. Cross refer F281 and F322. Review of the facility's incident report dated 1/25/13 and timed 6:47 PM documented that R7 was observed with the PEG (percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach) tube almost out with the balloon busted. R7's Nurse's Note (N.N.) dated 1/24/13 at 6:42 PM documented the PEG tube was clogged and a Licensed Practical Nurse, E4 replaced the tube with a 18 french with 30 cc (cubic centimeter) balloon. The note documented that the placement was checked and the new tube flushed without difficulty. The facility's policy and procedure (P & P) for gastrostomy tube (GT) replacement failed to	F 225	Please refer to the entire Abuse Prevention and Reporting Policy (Attachment #41). On page two of the Abuse policy, it was stressed to the staff that failure to provided the necessary treatments to a patient constitutes neglect. The DON and nursing administrative personnel have been educated on the disciplinary write up process (Attachment #23) and how to conduct an investigation to include state regulation for timeliness of reporting, questions to ask to obtain accurate and thorough information during interviews and how to determine root cause. An "Occurrence Investigation Flow Chart was provided as a guideline. (Attachments #9, #41 & #43). The DON received additional training on the investigation process on July 8th by the nurse consultant.. On July 8th, Additional training to Nursing Administration including the Nurse Supervisors have been in-serviced that all alleged violations involving neglect and abuse are to have a Investigation Report completed. **System change:**	

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F 225	Continued From page 23 include the approval date and the effective date. This P & P indicated that the physician shall change GT inserted via PEG method at the hospital. Subsequent N.N. dated 1/25/13 and timed 6:33 PM documented that at 3:30 PM on 1/25/13, R7's PEG tube was partially dislodged, balloon busted, and "good" amount of feed on R7's gown. The nurse practitioner, E13 was contacted and at 4 PM, an order was obtained to send R7 to the emergency room for evaluation of the PEG site. An interview with E4 on 5/7/13 at approximately 9 AM revealed that when he replaced R7's PEG tube on 1/24/13, E4 was not aware of the above P & P and proceeded to replace the tube based on his nursing judgement. Review of the facility's 5 day follow-up to the above incident of allegation of neglect dated 1/30/13 was conducted. The facility's investigative records revealed that the facility incorrectly identified that a wrong size PEG tube was utilized rather than that E4 failed to follow the facility's P & P and proceeded to replace the PEG without an order. An interview with E2, Director of Nursing on 5/8/12 at approximately 12 noon confirmed that the facility's investigation revealed that the incorrect tube size was utilized to replace R7 PEG tube. During this interview, the surveyor requested E2 to identify the physician's order for the size of the PEG tube in R7's clinical records since the surveyor was not able to identify an order. E2 confirmed that there was no order for	F 225	Nurse supervisor responsibilities include direct involvement with initiating the investigative portion of the incidents during the shift of occurrence. The DON and/or QA nurse will ensure the accuracy, timeliness of reporting and completion of the incident. The DON or Administrator is contacted of a reportable incident 24 hours per day to ensure investigation is in progress with notification to agencies as required. An audit tool has been created to address the investigative process (Attachment #13). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Administrator and QA nurse will review investigations for thoroughness, accuracy and completion. The investigative process will be monitored for thoroughness, accuracy and completion daily until 100% success over 3 consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3 consecutive evaluations and then in one month . Any negative trends will be reported to QA for investigation and	

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		F225	follow –up. Trends are referred to the QA committee for investigation. **Measures for success:** 100% compliance with investigative Kryterium room tool and disciplinary write up process.	

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F 225	Continued From page 24 the PEG tube since per the facility's P & P, the replacement would be completed by a physician in the hospital.	F 225		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it was determined that for two (2) of seventeen (17) residents reviewed (R10 and R8) the facility failed to provide medically-related social services to enable the residents to attain their highest practicable physical, mental, and psychosocial well-being. The facility failed to ensure that R10, a resident with mental illness, received social services to ensure that he had a clearly identified decision maker who was kept informed by facility staff. The facility failed to provide R8 with social services to ensure that the decision maker she had chosen for herself was identified and known to the staff. Findings include: 1. R10 was admitted to the facility with a diagnosis of mental and physical illness and an identified decision maker (F2, his sister). The initial history and physical by the attending physician (E5) indicated that R10 was "marginally incompetent". The initial Minimum Data Set dated 10/9/12 indicated significant cognitive impairment while the last MDS assessment for	F 250	F-Tag 250 The centers strive to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** #10- Resident no longer resides at the facility. #8 – Resident no longer resides at the facility. **How we will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** A house audit (Attachment #7) has been completed on all residents to determine decision making capacity and/or the responsible party for each resident. Residents that lack decision making capability and do no have a clearly identified decision maker have been referred for guardianship. **What measures will be put in place or what systemic changes you will make**	7/30/13

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F 250	Continued From page 25 R10 dated 4/16/13 indicated moderate cognitive impairment for daily decision making. Despite R10's known cognitive issues and mental illness, the facility failed to provide social services to promote effective communication with his family for decision making. E25, the facility's former social worker, reported to the surveyor on 5/9/13 at 2 PM that R10 had a legally appointed guardian (F2) and that she had seen the legal papers for this in his chart. E25, however, explained that the last time she looked for these papers they were no longer in the chart. No legal guardian papers were found in the closed clinical record when reviewed by the surveyor on 5/5/13. According to a social services note dated 12/21/12, R10's brother (F3) had called the facility and informed them that R10's sister (F2) had died. F2 had been R10's decision maker. On 1/7/13 at 2:33 PM, the social worker documented that she had referred F3 to the Ombudsman's office (a State agency that assists residents of nursing facilities) for assistance with completing Power-of-Attorney documents. On 2/8/13 at 12:10 PM, the social worker documented that another family member (F4, R10's niece) had contacted her to discuss guardianship of R10. E25 documented that R10 agreed to have his niece (F4) listed as an emergency contact. On 4/12/13 at 2:51 PM the social worker again documented that his healthcare information could be shared with his niece, F4. In an interview with the surveyor on 5/6/13 at 2:35 PM, F4 stated that the facility staff kept saying that R10 could make his own decisions but this was not true and R10 had a long term guardian (F2) before coming to the	F 250	**to ensure that the deficient practice does not recur:** **Education:** Education provided by corporate staff to all departments regarding the identification and reporting requirements of changes in behavior and/or cognition. Social services educated on obtaining decision makers or guardians for residents as appropriate. Nursing and social services educated regarding the referral process for social service and/or psychiatric service needs. **Systems:** Resident competency is reviewed by the attending physician during initial examination. Social Services reviews resident competency as part of the admission process and with any change of status (Attachment #13). Residents are also identified as part of the RAI process, as well as the quarterly social services assessments to include cognitive, mood and behavior patterns. When changes in decision making are identified, the resident will be referred to the attending physician and social services to update the residents plan of care and, if needed, identify a surrogate decision maker.	

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F 250	Continued From page 26 facility. F4 explained that she lived 2 hours away and it was hard to get information from the facility by phone. For over 3 months after R10's guardian (F2) died, the facility failed to provide social services to R10 to establish an identified decision maker for this cognitively impaired resident with mental illness and physical illness. E3 confirmed to the surveyor on 5/7/13 at 11:55 PM that it was never clear to the staff who R10's responsible party was after F2 died. When R10 had respiratory related health issues in April, 2013, no family member was notified. In April, 2013, the facility sent a letter regarding a care plan meeting addressed to F2 (who had died over 3 months prior). This letter was received by F4 (R10's niece) who called the facility and asked to participate in the meeting by speaker phone since she lived 2 hours away from the facility. F4 told the surveyor on 5/9/12 at approximately 4:10 PM that she was told there was no phone in the room where the care plan meeting was held so the staff would have to update her after the meeting. On 5/7/13 at 11:55 PM E3 (ADON) confirmed to the surveyor that the facility had speaker phones and there would be no reason not to have a family member participate by phone if necessary. 2. R8 was an 89 year old resident with multiple medical diagnoses including diabetes and chronic kidney disease. According to a social services note dated 7/12/12, a family member, F5, had begun the process for obtaining guardianship of R8. No evidence of facility follow-up to this was	F 250	The nurse will review upon admission/readmission the diagnoses, psychiatric related medications and behavioral issues. The patient will be referred by nursing via fax or telephone to the physician psych and social services accordingly to address both acute and ongoing as identified psychiatric and psychosocial needs. Patient contact information will be reviewed at least quarterly by Social services to ensure current contact information is accurate. When family of incompetent patients or patients who want family involved in their care planning, but the family do not live in the area, conference calls will be offered in the quarterly care plan notification letter as an option (sent by social services) to include all interested parties in the care planning process. As defined in Attachment #42, the Kryterium Room Process, the social worker (as a member of the interdisciplinary team) is an active member of the Kryterium Room meetings. In the POC for F 250, under systems, it is also stated that the social worker completes quarterly assessments, is informed of any cognitive, mood or behavioral changes. Through the Kryterium Room Process tools (attachment #13 – Issue: Behavior,	

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		F250	Issue: Psych Consult, Issue: Admissions/Social Services; and Issue: Advance Directives) the social worker is actively involved and participates in the resident's plan of care. Policies and procedures will be reviewed annually and amended with any changes submitted to the QA committee. Weekly Medical Director meeting implemented to review acute change in condition, falls, abuse allegations, weight changes, etc. And identifying QA issues, root cause analysis (include monthly QA meeting) Patient capacity will be monitored during on-going medical rounds with changes reported to the DON or SW for follow-up. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Administrator and QA nurse will review monitor follow up with the consults and responsible party information to include accuracy documentation daily until 100% success over 3 consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3	

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		F250	consecutive evaluations and then in one month. Any negative trends will be reported to QA for investigation and follow-up. Trends are referred to the QA committee for investigation (Attachment #16). Any negative trends will be reported to QA for investigation and follow up. **Measures for Success:** 100% compliance with consult follow up and accuracy and of responsible party information.	

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F 250	Continued From page 27 documented. In an interview with a State survey agency investigator on 2/26/13, E2 (Director of Nursing) identified by name the family member R8 wanted to name as her guardian (F5). F5's name was not listed as a responsible party in the clinical record and as of 2/5/13 the facility staff was communicating with another family member, F6. The facility failed to provide medically related social services over a period of 7 months to ensure that R8 had the decision maker of her choice. There was no evidence of facility follow-up on the status of the guardianship application and it was unclear why F5 wasn't identified in the clinical record as an involved family member.	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending 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 periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	**Tag 280** The center strives to ensure that each resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team; that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and,	7/30/13

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		F 280	to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.** #1 – Resident no longer resides at the facility **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** House audit completed (Attachment #26) to ensure all residents with skin related issues have accurate care plans. Readmissions for the last 60 days reviewed to ensure skin care plan preventative measures are ordered and care planned. Other care plans have been audited to ensure they match the patient's current needs (Attachment #27). **What measures will be put in place or what systemic changes we will make to ensure that the deficient practice does not recur:**	

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		F 280	**Education:** Education provided to the Kryterium room team regarding the use of the Kryterium room tools to ensure the team understands the components and use of the skin tool and the admission/readmission. Staff has been in-serviced on the care planning process to include development of initial or acute care plans to be initiated at the time of admission or identified patient change. (Attachment #29) **Systems:** The completion of the care plans will be monitored via the Kryterium room (Attachment #13) process skin tools (see attached) to insure the care plans and orders are updated in a timely manner. Admission and readmission charts are reviewed in the Kryterium room (Attachment #13) admission/readmission audit tool to ensure the team captures the treatment orders and care plan needs. Kryterium room tools have been updated to include care plan review for changes in condition. Weekly skin rounds with the IDT will validate that the care plans are accurate. Care review systems Kryterium room skin tool and admission/readmission	

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		F280	audit tool will be monitored by the QA nurse or designee for occurrence and completion daily until 100% success over 3 consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3 consecutive evaluations and then in one month. Any negative trends will be reported to QA for investigation and follow-up. Trends are referred to the QA committee for investigation. **Measures for success:** 100% compliance will be determined by the outcome of the audits.	

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F 280	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R1) out of 17 sampled residents the facility failed to ensure that the care plan was updated to reflect identified care needs. Findings include: Cross refer F314 example #1. R1 was re-admitted to the facility from the hospital on 9/20/12 with a documented wound to the right heel that was subsequently identified as a pressure ulcer. Review of the resident's care plan initiated on 7/23/10 for pressure ulcer prevention and treatment did not include this new skin breakdown found on 9/20/12 until 1/10/13 when it was documented that there was a dry scab on the left (incorrectly identified actually right) heel and skin prep was being applied daily. At the same time the approach to elevate/float heels in bed was added to the care plan. This was review with E1, Administrator and E2, Director of Nursing on 5/10/13 at 2 PM.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	**F-Tag 281** The center strives to ensure that the services provided or arranged by the facility must meet professional standards of quality.	7/30/13

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F 281	Continued From page 29 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that services were provided to meet professional standards of quality for one (R7) out of 17 sampled residents. Findings include: 1. Cross refer to F322. Review of the Nurse's Note (N.N.) dated 1/24/13 at 6:42 PM documented the PEG (percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach) tube was clogged and a Licensed Practical Nurse, E4 replaced the tube with a 18 french with 30 cc (cubic centimeter) balloon. Review of the facility's policy and procedure (P & P) for gastrostomy tube (GT) replacement failed to include the approval date and the effective date. This P & P indicated that the physician shall change GT inserted via PEG method at the hospital. An interview with E4 on 5/7/13 at approximately 9 AM revealed that when he replaced R7's PEG tube on 1/24/13, E4 was not aware of the above P & P and proceeded to replace the tube based on his nursing judgement. An interview with E2, Director of Nursing on 5/8/12 at approximately 12 noon confirmed when R7's PEG tube was clogged, the facility failed to notify the physician and have the replacement completed at the hospital per the facility's P & P. An interview with R7's attending physician, E5 on 5/9/13 at approximately 2:10 PM confirmed that it	F 281	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** #7 – Physician has been made aware of the resident's clogged tube and replacement of the tube. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** A house audit (Attachment #5) has been completed by the unit Managers of all Gastrostomy Tubes and G-tube related orders. All were patent and intact. Orders written that G-tubes may not be replaced in-house and to notify the physician. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur:** **Education:** Staff was in serviced by the corporate staff on the following: Gastrostomy Tube Replacement; Notification of Physician and Family Members – Change of Status Notification; Change of Condition – Detecting and Communicating Change	

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		F281	In Resident Condition; and Scope of Practice – Delaware Nursing Practice Act Highlights (Attachment #9). **Systems:** Resident change of status and follow-up are reviewed in the Kryterium Room acute change in condition tool (Attachment#13). This includes physician and family member notification. Order reports are pulled daily to ensure all orders, treatments and interventions are initiated per physician orders as it related to G-tube issues. When there is a change of status; to include dislodgement of a g-tube, the RN Supervisor will be notified as well as the PCP. The supervisor will assess the patient prior to transfer if indicated. Kryterium room acute change in condition tool (Attachment #13) will be monitored by the QA nurse or designee for occurrence and completion daily until 100% compliance x 5 evaluations achieved; then 3 x week until 100% compliant 5 consecutive evaluations; then once per week until 100% compliant 3 consecutive evaluations, then in one month. At the completion of this schedule and is successful will then will monitor monthly x 3. Negative trends will be reported to QA for investigation and follow-up. Trends are	

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		F281	referred to the QA committee for investigation. **Measures for success:** 100% compliance based on the completion and validation regarding G-tubes on the acute change in condition tool.	

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F 281	Continued From page 30 was his expectation that if a PEG tube required replacement, per the facility's policy/procedure requirement that the replacement be completed in the hospital.	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other clinical documentation it was determined that the facility failed to ensure that six (R2, R9, R12, R15, R10, and R8) out of 17 sampled residents received 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. R9 hit his head during a fall and had a change in status as evidenced by descending blood pressure (BP) and also developed fluid in the lungs. The facility failed to recognize the significance of R9's neurological status change[change in level of consciousness] along with the presence of fluid in the lungs. The facility failed to closely monitor R9's condition by failing to consistently complete R9's neurological assessment. These failures resulted in R9 being found unresponsive with no pulse or respiration. Cardiopulmonary	F 309	**F-Tag 309** The center strives to assure that every resident receives and is provided the necessary care and services to attain and maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment, plan of care and physician orders **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident #9 no longer resides at the center. Resident #2 no longer resides at the center. Resident #10 no longer resides at the center. Resident #12 no longer resides at the center Resident #8 no longer resides at the center. Resident #15 has had a full neurological assessment completed with no negative outcome noted.	7/30/13

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F 309	Continued From page 31 resuscitation (CPR) was initiated and R9 was sent to the hospital. R2 had a debridment (removing unhealthy or dead tissue from a wound) of a right toe corn ulceration at a podiatrist's office and did not receive the recommended treatment in the facility for the wound for one month. This resulted in the wound not healing and developing an infection that moved to the bone and blood of the resident requiring hospitalization. R12 had an unwitnessed fall and neurological checks were not initiated. R15 had two unwitnessed falls and neurological checks were not thoroughly completed. The facility failed to ensure that R10 received the care necessary to attain his highest level of well-being when he had a change in his respiratory status. R10 was noted to be "breathing funny" between 11:15 PM and 11:30 PM on 4/16/13 but no nursing assessment and intervention were identified in the record until approximately 2 AM when R10 reported difficulty breathing and soon became unresponsive requiring cardiopulmonary resuscitation (CPR) and transfer to the hospital via 911.The facility failed to ensure that R8 received the care necessary for her highest level of well-being when the facility failed to obtain emergency care on 2/5/13 at the instruction of a cardiologist (E33). This resulted in a 2 day delay in R8 being treated for a partial bowel obstruction. Findings include: 1. R9 was readmitted to the facility from the hospital on 4/4/13. Review of R9's Medication Administration Record for 4/8/13 revealed that R9 was administered Oxycodone (narcotic for pain control) 5 mg. (milligram) by mouth at 7:19 PM and Zolpidem	F 309	**How you will identify other residents having the potential to be affected by the same deficient practice:** Skin sweeps have been performed by the Nursing Administrative team which includes the DON, ADON, to assess current status of residents' skin (Attachment #17). No unknown areas were identified. House audit was completed by the Unit Managers of falls and neurological assessments (Attachment #6) for the past 90 days to ensure neuro checks have been appropriately initiated and have been completed. Those neuro checks found to be incomplete were initiated and completed. Residents' appointments have been reviewed for the last 30 days (Attachment #8) to ensure recommendations have been followed up. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur:** **Education:** One of the Corporate Nurse Consultants has educated staff on the following:	

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F 309	Continued From page 32 (hypnotic for insomnia) 10 mg. by mouth at 9 PM. Review of the facility's incident report dated 4/8/13 documented that R9 experienced a fall on 4/8/13 at approximately 10:10 PM in which R9 reported that he hit his head. This report documented that the attending physician, E5 was notified of the fall on the following day, 4/9/13 at 8 AM. The facility's policy and procedure titled "Neurological Checks" was reviewed which indicated: - Neurological checks with complete vital signs are completed every 15 min. (minutes) for the first hour post injury, then every hour for four hours, and then every eight hours for 72 hours unless assessment reveals a more frequent assessment is indicated. Observe for changes from baseline assessment data such as refusal to eat or drink, restlessness, increased confusion, progressive drowsiness or any other progressive deterioration. - Notify physician of any negative changes in assessment status that develop or continue or as neurological status is evaluated over the 72 hours post injury. R9's "Neurological Assessment Flowsheet" dated 4/8/13 was reviewed. The baseline assessment was completed at 10:15 PM on 4/8/13 which documented that R9's level of consciousness (LOC) was alert, pupils equal and reactive to light (PERL), hand grasps equal, appropriate response to pain, blood pressure (BP) 130/60; no temperature obtained; heart rate (HR) per minute 76; respiration rate (RR) per minute of 20 and was signed by E6 (Registered Nurse).	F 309	Center protocol for falls to include completion of neuro checks and trends that signify change of condition and require physician notification. (Attachment #9) Competency checks on completion of neuro checks and reporting changes also completed (Attachment #9) Preprinted documentation for neurological checks has been implemented to cue staff on timing and completion of neurological checks (Attachment #9); Physical assessment with focus on respiratory and cardiac systems with competency testing. (Attachment #9); Nursing staff have been educated on following up on consults and reporting recommendations to the physician to obtain orders; And critical thinking with review of case scenarios (Attachment #9a). Case scenarios are also discussed during the weekly teaching rounds discussed later in this POC. **System Changes** During the week on day shift; the unit managers and on off shifts during the week and weekends the RN Nurse Supervisor to monitor and assess patient care. Supervisors have a checklist to monitor the live time condition changes to include neuro check documentation and communication needs for the off	

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F 309	Continued From page 33 For the 10:30 PM assessment, there were no assessments for LOC, pupil response, hand grasps, and pain response. BP decreased to 100/70; no temperature; HR 70, RR 22 and no signature of the staff who completed the assessment. For the 10:45 PM assessment, there were no assessments for LOC, pupil response, hand grasps, and pain response. BP decreased to 90/60; no temperature; HR 74, RR 20 and with no signature of the staff who completed the assessment. An interview with E6, who provided care during the 3 PM-11 PM shift on 4/8/13 was conducted on 5/3/13 at approximately 2:55 PM. E6 confirmed that complete neurological assessments were not obtained at10:30 PM and 10:45 PM. In addition, E6 verbalized that she did not recall whether the physician and/or R9's power of attorney were notified of the fall. Lastly, E6 confirmed that the physician was not consulted regarding the decreasing BP from the baseline of 130/60. At 11 PM, R9's LOC documented a change to drowsy and PERL. For hand grasps and pain response, it was documented, "Unable to obtain." BP 98/62; T 97 F (Fahrenheit) ; HR 60; RR 18 and R9 was observed "sleeping" and was signed by the night shift Registered Nurse, E7. At 12 midnight, R9's LOC was documented as drowsy and PERL. For hand grasps and pain response, it was documented, "Unable to obtain." BP decreased to 84/56; no T; HR was 57; RR	F 309	shifts and weekends (Attachment #15). The supervisor will complete the checklist, sign it and review it with the oncoming supervisor or Unit Manager as appropriate. Completed checklists will then be forwarded to the DON. The role of the RN Supervisor Responsibilities will also include frequent patient rounds, communication with the nursing staff to identify condition changes, nursing interventions, monitoring follow up and supporting documentation. Ongoing teaching (educational moments) by supervisory staff in live time will be provided as necessary When patients return from outside appointments or consults, a copy of the report and recommendations is made and given to the Unit Managers to review staff follow-up and completion. If patient returns without documentation the consulting physician will be notified by the licensed nurse. The "Stop and Watch" system from the Interact II protocols has been in-serviced and put in place with staff This is a system that empowers all levels of staff to report noted changes in resident status. Staff have been inserviced on the the Interact assessment cues to assist staff in the level of expediency of notification of change and the SBAR	

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F 309	Continued From page 34 was 20, and R9 was observed "sleeping." This assessment was signed by E7. Despite the negative changes in BP from baseline of 130/80 to 84/56 at 12 midnight, record review lacked evidence that the physician was notified of the changes in assessment. An interview with E2 (Director of Nursing) on 5/3/13 at approximately 2 PM confirmed that the neurological assessment was not complete and that if a resident was sleeping, the expectation was that the nurse attempt to wake the resident in order to complete the neurological assessment. At the 1 AM assessment, R9 continued to be drowsy with PERL. Hand grasps and pain response were documented as "Unable to obtain." For the vital signs, the staff documented "Ref. BP" or refused BP and signed by E7. At the 2 AM assessment, R9 continued to be drowsy with PERL. Hand grasps and pain response were documented as "Unable to obtain." BP was 108/58; T 98; HR 72; RR 18 and R9 observed sleeping. This assessment was signed by E7. At the 3 AM assessment, R9 continued to be drowsy with PERL. Hand grasps not assessed, however, R9 moved all his extremities and appropriately responded to pain stimuli. For the vital signs, the staff documented "Ref. BP" or refused BP and signed by E7. Nurse's Note (N.N.) dated 4/9/13 and timed 3:42 AM documented that R9 appeared to be sleeping as evidenced by even respirations and unlabored	F 309	system (which stands for Situation; Background; Assessment; Request)for accurate assessment and communication of change of patient status for the physician. (Attachment #9). Weekly medical teaching rounds (Attachment #1) have been initiated to include the Medical Director or designated Nurse Practitioner, DON, ADON, Unit Managers as well as other members of the IDT as indicated to assist staff with assessment and critical thinking. Supervisor checklist implemented to monitor the live time condition changes and communication needs for the off shifts and weekends (Attachment #15)) The center has developed "Unexpected Discharge Committee" which consists of the center medical Director, the nursing administrative team, the Administrator. They meet monthly to review patients that had an unexpected return to the hospital. The records are reviewed to identify opportunity for improvement to validate early identification of resident changes and identify opportunities for education. (Attachment #30) **What corrective action(s) will be monitored to ensure the deficient**	

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F 309	Continued From page 35 on oxygen at 2 liters via nasal cannula. R9 opens eyes for neuro checks and then returns to sleep easily. Ambien (brand name for Zolpidem) from prior shift effective. No new neuro symptoms noted. BP 98/62 P (pulse) 57 and R 18. Review of written statement by E7(Registered Nurse) dated 4/10/13 documented that R9 responded appropriately during neuro checks by opening his eyes and lifting his hands to command. Respirations remained even and unlabored, lungs clear in upper lobes, pulse ox 94-96% consistently. Fluid heard in lower lobes but R9 scheduled for dialysis on the morning of 4/9/13. [Last respiratory assessment dated 4/4/13 stated clear breath sounds, diminished bases.] This assessment did not present different behavior from resident's previous assessment after taking Ambien. 4:44 AM, E9 Certified Nursing Assistant (CNA)was in room talking with R9 about getting his bath and having breakfast before dialysis. 4:45 AM, E7 found resident unresponsive. Although the above written statement documented that pulse oximetry was obtained, interview with E2, Director of Nursing on 5/15/13 at 1:45 PM revealed that the facility had no evidence of any pulse oximetry after R9's fall on 4/8/13. An interview with E7 on 5/7/13 at approximately 10:30 AM revealed that she documented "unable to obtain" during the assessments at 11 PM, 12 MN, 1 AM and 2 AM since R9 was sleeping so well which E7 attributed to the Zolpidem and the Oxycodone which were administered prior to the fall at approximately 9 PM and 7 PM respectively.	F 309	**practice will not recur, i.e., what quality assurance program will be put into place.** The Kryterium process described here is used to monitor patient care. The IDT meets in the morning. Each unit manager is prepared to discuss their 24 hour report and EMR monitoring tools. During this discussion, a member of the IDT documents, on the appropriate monitoring tools, to ensure completion of all necessary steps. A "to do" list is also generated for the Unit Manager to complete during the course of the day. "To do" lists and monitoring tools are reviewed daily to make sure all necessary tasks are completed. Although the Kryterium room process includes many forms, the forms are used as needed depending upon the condition change/issue that occurred. The forms guide the administrative staff through the follow up process in a particular area to ensure all components associated with the situation/condition change have been addressed. (Attachment #13) As the Kryterium Room Process is essential to maintaining care compliance, the Kryterium room will be monitored daily to ensure it occurs in it's entirety daily until 100% success over 3	

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F 309	Continued From page 36 E7 verbalized that R9 would not grasp his hands but would lift his hands to command, however, unable to assess pain stimuli. For the lack of vital signs at 1 AM and 3 PM, E7 verbalized that she recalled the certified nursing assistant, E9 informing her that E9 was not able to obtain vital signs due to R9's refusal and E7 proceeded to obtain vital signs. E7 further verbalized that she did not recall the vital signs and/or whether E7 documented this in the clinical record. Lastly, E7 verbalized that she did not consult the attending physician when R9's BP decreased to 84/56 at 12 midnight assessment and/or the inability to complete neurological assessment including refusal by R9. An interview with E9 on 5/8/13 at 9:30 AM revealed that she did not complete any vital signs after R9's fall on 4/8/13. An interview with E3 (current Assistant Director of Nursing and unit manager for unit 1) on 5/9/13 at approximately 1 PM confirmed that the neurological assessments were not consistently completed after R9's fall on 4/8/13. N.N. dated 4/9/13 and timed 5:32 AM documented that at 4:45 AM, R9 was found with his feet on the floor lying in his bed with no respiration or pulse and CPR was initiated. An interview with R9's attending physician, E5 on 5/9/13 at approximately 2 PM confirmed that it was his expectation that a complete neurological assessment be conducted per the facility's policy. This included, awakening a resident, such as R9, who was sleeping to complete the assessment. E5 verbalized the lack of critical thinking by the	F 309	consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3 consecutive evaluations and then monthly. The Corporate Nurse Consultant will attend Kryterium Room at least weekly to ensure compliance thereafter. The DON will monitor the supervisor reports for changes in patient status and care. When a change has been noted on the report, the DON or designee will review the patient chart to ensure appropriate follow up and documentation was completed. At least 30% of changes will be reviewed daily with a goal of 100% compliance. The QA committee will monitor overall patient care and services through the use of the QA audit tools. Any negative trends will be reported to QA for investigation and follow-up. Trends are referred to the QA committee for investigation.	

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F 309	Continued From page 37 staff which resulted in the physician not being notified of the descending BP as well as the inability to consistently complete the neurological assessment. The facility failed to recognize the significance of completing a neurological assessment after R9's fall. In addition, the facility failed to identify R9's decreasing BPs and refusal for an assessment as a negative change, thus, failed to consult E5. These failures resulted in R9 being found unresponsive with no pulse or respiration. Cardiopulmonary resuscitation (CPR) was initiated and R9 was sent to the hospital. Review of emergency room records from the hospital dated 4/9/13 and timed 5:58 AM documented that R9 had no spontaneous respiration and no audible heart sounds. Computed tomography (CT is a diagnostic procedure that uses special X-ray equipment to create cross-sectional pictures of the body) of R9's head was normal. R9 remained in comatose state and on a ventilator. R9 expired in the hospital on 4/10/13. Findings reviewed with E1, Administrator and E2, Director of Nursing on 5/10/13 at 2 PM. 2. R2's annual minimum data set assessment (MDS) dated 8/8/12 documented the resident was severely cognitively impaired for decision making, was dependent on staff for all activities of daily living and had no foot problems. According to clinical record documentation R2 had an appointment with E21, Podiatrist on	F 309		

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F 309	Continued From page 38 8/16/12. According to a report from E21, the physical examination revealed; there was an ulceration of the right second toe over the proximal interphalangeal joint (hinge joint between toe bones). There was a portion of the base of the middle phalanx (toe bone) present in the wound. E21 further described; debrided the ulcer on the left (sic written as left but annotation note says right second toe not left) second toe. A portion of the cartilage and bone were removed as well. The area was bleeding well. It appears this wound should heal. The patient is to avoid shoe pressure to the area. The wound should be dressed daily with Neosporin cream. We will see the patient again in one month. The patient is to avoid all shoe pressure to the dorsal aspect (top surface) of the right foot. It was documented that education materials "wound care" were provided. A Division of Long Term Care Residents Protection Investigative witness statement 10/22/12 from E19, CNA documented that she accompanied R2 to the podiatrist appointment. She stated that when she returned back to the nursing home she gave the paperwork to E22 licensed practical nurse (LPN) with the appointment card for the next visit. This statement was confirmed again with E19 on 5/6/13. The Physician order report lacked evidence of a physician order for wound dressing & Neosporin daily on 8/16/2012 or thereafter. Review of the August 2012 and September 2012 Treatment Orders revealed that there was no treatment ordered to the right foot or toe. Review of Nurses' Notes from 8/4/12 until	F 309		

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F 309	Continued From page 39 9/14/12 lacked any documentation about the ulceration to the right toe. Review of the electronic Grid Treatment / Assessment Report Skin Weekly Audit documentation for 8/20/12, 8/27/12, 9/3/12 and 9/10/12 documented there was "no new skin issues noted". A written statement from E17, LPN documented that on 9/10/12 when doing the skin check she got called away and never got back to check her feet. On 5/6/13 at 10 AM this statement was confirmed with E17. There were no physician visits documented during this period of time. This was confirmed in writing on 5/14/13 with E1, Administrator. The facility failed to have a system in place for the incorporation of recommendations and or orders from outside providers onto the physician order sheet (POS). A nurse's note dated 9/15/12 and timed 12:13 AM documented that "(name of E23 aide) reported that R2 has a dressing on her right toes with thick dried blood around it. I went in room to assess the area. I took the dressing off and saw a wound on the top of her right second toe that measures 1.3 cm x 1.5 cm. The toe looks black and look like it going to fall apart. Resident was pulling her foot away from me when I was cleaning the area. I administered prn (as needed) Tylenol 650 mg for s/s (signs and symptoms) of pain. Which is effective as resident stayed quietly until the ambulance came get her ". A nurse's note dated 9/15/12 and timed 10:37 AM documented that E2 had returned from the	F 309		

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F 309	Continued From page 40 hospital and was to follow-up with the wound center on Monday. A nurse's note dated 9/16/12 and timed 10:27 AM documented that the hospital had called with positive blood cultures (infection in blood) and wanted the resident sent back to the emergency room for possible admission. Hospital records dated 9/19/12 documented final diagnoses that included osteomyelitis (bone infection) of the right second terminal phalanx (bone) of the right second digit (toe). "The toe will fall off by itself and she was just treated for pain and received antibiotics," ... and bacteremia (blood infection) with methicillin negative staphylococcus aureus (MRSA) due to above. A nurse's noted dated 9/19/12 and timed 5:43 PM documented that the resident was readmitted to the facility on comfort care. The resident expired on 9/20/12 at 6:30 AM. R2's death certificate documented the immediate cause of death to be Alzheimer's disease with peripheral vascular disease and coronary disease as secondary. On 5/6/13 at 1:30 PM the above facts were reviewed with E2, Director of Nursing (DON) and E11, Clinical Services Coordinator. On 5/7/12 E2 provided some corrective action documents that the facility initiated including staff discipline forms, chart audits, new skin audit forms and an aide to nurse communication book. 3. Cross-refer F157, example 5 and F250,	F 309		

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F 309	Continued From page 41 example 1. R10 had multiple diagnoses including mental illness (Schizoaffective bipolar disorder), heart problems (infection), and hypertension (high blood pressure). R10 had low oxygen levels documented in a nursing note dated 3/31/13 timed 4:30 PM (88% - 91%) and a chest x-ray was ordered by the physician on 4/4/13. On 4/9/13 the order for the chest x-ray was discontinued due to R10 refusing. R10's involved family member (F4) was not notified of these events. On 4/16/13 beginning at about 11:15 PM - 11:30 PM, R10 experienced a change in his breathing according to an undated written statement obtained by facility staff from CNA E26 and given to the surveyor upon request on 5/5/13. E26 wrote that R10 "was breathing funny and had blood on his shirt (a little spot but noticeable on his left arm)". E26 wrote that nurse E27 checked on R10 who said he was fine and the blood was probably from a nose bleed (R10 had one a few days prior). The clinical record contained no documentation of how R10 was "breathing funny" at the start of the shift or what assessment and intervention, if any, the nurse (E27) had performed. CNA E26 wrote that later in the shift, R10 came to the nursing station and was hard to understand because his words weren't coming together and it looked like he was struggling to breathe. CNA E26 wrote that she ran and got nurse E27 to come check R10. E27 wrote a nursing note dated 4/16/13 timed 3:01 AM that around 2 AM, R10 was short of breath with an oxygen saturation level of 91% and a pulse of 102 beats / minute. E27 wrote that R10 refused oxygen and	F 309		

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F 309	Continued From page 42 became unresponsive shortly after this requiring cardiopulmonary resuscitation (CPR) and transfer to the hospital via 911. Interview with the RN supervisor (E28) on 5/7/13 at 11:06 AM revealed that she had been called by nurse E27 to evaluate R10 for chest pain and found R10 to be lethargic with an extremely low oxygen level below 70%. There was no documentation of R10 reporting chest pain or of any assessment of R10's chest pain by E27. E28 stated that R10 quickly became unresponsive after she arrived to the unit and she then assisted with CPR. E27 stated to the surveyor on 5/7/13 at 10:35 AM that before E28 arrived, he (E27) was looking in R10's chart to "see what medications" he could give R10 but E27 never stated to the surveyor that R10 was having chest pain. R10 was "breathing funny" between 11:15 PM and 11:30 PM on 4/16/13 but no nursing assessment or intervention was identified until about 2 AM when the resident was having difficulty breathing and then became unresponsive. Chest pain was reported by R10 according to nurse E28 who was called to evaluate the resident but no chest pain was documented by any nurse and there was no evidence of assessment or intervention in response to the chest pain. A chest x-ray ordered on 4/4/13 was never performed due to refusal although R10 had cognitive impairment and mental illness requiring family assistance with decision making. R10's family was never notified of his respiratory issues and need for a chest x-ray. A few weeks later, R10 became unresponsive and required CPR in the facility.	F 309		

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F 309	Continued From page 43 4. R8 had diagnoses including hypertension (high blood pressure) and coronary artery disease (heart disease). Nursing note documentation beginning on 1/15/13 indicated that R8 had a decreased appetite and intermittent nausea, vomiting, and stomach upset. Facility staff reported these issues to the physician (E5) and the nurse practitioner (E13) and monitoring of R8's condition was provided along with medication changes. A nursing note dated 2/3/13 timed 6:30 PM documented that R8 vomited and on 2/4/13 R8 complained of stomach upset and was not eating much. On 2/5/13 at 2:35 PM, a nurse documented that a "moderate sized area of partially dried substance" with a foul odor was found on the floor of R8's room and that R8 was unable to say if she had vomited or been incontinent of stool. According to the note, R8 was cleaned up and after consuming milk and a can of Glucerna (a nutritional supplement drink) she (R8) was transported to a scheduled office appointment with E33, a cardiologist (physician heart specialist). According to a 5/8/13 8:29 AM interview with E19, she was the transport CNA who drove the facility vehicle to take R8 to the cardiologist (E33) about a 10 or 15 minutes drive from the facility. E19 told the surveyor that while in the examination room prior to the cardiologist (E33) seeing her, R8 vomited dark brown greenish colored liquid that smelled like feces. E19 explained that she recognized this as the same substance she had seen that morning on the floor and on the wheels of R8's bed in the facility. E19 recalled that when	F 309		

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F 309	Continued From page 44 E33 (cardiologist) came to the door of the examination room, he told her to take R8 over to the emergency room (which was across the street from his office). E19 stated that she drove R8 to the hospital as she was told, pulled up to the emergency room (ER) door, and opened the door of the vehicle. E19 stated that before getting R8 out of the vehicle, she remembered she had other transports that morning so she called the Director of Nursing (E2) so other arrangements could be made. E19 stated that E2 told her to bring R8 back to the facility because the facility's physician wasn't aware of R8 going to the hospital. R8 stated that she drove R8 back to the facility as instructed by E2. Documentation (office visit note dated 2/5/13) from E33, the cardiologist, confirmed that R8 vomited "a large volume of bilious emesis" (contained bile) and that E33 had "explained (to E19) that she (R8) needed care beyond what we could provide in the office setting, and instructed the aide (E19) to take her (R8) directly to the emergency room. I (E33) called the emergency room physician on duty and presented the case to him and told him to expect (R8)". E33 listed this instruction as an order in his note: "Consult with Emergency Medicine on 2/5/13". Nurse E34 was interviewed by the surveyor on 5/9/13 at 9:50 AM and stated that she received a call from E19 on 2/5/13 and E19 said she had been told by E33 to take R8 to the hospital. E34 stated that she (E34) then called R8's responsible party and told them R8 was being taken to the hospital. E34 stated that she then walked to E2's office to tell her and found that E2 was on the phone with E19.	F 309		

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F 309	Continued From page 45 In a written statement dated 3/3/13 provided to a State survey agency investigator, E2 wrote that she was notified by E19 that R8 had vomited in E33's office and that E33 had recommended R8 be sent to the ER. E2 wrote that E12 (nurse practitioner) was in the facility that day, evaluated R8, and did not want her sent to the ER. Surveyor interview on 5/8/13 at 12:15 PM with E12, however, revealed that she was not aware of the appearance and odor of R8's emesis (vomit) at E33's office and that the decision to have R8 return to the facility was E2's. The facility's other nurse practitioner, E13 was interviewed on 5/8/13 at 11:45 AM and she stated that she told the staff not to send R8 to the hospital for vomiting, however, she stated that she was not aware of the appearance or odor of the emesis. E13 stated that if she knew that, she would have sent R8 to the ER and that she has sent other residents to the ER for the same thing. E12 examined R8 upon R8's return to the facility on 2/5/13. R8 remained in the facility until 2/7/13 when she was admitted to the hospital after an x-ray performed in the facility on that date revealed a partial bowel obstruction. There was a two day delay in diagnosis and treatment of this condition, however, because of the facility's failure to comply with E33's instruction to take R8 to the ER. The facility also failed to ensure that the nurse practitioners (E12 and E13) had complete information about R8's condition. 5. R12 was admitted to the facility 9/13/12 for a 5-day hospice respite.	F 309		

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F 309	Continued From page 46 A nurse's note dated 9/16/12 and timed 9:57 PM documented "This nurse had just left resident to go to nurse's station to get CNA to clean resident up. CNA went to clean resident up.CNA went to resident's room and found resident on floor, supine, on floor mat. Resident had period of apnea lasting 30 secs. After shaking resident's shoulder, resident took a big breath and answered staff. Resident is awake, alert and oriented to self and place. Resident stated he was going to get up and sit in chair so staff could change his bed. Resident offers no complaints at this time of pain or discomfort. No injuries noted at this time. CNA states she had checked personal bed alarm every time she was in room the change resident and it was turned on. Bed alarm was checked during post fall and it was turned off. Resident states he does not like the sound when it alarms. (Dr. name) notified and Girlfriend notified. CNAs back at nurses' station stating they just watched the resident turn off the bed alarm". An interview on 5/8/13 at 10:35 AM with E30, LPN, revealed that if a fall is unwitnessed then neurological checks should be done. He stated that he remembered this resident and he was not totally alert and oriented. Review of the clinical record lacked evidence that the facility initiated neurological checks for this unwitnessed fall. This was confirmed by interview with E1, Administrator and E2, Director of Nursing on 5/10/13 at 2 PM.	F 309		

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F 309	Continued From page 47 6. R15 had two falls on 11/16/12 one at 6:10 PM and another at 8 PM. The facility incident reports documented that R15 was found on the floor in her room from an unwitnessed falls and neurological checks were initiated. Review of the Neurological Assessment Flow sheet revealed that R15 was assessed 17 times between 6:19 PM on 11/16/12 and 11 PM on 11/18/12. The following assessments were absent; -The right eye was not checked for pupil response 17 of the 17 opportunities with staff documenting four times "right cataract". -The left eye was not checked for pupil response 13 out of 17 opportunities. -Hand grasp was not checked 5 out of 17 opportunities. -Vital signs were not checked for 9 out of 17 opportunities. R15 was seen by the eye doctor on 10/23/12 at which time the doctor was able to assess both eyes for pupil response in spite of the cataracts. The facility failed to do complete neurological assessments after R15 had two unwitnessed falls. These findings were reviewed with E1, Administrator and E2, Director of Nursing on 5/10/13 at 2 PM.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314	F-Tag 314 The center strives to ensure that based on the comprehensive assessment of a	7/30/13

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F 314	Continued From page 48 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R1 and R6) out of 17 sampled residents the facility failed to ensure that two residents with pressure ulcers received the treatment and services necessary to promote healing and prevent new sores from developing. The facility failed to accurately identify the type of wound and failed to reassess the pressure ulcer weekly. Findings include: 1. R1 was hospitalized on 9/15/12 related to weeping, redness, and itching of the lower extremities. R1 had a history of lower leg vascular problems with cellulitis (skin/tissue infection). R1 returned to the facility on 9/20/12. Review of the Nursing Admission Assessment dated 9/20/12 did not mention assessment of R1's heels. Review of the Treatment/Assessment Report dated 9/20/12 documented the resident had an "other" type of wound with eschar to the left (incorrectly documented actually right) heel that measured 2 centimeters (cm.) by 3 cm. There was no physician's order for care or treatment of this area.	F 314	resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable; and a resident having pressure receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. **Corrective Action(s) accomplished for those residents found to have been affected by the deficient practice.** #1 – Resident no longer resides at the facility #6 – Resident no longer resides at the facility **How we will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** Skin sweeps have been performed to assess current status of residents' skin (Attachment #17). Any noted change in patients' skin to be assessed by licensed nurse. Wound assessment is accurate and up to date for residents with altered skin integrity (Attachment #31). Audits will be conducted to ensure residents at high risk for pressure ulcer development and/or with current pressure ulcers as well preventative measures have been	

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F 314	Continued From page 49 Prior to the admission to the hospital on 9/15/12 R1 had a nursing approach to float the resident's heels that was documented in the electronic record by the CNAs each shift. When R1 returned from the hospital on 9/20/12, this approach was not included in the electronic record to be carried out by the aides. This approach was not re-initiated in the electronic record until 3/31/13. Review of the care plan initiated on 7/23/10 for pressure ulcer prevention and treatment did not include this new skin breakdown found on 9/20/12 until 1/10/13 when it was documented that there was a dry scab on the left (incorrectly identified actually right) heel and skin prep was being applied daily. At the same time the approach to elevate/float heels in bed was added to the care plan. This approach did not get into the electronic record for the aides to carry out until 3/31/13. The care plan did however have an approach to assess residents skin condition on admission, or hospital return and document in chart on skin report and weekly skin assessments by nurse and document on TAR (treatment administration record) and skin sheet. An assessment by the nurse practitioner (NP) E12 dated 9/27/12 documented cellulitis of lower extremities, on IV (intravenous) antibiotics for cellulitis, +3 edema present, chronic venous stasis and skin breakdown lower extremities. There was no specific mention of the condition of the heels. R1 had a wound care consult at the local hospital on 10/2/12 but this was limited to the left lower extremity cellulitis and did not mention the eschar on the right heel.	F 314	ordered and care planned (Attachment #26). **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur:** Weekly medical teaching rounds (Attachment #1) have been initiated to include the Medical Director or designated Nurse Practitioner, DON, ADON, Unit Managers as well as other members of the IDT as indicated. Residents to be reviewed during grand rounds include specific focus on patients that have experienced a change in condition, pressure ulcers and new admissions as well as review of other residents Weekly wound rounds are completed by the NP wound specialist along with the IDT. While nursing staff treats and documents on wounds as per physician orders, actual staging is done by the NP to ensure accuracy. Staff was in serviced on the following: Head to Toe Assessment; Bath and Skin Reports/nurse wound assessments; Change of Condition/Nursing Assessment -- Detecting and Communicating Change in Resident	

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F 314	Continued From page 50 On 10/2/12 the physician ordered for the eschar to the left (right) heel to be monitored every shift and notify physician of any changes. On 10/11/12 the physician ordered a heel protector/cushion to right heel while in wheelchair. The quarterly minimum data set (MDS) assessment dated 10/12/12 documented the presence of one unstageable pressure ulcer with slough or eschar that was present upon admission. A nurse's note dated 10/15/12 documented the resident had an area on right heel 1.5 cm. x 1.5 cm. black eschar tx (treatment) started skin prep to area q (every) shift and monitor area q shift The next nursing assessment of the heel was on 10/17/12, four weeks after it was identified and indicated that there was eschar on the right heel that measured 1.5 cm x 1.5 cm. The next documented wound assessment was a month later on 11/14/12 noting eschar to the right heel that was 1.5 cm in diameter. A nurse's note dated 12/2/12 documented R1 had a 1 cm diameter eschar on right heel. An assessment by the NP E12 dated 12/4/12 documented a wound to the lateral aspect right heel area approximately 1.5 cm diameter firm dark eschar, peri wound firm no drainage. Diagnosis pressure ulcer right heel, chronic venous stasis. The next documented wound assessment was	F 314	Condition; 24 Hour Report Documentation and Follow-up; Consults – Change of Status Notification; and Wound Identification and Wound Staging; Training included assessing and communicating change in status and included tools from the Interact II system. In particular, the "Stop and Watch" program has been in-serviced to center staff for reporting noted changes in resident status; the Interact assessment cues to assist staff in the level of expediency of notification of change and the SBAR system for accurate communication of change of patient status (Attachment #9). RN's will be inserviced on wound staging and identification. **How the corrective(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Resident alteration in skin integrity and follow-up are reviewed in the Kryterium Room by the IDT using the alteration in skin/pressure ulcer tool (Attachment #13) Skin assessments and bath sheets will be monitored via Kryterium room daily	

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F 314	Continued From page 51 12/12/12 noting a pressure ulcer to the right heel that was 1.5 cm x 1.5 cm. An assessment by the NP E12 on 12/18/12 to evaluate the right heel area documented a pressure ulcer to the right heel with skin prep to the area. The wound was described as approximately 1 cm in diameter with dry eschar and no drainage. Review of the quarterly MDS dated 1/10/13 documented R1 no longer had a pressure ulcer. The Weekly Skin Assessment Sheet documented only three entries related to the right heel; 10/20/12 weekly skin assessment completed area of eschar noted on right heel which is old and has been documented on previously, no other areas noted. 12/2/12 1 cm diameter eschar on right heel and 3/15/13 right heel eschar is completely healed. The facility failed to correctly identify the location of the wound upon readmission from the hospital. The facility failed to start treatment and monitoring of the wound upon identification of the wound and for the first 4 weeks. Once the pressure ulcer was identified and being treated the facility failed to conduct weekly assessments of the wound including a description of the wound with measurements, color, drainage and condition of the peri-wound (skin around the pressure ulcer). The facility failed to ensure the approach of off-loading heels to prevent additional pressure ulcer development was in place and being implemented. An interview on 5/8/13 at 2 PM E2, Director of	F 314	by the Unit Manager or designee and reported to the DON. New policy and procedure implemented regarding staging of wounds by nursing (Attachment #32). Supervisors/ Unit Managers will verify the accuracy live time of wound staging and documentation as pressure ulcers are identified with guidance from the NP Wound Nurse The center's skin program has been reviewed and updated to include weekly wound rounds by the IDT and Nurse Practitioner or designee (Attachment #33). Admission and readmission patients and charts will be assessed/reviewed within 48 hours to insure accuracy of skin assessments, orders and care plans (Attachment #13). The nurse wound assessments will be monitored and reviewed on a weekly basis for accuracy, appropriate treatment orders and completion of orders (Attachment #31) Charts from recent previous admissions will be reviewed to ensure all appropriate treatment and care plan interventions are in place (Attachment #13)	

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F 314	Continued From page 52 Nursing (DON) revealed that there was not a policy and procedure that addressed wound care and the frequency of wound assessments. She stated that orders were obtained from the doctor on an individual basis for the residents. E2 stated that the nurse practitioner is now doing the wound measurements and she does it once a week. E2 stated that it would have been her expectation that nursing was doing a weekly updated current assessment of each wound. 2. Review of R6's Nurse's Note (N.N.) dated 8/1/12 timed 3 PM documented a new intact blister on the right heel measuring 5.5 centimeters (cm.) in length (L) by 5.5 cm. in width (W) intact. Skin prep was ordered and to continue to elevate heels off the bed. Review of the facility's wound sheet documented a right heel blister with the above measurements. An interview with the Licensed Practical Nurse, E8 who completed this wound sheet was conducted on 5/7/13 at approximately 2 PM. E8 verbalized that she did not identify the type of wound during the first assessment on 8/1/12 but rather, she described the presentation of the skin impairment as an intact blister. E8 incorrectly verbalized that an intact blister on the right heel cannot be staged. The next reassessment of the right heel was completed on 8/20/12 by E8; approximately 19 days after and the wound type was documented as a healed pressure ulcer (PU). The subsequent reassessment was completed on 9/19/12 documented a new area which was a necrotic right heel measuring 2.5 cm. X 2 cm. old blister area that resolved.	F 314	New order reports are pulled daily to ensure all orders, treatments, interventions and transcribed to nursing kardexes are completed per physician orders. Skin assessed during baths, showers and while turning and repositioning. The CNA's will document any alteration in skin integrity on bath sheets and stop and watch forms. The documentation is forwarded to the Charge nurse for verification and follow-up to include wound assessments, treatments, notification to MD/NP and RP Care review systems (Kryterium room alteration in skin integrity and pressure ulcer forms, skin, bath sheets, nurse wound assessments, orders and care plans) will be monitored by QA or designee for occurrence and completion daily until 100% success over 3 consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3 consecutive evaluations and then in one month. Any negative trends will be reported to QA for investigation and follow-up. Trends are referred to the QA committee for investigation. (Attachment #16) **Measure of success:**	

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F 314	Continued From page 53 The facility failed to accurately identify the type of wound when R6 acquired an intact blister (stage II pressure ulcer) on his right heel and failed to comprehensively assess the pressure ulcer on a weekly basis.	F 314	100% compliance of wound identification and accuracy of documentation as evidenced by the audit tools.	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, interview and review of the facility's policy and procedures, it was determined that for one (R7) out of 17 sampled residents, the facility failed to follow established policy/procedure by replacing	F 322	F-Tag 322 The center strives to ensure that based upon the comprehensive assessment of a resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's clinical condition demonstrates that use a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or Gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. #7 – The appropriate Gastrostomy Tube was inserted and replaced A house audit (Attachment #5) has been completed of Gastrostomy Tubes to ensure they are patent and intact. G-tubes were found to be intact and patent.	7/30/13

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F 322	Continued From page 54 the gastrostomy tube via the PEG (percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach) method. Findings include: Review of the Nurse's Note (N.N.) dated 1/24/13 at 6:42 PM documented the PEG tube was clogged and a Licensed Practical Nurse, E4 replaced the tube with an 18 french catheter with 30 cc (cubic centimeter) balloon. The note documented that the placement was checked and the new tube flushed without difficulty. Review of the facility's policy and procedure (P & P) for gastrostomy tube (GT) replacement failed to include the approval date and the effective date. This P & P indicated that the physician shall change GT inserted via PEG method at the hospital. An interview with E4 on 5/7/13 at approximately 9 AM revealed that when he replaced R7's PEG tube on 1/24/13, E4 was not aware of the above P & P and proceeded to replace the tube based on his nursing judgement. The surveyor requested E4's assistance in identifying the physician's order for the size of the tube which was utilized on 1/24/13, however, no information was provided to the surveyor. Subsequent N.N. dated 1/25/13 and timed 6:33 PM documented that at 3:30 PM on 1/25/13, R7's PEG tube was partially dislodged, balloon busted, and "good" amount of tube feeding on R7's gown. The nurse practitioner, E13 was contacted and at 4 PM, an order was obtained to send R7 to the emergency room for evaluation of the PEG site.	F 322	Policy updated to instruct staff (Attachment #10) to notify physician and send patients with G-tube issues to the hospital for follow-up. Medical Director has reviewed and approved this policy. Physician orders have been obtained to reflect new policy. Staff has been in-serviced on gastronomy tube policy. Unit managers or designee will review Gastrostomy tubes during rounds to identify issues requiring physician intervention (Attachment #15) The Kryterium room condition change tool will be monitored for occurrence and completion daily. Success will be measured by: 100% audit of tool to ensure no G-tubes changed by nursing daily until 100% success over 3 consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3 consecutive evaluations and then in one month. Any negative trends will be reported to QA for investigation and follow-up. Trends are referred to the QA committee for investigation. **Measurement for success:** 100% compliance with the G-tube policy as evidenced by the audit tools.	

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F 322	Continued From page 55 At 9:45 PM on 1/25/13, R7 returned to the facility after insertion of a new tube in the PEG in the emergency room. Record review reveled that R7 was closely monitored with no evidence of pain and discomfort. Interviews with E11 (Clinical Services Consultant) and E2 (Director of Nursing) on 5/8/13 at 12 noon confirmed that the facility failed to notify the physician; failed to follow the above P & P and replaced the PEG tube at the facility and without an order. An interview, with R7's attending physician, E5, on 5/9/13 at approximately 2:10 PM, confirmed that it was his expectation that if a PEG tube required replacement, per the facility's policy/procedure that the replacement be completed in the hospital.	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations it was determined that for one (1) out of seventeen (17) residents reviewed (R10) and for three (3) sub-sample residents (SS1,	F 323	F-Tag 323 The center strives to ensure that the resident environment remains as free of accidents hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. #10 – Resident no longer resides at the facility SS1 – Resident is following the facility's smoking policy.	7/30/13

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F 323	Continued From page 56 SS2, and SS3) the facility failed to ensure that the resident environment was as free of accident hazards as possible. Facility staff allowed R10, a resident with documented cognitive impairment and mental illness, to have cigarettes and a lighter although he was known to attempt to smoke in the building. For SS1, SS2, and SS3, the facility failed to enforce the new smoking policy implemented on 4/1/13 and these residents each had a lighter in their personal possession when questioned by the surveyor and a staff member on 5/5/13. Findings include: 1. R10 was admitted to the facility on 10/5/12 with known cognitive impairment and mental illness. R10's care plan for "smoking" included an entry dated 10/24/12 that "lighter to be kept at nursing station and given to resident when he smokes. To be returned when done". A care plan entry dated 12/20/12 indicated that R10 "is to be supervised while smoking". A care plan entry dated 1/4/13 documented that R10 "was an independent smoker but had 2 episodes where he was found smoking inside building so now he is supervised smoking with smoking group but he is not participating. Goes outside when he sees other independent smokers outside and gets cigarettes from them and lighter". A nursing note dated 1/28/13 timed 6:41 PM documented that R10 received cigarettes in the mail and "refuses to give cigarettes to the nurses" or to the Administrator. The nurse wrote that the staff would "monitor the resident (R10) for smoking". On 1/29/13 a social services note time 12:17 PM documented "if he (R10) continues to smoke within facility he will become non-compliant with our smoking policy" but that	F 323	parameters and repercussions for failure to follow smoking policy. On initial assessment, readmission or change of condition, the MD/NP will assess and document their level of cognitive capacity to make decisions. Smoking assessments will be completed on admission, quarterly and with change of status. The DON or designee will perform random audits of the residents daily until 100% success over 3 consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3 consecutive evaluations and then in one month. Trends are referred to the QA committee for investigation. Any negative trends will be reported to QA for investigation and follow-up to ensure the residents and the facility staff is following the facility's smoking policy. Trends are referred to the QA committee for investigation. **Measures for success:** 100% compliance with the smoking policy as evidenced by the outcome of the audit tools.	

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F 323	Continued From page 57 R10 still had his own smoking supplies. On 5/5/13 at 2:35 PM, E2, the facility's Director of Nursing, stated to the surveyor that the facility couldn't take R10's cigarettes because that would be stealing. E2 provided copies of the facility's smoking assessments of R10 dated 10/5/12, 11/5/12, and 3/29/13. Each of these assessments incorrectly indicated that there was no "care plan concern" for R10's smoking. The facility failed to ensure that R10 only smoked when supervised and did not have access to smoking supplies without direct staff supervision. Consequently, R10 attempted to smoke in the building at times placing himself and other residents at risk. Interview with R10's niece (F4) on 5/6/13 at 2:35 PM revealed that in the family's opinion R10 definitely needed supervision with smoking for his safety because he was not able to make good decisions. F3, R10's brother, stated to the surveyor on 5/8/13 at 3:30 PM that the facility was supposed to be supervising R10 with smoking and that the facility was supposed to store the cigarettes that the family mailed to the facility for R10. R10's access to smoking supplies and smoking attempts in the facility placed himself and other residents at risk. 2. According to the "Resident Smoking" policy / procedure implemented on 4/1/13, safe, independent smokers "may not hold their own smoking materials" and will be provided a smoking apron. On 5/5/13 at 4:45 PM, the supply box at the front desk where the smoking supplies for independent smokers were stored was observed by the surveyor. The box contained multiple packs of cigarettes but no lighters. SS1	F 323		

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F 323	Continued From page 58 was sitting near the front desk and the surveyor asked about his lighter. SS1 pulled a lighter from his right pocket and showed the surveyor. 3. At 4:55 PM, SS2 was asked about his lighter by the surveyor and E10 [unit manager, station 2]. SS2 replied that he had his lighter "on my (SS2's) person". 4. At 5 PM, SS3 was asked about his lighter and he showed the surveyor and E10 the lighter he had in his right pocket stating that he liked to have it in case he needed to work on "wires". These residents had lighters in their possession in violation of facility policy / procedure. E2 confirmed to the surveyor on 5/5/13 at approximately 5:10 PM that this was not acceptable. E10 also reported to the surveyor at that time that smoking aprons were available but not always used by the facility's residents who smoked. These findings were confirmed with E2 on 5/5/13 at 5:10 PM and E2 and E10 stated that they were going to make rounds and obtain any lighters in the possession of facility residents.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	**F-Tag 328** The center strives to ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. **What corrective action(s) will be accomplished for those residents**	7/30/13

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F 328	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide proper treatment and care for one (R5) out of 17 sampled residents. The facility failed to identify and notify the physician of R5's change in condition with hypoxemia (low oxygen saturation in the blood). In addition, the facility failed to thoroughly assess and closely monitor R5 who had a change in condition. Findings include: Review of the Nurses Notes (N.N.) by Registered Nurse, E14 dated 11/2/12 and timed 10:32 AM documented when administering the morning medications to R5, E14 observed that the resident seemed very tired and was not eating her breakfast. R5 did minimal verbal conversations and E14 checked her vital signs and they were blood pressure (BP) 110/60, heart rate of 62 per minute, 12 respiration rate per minute and temperature of 97.1 Fahrenheit. R5's pulse oximetry (is a non-invasive method allowing the monitoring of the oxygen saturation of a resident's hemoglobin in the blood) were initially 88% (low oxygen saturation or hypoxemia) but after couple deep breathes it rose to 92% therefore E14 decided to continue to monitor the resident. Although R5 had a significant change in condition as evidenced by low pulse oximetry of 88%, record review lacked evidence that R5's attending physician was consulted and that a comprehensive respiratory system assessment was completed including assessing lung sounds.	F 328	**found to have been affected by the deficient practice:** #5 – Resident no longer resides at the facility. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Audited residents with pulse ox orders to insure they are within normal parameters. Residents with a respiratory diagnosis have been assessed by the medical director for a baseline respiratory status and for abnormalities. No other residents were affected. **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur:** **Education:** Nursing staff was in serviced on the following: Change of Condition/Nursing Assessment – Detecting and Communicating Change in Resident Condition to include respiratory assessments and interventions with return demonstrations, pulse ox parameters, SBAR (Attachment #9) **Systems:**	

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F 328	Continued From page 60 In addition, when R5's pulse oximetry increased to 92% and the above note documented that R5 would be monitored, record lacked evidence how the facility monitored R5's condition. Subsequent N.N. dated 11/2/12 and timed 1:55 PM documented that R5 was sent to the hospital due to decrease in alertness and abnormal vital signs. R5 was flushed, pale in color and unable to obtain blood pressure times two by two additional registered nurses, heart rate of 59, and respiration per minute of 10 with two apnea episodes (temporarily stop breathing). The resident opened her eyes to painful stimuli but not to basic verbal command. Nurse Practitioner, E32 was contacted and orders were obtained to send the resident to the emergency room. An interview conducted by the Division's investigator on 11/14/12 with E14 revealed that she instructed a certified nursing assistant, E15 to monitor the resident. During the survey, the surveyor attempted to interview E14, however, no return telephone call was received from E14. Interviews were conducted with thee staff nurses, E29(Registered Nurse), E30 (Licensed Practical Nurse/LPN), and E31 (LPN) on 5/9/13 from approximately 1:30 PM- 2 PM confirmed that the facility did not have a policy and procedure and/or a standing order for administering oxygen. Interviews with E11 (Clinical Services Consultant) and E2 (Director of Nursing) on 5/8/13 at 12 noon confirmed that the facility failed to notify the physician when R5 had a significant change in condition as evidenced by oxygen saturation of 88%; failed to comprehensively assess R5's respiratory system. In addition, E2 confirmed that	F 328	Updated policy and procedure to reflect a threshold for pulse oximetry (Attachment #37) or medical conditions that would indicate need for oxygen and physician notification. Pulse oximetry and blood pressures reports are reviewed in Kryterium room. Supervisor checklist (Attachment #15) implemented to monitor the live time condition changes to include neuro check documentation and communication needs for the off shifts and weekends. DON or designee on call 24/7 for incident reporting to ensure timely and proper follow up of notification occurs. Resident change of status form and follow-up are reviewed in the Kryterium room. New order reports are pulled daily to ensure all orders, pulse ox and interventions are followed up completed per physician orders. On-going mentoring, education will continue via the Medical Director or NP at the time of the event to ensure follow-up assessment and documentation is complete. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what**	

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		F 328	**quality assurance program will be put into place.** Care review systems (24 hour report, change o f status notification, abnormal pulse ox and respiratory interventions) will be monitored by the QA nurse or designee for occurrence and completion daily until 100% success over 3 consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3 consecutive evaluations and then in one month. Any negative trends will be reported to QA for investigation and follow-up. Trends are referred to the QA committee for investigation (Attachment #16). Any negative trends will be reported to QA for investigation and follow-up. Trends are referred to the QA committee for investigation. **Measures of success** 100% compliance and will be determined by the outcome of the audit tools.	

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F 328	Continued From page 61 the facility did not have a policy which directed staff when to administered oxygen. An interview with E3 (Associate Director of Nursing and Unit Manager for units 1 and 3) confirmed that when R5 had oxygen saturation of 88%, the physician should have been consulted and immediately notified. In addition, the facility failed to comprehensively assess R5's respiratory status including lung sounds and closely monitor the resident including reassessing R5's oxygen saturation. An interview with R5's attending physician, E5 was conducted on 5/9/13 at approximately 2 PM. E5 verbalized the physician not being notified of the 88% oxygen saturation. The review of the hospital history and physical dated 11/2/12 documented that R5 was very lethargic, hardly arousable with BP of 88/47, HR of 101, RR of 16, T of 96.7 and oxygen saturation of 95% on room air.	F 328		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	F 406	**F-Tag 406** The center strives to ensure that if specialized rehabilitation services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resources from	7/30/13

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		F 406	a provider of specialized rehabilitation services. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** #10 – Resident no longer resides at the facility. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** Audit of medical diagnoses to identify psychiatric needs will be conducted by the Social Worker (Attachment #18). Psych services will be scheduled as needed for psych diagnoses/mental health issues and medication monitoring. A house audit has been completed on psychiatrists/psychologist consultations by the Unit Managers (Attachment #24). The resident's physician has been made aware of any recommendations. Recommendations have been addressed and followed upon. **Education:** The interdisciplinary team, including the social services director, has been in-serviced by the corporate staff on the admission process to include review of	

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		F 4D0	PASAAR and psychotropic related diagnoses, medications, and mental health issues to identify those residents requiring psychiatric services. Nursing staff have been educated on following up on consults and reporting recommendations, stop and watch, and SBAR to identify changes and report to the physician . Nursing staff have been educated on the referral process for reporting psychiatric and psychosocial issues utilizing the facility's current provider (Attachment #44). As described under F 224 **Systems:** Kryterium social service tool created to track PASAAR review and diagnosis review upon the admission process (Attachment #13). The nurse will review upon admission/readmission the diagnoses, psychiatric related medications and mental health needs. The patient will be referred by nursing staff via fax or telephone to psych and social services accordingly to address both acute and ongoing psychiatric and psychosocial needs (Attachment #44). Process and provider information described in more depth under F224. The CNA's will report via the stop and watch changes in condition including	

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		F 4D0	behaviors identified to charge nurse. The charge nurse will assess the patient and report changes via the SBAR for follow up. Currently, the facility has a psychological service contract with Deer Oaks. Within 30 days the new psych service contract will be with Med Options. Med Options will conduct screens on every new admission for psych needs and on an ongoing basis. The referral process for psych services will remain the same using the Med Options forms. See F 224 The attending physician and/or medical director will evaluate and identify any new psychotropic diagnosis with their routine examinations and when staff identifies behavioral issues. If clinically indicated by the medical staff, the resident will be referred to the appropriate psychological services provider for follow-up. Psych consult appointments/follow up will be documented on the psych consult tracking form until the consult takes place and recommendations are received for follow up. Social Services will review resident behavioral issues with any change of status. Residents are also identified as part of the quarterly social services assessments to include MDS mood a behavior section.. When issues are	

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		F 406	identified, the resident will be referred to the medical staff for further evaluation. The Social worker will continue to be included in all necessary areas of patient care through daily attendance of the Kryterium Room Process which includes the morning meeting ; rounds on then nursing units, and attendance at care plans. The social worker has relocated her office to be more accessible to patients; families and staff to encourage effective communications. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.** Resident change of status and follow-up are reviewed in the Kryterium Room (morning clinical meeting). This includes family member notification. New order reports are pulled daily to ensure all orders, treatments and interventions are completed per physician orders (Attachment #16) Care review systems (these are areas of identified clinical issues requiring interventions as noted on the Kryterium tools) will be monitored by QA nurse or designee for occurrence and completion daily until 100% success over 3 consecutive evaluations, then 3 times	

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		F 406	per week until 100% success at 3 consecutive evaluations then once per week until 100% success over 3 consecutive evaluations and then monthly. Any negative trends will be reported to QA for investigation and follow-up. Trends are referred to the QA committee for investigation. Measure for success – 100% compliance to be determined by the documentation on the audit tools.	

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F 406	Continued From page 62 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that for one (1) of seventeen (17) residents reviewed (R10), the facility failed to provide or obtain mental health rehabilitative services for this resident who was admitted with a mental illness diagnosis. The facility failed to provide a psychiatric assessment for R10 even after a physician at a clinic examined R10 and submitted a written report that a psychiatric assessment was needed. Findings include: Cross-refer F224example #2. R10 was admitted to the facility on 10/5/12 with a mental illness diagnosis (Schizoaffective Bipolar Disorder). R10 received psychiatric services in the community and in the hospital prior to admission to the facility. It was confirmed by E2, the facility's Director of Nursing, on 5/10/13 at 9:03 AM that no psychiatric services were provided to R10 during the six months that R10 was a resident of the facility.	F 406		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and review of other facility documentation, it was determined that the facility was not administered	F 490	F-Tag 490 The center strives to ensure that it is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being or each resident. #9 – Resident no longer resides at the facility – cross reference with F-157, F-224	7/30/13

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F 490	Continued From page 63 in a manner that enabled it to use its resources effectively and efficiently to attain the highest practicable well-being of each resident. This affected seven (7) of seventeen (17) residents reviewed (R9, R7, R12, R5, R10, R8, and R2) and three (3) sub-sample residents (SS1, SS2, and SS3). Findings include: 1. Cross-refer F157. Facility staff failed to consult with the physician regarding significant changes in resident condition (R9, R7, R12, R5, R10, and R8). 2. Cross-refer F224. The facility neglected the care needs of three residents (R2, R9, and R10) resulting in actual harm to two resident (R2 and R9. R2 developed a medical complication (infection) from the lack of assessment and care (dressing on an open skin area of the toe not changed for one month after a procedure was performed by a podiatrist). R9 hit his head during a fall and had a change in status as evidenced by descending blood pressure (BP) and also developed fluid in the lungs. The facility failed to recognize the significance of R9's neurological status change along with the presence of fluid in the lungs. The facility failed to closely monitor R9's condition by failing to consistently complete R9's neurological assessment. These failures resulted in R9 being found unresponsive with no pulse or respiration. Cardiopulmonary resuscitation (CPR) was initiated and R9 was sent to the hospital 3. Cross-refer F225. The facility failed to recognize, report, and investigate the alleged neglect of R2 and R7 so that the underlying cause of the neglect could be identified and	F 490	#7 - Appropriate Gastrostomy Tube was inserted and replaced – cross reference with F-225, F-157 #12- Resident no longer resides at the facility – cross reference with F-157 #5 - Resident no longer resides at the facility – cross reference with F-157, F-224 #10- Resident no longer resides at the facility – cross reference with F-157, F-250 #8 - Resident no longer resides at the facility – cross reference with F-250, 309 #2 - Resident no longer resides at the facility – cross reference with F-225, F-224 SS1 – Resident is following the facility's smoking policy – see F-323 SS2 – Resident is following the facility's smoking policy – see F-323 SS3 – Resident is following the facility's smoking policy – see F-323 In order to increase communication by the facility administrative team the following will be implemented: Monthly meetings with the front line staff to identify educational opportunities and	

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F 490	Continued From page 64 addressed by the facility administration (including E2, Director of Nursing). 4. Cross-refer F250. Residents R10 and R8 failed to receive medically related services to ensure that their decision maker was known to all staff and that timely notification of changes occurred. 5. Cross-refer F309. The facility failed to ensure that residents R2, R9, R10, and R8 received the care necessary for their highest practicable level of well-being. This resulted in the development of an infection (R2) and delayed medical treatment for deteriorated medical condition (R9, R10 and R8). 6. Cross-refer F322. A facility nurse performed a procedure (PEG tube replacement) on R7 in violation of established facility policy which required the procedure be performed in the hospital. The facility's DON, E2, however, focused investigative efforts on the size of the tube, not the issue of a procedure being performed by a facility nurse that should only have occurred in the hospital. 7. Cross-refer F328. Facility staff failed to provide a thorough nursing assessment of R5 when this resident had respiratory issues. A facility nurse then delegated monitoring of the resident to a CNA. 8. Cross-refer F323. The facility implemented a new "Resident Smoking" policy / procedure on 4/1/13 but as of 5/5/13 noncompliance was identified by the surveyor involving SS1, SS2, and SS3.	F 490	educate on issues identified by the QA process; The DON, the nursing management team and front line staff , members of the interdisciplinary team will be participating in medical director teaching rounds on a weekly basis refer to F-501 for explanation; The Medical Director's will hold a weekly meeting to include the DON, Administrator, nursing administration to review special areas of concern as indicated on the "Medical Director Meeting Sign In Sheet" (Attachment #38);The Administrator is now attending the Kryterium room; And educational moments are occurring with the front line staff. Educational moments are on the spot trainings that occur in real time when issues are identified by administrative staff during rounds. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place.** Resident change of status and follow-up are reviewed in the Kryterium Room. This includes family member notification. New order reports are pulled daily to ensure all orders, treatments and interventions are completed per physician order (Attachment #16). Patients requiring psychiatric services are referred to Dr. Kalkstein. The center	

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		F490	is currently in the process of contracting with a Psychiatrist who will make visits in the center. Care review systems will be monitored for occurrence and completion daily until 100% success over 3 consecutive evaluations, then 3 times per week until 100% success at 3 consecutive evaluations and then in one month. Any negative trends will be reported to QA for investigation and follow-up. Trends are referred to the QA committee for investigation. Processes will be monitored by the QA committee by a review of meeting minutes monthly to ensure occurrence. Minutes will be submitted to the QA committee for identification of trends requiring follow-up.	

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F 490	Continued From page 65 9. Cross-refer F406. The facility staff failed to update a mental health services provider when R10's responsible party died resulting in this provider spending 2 and one/half months in futile attempts to contact a deceased individual. Facility staff failed to identify and address the obvious delay in R10, a resident of the facility for 6 months, receiving required mental health / psychiatric services.	F 490		
F 501 SS=E	483.75(l) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and review of other facility documentation as indicated, it was determined that the facility failed to ensure that the medical director was enabled to perform the role of ensuring implementation of policies and procedures as well as coordinating medical care in the facility. Identified deficiencies revealed a lack of effective communication between nursing staff and the medical director (E5). This impacted the seven (7) of seventeen (17) residents reviewed (R9, R7, R12, R5, R10, R8, and R2) and three (3) sub-sample residents (SS1, SS2, and SS3). Findings include: Deficiencies identified during the complaint visit	F 501	F Tag 501 The center strives to ensure that a physician is designated to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. Cross reference F157 - see POC House audit to identify change in condition. Weekly medical director review meeting (Attachment #38) to include but not limited to consultation review, incidents/accident review, psychiatric medication/behavioral and wound management review. Cross reference F224 – see POC – House audit of consultations	7/30/13

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F 501	Continued From page 66 indicated a pattern of ineffective communication between the nursing staff and the medical director (E5) resulting in a lack of coordination of medical care and services for facility residents, this includes: -a lack of physician consultation for significant changes in resident condition (F157); -neglected care needs including failure to perform dressing changes, failure to perform neurological assessment, and provide psychiatric care (F224); -a lack of compliance with a podiatrist's post-procedure recommendations (F309, example 2); -a lack of compliance with established Neurological Checks policy/procedure (F309, examples 1, 5, and 6); -a lack of compliance with consulted physician's orders (F309, example 4); -a lack of facility policy / procedure related to pressure sore care in the facility (F314); -a lack of compliance with established policy / procedure on gastrostomy tube replacement (F322); -a lack of compliance with established facility policies and procedures related to resident smoking (F323); -a lack of facility policy/procedure related to the use of oxygen (F328); and	F 501	Weekly medical director review meeting (Attachment #38) to include but not limited to consultation review, incidents/accident review, psychiatric medication/behavioral and wound management review. Medical director teaching rounds. Promoting and educating the SBAR process in live time as nursing contact occurs prompting SBAR review, education and critical thinking skills. Cross reference F309 example 2 Weekly medical director review meeting to include but not limited to consultation review, incidents/accident review, psychiatric medication/behavioral and wound management. Cross reference F309 examples 1,5,6 Review policy/procedure manual for appropriateness Medical director teaching rounds, promoting and educating the SBAR process in live time as nursing contact occurs prompting SBAR review and reiterating neuro checks with falls, education and critical thinking skills Cross reference F309 example 4	

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		F501	Weekly Medical director review to include but not limited to consultation review, incidents/accident review, psychiatric medication/behavioral and wound management review. Medical director will regularly speak with the medical staff to create opportunities for better, more consistent communication. MD will include all layers of clinical staff in the rounding process noted above. Cross reference F314 – see POC Weekly Medical director review to include but not limited to consultation review, incidents/accident review, psychiatric medication/behavioral and wound management review. Medical director teaching rounds (Attachment #1), promoting and educating the SBAR process in live time as nursing contact occurs prompting SBAR review and reiterating neuro checks with falls, education and critical thinking skills Policies/Procedure review by Medical Director Cross reference F322	

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		F501	Policy/Procedure review by Medical Director Cross reference F323 Weekly Medical director review to include but not limited to consultation review, incidents/accident review, psychiatric medication/behavioral and wound management review. Cross reference F328 Medical review of the policy/procedure Cross reference F 406 Weekly Medical director review to include but not limited to consultation review, incidents/accident review, psychiatric medication/behavioral and wound management review. **Education:** Corporate Medical Director met with facility Medical Director to review and discuss the cited deficiencies. Facility Medical Director produced a medical director plan of correction. Corporate Medical Director and Facility Medical Director met with facility administration to share plan of correction details (Attachment #39). **Monitoring:**	

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		F501	The corporate medical director will meet with facility medical director at least weekly x 4 weeks and then monthly x 3 months to validate facility medical director compliance is complete. The center strives to ensure that clinical medical records are maintained on each resident in accordance with accepted rofessional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the result of any preadmission screening conducted by the State; and progress notes. #4 – Physician verbal orders were signed. #10 - Resident no longer resides at the facility. The medical records were corrected and placed in the correct chart. A house audit was been completed on resident medical records and physician orders. Orders that were missing signatures were addressed.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	101 E. DELAWARE AVENUE DELMAR, DE 19940

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		F501	Staff was educated on medical record keeping and verbal order protocols. The DON or designee will perform audits of the following: medical records, physician notification and physician follow-up for occurrence and completion every two weeks x 3 months and any negative trends will be reported to QA for investigation and follow-up. Results of the audits will be forwarded to the QA committee for follow-up.	

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F 501	Continued From page 67 -Ineffective communication with a mental health provider resulting in failure to provide necessary psychiatric care (F406).	F 501		7/30/13
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R4 and R10) out of 17 sampled resident the facility failed to ensure accurately documented and systematically organized clinical records. Findings include: 1. Review of R4's clinical record revealed the following physician telephone/verbal orders that were never signed by the physician (MD) or designee; - On 9/4/12 Send to ER for eval (evaluation) ordered by E32, nurse practitioner (NP) and written by E6, registered nurse (RN). There was no time on the order and it was never signed by	F 514	F Tag 514 The center strives to ensure that clinical medical records are maintained on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the result of any preadmission screening conducted by the State; and progress notes. #4 – Physician verbal orders were signed. #10 - Resident no longer resides at the facility. The medical records were corrected and placed in the correct chart. A house audit was been completed by Medical Records clerk on resident medical records and physician orders. Orders that were missing signatures were addressed.	

SETTLEMENT AGREEMENT

I Recitals

1. Parties. The Parties to this Settlement Agreement (Agreement) are the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) and Mid-Atlantic of Delmar, LLC (Respondent)

2. Factual Background and Covered Conduct. The OIG contends that from October 18, 2013 through May 30, 2014, Respondent employed Douglas Entenman (DE) for the provision of items or services for which payment may be made under a Federal health care program. On June 7, 2014, Respondent made a submission pursuant to OIG's Self Disclosure Protocol (Protocol), and OIG accepted Respondent into the Protocol on July 23, 2014. The OIG contends that Respondent knew or should have known that DE was excluded from participation in all Federal health care programs and that no Federal health care program payments could be made for items or services furnished by DE. The OIG contends that the conduct described in this Paragraph (hereinafter referred to as the "Covered Conduct") subjects Respondent to civil monetary penalties, assessments, and exclusion under 42 U.S.C. §§ 1320a-7a and 1320a-7(b)(7)

3 No Admission or Concession. This Agreement is neither an admission of liability by Respondent nor a concession by the OIG that its claims are not well-founded.

4. Intention of Parties to Effect Settlement In order to avoid the uncertainty and expense of litigation, the Parties agree to resolve this matter according to the Terms and Conditions of this Agreement.

II Terms and Conditions

5 Payment. Respondent agrees to pay to OIG $92,344.60 (Settlement Amount). This payment shall be made via wire transfer to the United States Department of Health and Human Services according to written instructions provided by OIG Respondent shall make full payment no later than three business days after the Effective Date

6. Release by the OIG. In consideration of the obligations of Respondent under this Agreement and conditioned upon Respondent's full payment of the Settlement Amount, the OIG releases Respondent from any claims or causes of action it may have against Respondent under 42 U.S.C. §§ 1320a-7a and 1320a-7(b)(7) for the Covered Conduct. The OIG and HHS do not agree to waive any rights, obligations, or causes of action other than those specifically referred to in this Paragraph. This release is applicable only to Respondent and is not applicable in any manner to any other individual, partnership, corporation, or entity.

7. Agreement by Respondent. Respondent shall not contest the Settlement Amount under this Agreement or any other remedy agreed to under this Agreement. Respondent waives all procedural rights granted under the exclusion statute (42 U.S.C. § 1320a-7), the CMPL (42 U.S.C. § 1320a-7a) and related regulations (42 C.F.R. Part 1003), and HHS claims collection regulations (45 C.F.R. Part 30), including, but not limited to, notice, hearing, and appeal with respect to the Settlement Amount.

8 Reservation of Claims. Notwithstanding any term of this Agreement, specifically reserved and excluded from the scope and terms of this Agreement as to any entity or person (including Respondent) are the following:

a. Any criminal, civil, or administrative claims arising under Title 26 U.S. Code (Internal Revenue Code),

b. Any criminal liability,

c Except as explicitly stated in this Agreement, any other administrative liability, including mandatory exclusion from Federal health care programs, and

d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct.

9 Binding on Successors. This Agreement is binding on Respondent and its successors, transferees, and assigns.

10 Costs. Each Party to this Agreement shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

11. No Additional Releases. This Agreement is intended for the benefit of the Parties only, and by this instrument the Parties do not release any claims against any other person or entity except as provided in paragraph 12

12. Claims Against Beneficiaries Respondent waives and shall not seek payment, including co-pay and deductible amounts, for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payers based upon the claims defined as Covered Conduct.

13 Effect of Agreement. This Agreement constitutes the complete agreement between the Parties All material representations, understandings, and promises of the

Parties are contained in this Agreement. Any modifications to this Agreement shall be set forth in writing and signed by all Parties. Respondent represents that this Agreement is entered into with advice of counsel and knowledge of the events described herein Respondent further represents that this Agreement is voluntarily entered into in order to avoid further administrative proceedings and litigation, without any degree of duress or compulsion

14 Disclosure. Respondent consents to the OIG's disclosure of this Agreement, and information about this Agreement, to the public.

15 Effective Date The Effective Date of this Agreement shall be the date of signing by the last signatory

16 Execution in Counterparts. This Agreement may be executed in counterparts, each of which constitutes an original, and all of which shall constitute one and the same agreement

17 Authorizations The individuals signing this Agreement on behalf of the Respondent represent and warrant that they are authorized by Respondent to execute this Agreement The individuals signing this Agreement on behalf of the OIG represent that they are signing this Agreement in their official capacities and that they are authorized to execute this Agreement

RESPONDENT

Donna L. Rooney, JD, BSN, CHC, CPC
Vice President of Corporate Compliance
Mid-Atlantic of Delmar, LLC

10/30/2014
Date

FOR THE OFFICE OF INSPECTOR GENERAL OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROBERT K. DECONTI
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services

10/31/14
DATE

ADRIENNE SHELFER
Program Analyst
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services

10/31/2014
DATE

STATE OF MARYLAND

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

March 30, 2016

Mr. Chris Coronado, Administrator
Northampton Manor Nursing And Rehabilitation Cente
200 East 16th Street
Frederick, MD 21701

PROVIDER # 215217
RE:NOTICE OF CURRENT DEFICIENCIES AND POSSIBLE IMPOSITION OF REMEDIES

Dear Mr. Coronado:

On March 7, 8, 9, and 10, 2016, a QIS Medicare/ Medicaid recertification survey was conducted at your facility by the Office of Health Care Quality to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey was also conducted for the purpose of State licensure. This survey found that your facility was not in substantial compliance with the participation requirements.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (C.F.R.), COMAR Title 10, and the State Government Article.

I. PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within 10 days after the facility receives its Form CMS 2567. Failure to submit an acceptable PoC within the above time frames may result in the imposition of a civil money penalty twenty (20) days after the due date for submission of the PoC.

Your PoC must contain the following:

- What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure

that the deficient practice does not recur:

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur. i.e., what quality assurance program will be put into place and:

- Specific date when the corrective action will be completed.

- References to a resident(s) by Resident # only. This applies to the PoC as well as any attachments to the PoC. It is un-acceptable to include a resident(s) name in these documents since the documents are released to the public.

II. IMPOSITION OF REMEDIES

The following remedies will be recommended for imposition by the Center for Medicare and Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by April 24, 2016. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended on this date. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

If you do not achieve substantial compliance within 3 months after the last day of the survey (i.e.June 10, 2016) identifying non-compliance, we must deny payments for new admissions. (§488.417(a)) Also, if the denial of payment for new admissions sanction is imposed, your facility is prohibited from operating a nurse aide training program for two years from the last day of the survey. (§483.151)

If your facility has failed to achieve substantial compliance by September 10, 2016, your Medicare provider agreement will be terminated.

III. ALLEGATION OF COMPLIANCE

If you believe that the deficiencies identified in the CMS form 2567 have been corrected, you may contact me at the Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228 with your written credible allegation of compliance **(i.e. attached lists of attendance at provided training and/or revised statements of policies/procedures and/or staffing patterns with revisions or additions).**

If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance **and credible evidence** of your allegation of compliance until substantiated by a revisit or other means. In such a case, the previously proposed remedy(ies) will not be imposed at that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we may

impose remedies previously mentioned in this letter beginning March 10, 2016 and will continue until substantial compliance is achieved. Additionally, we may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

IV. INFORMAL DISPUTE RESOLUTION

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency(ies) being disputed, and an explanation of why you are disputing those deficiencies, to Ms. Margie Heald, Deputy Director, Office of Health Care Quality, Bland Bryant Building, Spring Grove Center, 55 Wade Avenue, Catonsville, Maryland 21228, fax 410-402-8234. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

V. LICENSURE ACTION

As you are aware, the cited Federal deficiencies have a counter part in State regulations. These deficiencies are cited on the enclosed State Form. Please provide a plan of correction for these deficiencies within 10 days of receipt of this letter. In the event a revisit determines that substantial compliance has not been achieved, appropriate administrative action may be taken against your State license.

If you have any questions concerning the instructions contained in this letter, please contact me at 410-402-8201 or fax 410-402-8234.

Sincerely,

Patti Melodini
Health Facilities Survey Coordinator
Long Term Care

Enclosures: CMS 2567
State Form

cc: Stevanne Ellis
Jane Sacco
File II

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. BUILDING _____ B. WING _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON MANOR NURSING AND REHABILITATION CENTE	200 EAST 16TH STREET FREDERICK, MD 21701

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F 000	INITIAL COMMENTS	F 000		

On March 7, 8, 9, and 10, 2016, an annual Medicare/Medicaid Quality Indicator Survey was conducted by the Office of Health Care Quality. The licensed bed capacity for this facility is 196 and the resident census at the start of the survey was 173. Survey activities consisted of a review of 68 medical records (during stage 1), interviews with residents, families, facility staff and the ombudsman, as well as observations of residents and staff practices. Administrative reports and facility policies and procedures were reviewed as well.

Additionally, 1 facility reported incident MD00098923 and 3 complaints, MD00098880, MD00096417 and MD00092110 was reviewed with no deficient practice identified.

The following deficiencies are a result of stage 2 investigation, 35 residents reviewed.

F 253 SS=D 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES — F 253

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that the facility staff failed to provide housekeeping and maintenance services to resident rooms. This was evident for 2 (Resident #64 & #1) of 40 rooms observed during stage 1 of the survey process.
The findings include:

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

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F 253	Continued From page 1	F 253		

1) Observation, on 3/8/16 at 9:30 AM, of Resident #64's room found their over bed table missing an approximate 2 inch area of the laminate on top of the table in the top right hand corner (when the over bed table is across the bed on the resident's left side of the bed). This was again observed on 3/10/16 at 8/30 AM.

2) Observation, on 3/8/16 at 10:15 AM of Resident #1's room, found the resident lying in bed. Resident #1's bed was against the wall on their right side, and there were 2 areas of a dried brown substance on the wall. This was observed again on 3/10/16 at 8:40 AM.

Unit Manager #1 was made aware of these observations on 3/10/16 at 9 AM.

F 272 SS=D 483.20(b)(1) COMPREHENSIVE ASSESSMENTS — F 272

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;

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F 272	Continued From page 2 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, it was determined that the facility staff failed to accurately complete a resident's comprehensive MDS (Minimum Data Set). This was evident for 1 (Resident #15) of 3 residents reviewed for incontinence. The findings include:
The MDS forms the foundation of a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status.

Review of the annual MDS assessment for Resident #15 with an assessment reference date (ARD) of 12/27/15, H0400 bowel continence,

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F 272	Continued From page 3 documented that the resident was frequently incontinent. Resident #15 had a colostomy, therefore should have been coded "not rated." Discussed with MDS Nurse #1, on 3/10/16 at 12:30 PM, who agreed it was a coding error.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending 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 periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, it was determined that the facility failed to update the care plan for refusal of showers and toileting. This was evident for 2 (Resident's # 137 and # 15) of 35 residents reviewed during stage 2 of the survey.	F 280		

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F 280	Continued From page 4	F 280		

The findings include:

1) Observations made on Monday, 3/7/16 at 5:34 PM and Tuesday, 3/8/16 at 10:30 AM noted Resident #137's unkept, oily hair. On 3/7/16 at 5:34 PM, observation was made of the resident's fingernails which were long with brown/black material under the nails, and the left hand had an odor when the resident tried to pull the fingers up.

Interview with the Director of Nursing (DON), on 3/10/16 at 2:00 PM, revealed that the resident refuses to allow staff to shower or bath him/her at times. The resident's care plan was not updated for the refusal of showers, which the DON confirmed.

2) During an interview with Resident #15,on 3/8/16 at 10:08 AM, an odor of urine was noted by the surveyor while sitting next to the resident. Resident #15 stated that he/she wore briefs. The surveyor asked if the resident "dribbled" and the reply was "I have to go frequently and they can't get to me in time so they said it was ok if went in the brief. In the morning, I have to go every half hour because I am on a diuretic and they are busy." The surveyor asked the resident if someone could get the resident to the toilet would the resident prefer to go into the bathroom and the resident stated "I would love to."

On 3/10/16 at 10:05 AM, Registered Nurse (RN) #1 was asked if a bladder assessment was ever done on the resident and the reply was "on admission." Review of the medical record revealed a hospital note which stated the resident had an overactive bladder. A bladder assessment done on 12/16/14 stated "incontinent greater than 1 month but less than 1 year." A second bladder

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F 280	Continued From page 5	F 280		

assessment was done on re-admission to the facility on 8/6/15 which stated "wet once or more per shift, day and night, small amount of urine."

There were no additional assessments and the care plan was not updated to include interventions of offering to toilet every 2 hours.

On 3/10/16 at 1:17 PM, the Director of Nursing confirmed that the resident was never put on a toileting program.

F 282 SS=E 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN — F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on review of the medical record and staff interview it was determined that the facility staff failed to follow resident plans of care. This was evident for 2 (Resident #129,# 214) of 5 residents reviewed for unnecessary medications and 1 (Resident #98) reviewed for falls.
The findings include:

1) Resident #129, according to current physician order dated 1/23/16 and their medication administration records, received the medication Digoxin daily for atrial fibrillation (a rapid irregular heart beat). The resident had a physician's order dated 5/8/15 for a Digoxin level to be completed every 3 months, and a current care plan with interventions for Digoxin levels as ordered by the

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F 282	Continued From page 6	F 282		

physician, and a list of signs of suspected Digoxin toxicity.

Review of the medical record revealed a Digoxin level completed on 11/6/15. No Digoxin level was found 3 months later in February of 2016. Interview of Unit Manager #1, on 3/10/16 at 9 AM, revealed that the quarterly (every three months) lab for Digoxin had not been completed as of 3/10/16, and the physician would be notified.

2) Resident #214 had a physician's order for HGBA1C (Hemoglobin A1C- test result gives a measure of how well your body has controlled the amount of sugar in the blood over the past two to three months.) every 3 months. Review of the medical record on 3/10/16 revealed that the last HGA1C was last done on 10/15/15, almost 5 months ago. This was confirmed by the Director of Nursing (DON) on 3/10/16 at 10 AM.

Review of Resident #214's nutritional care plan, which was last revised on 1/29/16, had a goal that Resident #214 would have improved BS (Blood Sugar) and HGA1C levels along with an intervention to monitor nutritionally pertinent laboratory values and ensure that the dietitian was made aware.

The facility staff failed to obtain a HGA1C, overdue since January of 2016, which was used to adjust Resident #214's insulin dosage previously in October of 2015, and would indicate effectiveness of the insulin adjustment made in October of 2015. Cross reference F 329.
The facility staff failed to follow the plan of care for a resident assessed to be a high falls risk.

Review of Resident #98's March 2016 physician's

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	215217	A. BUILDING _____ B. WING _____	C 03/10/2016

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F 282	Continued From page 7 orders revealed the order "hipsters for safety every shift." Hipsters are impact absorbing pads over the critical fracture area to minimize potential damage, including hip fractures that can occur from a fall. Also reviewed in the medical record were 2 Fall Risk Screeners dated 12/4/15 and 2/17/16 which categorized the resident as a "high risk" for falls. Observation was made, on 3/8/16 at 11:37 AM, of Resident #98 sitting in a wheelchair in the Cross Creek 1 dining room wearing blue pants. There was no visible padding in the hip area. A second observation was made of Resident #98, on 3/10/16 at 1:26 PM, sitting in a wheelchair in the hall area across from the nursing station in the Cross Creek 1 unit. The surveyor asked Licensed Practical Nurse (LPN) #1 if the resident was wearing hipsters as there was no noticeable padding around the hip area. LPN #1 pulled the top of the resident's pants down and said "no they aren't back from the laundry yet. She only has 1 pair that fits her and I last saw her with them on Sunday." LPN #1 proceeded to call the laundry, and was told the hipsters had been returned to the resident's room in the clothing drawer. Geriatric Nursing Assistant (GNA) #3 was asked on 3/10/16 at 1:50 PM if the resident was wearing hipsters when the GNA came on at the beginning of the shift. GNA #3 replied "no."	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review and staff interview, it was determined that the facility staff failed to provide the necessary services to maintain grooming and personal hygiene. This was evident for 1 of 5 residents (Resident #137) triggered for activities of daily living review in stage 2 of the survey sample. The findings include:

Observations made on Monday, 3/7/16 at 5:34 PM and Tuesday, 3/8/16 at 10:30 AM, noted Resident #137's unkept, oily hair. On 3/7/16 at 5:34 PM, observation was made of the resident's fingernails which were long with brown/black material under the nails and the left hand had an odor when the resident tried to pull the fingers up.

Interview with the Director of Nursing on 3/10/16 at 2:00 PM revealed that the resident refuses to allow staff to shower or bath him/her at times. The resident was to have a shower on Monday and Thursday, day shift. There was no documentation in the medical record or behaviors documented between 2/29/16 and 3/7/16 of the resident refusing a bath, shower, or hair wash. The record indicated there was no shower between 2/29/16 and 3/7/16.

F 315 SS=D 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER — F 315

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an

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indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, and resident and staff interview, it was determined that the facility staff failed to provide appropriate treatment and services to achieve or maintain as much normal urinary function as possible for a resident assessed to have urinary incontinence. This was evident for 1 (Resident #15) of 3 residents reviewed for urinary incontinence.
The findings include:

During an interview with Resident #15, on 3/8/16 at 10:08 AM, an odor of urine was noted by the surveyor while sitting next to the resident. Resident #15 stated that he/she wore briefs. The surveyor asked if the resident "dribbled" and the reply was "I have to go frequently and they can't get to me in time so they said it was ok if went in the brief. In the morning I have to go every half hour because I am on a diuretic and they are busy." The surveyor asked the resident if someone could get the resident to the toilet would the resident prefer to go into the bathroom and the resident stated "I would love to."

On 3/10/16 at 9:55 AM, Geriatric Nursing Assistant (GNA) #4 was asked about taking the resident to the bathroom and GNA #4 stated the

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F 315	Continued From page 10 resident "didn't have a lot of urine, does own hygiene and doesn't like going to the bathroom." On 3/10/16 at 10:05 AM, Registered Nurse (RN) #1 was asked if a bladder assessment was ever done on the resident and the reply was "on admission." Review of the medical record revealed a hospital note which stated the resident had an overactive bladder. A bladder assessment done on 12/16/14 stated "incontinent greater than 1 month but less than 1 year." A second bladder assessment was done on re-admission to the facility on 8/6/15 which stated "wet once or more per shift, day and night, small amount of urine." There were no additional assessments and no interventions put into place such as toileting every 2 hours. On 3/10/16 at 1:17 PM, the Director of Nursing confirmed that the resident was never put on a toileting program.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined that the facility failed	F 318		

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to put services in place to prevent further decreases in range of motion. This was evident for 1 (Resident #137) of 40 residents observed during stage 1 of the survey.
The findings include:

Observation was made, on 3/7/16 at 5:34 PM, of Resident #137 sitting in a wheelchair in the dining room on Carroll Creek Unit 2. The surveyor asked the resident if he/she could open his/her hands and at that time, the resident could not open the left hand. The resident took his/her right hand to open the fingers on the left hand. The last 3 fingers were contracted. The resident did not have a splint device or rolled washcloth, cloth carrot in place. An odor was also noted coming from the palm of the hand.

A second observation was made of Resident #137 on 3/8/16 at 9:32 AM sitting in a wheelchair across from the nursing station. The resident did not have anything in the left hand. During an initial staff interview on 3/8/16 at 9:25 AM, the surveyor asked if the resident had a contracture and the reply was "yes, and therapy is going to screen her today for that."

Review of the medical record revealed a note, written on 3/8/16, which stated that a care plan note was initiated due to rehab screen for left hand contracture. The CRNP (Certified Registered Nurse Practitioner) was updated and an order received to wash left hand with soap and water, pat dry and apply rolled wash cloth (dry) into left hand."

The rehab note written on 3/8/16 which stated "f/u L hand reported contracture. pt with significant left 5th, 4th and 3rd MPC/PIP joint fixed contracture.

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drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on review of the medical record and staff interview, it was determined that the facility staff failed to have adequate monitoring for an insulin dependent diabetic resident as evidenced by failing to obtain laboratory blood work used to adjust insulin dosage. This was evident for 1 (Resident #214) of 5 residents reviewed for unnecessary medications. The findings include:

Resident #214 received Lantus insulin twice a day (which is a long acting insulin), and has finger sticks done 3 times a day with coverage depending on the results with Novolog insulin, a short acting insulin. They have a physician's order dated 1/15/16 for a HGA1C every 3 months. A Hemoglobin A1C test result gives a measure of how well your body has controlled the amount of sugar in the blood over the past two to three months. Interview of Unit Manager #1 on, 3/10/16 at 9 AM, revealed that Resident #214 had an HGA1C done on 10/15/15, and no HGA1C has been done since then. Review of the medical record revealed a progress note by the Nurse Practitioner on 10/15/15 addressing the resident's HGA1C result, which was elevated at 8.8% based on a reference range of 4.9-5.6%. The plan in the progress note was to increase Resident #214's Lantus insulin from 45 units twice a day to

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F 329	Continued From page 14 50 units twice a day and for HGA1C every 3 months. Review of Resident #214's nutritional care plan, which was last revised on 1/29/16, has a goal that Resident #214 will have improved BS (Blood Sugar) and HGA1C levels, along with an intervention to monitor nutritionally pertinent laboratory values and ensure that the dietitian was made aware. The facility staff failed to obtain a HGA1C, overdue since January of 2016, the results of which were used to adjust Resident #214's insulin dosage previously in October of 2015, and would indicate effectiveness of the insulin adjustment made in October of 2015.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility 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 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. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		

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determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that the facility staff failed to maintain a sanitary environment by improper storage on a resident bedpan. This was evident for 1 (Resident #290) of 40 resident rooms observed during stage 1 of the survey process. The findings include:

Observation of Resident #290"s bathroom, on 3/8/16 at 8:35 AM, revealed a bedpan sitting on the bathroom floor with dried brown liquid in it. On 3/10/16 at 8:34 AM, the same observation was made.

Interview of Unit Manager #1, on 3/10/16 at 9 AM, revealed that bedpans are to be cleaned, and then stored in a plastic bag in the resident's bedside stand.

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F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		

The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that the facility staff failed to maintain a functioning call system in 5 of 35 bathrooms observed during stage 1 of the survey.
The findings include:

Observation was made, on 3/8/16 at 9:38 AM, of the bathroom in Room #243. The call bell cord in the bathroom was wrapped around the grab bar 5 times. When the call bell cord was pulled from the bottom of the cord, the call bell did not activate. Advised Registered Nurse (RN) #1 at that time.

Observation was made, on 3/8/16 at 10:20 AM, of the bathroom in Room #252. The call bell cord was wrapped around the grab handle bar several times and when the surveyor pulled the cord from the bottom the call bell did not activate. Geriatric Nursing Assistant (GNA) #2 was advised and unwrapped the cord at that time.

Observation was made, on 3/8/16 at 10:47 AM, in Room #134, #135 and #132 of the call bell cords wrapped around the grab bars.The call bells did not activate when the bottom of the cord was pulled. Licensed Practical Nurse (LPN) #2 was advised at that time.

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F 502 SS=D	483.75(j)(1) ADMINISTRATION	F 502		

The facility 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.

This REQUIREMENT is not met as evidenced by:
Based on review of the medical record and staff interview, it was determined that the facility staff failed to obtain physician ordered laboratory blood work for 2 (Resident #129 & #214) of 5 residents reviewed for unnecessary medications. The findings include:

1) Resident #129, according to current physician order dated 1/23/16, and medication administration records, received the medication Digoxin daily for atrial fibrillation (a rapid irregular heart beat). The resident had a physician's order, dated 5/8/15, for a Digoxin level to be completed every 3 months and a current care plan with interventions for Digoxin levels as ordered by the physician, and a list of signs of suspected Digoxin toxicity.

Review of the medical record revealed that a Digoxin level was completed on 11/6/15. No level was found 3 months later in February of 2016. Interview of Unit Manager #1 on 3/10/16 at 9 AM, revealed that the quarterly (every 3 months) lab for Digoxin had not been completed as of 3/10/16, and the physician would be notified.

2) Resident #214 had a physician's order for HGBA1C (Hemoglobin A1C- test result gives a measure of how well your body has controlled the amount of sugar in the blood over the past two to

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F 502	Continued From page 18 three months.) every 3 months. Review of the medical record, on 3/10/16, revealed that the last HGA1C was last done on 10/15/15, almost 5 months ago. This was confirmed by the Director of Nursing (DON) on 3/10/16 at 10 AM.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on review of medical records and staff interview it was determined that the facility staff failed to maintain accurate resident records, as evidenced by laboratory blood work, documented on the resident's treatment administration record as complete, and physician ordered treatment signed off as performed, when it was not done. This was evident for 1 (Resident #129) of 5 resident's reviewed for unnecessary medications and 1 (Resident # 98) reviewed for falls. The findings include: 1) Resident#129 had a physician's order, dated	F 514		

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F 514	Continued From page 19	F 514		

8/5/15, for a digoxin level every 3 months. Review of the resident's Treatment Administration Record (TAR) for February of 2016 had documentation on 2/5/16 that the lab was done. The results were not found in the medical record, and interview of Unit Manager #1, on 3/10/16 at 9 AM, revealed that the lab was not done. Cross reference F 502.

2) Review of Resident #98's March 2016 physician's orders, revealed the order "hipsters for safety every shift." Hipsters are impact absorbing pads over the critical fracture area to minimize potential damage that can occur from a fall.

Observation was made, on 3/8/16 at 11:37 AM, of Resident #98 sitting in a wheelchair in the Cross Creek 1 dining room wearing blue pants. There was no visible padding in the hip area. A second observation was made of Resident #98 on 3/10/16 at 1:26 PM, sitting in a wheelchair in the hall area across from the nursing station in the Cross Creek 1 unit. The surveyor asked Licensed Practical Nurse (LPN) #1 if the resident was wearing hipsters, as there was no noticeable padding around the hip area. LPN #1 pulled the top of the resident's pants down and said "no they aren't back from the laundry yet. She only has 1 pair that fits her and I last saw her with them on Sunday." LPN #1 proceeded to call the laundry and was told the hipsters had been returned to the resident's room in the clothing drawer.

Review of the March 2016 Treatment Administration Record (TAR) for Resident #98 documented that the hipsters were worn on 3/8/16 on all 3 shifts, and on the 7 AM to 3 PM

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F 514	Continued From page 20 shift on 3/9/16. Geriatric Nursing Assistant (GNA) #3 was asked, on 3/10/16 at 1:50 PM, if the resident was wearing hipsters when the GNA came on at the beginning of the shift. GNA #3 replied "no." The surveyor asked LPN #1 on 3/10/16 if she signed off that the hipsters were worn on 3/8/16 and 3/9/16. LPN #1 stated "yes." The surveyor stated to LPN #1 "so you signed off that the hipsters were worn when they actually weren't?" LPN #1 stated "yes."	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		

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F 520	Continued From page 21 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the medical record, and review of facility documents it was determined that the facility staff failed to have an effective Quality Assessment and Assurance program in place by failing to ensure that staff only document care and services that they have provided. This was evident during stage 2 of the survey. The findings include: During the survey, it was determined that the facility staff signed off hipsters in the medical record, for a resident without actually providing the hipsters. This is a repeat deficiency from the previous recertification survey in which a plan of correction was developed to correct the deficient practice. During an interview, on 3/10/16 at approximately 2:00 PM, the QA (Quality Assurance) nurse was asked what measures were put in place after the previous annual survey to correct this deficient practice. He/She indicated that staff had been educated on proper documentation and not to document anything that they did not see with their own eyes. Cross reference F-514.	F 520		

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S 000	10.07.02 Initial comments On March 7, 8, 9, and 10, 2016, an annual Medicare/Medicaid Quality Indicator Survey was conducted by the Office of Health Care Quality. The licensed bed capacity for this facility is 196 and the resident census at the start of the survey was 173. Survey activities consisted of a review of 68 medical records (during stage 1), interviews with residents, families, facility staff and the ombudsman, as well as observations of residents and staff practices. Administrative reports and facility policies and procedures were reviewed as well. Additionally 1 facility reported incident MD00098923 and 3 complaints, MD00098880, MD00096417 and MD00092110 was reviewed with no deficient practice identified. The following deficiencies are a result of stage 2 investigation, 35 residents reviewed.	S 000		
S 512	10.07.02.12 R Nsg Svcs; Charge Nurse Daily Rounds .12 Nursing Services. R. Charge Nurses' Daily Rounds. The charge nurse or nurses shall make daily rounds to all nursing units for which responsible, performing such functions as: (1) Visiting each patient; (2) Reviewing clinical records, medication orders, patient care plans, and staff assignments; (3) To the degree possible, accompanying physicians when visiting patients. This Regulation is not met as evidenced by: Refer to CMS 2567	S 512		

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

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S 512	Continued From page 1 F282 F329 F 502 Refer to CMS 2567 F 282 F 312 F 318	S 512		
S1090	10.07.02.20 Clinical Records .20 Clinical Records. A. Records for all Patients. Records for all patients shall be maintained in accordance with accepted professional standards and practices. B. Contents of Record. Contents of record shall be: (1) Identification and summary sheet or sheets including patient's name, social security number, armed forces status, citizenship, marital status, age, sex, home address, and religion; (2) Names, addresses, and telephone numbers of referral agencies (including hospital from which admitted), personal physician, dentist, parents' names or next of kin, or authorized representative; (3) Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of initial and ongoing treatment, and of the care and services provided; (4) Authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form); (5) Consent forms when required (such as consent for administering investigational drugs, for burial arrangements made in advance, for release of medical record information, for handling of finances); (6) Medical and social history of patient;	S1090		

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S1090	Continued From page 2	S1090		

(7) Report of physical examination;
(8) Diagnostic and therapeutic orders;
(9) Consultation reports;
(10) Observations and progress notes;
(11) Reports of medication administration, treatments, and clinical findings;
(12) Discharge summary including final diagnosis and prognosis;
(13) Discipline assessment; and
(14) Interdisciplinary care plan.
C. Staffing. An employee of the facility shall be designated as the person responsible for the overall supervision of the medical record service. There shall be sufficient supportive staff to accomplish all medical record functions.
D. Consultation. If the medical record supervisor is not a qualified medical record practitioner, the Department may require that the supervisor receive consultation from a person so qualified.
E. Completion of Records and Centralization of Reports. Current medical records and those of discharged patients shall be completed promptly. All clinical information pertaining to a patient's stay shall be centralized in the patient's medical record.
F. Retention and Preservation of Records. Medical records shall be retained for a period of not less than 5 years from the date of discharge or, in the case of a minor, 3 years after the patient becomes of age or 5 years, whichever is longer.
G. Current Records--Location and Facilities. The facility shall maintain adequate space and equipment, conveniently located, to provide for efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).
H. Closed or Inactive Records. Closed or inactive records shall be filed and stored in a safe place (free from fire hazards) which provides for

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S1090	Continued From page 3 confidentiality and, when necessary, retrieval. This Regulation is not met as evidenced by: Refer to CMS 2567 F 514 Refer to CMS 2567 F 514	S1090		
S1116	10.07.02.21 F Inf Control Program; Policies and Procedures .21 Infection Control Program. F. Infection Control Policies and Procedures. (1) The infection control program shall establish written policies and procedures to investigate, control, and prevent infections in the facility including policies and procedures to: (a) Identify facility-associated infections and communicable diseases in accordance with COMAR 10.06.01; (b) Report occurrences of certain communicable diseases and outbreaks of communicable diseases to the local health department in accordance with COMAR 10.06.01 and Health-General Article, §18-202, Annotated Code of Maryland; (c) Institute appropriate infection control steps when an infection is suspected or identified in order to control infection and prevent spread to other residents; (d) Perform surveillance of residents and employees at appropriate intervals to monitor and investigate causes of infection, facility-associated and community acquired, and the manner in which it was spread;	S1116		

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S1116	Continued From page 4 (e) Train employees about infection control and hygiene including: (i) Hand hygiene; (ii) Respiratory protection; (iii) Soiled laundry and linen processing; (iv) Needles, sharps, or both; (v) Special medical waste handling and disposal; and (vi) Appropriate use of antiseptics and disinfectants. (f) Train and monitor employee application of infection control and aseptic techniques; and (g) Review the infection control program at least annually and revise as necessary. (2) The facility shall provide information concerning the communicable disease status of any resident being transferred or discharged to any other facility, including a funeral home. (3) The facility shall obtain information concerning the communicable disease status of any resident being transferred or discharged to the facility. This Regulation is not met as evidenced by: Refer to CMS 2567 F 441	S1116		
S1120	10.07.02.21-1 A Employee Health Program; Monitor Health Stat .21-1 Employee Health Program. A. The facility's infection control program shall monitor the relevant health status of all employees, as it relates to infection control. The following guidelines shall aid the facility in implementing its employee health program: (1) Guideline for Infection Control in Health Care Personnel;	S1120		

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S1120	Continued From page 5 (2) Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC); and (3) COMAR 09.12.31. This Regulation is not met as evidenced by: Based on administrative record review and interviews with facility staff, it was determined the facility staff failed to offer a newly hired employee the influenza vaccine. This was evident for 1 of 5 newly hired employee files reviewed. Findings include: A random review of five newly hired employee files were reviewed on 3/10/16. Employee # 1 was hired on 2/16/16 and upon review, it was identified that there was no influenza vaccination form inside of his/her folder. An interview was conducted with the DON (Director of Nursing) on 3/10/16 at 12:00 PM, and he/she confirmed that employee # 1 did not have an influenza vaccination form inside of his/her folder. An interview was conducted with the Human Resources Manager (HRM) on 3/10/16 at 2:00 PM and he/she submitted a copy of employee # 1 influenza vaccine. The HRM reported that employee # 1 stated that he/she would bring in a copy of the influenza vaccine when he/she was initially hired on 2/16/16. The HRM offered, employee # 1 only works PRN (as needed).	S1120		
S1320	10.07.02.27 D Nusring Care Unit;Call system, existing fac	S1320		

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S1320	Continued From page 6 .27 Nursing Care Unit. D. Call System-Existing Facilities. Existing facilities (those facilities licensed at the time this regulation becomes effective) shall provide some method/means of a patient summoning aid that shall include as minimum a combined visual and audible signal that is audible at the nurses' station and simultaneously activates a light located in the hall, outside of and adjacent to the patient's room. The activating device for those signals shall be located in each patient's room and each and every bathing compartment and toilet room or compartment used by patients. Exceptions may be made in part at the discretion of the Department for an individual facility only when the facility can demonstrate compliance with the intent of this section by showing an effective patient call system to provide quality patient care. This Regulation is not met as evidenced by: Refer to CMS 2567 F 463	S1320		
S1654	10.07.02.34 B(2) Hskpg; clean walls/floors .34 Housekeeping Services, Pest Control, and Laundry. B. Cleanliness and Maintenance. The following shall be observed: (2) All walls, floors, ceilings, windows, and fixtures shall be kept clean. Interior walls and	S1654		

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S1654	Continued From page 7 floors shall be of a character to permit frequent and easy cleaning. This Regulation is not met as evidenced by: Refer to CMS 2567 F 253	S1654		
S1686	10.07.02.36 D Resident Status Assessment; assessments .36 Resident Status Assessment. D. The facility shall complete all assessments in accordance with the provisions of 42 CFR §§483.20 and 413.343. This Regulation is not met as evidenced by: Refer to CMS 2567 F 272	S1686		
S1740	10.07.02.37 F Care Planning;updates at least quarterly .37 Care Planning. F. Disciplines shall update the care plans as the resident's assessment warrants, but not less than quarterly. This Regulation is not met as evidenced by: Refer to CMS 2567 F 280	S1740		

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S1830	Continued From page 8	S1830		
S1830	10.07.02.45 A Quality Assurance Program. .45 Quality Assurance Program. A. By January 1, 2001, each nursing facility shall establish an effective quality assurance program that includes components described in this regulation and Regulation .46 of this chapter. This Regulation is not met as evidenced by: Refer t CMS 2567 F 520	S1830		

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F 000	INITIAL COMMENTS On March 7, 8, 9, and 10, 2016, an annual Medicare/Medicaid Quality Indicator Survey was conducted by the Office of Health Care Quality. The licensed bed capacity for this facility is 196 and the resident census at the start of the survey was 173. Survey activities consisted of a review of 68 medical records (during stage 1), interviews with residents, families, facility staff and the ombudsman, as well as observations of residents and staff practices. Administrative reports and facility policies and procedures were reviewed as well. Additionally, 1 facility reported incident MD00098923 and 3 complaints, MD00098880, MD00096417 and MD00092110 was reviewed with no deficient practice identified. The following deficiencies are a result of stage 2 investigation, 35 residents reviewed.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to provide housekeeping and maintenance services to resident rooms. This was evident for 2 (Resident #64 & #1) of 40 rooms observed during stage 1 of the survey process. The findings include:	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/6/16

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

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F 253	Continued From page 1 1) Observation, on 3/8/16 at 9:30 AM, of Resident #64's room found their over bed table missing an approximate 2 inch area of the laminate on top of the table in the top right hand corner (when the over bed table is across the bed on the resident's left side of the bed). This was again observed on 3/10/16 at 8/30 AM. 2) Observation, on 3/8/16 at 10:15 AM of Resident #1's room, found the resident lying in bed. Resident #1's bed was against the wall on their right side, and there were 2 areas of a dried brown substance on the wall. This was observed again on 3/10/16 at 8:40 AM. Unit Manager #1 was made aware of these observations on 3/10/16 at 9 AM.	F 253	No residents were adversely affected by deficient practices. Bedside table removed immediately and replaced with new bedside table. Wall was cleaned immediately. Audited 100% on bedside tables and all identified areas were repaired. Facility wide audit completed on all rooms and all areas identified cleaned. Environmental Director/designee will complete audit on 25% bedside tables and cleanliness of rooms and report findings to the QI/QA Committee monthly x 3 months or until resolved	4/20/2016
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272		

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F 272	Continued From page 2 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined that the facility staff failed to accurately complete a resident's comprehensive MDS (Minimum Data Set). This was evident for 1 (Resident #15) of 3 residents reviewed for incontinence. The findings include: The MDS forms the foundation of a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Review of the annual MDS assessment for Resident #15 with an assessment reference date (ARD) of 12/27/15, H0400 bowel continence,	F 272	No residents were adversely affected by deficient practices. MDS assessment was modified to reflect correction. Audited 100% of residents with ostomy for proper documentation. RNAC provided In-service to MDS nurses on proper coding of bowel continence in Section H. RNAC Director/designee will complete audit of 25% on MDS assessments on section H for proper coding and report findings to the QI/QA Committee monthly x 3 months or until resolved.	4/20/2016

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F 272	Continued From page 3 documented that the resident was frequently incontinent. Resident #15 had a colostomy, therefore should have been coded "not rated." Discussed with MDS Nurse #1, on 3/10/16 at 12:30 PM, who agreed it was a coding error.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending 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 periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, it was determined that the facility failed to update the care plan for refusal of showers and toileting. This was evident for 2 (Resident's # 137 and # 15) of 35 residents reviewed during stage 2 of the survey.	F 280		

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F 280	Continued From page 4 The findings include: 1) Observations made on Monday, 3/7/16 at 5:34 PM and Tuesday, 3/8/16 at 10:30 AM noted Resident #137's unkept, oily hair. On 3/7/16 at 5:34 PM, observation was made of the resident's fingernails which were long with brown/black material under the nails, and the left hand had an odor when the resident tried to pull the fingers up. Interview with the Director of Nursing (DON), on 3/10/16 at 2:00 PM, revealed that the resident refuses to allow staff to shower or bath him/her at times. The resident's care plan was not updated for the refusal of showers, which the DON confirmed. 2) During an interview with Resident #15,on 3/8/16 at 10:08 AM, an odor of urine was noted by the surveyor while sitting next to the resident. Resident #15 stated that he/she wore briefs. The surveyor asked if the resident "dribbled" and the reply was "I have to go frequently and they can't get to me in time so they said it was ok if went in the brief. In the morning, I have to go every half hour because I am on a diuretic and they are busy." The surveyor asked the resident if someone could get the resident to the toilet would the resident prefer to go into the bathroom and the resident stated "I would love to." On 3/10/16 at 10:05 AM, Registered Nurse (RN) #1 was asked if a bladder assessment was ever done on the resident and the reply was "on admission." Review of the medical record revealed a hospital note which stated the resident had an overactive bladder. A bladder assessment done on 12/16/14 stated "incontinent greater than 1 month but less than 1 year." A second bladder	F 280	No residents were adversely affected by deficient practices. Resident #137 Care plans immediately updated to reflect residents refusal of showers and ADL care. Fingernails trimmed and hand was cleaned on 3/8/16 at 7am. Resident #15 offered toileting and refused. Care plan updated immediately to reflect refusal of toileting. Bowel and Bladder assessment completed and toileting program implemented. In-service provided to nursing staff on toileting schedules, finger nail care and documentation of refusal of care. Evaluation and implement toileting schedules on 100% of residents who triggered low risk lose bowel and bladder and implement toileting schedule as appropriate. Bowel and Bladder assessments completed annually. Director of Nursing/designee will complete audit on 25% of residents fingernail care, bowel and bladder assessments and the implementation of toileting schedules and report findings monthly QA/QI Committee x 3 months or until resolved.	4/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 5 assessment was done on re-admission to the facility on 8/6/15 which stated "wet once or more per shift, day and night, small amount of urine." There were no additional assessments and the care plan was not updated to include interventions of offering to toilet every 2 hours. On 3/10/16 at 1:17 PM, the Director of Nursing confirmed that the resident was never put on a toileting program.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on review of the medical record and staff interview it was determined that the facility staff failed to follow resident plans of care. This was evident for 2 (Resident #129,# 214) of 5 residents reviewed for unnecessary medications and 1 (Resident #98) reviewed for falls. The findings include: 1) Resident #129, according to current physician order dated 1/23/16 and their medication administration records, received the medication Digoxin daily for atrial fibrillation (a rapid irregular heart beat). The resident had a physician's order dated 5/8/15 for a Digoxin level to be completed every 3 months, and a current care plan with interventions for Digoxin levels as ordered by the	F 282		

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F 282	Continued From page 6 physician, and a list of signs of suspected Digoxin toxicity. Review of the medical record revealed a Digoxin level completed on 11/6/15. No Digoxin level was found 3 months later in February of 2016. Interview of Unit Manager #1, on 3/10/16 at 9 AM, revealed that the quarterly (every three months) lab for Digoxin had not been completed as of 3/10/16, and the physician would be notified. 2) Resident #214 had a physician's order for HGBA1C (Hemoglobin A1C- test result gives a measure of how well your body has controlled the amount of sugar in the blood over the past two to three months.) every 3 months. Review of the medical record on 3/10/16 revealed that the last HGA1C was last done on 10/15/15, almost 5 months ago. This was confirmed by the Director of Nursing (DON) on 3/10/16 at 10 AM. Review of Resident #214's nutritional care plan, which was last revised on 1/29/16, had a goal that Resident #214 would have improved BS (Blood Sugar) and HGA1C levels along with an intervention to monitor nutritionally pertinent laboratory values and ensure that the dietitian was made aware. The facility staff failed to obtain a HGA1C, overdue since January of 2016, which was used to adjust Resident #214's insulin dosage previously in October of 2015, and would indicate effectiveness of the insulin adjustment made in October of 2015. Cross reference F 329. The facility staff failed to follow the plan of care for a resident assessed to be a high falls risk. Review of Resident #98's March 2016 physician's	F 282	No residents were adversely affected by deficient practice. Resident #129 lab obtained on 3/11, #214 lab obtained 3/10. Resident #98 Hipsters placed on resident immediately. Audit 100% of residents completed on lab completion as scheduled and residents with orders for hipsters are in place. In-service on proper documentation of labs, hipsters and following care plan. Director of Nursing/designee will complete random audit on 25% of residents labs for completion, accuracy of care plan and placement of hipsters monthly and report findings monthly to QA/QI Committee x 3 months or until resolved.	4/20/2016

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F 282	Continued From page 7 orders revealed the order "hipsters for safety every shift." Hipsters are impact absorbing pads over the critical fracture area to minimize potential damage, including hip fractures that can occur from a fall. Also reviewed in the medical record were 2 Fall Risk Screeners dated 12/4/15 and 2/17/16 which categorized the resident as a "high risk" for falls. Observation was made, on 3/8/16 at 11:37 AM, of Resident #98 sitting in a wheelchair in the Cross Creek 1 dining room wearing blue pants. There was no visible padding in the hip area. A second observation was made of Resident #98, on 3/10/16 at 1:26 PM, sitting in a wheelchair in the hall area across from the nursing station in the Cross Creek 1 unit. The surveyor asked Licensed Practical Nurse (LPN) #1 if the resident was wearing hipsters as there was no noticeable padding around the hip area. LPN #1 pulled the top of the resident's pants down and said "no they aren't back from the laundry yet. She only has 1 pair that fits her and I last saw her with them on Sunday." LPN #1 proceeded to call the laundry, and was told the hipsters had been returned to the resident's room in the clothing drawer. Geriatric Nursing Assistant (GNA) #3 was asked on 3/10/16 at 1:50 PM if the resident was wearing hipsters when the GNA came on at the beginning of the shift. GNA #3 replied "no."	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, it was determined that the facility staff failed to provide the necessary services to maintain grooming and personal hygiene. This was evident for 1 of 5 residents (Resident #137) triggered for activities of daily living review in stage 2 of the survey sample. The findings include: Observations made on Monday, 3/7/16 at 5:34 PM and Tuesday, 3/8/16 at 10:30 AM, noted Resident #137's unkept, oily hair. On 3/7/16 at 5:34 PM, observation was made of the resident's fingernails which were long with brown/black material under the nails and the left hand had an odor when the resident tried to pull the fingers up. Interview with the Director of Nursing on 3/10/16 at 2:00 PM revealed that the resident refuses to allow staff to shower or bath him/her at times. The resident was to have a shower on Monday and Thursday, day shift. There was no documentation in the medical record or behaviors documented between 2/29/16 and 3/7/16 of the resident refusing a bath, shower, or hair wash. The record indicated there was no shower between 2/29/16 and 3/7/16.	F 312	No residents were adversely affected by deficient practices. Resident #137 received bed bath daily when shower not provided. Resident #137 fingernails trimmed and hand was cleaned on 3/8 at 7am. Care plan updated to reflect refusals of showers. In-service nursing staff on proper documentation of refusal of care. 100% of residents identified for refusing care were care planned. Weekly rounds to be completed by managers/designee on residents and report findings in Kryterium Room. Director of Nursing/designee will audit monthly and report findings to QI/QA Committee x 3 months or until resolved.	4/20/2016
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315		

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F 315	Continued From page 9 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, it was determined that the facility staff failed to provide appropriate treatment and services to achieve or maintain as much normal urinary function as possible for a resident assessed to have urinary incontinence. This was evident for 1 (Resident #15) of 3 residents reviewed for urinary incontinence. The findings include: During an interview with Resident #15, on 3/8/16 at 10:08 AM, an odor of urine was noted by the surveyor while sitting next to the resident. Resident #15 stated that he/she wore briefs. The surveyor asked if the resident "dribbled" and the reply was "I have to go frequently and they can't get to me in time so they said it was ok if went in the brief. In the morning I have to go every half hour because I am on a diuretic and they are busy." The surveyor asked the resident if someone could get the resident to the toilet would the resident prefer to go into the bathroom and the resident stated "I would love to." On 3/10/16 at 9:55 AM, Geriatric Nursing Assistant (GNA) #4 was asked about taking the resident to the bathroom and GNA #4 stated the	F 315	No residents were adversely affected by deficient practice. Resident #15 offered toileting refused. Care plan updated immediately to reflect refusal of toileting. Bowel and Bladder assessment completed and toileting program implemented. In-service provided to nursing staff on toileting schedules and documentation of refusal of care. Evaluation and implement toileting schedules on 100% of residents who triggered low risk lose bowel and bladder and implement toileting schedule as appropriate. Bowel and Bladder assessments completed annually. Director of Nursing/designee will complete audit of 25% on bowel and bladder assessments and the implementation of toileting schedules and report findings monthly QA/QI Committee x 3 months or until resolved.	4/20/2016

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F 315	Continued From page 10 resident "didn't have a lot of urine, does own hygiene and doesn't like going to the bathroom." On 3/10/16 at 10:05 AM, Registered Nurse (RN) #1 was asked if a bladder assessment was ever done on the resident and the reply was "on admission." Review of the medical record revealed a hospital note which stated the resident had an overactive bladder. A bladder assessment done on 12/16/14 stated "incontinent greater than 1 month but less than 1 year." A second bladder assessment was done on re-admission to the facility on 8/6/15 which stated "wet once or more per shift, day and night, small amount of urine." There were no additional assessments and no interventions put into place such as toileting every 2 hours. On 3/10/16 at 1:17 PM, the Director of Nursing confirmed that the resident was never put on a toileting program.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined that the facility failed	F 318		

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F 318	Continued From page 11 to put services in place to prevent further decreases in range of motion. This was evident for 1 (Resident #137) of 40 residents observed during stage 1 of the survey. The findings include: Observation was made, on 3/7/16 at 5:34 PM, of Resident #137 sitting in a wheelchair in the dining room on Carroll Creek Unit 2. The surveyor asked the resident if he/she could open his/her hands and at that time, the resident could not open the left hand. The resident took his/her right hand to open the fingers on the left hand. The last 3 fingers were contracted. The resident did not have a splint device or rolled washcloth, cloth carrot in place. An odor was also noted coming from the palm of the hand. A second observation was made of Resident #137 on 3/8/16 at 9:32 AM sitting in a wheelchair across from the nursing station. The resident did not have anything in the left hand. During an initial staff interview on 3/8/16 at 9:25 AM, the surveyor asked if the resident had a contracture and the reply was "yes, and therapy is going to screen her today for that." Review of the medical record revealed a note, written on 3/8/16, which stated that a care plan note was initiated due to rehab screen for left hand contracture. The CRNP (Certified Registered Nurse Practitioner) was updated and an order received to wash left hand with soap and water, pat dry and apply rolled wash cloth (dry) into left hand." The rehab note written on 3/8/16 which stated "f/u L hand reported contracture. pt with significant left 5th, 4th and 3rd MPC/PIP joint fixed contracture.	F 318	No residents were adversely affected by deficient practice. Rehab screened resident #137 implemented splint orthotics on 3/8/2016. Care plan updated immediately on contracture. Audited 100% on all residents to identify any new or worsening contractures and implement range of motion as appropriate. In-service on identifying new and worsening contractures and implement range of motion and a rehab screen. Director of Nursing/designee will complete audit on 25% residents with contractures rehab screens and report findings to the QI/QA Committee monthly x 3 months or until resolved.	4/20/2016

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F 318	Continued From page 12 pt would benefit from skill OT interventions." On 3/9/16 at 11:25 PM, Occupational Therapist (OT) #1 was interviewed regarding the development of Resident #137's contracture. OT #1 shared a discharge treatment plan from occupational therapy, dated 12/18/12, which stated the resident had tolerated a left upper extremity handsplint for 3 hours and was discharged with a splint to avoid further contraction of the left upper extremity. The Director of Nursing (DON) was asked, on 3/10/16 at 2:00 PM, what happened to the splint. The DON could not find documentation as to what happened to the splint. There was nothing documented in the medical record or care plan addressing the hand contracture.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that 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 residents who use antipsychotic	F 329		

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F 329	Continued From page 13 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on review of the medical record and staff interview, it was determined that the facility staff failed to have adequate monitoring for an insulin dependent diabetic resident as evidenced by failing to obtain laboratory blood work used to adjust insulin dosage. This was evident for 1 (Resident #214) of 5 residents reviewed for unnecessary medications. The findings include: Resident #214 received Lantus insulin twice a day (which is a long acting insulin), and has finger sticks done 3 times a day with coverage depending on the results with Novolog insulin, a short acting insulin. They have a physician's order dated 1/15/16 for a HGA1C every 3 months. A Hemoglobin A1C test result gives a measure of how well your body has controlled the amount of sugar in the blood over the past two to three months. Interview of Unit Manager #1 on, 3/10/16 at 9 AM, revealed that Resident #214 had an HGA1C done on 10/15/15, and no HGA1C has been done since then. Review of the medical record revealed a progress note by the Nurse Practitioner on 10/15/15 addressing the resident's HGA1C result, which was elevated at 8.8% based on a reference range of 4.9-5.6%. The plan in the progress note was to increase Resident #214's Lantus insulin from 45 units twice a day to	F 329	No residents were adversely affected by deficient practice. Resident #214 lab obtained 3/10. Audited completed on 100% of all residents for lab completion as scheduled. In-service on proper documentation of labs. Director of Nursing/designee will complete audit 25% on labs for completion and report findings monthly to QA/QI Committee x 3 until resolved.	4/20/2016

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F 329	Continued From page 14 50 units twice a day and for HGA1C every 3 months. Review of Resident #214's nutritional care plan, which was last revised on 1/29/16, has a goal that Resident #214 will have improved BS (Blood Sugar) and HGA1C levels, along with an intervention to monitor nutritionally pertinent laboratory values and ensure that the dietitian was made aware. The facility staff failed to obtain a HGA1C, overdue since January of 2016, the results of which were used to adjust Resident #214's insulin dosage previously in October of 2015, and would indicate effectiveness of the insulin adjustment made in October of 2015.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility 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 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. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		

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F 441	Continued From page 15 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain a sanitary environment by improper storage on a resident bedpan. This was evident for 1 (Resident #290) of 40 resident rooms observed during stage 1 of the survey process. The findings include: Observation of Resident #290"s bathroom, on 3/8/16 at 8:35 AM, revealed a bedpan sitting on the bathroom floor with dried brown liquid in it. On 3/10/16 at 8:34 AM, the same observation was made. Interview of Unit Manager #1, on 3/10/16 at 9 AM, revealed that bedpans are to be cleaned, and then stored in a plastic bag in the resident's bedside stand.	F 441	No residents were adversely affected by deficient practice. The bedpan was immediately removed and disposed of. New bedpan placed in plastic bag and placed in bedside stand. 100% of rooms audited all identified areas fixed immediately. In-service on proper placement of bedpan when in not in use. Director of Nursing/designee will complete 25% of bathroom audits for proper placement of bedpans and report findings monthly to QA/QI Committee x 3 months or until resolved.	4/20/2016

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	215217	A. BUILDING _____ B. WING _____	C 03/10/2016

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NORTHAMPTON MANOR NURSING AND REHABILITATION CENTE	200 EAST 16TH STREET FREDERICK, MD 21701

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F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain a functioning call system in 5 of 35 bathrooms observed during stage 1 of the survey. The findings include: Observation was made, on 3/8/16 at 9:38 AM, of the bathroom in Room #243. The call bell cord in the bathroom was wrapped around the grab bar 5 times. When the call bell cord was pulled from the bottom of the cord, the call bell did not activate. Advised Registered Nurse (RN) #1 at that time. Observation was made, on 3/8/16 at 10:20 AM, of the bathroom in Room #252. The call bell cord was wrapped around the grab handle bar several times and when the surveyor pulled the cord from the bottom the call bell did not activate. Geriatric Nursing Assistant (GNA) #2 was advised and unwrapped the cord at that time. Observation was made, on 3/8/16 at 10:47 AM, in Room #134, #135 and #132 of the call bell cords wrapped around the grab bars.The call bells did not activate when the bottom of the cord was pulled. Licensed Practical Nurse (LPN) #2 was advised at that time.	F 463	No residents were adversely affected by deficient practice. Rooms #243 #252, #134, #135, #132 call lights immediately unwrapped from grab bar.100% Audit completed on call light placement on units at the time of survey. Staff to be In-serviced on proper placement of call lights in the bathroom. Director of Nursing/designee will complete 25% audit of bathroom call light placement and report findings monthly to QA/QI Committee x3 months or until resolved.	4/20/2016

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F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility 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. This REQUIREMENT is not met as evidenced by: Based on review of the medical record and staff interview, it was determined that the facility staff failed to obtain physician ordered laboratory blood work for 2 (Resident #129 & #214) of 5 residents reviewed for unnecessary medications. The findings include: 1) Resident #129, according to current physician order dated 1/23/16, and medication administration records, received the medication Digoxin daily for atrial fibrillation (a rapid irregular heart beat). The resident had a physician's order, dated 5/8/15, for a Digoxin level to be completed every 3 months and a current care plan with interventions for Digoxin levels as ordered by the physician, and a list of signs of suspected Digoxin toxicity. Review of the medical record revealed that a Digoxin level was completed on 11/6/15. No level was found 3 months later in February of 2016. Interview of Unit Manager #1 on 3/10/16 at 9 AM, revealed that the quarterly (every 3 months) lab for Digoxin had not been completed as of 3/10/16, and the physician would be notified. 2) Resident #214 had a physician's order for HGBA1C (Hemoglobin A1C- test result gives a measure of how well your body has controlled the amount of sugar in the blood over the past two to	F 502	No residents were adversely affected by deficient practice. Resident #129 lab obtained on 3/11 and resident #214 lab obtained 3/10. Audited 100% of current residents on completion of all labs as scheduled. In-service on proper documentation of labs. Director of Nursing/designee will complete random audit on 25% of labs for completion and report findings monthly to QA/QI Committee x 3 until resolved.	4/20/2016

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F 502	Continued From page 18 three months.) every 3 months. Review of the medical record, on 3/10/16, revealed that the last HGA1C was last done on 10/15/15, almost 5 months ago. This was confirmed by the Director of Nursing (DON) on 3/10/16 at 10 AM.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on review of medical records and staff interview it was determined that the facility staff failed to maintain accurate resident records, as evidenced by laboratory blood work, documented on the resident's treatment administration record as complete, and physician ordered treatment signed off as performed, when it was not done. This was evident for 1 (Resident #129) of 5 resident's reviewed for unnecessary medications and 1 (Resident # 98) reviewed for falls. The findings include: 1) Resident#129 had a physician's order, dated	F 514		

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F 514	Continued From page 19 8/5/15, for a digoxin level every 3 months. Review of the resident's Treatment Administration Record (TAR) for February of 2016 had documentation on 2/5/16 that the lab was done. The results were not found in the medical record, and interview of Unit Manager #1, on 3/10/16 at 9 AM, revealed that the lab was not done. Cross reference F 502. 2) Review of Resident #98's March 2016 physician's orders, revealed the order "hipsters for safety every shift." Hipsters are impact absorbing pads over the critical fracture area to minimize potential damage that can occur from a fall. Observation was made, on 3/8/16 at 11:37 AM, of Resident #98 sitting in a wheelchair in the Cross Creek 1 dining room wearing blue pants. There was no visible padding in the hip area. A second observation was made of Resident #98 on 3/10/16 at 1:26 PM, sitting in a wheelchair in the hall area across from the nursing station in the Cross Creek 1 unit. The surveyor asked Licensed Practical Nurse (LPN) #1 if the resident was wearing hipsters, as there was no noticeable padding around the hip area. LPN #1 pulled the top of the resident's pants down and said "no they aren't back from the laundry yet. She only has 1 pair that fits her and I last saw her with them on Sunday." LPN #1 proceeded to call the laundry and was told the hipsters had been returned to the resident's room in the clothing drawer. Review of the March 2016 Treatment Administration Record (TAR) for Resident #98 documented that the hipsters were worn on 3/8/16 on all 3 shifts, and on the 7 AM to 3 PM	F 514	No residents were adversely affected by deficient practice. Resident #129 lab obtained on 3/11, #214 lab obtained 3/10. Resident #98 hipsters placed on resident immediately. Audited 100% of current resident's on completion of all labs as scheduled and all on residents with orders for hipsters are in place. In-service on proper documentation of labs and hipsters. Director of Nursing/designee will complete an audit of 25% of residents on labs for completion and placement of hipsters monthly and report findings monthly to QA/QI Committee x 3 months or until resolved.	4/20/2016

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F 514	Continued From page 20 shift on 3/9/16. Geriatric Nursing Assistant (GNA) #3 was asked, on 3/10/16 at 1:50 PM, if the resident was wearing hipsters when the GNA came on at the beginning of the shift. GNA #3 replied "no." The surveyor asked LPN #1 on 3/10/16 if she signed off that the hipsters were worn on 3/8/16 and 3/9/16. LPN #1 stated "yes." The surveyor stated to LPN #1 "so you signed off that the hipsters were worn when they actually weren't?" LPN #1 stated "yes."	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		

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F 520	Continued From page 21 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the medical record, and review of facility documents it was determined that the facility staff failed to have an effective Quality Assessment and Assurance program in place by failing to ensure that staff only document care and services that they have provided. This was evident during stage 2 of the survey. The findings include: During the survey, it was determined that the facility staff signed off hipsters in the medical record, for a resident without actually providing the hipsters. This is a repeat deficiency from the previous recertification survey in which a plan of correction was developed to correct the deficient practice. During an interview, on 3/10/16 at approximately 2:00 PM, the QA (Quality Assurance) nurse was asked what measures were put in place after the previous annual survey to correct this deficient practice. He/She indicated that staff had been educated on proper documentation and not to document anything that they did not see with their own eyes. Cross reference F-514.	F 520	No residents were adversely affected by deficient practice. Audit completed on 100% of current residents on lab completion as scheduled and all on residents with orders for hipsters are in place. In-service on proper documentation of labs and hipsters Director of Nursing/designee will complete an audit of 100% placement of hipsters and proper documentation weekly x 3 months until 100% compliance achieved and then every 2 weeks x 3 months, then monthly and report findings monthly to QA/QI Committee x 12 months or until resolved.	4/20/2016

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S 000	10.07.02 Initial comments On March 7, 8, 9, and 10, 2016, an annual Medicare/Medicaid Quality Indicator Survey was conducted by the Office of Health Care Quality. The licensed bed capacity for this facility is 196 and the resident census at the start of the survey was 173. Survey activities consisted of a review of 68 medical records (during stage 1), interviews with residents, families, facility staff and the ombudsman, as well as observations of residents and staff practices. Administrative reports and facility policies and procedures were reviewed as well. Additionally 1 facility reported incident MD00098923 and 3 complaints, MD00098880, MD00096417 and MD00092110 was reviewed with no deficient practice identified. The following deficiencies are a result of stage 2 investigation, 35 residents reviewed.	S 000		
S 512	10.07.02.12 R Nsg Svcs; Charge Nurse Daily Rounds .12 Nursing Services. R. Charge Nurses' Daily Rounds. The charge nurse or nurses shall make daily rounds to all nursing units for which responsible, performing such functions as: (1) Visiting each patient; (2) Reviewing clinical records, medication orders, patient care plans, and staff assignments; (3) To the degree possible, accompanying physicians when visiting patients. This Regulation is not met as evidenced by: Refer to CMS 2567	S 512	See F-tag F282, 329, 502,312,318	4/20/2016

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/6/16

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S 512	Continued From page 1 F282 F329 F 502 Refer to CMS 2567 F 282 F 312 F 318	S 512		
S1090	10.07.02.20 Clinical Records .20 Clinical Records. A. Records for all Patients. Records for all patients shall be maintained in accordance with accepted professional standards and practices. B. Contents of Record. Contents of record shall be: (1) Identification and summary sheet or sheets including patient's name, social security number, armed forces status, citizenship, marital status, age, sex, home address, and religion; (2) Names, addresses, and telephone numbers of referral agencies (including hospital from which admitted), personal physician, dentist, parents' names or next of kin, or authorized representative; (3) Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of initial and ongoing treatment, and of the care and services provided; (4) Authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form); (5) Consent forms when required (such as consent for administering investigational drugs, for burial arrangements made in advance, for release of medical record information, for handling of finances); (6) Medical and social history of patient;	S1090		

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S1090	Continued From page 2 (7) Report of physical examination; (8) Diagnostic and therapeutic orders; (9) Consultation reports; (10) Observations and progress notes; (11) Reports of medication administration, treatments, and clinical findings; (12) Discharge summary including final diagnosis and prognosis; (13) Discipline assessment; and (14) Interdisciplinary care plan. C. Staffing. An employee of the facility shall be designated as the person responsible for the overall supervision of the medical record service. There shall be sufficient supportive staff to accomplish all medical record functions. D. Consultation. If the medical record supervisor is not a qualified medical record practitioner, the Department may require that the supervisor receive consultation from a person so qualified. E. Completion of Records and Centralization of Reports. Current medical records and those of discharged patients shall be completed promptly. All clinical information pertaining to a patient's stay shall be centralized in the patient's medical record. F. Retention and Preservation of Records. Medical records shall be retained for a period of not less than 5 years from the date of discharge or, in the case of a minor, 3 years after the patient becomes of age or 5 years, whichever is longer. G. Current Records--Location and Facilities. The facility shall maintain adequate space and equipment, conveniently located, to provide for efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval). H. Closed or Inactive Records. Closed or inactive records shall be filed and stored in a safe place (free from fire hazards) which provides for	S1090	See F-tag F 514	4/20/2016

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S1090	Continued From page 3 confidentiality and, when necessary, retrieval. This Regulation is not met as evidenced by: Refer to CMS 2567 F 514 Refer to CMS 2567 F 514	S1090		
S1116	10.07.02.21 F Inf Control Program; Policies and Procedures .21 Infection Control Program. F. Infection Control Policies and Procedures. (1) The infection control program shall establish written policies and procedures to investigate, control, and prevent infections in the facility including policies and procedures to: (a) Identify facility-associated infections and communicable diseases in accordance with COMAR 10.06.01; (b) Report occurrences of certain communicable diseases and outbreaks of communicable diseases to the local health department in accordance with COMAR 10.06.01 and Health-General Article, §18-202, Annotated Code of Maryland; (c) Institute appropriate infection control steps when an infection is suspected or identified in order to control infection and prevent spread to other residents; (d) Perform surveillance of residents and employees at appropriate intervals to monitor and investigate causes of infection, facility-associated and community acquired, and the manner in which it was spread;	S1116		

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S1116	Continued From page 4 (e) Train employees about infection control and hygiene including: (i) Hand hygiene; (ii) Respiratory protection; (iii) Soiled laundry and linen processing; (iv) Needles, sharps, or both; (v) Special medical waste handling and disposal; and (vi) Appropriate use of antiseptics and disinfectants. (f) Train and monitor employee application of infection control and aseptic techniques; and (g) Review the infection control program at least annually and revise as necessary. (2) The facility shall provide information concerning the communicable disease status of any resident being transferred or discharged to any other facility, including a funeral home. (3) The facility shall obtain information concerning the communicable disease status of any resident being transferred or discharged to the facility. This Regulation is not met as evidenced by: Refer to CMS 2567 F 441	S1116	See F-tag 441	4/20/2016
S1120	10.07.02.21-1 A Employee Health Program; Monitor Health Stat .21-1 Employee Health Program. A. The facility's infection control program shall monitor the relevant health status of all employees, as it relates to infection control. The following guidelines shall aid the facility in implementing its employee health program: (1) Guideline for Infection Control in Health Care Personnel;	S1120		

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S1120	Continued From page 5 (2) Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC); and (3) COMAR 09.12.31. This Regulation is not met as evidenced by: Based on administrative record review and interviews with facility staff, it was determined the facility staff failed to offer a newly hired employee the influenza vaccine. This was evident for 1 of 5 newly hired employee files reviewed. Findings include: A random review of five newly hired employee files were reviewed on 3/10/16. Employee # 1 was hired on 2/16/16 and upon review, it was identified that there was no influenza vaccination form inside of his/her folder. An interview was conducted with the DON (Director of Nursing) on 3/10/16 at 12:00 PM, and he/she confirmed that employee # 1 did not have an influenza vaccination form inside of his/her folder. An interview was conducted with the Human Resources Manager (HRM) on 3/10/16 at 2:00 PM and he/she submitted a copy of employee # 1 influenza vaccine. The HRM reported that employee # 1 stated that he/she would bring in a copy of the influenza vaccine when he/she was initially hired on 2/16/16. The HRM offered, employee # 1 only works PRN (as needed).	S1120	No resident adversely affected by deficient practice HR Manager in-serviced on completion of influenza vaccination records upon hire. Administrator or designee will audit monthly on required flu vaccination consent and report findings monthly in QA/QI Committee x 3 months or until resolved.	4/20/2016
S1320	10.07.02.27 D Nusring Care Unit;Call system, existing fac	S1320		

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S1320	Continued From page 6 .27 Nursing Care Unit. D. Call System-Existing Facilities. Existing facilities (those facilities licensed at the time this regulation becomes effective) shall provide some method/means of a patient summoning aid that shall include as minimum a combined visual and audible signal that is audible at the nurses' station and simultaneously activates a light located in the hall, outside of and adjacent to the patient's room. The activating device for those signals shall be located in each patient's room and each and every bathing compartment and toilet room or compartment used by patients. Exceptions may be made in part at the discretion of the Department for an individual facility only when the facility can demonstrate compliance with the intent of this section by showing an effective patient call system to provide quality patient care. This Regulation is not met as evidenced by: Refer to CMS 2567 F 463	S1320	See F-tag 463	4/20/2016
S1654	10.07.02.34 B(2) Hskpg; clean walls/floors .34 Housekeeping Services, Pest Control, and Laundry. B. Cleanliness and Maintenance. The following shall be observed: (2) All walls, floors, ceilings, windows, and fixtures shall be kept clean. Interior walls and	S1654		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. BUILDING: _____ B. WING _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON MANOR NURSING AND REHA	200 EAST 16TH STREET FREDERICK, MD 21701

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S1654	Continued From page 7 floors shall be of a character to permit frequent and easy cleaning. This Regulation is not met as evidenced by: Refer to CMS 2567 F 253	S1654	See F-tag 253	4/20/2016
S1686	10.07.02.36 D Resident Status Assessment; assessments .36 Resident Status Assessment. D. The facility shall complete all assessments in accordance with the provisions of 42 CFR §§483.20 and 413.343. This Regulation is not met as evidenced by: Refer to CMS 2567 F 272	S1686	See F-tag 272	4/20/2016
S1740	10.07.02.37 F Care Planning;updates at least quarterly .37 Care Planning. F. Disciplines shall update the care plans as the resident's assessment warrants, but not less than quarterly. This Regulation is not met as evidenced by: Refer to CMS 2567 F 280	S1740	See F-tag 280	4/20/2016

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1830	Continued From page 8	S1830		
S1830	10.07.02.45 A Quality Assurance Program. .45 Quality Assurance Program. A. By January 1, 2001, each nursing facility shall establish an effective quality assurance program that includes components described in this regulation and Regulation .46 of this chapter. This Regulation is not met as evidenced by: Refer t CMS 2567 F 520	S1830	See F-tag 520	4/20/2016

If you want to go home, there may be a way!

Get long term services and supports in the community!

If Medical Assistance pays for any part of your nursing home care, you may be able to get care and services in your own community home instead of in a nursing home.

In the last few years, hundreds of people have moved out of nursing homes to receive services in the community. There are several programs that provide services in the community. We can help you decide which one may be right for you and help you apply. **Just let us know.**

If you would like to learn more about services that may help you move back to the community, ask a social worker at your nursing home, or contact one of the places listed on the back of this page.

State Government	
Maryland Department of Disabilities	800-637-4113
Maryland Department of Health and Mental Hygiene Community First Choice/Community Options Waiver MFP Nursing Facility Transition Program	 877-463-3464 or 410-767-1739 410-767-7242 (MFP)
Maryland Department on Aging	1-800-AGE-DIAL (1-800-243-3425)
Maryland Access Point	1-844 MAP-LINK (844-627-5465) www.marylandaccesspoint.info
Adult Evaluation and Review Services (AERS)	877-463-3464 or 410-767-7479
Developmental Disabilities Administration	Central MD 410-234-8200 Western MD 301-791-4670 Southern MD 301-362-5100 Eastern Shore 410-572-5920

Advocacy	
Independence Now (PG & Montgomery Counties)	301-277-2839
Southern MD CIL (Calvert, Charles, St. Mary's Counties)	301-884-4498
The Freedom Center (Frederick & Carroll Counties)	301-846-7811
Resources for Independence (Western Maryland)	800-371-1986
Bay Area CIL (BACIL) (Cecil Co. and the Eastern Shore)	443-260-0822 or 877-511-0744
The IMAGE Center (Baltimore City/Co. & Harford)	410-982-6311
Accessible Resources for Independence (Howard & Anne Arundel Counties)	410-636-2274
Brain Injury Association of Maryland	410-448-2924 or 800-221-6443
Maryland Statewide Independent Living Council	240-638-0074
Mental Health Association of Maryland	443-901-1550

Legal Resources	
Legal Aid Bureau LTC Assistance Program & MD Senior Legal Hotline1-866-635-2948 www.mdlab.org The Assisted Living/Nursing Home Program provides legal assistance to financially eligible nursing home residents anywhere in Maryland.	Maryland Disability Law Center (MDLC) 1-800-233-7201, TDD number: 410-727-6387 www.mdlclaw.org MDLC is a non-profit legal services established by federal and state law to advocate for the rights of persons with disabilities in Maryland.

This document is produced by the Maryland Department of Health and Mental Hygiene. By law, nursing homes ...

Long Term Care Services in the Community

Please sign on the line below to certify that you have received the one page information sheet on long term care services in the community.

Signature _____ Date _____

Print Name _____

(This form must be kept in the resident's medical record.)

AGE SPECIFIC CARE

All staff taking on-line class yearly.

COURSE DESCRIPTION

This Course is part of the Health and Safety Compliance Training Curriculum. This course explains the JCAHO age specific expectations. This course will give you a better understanding of why age-specific characteristics are incorporated into the workplace scope and responsibilities.

COURSE OBJECTIVES

At the completion of this course you should be able to:

- Articulate and integrate JCAHO age-specific expectations into the planning, implementation, continuation and evaluation of care.
- Understand why we incorporate age-specific characteristics into our workplace scope and responsibilities

OUTLINE

- JCAHCO Standards
- Age Specific Care
- Pediatric Care
- Adolescent Care
- Geriatric Care

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

SKILLED NURSING FACILITIES OFTEN FAIL TO MEET CARE PLANNING AND DISCHARGE PLANNING REQUIREMENTS

Daniel R. Levinson
Inspector General

February 2013
OEI-02-09-00201

EXECUTIVE SUMMARY: SKILLED NURSING FACILITIES OFTEN FAIL TO MEET CARE PLANNING AND DISCHARGE PLANNING REQUIREMENTS
OEI-02-09-00201

WHY WE DID THIS STUDY

Skilled nursing facilities (SNF) are required to develop a care plan for each beneficiary and provide services in accordance with the care plan, as well as to plan for each beneficiary's discharge. These requirements are essential to ensuring that beneficiaries receive appropriate care and safely transition from one care setting to another. Several Office of Inspector General studies and investigations found that SNFs had deficiencies in quality of care, did not develop appropriate care plans, and failed to provide adequate care to beneficiaries. In fiscal year 2012, Medicare paid $32.2 billion for SNF services. This study is part of a larger body of work about SNF payments and quality of care.

HOW WE DID THIS STUDY

We based this study on a medical record review of a stratified simple random sample of SNF stays from 2009. The reviewers determined the extent to which SNFs developed care plans that met Medicare requirements, provided services in accordance with care plans, and planned for beneficiaries' discharges as required. Reviewers also identified examples of poor quality care.

WHAT WE FOUND

For 37 percent of stays, SNFs did not develop care plans that met requirements or did not provide services in accordance with care plans. For 31 percent of stays, SNFs did not meet discharge planning requirements. Medicare paid approximately $5.1 billion for stays in which SNFs did not meet these quality-of-care requirements. Additionally, reviewers found examples of poor quality care related to wound care, medication management, and therapy. These findings raise concerns about what Medicare is paying for. They also demonstrate that SNF oversight needs to be strengthened to ensure that SNFs perform appropriate care planning and discharge planning.

WHAT WE RECOMMEND

We recommend that the Centers for Medicare & Medicaid Services (CMS): (1) strengthen the regulations on care planning and discharge planning, (2) provide guidance to SNFs to improve care planning and discharge planning, (3) increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable, (4) link payments to meeting quality-of-care requirements, and (5) follow up on the SNFs that failed to meet care planning and discharge planning requirements or that provided poor quality care. CMS concurred with all five of our recommendations.

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OBJECTIVES

1. To determine the extent to which skilled nursing facilities (SNFs) met Medicare requirements for care planning.
2. To determine the extent to which SNFs met Medicare requirements for discharge planning.
3. To describe instances of poor quality care provided by SNFs.

BACKGROUND

SNFs provide skilled nursing care, rehabilitation services, and other services to Medicare beneficiaries who meet certain conditions. In fiscal year (FY) 2012, Medicare paid $32.2 billion for SNF services.[1] To participate in Medicare, SNFs must meet certain quality-of-care requirements. SNFs must develop a care plan for each beneficiary and provide services in accordance with the care plan, as well as plan for each beneficiary's discharge.[2] These requirements are essential to ensuring that beneficiaries receive appropriate care and safely transition from one care setting to another.

The Office of Inspector General (OIG) has identified a number of problems with the quality of care provided in nursing facilities. Notably, OIG found that 74 percent of nursing facilities surveyed in 2007 had at least one deficiency related to quality of care.[3] Another OIG report about psychosocial services found that SNFs often did not develop appropriate care plans or provide all services identified in care plans.[4] In another report about atypical antipsychotic drugs, OIG found that nearly all records reviewed failed to meet one or more Medicare requirements for beneficiary assessments or care plans.[5] OIG also

[1] Centers for Medicare & Medicaid Services (CMS), *2012 CMS Statistics*, Table III.6. Accessed at https://www.cms.gov/ResearchGenInfo/02_CMSStatistics.asp on September 14, 2012. Note that 9.3 million Americans, or 21 percent of all Medicare enrollees in 2008 (see the CMS Web site at https://dnav.cms.gov/), were eligible for both Medicare and Medicaid and participated in both programs.

[2] Social Security Act (SSA), § 1819(b)(2) and (c)(2), 42 U.S.C. § 1395i-3(b)(2) and (c)(2), 42 CFR § 483.20(k) and (l).

[3] OIG, *Trends in Nursing Home Deficiencies and Complaints*, OEI-02-08-00140, *September* 2008.

[4] OIG, *Psychosocial Services in Skilled Nursing Facilities*, OEI-02-01-00610, March 2003.

[5] OIG, *Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs*, OEI-07-08-00151, July 2012.

found quality-of-care problems associated with beneficiaries discharged between SNFs and other facilities.[6]

Further, recent investigations have found a number of SNFs that failed to provide adequate care to beneficiaries. In one case, five facilities did not provide adequate staffing and services to beneficiaries, resulting in beneficiaries' developing pressure ulcers, malnutrition, dehydration, and side effects from not receiving medications.[7] In another case, three facilities were charged with providing inadequate food and medication to beneficiaries.[8] In a third case, inadequate staffing caused numerous beneficiaries to develop pressure ulcers, some of which were left untreated.[9]

This study is part of a larger body of work about SNF payments and quality of care. The first study found that from 2006 to 2008, SNFs increasingly billed for higher paying categories, even though beneficiary characteristics remained largely unchanged.[10] Another study found that SNFs billed one-quarter of claims in error in 2009, resulting in $1.5 billion in inappropriate Medicare payments.[11] Moreover, the study found that for 47 percent of claims, SNFs misreported information on the beneficiary assessment, which is used to create care plans. Lastly, an upcoming study will review the quality of care and safety of Medicare beneficiaries transferred from acute-care hospitals to SNFs.[12]

Medicare Coverage Requirements for Part A SNF Stays

The Part A SNF benefit covers skilled nursing care, rehabilitation services, and other services. These services commonly include physical, occupational, and

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[6] OIG, *Consecutive Medicare Stays Involving Inpatient and Skilled Nursing Facilities*, OEI-07-05-00340, June 2007.

[7] Department of Justice (DOJ), *Cathedral Rock Nursing Homes and a Nursing Home Operator Resolve Criminal and Civil Health Care Fraud Allegations Related to Failure of Care and Agree to Pay the United States over $1.6 Million*, January 7, 2010. Accessed at http://www.justice.gov/usao/moe/press_releases/archived_press_releases/2010_press_releases/january/cathedral_rock.html on November 10, 2011.

[8] DOJ, *Rome Couple Charged With $30 Million Medicare & Medicaid Fraud Through Failure of Care at Three Nursing Homes*, April 16, 2010. Accessed at http://www.justice.gov/usao/gan/press/2010/04-16-10b.pdf on November 10, 2011.

[9] Keenan Cummings, "Nursing Home Puts Residents in Jeopardy," *The Daily Athenaeum*, December 6, 2007.

[10] OIG, *Questionable Billing by Skilled Nursing Facilities*, OEI-02-09-00202, December 2010.

[11] OIG, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200, November 2012.

[12] OIG, *Adverse Events in Post-Acute Care: Skilled Nursing Facilities*, OEI-06-11-00370, forthcoming.

speech therapy; skin treatments; and assistance with eating, bathing, and toileting. Medicare covers these services for up to 100 days during any spell of illness.[13]

To qualify for the SNF benefit, the beneficiary must have been in the hospital for at least 3 consecutive days and the hospital stay must have occurred within 30 days of the admission to the SNF.[14] The beneficiary must need skilled services daily in an inpatient setting and must require the skills of technical or professional personnel to provide these services.[15] In addition, these services must be ordered by a physician and must be for the same condition that the beneficiary was treated for in the hospital.[16]

Medicare Requirements Related to Quality of Care

To ensure quality of care, SNFs are required to develop a care plan for each beneficiary and provide services in accordance with care plans.[17] Specifically, Section 1819 of the SSA requires SNFs to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each beneficiary in accordance with the care plan.[18] To ensure that beneficiaries safely transition to the next care setting, SNFs are required to plan for each beneficiary's discharge when facilities anticipate a discharge.[19]

Developing Care Plans and Providing Services. SNFs are required to develop care plans that describe the beneficiary's medical, nursing, and psychosocial needs and how the SNF will meet these needs.[20] Care plans must include measurable objectives and timetables and be customized to the beneficiary.[21] To develop a care plan, SNFs use a tool called the Minimum Data Set (MDS) to assess the beneficiary's clinical condition, functional status, and

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[13] SSA, § 1812(a)(2)(A), 42 U.S.C. § 1395d(a)(2)(A).

[14] 42 CFR § 409.30(a)(1) and (b)(1).

[15] 42 CFR §§ 409.31(b)(1) and (3) and 409.31(a)(2).

[16] 42 CFR § 409.31(a)(1) and (b)(2). Medicare also covers SNF services if the condition requiring such services arose when the beneficiary was receiving care in a SNF for a condition treated during the prior hospital stay.

[17] SSA, § 1819(b)(2) and (c)(2), 42 U.S.C. § 1395i-3(b)(2) and (c)(2), 42 CFR § 483.20(k).

[18] SSA, § 1819(b)(2), 42 U.S.C. § 1395i-3(b)(2).

[19] 42 CFR § 483.20(l).

[20] SSA, § 1819(b)(2), 42 U.S.C. § 1395i-3(b)(2).

[21] 42 CFR § 483.20(k)(1). See also CMS, *Revised Long-Term Care Facility Resident Assessment Instrument User's Manual Version 2.0 (RAI Version 2.0 Manual)*, Dec. 2002, rev. Dec. 2008, § 1.1. The *RAI Manual* was updated October 2010 to Version 3.0 (*RAI Version 3.0 Manual*); however, we used the 2008 revision of version 2.0 because it was in effect during the time period we were studying.

expected and actual use of services.[22] SNFs must develop the care plan within 7 days of this assessment and no more than 21 days after admission.[23] Depending upon the responses to the assessment, different Resident Assessment Protocols (RAP) may be "triggered" that indicate the beneficiary may be at risk for certain problems, such as delirium, falls, and pressure ulcers.[24] See Appendix A for a list of all the RAPs.

If a RAP is triggered, the SNF must assess the beneficiary further to determine whether the beneficiary is at risk of developing, or currently has, the problem associated with that RAP. If so, the SNF must specify in the beneficiary's care plan how the SNF will prevent or address the problem.[25] If the SNF determines that the RAP problem area does not need to be addressed in the care plan, the SNF must document the reason in the medical record.[26]

An interdisciplinary team that includes at least the attending physician and a registered nurse with responsibility for the beneficiary must prepare the care plan.[27] In addition, to the extent practicable, the beneficiary, the beneficiary's family, or the beneficiary's legal representative should participate in the initial care planning.[28] This participation helps to ensure that the interdisciplinary team develops a care plan that addresses all of the beneficiary's needs.[29]

Discharge planning. When the SNF anticipates the discharge of a beneficiary to another care setting or home, it must plan for the discharge. As part of this planning, the SNF must develop a discharge summary to help ensure that the beneficiary's care is coordinated and that the beneficiary transitions safely to his

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[22] 42 CFR §§ 483.315(e) and 483.20(d); *RAI Version 2.0 Manual*, § 2.3. The MDS is part of a comprehensive assessment called the Resident Assessment Instrument (RAI); the RAI also includes Resident Assessment Protocols and Utilization Guidelines. CMS implemented a new version of the MDS for FY 2011. The new version puts more focus on assessing the beneficiary for certain MDS items through interviews with the beneficiary rather than on observations or document reviews. See *RAI Version 3.0 Manual,* § 1.5.

[23] SSA, § 1819(b)(3)(C), 42 U.S.C. § 1395i-3(b)(3)(C); 42 CFR § 483.20(b)(2)(i); 42 CFR § 483.20(k)(2)(i). See also *RAI Version 2.0 Manual*, §§ 2.2 and 2.3. Specifically, the admission assessment must be completed within 14 days of the admission date, and the care plan must be completed within 7 days of the completion of the admission assessment.

[24] *RAI Version 2.0 Manual*, §§ 4.1 and 4.2. As of October 1, 2010, CMS updated the RAPs and renamed them "Care Area Assessments" (CAA). See *RAI Version 3.0 Manual*, ch. 3, section V.

[25] *RAI Version 2.0 Manual*, § 4.2.

[26] Ibid., § 4.6.

[27] SSA, § 1819(b)(2)(B), 42 U.S.C. 1395i–3(b)(2)(B).

[28] Ibid.

[29] CMS, *State Operations Manual [SOM]*, Appendix PP, Tags F279 and F280.

or her new setting. The discharge summary should include a summary of the beneficiary's stay, a summary of the beneficiary's status at the time of discharge, and a post-discharge plan of care.[30] The post-discharge plan of care should describe what the beneficiary's and family's preferences for care are, how the beneficiary and family will access these services, how care should be coordinated if continuing treatment involves multiple caregivers, and what education or instructions should be provided to the beneficiary and his or her family.[31]

Monitoring by State Surveyors

CMS contracts with State Survey and Certification agencies to determine whether nursing facilities are in compliance with Medicare requirements.[32] The State agencies conduct periodic surveys of each facility. If facilities are out of compliance with one or more requirements, surveyors cite them for deficiencies. In 2011, 22 percent of facilities surveyed did not meet care planning requirements, 14 percent did not provide services in accordance with care plans, and 1 percent did not meet the discharge planning requirements.

When facilities are cited for deficiencies, CMS or the State may choose to impose a number of different enforcement actions depending upon the scope and severity of the deficiencies found.[33] These actions include requiring a plan of correction, denying future payment, or terminating the provider agreement.

METHODOLOGY

We based this study on a medical record review of a stratified simple random sample of Part A SNF stays from calendar year 2009.

Selection of Sample for Medical Review

Using CMS's National Claims History File, we first identified all Part A SNF claims with dates of service in 2009. We grouped these claims by stay using the admission dates and identified the stays that ended in 2009. We then grouped these stays into three strata defined by the length of the stay and the number of claims. We selected a stratified simple random sample of 245 stays. See

[30] 42 CFR § 483.20(l).

[31] CMS, *SOM*, Appendix PP, Tags F283 and F284.

[32] CMS, *SOM*, ch. 1, §§ 1004 and 1016. The surveys are conducted in accordance with CMS's *SOM*. This manual includes the interpretive guidelines that surveyors follow to determine whether a facility complies with Medicare requirements.

[33] CMS, *SOM*, ch. 7.

Appendix B for more information about how we selected the sample. We used this sample to meet the objectives of this study and a companion study.[34] In our companion study, we included all stays. However, for this study, we focused on the stays that were 21 days or longer, because care plans must be completed within 21 days of admission to a SNF. This resulted in a sample of 190 stays that projects to 1,104,692 stays in the population.

Medical Record Review

We used a contractor to collect the medical records for each of the beneficiaries associated with the sampled stays. The contractor requested the medical record for each stay, which included the care plan; the beneficiary assessment, including the MDS and RAP information; and the post-discharge care plan; as well as physician orders, progress notes, therapy records and logs, and other documentation of the services that the beneficiary received. We had a 100-percent response rate.

We also contracted with medical record reviewers, who consisted of three registered nurses, each of whom had at least 12 years of SNF experience; and a physical therapist, an occupational therapist, and a speech therapist. The nurses reviewed the records and consulted with the therapists as needed. The reviewers used a standardized data collection instrument that was developed in accordance with the Medicare requirements related to care planning, provision of services, and discharge planning. The reviewers also identified any instances of poor quality care that they determined to be egregious. The instrument was developed in collaboration with the reviewers and tested on a sample of stays.[35] The reviewers conducted the medical review between April and September 2011.

Analysis

Care Planning and Provision of Services. To determine the extent to which SNFs developed care plans and provided services in accordance with care plans, we analyzed the data from the medical record review. We identified the stays in which the care plans: (1) did not address one or more RAPs (hereinafter referred to as "problem areas") and provided no explanation in the medical

[34] The companion study is *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200, November 2012.

[35] We conducted a preliminary review of a separate sample of 10 stays to test the instrument and to ensure consistency among the reviewers.

records; (2) lacked measurable objectives and detailed timeframes, i.e., duration or frequency; or (3) were not completed by an interdisciplinary team.

For each stay, we determined whether care plans contained measurable objectives and detailed timeframes for the following eight categories of services: (1) scheduled toileting plans or bladder retraining programs, (2) parenteral IV or feeding tubes, (3) skin treatments, (4) speech therapy, (5) occupational therapy, (6) physical therapy, (7) respiratory therapy, and (8) restorative nursing services.

Next, we identified the stays in which the SNFs did not provide services in accordance with care plans. Using the same service categories, we determined whether the duration and frequency of services provided was consistent with the duration and frequency called for in the care plans. We did not include instances when frequency was not applicable, such as the use of a specialized mattress, or when the duration of a service was understood without additional documentation, such as the dressing of a wound until it has healed. We also did not include instances when the SNFs changed the duration or frequency of services and provided explanations in the medical records. For example, if the record indicated that services were missed because the beneficiary refused treatment or was ill, we considered the frequency of services provided to be consistent with the care plan.

Using our sample results, we estimated the percentage of all stays in the population that the care plans did not meet one or more Medicare requirements. We also estimated the percentage of all stays in the population in which the SNFs did not provide services in accordance with the care plans.

Discharge Planning. To determine the extent to which SNFs planned for each beneficiary's discharge, we identified each stay that did not have a summary of the stay and status at discharge and post-discharge plan of care. We based this analysis on stays for which the SNFs should have planned for the beneficiaries' discharge. Specifically, the analysis included 83 stays in which the beneficiaries were discharged to another institutional setting (e.g., another nursing facility or a hospital) or to the community (e.g., a group home or the beneficiaries' own homes).[36] Using our sample results, we estimated the percentage of all stays in

[36] This analysis did not include stays in which the beneficiaries died, went to the hospital unexpectedly because of medical emergencies, or remained in the SNFs after the Part A stays ended.

the subpopulation described above in which the SNFs did not meet discharge planning requirements.

Poor Quality Care. As part of the medical record review, we asked the reviewers to identify examples of poor care that that they determined to be egregious. We analyzed their responses and grouped them into common areas of concern.

Limitations

This report was based solely on a medical record review. It does not identify all instances of poor quality care. It highlights examples that reviewers determined were egregious on the basis of their review of the medical records. Reviewers did not systematically review the records for poor quality care provided during each stay.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

For 37 percent of stays, SNFs did not meet care plan or service requirements

For 37 percent of stays, the SNFs did not develop care plans that met requirements or provide services in accordance with care plans. Medicare paid approximately $4.5 billion for these stays, which did not meet these quality-of-care requirements. See Table 1 for the percentage of stays in which SNFs did not meet care plan and service requirements. See Appendix C-1 for the point estimates and confidence intervals.

Table 1: Percentage of Stays in Which SNFs Did Not Meet Care Plan or Service Requirements, 2009

Requirements	Percentage of Stays in Which SNFs Did Not Meet Requirements	Medicare Payments for Stays in Which SNFs Did Not Meet Requirements
Care plan requirements	25.6%	$3.1 billion
Service requirements	15.4%	$2.0 billion
Total	**36.7%**	**$4.5 billion**

Source: Office of Inspector General medical record review, 2012.

Note: The rows do not sum to the total because some stays met neither the care plan requirements nor the service requirements.

For 26 percent of stays, SNFs did not develop care plans that met requirements

SNFs are required to develop care plans that address problem areas identified in beneficiaries' assessments, include measurable objectives and detailed timeframes, and are completed by an interdisciplinary team. These requirements help to ensure that beneficiaries' needs are addressed and that care plans provide clear, individualized instructions about the most appropriate care for each beneficiary. For 26 percent of stays, the SNFs' care plans did not meet at least one of the requirements. See Table 2 for the percentage of stays in which SNFs did not meet the specific requirements.

Table 2: Percentage of Stays in Which SNFs Did Not Meet Care Plan Requirements, 2009

Care Plan Requirements	Percentage of Stays in Which SNFs Did Not Meet Care Plan Requirements
Care plans address problem areas identified in the assessments	19.2%
Care plans have measurable objectives and detailed timeframes*	6.8%
Care plans are developed by an interdisciplinary team	2.1%
Total	**25.6%**

Source: Office of Inspector General medical record review, 2012.

Note: The rows do not sum to the total because some stays did not meet two or more care plan requirements.

* The requirement states that both measurable objectives and timeframes must be in the care plan. The 6.8 percent represents the stays in which either measurable objectives or timeframes were missing.

For 19 percent of stays, SNFs developed care plans that did not address one or more problem areas identified in the beneficiaries' assessments. For example, in one stay, the SNF made no plans to monitor a beneficiary's use of antipsychotic medication that had potentially severe adverse reactions. In another stay, the SNF did not address the psychosocial needs of a beneficiary who had anxiety and made repeated health complaints. On average, beneficiaries had seven problem areas identified in their assessments. Some of the more common areas included activities of daily living, pressure ulcers, nutrition, and falls. See Appendix C-2 for the point estimates and confidence intervals for all 18 problem areas.

For 7 percent of stays, the SNFs' care plans did not include measurable objectives or detailed timeframes. These objectives and timeframes are intended to ensure that SNFs provide appropriate care in duration and frequency and that they monitor progress. Additionally, for 2 percent of stays, an interdisciplinary team did not complete the care plans. In one case, only one individual completed the care plan, and this care plan was completed after the beneficiary was discharged from the facility.

The reviewers further observed that care plans were not always customized to the beneficiaries' needs. One reviewer noted that care plans often had generic interventions or approaches and that there was not always evidence that the care plans for problem areas were developed using the information collected in the assessments. Another reviewer agreed, noting that the records had "many perfect computer-generated care plans" that were not individualized or customized for the beneficiaries. One reviewer also noted that sometimes the

records had little to no documentation that the care plans were implemented. This reviewer noted that information on restorative nursing services, toileting programs, and preventive wound care was sometimes missing from the records.

For 15 percent of stays, SNFs did not provide services in accordance with care plans

For 15 percent of stays, SNFs failed to provide at least one service at the frequency or duration prescribed in the care plans. Reviewers found several examples in which SNFs provided more services than were indicated in the care plans; these examples commonly involved therapy. SNFs have an incentive to provide more therapy than indicated in the plan of care because the amount of therapy that SNFs provide to beneficiaries largely determines the amount that Medicare pays SNFs. In one example, the SNF provided therapy for 12 continuous days without an explanation for the need for that amount of therapy. In another example, the SNF continued providing therapy even though the beneficiary had met all therapy goals.

Reviewers also found examples in which SNFs provided fewer services than were indicated in the care plans. In one example, the beneficiary was scheduled to receive assistance with toileting at least three times a day; however, the record showed that this assistance was provided much less often. In another example, the beneficiary was scheduled to receive assistance with activities of daily living every day; however, these activities were performed for the first few days and then stopped without any explanation.

For 31 percent of stays, SNFs did not meet discharge planning requirements

SNFs must provide a plan for each beneficiary being discharged to another facility or to home. The plan must have a summary of the beneficiary's stay and status at discharge, as well as a post-discharge plan of care. These requirements help ensure that care is coordinated and that the beneficiary's needs are met after discharge. Not having this information can lead to inadequate care or even to serious medical errors and life-threatening situations.

For 31 percent of stays, the SNFs failed to meet at least one of the discharge planning requirements.[37] Medicare paid approximately $1.9 billion for these stays. See Table 3 for the percentage of stays in which SNFs did not meet

[37] The point estimate is 31 percent with a 95-percent confidence interval of 21 to 43 percent.

discharge planning requirements. See Appendix C-3 for the point estimates and confidence intervals.

Table 3: Percentage of Stays in Which SNFs Did Not Meet Discharge Planning Requirements, 2009

Discharge Planning Requirement	Percentage of Stays in Which SNFs Did Not Meet Discharge Planning Requirement
Summary of beneficiary's stay and status at discharge	16.0%
Post-discharge plan of care	23.3%
Total	**30.9%**

Source: Office of Inspector General medical record review, 2012.

Note: The rows do not sum to the total because some stays did not meet either requirement.

For 16 percent of stays, SNFs did not have summaries of the beneficiaries' stays or statuses at discharge. Such summaries ensure that the next care provider has the necessary information regarding the beneficiary's current and prior health, including any treatments received and the beneficiary's response to them. Additionally, for several of the stays for which SNFs had summaries, the reviewers noted that the summaries had only minimum information, such as the statement "Has done well." The reviewers also found a few discharge-status summaries that contained no clinical information; this information is essential to ensuring a safe transition for the beneficiary to another care setting. In one case, the discharge status contained only the statement "[D]ischarged in stable condition, vital signs." The summaries may have lacked clinical information because physicians were not always part of the teams that completed them. For example, the reviewers noted that sometimes the discharge statuses were written by therapists and included only information regarding the beneficiaries' functional levels and therapy goals.

For 23 percent of stays, SNFs did not have post-discharge plans of care. Such instructions are essential to ensuring that the beneficiary's needs are met after discharge. In one example, the beneficiary needed specific instructions about her medication; however, the medical record noted that this was not provided. The reviewers also noted several instances when the medical records indicated that staff provided only verbal instructions to the beneficiaries.

Medical reviewers found examples of poor quality care related to wound care, medication management, and therapy

The medical reviewers found a number of egregious examples of poor quality care that were related to wound care, medication management, and therapy.

Wound care

The medical reviewers identified three instances in which SNFs provided poor wound care that may have resulted in the beneficiaries' condition worsening. Wound care refers to the various treatments provided to heal wounds, which may include application of dressings to the wound and the removal of nonviable tissue. The following two examples illustrate the issues that the reviewers found.

- A beneficiary was admitted to a SNF with a pressure ulcer. During her stay, the beneficiary developed three other pressure ulcers. The SNF had difficulty tracking and treating each wound properly, which made healing more difficult. In addition, nursing notes regarding the treatment provided for each wound were confusing and inconsistent.
- Another beneficiary developed a heel ulcer during her stay. The SNF provided inadequate wound care and neglected to provide interventions aimed at relieving pressure on the heel. The ulcer worsened considerably over the course of 2 months.

Furthermore, one medical reviewer observed that several SNFs did not include detailed information about wounds in the medical records. The reviewer noted that SNFs may not want to call attention to any pressure ulcers acquired during a beneficiary's stay. SNFs are required to report such instances to CMS. CMS then includes this data in its Nursing Home Compare Web site, which provides information to the public about each nursing facility.[38]

[38] For more information on the data collected for Nursing Home Compare, see http://www.medicare.gov/NursingHomeCompare.

Medication Management

The medical reviewers identified five instances in which SNFs did not appropriately manage beneficiaries' medications. The following two examples illustrate such issues.

- A beneficiary with dementia was given an antipsychotic drug during her SNF stay. This drug has a "black-box warning" that it is not approved for patients with dementia-related psychosis and may result in severe or life-threatening risks.[39] The medical record indicated that SNF staff and the beneficiary's roommate saw that the beneficiary was more confused, was agitated, and was not sleeping well after using the drug. However, the SNF did not address these issues in any way.
- Another beneficiary was given an antipsychotic drug when she did not have a diagnosis for psychosis and her care plan did not indicate that she had a mood disorder. The physician noted that the beneficiary was confused while on the drug, but he still increased the dosage. A month later, the beneficiary's family complained that the physician and SNF staff were trying to sedate the beneficiary with the drug.

These examples illustrate some of the same issues found in a previous OIG study.[40] That study found that 95 percent of claims for atypical antipsychotic drugs for elderly nursing facility residents were for off-label use and/or the condition specified in the black-box warning.[41] Although physicians are not prohibited from prescribing drugs for off-label use or for conditions specified in the black-box warning, Medicare will pay only for drugs that are used for medically accepted indications. The study found that 50 percent of claims did not meet this criterion.

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[39] If drug manufacturers or the Food and Drug Administration (FDA) determines during the approval process or after a drug has been approved for marketing that the drug may produce severe or life-threatening risks, FDA requires that drug manufacturers include a boxed warning (also referred to as a "black-box warning") on the product's labeling to warn prescribers and consumers of these risks. See 21 CFR § 201.57(c)(1).

[40] OIG, *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, OEI-07-08-00150, May 2011.

[41] "Off-label use" is the term used to describe the provision of a drug for an indication other than the one approved by FDA.

Therapy

The medical reviewers identified two instances in which SNFs provided inappropriately high levels of therapy to beneficiaries given their conditions. The following illustrate these issues.

- A beneficiary received hospice care for terminal lung cancer and bone metastasis prior to SNF admission.[42] During the beneficiary's SNF stay, the SNF provided her with physical therapy 5 days a week for 5 weeks. The medical record showed that the beneficiary participated in therapy at first, but at some point, she did not want to continue. However, the SNF continued the therapy at the same intensity for the remainder of her stay until she was discharged to home with hospice care.
- Another beneficiary had a dislocated hip and could not bear weight on that side. Even though the beneficiary should not have been ambulating, the SNF provided "ultrahigh" levels of physical therapy to the beneficiary for the entire stay.[43]

These examples are consistent with the findings from a previous OIG study.[44] That study found that SNFs billed for a higher payment category than was appropriate for 20 percent of all claims in 2009. For approximately half of these claims, SNFs billed for ultrahigh levels of therapy when they should have billed for lower levels of therapy or no therapy at all. For some of these claims, the reviewers determined that the amount of therapy indicated in the beneficiary's medical record was not reasonable and necessary. As noted earlier, the amount of therapy that the SNF provides to the beneficiary largely determines the amount that Medicare pays the SNF.

[42] Metastasis is the spread of cancer from one part of the body to another.

[43] Ultrahigh therapy is the highest level of therapy a beneficiary may receive under the SNF payment system. It is 720 minutes or more of therapy per week. Medicare generally pays the most for this level of therapy.

[44] OIG, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200, November 2012.

CONCLUSION AND RECOMMENDATIONS

SNFs are required to provide care planning and discharge planning for beneficiaries. These requirements are essential to ensuring that beneficiaries receive appropriate care and safely transition from one care setting to another. For 37 percent of stays, SNFs did not develop care plans that met requirements or provide services that were consistent with care plans. For 31 percent of stays, SNFs did not meet discharge planning requirements. Medicare paid approximately $5.1 billion for stays in which SNFs did not meet these quality-of-care requirements. Additionally, reviewers found a number of examples of poor quality care related to wound care, medication management, and therapy.

These findings raise concerns about what Medicare is paying for. They also demonstrate that CMS should do more to strengthen its oversight of SNFs to ensure that they perform appropriate care planning and discharge planning for beneficiaries.

We recommend that CMS:

Strengthen the Regulations on Care Planning and Discharge Planning

CMS should revise the regulations on care planning and discharge planning to reflect current standards of practice and to address the vulnerabilities identified in this report. For example, CMS should strengthen the requirement that services be provided in accordance with care plans. Specifically, it should require SNFs to document in the medical records the reasons why they did not provide services in accordance with the care plans, similar to the existing requirement for SNFs to document the reasons why they did not develop care plans to address identified problem areas. CMS should also add a requirement that discharge planning be conducted by an interdisciplinary team, including a physician.

Provide Guidance to SNFs To Improve Care Planning and Discharge Planning

CMS should provide guidance to SNFs about care planning and discharge planning to ensure that SNFs make improvements in these areas. The guidance should reiterate and expand on the requirements. For care planning, it should emphasize the importance of addressing the problem areas identified in the beneficiary's assessment. To ensure that all of the beneficiary's needs are met, the guidance should stress that the care plan must be customized to the beneficiary and include measurable objectives and timeframes. In addition, the care plan

should be based on communication among interdisciplinary team members, the beneficiary, and the beneficiary's family. CMS should also emphasize that the care plan should be treated not as a documentation exercise but rather as an integral step in meeting the beneficiary's needs.

For discharge planning, the guidance should state that the discharge summary needs to provide an adequate clinical picture of the beneficiary and detailed individualized care instructions to ensure that care is coordinated and that the beneficiary transitions safely from one care setting to another. CMS should clarify the type of information that should be included in the discharge summary and specify that an interdisciplinary team, including a physician, should develop the summary of the beneficiary's stay and status at discharge.

Increase Surveyor Efforts To Identify SNFs That Do Not Meet Care Planning and Discharge Planning Requirements and To Hold These SNFs Accountable

State surveyors are CMS's primary tool to verify that SNFs are meeting care planning and discharge planning requirements and to enforce these requirements. CMS should increase surveyor efforts to make SNFs more accountable. It should provide more detailed guidance to surveyors to improve the detection of noncompliance, particularly for discharge planning. Specifically, CMS should revise its interpretive guidelines in the *SOM* and train surveyors to ensure that they cite facilities that are not developing individualized care plans or are not developing specific discharge plans that involve an interdisciplinary team, including a physician.

In addition, CMS should increase the use of existing enforcement remedies when SNFs do not meet care planning and discharge planning requirements. CMS should determine when enforcement actions should be taken for SNFs that are out of compliance with these requirements and which actions are most appropriate, such as increased State monitoring, a directed plan of correction, or civil monetary penalties.

Link Payments to Meeting Quality-of-Care Requirements

CMS should develop and expand alternative methods beyond the State survey and certification process to promote compliance and make improvements in the areas of care planning and discharge planning. CMS should link SNF payments more closely to meeting the requirements. To do so, it could build upon lessons learned from existing pay-for-performance incentive programs that reward SNFs for quality and improvement in care. For example, CMS could incorporate quality

measures for care planning and discharge planning in its Skilled Nursing Facility Value-Based Purchasing program.

Follow Up on the SNFs That Failed To Meet Care Planning and Discharge Planning Requirements or That Provided Poor Quality Care

We will provide CMS with a list of SNFs that failed to meet care planning and discharge planning requirements or provided poor quality care. When one problem is found, it may indicate a wider problem in the facility. CMS should provide the list to State Survey and Certification agencies to prioritize these facilities for review and determine whether enforcement actions are needed.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all five of our recommendations. CMS concurred with our first recommendation and stated that it is conducting a comprehensive review of the requirements for participation for long term care facilities to ensure that the regulations are effective and these facilities provide quality care. In addition, it has reached out to several external stakeholder groups for public input on these issues.

CMS concurred with our second recommendation and stated that its contractors, the Quality Improvement Organizations, are enrolling nursing homes in the Nursing Home Quality Care Collaborative. This initiative uses a menu of actionable items to improve the overall quality of care being received by residents and their quality of life. One of the items focused on in this initiative is care planning. CMS has also assembled a workgroup to identify areas of the *SOM* that might better address the discharge planning requirements.

CMS concurred with our third recommendation and stated that it will consider ways to increase oversight of care planning and discharge planning issues in SNFs. With regard to increasing the use of existing enforcement remedies, CMS stated that it will review the current citations related to care planning and discharge planning, including the severity determinations and enforcement actions taken, and work to develop ways to improve its enforcement efforts.

CMS concurred with our fourth recommendation and stated that it will consider incorporating care planning and discharge planning in future nursing home demonstrations. Finally, CMS concurred with our fifth recommendation and stated that it will analyze the survey data and determine appropriate methods to strengthen enforcement of CMS requirements.

We support CMS's efforts to address these issues. For the full text of CMS's comments, see Appendix D.

APPENDIX A

List of the 18 Resident Assessment Protocols

Activities
Activities of daily living functional/rehabilitation potential
Behavior symptoms
Cognitive loss
Communication
Dehydration/fluid maintenance
Delirium
Dental care
Falls
Feeding tubes
Mood state
Nutritional status
Physical restraints
Pressure ulcers
Psychosocial well-being
Psychotropic drug use
Urinary incontinence and indwelling catheter
Visual function

APPENDIX B

Sample Design

We used this sample design to meet the objectives of this study and our companion study, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200. For this study, we analyzed stay-level data from strata 2 and 3, for a total of 190 stays.

Stratum	Stratum Description	Number of Stays in Population	Number of Stays in Sample
1	Length of stay less than 21 days in 2009 and 3 or fewer claims in 2009	1,264,073	55
2	Length of stay 21 or more days in 2009 and 3 or fewer claims in 2009	435,893	45
3	Stays with over 3 claims in 2009 (by default, length of stay is more than 21 days)	668,799	145
Total		**2,368,765**	**245**

Source: Office of Inspector General medical record review, 2012.

APPENDIX C

Point Estimates, Sample Sizes, and 95-Percent Confidence Intervals for All Estimates Presented in the Report

C-1: Estimates for All Stays

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval
Stays in which skilled nursing facilities (SNF) did not meet care plan or service requirements	190	36.7%	29.7%–44.5%
Payment for stays in which SNFs did not meet care plan or service requirements	190	$4.5 billion	$3.5 billion–$5.5 billion
Payment for stays in which SNFs did not meet care plan requirements	190	$3.1 billion	$2.1 billion–$4.0 billion
Payment for stays in which SNFs did not meet service requirements	190	$2.0 billion	$1.2 billion–$2.8 billion
Stays in which SNFs did not develop care plans that met requirements	190	25.6%	19.4%–32.9%
- Care plans did not address one or more problem areas identified in the assessments	190	19.2%	13.8%–26.0%
- Care plans did not include measurable objectives or detailed timeframes	190	6.8%	3.8%–12.2%
- Interdisciplinary teams did not complete the care plans	190	2.1%	0.7%–6.0%
The average number of problem areas per beneficiary	190	7.0	6.5–7.6
Stays in which SNFs did not provide services in accordance with care plans	190	15.4%	10.5%–22.2%
Payment for stays in which SNFs did not meet care plan requirements, service requirements, or discharge planning requirements	190	$5.1 billion	$4.1 billion–$6.2 billion

Source: Office of Inspector General medical record review, 2012.

APPENDIX C (CONTINUED)

C-2: Percentage of Stays in Which Beneficiaries Had Problem Areas (Resident Assessment Protocols) Identified in Their Assessments

Resident Assessment Protocol	Sample Size	Point Estimate	95-Percent Confidence Interval
Activities of daily living functional/rehabilitation potential	190	86.1%	80.5%–90.3%
Pressure ulcers	190	81.0%	74.7%–86.0%
Nutritional status	190	69.1%	61.9%–75.5%
Falls	190	61.4%	53.9%–68.5%
Dehydration/fluid maintenance	190	55.4%	47.7%–62.8%
Urinary incontinence and indwelling catheter	190	54.0%	46.3%–61.5%
Cognitive loss	190	53.1%	45.4%–60.6%
Psychotropic drug use	190	44.2%	36.8%–51.9%
Mood state	190	40.9%	33.6%–48.7%
Psychosocial well-being	190	40.4%	33.1%–48.1%
Communication	190	33.5%	26.8%–40.9%
Visual function	190	22.5%	16.8%–29.5%
Dental care	190	21.7%	16.0%–28.7%
Delirium	190	15.4%	10.5%–22.2%
Behavior symptoms	190	10.6%	6.7%–16.4%
Activities	190	8.0%	4.9%–12.8%
Feeding tubes	190	5.5%	3.0%–9.6%
Physical restraints	190	1.3%	0.3%–5.5%

Source: Office of Inspector General medical record review, 2012.

APPENDIX C (CONTINUED)

C-3: Estimates for Stays in Which the Beneficiaries Were Discharged

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval
Stays in which SNFs did not meet discharge planning requirements	83	30.9%	21.2%–42.6%
Payment for stays in which SNFs did not meet discharge planning requirements	83	$1.9 billion	$1.1 billion–$2.7 billion
Stays in which SNFs' discharge planning did not include summaries of the stays or statuses at discharge	83	16.0%	9.0%–26.9%
Stays in which SNFs' discharge planning did not include post-discharge plans of care	83	23.3%	15.0%–34.4%

Source: Office of Inspector General medical record review, 2012.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 17 2013

TO: Daniel R. Levinson
Inspector General

FROM: /S/
Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements" OEI-02-09-00201

The Centers for Medicare & Medicaid Services (CMS) would like to thank the OIG for the opportunity to review and comment on the subject OIG draft report. CMS recognizes the importance and impact of effective care planning and discharge planning on the quality of life and care for nursing home residents. The OIG's objectives for this report are to determine the extent to which skilled nursing facilities (SNFs) met Medicare requirements for care planning and discharge planning, and describe instances of poor quality care provided by SNFs.

The CMS responses to the OIG recommendations are discussed below.

OIG Recommendation 1

The OIG recommends that CMS strengthen the regulations on care planning and discharge planning.

CMS Response

The CMS concurs with this recommendation. Care planning and discharge planning are important aspects of providing quality care. CMS is currently conducting a comprehensive review of the requirements for participation for long term care facilities to ensure that the regulations are effective and these facilities provide quality care. The applicable regulatory provisions in 42 CFR Part 483, Subpart B are being reviewed for possible areas of improvement to ensure the health and safety of long-term care residents. Our review of these regulations includes consideration of timeliness, resident-centeredness, and quality improvement. In addition, CMS has reached out to several external stakeholder groups for public input on their key concerns and suggestions on these issues. We appreciate this timely and informative OIG report and will consider the results and recommendations of this study as we conclude our regulations review process.

OIG Recommendation 2

The OIG recommends that CMS provide guidance to SNFs to improve care planning and discharge planning.

CMS Response

The CMS concurs with this recommendation. Quality Improvement Organizations (QIOs), in their capacity as contractors to the Federal government, facilitate continual improvement of health care services to Medicare beneficiaries. QIOs are currently enrolling nursing homes in the Nursing Home Quality Care Collaborative (NHQCC) as part of the 10th Statement of Work. This initiative utilizes a menu of actionable items derived from high performing nursing homes to improve the overall quality of care and quality of life being received by residents. One of the items focused on in this initiative is nursing home care planning. As the NHQCC unfolds across the next 18 months, so too will our understanding of what works well in nursing home care plan development.

In addition, CMS has assembled a workgroup to identify areas of the State Operations Manual that might better address the discharge planning requirements. OIG's recommendation will be helpful as the workgroup prioritizes its efforts to improve surveyor guidance.

OIG Recommendation 3

The OIG recommends that CMS increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable.

CMS Response

The CMS concurs with this recommendation. CMS agrees with the desirability of increasing surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements. Therefore, we will consider ways to increase oversight of care planning and discharge planning issues in SNFs. With regard to increasing the use of existing enforcement remedies, we will review the current citations related to care planning and discharge planning including the severity determinations and enforcement actions taken and work to develop ways to improve our enforcement efforts.

OIG Recommendation 4

The OIG recommends that CMS link payments to SNFs meeting quality of care requirements.

CMS Response

The CMS concurs with this recommendation. CMS will consider incorporating care planning and discharge planning in future nursing home demonstrations.

OIG Recommendation 5

The OIG recommends that CMS follow-up on the SNFs that failed to meet care planning and discharge planning requirements or that provided poor quality care.

CMS Response

The CMS concurs with this recommendation. OIG recommends that CMS prioritize the facilities for review and determine whether enforcement actions are needed. The standard survey process requires surveyors to inspect each nursing home to evaluate them for compliance with CMS conditions of participation once every 9 – 15 months. We will analyze the survey data and determine appropriate methods to strengthen enforcement of CMS requirements.

We appreciate the opportunity to comment on this draft report, and we look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Judy Kellis served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Judy Bartlett. Central office staff who provided support include Berivan Demir Neubert, Kevin Farber, Sandy Khoury, Christine Moritz, Sue Nonemaker, and Julie Taitsman.

Office of Inspector General

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Envisioning your future in a nursing home

Margaret P. Calkins, Ph.D.

President, IDEAS Inc.

Board Chair, IDEAS Institute

Founding member and Board Member, SAGE

Ask any gathering of people – if they had to move into a nursing home tomorrow, would they want to share a room with someone they had never met before? Especially if the room looked like a hospital room with the beds separated by a piece of fabric? I have done this, and I can tell you the answer is a resounding, "NO!"

Ask the family members of someone who has just passed away in a nursing home whether they didn't visit as often, or as long, or whether some family members did not come at the end, because there wasn't enough space in the room, and they felt like they were impinging on the rights of the roommate to have their own room. Or whether the presence of the roommate kept them from being able to say the things that needed to be said before this individual died. Or whether they were disturbed because the roommate had dementia, and kept coming over and interrupting conversations and picking up things they had brought.

Ask the roommate how she felt, wanting to go into her room to take a nap but not wanting to disturb the family who was gathering, also knowing they didn't want to disturb her or disrupt her routine. Or how she felt 3 months ago when her roommate couldn't make it to the bathroom, and so used a commode chair next to the bed, but couldn't pull the curtain either. Ask her how embarrassed she was when her roommate did this in front of her visitors.

Ask the staff how much time they spend trying to manage roommate conflict. When one person likes to stay up late and watch TV, with the volume so loud the roommate can't get to sleep. When one prefers music to game shows, or when the person near the thermostat (and who therefore controls the thermostat) likes the room warmer than the roommate, or when the person near the bed likes the curtains closed all day so she can sleep, and the roommate complains to everyone who will listen, and even to those who don't listen anymore, because they're heard it all before and there's nothing they can do about it anyway. The "complainer" complains louder and louder, and then her family starts complaining, so the social worker tries to make peace, but fails. So they decide to move the complainer, but the only person she'll share a room with already has a roommate, so the facility has to force 2 other residents to move, just to keep the peace and stop the complaining. Ask staff how they feel about all this.

These are all commonplace events in the daily life of the majority of nursing home residents who share a bedroom with a stranger.

History

Originally conceived of as sub-acute hospitals, nursing homes were built on the same institutional model. Large open wards were thought to be the most efficient, in those early days before call bell system, because staff could see all the patients who stayed in bed most of the time. Over time, the wards became smaller, to the point where 4 and 6-person bedrooms were the norm. At the same time, patients in nursing homes were being encouraged to get out of bed and go to the central "day room" (another institutional concept) to socialize. But problems persisted. Several studies show that people in shared rooms, particularly rooms without a clearly defined territory for each individual, are less social in shared or public areas of the unit, and more territorial in claiming space, be it a section of the hallway or a chair in the day room (Kinney, Stephens, & Brockman, 1987; Lipman, 1967; Nelson & Paluk, 1980). In other words, when people do not have sufficient privacy and personal territory provided through the physical environment, they create their own social and psychological privacy by limiting their interactions with other people.

Private vs. semi-private

CMS Tag F460 (§483.70(d)(1)(iv)) states that bedrooms "be designed or equipped to assure full visual privacy for each resident." The interpretive guidelines suggest that "full visual privacy" means that residents have a means of completely withdrawing from public view while occupying their bed (e.g., curtain, moveable screens, private room)." Typically, when a room is shared with one or more persons, it is described as semi-private. What is semi-private? It is an oxymoron. It is a little like being "slightly

pregnant." Let's start with an examination of privacy. The American Heritage dictionary defines private as "secluded from the sight, presence, or intrusion of others; designed or intended for one's exclusive use" (American Heritage nd). Dictionary.com defines it as "without the presence of others; alone" (Dictionary.com, nd).

Semi-private, on the other hand, is defined as "of, receiving, or associated with hospital service giving a patient more privileges than a ward patient but fewer than a private patient" (Merriam Webster, nd) or "shared with usually one to three other hospital patients" (American Heritage, 2000). In both of these definitions, semi-private is defined in terms of being in a hospital, whereas the definitions for privacy never mentioned being in a hospital. Thus, it is reasonable to question how "semi-private" came to be defined solely in terms of being in a hospital. One definition refers to "privileges" though it is unclear what those privileges are. The reality is that privacy, in a semi-private room, refers only to visual privacy (as stated in CMS Tag 460). That's what a so-called (or mis-named) "privacy" curtain does—limits visual privacy. It does nothing to protect the privacy of auditory or olfactory information, or control over who comes into a space.

There are clearly different kinds of privacy- as the current concern over identity theft proves. Identity theft is loss of control over one's personal information. Identity theft is not dissimilar from what happens in a nursing home when staff discuss diagnoses and personal care issues with a person on their side of a room, when the roommate is present separated only by a piece of fabric. Despite the intentions of HIPPA, it is just not practical to keep all diagnostic and care issues private from a roommate. So it can be

argued that care in a shared room will almost certainly involve HIPPA violations. If there is more than one roommate (CMS Tag F457 states bedrooms must accommodate no more than 4 residents), HIPPA violations are virtually guaranteed.

In reality, though, keeping information private is generally not at the top of the list of issues or concerns to people living in shared rooms. Much more important to them is adjusting to the day-to-day routines, behaviors and activities of another person. Hearing someone moaning constantly, seeing them use their bedside commode, listening to their TV shows, not being able to set the temperature the way you want, not be able to keep the door open (or closed) as is your preference, having their clothing take up more than half of the closet—these are the everyday irritants that cause friction among roommates. These are issues of basic control over the environment. A resident can't even keep people out of their room, if the roommate wants to let them in.

Not being able to have a private conversation is cited by family members as an important issue. Many nursing homes have few shared social spaces and they are often occupied, so finding a location other than the bedroom to have a private conversation can be difficult. Furthermore, nursing home residents are frail and tire easily, so it may be more convenient to visit in the bedroom. But if there is a roommate, this can stifle the ability to spend quality time together. Bedrooms tend to be so small that there is seldom room for more than one person to visit at a time or more than one chair, limiting the number of people who can visit, or impinging on the space of the roommate. CMS Tag 248 gives minimum requirements of 80 square foot per person in a shared room and 100 square foot

for a private room, but with furniture and wheelchair and other mobility devices, possibly oxygen or other medical support devices, there is barely room for a single chair, much less two to have a conversation with a visitor. This is an especially sensitive issue at end-of-life. Families and loved ones want to gather at the bedside of the dying individual. But there is tension between wanting to have everyone important there and knowing that the presence of large numbers of people is even more disruptive to the roommate. In most cases, the roommate is equally unhappy by the situation, feeling awkward and forced to be an unwilling participant in what ought to be a private time for families. This problem is compounded with there are more than two people sharing the room. It is even less likely that a gathering family can find any time alone with their dying relative.

Having a roommate is not necessarily always a completely negative experience. Anecdotally, administrators, nurses and social workers will say that there are some people who really prefer not to live alone, who do better with the companionship of a roommate. One research project specifically explored the relationship between roommates in nursing homes (Bitzan, 1998). In this study, 22% of residents interviewed indicated an overall strong or positive emotional bond with their roommate (which is higher than in many other studies), although this means that 77% had moderate or weak emotional bond with their roommate. Overall, 80% denied having problems getting along with their roommate. However, 80% also denied any intimacy of sharing problems or concerns with their roommate. The majority of roommates did not enjoy spending time with their roommate, did not perceive their roommate to be sensitive to their feelings, and agreed they got along best when they kept their feelings and activities to

themselves. Another study (Terakawa, 2004) explored satisfaction of residents who lived in shared rooms and then moved into a new building with all private rooms. Although 39% of the residents initially indicated complete satisfaction with having a roommate and did not want to have a private room, by eight months after the move, 100% of the residents were completely satisfied with having a private room. This suggests people may tolerate and even accommodate to having a roommate, when it's necessary (making the best of it), but once they've had the opportunity to experience living in a private room, that's what they prefer.

Other Factors

Satisfaction is only one factor that is impacted by being in a private or a shared room. There are also clinical consequences, most notably in the area of nosocomial infections. Virtually every study that has explored this topic, both in hospitals and in nursing homes, found patients/residents living in shared rooms were at a significantly higher risk of nosocomial infections (clostridium difficile-associated diarrhea, antibiotic-associated diarrhea, methicillin-resistant staphylococcus aureus, influenza A, acute nonbacterial gastroenteritis and pneumonia) than their counterparts in private rooms (Boyce, Potter-Bynoe, Chenevert & King, 1997; Drinka, Krause, Nest, Goodman, & Gravenstein, 2003; Harkness, Bentley & Roghmann 1990; *State Ombudsman Data: Nursing Home Complaints*, 2003). Nursing home residents contract more than 1.5 million infections annually, have a median incidence rate of 1 to 1.2 per 1,000 patient-days, and each resident faces a 5% to 10% risk per year of infection (Furman, Rayner & Tobin, 2004; Zimmerman, Gruber-Baldini, Hebel, Sloane & Magaziner, 2002). These infections

(primarily pneumonia and influenza A) account for almost 1/4 of hospitalizations of nursing home residents (Zimmerman, Gruber-Baldini, Hebel, Sloane & Magaziner, 2002). One study followed all nursing home admissions to 59 nursing homes in Maryland over a 2.5 year period. Of 2,153 admissions, there were 4,903 episodes of infections in 1,267 residents, of which 375 (7.6%) required a hospital admission (Boockvar, Gruber-Baldini, Burton, Zimmerman, May & magaziner, 2005). Another study specifically looked at the differential risk of acquiring influenza A in private and shared rooms, and found "those who lived in double rooms with roommates who were identified as cases had a higher relative risk of acquiring influenza A of 3.07 (95% confidence interval. 1.61 to 5.78) compared with those who lived in single rooms" (Drinka, Krause, Nest, Goodman, & Gravenstein, 2003). Finally, a study conducted in 1994 estimated that the average cost of hospitalizing a nursing home resident to treat pneumonia to be $7500 (Lave, Lin, Hughes-Cromwick & Fine, 1999). Since most of these infections are difficult and expensive to treat, and increase risk of mortality, this is a particularly significant issue for both patients and the health care system at large.

There are other financial implications. Preliminary research also suggests that it is more difficult to market a shared bedroom, resulting in significant lost revenue when people choose a different facility because it has a private room available. The impact of this can be seen in the construction cost analysis conducted by Calkins and Cassella (2007). After analyzing 189 bedroom plans and developing a detailed cost analysis, the average cost of construction plus capital costs (debt) of a traditional, side-by-side shared room was found to be $41,012 or $20,506 per person, while the average cost of a private room was

$36,515 (2005 dollars). Thus, it costs $16,009 more per person to build private versus traditional shared rooms. Stated another way, it costs $32,018 more to build two private rooms than one shared room. This would seem to support those who say that private rooms are too expensive to build. But taking a life-cycle costing approach, it can be demonstrated that this difference in construction cost is not as great as it might appear. Based on a large national study, the average daily cost of a private room in a nursing home is $23 more than a shared room. If the beds are all occupied, assuming a $23 dollar a day difference, it would take 1.9 years to recoup the cost differential of building 2 private rooms versus 1 shared room. However, if the facility cannot fill a bed in a shared room, the lost revenue is not $23, but $167 per day —the average daily cost of a shared bedroom. At $167 a day it takes only 6.4 months to recoup the construction and debt differential (Calkins & Cassella, 2007).

Medicaid, which is the largest payor source for nursing homes, in general will not pay more for a private room. However, in Michigan, the legislature approved a $5/day higher reimbursement for nursing homes that constructed private rooms. Even with a higher reimbursement of just $5/day, the construction/capital cost differential is recouped in less than 9 years, meaning the facility is ahead financially for 21 years (calculations assumed a 30 year mortgage). Thus, if a facility is concerned about their long-term finances, it may make more sense to have more private rooms than shared rooms.

Staff Factors

There is some evidence, albeit slim, that staff also prefer it when more residents are in private rooms. Calkins and Cassella (2007) conducted focus groups in nursing homes, were direct care workers said they had a easier time with residents who lived in private rooms than in shared rooms. Maintenance and housekeeping also suggested their activities took longer in shared rooms, possibly because the rooms were more crowded or because residents in shared rooms felt like the space was more "public" (especially the bathroom) and didn't work to keep it clean, whereas residents in private rooms treated it more like their own bathroom at home, keeping it cleaner. There is also some evidence that staff turnover may be lower in units with a higher percentage of private rooms (Degenholtz, 2007). Both of these factors should be examined more carefully. Given the estimates that construction accounts for about 6% of the life-cycle cost of a nursing home and consumables 11% to 16%. staffing accounts for roughly 66%-78% (Hiatt 1989). Therefore, spending more money on construction in ways that increase staff efficiencies and reduce staff costs could save money in the long run.

Other Alternatives

Thus far, the discussion has been about traditional, side-by-side shared rooms versus private rooms. In fact, there are other alternatives. There are a variety of shared bedroom configurations where each person has their own space, their own territory, their own window, but share a bathroom. The figures below show two examples of these different configurations.

Toe-to-toe Enhanced Shared Room

L-Shaped Enhanced Shared Room

None of the research reported above on satisfaction or nosocomial infections addressed the style of the shared room, so there is not empirical data on how these "enhanced" shared rooms are perceived by residents and family, or might impact the spread of various infections. There is some anecdotal evidence that staff and residents prefer these enhanced rooms over traditional shared rooms (reported in Calkins & Cassella, 2007). In one interview, a resident was asked how she liked this shared room arrangement, and she replied that she "didn't have a shared room, though I do have to share the bathroom, which is sometimes a problem. But I have my own room here" (Calkins, 2005). It is not possible at this time to do a similar cost analysis as was done above for traditional shared and private rooms, because there is no cost information available on these enhanced shared rooms.

Summary

There is clear and convincing evidence that the traditional shared bedroom, with two beds along the same wall, is associated with poor clinical and psychosocial outcomes in nursing home residents. The financial cost to the healthcare system of treating nosocomial infections is substantial. The average cost (in 1994 dollars) of hospitalization for an infection was $7500, and this has undoubtedly increased in the intervening years. But even at $7,500, it only takes 4 ½ hospitalizations to recoup the cost differential of constructing two private rooms instead of one traditional shared room. Given the high rate of nosocomial infections in nursing homes in general, and the high relative risk

(3.07) of acquiring an infection when living in a shared room over being in a private room (Drinka, Krause, Nest, Goodman, & Gravenstein, 2003), it is likely that these healthcare costs might be recouped within a few years with private rooms. Unfortunately, because nursing homes do not pay for the costs of these hospitalizations, the potential cost savings serve as less of an incentive to them. Policy makers, however, should be concerned with the potential for significant cost savings. The savings to Medicare of these prevented hospitalizations is significant. More research that specifically examines rates of infections and hospitalizations by room type (private, traditional shared or enhanced shared) is needed.

It is more difficult to put a concrete price on the lower satisfaction of residents in shared rooms. Certainly, low satisfaction is contrary to the goal of maximizing quality of life for residents in nursing homes, which is at the very heart of the culture change movement. It also has some financial implication for facilities, in lower census and therefore lost revenue because people refuse to move into a shared room.

Given these findings, regulators should give serious consideration to revising codes to disallow new construction of the traditional, side-by-side shared room. The enhanced shared rooms may be an acceptable alternative, but there has simply not been enough research that examines this style of bedroom to say definitively one way or the other how they impact psychosocial and clinical outcomes and costs. There are sufficient differences within this style or category of room in terms of layout, which impacts degree of auditory privacy and territoriality, that research needs to be very specific in what

variables it considers. Finally, those facilities that are looking to position themselves as the place of choice for the coming Baby Boom generation will do well to provide a significant majority of private rooms.

Recommendations

Recommendations

1) Change regulations to prohibit new construction of traditional, side-by-side shared rooms.
2) Change regulations to disallow 4-person rooms.
3) Change regulations to prohibit the use of a "privacy" curtain as an allowable separator between people who share a room. Privacy should be defined to include acoustic privacy and the right and ability to close a door between two separate parts of the shared room.
4) Increase minimum room size to 125 square foot for a private, and 125 per person in a shared room (exclusive of toilet room)
5) Fund research to examine in greater depth the differences between traditional shared, enhanced shared rooms (accounting for differences in layout that affect privacy and control) and private rooms across the following variables/outcomes of interest:
    a. Rate of nosocomial infections
    b. Rate of hospitalizations
    c. Rate of falls
    d. Resident, family and staff satisfaction
    e. Staff turnover
    f. Census
    g. Operational cost factors (differentials in staff time for care and cleaning/maintenance)

6) Develop easy-to-use MDS analytic tool that facilities can use to track differential outcomes and costs associated with their different bedroom configurations
7) Modify Medicaid/Medicare funding calculations to take into account cost savings accrued to the system from reduced infections and hospitalizations of individuals in private rooms.
8) Culture Change Coalitions and other advocates should work to educate state legislators (who often control state codes) on the value of private versus shared rooms for both quality of life and quality of care/costs.
9) Teach surveyors/give regulators the tools to more deeply assess satisfaction with roommate situation by room type. Of critical concern is control/lack of control residents have over whether they have a roommate and who that individual is.
10) Use results of research (#2, above) examining the life-cycle costs of constructing larger and/or more private rooms, to revise building codes and reimbursement formulas to support the least expensive life-cycle costs with acceptable outcomes (satisfaction and quality of life), not just the least expensive initial construction costs.

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Household Models for Nursing Home Environments

There will always be a need for long term, medically supervised, personal care settings. Current financing and care models dictate that these settings group individuals together for efficiency. At the same time, studies point to the positive effects resulting from social interaction. The form these settings take, depends not only upon the vision and resources that sponsoring organizati ons offer, but also to the approach regulatory agencies use to protect public health, safety and welfare. This paper examines concepts that influence the design of long -term care settings, demonstrates several newer household typologies, and suggests regul atory modifications that would enable further development of this new generation of nursing home.

Form Follows Regulation

For many years, the program brief for the design of nursing homes was based upon the regulatory model of an institutional based setting. This began with the publication of the original *General Standards* in 1947 for the implementation of the Hill -Burton requirements for health care facilities. This later became the *Minimum Requirements of Construction and Equipment for Medical Facilities* that set down the design requirements for nursing homes participating in Medicare and Medicaid programs (Guidelines 1996 - 1997).

The Hill-Burton requirements were a set of prescriptive regulations defining minimum standards of design and construction. Prescriptive requirements included elements such as: maximum number of residents per sleeping room; minimum square feet per patient within a sleeping room; minimum square feet of dining and activity space per patient; minimum quantities of toilet and bathing fixtures per patient; maximum travel distance from a nursing station to each patient room door; and requirements for visualization of the corridor from the nursing station.

Prescriptive requirements led to a situation where architects and designers used the regulations as the basis for all planning and design decisions. Due to cost constraints, minimum requirements quickly became maximum allowable quantities and sizes of facilities, and in some jurisdictions, these maximums were mandated. Such mandates no t to exceed particular size requirements grew from a fear that the state government may need to take over and operate poorly performing facilities. It only makes common sense that a facility with more square feet per patient is more costly to operate than a smaller facility.

Over time, nursing homes began to look alike, with large nursing stations, situated to provide direct view, down a series of double-loaded corridors, radiating from a central observation point. This unintended similarity of outcomes is what I refer to as *Form Follows Regulation* a situation where regulations seem to dictate the ultimate form of the physical environment.

Hierarchy of Space

The field of Environmental Psychology is based upon the concept that the physical environment has a significant impact in shaping the actions of individuals and groups. The layout and composition of spaces can either inhibit or encourage social interaction among individuals. Similar to the way a line of chairs set in rows at a bus depot discourage int eraction, double loaded corridors, lined with adjacent bedrooms, allow little oppo rtunity to socialize. This type of spatial organization is referred to as *sociofugal*, space that separates people. To promote interaction one should create *sociopetal space*, space that brings people together in groupings that face one another (Osmund 1957).

Another important concept that must be considered in the arrangement of space is what I refer to as the *Hierarchy of Space*. This is a spatial concept that refers to the pr ogression of space in terms of access and activity. The progression is often defined as four different zones: *Private; Semi-private; Semi-public; and Public* (Howell 1980) (Figure 1). Each of these zones moves progressively from the individual control and s afety of one's private space to increased opportunity for interaction with others in the public realm. All zones are important and are required to live life completely.

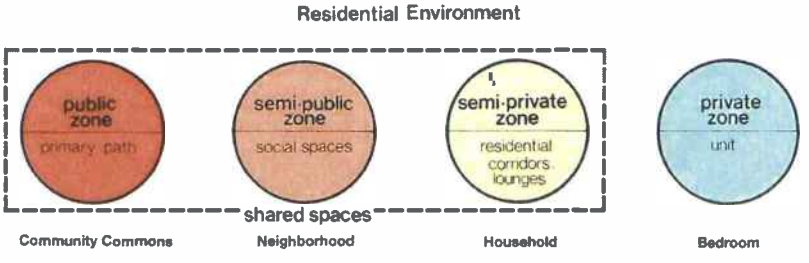
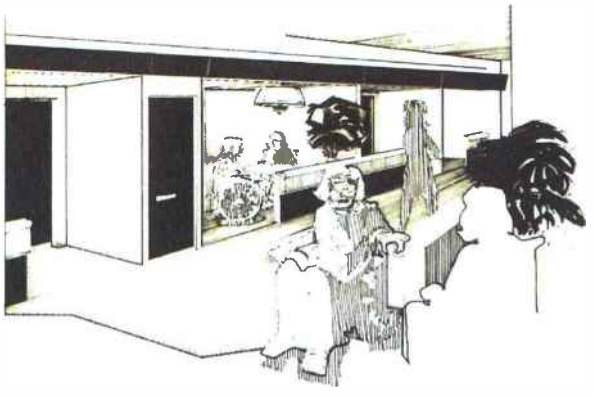


Figure 1

This progression of the physical environment is of particular importance to older people who are increasingly vulnerable to abrupt changes in environmental stimuli. They may no longer possess the resiliency to moderate this environmental press, or impact that the physical environment can impose. Unfortunately, within the typical nursing home the hierarchy of space is truncated into only two zones, private and semi -public. There is little opportunity for life that is not either confined to the private zone of one's bedroom (if one considers a shared bedroom private), or as a lonely bystander within the semi -public zone of large, undifferentiated dining rooms, dayrooms and corridors.

An early concept for improving the hierarchy of space within nursing homes was proposed in *Designing the Open Nursing Home* (Koncelik 1976) (Figure 2). This design took the typical lounge or dayroom of the institutional model, often found at the end of the corridor, divided it into smaller areas and relocated the space as a "front porch" between the private resident bedroom and the public corridor space. These transitional semi -public/semi -private spaces provided a zone referred to as the "corridor neighborhood" offering opportunities for personalization and a variety of visual stimuli, reducing the typical repetition of corridors.



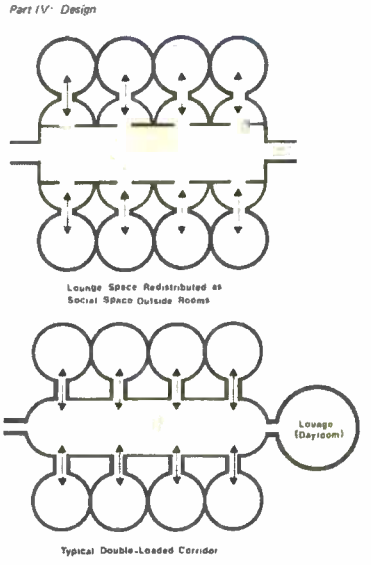


Figure 2

Designing the Open Nursing Home
Joseph A. Koncelik, 1976

Quality of Life

Until the Omnibus Reconciliation Act (OBRA) of 1987 little progress was made in the advancement of designs for nursing home environments beyond the traditional hospital -based institution. Even today, radial wings of double -loaded corridors with a majority of side -by-side semi -private bedrooms are still being constructed. But with the advent of OBRA 1987, nursing home operators were required to consider resident rights, autonomy, choice, control and dignity. Many forward -thinking operators saw this also as a mandate to significantly change the institutional design model of the physical environment.

Enhancing *Quality of Life* for residents has become a requirement. Yet little research or guidance exists to help facility operators and designers understand what it means to provide a life of quality.

Some organizations have conducted resident, family and staff *satisfaction surveys* to help understand how they are performing in the eyes of their constituents. Though helpful to some extent, these surveys provide little new information with regard to the physical environment. Regulators, architects and designers are not the only groups that are unable to break away from the institutional model that has been the standard for so many years. Residents, families and staff can only know the types of nursing home environments they have experienced.

The CMS State Operations Manual speaks in detail to many of the psycho-social aspects related to *Quality of Life* such as Dignity (F241), Self -Determination and Participation (F242), Participation in Activities (F245) and Activities (F248). But when it comes to direction with regard to the physical Environment (F252), it offers only that "The facility must provide a safe, clean, comfortable and homelike envi ronment." And goes further to indicate that the environment must be "sanitary and orderly" (F253), provide "private closet space" (F255), "adequate and comfortable lighting" (F256), comfortable and safe temperature levels" (F257) and finally "comfortable s ound levels" (F258). Only the last five requirements have any direct relationship to the design of the physical environment and provide very little

guidance indeed. Yet it is understandable that such requirements be performance-based rather than prescripti ve in nature. It is extremely difficult to define what is, or is not "homelike," or how one might actually create "home" within institutional settings.

The American Institute of Architects (AIA) Guidelines for the Design of Healthcare Facilities is a cons ensus-based standard that provides much greater detail in its design guidance. Developed as both a regulatory document for adoption by legislative authorities, and as a guide to best practices, the document provides both minimum standards and educational g uidance. Through the use of appendix material that sits adjacent to the regulatory language, designers and regulators are able to directly compare minimum requirements with newer design concepts. The appendices often serve as an introduction for new materi al that, in subsequent editions of the document, is adopted as requirements. The AIA Guidelines are a building design guide that works to avoid definition of operational requirements.

To Live in Fullness

Wikipedia defines *Quality of Life* as "the degree o f well-being felt by an individual or group of people" (en.wikipedia.org/wiki/Quality_of_life). Though not tangible or measurable, quality of life may be thought of as being comprised of two components: the physical and the psychological. Physical definitions of well-being would include ones level of health and safety. These are the aspects that have traditionally been heavily regulated within the long-term care environment, often to the detriment of psychological well-being.

It is the psychological aspect s of well-being that offer the greatest potential to inform the way that physical environments for long-term care are conceived and constructed. Studies investigating the psychological concept of *Flow* provide much information.

Flow describes a state of be ing where one is completely immersed in an activity to the extent that one loses track of time. It is often associated with sporting activities where the concentration and effort required are closely matched to the challenge. In

sports it may be know n as being in the groove. In religious settings, as a state of ecstasy.

Flow is the experience of "being in harmony with what we *Wish, Think, and Feel*" (Csyikszentmihalyi 1997) being at one with the moment, so much so, that we lose ourselves to the task at hand as well as the sense of time. We have all heard the saying: "Time flies when you're having fun." The satisfaction that results from Flow experiences provides a true measure of the Quality of Life.

What is most helpful are studies that looked at the Flow potential of everyday activities (Csyikszentmihalyi 1997). In these studies, people were asked to document their activities, whether alone or in groups, and their feelings about the activities. Unlike many studies that rely upon the memories of individual s entering their daily activities into a diary at the end of the day these studies required extemporaneous documentation at random intervals throughout the day. This methodology provides remarkable insight into the activities, feelings and participants inv olved in everyday living.

Within the studies, daily activities are broken into three categories that each occupy approximately one third of our waking hours. These activities include *Productive Activities, Maintenance Activities,* and *Leisure Activities.* The following chart indicating how people experience the various categories of activities and provides knowledge as to how we feel about w hat we do on a day-to-day basis (Figure 3).

The Quality of Experience in Everyday Activities

Based on daytime activities reported by representative adults and teenagers in recent U.S. studies, the typical quality of experience in various activities is indicated as follows:
- negative; – very negative; • average or neutral; + positive; ++ very positive

Productive Activities	Happiness	Motivation	Concentration	Flow
Working at work or studying		-	–	++ +
Maintenance Activities				
Housework	-	-	•	-
Eating	++	++	-	•
Grooming	•	•	•	•
Driving, transportation	•	•	+	+
Leisure Activities				
Media (TV and reading)	•	++	-	-
Hobbies, sports, movies	+	++	+	++
Talking, socializing, sex		++	++	• +
Idling, resting	•	+	-	–

Sources: Csikszentmihalyi and Csikszentmihalyi 1988; Csikszentmihalyi and Graef 1980; Csikszentmihalyi and LeFevre 1989; Csikszentmihalyi, Rathunde, and Whalen 1993; Kubey and Csikszentmihalyi 1990; and Larson and Richards 1994.

Figure 3
(Csyikszentmihalyi 1997)

From this analysis it was found that those daily activities that produce the greatest potential to generate an experience of Flow include: Working, Studying, Drivin g, Hobbies, Sports, Movies, Talking, Socializing, and Sex.

Life is *What we do, How we feel about it,* and *Who we do it with* (Csyikszentmihalyi 1997). The chart above tracks the first two elements, but it is the third, with *whom* we participate with in these activities, that adds a dimension to further enhance the experience.

Though a solitary engaged mind and body can provide much satisfaction, Csyikszentmihalyi finds that "we depend upon the company of others" to live a life of fullness. "Over and over again, findings suggest that people get depressed when they are alone and they revive when they rejoin the company of others." He goes on to say, "The importance of friendships on well -being is difficult to overestimate. The quality of life improves immensely when there is at least one other person willing to listen to our troubles and support us emotionally."

Much of what the study found is that, "a typical day is full of anxiety and boredom. Flow experiences provide the flashes of intense living against thi s dull background." This points to the notion that in order to improve quality of life, one must engineer one's daily life to maximize participation in high Flow potential activities. Or as care providers, we must provide the opportunities to participate i n activities that are engaging and challenging within a setting that enables the development of relationships.

At the Walden School in Vermont, students follow the philosophy of Henry David Thoreau by continually asking themselves three questions: *What is my relationship to myself? What is my relationship to culture? What is my relationship to the natural world?* (waldenschoolvt.org) In a similar fashion, it is helpful in the design of long-term care environments within a *culture change* milieu to think in t erms of relationships. Focusing solely on the person or resident, as in *resident-centered care* or *person-directed care*, limits our thinking. Q uality of life is enhanced when we consider the totality of experience within *Relationship-Enabling Environments*.

The Nursing Home - As Institution

Clearly, the traditional institutional model of the nursing home falls far short of providing an environment that enables a fulfilling quality of life. The physical environment of institutions are sociofugal in nature, l acking in the appropriate hierarchy of spaces and provide little to enhance quality of life in resident' relationships with themselves, the community, or nature. Early concepts toward improving the physical environment provided only modest steps forward. R egulatory hurdles including health care design guidelines, building codes, life safety codes, food safety regulations, and a plethora of overlapping state and local health and safety requirements are all focused upon maintaining the institutional model of nursing home construction.

This institutional bias proved a difficult obstacle to overcome. As the image of nursing homes became less desirable to residents and families, alternatives such as assisted living began to appear in the marketplace. These alter natives provide an attractive image to residents and families, in many cases advertising themselves as "nursing home alternatives" through the provision of home health

care and visiting nursing services. Conformance to less restrictive residential codes an d regulations help to achieve the desired "homelike" feel by allowing narrower corridors, elimination of the central nurse station and creation of smaller more intimate settings. Many in the long -term care industry predicted the end of nursing homes.

At the same time, many operators and designers were embarking on an alternative approach, not to supplant, but to reform the vision of the nursing home. Designs appeared with high proportions of private rooms, and shared rooms providing enhanced environments where each resident received separate sleeping areas with *each their own window* and furnishings, sharing only the room entry and toilet facilities. Corridors were shortened, nursing stations became less pronounced within nursing units of 36 -45 residents as opposed to the traditional 60 beds. Smaller decentralized clusters or pods that provided small -scale social settings closer to resident rooms were created. Staff support areas, including small work desks were also decentralized to increase staff efficiency by locating direct -care staff closer to resident bedrooms.

Most of these newer cluster concepts, however, are still corridor - based schemes with inconsistent or incorrect hierarchies of space where semi -public corridors pass directly outside of private bedrooms with little or no transition zone. Still, the institutional bias prevails due to requirements that all rooms open onto corridors that are physically separated from spaces as protection from smoke and fire, and that allow direct visual supervision of staff on a 24 -hour basis. These requirements and many others conspire against the creation of a true home for residents.

The Household - A Relationship-Enabling Environment

The Household model can be described as a living ar rangement where all activitie s of daily living occur within a small -scaled environment, reminiscent of a large family home. This type of living arrangement has been used for many years as group home settings for developmentally disabled populations. The first use of the term *household* in a skilled nursing home setting described Evergreen Manor in Oshkosh, Wisconsin as "two neighborhoods with dining and bathing facilities shared by three "households" of six

private rooms which in turn share family rooms and kitchenettes" (Architectural Record, April 1988).

Figure 4
(Gaius G. Nelson @ KKE, 1987)

The initial concept (Figure 4), designed by this author in 1987, was developed ten years later into the fully formed household model by taking the crucial step of including the di ning room within its nine resident household environment as a country kitchen. Opened in 1997, the fully operational Creekview at Evergreen Retirement Community is described as "a creative effort to rethink the nature of skilled care organizationally as we ll as architecturally" (DESIGN '98, 1998). Subsequent refinement of the household/neighborhood model resulted in the 2005 addition at Evergreen Retirement Community of *Creekview South* utilizing households of eleven residents each (Figure 5).

Household Plan

Figure 5

The household model provides an environment that is immediately understandable to residents and visitors as a setting that has been a natural part of everyday life. Individuals intrinsically know how to act within a household. All activities of daily living occur within closely related *private* or *semi-private* zones that are discrete from other portions of the facility.

In addition to private or shared resident slee ping rooms with their own bath room with toilet (and sometimes shower), households typically contain a living room, dining room, kitchen, and common bathing facilities. Often an additional, flexible activity space is included for use as a quiet room or small conference/work space. Open access to a secure bac kyard directly available to residents, enables a continuing relationship to the natural environment. Support areas for staff include a workspace used for storage of medicine and supplies as well as necessary paperwork, a soiled utility room, storage of cle an and soiled items and equipment for laundering personal clothing.

The small scale of the household, with its open floor plan, virtually eliminates corridors and allows orientation and easy access for residents to all daily activities.

Living Room at Creekview

Partnership

Dining Room at Creekview

Backyard at Creekview

The households at Creekview South are each part of a larger nursing unit known as a *Neighborhood*. Four households of eleven residents each are connected together through a *Neighborhood Center*. This organization (Figure 6) provides clearly defined geographic zones of responsibility for *resident assistants* within each household and the *team manager* for the entire neighborhood. Support is provided to each neighborhood and household from the adjoining CCRC campus through central services including procurement, housekeeping, commercial laundry (not resident clothing), and food service that provides prepared bulk food for individual plating from steam wells at each country kitchen.

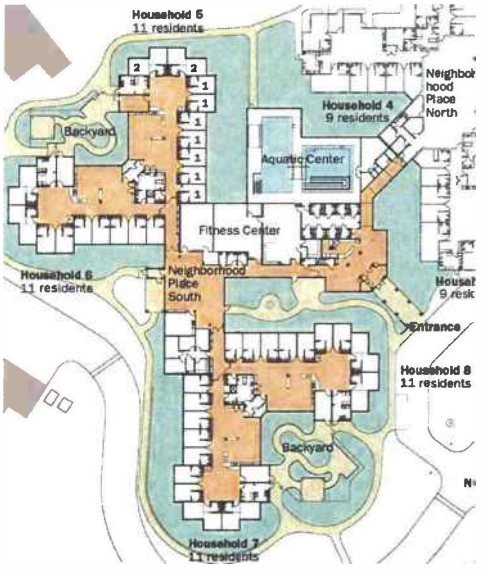


Figure 6

The Green House® and Small House models of the household offer a complete break with the institutional nature of traditional nursing homes. "Intended to be a self -contained home for a group of 7-10 elders…a Green House® blends architecturally with other homes in its neighborhood" (The Gerontologist, Vol. 46, No. 4, pg. 538). It is envisioned that eventually these types of small, self - contained facilities could be developed as parts of typical residential neighborhoods with one or more "houses" integrated into the community.

The Green House® concept was developed by Dr. Bill Thomas. He states: "We wanted there to be a heart, a center , a focus of the house. So you know, what you have in the hearth is sort of food on one end, fire on the other, and a place to share convivium or the pleasure of a good meal sort of in the middle." He continues "We've always insisted in the Green House® that there be one big table, because that's how - that makes a meal into a community experience." (PBS Lehrer NewsHour, 01/23/08).

Similar in organization to the Creekview households, ten private resident bedrooms surround a large semi -private living space called "The Hearth" which includes a fireplace, living room, dining table, and open kitchen. Residents are encouraged to participate in household activities including meal planning and preparation, clean up and other activities. As a self -contained house, all resident and staff support areas are provided (Figure 7).

Personal care services are provided by specially trained staff dedicated to each house, while nursing services are provided by visiting nurses who are responsible for multiple houses.

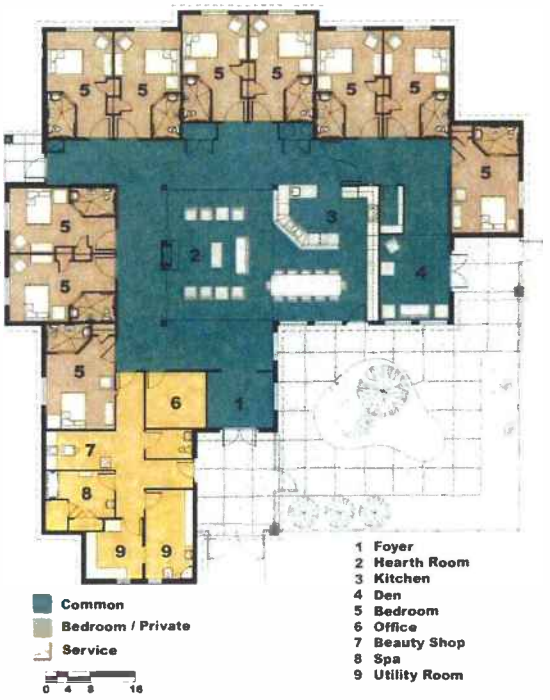


Figure 7

(DESIGN 2004)

Although the Green House® model envisions stand alone, self - sufficient homes, in practice, the first Green Houses® in Tupelo, Mississippi rely upon the support of the adjacent traditional nursing home for services such as hou sekeeping, central supplies and food purchasing, including some of the food preparation already accomplished (The Gerontologist, Vol. 46, No. 4, pg. 538).

Green House® Hearth Room looking toward kitchen
(DESIGN 2004)

Green House® Hearth
(DESIGN 2004)

While Creekview and the Green House ® demonstrate a household plan layout where private resident bedrooms open directly toward the semi-private living spaces, other organizational approaches are also in use. Household organizations that locate reside nt bedrooms along corridors used only for accessing the bedrooms can provide an environment more closely related to a single family home, where one typically finds bedrooms separated down a short hallway from living, dining and kitchen areas. This concept was used at Meadowlark Hills and can be seen in the Chapman Sha lom Home East nursing homes design currently under construction in Saint Paul, MN (Figure 8).

(Figure 8)

Within this alternative organization of the environment, the corridor serves as an additional transition zone between the semi - private living areas and the private bedrooms. It is important when using this organizational technique that entrance to the household from semi -public areas occurs f irst into the semi - private social areas of the household. As in our homes, the front door does not enter into the bedroom hallway.

Household Size

The scale of the environment is one of the most significant aspects to determine whether it is perceived as institutional or homelike in nature. In the case of the household model there are three major factors that influence the size and scale of the environment: the number of residents that make up the household grouping, the physical size of the environment, a nd the staff ratios necessary to provide the desired levels of care.

Recently constructed households tend to consist of between eight and twelve residents. This size of social grouping appears to be small enough to eliminate the potential disruption cause d by excessive numbers of social interactions associated with larger group size, while also providing the desired critical mass needed

to foster personal relationships. " In any group we tend to see one-third of residents who participate in all offered act ivities, one-third who almost never participate and on -third who may or may not join in" (Powell 1998)(bibliography -personal discussion during project meetings while designing PGC replacement facility). Using this observation, with a household size of 8 -12, between three and eight residents will be available as part of the social environment. This size of social group also provides enough diversity to assure some level of common interest within the group. This is important as it is highly unlikely that all residents of what are often random groupings of individuals, whose only commonality is their need for skilled nursing care, will be in harmony with what they *wish, think, and feel.*

The dimensional size of the physical environment should be matched to the activities and group size being accommodated. If the physical environment is too small, overcrowding occurs. Too large, and the group may be overwhelmed by the space, therefore losing the intimacy and comfort associated within residentially scaled environments. The influence of geometry cannot be underestimated as a factor in creating appropriate scaled environments. Resident bedroom spaces require a given area (approximately 13 feet by 20 feet), a means of access into the space and enough exterior wall for placement of a window. When arranging more than ten or twelve resident bedrooms in a plan, one of two things occurs. Either the social areas around which the bedrooms are arranged become oversized, or resident rooms must be located along corridors leading to and from the semi -private, social areas of the household. Shared bedrooms alter the geometry somewhat, as these rooms only require a single entry door and bathroom for two sleeping spaces. But use of shared rooms provides only marginal advantages in the geometry of the arrangement.

Examples of designs that are described as households or sometimes neighborhoods that accommodate from 16 to 24 residents are inconsistent with the concept of a true household. Primary groupings of living and dining areas for this magnitude of group size may be far better than the 40 -60 resident groupings they replace, but once the quantity of twelve residents is exceeded, it appears that the positive potential of the household model is diminished and confused. One exception h owever, may be in the case of short-term stay populations. This population group often is comprised of younger "patients" residing within a short -term stay

nursing home to receive intensive physical or occupational rehabilitation therapy after a hospital s tay. These patients have no desire or inclination to remain as residents of the facility. Short-term rehabilitation facilities offer a high -tech, high-touch environment reminiscent of a hotel or spa experience. In this situation, larger scale social areas and patient rooms located along corridors may be a reasonable response to a transient population concentrating upon "graduating" out of the program.

The third factor that influences household size is the ratio of direct care staff to the number of residen ts being served. Ideally, the residents of a household would be served by at least one dedicated resident assistant during each of the day, evening, and night shifts. Additional staff would then be added during the heavier care day and evening to assure th at residents receive the assistance needed. This can be a difficult balancing act since required assistance can vary considerably depending upon the acuity level of the residents being served, or even from one day to the next, as resident well being change s due to short term episodes of sickness.

Multiple households that are interconnected, have greater flexibility in either adding staff as needs increase, or reducing staff levels during the night shift when one assistant can cover multiple households under one roof. Adjustments in staffing levels are more difficult to achieve in the case of separate detached, Green House® or Small House models where staffing can never be reduced to less than one staff member per household.

Flexibility for a Variety of Population Groups

Small clusters of residents within household scale environments provide the opportunity for operators to develop individual strategies in the grouping of resident populations. Some care providers may chose to group residents with similar "diagnoses" or care needs, together within homogenous household settings. This calls for specialized staff trained in particular interventions necessary to care for specialized populations. It may also enhance camaraderie among residents with similar backg rounds and experiences. Other reasons for homogenous grouping may be funding and referral advantages as in the case of the Green Houses ® of Chelsea, Massachusetts where plans call for houses identified by different populations including people with Lou Geh rig's Disease (ALS), AIDS, Hospice, or the most common special population group, those with Alzheimer's or other dementias.

Other care providers prefer to allow houses to fill organically with the intention that, over time, staffing requirements among houses may equalize as each house gains a heterogeneous population with a mix of heavy care and lighter care residents. This philosophy reinforces the concept of home in that, once a resident moves into a room, and becomes part of a household they can remain as long as desired without the need to move again.

Deinstitutionalize Clinical Resources

Providing a normal living environment requires intentionally working to eliminate, or re -envision the many clinical elements found within the traditional institution al setting. Even within smaller scale environments, the need remains for staff to complete tasks such as charting, distribution of medicine, processing soiled items, and bathing residents. Many examples of innovative, homelike solutions are currently in us e including the staff work area, medicine distribution cabinet and bathing room illustrated below.

Creekview - Medicine Island (foreground) and Staff Work Desk © Nelson•Tremain Partnership

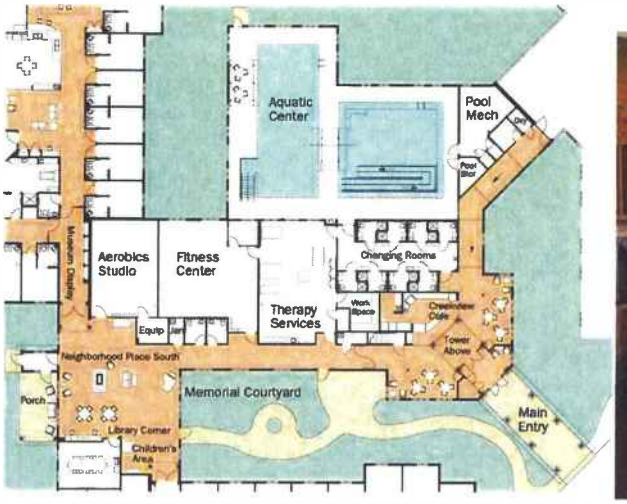
Creekview - Bathing Spa with Fireplace © Nelson•Tremain Partnership

The Neighborhood – Enabling Relationships within Community

The household models encompass the *private* and *semi-private* zones within the *hierarchy of space*. Yet in creating a quality of life that encompasses life in all its fullne ss it is necessary to maintain relationships with the greater community and culture. These types of relationships occur best within the *semi-public* and *public* realms.

We all need to get out of the house on occasion to meet with others and participate in a wider range of activities than may be available within our immediate "family group." In order to engineer one's life to maximize high *flow* activities (*Working, Studying, Driving, Hobbies, Sports, Movies, Talking, Socializing, and Sex*), a variety of oppor tunities must be reasonably available. Not all activities and personal encounters can be pre -planned. There is value in serendipity and chance meetings that require exposure to a larger community. A neighborhood center shared among several households also encourages participation from members of the greater community can serve this function. Large group activities, religious services, music, theater and fitness opportunities within easy access can be made available to residents. At Creekview at Evergreen Re tirement Community, a

fitness center including a warm water aquatic therapy center, providing memberships to community elders is located in the heart of the nursing home (Figure 9). By providing a hub of activity within the nursing home, residents' lives a re enhanced through greater opportunities, while at the same time demonstrating to the community that aging is a natural part of life and the nursing home is not the last place one would like to find oneself.



(Figure 9)

South

Creekview - Neighborhood Place

Creekview - Aquatic Center

Creekview Café'

Household Models and the Regulatory Mi leau

Ten years elapsed between the initial conception of the household in 1987 and its realization with the opening of Creekview at Evergreen Retirement Community in 1997. This time lag resulted from a need to clearly understand the impacts that such a ra dical reworking of the nursing home would have on the physical, operational, and financial aspects of the sponsoring organization. It was also necessary to gain the support of regulatory agencies that, in their conceptual review, identified over 100 potent ial areas of regulatory conflict. With the assistance of a small -scale pilot project of eight beds within a portion of the existing nursing home, and some creative problem -solving by the entire team, including some helpful regulators, this list of conflict s was reduced to just a handful of issues that were able to be addressed without waivers.

This positive ending might cause one to believe that the creation of household model nursing homes is not impeded by regulations and that any organization should be able to replicate the process and outcomes pioneered by early household advocates. This however, is not the case. Even within a supportive State regulatory environment that enabled the creation of Creekview, subsequent Wisconsin projects encountered simila r difficulties. This can be attributed to the fact that no two projects or sponsors are identical, and that interpretations and "alternative methods" for compliance are always individual and specific in their application. Education and negotiation with cod e officials and regulators, often over seemingly small issues, must occur over and over again, one project after another.

During the past twenty years of working to create small -scale environments that enable a normal life of quality for nursing home residents, we have encountered a number of recurring issues. It is discouraging, having worked diligently to gain acceptance in one situation, to start over again in the next to gain favorable interpretations, receive waivers or be denied approval for nearly identical concepts and designs. The following is a review of recurring regulatory hurdles that are commonly encountered.

Overlapped, Confusing and Contradictory Regulatory Jurisdictions

An often heard complaint of facility operators and designers is that various regulatory agencies have overlapping and at times conflicting requirements. A single project may be required to comply with three or four separate regulations addressing the same issue. A common example is that facilities must meet the local building code requirements that protect occupants against a variety of life safety issues. Nursing homes are also required to comply with the NFPA 2000 Life Safety Code. On top of this, many state or local jurisdictions and their fire inspectors have adopted more recent editions of the NFPA Life Safety Code (either 2003 or 2006). State licensure regulations also have extensive requirements that cover many of the same life safety concerns. It is inevitable that the requirements from four separate regulations or standards will contain contradictory requirements, of which the design team is required to determine which is the most restrictive. Similar situations occur with requirements pertaining to food service operations, accessibility standards, and elevators, to name a few.

Several years ago the State of Wisconsin reorganized the method by which health care facility plan reviews and approvals are conducted. A process that formerly involved several jurisdictions including the state health department, fire marshal's office and building codes division was consolidated into a single review. All health care facility plan reviews within the State are now conducted solely by the health department. This provides a clear and direct jurisdictional responsibility. One signi ficant advantage to this situation is that in the case of conflicts between various codes and standards, facility operators and designers are no longer put into the situation of trying to mediate solutions between multiple bureaucracies. Conflicts and discrepancies are able to be solved by working within a single state agency.

Recommendation: States should be encouraged to develop methods whereby plan reviews for health care facilities are consolidated under a single entity in order to minimize redundant and overlapping requirements.

Interpretations Approved in Plan Review are not Recognized at Final Inspection

It is not unusual that during a final inspection survey, prior to occupancy, portions of the design that received approval or favorable interpretation during plan review, are found out of compliance by the survey team. This is the most costly time for compliance issues to be discovered and can lead to significant delays in people moving into their new home and compromises to the desired environmental outcome in addition to the financial costs.

In our practice, to alert owners to this potential, we have been required to include contract language within our owner/architect agreements that reads: "The Owner may request certain design elements that do not strictly comply with some regulations and codes. The Architect will work with the Owner to receive favorable interpretations, waivers, or variances of such requirements. Additionally, the Owner acknowledges that regulatory plan reviewer and field inspectors may interpret requirements differently leading to conflicting requirements that the Architect will endeavor to resolve in association with the Owner."

Facility operators and designers need to be given assurance that a plan approval actually has meaning.

Recommendation: States should be encouraged to maintain consistency in the interpretation of codes and regulations. This can be accomplished by requiring that Plan Reviewers and Final Inspectors are the same person. This will create a situation where the regulator has an interest in the final outcome and firsthand knowledge of issues covered during the plan approval process. Additionally, a mechanism for tracking and documenting interpretations (both positive and negative) would help maintain an institutional memory in case of staffing changes.

Kitchen Spaces Open to Corridors

An open floor plan that eliminates barriers, allows interconnection among spaces and easy access by residents, is one of the most critical features of the household model. Prior to the year 2000, providing spaces open to corridors was extremely difficult and required use of "suites of rooms," or the staffing of "nursing stations" on a 24-hour basis to provide direct supervision of the open spaces. Today, all model building codes have adopted language similar to that within the NFPA 101, Life

Safety Code, allowing spaces that are not used as sleeping areas, or for hazardous uses to be unlimited in size, provided appropriate fire suppression and smoke detection systems are installed.

Kitchens remain a difficult area of interpretation. *Cooking Facilities* are required to be protected in accordance with NFPA 96, using a commercial vent hood with specialty fire suppression systems (NFPA 101, LSC paragraph 9.2.3). An exception is allowed for "small appliances used for reheating, such as microwave ovens, hot plates, toasters and nourishment centers" that are exempt from "requirements for commercial cooking equipment" (NFPA 101, LSC paragraph A18.3.2.6).

The difficulty with these requirements occurs with the interpretation of what constitutes commercial equipment and the difference between cooking and reheating. Some jurisdictions allow the use of commercial, convection ovens for baking of bread and muffins, or even pizza. Others will not. Large "pannini grills" (a commercial size George Forman® grill) may be allowed to cook grilled cheese sandwiches, or pastrami on rye, while grilling a hamburger is not allowed. Is heating of a pre-cooked hot dog allowed, but not an uncooked sausage? The rationale for these requirements is that heating is different from cooking, especially in the case of foods that may produce "grease laden fumes." This is backed up by data that a large percentage of fires within nursing homes originate in kitchens, with *Confined cooking fires in kitchens* accounting for 24%; and *Kitchen or cooking areas* 19% of all nursing home fires (March 2006 NFPA Report "U.S. Fires in Selected Occupancies).

These statistics do not however, differentiate fires by size of kitchen or number of meals being produced. There is a quantitative and qualitative difference between a large commercial food service operation and a household kitchen producing family-sized meals.

In consideration of these differences, the Minnesota Department of Health (MDH) has developed a *Waiver for Neighborhood Kitchens*. Recognizing that flexibility in timing of the breakfast meal will improve the quality of life for residents with varying morning routines, this waiver was developed to allow cooking of breakfast within "neighborhood" size groups, using residential kitchen equipment. There are a number of requirements that must be met in

order to allow this waiver including: the kitchen serves 25 or fewer residents; breakfast preparation is only for those residen ts and staff in the neighborhood served by the kitchen; breakfasts are served sequentially, meaning that breakfast is served on the residents' schedule and that gathering of all residents at one time is not allowed; a residential range must be electric wit h key-operated disconnect switch; and a residential vent hood may be used that exhausts directly to the exterior provided meats that produce grease as they cook are p repared in a commercial kitchen . Other requirements, not related to fire safety also apply and will be discussed in a later section.

The MDH neighborhood kitchen waiver is an excellent *initial* response to this important issue, however, expansion of this concept to allow the cooking of lunch and dinner meals without stringent limitations on the types of food allowed to be cooked, needs to be addressed. Costly, commercial vent hoods required to comply with NFPA 96 are an impediment to the creation of normal homelike environments providing the activities and aroma of mealtime preparation. Strict a dherence to the current requirements may contribute little to the protection of resident life safety when less costly alternatives are available. A recent federal government workshop identified that a single sprinkler head in a residential kitchen would be an effective fire suppression measure, although the best situation is a fully sprinklered residence in accordance with NFPA 13D, 13R, or 13 (NIST Special Publication 1066, 2007). Nursing homes are already fully sprinklered, thus meeting this finding.

Recommendation: Research needs to be conducted to determine the actual life safety risks associated with cooking fires in small-scale operations. Alternatives to NFPA 96 standards for protection of cooking equipment must be allowed in the case of small-scale environments. It must be recognized that residential scale kitchens, fully protected by fire suppression systems provide adequate life safety without additional fire suppression measures. Similar alternative consideration must be made for small-scale operations including facility cafés and delis that serve limited menus for visitors, staff and residents.

Protection against Non-Fire Dangers in the Kitchen

In additional to fire safety, there are many regulations that are intended to protect residents aga inst perceived or real dangers in

the kitchen. These typically include protection against food borne illness or physical safety against injury.

National Sanitary Foundation International (NSFI) requirements provide specification of materials and equipment to reduce the spread of disease. Yet these requirements make no distinction between large and small food operations. Requirements within small-scale households for 6" sanitary legs on cabinets, and commercial refrigeration and dishwashing equipment , impinge on the residential nature of the environment, add ing significant cost without proven protection against risks. In the case of dishwashing equipment, there is no difference in sanitation between residential and commercial equipment as evidenced by tests conducted at Evergreen Retirement Community under the supervision of the Wisconsin State Department of Health. Other facilities using commercial equipment within household settings have found that dangers to residents actually increase with the addition of these unfamiliar hot surfaces and steam in the kitchen. True disinfection of surfaces only occurs at temperatures far higher than the 180 degrees required by NSFI.

Protection against physical harm typically includes requirements to secure noxious chemica ls, or dangerous items such as knives, and appliances. Anecdotal evidence indicates that, within a normal residential environment, residents retain an understanding of potential risks associated with many such dangers, and that safety measures built into f acilities are often not implemented once the facility opens.

Recognizing the benefits of normal home environments, the *Waiver for Neighborhood Kitchens* in Minnesota also addresses these additional safety issues. Although Minnesota still requires commercial dish washing equipment, residential style cabinets are allowed with NSFI laminate countertops and durable laminate interior surfaces, and breakfast foods may be stored in residential refrigerators overnight. The kitche n may also be used for activity prog rams. Though a key-operated disconnect for the range is required, use of the switch and securing of other items is not mandated. This waiver program is also recognized by the Minnesota Environmental Health Division, charged with food safety, which also allows similar arrangements within assisted living and adult day facilities.

Recommendation: Exceptions to compliance with NSFI requirements should be provided for small-scale food preparation areas. State and local regulatory agencies should be encouraged to defer food service sanitary oversight to long-term care regulators who are more familiar with the needs of nursing home residents. Research needs to be conducted to determine the need for commercial food service requirements within small-scale operations.

Laundry Facilities

Many state health requirements mandate separation of soiled and clean processing areas within a laundry. In is unnecessary and impractical to provide separate processing areas within small household-scale environments. In these set tings there is less risk of cross contamination and infection and operational measures can be taken, such as washing individual resident clothing separately if needed. In Wisconsin, the personal laundry and soiled utility areas rooms are allowed within the same area, provided air flow is provided in the direction from clean to soiled. This is a reasonable approach to clean and soiled function s sharing a space without requiring separation by walls.

Recommendation: It should be made clear that in small-scale operations, separation of clean and soiled areas is not required.

Handrails

According to a CMS Survey & Certification letter (12/21/06), "The purpose of the handrail is to assist residents with ambulation and/or wheelchair navigation." The need for ha ndrails is clearly an artifact from the corridor -based model of facility design. In facilities with long corridors, residents are required to navigate the corridors in order to access activities of daily living not available within one's "private" bedroom, including dining and social activities. Within a household, the need for and desirability of handrails is significantly reduced, if not eliminated. Household corridors are an extension of the semi - private social spaces.

Requirements for handrails limit t he potential to fully utilize circulation spaces for meaningful and valuable activities. In some

configurations, resident bedrooms are literally "across the hall" from the country kitchen, and often only short distances must be traversed to access other ac tivities. Participation in daily activities is directly influenced by proximity and ease of access, and the intrinsic design of a household maximizes each, providing a significantly greater "mobility enhancer" than any handrail.

It is unreasonable to req uire handrails along "each side" of a corridor that separates spaces allowed to be open to the corridor for life safety purposes, thereby "fencing off" and limiting direct access to these spaces. This situation has occurred, and has been vigorously support ed by some state regulators.

Inclusion of furniture along walls of corridors can provide resting points for elders, thereby improving ambulation while enhancing hominess. Handrails interfere with use of wall space in this manner.

Recommendation: Handrails should be explicitly exempted from installation along spaces open to the corridor. Handrails should be allowed to be discontinuous to allow for furniture placement and other installations (e.g. display cases, artwork, etc.), that do not reduce the required width of egress. Alternatives to handrails, such as "lean rails" (plate rail design for stability) should be allowed.

Protrusions into the Corridor Width

There are conflicting requirements as to the allowable distance elements may protrude into the width of corridors. NFPA 101, LSC allows only 3 ½" protrusion, while the Americans with Disabilities Act Architectural Guidelines (ADAAG) allows 4" for items within 6'-8" of the floor level. Unfortunately many industries, such as lighting manufacturers ut ilize ADAAG standards in design and manufacture of products. Compliance with NFPA 101, LSC precludes the use of typical elements of home, including furniture, plants or wall mounted, sconce lighting fixtures.

Many CMS regional offices have interpreted th at the 3 ½" protrusion applies to all corridors, regardless of width, meaning that in the case of corridors that exceed minimum width

requirements, protrusions are still limited to 3 ½" even though the required exit width is maintained.

Recommendation: Protrusions within corridors greater than 3 ½" or 4" should be allowed within defined circumstances. Explicit allowance should be made for protrusions that are unlimited in dimension, provided the required exit width is not reduced in excess of a specified (4") distance.

Eight-Foot Corridor Width

There are only two provisions within the Life Safety Code that have nothing to do with life safety within health care occupancies. These are the requirements f or windows in resident rooms and the requirement for eight foot wide corridors. No one would promote the elimination of windows, but eight foot wide corridors are another matter. This requirement has been rationalized as the min imum width necessary to push beds or gurneys past each other. If this is the cas e, what happens in a fire emergency when two beds are blocking the fire exit at the end of the corridor? Emergency procedures do not include the transportation of residents in their beds. This requirement may have had a functional basis in the case of hosp itals but is costly and unneeded requirement in nursing homes.

Recommendation: Eliminate the requirement for eight foot corridors in nursing homes perhaps considering six feet instead.

Three Foot - Eight Inch Wide Administrative Office Doors

Regional CMS offices are requiring that door s to offices for administrator s, directors of nursing and social workers be 3' -8" wide and located on an eight foot wide corridor. This requirement is based upon the assumption that resident s must be provided access to the se important administrative personnel, while being transported in their bed. There are certainly more dignified, alternative methods for providing such access that do not require construction of excessively wide doors and office corridors.

Recommendation: CMS should make it clear that alternative and dignified means of access to administrative services are allowable without requirements for wide halls and doors.

Direct Line-of-Sight as Control over the Corridor

When staff members are assisting resident s and performing meaningful care tasks, they are most often wit hin the resident room or bath room, with no visual connection to public spaces. This need for visual control has been rationalized as providing quick assistance to a resident who may fall, yet m ost falls occur within private resident rooms. No one would suggest line -of-sight into all bathrooms. Requiring visual control is an outdated concept that does not recognize the realities of nursing care, nor the advances achieved through communication tec hnologies.

Recommendation: CMS should stipulate that a requirement for direct line-of-sight from staff work areas or "nursing stations" is not required within nursing facilities.

Distance to the "Nurses' Station"

Many state requirements include maximum travel distance from a nursing station to resident rooms. These requirements assume that a fixed nursing station is required for staff to perform their work and for electronic calls to be received. There are many approaches to resident care that do not ne cessitate a fixed location. The only requirement should be that adequate staffing levels be provided to meet the care needs of residents.

Recommendation: CMS should stipulate that no fixed location is required for nursing staff to care for residents.

Wired and Wireless Call Systems (UL 169)

Requirements that various alarms or notification be directed to a nurse station or other permanently staffed location does not recognize the reality that nursing staff do not remain in fixed locations. Technological advances in resident to staff communication systems that do not require the use of hard wired systems can provide superior performance, allowing resident

assistants and nursing staff to respond to resident calls from any location.

Recommendation: Consistent specifications for wireless call systems should be defined that eliminate the need for individual state regulators to evaluate the efficacy of multiple nurse call systems.

Security against Residents leaving Unescorted vs. Fire Safety

To address the issue of security against residents leaving the building unescorted, the State of Minnesota Department of Health, Department of Administration, and Office of the Fire Marshal met with designers and operators to devise a methodology by which health care facilities could secure areas of buildings through the use of magnetic locking devices with keypad controls. Locking of facilities was important not just in long-term care populations but also as a means to secure patients of hospitals against outside intrusion after a series of high profile abductions of newborns and gang related shootings. Minnesota's *Special Emergency Egress Control* required that magnetic locks must be interconnected to the fire alarm system, as well as, provide a manual control whereby nursing staff could release the lock in case of non-fire related emergencies. This process demonstrated the ability of several State agencies to work out a solution that met the needs of caregivers to protect patients and residents and to address the legitimate life safety concerns. This provision in the Minnesota state regulations worked alternative solutions to egress and security issues for a number of years. Unfortunately, regional CMS enforcement of the NFPA 2000 provision that *delayed egress devices* (NFPA 101, LSC 2000, Paragraph 7.2.1.6.1) are the only allowable means to secure exits, eliminated this well thought out option.

Recommendation: The risks surrounding security against intrusion or residents leaving unescorted are equally as legitimate as those for fire safety. It is unreasonable to believe that delayed egress hardware is the only safe method to secure a path of egress. Alternative methodologies such as Minnesota's Special Emergency Egress Control should be allowed.

Security for Outdoor Spaces

Access to the natural environment is an extremely important quality of life measure. Securing exterior yard space is difficult to achieve given the requirement that two egress controlled doors are not allowed (only one delayed egress device is permitte d) within a means of egress. It often is not possible to provide an area of refuge fifty feet from the exterior face of a structure. Alternatives must be made available that allow safe yet secure access to outdoor areas.

Recommendation: Yard spaces should be allowed to be independently secured with provisions for emergency egress in case of fire.

Smoke Compartment Requirements

Nursing home fire safety requirements are based upon a concept described as "defend in place." This concept recognizes that th e population groups served within these facilities may be incapable of independent exiting in an emergency due to reduced cognitive or physical capabilities. Therefore buildings are constructed using safety standards that are intended first, to limit the s pread of a fire from its origin and second, to allow movement of residents to another compartment of safety, on the same level within the building, eliminating the need for an exit. In the case of large facilities, this requirement would typically provide "smoke compartments" serving between twenty and sixty resident rooms. In the case of small facilities with open floor plans, the provision of separate smoke compartments may be difficult, without compromising the physical proximity of resident bedrooms to the semi-private social areas of the household. Most household scaled environments are far smaller (from 6,000 -12,000 square feet) than the allowable 22,500 square feet allowable within a smoke compartment (NFPA 101, LSC paragraph 18.3.7).

Recommendation: The requirement for subdivision of small-scale household environments into two separate smoke compartments should be evaluated as to its efficacy and impact on the living environment for residents.

Accessibility Standards

Accessibility standards as d efined by the Americans with Disabilities Architectural Gui delines (ADAAG) do recognize the fact the strength and stature of older people differs significantly from that of independently functioning disabled individuals. In the case of nursing environments , current ADAAG standards hinder the safe and effective care of people requiring assistance with activities of daily living as they require institutional grab bar configurations that are of little use, such as requiring grab bars located behind toilets.

Recommendation: Within care environments where residents are assisted with transfers, research should determine the optimal range, as opposed to extreme range, of use to determine the required size and location of grab bars. Extension of side grab bars from the back wall should be reduced to allow shorter, fold-down bars and rear wall grab bar requirements should be eliminated.

Sliding Doors in Low Occupancy Areas

Building codes have stepped backward by no longer allowing sliding doors in low occupancy sp aces such as resident bathrooms. Sliding doors provide superior utility in these situations by providing door operation that as easily within the ADAAG specified range of motion without the need to maneuver wheelchairs backwards in tight quarters. Sliding doors also have no "door swing," thus requiring less floor space. Many state health departments also preclude use of sliding doors.

Recommendation: Sliding doors must be explicitly allowed within all occupancy types within rooms serving low occupancy spaces.

Separation between Nursing Home and Daycare Occupancies

State licensure requirements often require a two -hour occupancy separation between nursing home and daycare (either child or adult) occupancies. Significant benefits are gained by the provision of opportunities for intergenerational activities within long term care environments. This requirement does not seem

reasonable particularly in the case where the daycare meets the same construction classification a s the adjoining nursing home.

Recommendation: Intergeneration programming should be encouraged to the greatest extent possible by allowing programs to co-exist under one roof.

Allowance for Use of Personal Furniture

CAL 133 is a flammability standard for upholstered furniture that has been adopted in many jurisdictions. This standard was developed to limit the fuel load within certain public occupancies including nursing homes. The original standard was developed with an exception for occupancies that are protected by a fire protection system. This exception has been eliminated or severely restricted in many jurisdictions. For example, the Minnesota Fire Marshal promulgated rules that limit residents to one piece of upholstered furniture, within their own bedroom, that does not meet commercial furniture standards. This is a restriction that limits resident rights based upon overzealous fire officials ' individual determination of risk. Asbestos was once used in the name of fire safety, now the fire retardant chemicals used for several decades are being linked to cancer deaths and California is attempting to outlaws their use (www.latimes.com/news/local/la - me-couches7mar07,1,3742510.story). Where are the grea ter risks?

Recommendation: It must be made clear that resident rights to use their own furniture should not be limited within fire sprinklered buildings.

Standards for Small-scale Environments

By definition, a nursing home is "A building or portion o f a building used on a 24 -hour basis for the housing and nursing care of *four* or more persons who, because of mental or physical incapacity, might be unable to provide for their own needs and safety without the assistance of another person" (Paragraph 3.3.132, NFPA 101 LSC 2000).

Four residents is an extremely low threshold when 16 is common within other occupancy types. It needs to be recognized, as it is within other occupancy classifications such as Board and Lodging, that the level of risk in small fac ilities is not as great as in larger facilities and that different requirements are reasonable.

Recommendation: Separate Life Safety and Building Codes must be developed to provide appropriate but less stringent requirements than those currently allowed for small-scale environments.

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MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY
SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 10010

Issued to: Northampton Manor Nursing and Rehabilitation Center, LLC
200 East 16th Street
Frederick, MD 21701

Type of Facility and Number of Beds:
Comprehensive Care Facility - 196 Beds

Date Issued: January 1, 2016

This license has been granted to: Northampton Manor Realty, LLC

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318, Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated there under. This document is not transferable.

Expiration Date: June 1, 2016

Patricia Tomasko May, M.D.

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

January 28, 2016

Attn: Christopher Coronado, Administrator
Northampton Manor
200 East 16th Street
Frederick, MD 21701

Dear Mr. Coronado:

This is acknowledging receipt of a license fee of $7,000.00 for 196 beds and an application for a license to operate Northampton Manor Nursing and Rehabilitation Center, LLC as a result of a change of ownership.

The enclosed provisional license is issued to Northampton Manor Nursing and Rehabilitation Center, LLC for the period of January 1, 2016 to June 1, 2016, unless revoked. A new license will be issued upon completion of the provisional period. It is your authority to maintain a comprehensive care facility with a license capacity of 196 beds under COMAR 10.07.02.

The license is to be displayed in a conspicuous place, at or near the entrance, plainly visible and easily read by the public.

The room and bed breakdown is attached.

Sincerely,

Margie Heald

Margie Heald, Deputy Director
Office of Health Care Quality

MH/cjc

Enclosures: License No. 10-010

Cc: Frederick County Health Officer
Maryland Health Care Commission
Medical Care Operations Administration
Medical Care Policy Administration
Myers and Stauffer
Lynda Lazaro
Patti Melodini, Survey Coordinator
License File

The room and bed breakdown is as follows:

CATEGORY	LOCATION	TOTAL
Comprehensive Care Facility	**Potomac 1**	
	Single Rooms: 123	01 beds
	Duplex Rooms: 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 122, 124, 125, 126, 127, 128, 129, 130, 131	58 beds
	Total Potomac 1	**59 beds**
	Potomac 2	
	Single Rooms: 225	01 beds
	Duplex Rooms: 201, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 224, 226, 227, 228, 229, 230, 231, 232	58 beds
	Total Potomac 2	**59 beds**
	Carroll Creek 1	
	Duplex Rooms: 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150	38 beds
	Total Carroll Creek 1	**38 beds**

Room and bed breakdown:

CATEGORY	LOCATION	TOTAL
Comprehensive Care Facility	**Carroll Creek 2**	
	Duplex Rooms: 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252	40 beds
	Total Carroll Creek 2	**40 beds**
	Overall Total	**196 beds**

HERTZBACH
certified public accountants · consultants

April 28, 2016

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Northampton Manor Realty, LLC Certificate of Need in City of Frederick

To whom it may concern:

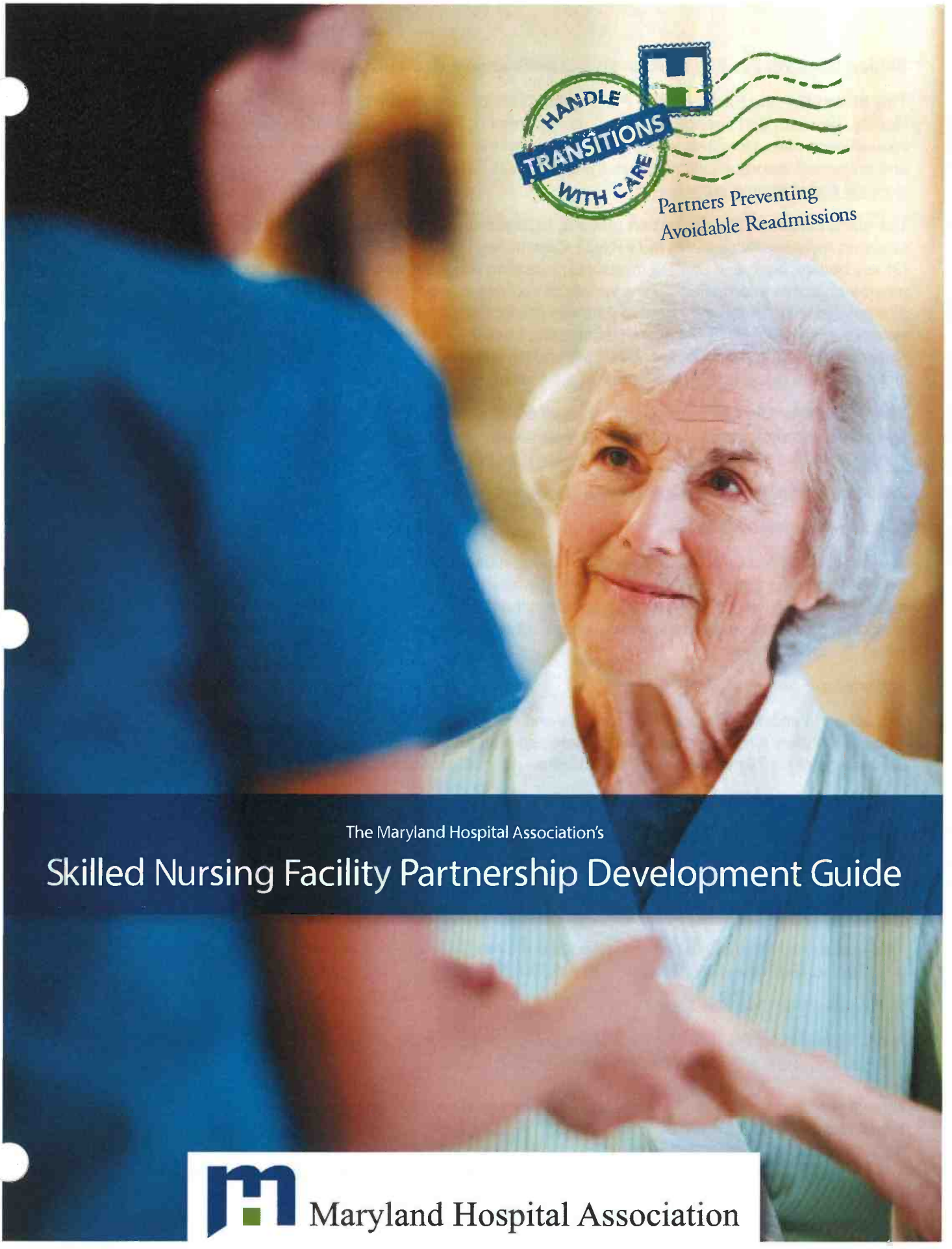
We are the accountants and auditors for Mid-Atlantic Healthcare, LLC and its subsidiaries, including Northampton Manor Realty, LLC and Northampton Manor Nursing and Rehabilitation, LLC. We have been the accountants and auditors for the consolidated entity for over 10 years. Mid-Atlantic Health Care (the Company) has asked us to comment on their ability to provide the $2-3 million in equity and obtain the $6-7 million in necessary debt financing to expand the existing facility in the City of Frederick.

Mid-Atlantic Health Care et al owns and operates approximately 21 skilled nursing facilities in the Mid-Atlantic region. Based on our review of the financial statements and conditions of the Company, the Company has been profitable and is expected to continue to increase its profitability. The Company has a very healthy balance sheet and presently has the ability to provide the equity and obtain the necessary financing for the above referenced proposed project.

Please contact the undersigned if you have any questions regarding this communication.

Very truly yours,

Leonard Sacks, CPA, CVA, CFF, CIRA, CDBV



The Maryland Hospital Association's

Skilled Nursing Facility Partnership Development Guide

Maryland Hospital Association

Skilled Nursing Facility Partnership Development Guide Overview

This Skilled Nursing Facility (SNF) Partnership Development Guide aims to help Maryland's hospitals identify, develop, and strengthen formal and informal SNF partnerships that demonstrate high quality and cost-efficient care. Hospitals and SNF partners can improve care coordination by facilitating awareness and enhanced communication across the continuum. The guide can be found online at the Maryland Hospital Association's website.

The guide includes (1) a discussion guide to facilitate communication in the interest of developing stronger, high-quality care, (2) INTERACT Capabilities List that SNFs could be asked to complete, and (3) key quality, cost, and staffing measures, including readmissions rates. This guide is intended to provide objective information from a variety of sources in a single place and reflects SNFs' performance at a point in time. State and national data are presented as reference points. Data comes from Avalere Health's analysis of 2013 Medicare claims data, MHCC's *Maryland Guide to Long Term Care*, and CMS' Nursing Home Compare website. MHA will update this guide annually. At the time of publication, the data included in the guide is the most current data available.

The CMS 5 Star Overall Rating is not included in the guide as the rating may change monthly, however, up-to-date information can be found here. Additionally, Nursing Home Family Satisfaction Survey Results can be found for each SNF within MHCC's *Maryland Guide to Long Term Care*.

Important information to consider as you examine these data:

1. Acute Readmission Rates

While reducing Medicare readmissions is a key test under the waiver, hospitals do not have data to track SNF readmission rates. Using the most recently available Medicare data, this guide shows readmission rates within 7, 15, and 30 days post hospital discharge compared to Maryland and national averages (e.g., that patients that are readmitted within 7 days are also included in the calculations for readmissions within 15 and 30 days).

2. Staffing

In addition to showing staffing rates for RNs and CNAs, the guide includes information on staff turnover. Research shows a negative association between staff turnover and quality of care; thus, a high percentage of staff employed two years or more may be associated with high quality of care.

3. Quality Measures and SNF Capabilities

Presenting information from government sources in one place will inform executive relationship development as well as emergency department and case management personnel to facilitate patient-centered selection of SNFs.

4. Average length of stay at the SNF for Commonly Billed DRGs for Prior Hospitalization

This measure is intended to help hospitals see the top DRGs treated at SNFs, and may show SNF areas of expertise. Examining ALOS relative to readmission rates can also be informative.

5. Payment Per Day, Per Stay

A key metric under the waiver is total Medicare spending per beneficiary. Examining payment per day in combination with ALOS is one way to consider SNF efficiency.

Note that SNFs are indexed alphabetically and by county in the table of contents. Facility names are hyperlinked for easy access.

If you have any questions, please contact Sheena Siddiqui at ssiddiqui@mhaonline.org

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Baltimore County

Calvert County

Caroline County

Carroll County

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Montgomery County

Prince George's County

Queen Anne's County

St. Mary's County

Somerset County

Talbot County

Washington County

Wicomico County

Worcester County

Section 2: Discussion Guide

1. Are residents seen by a physician or physician extender within 48 hours of admission?
    a. If yes, please describe the SNF-ist or other program you have in place.
    b. If not, please indicate the average time to first physician provider assessment.

2. Describe the standard physician/extender rounding schedule, if one exists.

3. Describe RN/CNA coverage for evenings, nights, and weekends.

4. How many days per week are rehabilitation services available (5 days/week? 7 days/week?)
    a. Please list out how many days/week each type rehabilitation services are provided such as joint replacement, CVA.

5. Describe your processes for:
    - Medication reconciliation
    - Glucose management
    - Pain management
    - Anticoagulation management

6. Describe your error monitoring process, and the recent actions taken as a result.

7. Describe your standard process for identifying changes in clinical status among residents.

8. Describe your standard process for responding to changes in clinical status such as fever, cough, shortness of breath, weight gain, altered mental status, UTI, dislodged tubes/lines.

9. Do you ensure goals of care are addressed with all residents?

10. What process do you have in place to ensure all residents have a MOLST form?

11. Describe your facility's admission schedule. Specifically, can your facility admit patients
    a. 24 hours a day? Can your facility accept "direct admits" from the community or ED?

12. Does your facility utilize CRISP to promote health information exchange with referring or receiving providers? If yes, please describe your current use of CRISP. If no, please indicate whether you are interested in learning about CRISP.

13. What is your facility's standard communication for sharing medical information during hand-off?

14. What processes do you have in place to reduce frequency of potentially avoidable transfers to hospitals?

15. What fall prevention programs do you have in place?

16. Does your facility utilize Maryland Patient Safety Center (MPSC) program?

17. Describe any hospice/palliative care services that your facility provides and provide a list of any hospice agencies that work with or are contracted with your facility.

18. What are some opportunities for our hospital to improve transition of care?

Nursing Home Capabilities List

INTERACT®
Version 4.0 Tool

This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility _____

Address _____

Tel (_____) _____ **Key Contact** _____

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing		
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
EKG	Y	N
Bladder Ultrasound	Y	N
Venous Doppler	Y	N
Cardiac Echo	Y	N
Swallow Studies	Y	N
Consultations		
Psychiatry	Y	N
Cardiology	Y	N
Pulmonary	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations *specify:*	Y	N
Social and Psychology Services		
Licensed Social Worker	Y	N
Psychological Evaluation and Counseling by a Licensed Clinical Psychologist	Y	N
Therapies on Site		
Occupational	Y	N
Physical	Y	N
Respiratory	Y	N
Speech	Y	N

Capabilities	Yes	No
Nursing Services		
Frequent vital signs *(e.g. every 2 hrs)*	Y	N
Strict intake and output (I&O) monitoring	Y	N
Daily weights	Y	N
Accuchecks for glucose at least every shift	Y	N
INR	Y	N
O2 saturation	Y	N
Nebulizer treatments	Y	N
Incentive spirometry	Y	N
Interventions		
IV Fluids *(initiation and maintenance)*	Y	N
IV Antibiotics	Y	N
IV Meds – Other *(e.g. furosemide)*	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Isolation *(for MRSA, VRE, etc...)*	Y	N
Surgical Drain Management	Y	N
Tracheostomy Management	Y	N
Analgesic Pumps	Y	N
Dialysis	Y	N
Advanced CPR *(ACLS capability)*	Y	N
Automatic Defibrillator	Y	N
Pharmacy Services		
Emergency kit with common medications for acute conditions available	Y	N
New medications filled within 8 hours	Y	N
Other Specialized Services *(specify)*		

County Name: Frederick County

Facility: Buckingham's Choice

Address: 3200 Baker Circle
Adamstown, MD
21710

Phone Number: (301) 644-1600

Provider Number: 215329

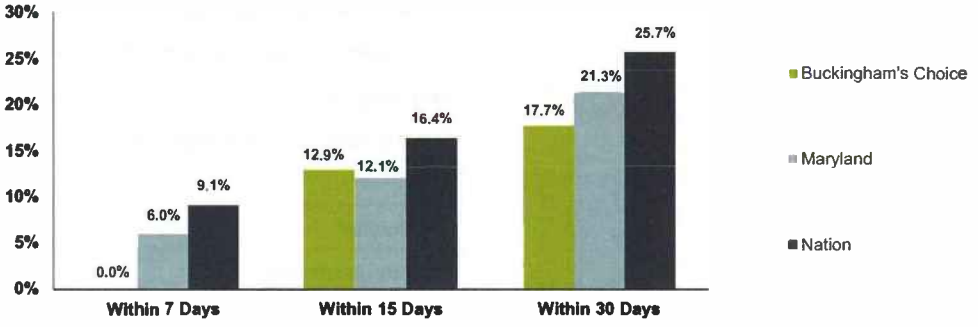
Number of Beds: 41
Source: CMS Nursing Home Compare, data as of 4/2015

Buckingham's Choice ALOS: 27.5

Maryland Average ALOS: 24.3
Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Readmission Rate Back to Hospital After SNF Discharge

7 Day Readmissions Data Unavailable



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Clinical Service Offerings

	Buckingham's Choice	Percent of Maryland SNFs Offering Services
Alzheimer's Care	No	94%
Care for Tracheostomy Patients	No	78%
Catheter Care	Yes	100%
Central IV Therapy	Yes	91%
Dialysis Care	No	26%
Hospice Care	Yes	92%
Peritoneal Dialysis Care	No	19%
Rehabilitation Care	Yes	98%
Respite Care	No	89%
Total Parenteral Nutrition (TPN)	No	23%
Ventilator Care	No	10%

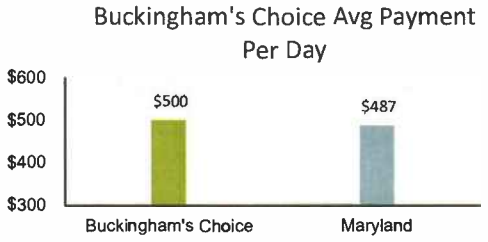
Source: MD Guide to Long Term Care, data as of 12/2014

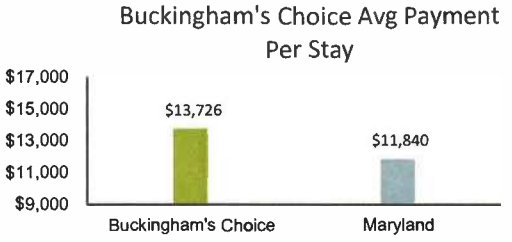
Staffing Measures

	Buckingham's Choice	Compared to Maryland Average	Compared to National Average
RN staffing hours per resident per day[1]	1.7	84% Above	106% Above
CNA hours per resident per day[1]	2.5	3% Above	2% Above
Percent of staff employed two years or more[2]	73%	22% Above	NA

Source: [1] CMS Nursing Home Compare, data as of 4/2015; [2] MD Guide to Long Term Care, CY 2013 data

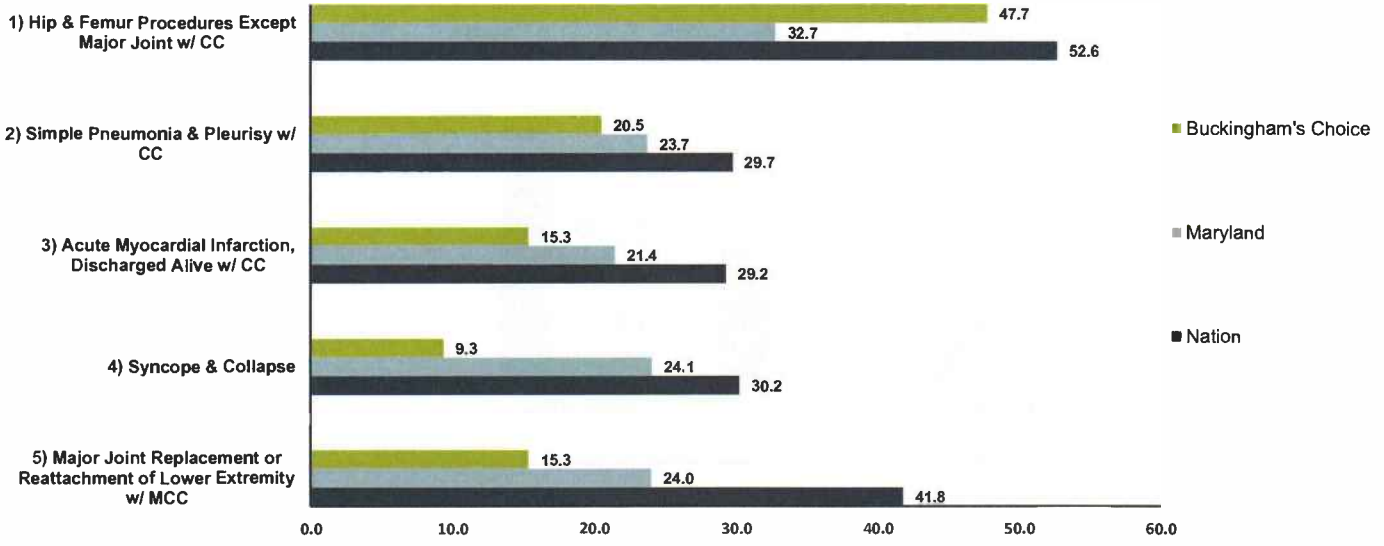
Payments Per Day, Per Stay





Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Average Length of Stay at SNF for Commonly Billed DRGs During Prior Hospitalization



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data
Note: CC = Complications or Comorbidities; MCC = Major Complications or Comorbidities

Federal Quality Measure Scores For Long Stay Residents

	Buckingham's Choice	Maryland Average	National Average
Percent of residents experiencing one or more falls with major injury	2.9%	2.7%	3.2%
Percent of residents with a urinary tract infection	4.9%	4.8%	5.7%
Percent of who self report moderate to severe pain	5.8%	4.9%	7.4%
Percent of high risk residents with pressure ulcers	10.2%	6.7%	5.9%
Percent of residents with a catheter inserted and left in their bladder	2.7%	2.4%	3.1%
Percent of residents whose need for help with ADLs has increased	2.3%	18.2%	15.6%
Percent of residents who were physically restrained	0.0%	0.9%	1.1%
Percent of residents assessed and appropriately given the seasonal influenza vaccine	91.2%	93.3%	92.6%
Percent of residents assessed and appropriately given the pneumococcal vaccine	99.0%	93.9%	93.8%

ource: CMS Nursing Home Compare, data collected 4/2014 through 12/2014

County Name: Frederick County

Facility: Citizens Care & Rehab Ctr of Frederick

Address: 1920 Rosemont Avenue
Frederick, MD
21702

Phone Number: (301) 600-5600

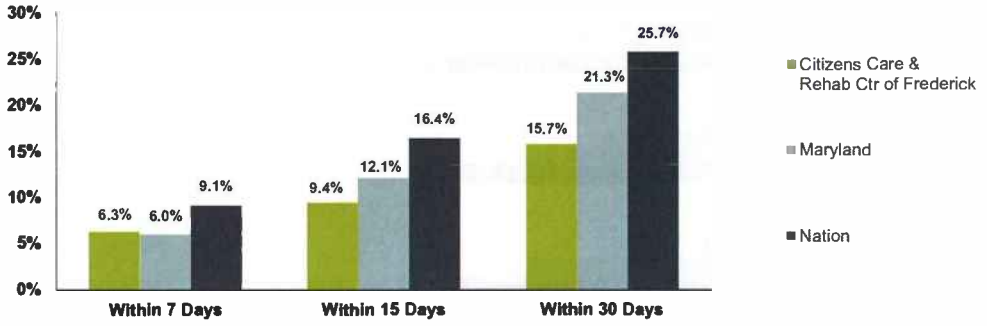
Provider Number: 215105

Number of Beds: 2
Source: CMS Nursing Home Compare, data as of 4/2015

Citizens Care & Rehab Ctr of Frederick ALOS: 170

Maryland Average ALOS: 29.9
Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data 24.3

Readmission Rate Back to Hospital After SNF Discharge



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Clinical Service Offerings

	Citizens Care & Rehab Ctr of Frederick	Percent of Maryland SNFs Offering Services
Alzheimer's Care	Yes	94%
Care for Tracheostomy Patients	Yes	78%
Catheter Care	Yes	100%
Central IV Therapy	Yes	91%
Dialysis Care	Yes	26%
Hospice Care	Yes	92%
Peritoneal Dialysis Care	No	19%
Rehabilitation Care	Yes	98%
Respite Care	Yes	89%
Total Parenteral Nutrition (TPN)	No	23%
Ventilator Care	Yes	10%

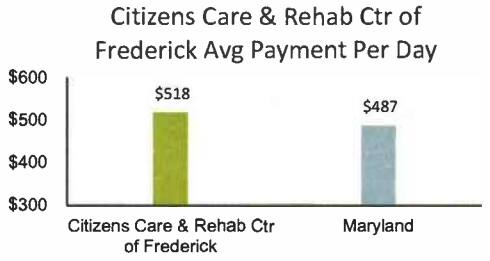
Source: MD Guide to Long Term Care, data as of 12/2014

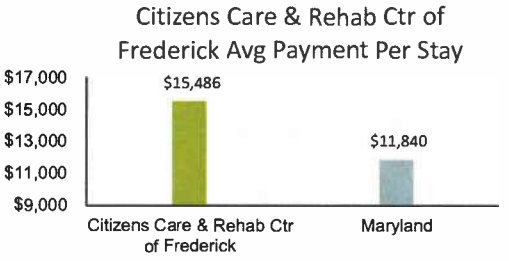
Staffing Measures

	Citizens Care & Rehab Ctr of Frederick	Compared to Maryland Average	Compared to National Average
RN staffing hours per resident per day[1]	0.8	14% Below	3% Below
CNA hours per resident per day[1]	2.8	17% Above	15% Above
Percent of staff employed two years or more[2]	80%	33% Above	NA

Source: [1] CMS Nursing Home Compare, data as of 4/2015; [2] MD Guide to Long Term Care, CY 2013 data

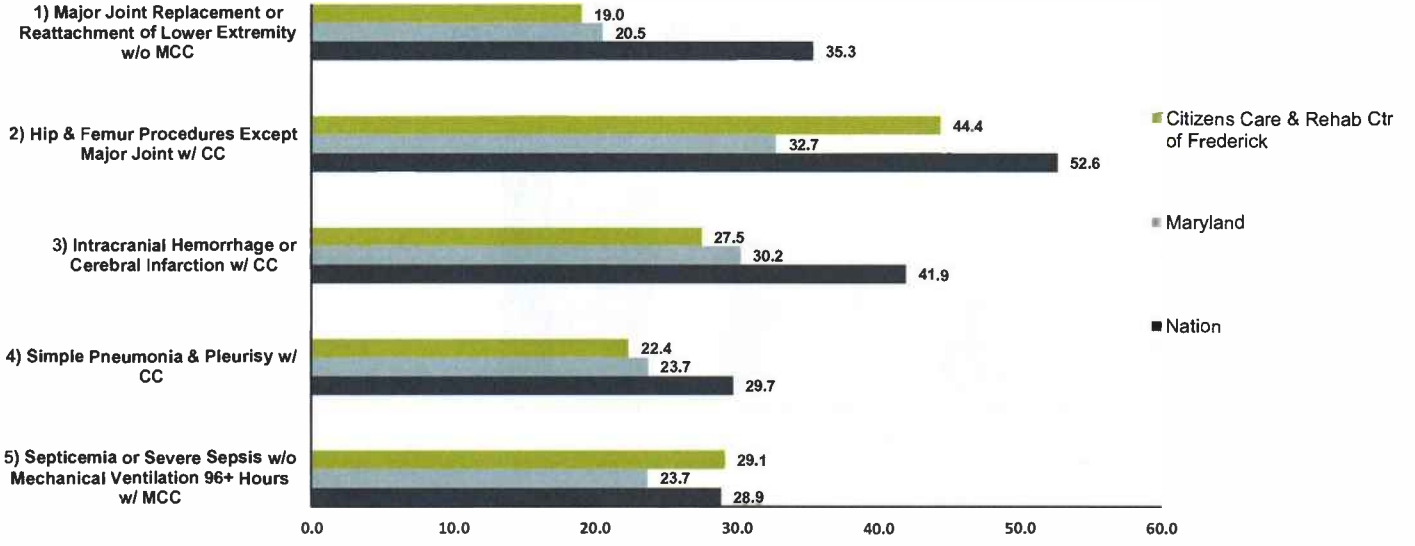
Payments Per Day, Per Stay





Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Average Length of Stay at SNF for Commonly Billed DRGs During Prior Hospitalization



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data
Note: CC = Complications or Comorbidities; MCC = Major Complications or Comorbidities

Federal Quality Measure Scores For Long Stay Residents

	Citizens Care & Rehab Ctr of Frederick	Maryland Average	National Average
Percent of residents experiencing one or more falls with major injury	3.2%	2.7%	3.2%
Percent of residents with a urinary tract infection	8.4%	4.8%	5.7%
Percent of who self report moderate to severe pain	6.7%	4.9%	7.4%
Percent of high risk residents with pressure ulcers	8.3%	6.7%	5.9%
Percent of residents with a catheter inserted and left in their bladder	1.9%	2.4%	3.1%
Percent of residents whose need for help with ADLs has increased	27.5%	18.2%	15.6%
Percent of residents who were physically restrained	1.0%	0.9%	1.1%
Percent of residents assessed and appropriately given the seasonal influenza vaccine	99.0%	93.3%	92.6%
Percent of residents assessed and appropriately given the pneumococcal vaccine	95.4%	93.9%	93.8%

ource: CMS Nursing Home Compare, data collected 4/2014 through 12/2014

County Name: Frederick County

Facility: College View Ctr

Address: 700 Toll House Avenue
Frederick, MD
21701

Phone Number: (301) 663-5181

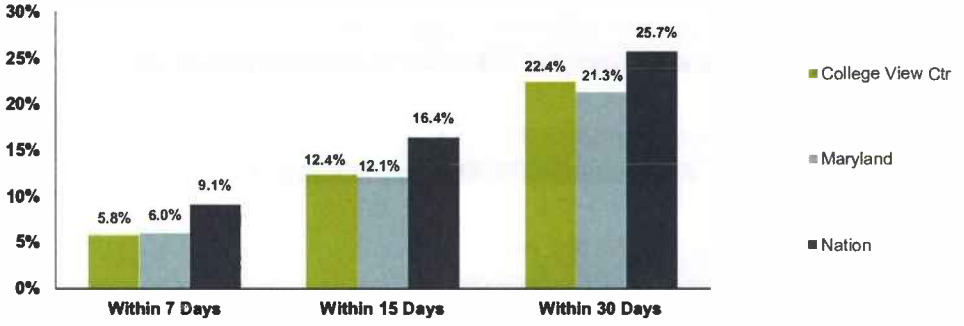
Provider Number: 215001

Number of Beds: 143
Source: CMS Nursing Home Compare, data as of 4/2015

College View Ctr ALOS: 19.5

Maryland Average ALOS: 24.3
Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Readmission Rate Back to Hospital After SNF Discharge



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Clinical Service Offerings

	College View Ctr	Percent of Maryland SNFs Offering Services
Alzheimer's Care	Yes	94%
Care for Tracheostomy Patients	Yes	78%
Catheter Care	Yes	100%
Central IV Therapy	Yes	91%
Dialysis Care	Yes	26%
Hospice Care	Yes	92%
Peritoneal Dialysis Care	Yes	19%
Rehabilitation Care	Yes	98%
Respite Care	Yes	89%
Total Parenteral Nutrition (TPN)	No	23%
Ventilator Care	No	10%

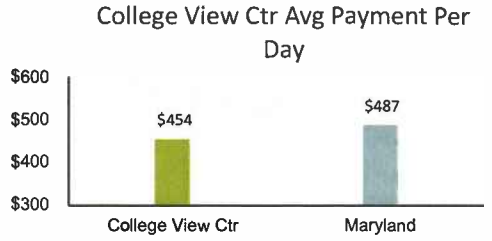
Source: MD Guide to Long Term Care, data as of 12/2014

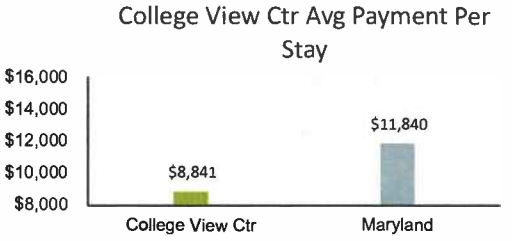
Staffing Measures

	College View Ctr	Compared to Maryland Average	Compared to National Average
RN staffing hours per resident per day[1]	0.7	24% Below	15% Below
CNA hours per resident per day[1]	2.1	15% Below	16% Below
Percent of staff employed two years or more[2]	61%	2% Above	NA

Source: [1] CMS Nursing Home Compare, data as of 4/2015; [2] MD Guide to Long Term Care, CY 2013 data

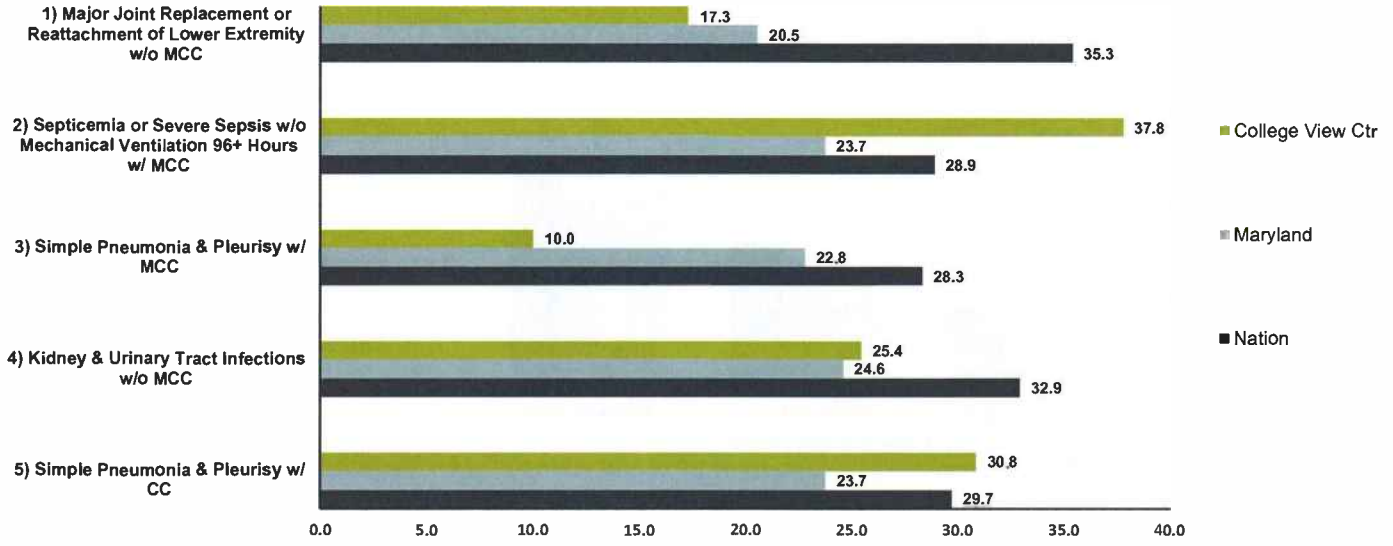
Payments Per Day, Per Stay





Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Average Length of Stay at SNF for Commonly Billed DRGs During Prior Hospitalization



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data
Note: CC = Complications or Comorbidities; MCC = Major Complications or Comorbidities

Federal Quality Measure Scores For Long Stay Residents

	College View Ctr	Maryland Average	National Average
Percent of residents experiencing one or more falls with major injury	6.6%	2.7%	3.2%
Percent of residents with a urinary tract infection	0.8%	4.8%	5.7%
Percent of who self report moderate to severe pain	11.4%	4.9%	7.4%
Percent of high risk residents with pressure ulcers	3.2%	6.7%	5.9%
Percent of residents with a catheter inserted and left in their bladder	5.9%	2.4%	3.1%
Percent of residents whose need for help with ADLs has increased	22.6%	18.2%	15.6%
Percent of residents who were physically restrained	0.0%	0.9%	1.1%
Percent of residents assessed and appropriately given the seasonal influenza vaccine	95.0%	93.3%	92.6%
Percent of residents assessed and appropriately given the pneumococcal vaccine	99.6%	93.9%	93.8%

Source: CMS Nursing Home Compare, data collected 4/2014 through 12/2014

County Name: Frederick County

Facility: Glade Valley Ctr

Address: 56 West Frederick Street
Walkersville, MD
21793

Phone Number: (301) 898-4300

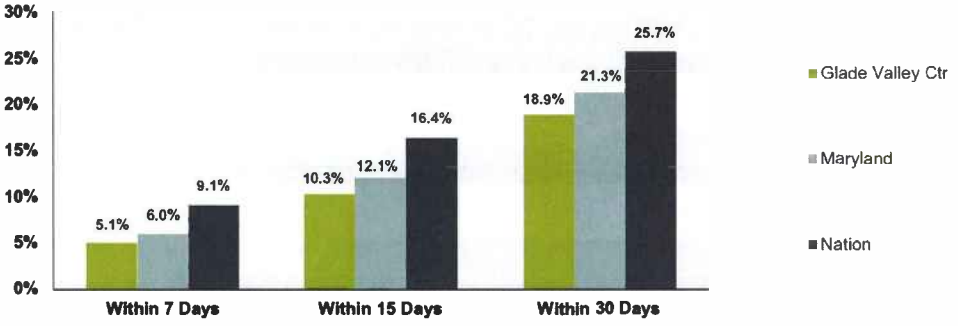
Provider Number: 215313

Number of Beds: 124
Source: CMS Nursing Home Compare, data as of 4/2015

Glade Valley Ctr ALOS: 29.7

Maryland Average ALOS: 24.3
Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Readmission Rate Back to Hospital After SNF Discharge



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Clinical Service Offerings

	Glade Valley Ctr	Percent of Maryland SNFs Offering Services
Alzheimer's Care	Yes	94%
Care for Tracheostomy Patients	Yes	78%
Catheter Care	Yes	100%
Central IV Therapy	Yes	91%
Dialysis Care	No	26%
Hospice Care	Yes	92%
Peritoneal Dialysis Care	No	19%
Rehabilitation Care	Yes	98%
Respite Care	Yes	89%
Total Parenteral Nutrition (TPN)	No	23%
Ventilator Care	No	10%

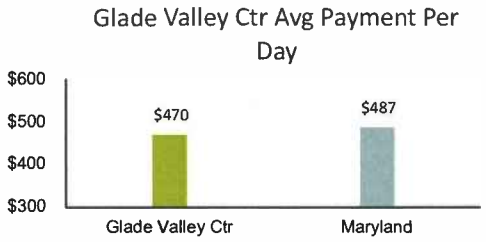
Source: MD Guide to Long Term Care, data as of 12/2014

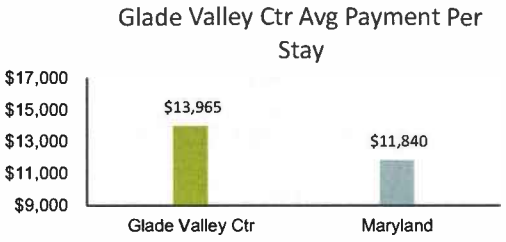
Staffing Measures

	Glade Valley Ctr	Compared to Maryland Average	Compared to National Average
RN staffing hours per resident per day[1]	0.9	4% Below	8% Above
CNA hours per resident per day[1]	1.9	20% Below	21% Below
Percent of staff employed two years or more[2]	61%	2% Above	NA

Source: [1] CMS Nursing Home Compare, data as of 4/2015; [2] MD Guide to Long Term Care, CY 2013 data

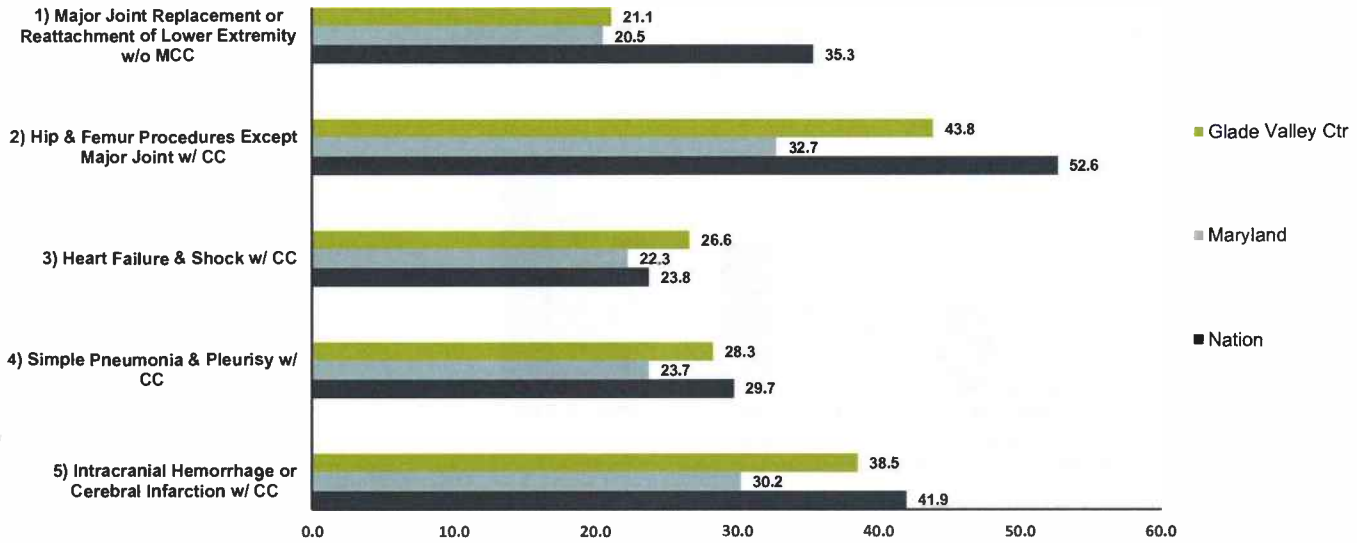
Payments Per Day, Per Stay





Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Average Length of Stay at SNF for Commonly Billed DRGs During Prior Hospitalization



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data
Note: CC = Complications or Comorbidities; MCC = Major Complications or Comorbidities

Federal Quality Measure Scores For Long Stay Residents

	Glade Valley Ctr	Maryland Average	National Average
Percent of residents experiencing one or more falls with major injury	7.8%	2.7%	3.2%
Percent of residents with a urinary tract infection	2.5%	4.8%	5.7%
Percent of who self report moderate to severe pain	4.5%	4.9%	7.4%
Percent of high risk residents with pressure ulcers	6.0%	6.7%	5.9%
Percent of residents with a catheter inserted and left in their bladder	2.4%	2.4%	3.1%
Percent of residents whose need for help with ADLs has increased	32.1%	18.2%	15.6%
Percent of residents who were physically restrained	0.0%	0.9%	1.1%
Percent of residents assessed and appropriately given the seasonal influenza vaccine	100.0%	93.3%	92.6%
Percent of residents assessed and appropriately given the pneumococcal vaccine	100.0%	93.9%	93.8%

Source: CMS Nursing Home Compare, data collected 4/2014 through 12/2014

County Name: Frederick County

Facility: Golden Living Ctr - Frederick

Address: 30 North Place
Frederick, MD
21701

Phone Number: (301) 695-6618

Provider Number: 215184

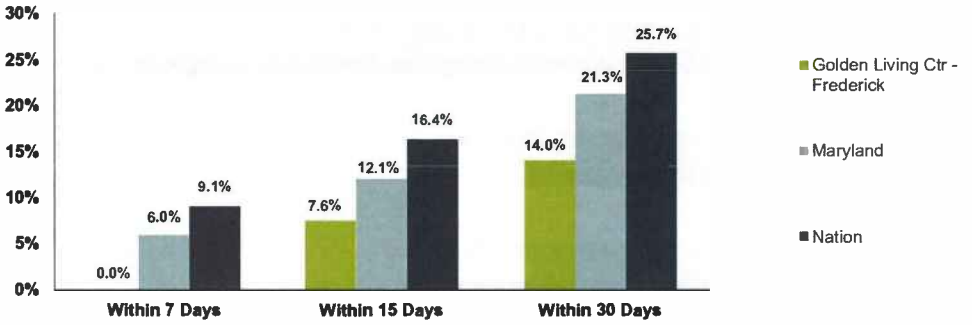
Number of Beds: 120
Source: CMS Nursing Home Compare, data as of 4/2015

Golden Living Ctr - Frederick ALOS: 22.3

Maryland Average ALOS: 24.3
Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Readmission Rate Back to Hospital After SNF Discharge

7 Day Readmissions Data Unavailable



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Clinical Service Offerings

	Golden Living Ctr - Frederick	Percent of Maryland SNFs Offering Services
Alzheimer's Care	Yes	94%
Care for Tracheostomy Patients	Yes	78%
Catheter Care	Yes	100%
Central IV Therapy	Yes	91%
Dialysis Care	No	26%
Hospice Care	No	92%
Peritoneal Dialysis Care	Yes	19%
Rehabilitation Care	Yes	98%
Respite Care	Yes	89%
Total Parenteral Nutrition (TPN)	Yes	23%
Ventilator Care	No	10%

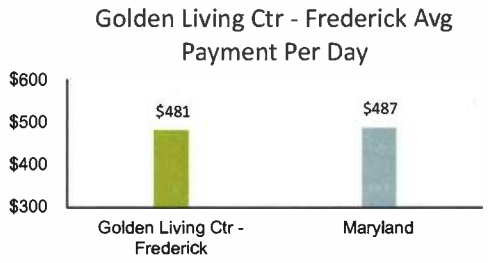
Source: MD Guide to Long Term Care, data as of 12/2014

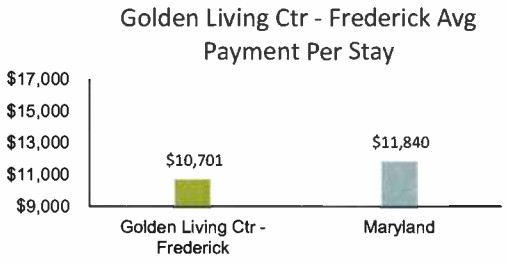
Staffing Measures

	Golden Living Ctr - Frederick	Compared to Maryland Average	Compared to National Average
RN staffing hours per resident per day[1]	0.4	55% Below	49% Below
CNA hours per resident per day[1]	1.9	21% Below	23% Below
Percent of staff employed two years or more[2]	82%	37% Above	NA

Source: [1] CMS Nursing Home Compare, data as of 4/2015; [2] MD Guide to Long Term Care, CY 2013 data

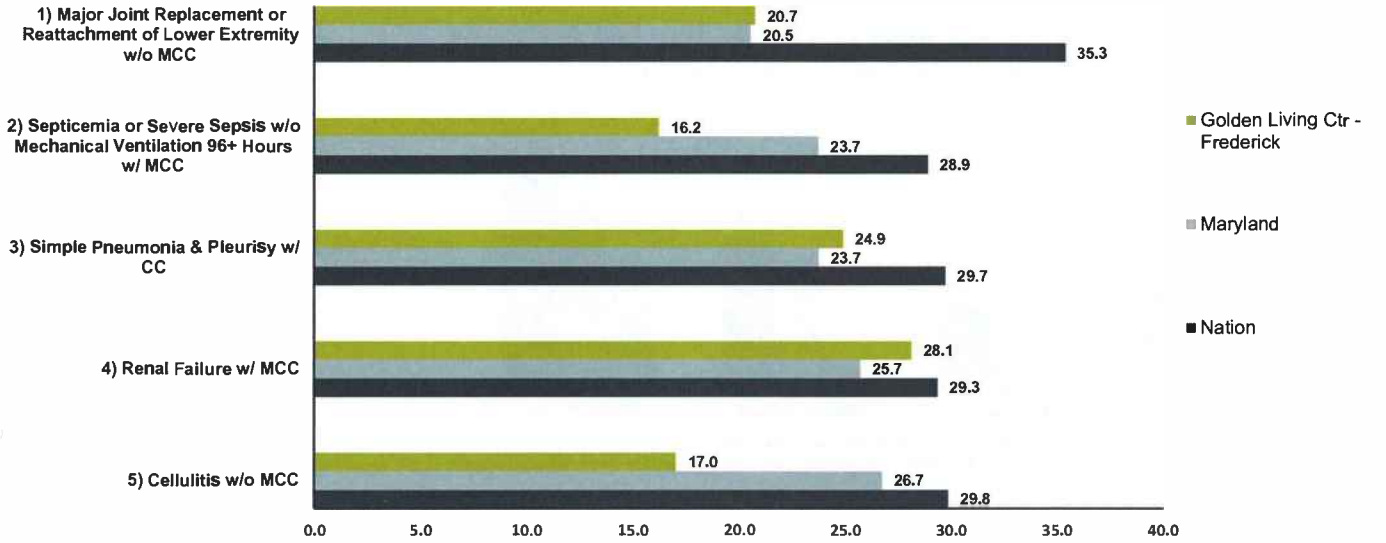
Payments Per Day, Per Stay





Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Average Length of Stay at SNF for Commonly Billed DRGs During Prior Hospitalization



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data
Note: CC = Complications or Comorbidities; MCC = Major Complications or Comorbidities

Federal Quality Measure Scores For Long Stay Residents

	Golden Living Ctr - Frederick	Maryland Average	National Average
Percent of residents experiencing one or more falls with major injury	8.9%	2.7%	3.2%
Percent of residents with a urinary tract infection	4.3%	4.8%	5.7%
Percent of who self report moderate to severe pain	8.3%	4.9%	7.4%
Percent of high risk residents with pressure ulcers	6.4%	6.7%	5.9%
Percent of residents with a catheter inserted and left in their bladder	0.9%	2.4%	3.1%
Percent of residents whose need for help with ADLs has increased	19.7%	18.2%	15.6%
Percent of residents who were physically restrained	0.0%	0.9%	1.1%
Percent of residents assessed and appropriately given the seasonal influenza vaccine	91.6%	93.3%	92.6%
Percent of residents assessed and appropriately given the pneumococcal vaccine	39.6%	93.9%	93.8%

Source: CMS Nursing Home Compare, data collected 4/2014 through 12/2014

County Name: Frederick County

Facility: Homewood at Crumland Farms

Address: 7407 Willow Road
Frederick, MD
21702

Phone Number: (301) 644-5600

Provider Number: 215245

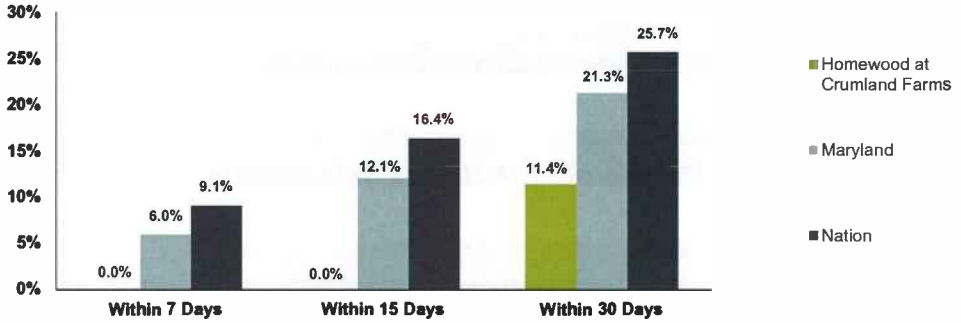
Number of Beds: 117
Source: CMS Nursing Home Compare, data as of 4/2015

Homewood at Crumland Farms ALOS: 28.6

Maryland Average ALOS: 24.3
Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Readmission Rate Back to Hospital After SNF Discharge

7 Day, 15 Day Readmissions Data Unavailable



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Clinical Service Offerings

	Homewood at Crumland Farms	Percent of Maryland SNFs Offering Services
Alzheimer's Care	Yes	94%
Care for Tracheostomy Patients	Yes	78%
Catheter Care	Yes	100%
Central IV Therapy	Yes	91%
Dialysis Care	No	26%
Hospice Care	Yes	92%
Peritoneal Dialysis Care	Yes	19%
Rehabilitation Care	Yes	98%
Respite Care	Yes	89%
Total Parenteral Nutrition (TPN)	Yes	23%
Ventilator Care	No	10%

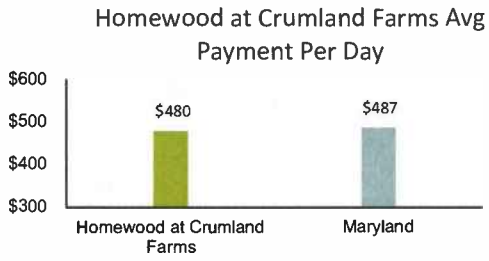
Source: MD Guide to Long Term Care, data as of 12/2014

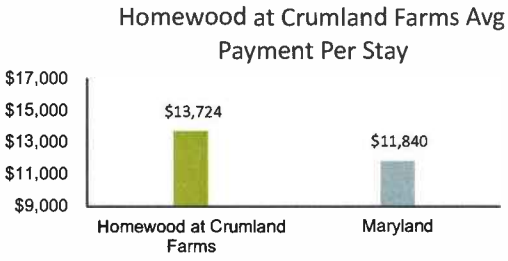
Staffing Measures

	Homewood at Crumland Farms	Compared to Maryland Average	Compared to National Average
RN staffing hours per resident per day[1]	0.9	1% Below	11% Above
CNA hours per resident per day[1]	2.8	15% Above	13% Above
Percent of staff employed two years or more[2]	66%	10% Above	NA

Source: [1] CMS Nursing Home Compare, data as of 4/2015; [2] MD Guide to Long Term Care, CY 2013 data

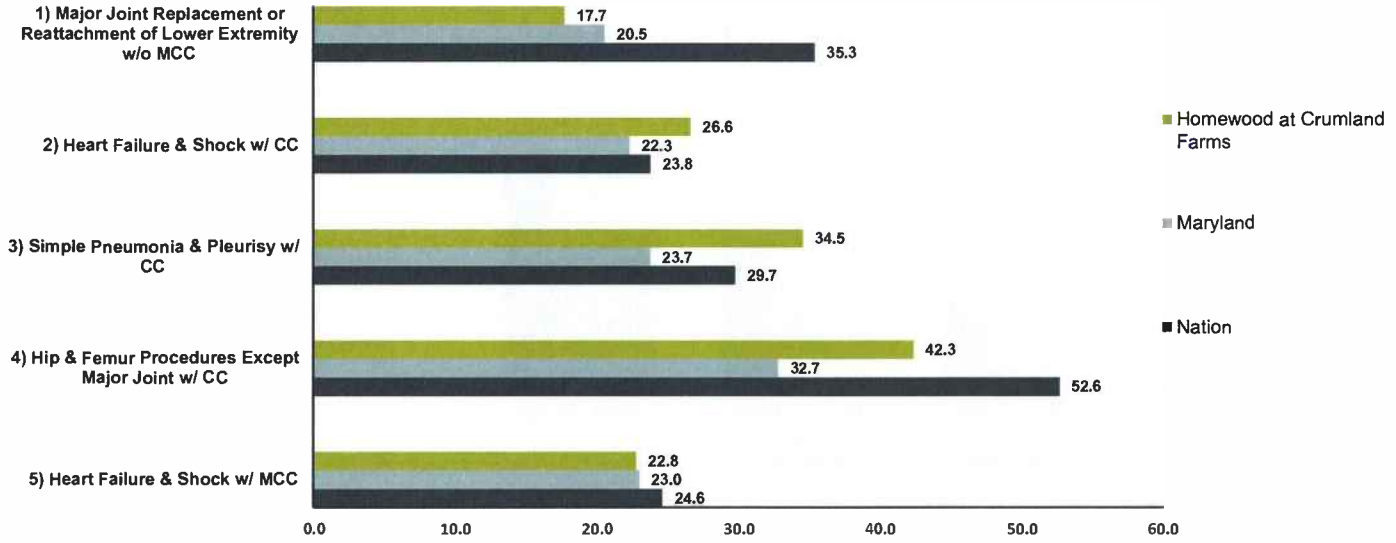
Payments Per Day, Per Stay





Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Average Length of Stay at SNF for Commonly Billed DRGs During Prior Hospitalization



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data
Note: CC = Complications or Comorbidities; MCC = Major Complications or Comorbidities

Federal Quality Measure Scores For Long Stay Residents

	Homewood at Crumland Farms	Maryland Average	National Average
Percent of residents experiencing one or more falls with major injury	1.9%	2.7%	3.2%
Percent of residents with a urinary tract infection	5.9%	4.8%	5.7%
Percent of who self report moderate to severe pain	14.3%	4.9%	7.4%
Percent of high risk residents with pressure ulcers	3.9%	6.7%	5.9%
Percent of residents with a catheter inserted and left in their bladder	1.2%	2.4%	3.1%
Percent of residents whose need for help with ADLs has increased	9.8%	18.2%	15.6%
Percent of residents who were physically restrained	2.3%	0.9%	1.1%
Percent of residents assessed and appropriately given the seasonal influenza vaccine	98.7%	93.3%	92.6%
Percent of residents assessed and appropriately given the pneumococcal vaccine	99.0%	93.9%	93.8%

Source: CMS Nursing Home Compare, data collected 4/2014 through 12/2014

County Name: Frederick County

Facility: Northampton Manor

Address: 200 East 16th Street
Frederick, MD
21701

Phone Number: (301) 662-8700

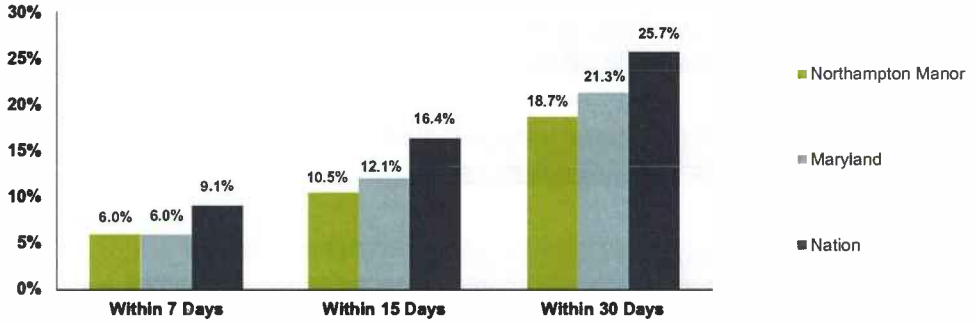
Provider Number: 215217

Number of Beds: 190
Source: CMS Nursing Home Compare, data as of 4/2015

Northampton Manor ALOS: 29.4

Maryland Average ALOS: 24.3
Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Readmission Rate Back to Hospital After SNF Discharge



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Clinical Service Offerings

	Northampton Manor	Percent of Maryland SNFs Offering Services
Alzheimer's Care	Yes	94%
Care for Tracheostomy Patients	Yes	78%
Catheter Care	Yes	100%
Central IV Therapy	Yes	91%
Dialysis Care	No	26%
Hospice Care	Yes	92%
Peritoneal Dialysis Care	No	19%
Rehabilitation Care	Yes	98%
Respite Care	Yes	89%
Total Parenteral Nutrition (TPN)	Yes	23%
Ventilator Care	Yes	10%

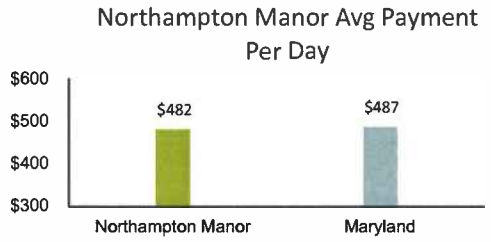
Source: MD Guide to Long Term Care, data as of 12/2014

Staffing Measures

	Northampton Manor	Compared to Maryland Average	Compared to National Average
RN staffing hours per resident per day[1]	1.0	5% Above	18% Above
CNA hours per resident per day[1]	2.0	19% Below	20% Below
Percent of staff employed two years or more[2]	73%	22% Above	NA

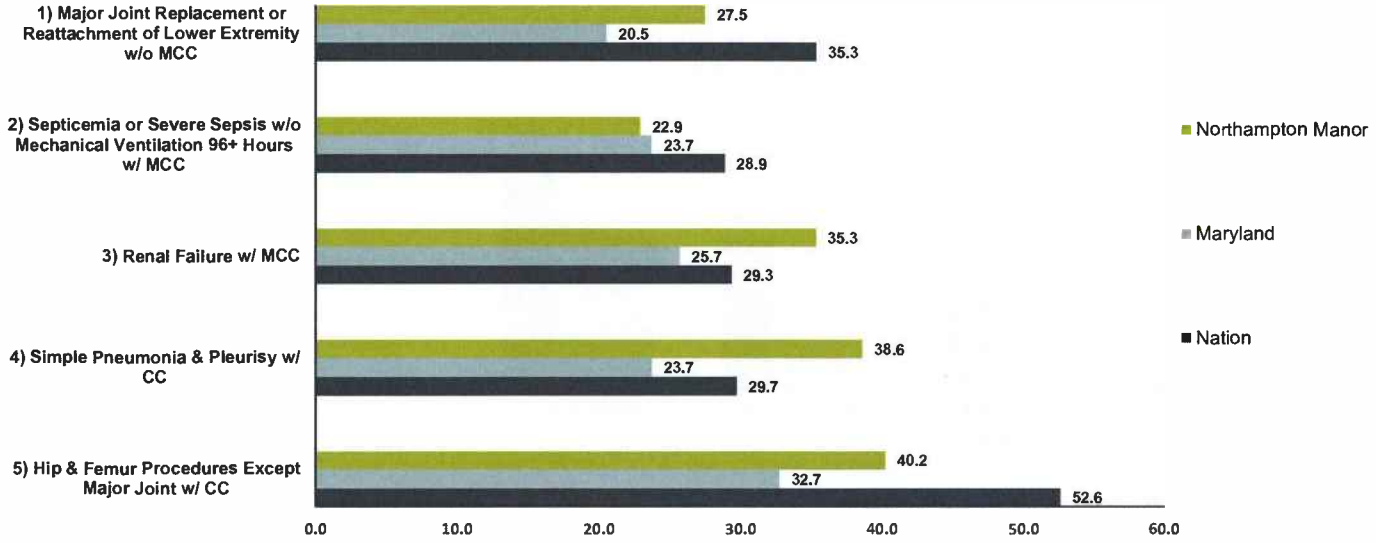
Source: [1] CMS Nursing Home Compare, data as of 4/2015; [2] MD Guide to Long Term Care, CY 2013 data

Payments Per Day, Per Stay



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Average Length of Stay at SNF for Commonly Billed DRGs During Prior Hospitalization



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data
Note: CC = Complications or Comorbidities; MCC = Major Complications or Comorbidities

Federal Quality Measure Scores For Long Stay Residents

	Northampton Manor	Maryland Average	National Average
Percent of residents experiencing one or more falls with major injury	1.7%	2.7%	3.2%
Percent of residents with a urinary tract infection	5.8%	4.8%	5.7%
Percent of who self report moderate to severe pain	1.6%	4.9%	7.4%
Percent of high risk residents with pressure ulcers	3.3%	6.7%	5.9%
Percent of residents with a catheter inserted and left in their bladder	1.9%	2.4%	3.1%
Percent of residents whose need for help with ADLs has increased	16.1%	18.2%	15.6%
Percent of residents who were physically restrained	2.4%	0.9%	1.1%
Percent of residents assessed and appropriately given the seasonal influenza vaccine	98.5%	93.3%	92.6%
Percent of residents assessed and appropriately given the pneumococcal vaccine	99.3%	93.9%	93.8%

Source: CMS Nursing Home Compare, data collected 4/2014 through 12/2014

County Name: Frederick County

Facility: St Joseph's Ministries

Address: 331 South Seton Avenue
Emmitsburg, MD
21727

Phone Number: (301) 447-7000

Provider Number: 215267

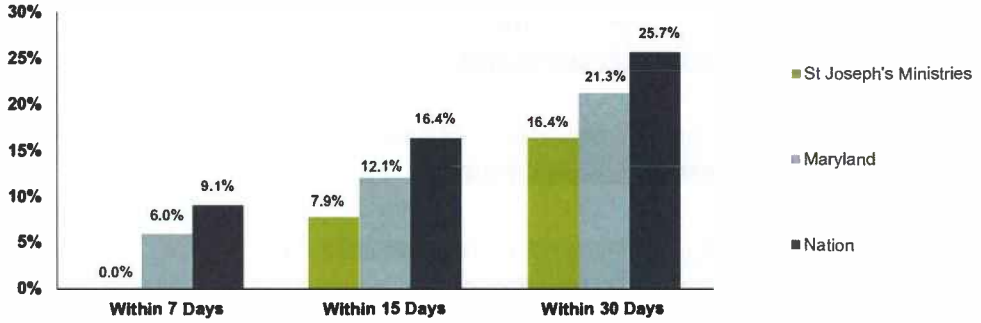
Number of Beds: 99
Source: CMS Nursing Home Compare, data as of 4/2015

St Joseph's Ministries ALOS: 33.1

Maryland Average ALOS: 24.3
Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Readmission Rate Back to Hospital After SNF Discharge

7 Day Readmissions Data Unavailable



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Clinical Service Offerings

	St Joseph's Ministries	Percent of Maryland SNFs Offering Services
Alzheimer's Care	Yes	94%
Care for Tracheostomy Patients	Yes	78%
Catheter Care	Yes	100%
Central IV Therapy	Yes	91%
Dialysis Care	No	26%
Hospice Care	Yes	92%
Peritoneal Dialysis Care	No	19%
Rehabilitation Care	Yes	98%
Respite Care	Yes	89%
Total Parenteral Nutrition (TPN)	No	23%
Ventilator Care	No	10%

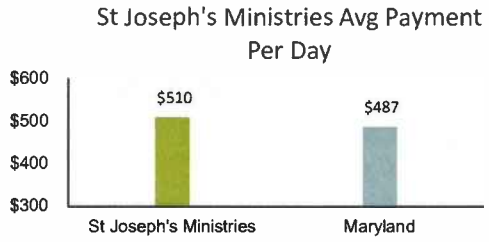
Source: MD Guide to Long Term Care, data as of 12/2014

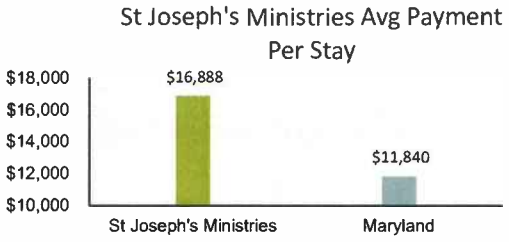
Staffing Measures

	St Joseph's Ministries	Compared to Maryland Average	Compared to National Average
RN staffing hours per resident per day[1]	0.8	15% Below	5% Below
CNA hours per resident per day[1]	3.3	38% Above	36% Above
Percent of staff employed two years or more[2]	35%	42% Below	NA

Source: [1] CMS Nursing Home Compare, data as of 4/2015; [2] MD Guide to Long Term Care, CY 2013 data

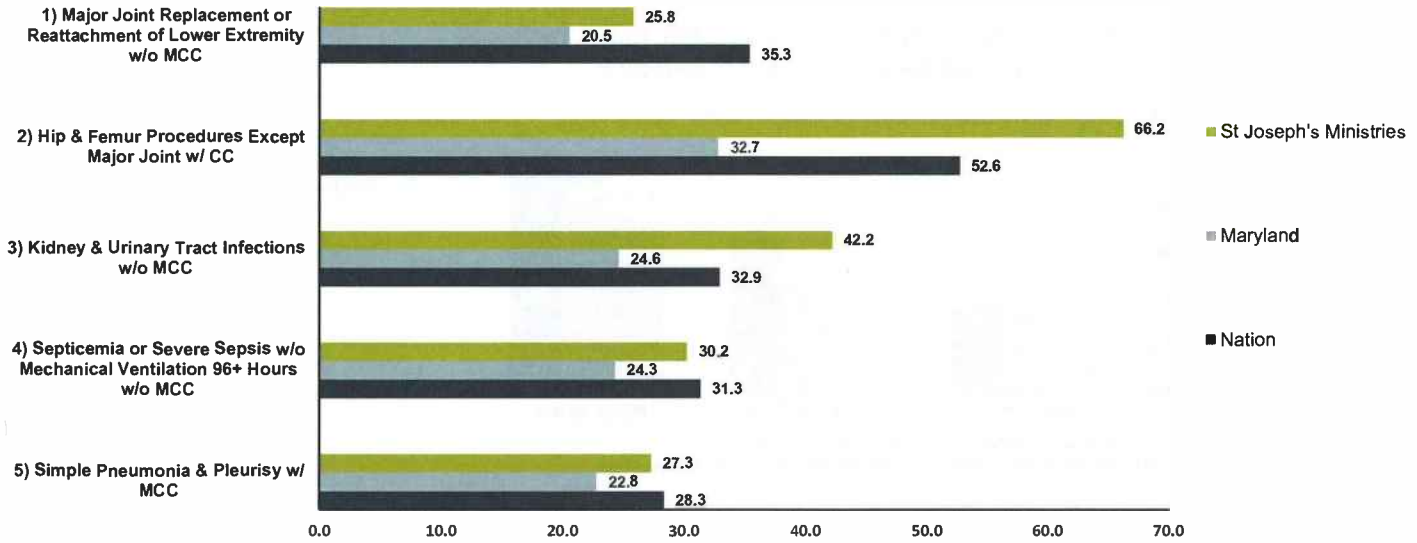
Payments Per Day, Per Stay





Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Average Length of Stay at SNF for Commonly Billed DRGs During Prior Hospitalization



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data
Note: CC = Complications or Comorbidities; MCC = Major Complications or Comorbidities

Federal Quality Measure Scores For Long Stay Residents

	St Joseph's Ministries	Maryland Average	National Average
Percent of residents experiencing one or more falls with major injury	4.4%	2.7%	3.2%
Percent of residents with a urinary tract infection	3.7%	4.8%	5.7%
Percent of who self report moderate to severe pain	8.8%	4.9%	7.4%
Percent of high risk residents with pressure ulcers	4.6%	6.7%	5.9%
Percent of residents with a catheter inserted and left in their bladder	0.4%	2.4%	3.1%
Percent of residents whose need for help with ADLs has increased	20.1%	18.2%	15.6%
Percent of residents who were physically restrained	0.0%	0.9%	1.1%
Percent of residents assessed and appropriately given the seasonal influenza vaccine	65.6%	93.3%	92.6%
Percent of residents assessed and appropriately given the pneumococcal vaccine	100.0%	93.9%	93.8%

Source: CMS Nursing Home Compare, data collected 4/2014 through 12/2014

County Name: Frederick County

Facility: Vindobona Nursing & Rehab Ctr

Address: 6012 Jefferson Blvd
Braddock Heights, MD
21714

Phone Number: (301) 371-7160

Provider Number: 215199

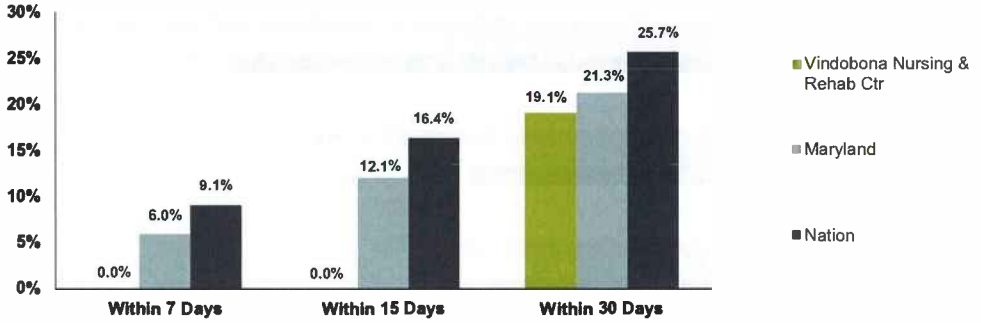
Number of Beds: 65
Source: CMS Nursing Home Compare, data as of 4/2015

Vindobona Nursing & Rehab Ctr ALOS: 30.7

Maryland Average ALOS: 24.3
Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Readmission Rate Back to Hospital After SNF Discharge

7 Day, 15 Day Readmissions Data Unavailable



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Clinical Service Offerings

	Vindobona Nursing & Rehab Ctr	Percent of Maryland SNFs Offering Services
Alzheimer's Care	Yes	94%
Care for Tracheostomy Patients	No	78%
Catheter Care	Yes	100%
Central IV Therapy	Yes	91%
Dialysis Care	No	26%
Hospice Care	Yes	92%
Peritoneal Dialysis Care	No	19%
Rehabilitation Care	Yes	98%
Respite Care	Yes	89%
Total Parenteral Nutrition (TPN)	No	23%
Ventilator Care	No	10%

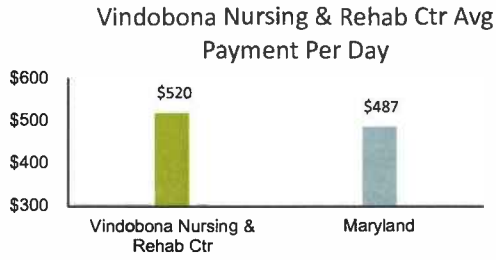
Source: MD Guide to Long Term Care, data as of 12/2014

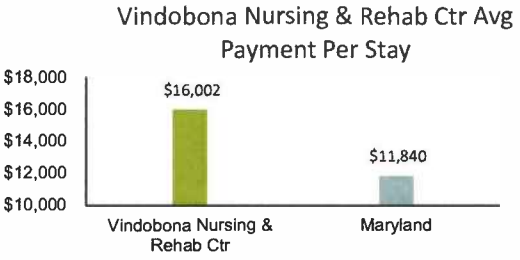
Staffing Measures

	Vindobona Nursing & Rehab Ctr	Compared to Maryland Average	Compared to National Average
RN staffing hours per resident per day[1]	1.3	35% Above	51% Above
CNA hours per resident per day[1]	1.6	34% Below	35% Below
Percent of staff employed two years or more[2]	55%	8% Below	NA

Source: [1] CMS Nursing Home Compare, data as of 4/2015; [2] MD Guide to Long Term Care, CY 2013 data

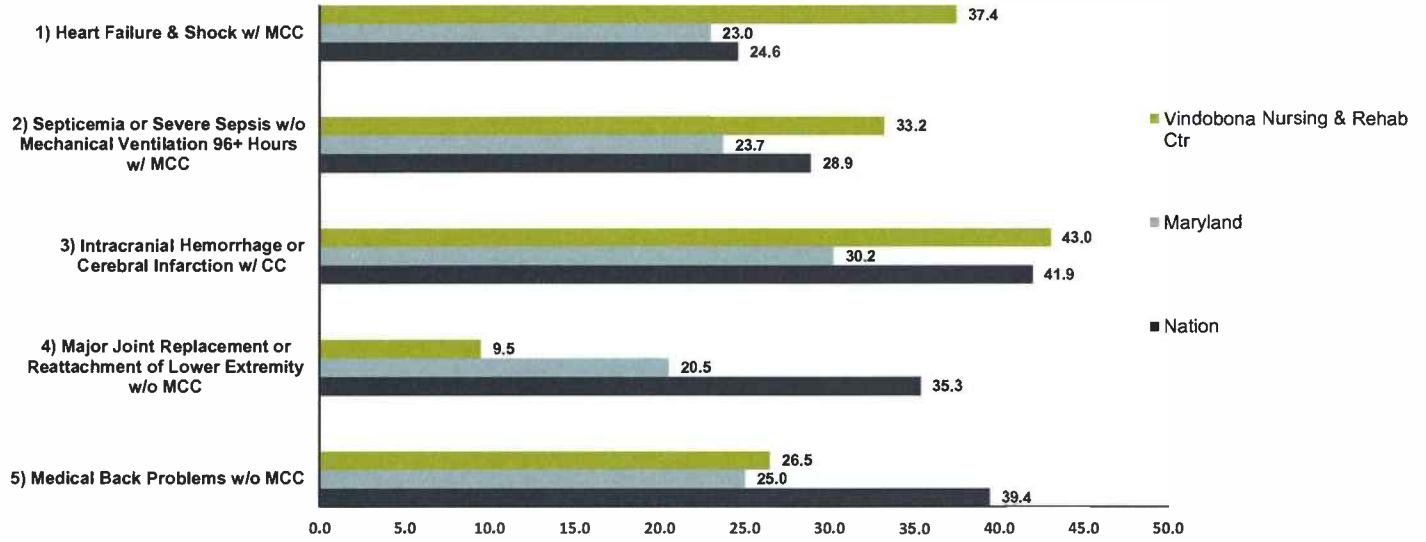
Payments Per Day, Per Stay





Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data

Average Length of Stay at SNF for Commonly Billed DRGs During Prior Hospitalization



Source: Avalere Health LLC analysis of 2013 Medicare fee-for-service claims data
Note: CC = Complications or Comorbidities; MCC = Major Complications or Comorbidities

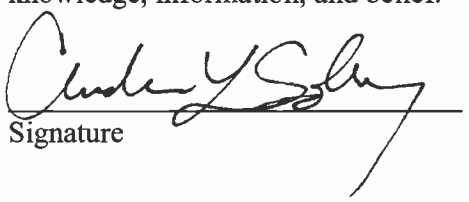
Federal Quality Measure Scores For Long Stay Residents

	Vindobona Nursing & Rehab Ctr	Maryland Average	National Average
Percent of residents experiencing one or more falls with major injury	5.6%	2.7%	3.2%
Percent of residents with a urinary tract infection	15.9%	4.8%	5.7%
Percent of who self report moderate to severe pain	1.5%	4.9%	7.4%
Percent of high risk residents with pressure ulcers	3.6%	6.7%	5.9%
Percent of residents with a catheter inserted and left in their bladder	0.9%	2.4%	3.1%
Percent of residents whose need for help with ADLs has increased	17.3%	18.2%	15.6%
Percent of residents who were physically restrained	0.0%	0.9%	1.1%
Percent of residents assessed and appropriately given the seasonal influenza vaccine	95.9%	93.3%	92.6%
Percent of residents assessed and appropriately given the pneumococcal vaccine	98.1%	93.9%	93.8%

Source: CMS Nursing Home Compare, data collected 4/2014 through 12/2014

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Certificate of Need Application and its exhibits and tables are true and correct to the best of my knowledge, information, and belief.



Signature

Andrew L. Solberg
Printed Name

President, A.L.S. Healthcare Consultant Services
Printed Title

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's Certificate of Need Application and its exhibits and tables are true and correct to the best of my knowledge, information, and belief.

Signature

George Watson

Printed Name

VP, Corporate Development

Printed Title