December 30, 2015

Cassandra Kingsberry, RN
Supervisory Nurse Consultant
Health Care Facilities Division
DC Department of Health
899 North Capitol Street, NE
2nd Floor
Washington, DC 20002

Dear Ms. Kingsberry:

Attached is the modified 2567 for BridgePoint Sub-Acute and Rehabilitation Capitol Hill for your review and approval.

Please don't hesitate to contact me at (202) 629-5471, should you have questions.

Sincerely,

James W. Linhares
Chief Executive Officer

Cc Keysha Dale, SNF Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING ______ B. WING ______	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL	**700 CONSTITUTION AVE. NE WASHINGTON, DC 20002**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Quality Indicator Survey (QIS) was conducted at your facility on September 9, 2015 through September 23, 2015. The following deficiencies are based on observations, record reviews, resident and staff interviews for 55 sampled residents. An Immediate Jeopardy (IJ) was identified at a scope and severity of " J " in the areas of CFR 483.25 Quality of Care, F-309 Failure to ensure that each resident attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care - specifically, Resident #145 and 11 additional ventilator dependent residents that have the potential to be affected by this deficient practice; F-328 Failure to ensure that residents receive the necessary care and treatment relative to ventilator services - specifically, Resident #145 and 11 additional ventilator dependent residents that have the potential to be affected by this deficient practice; scope and severity of " K " in the areas of F-353 Failure to have sufficient staff in both numbers and/or qualifications to meet the needs of residents; specifically, deficient practices related to the provision of needed care for residents identified in the regulatory groupings of quality of care and quality of life and 483.20 Resident Assessment; F-282 Failure to ensure that licensed nurses assigned to provide ventilator services were qualified and competent - specifically, Residents #98, 145, and 11 additional ventilator dependent residents that have the potential to be affected by this deficient practice.	F 000	Please begin typing here:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	11/02/2015

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

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F 000	Continued From page 1	F 000		

The facility's Administrator provided a letter noting a corrective action plan [see letter attached] and the IJ was removed on September 25, 2015 at 6:00 PM. Subsequently, the Immediate Jeopardy was lowered to a scope and severity of " E " for tags, F-309 and F-328, F-282 and F-353.

Substandard Quality of Care was identified during this survey.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations

AC - Assist control
AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice- a-day
B/P - Blood Pressure
CiPAP - Continuous positive airway pressure
CTA - Clear to auscultation
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
DBP - Diastolic blood pressure
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)

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F 000	Continued From page 2 FiO2 - Fraction of expired oxygen G-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligram (metric system unit of mass) mL - milliliter (metric system measure of volume) mg/dl - milligram per deciliter mm/Hg - millimeter of mercury Neuro - Neurological NP - Nurse Practitioner OX - oximetry PASRR - Preadmission screen and Resident Review PEEP - Positive Expiratory End Pressure Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RR - Rapid Response Rp, R/P- Responsible party SBP - systolic blood pressure S/he - She/he Sol- Solution TAR - Treatment Administration Record TV - Tidal Volume AMS - altered mental status A/C - assist control Sat - saturation	F 000		

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F 000	Continued From page 3 S-Bar - situation /background/assessment/recommendation - method of written communication used in healthcare	F 000		
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for 2 (two) of 55 sampled residents, it was determined the facility staff failed to ensure patient's right to be fully informed as evidenced by the failure to properly execute a consent for a Peripherally Inserted Central Catheter in two (2) of 55 sample resident records Residents' #111 and #140. The findings include: Facility failed to ensure the proper execution of consent for Peripherally Inserted Central Catheter. 1. Resident #111 was admitted on April 24, 2015	F 154		

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F 154	Continued From page 4 with diagnoses to include history of Respiratory Failure, Hypertension, and Cerebrovascular Accident. Medical record review conducted September 21, 2015 at 2:00 PM revealed a Peripheral Inserted Central Catheter (PICC) line was inserted on May 11, 2015 by an outside contract nurse. The Consents for Surgery, Procedures, Anesthesia, Transfusion and Other Treatments form dated May 11, 2015 at 6:05 PM revealed the signature of two nurses witnessing the telephone consent for the Peripherally Inserted Central Catheter; however, the form lacks the signature of the individual responsible for explaining the nature of the patient condition, procedure, and risks/ benefits associated with undergoing the procedure. Review of the Physician ' s Progress Notes for May 11, 2015 at 5:00 PM failed to reveal the medical staff spoke with the resident and/or responsible party about the need for a Peripherally Inserted Central Catheter and/or its risks and benefits. A face to face interview was conducted with Employee# 10 on September 21, 2015 at approximately 12:55 PM regarding the execution of the consent for Peripherally Inserted Central Catheters. S/he stated that it was the understanding that the individual performing the procedure would obtain the consent. When queried about the omission with regards to Resident #111, s/he was unable to provide further insight.	F 154	**483.100(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS** **Response to #1-2, Resident #111 and #140** 1. Immediately upon notification of this deficiency, the medical records for resident #111 and #140 to verify findings. 2. A concurrent chart audit of residents with a physician order for PICC insertion and a retrospective audit of residents who obtained a PICC in-house was reviewed by the RCCs of each unit. The audits found no other resident impacted by this deficient practice. 3. An in-serviced on 9/21 and is ongoing, for all nursing staff on standard of practice regarding obtain consent for all procedures. The contract nurse was reeducated regarding ensure all signatures are present prior to performing procedure. . The PICC Insertion Order Form will be revised to include a statement which will direct the Vascular Access Nurse to review the chart to ensure consent is present with all necessary signatures prior to insertion. The RCCs or designee will monitor all PICC orders to ensure all aspects of the consent is accurately documented in the medical record prior to the procedure. 4. The Resident Care Coordinator (RCC) or designee will audit all PICC orders. Results of the audits will be reported monthly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months.	11.10.2015

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F 154	Continued From page 5 The facility staff failed to ensure that consent was properly executed before an invasive procedure was performed. The clinical record was reviewed on September 21, 2015. 2. Resident #140 was admitted on August 18, 2015 with diagnoses to include Osteomyletis. Medical record review conducted September 18, 2015 at 2:00 PM revealed a Peripheral Inserted Central Catheter (PICC) line was inserted on September 9, 2015 by an outside contract nurse. The Consents for Surgery, Procedures, Anesthesia, Transfusion and Other Treatments form dated September 9, 2015 at 3:15 PM revealed the signature of the resident and one (1) nurse witnessing the consent for the Peripherally Inserted Central Catheter; however, the form lacks the signature of the individual responsible for explaining the nature of the patient condition, procedure, and risks/ benefits associated with undergoing the procedure. Review of the Physician ' s Progress Notes failed to reveal documentation to demonstrate the medical staff spoke with the resident about the need for a Peripherally Inserted Central Catheter and/or its risks and benefits. A face-to-face interview was conducted with Employee# 12 on September 18, 2015 at approximately 2:55 PM regarding the execution of the consent for Peripherally Inserted Central	F 154	**483.100(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS** **Response to #1-2, Resident #111 and #140** Refer to page 5 for response.	

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F 154	Continued From page 6 Catheters. S/he stated that it was the understanding that the individual performing the procedure would obtain the consent. When queried about the omission with regards to Resident #11, s/he was unable to provide further insight. The facility staff failed to ensure that consent was properly executed before an invasive procedure was performed. The findings were reviewed, discussed, and acknowledged. The clinical record was reviewed on September 18, 2015.	F 154	**483.100(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS** **Response to #1-2, Resident #111 and #140** Refer to page 5 for response.	
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	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #1 & #4, Resident #145, #5** Refer to page 8 for response.	

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F 157	Continued From page 7	F 157		

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 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 record review and staff interview for four (4) of 55 sampled residents it was determined that facility staff failed to notify the physician when two (2) ventilator dependent residents who demonstrated a compromise in respiratory function and two (2) residents that experienced a weight loss that exceeded five (5) percent in 30 days. Residents' #145 and #64 and #6, #5.

The findings include:

The facility ' s policy entitled, " Ventilator Weaning Protocol, " dated revised: June 17, 2015, stipulated; " 1. Purpose: To provide protocols for the management and weaning of ventilator support. Policy: Protocol will be applied per physician ' s written order of " Wean per protocol. " Page 8 ... In the event of acute exacerbation of the patient ' s pulmonary condition during vent management or weaning the therapist will immediately notify the pulmonary physician and take appropriate steps to treat the symptoms. "

1. Facility staff failed to notify the physician when

483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

Response to #1, Resident #145, #5

1. Immediately upon notification of this deficiency, the medical records for resident #145 and #5 to verify findings. On 9/16/15, 1:1 education of the Respiratory staff involved was held on the timeliness of completing respiratory orders and enhance accountability.

2. Nursing conducted a retrospective review of the 24-hr report for indications of status change, cross-referencing the medical record to ensure the physician was notified of any change in the resident's condition. The audit results found all medical records in compliance.

   Respiratory Therapist conducted medical record audits to identify new/changed orders and indications of missed orders. Those found out of compliance were addressed with the attending physician.

3. The clinical nursing staff were educated 9/22-9/26, 10/7 and ongoing by the Respiratory Department on the weaning protocol and related comprehensive assessment and interventions.

   The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and is ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable)

   The Respiratory staff were re-educated on 9/25/2015 related to the timeliness of completing physician orders, notification to physician, and the use of the communication binder.

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F 157	Continued From page 8 Resident #145, a ventilator dependent resident demonstrated a compromise in respiratory function. Resident #145 began complaining of shortness of breath on August 29, 2015, refused CPAP treatments beginning August 28, 2015 and demonstrated an alteration in the level of arousal on August 31, 2015. On August 31st at approximately 9:03 PM, Resident #145 sustained low blood pressure, increased respirations and tachycardia. Subsequently, the resident was transferred to the nearest emergency room (ER) and was hospitalized in intensive care. Resident #145 was admitted on August 24, 2015. According to the admitting history and physical examination signed by the physician August 25, 2015, Resident #145 ' s diagnoses included Chronic Respiratory Failure, Status Post Tracheotomy-Continue on [Ventilator], Quadriplegia [secondary] to cervical spine injury, Non-Ischemic Cardiomyopathy, Congestive Heart Failure, Major Depression with Anxiety and Diabetes Mellitus Type II. According to clinical record entries documented by respiratory therapy; in S-BAR format [situation/background/assessment/recommendation] the following was revealed: [August 28, 2015 to] August 29, 2015 - " 7PM-7AM-Shift Report - " Patient refused CPAP trails last night; Sat = 99% [oxygen saturation], [Heart Rate] 79, [Respiratory Rate] 24. Alert [and] stable. Patient has a lot of thick tan to white (oral) secretions. Continue to encourage patient to get weaned ...CPAP 5/10 x10[minutes], back on AC [assist control] due to patient complaining	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) [Cont'd)** **Response to #1, Resident #145, #5 (Cont'd)** 3. Residents on weaning protocol will be entered on the 24 hour report to ensure notification of residents' status and order changes are communicated across shift. Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. 4. The Resident Care Coordinator (RCC) will perform weekly audits of the 24 hour report to ensure appropriate protocol related to residents' change in condition are followed per policy. Results of the audits will be reported weekly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months. The Respiratory Department will conduct monthly audits to respiratory orders. A monthly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months.	11.10.2015

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F 157	Continued From page 9 of SOB [shortness of breath] " August 30, 2015 - " 7AM-7PM- Shift Report - " Received [patient] on AC mode, [nebulization treatment] given as ordered. [Patient]... (Illegible writing). [oxygen saturation] -99%, HR (illegible writing), Will continue to monitor patient. Special procedures done ...Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp [complaining] of SOB [shortness of breath], anxious. Placed back on AC [Assist Control] mode to rest. " [August 30, 2015 to] August 31, 2015- " 7PM-7AM- S- [Patient] is on AC 15/[Tidal Volume]-500, [Fractioned of Inspired Oxygen-45%, [Peep]-5, B- Respiratory Failure, A- Pt stable throughout shift- Sat-98%. HR-79, RR (Respiratory Rate) -21. Pt complains of being unable to breathe but in no apparent distress. Continue to monitor for changes. " August 31, 2015- " 7AM-7PM- S- Pt remains on AC mode, O [No] active weaning do [due] to pt being less arousable in PM. B- Respiratory failure, A- Alert [male/female], HR-84- RR-25, Sat-98%, small thin pale secretions, BS (breath sounds) clear, R- Will continue to monitor. " August 31, 2015 " Ventilator Flow Sheet " [recorded by respiratory therapist] revealed the following . " Rate Set/Total " on the A/C mode: [Rate Set/Total defined: 15/34 - "15" reflects ventilator preset respiratory rate and " 34" reflects - resident breaths above the set rate] 0130 (1:30 AM) - 15/34 - [Oxygen] Saturation[normal range 95 - 100%] - 97%, Heart Rate- 87	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #1 & #4, Resident #145, #5** Refer to page 8 for response.	

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F 157	Continued From page 10 0425 (4:25 AM) - 15/33 - [Oxygen] Saturation- 98%, Heart Rate-93 0855 (8:55 AM) - 15/32 - [Oxygen] Saturation-98%, Heart Rate-87 1230 (12:30 PM) - 15/33 - No Oxygen Saturation and Heart Rate documented in the allotted space. [1700] 5:00 PM - 15/29 - [Oxygen] - 98%, Heart Rate-80 2045 (8:45 PM) - 15/23, Saturation 96%, Heart Rate- 158. " The nurse practitioner documented a change in Resident #145 as follows: August 31, 2015 [no time indicated] - Certified Registered Nurse Practitioner ... Initial " Psych [psychiatric] and Mental Status Exam: Information obtained from staff/chart/resident [not] easily arousable ... [Patient] not arousable and does not answer questions at this time. Staff reports resident Alert and Oriented x3- [time, person and place], but just received pain meds. Concerns/Findings: Per staff resident normally [Alert and oriented x3], responds to questions asked. On exam, resident responding to painful stimuli but not easily arousable and [he/she] opens eyes to name but does not answer question, (-) Insomnia, " + " [Positive] Anxiety, " + " mood and affect [secondary to medical complications/conditions per staff. Plans: Monitor for safety and fall precautions, monitor for worsening anxiety, [Follow-up] in one (1) week to reassess mood/and anxiety. " The record revealed that nursing staff communicated to the nurse practitioner that the resident was " not arousable " due to " just received pain medication ". However, a review of the August 2015 Medication Administration	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #1 & #4, Resident #145, #5** Refer to page 8 for response.	

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F 157	Continued From page 11 Record [MAR] revealed Tylenol 500mg 2 caplets were administered 30 minutes prior to wound treatment during the 7AM - 3PM shift on August 31, 2015. The specific time was not noted. Further review of the MAR revealed that Resident #145 received Tylenol 500mg 2 caplets 30 minutes prior to wound treatment during the period of August 25th through August 30, 2015. There was no documented evidence that Resident #145 sustained " lack of arousal " associated with any preceding dosages of Tylenol administration or " just received pain medication. " Nursing Notes: August 28, 2015 3:13 PM - " ...V/S [vital signs]: [b/p-blood pressure] 108/58; [P-pulse] 99; [R-respirations] 18 ... no acute distress noted " August 29, 2015 3:00 AM - " ... [b/p] 116/62; [P] 78, [R] 20 ... " August 31, 2015- 12:35 PM - Resident remain alert and responsive. Vent [ventilator] dependent AC mode for respiratory support. Suction PRN (as needed) ...V/S- [Blood Pressure] - 134/74, 98.9 [Temperature]-, 74, 100 [two (2) different heart rates] no respirations documented... S-BAR (Situation-Background-Assessment-Recommendation) /Acute Change in Condition Report: Situation- Date: August 31, 2015, Time: 9:39 PM [of note, this is the successive nursing note to the August 31st 12:35 PM entry] ... low B/P- 77/53, P-153, R-24, lethargy [and] gasping for breath, although on vent. Background: Respiratory Failure, Temp: 98.6, B/P- 77/53, RESP: 24,	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #1 & #4, Resident #145, #5** Refer to page 8 for response.	

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F 157	Continued From page 12 Pulse: 153, Lung sounds: Crackles, Pulse ox: 93% ventilator ... Resident was noted [with] [decreased] B/P 77/53, elevated pulse rate. House officer notified who ordered to transport resident to [hospital] for further evaluation and treatment. " There was no evidence that licensed nursing and respiratory staff identified that Resident #145 exhibited progressive change in status (respiratory and mental) that warranted monitoring and/or intervention before the resident became obtunded, unresponsive with agonal breathing requiring transfer to higher level of care. August 31, 2015- 2103 (9:03 PM) - Hospitalist [physician] Note: I was called to evaluate [Resident #145] b/c (because) of hypotension, tachycardia, [and] acute AMS gradually since few hours ago. [His/her] HR (heart rate) has been elevated to 150 ' s [and] B/ P as low as 77/53. As per nurse even to earlier today [he/she] was A&O (alert and oriented), but currently [he/she] is obtunded (diminished arousal and awareness) [and] unresponsive with agonal (gasping) breathing. [He/she] is quadriplegic. Assessment/Plan: Acute AMS [and] hypotension-unknown cause ([he/she] finished [his/her] IV (Intravenous) Cipro (antibiotic) yesterday [and] Diflucan (anti-fungal medication) was discontinued). Transfer to nearest ER (Emergency Room). " The clinical record lacked evidence that nursing notified the physician regarding the resident's progressive complaint of having shortness of breath, refusing CPAP trials, alteration in the level of arousal from August 28, 2015 to August 31,	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #1 & #4, Resident #145, #5** Refer to page 8 for response.	

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F 157	Continued From page 13 2015 until 9:03PM when the resident was obtunded and with agonal breathing. Interviews A face-to-face interview was conducted with Employee #14 [on-coming day-shift team member, August 31, 2015 7AM - 7PM] September 18, 2015 at approximately 2:00 PM regarding the above aforementioned concerns. He/she said that the off-going team member [night shift August 30th 7PM through August 31, 2015 7AM] stated that the resident was calling all night, using the type of call bell one blows into. Employee #14 further stated the off-going therapist and the nurse was in and out of the resident ' s room all night. Employee #14 acknowledged the physician should have been informed of the resident's restlessness, complaint of having shortness of breath and refusal of CPAP treatments. The clinical record was reviewed September 18, 2015. Cross referenced 483.20(k)(3)(ii) F282; 483.25 F309; 483.30(a) F353; 483.25(k) F328 2. Facility staff failed to notify the attending physician in regards to a weight loss that exceeded five (5) percent in 30 days. Resident #64. According to the facility's policy; "Weight Assessment and Intervention" stipulates:, " Weight Assessment 1. The nursing staff will resident weights on admission, the next day, and weekly for one week thereafter. If no weight	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #1 & #4, Resident #145, #5** Refer to page 8 for response. **483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #2 & #3, Resident #64, #6** Refer to page 16 for response.	

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F 157	Continued From page 14 concerns are noted at this point, weights will be measured monthly thereafter ...3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietician in writing ...Analysis 1. Assessment information shall be analyzed by the multidisciplinary team and conclusions ...2. The Physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight... " Resident #64 was admitted on May 4, 2015 with diagnoses to include Sacral decubitus ulcer, Urinary Retention, Hypertension, Lymphedema Bilateral Lower Extremities, and Bilateral Lower Extremity Venous Stasis, and " Chief Complaint: Nutritional Deficient with deconditioning " as documented on the History and Physical dated May 4, 2015. Resident underwent a Percutaneous Endoscopic Gastrostomy on May 8, 2015 for Dysphagia and poor oral intake. Medical record review conducted on September 16, 2015 at 10:00 AM revealed the following documented weights: May 11, 2015- 186.8 pounds; May, 2015 (date of month unknown) - 177 pounds; June, 2015- 163 pounds; July, 2015- 150 pounds; and August, 2015- 141 pounds. Review of the Nurse ' s Notes and Physician ' s Progress Notes from June 22, 2015 through September 1, 2015 revealed the medical staff documented notification of significant weight loss on August 20, 2015. The medical record lacked	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #2 & #3, Resident #64, #6** Refer to page 16 for response.	

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F 157	Continued From page 15 documented evidence that the medical staff was notified of the weight loss documented between May and August 20, 2015. A face-to-face interview conducted with Employee #27 at 10:38 AM on September 16, 2015 revealed that Resident #64 was admitted as "obese". According to Employee #27, after it was determined the resident was not eating; the plan was changed to adjust the tube feeding because of volume intolerance and oral intake. When queried about labs, he/she stated the labs were not available and it was assumed the albumin was low because of the sacral wound and weight loss. Juven was started for 2 weeks and then changed to Beneprotein. The resident plan of care was discussed with the nurse manager at the time. S/he was unable to provide any further insight related to physician notification. Although the dietician continued to make adjustment to the tube feeding order and the physician authenticated the order as evidence by a signature. The medical record lacked documented the physician was notified of the weight loss until August 20, 2015 when at the time the resident had loss approximately 45.2 pounds since original weight of 186.8 pounds on May 11, 2015. The findings were discussed, reviewed and acknowledged by Employee # 11. The clinical record was reviewed on September 16, 2015.	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #2 and #3** **Resident #64, #6** 1. Immediately upon notification of this deficiency a review of the medical record for resident #6 to verify findings. 2. The Assistant Director of Clinical Nutrition performed a retrospective audit of the monthly weights on 10/1/2015 to ensure that all residents with significant weight changes were addressed and communicated to the attending physician. 3. Assessment and Intervention policy will be revised to reflect the Registered Dietitian (RD) as responsible for notifying the attending physician or NP of a confirmed significant weight change within 48 hours. The RD will call the attending physician or NP to inform about the significant weight change via phone and email. The RD will keep a record of physician/NP significant weight notification including date, time, and mode of communication. The RD will continue to communicate weekly to the Interdisciplinary Risk Management Subcommittee of interventions related to significant weight changes based on clinical collaborations. The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable) 4. The Assistant Director of Clinical Nutrition will perform monthly audits of the physician significant weight change notification record. The audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months.	11.10.2015

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F 157	Continued From page 16 3. Facility staff failed to notify the attending physician in regards to a weight loss as evidence by more than a 25% [percent] weight loss in 30 days for Resident #6. A review of the residents History and Physical conducted on February 13, 2015 revealed the resident has the following active diagnoses which included: Senile Dementia, Arthritis, Elephantiasis Varicosa legs, Cataract. A review of the resident's " Monthly Weights" sheet revealed the following: January 2015 - 112 pounds February 2015 -116 pounds March 2015 - 116 pounds April 2015 - 88 pounds ?? - the two (2) hand written question marks [??] were written in the corresponding space for " re-weight. " May 2015 - 88 pounds June 2015 - 89.4 pounds July 2015 - 91.2 pounds August 2015- 90.8 pounds A review of the clinical record (nursing, dietitian, physician notes and consults) lacked documented evidence that when the resident sustained a 28 pound weight loss for March 2015 to April 2015 neither the dietitian nor the physician were notified of the weight loss. In addition, there was no evidence in the clinical record that the facility staff obtained a reweight or weekly weights for confirmation or that the dietitian was notified of the weight change in April when first identified.	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #2 & #3, Resident #64, #6** Refer to page 16 for response.	

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F 157	Continued From page 17 Quarterly Nutrition Notes: A Quarterly Nutrition Review conducted dated May 19, 2015 revealed, "Swallowing /chewing difficulty; (etiology) dysphagia and missing teeth; (signs/symptoms) SLP [Speech Language Pathology] ordered ... mechanical soft diet; Boost Plus [nutritional supplement] BID [twice-a-day], needs assistance with eating, no teeth/dysphagia, [%] percent of meal intake (average) is 75% per RN [Registered Nurse], % Supplement ...50% per RN. Current weight 89 pounds/40.4 kg [kilograms] ... " A further review of the clinical record revealed more than 30 days had lapsed before the Quarterly Nutrition Review was conducted in May 2015. In addition, there was no evidence in the clinical record that a SLP consult was ordered. Quarterly Nutrition Review dated August 11, 2015 revealed, " Remeron [used to stimulate appetite] was added to the medications ... " which was more than 60 days since the resident ' s weight was identified at 88 pounds. Physician Notes: A review of a Physician ' s Progress Note " Attending " dated 3/20/15 [March 20, 2015] 7:45 PM revealed " pt. seen, s [none]; " O " [observation] small built, [no] distress, wt [weight] 112 pounds; A/P [Assessment/Plan] Senile Dementia, Elephentiasis, Cataract, P: Supp [supportive care]	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #2 & #3, Resident #64, #6** Refer to page 16 for response.	

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

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F 157	Continued From page 18 A review of a Physician ' s Progress Notes " Attending " dated 5/29/15, 7:50 PM revealed " pt. seen, reviewed labs and meds. " S " [none] " O " observation: [unclear writing] alert, disoriented, built small and frail, wt 88 pounds, A/P severe Dementia ...Plan: ADL [Activities of Daily Living], pt. will lose wt 20, Dementia (expected), pt. should be DNR [do Not Resuscitate], do Not Send to Hospital. " There was no evidence that the physician was notified of the 28 pound weight loss between March and April when it was first identified. A review of the NP [Nurse Practitioner] noted dated 6/17/15 [June 17, 2015] 2:40 PM revealed " asked to evaluate resident secondary progressive weight loss. She has severe dementia with increased risk for dysphagia and weight loss ...Resident has poor appetite and eats only some foods offered to [him/her.] Resident is alert, verbally responsive, but oriented to person only ...P:start Remeron 7.5 mg [milligrams] po [by mouth] QHS [at bed time] for appetite stimulant ... " There was no evidence that the NP was notified of the 28 pound weight loss when it first identified in April 2015 which was indicative of a 25% or more weight loss. Interviews:	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #2 & #3, Resident #64** Refer to page 16 for response.	

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F 157	Continued From page 19 A face-to-face interview was conducted with Employees' #26 and #27 on September 17, 2015 at approximately 9:50 AM regarding how is the dietician notified of weight changes. Employee #26 stated that after nursing takes the weight we [dietary] review the weights and then we will request a reweight. Employee #26 acknowledged that a reweight should have been conducted and the resident should have been placed on weekly weights. Employee #26 also acknowledged that the facility obtained new scales in April 2015 and the weights were stable since April on and the resident ' s condition nor behavior changed. A face-to-face interview was conducted on September 17, 2015 at approximately 9:00 AM with Employee #3. He/she stated that after review of the aforementioned, he/she believed the change was due to the new scales (weighing equipment). In summary, Resident #6 sustained a 28 pound weight loss from March 2015 to April 2015. There was no evidence that the physician was notified of the weight change. The record was reviewed on September 17, 2015. 5. Facility staff failed to notify the physician when Resident #5, a ventilator dependent resident demonstrated an elevated heart rate and subsequent compromise in respiratory function. A review of Resident #5's quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of April 22, 2015 revealed diagnoses in Section I (Active Diagnoses) that	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **Response to #5, Resident #5** Refer to page 8 for response.	

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F 157	Continued From page 20 included: Hypertension, Tracheostomy, Respiratory Failure, and Ventilator. Physician's orders dated May 9, 2015 directed; " Vent [Ventilator] Settings: AC (Assist Control) Mode- Rate-10, VT- 400 [Tidal Volume]- FIO2 [Fraction Inspired Oxygen]- 40% Physician ' s Progress Notes: Pulmonary Note - June 1, 2015 at 1:45 PM revealed " Patient [resident] remains on vent. Responds to stimuli, no purposeful movements. Vent settings AC [mode of Assist Control] 10, VT [tidal volume] 500, PEEP [positive expiratory end pressure] +5, Fi02 [room air] 40%. Exam: vitals 104/72, P 69, R 18, T 97.9; CTA-[clear to auscultation bilaterally no wheezes; CVS [cardiovascular] no murmurs; Abd [abdomen] + [positive] bs [bowel sounds]; Ext [extremities] no edema ...A/P Assessment/Plan (1) chronic Respiratory Failure; (2) Encephalopathy secondary CVA [Cerebral Vascular Accident] - Continue on vent support - no weaning - supportive care. " MD [Medical Doctor] Acute Note - June 2, 2015 at 08:50 AM revealed " Responding to " Rapid Response. " Patient [Resident] identified with tachycardia [rapid heart rate] with HR [heart rate] 140, SBP [systolic blood pressure] 110, RR [respiratory rate] 20s-30s; SAT [Saturation] 96%, 100% Fi02 with ambu bagging. Emesis, tube feeding witnessed; lung (+) Rhonchi, R [right] CTA [clear to auscultation] left. CVS[Cerebrovascular system]: tachycardia ...ABD: distended...hypo [hypoactive] bowel sounds; ENT [Ear, Nose, Throat] edema BUE [bilateral upper extremities], R [right] > [greater	F 157		

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F 157	Continued From page 21 than] L [left]. Warm extremities; A/P [Assessment/Plan] : Respiratory Distress, R/O [rule out] aspiration/sepsis. Will send to ER [Emergency Room] via [by] 911. " A review of the nursing notes revealed the following: " May 31, 2015 4:50 AM - " Resident is alert and responsive. AM care given, vs [vital signs] 98.4 temperature, P [pulse] 77 R[respirations] 16, BP [blood pressure]127/68, Pulse OX [oximetry] 96%. No evidence of pain noted. Care given will continue to monitor ... " May 31, 2015 6:30 PM - " Resident is alert and responsive, due medications given as ordered. No abnormal findings noted. Vs T 98.2, P 86 R 20, BP 133/78. Pulse Ox 96%. Will continue to monitor. " June 1, 2015 4:00 PM - " Resident is alert and responsive PM care given. VS [vital signs] T [temperature] 98.6, P [pulse] 87, R [respirations] 20, BP [blood pressure] 130/77 Pulse OX [oximetry] 98%. Turned and repositioned, due meds given. " June 2, 2015 5:00 AM - " Resident is alert. On vent [ventilator dependent] for support. Trach [tracheostomy] and suction care provided. Total care with ADL [Activities of Daily Living]. Enteral Feeding in progress. Peg [percutaneous endoscopic gastrostomy] tube patent and flushed well. Will monitor. Vs [BP] 131/72, [P] 76, [R] 18, [T] 98.3. June 2, 2015- 8:35 AM- SBAR [standardized	F 157		

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communication in healthcare - S = Situation, B = Background, A = Assessment, R = Recommendation]/Acute change in condition note read: " Resident was noted with respiratory distress and an elevated HR [heart rate] of 140 [bpm/beats per minute]. Resident was bagged by RT [Respiratory Therapy] while Rapid Response was called. Rapid Response team responded ....In house officer gave new order to transfer resident via [by] 911 [Emergency]. Emesis [vomiting] noted x [times] 1 [one] during bagging with seizure like activity. Resident was then transferred via 911 to [local hospital]. "

Respiratory Therapy Notes:

A review of the Respiratory Ventilator Flow Sheet for June 2, 2015 revealed the following:

"Date: June 2, 2015
Time: 0025 [12:25 AM]
Mode: AC
Fi02: 40%
PEEP: 5
Saturation: 97%
Heart Rate: 70

Date: June 2, 2015
Time: 0345 [3:45 AM]
Mode: AC
Fi02: 40%
PEEP 5
Saturation: 98%
Heart Rate: 121

Date: June 2, 2015
Time: 08:20 [8:20 AM]
Mode: AC
Fi02: 40%

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 23	F 157		

PEEP: 5
Saturation: 99%
Heart Rate [HR]: 129

There was no documented evidence that the physician was notified in regards to Resident #5's increased heart rate from June 2, 2015 (3:45 AM) to June 2, 2015 (08:20 AM), which is indicative of approximately 4 hours.

A review of the respiratory therapy shift notes revealed:

June 2, 2015 [notes beginning June 1, 2015 7PM - 11:59 PM thru June 2, 2015 12 Midnight - 7AM] - 7pm-7am shift note revealed:
S: Pt on A/C mode
B: Respiratory resident
A: Sat 98% HR 71, RR [respiratory rate] 18 BS [breath sounds] Rhonchi/clear, sxn [suction] moderate yellow suction, no distress.
R: monitor

June 2, 2015 -7AM- 7PM Shift- " PT [Patient] transferred to area Hospital. "

The clinical record lacked evidence that facility staff assessed and monitored Resident #5 when the resident ' s heart rate increased. The physician was not notified when the resident became tachycardic (increased heart rate), which was first documented on June 2, 2015 at 3:45 AM, heart rate - 121. The resident ' s condition declined as evidenced by increased tachycardia (HR elevated to 129). A rapid response [a team of health care providers that responds to intervene when a resident shows signs of clinical deterioration to prevent respiratory of cardiac arrest] was called and the resident was

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	095027	A. BUILDING ____ B. WING ____	09/23/2015

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F 157	Continued From page 24 subsequently transferred to the Emergency room via 911 [Emergency Medical Services] according to the SBAR at the time of transport the resident's heart rate was 140. A face-to-face interview was conducted on September 21, 2015 at approximately 10:30 AM with Employees #18 and #47. Employee #18 stated that his/her shift was 7:00AM to 7:00PM. Employee #18 also stated, when he/she first saw the resident with the heart rate 129 is when the rapid response was called at approximately 8:20AM, the resident vomited when he/she was bagged [manually resuscitated using a bag valve mask]. Employee #47 stated when he/she was conducting rounds from the rooms assigned when he/she was called to the rapid response by Employee #18 who stated that the rapid response [team] took over, and that the resident had vomited when he/she was bagged and then the resident was sent out 911 with a heart rate at 140. The night shift nurse was not available for interview. There was no evidence that facility staff notified the physician in regards to Resident #5 who was ventilator dependent and first experienced an increase in heart rate and was subsequently sent out 911 [Emergency Services]. The clinical record was reviewed on September 21, 2015.	F 157		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and	F 246		

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F 246	Continued From page 25 preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for one (1) of 55 sampled residents, it was determined that facility staff failed to ensure provision of reasonable accommodation relative to transfer assistance to get out of bed for a resident that has a desire and is was unable to do so on their own (Resident #80) . The findings include: 1. Resident #80 was admitted with diagnoses to include Amyotrophic Lateral Sclerosis (neurologic disorder), Anemia, Stage IV Sacral Ulcer, and Respiratory Failure. During observations September 10, 2015 at approximately 8:00 AM and September 14, 2015 at approximately 2:00 PM, Resident #80 was observed in bed wearing a dress and multipodus boots bilaterally. Medical record review conducted on September 16, 2015 at approximately 3:20 PM revealed Resident #80 ' s Annual Minimum Data Set (MDS) dated April 2, 2015 revealed s/he is dependent for Activities of Daily Living (ADL ' s) to include bed mobility, transfers, dressing, eating. In addition, Section F-Preference for Customary Routine and Activities Item 0500.	F 246	**483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES** **Response to #1 Resident #80** 1. The care needs for resident #80 was assessed and an appropriate care plan was developed immediately upon notification of this deficiency. A schedule for resident #80 to be out of bed was also created. 2. ADL needs for dependent residents on each unit were reassessed and an appropriate care plan with specific interventions was developed. 3. All clinical staff were re-educated regarding assessment, and documentation of ADLs emphasizing the mouth care policy and the importance of oral health care. Create quarterly care plan review of all ADL dependent residents. 4. The Resident Care Coordinators (RCC) or designee will perform weekly rounds on each unit and documentation audits ensure ADLs are performed per care plan for dependent residents. Audit findings will be reported weekly to the Risk Management Subcommittee for three (3) months. The Respiratory Department will conduct monthly audits to respiratory orders. A monthly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months.	11.10.2015

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F 246	Continued From page 26 Interview for Activity Preference: "G. how important is it to you to go outside to get fresh air when the weather is good? - 1= Very Important " . During a follow-up visit with Resident #80 on September 16, 2015 at 3:30 PM, Resident #80 nodded in the affirmative when Employee #10 informed him/her that s/he would be getting out of bed and asked if that was okay with him/her. Review of the care plans revealed the facility staff failed to initiate a care plan relative to Activities of Daily Living for a resident who is dependent on the staff to meet those needs. On September 16, 2015 at 3:20 PM a face to face interview was conducted with Employee #10. When queried about Resident #80 ' s out of bed schedules and showers Employee #80 stated that the resident is unable to get showers and does not get out of bed. According to employee #10, his/her isolation and ventilator status prevent the resident from leaving the room to shower. The resident is provided complete bed baths in the room. Employee #10 was unable to provide further explanation relative to the resident not being able to get out of bed. On September 16, 2015 the facility staff subsequently provided documentation of a physician order and care plan with date of initiation of September 16, 2015. The facility failed to provide reasonable accommodation to meet the need for transfer assistance to get out of bed for a resident who is unable to do so their own.	F 246		

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F 253 SS=E

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 observations made during an environmental tour of the facility on September 14, 2015 at approximately 2:30 PM and on September 16, 2015 at approximately 10:00 AM, it was determined that facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by marred walls in 23 of 42 resident's rooms, stained ceiling tiles in two (2) of 42 rooms, non-functioning sink hoopers on the fourth, fifth and sixth floor, marred entrance doors in 30 of 87 resident's rooms in the facility, wall lights that were out of order in two (2) of 42 resident's rooms surveyed, and broken ceiling lights in one of 42 resident's rooms surveyed, one (1) of one (1) expired eyewash solution in the utility room on the fifth floor and one (1) of one (1) eyewash solution with a missing cap in the utility room on the sixth floor.

The findings include:

1. Walls in resident's rooms were marred including rooms # 4111, # 4112, # 4115, # 4118, # 4119, # 4123, # 4132, # 4144, # 4153, # 4157, # 5102, # 5119, # 5133, # 5142, # 5143, # 5149, # 5156, # 5157, # 6119, #

F 253

483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

Response to #1, #2, #4

1. Immediately upon notification of these deficiencies the marred walls; marred entrance doors; stained ceiling tiles; non-functional bed wall lights; and ceiling lights were painted, repaired and/or replaced in the identified areas.

   The clinical sink hoppers located in the soiled utility rooms of each floor were repaired and functional, allowing complete water exchange when flushed.

   The expired eyewash on the 5th floor and the eyewash solution with a missing cap on the 6th floor was immediately replaced.

2. Environmental rounds were performed by the Interim Administrator and Maintenance Supervisor to identify additional areas out of compliance. Those rooms identify will be placed on a maintenance/repair schedule. An audit of all eyewash solutions was throughout the facility was completed, replacing any found expired.

3. Environmental Surveillance Rounds will continue to include Facilities Director, Maintenance Supervisor and EVS Supervisor.

   An electronic work order system was established to submit and track completion.

   An Environment of Care Committee (EOC) was formed to monitor maintenance/repair activities based on findings from the surveillance rounds and electronic work order system

4. The Facilities Director or designee will audit the work order system and surveillance round findings to ensure EOC activities are addressed. A compliance summary will be reported to the EOC Committee and Quality Assurance Committee monthly.

Completion date: 11.10.2015 & ongoing

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F 253	Continued From page 28 6129, # 6138, # 6146, # 6156, a total of 23 of 42 rooms surveyed. 2. Ceiling tiles were stained in resident room # 5156, # 5149, two (2) of 42 resident's rooms surveyed. 3. Three (3) of three (3) clinical sinks hoppers located in soiled utility rooms on the fourth, fifth and sixth floor (One per floor) failed to flush and were not functioning as intended. 4. Entrance doors to resident's rooms were marred including rooms # 4104, # 4123, # 4130, # 4132, # 4139, # 4144, # 4155, # 4156, # 4157, # 5102, # 5104, # 5106, # 5110, # 5111, # 5113, # 5116, # 5127, # 5130, # 5131, # 5132, # 5135, # 5142, # 5143, # 5146, # 5149, # 6113, # 6116, # 6145, # 6150 and # 6155, a total of 30 of 87 rooms in the facility. 5. Over the bed wall lights were not functioning when tested in resident's room # 5133 and # 6156, two (2) of 42 resident's rooms surveyed. 6. Three (3) of three (3) ceiling lights were out in room # 6146. 7. One (1) of one (1) eyewash solution located in the utility room on the fifth floor was expired as of February 2015 and one (1) of one (1) eyewash solution located in the utility room on the sixth floor was missing a missing a cap and could not be used as intended.	F 253		

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F 253	Continued From page 29 These observations were made in the presence of Employee #8 who acknowledged the findings.	F 253		
F 272 SS=E	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; 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		

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F 272	Continued From page 30	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.**	
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for 17 of 55 sampled residents, it was determined that facility staff failed to identify the location and date of Care Area (CAA)information on the admission, annual or significant change Minimum Data Sets (MDS) under Section V [V0200A]. Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141. The findings include: According to Chapter 4 of the MDS 3.0 Users ' Manual, " for each triggered care area, indicate the date and location of the CAA documentation ...CAA documentation should include information on the complicating factors, risks and any referrals for the resident for this care area ... " 1.Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. " Care Area Assessment Summary " of the significant change minimum data set for Resident #5. A review of Resident #5 ' s significant change MDS dated July 21, 2015 revealed the Care Areas and ' addressed ' in Care Plan triggered for #2 Cognitive Loss, #3 Visual Function, #4 Communication, #6 Urinary Incontinence/Catheter, #7 Psychosocial Well-Being, #10 activities, #11 Falls, #12		1. MDSs for residents #5, #6, #27, #43, #49, #63, #79, #80, #86, and #141 were reviewed and corrected on 10.28.2015. Residents' #9 and #122 no longer resides in the facility, therefore no further measures could be taken. Residents #41, #46, #51, #129, and #132 expired prior to identification of this deficiency therefore no further measures could be taken. 2. MDS Coordinators performed an audit of the medical record for any residents impacted by this deficiency, correcting those found out of compliance. 3. The MDS Coordinator revised the current MDS Audit Tool for retrospective reviews of the medical record to include monitoring of CAAs completion. The CAA worksheet, provided through the Electronic Charting System (ECS), will be used by the MDS Coordinators during Interdisciplinary Team meetings. 4. MDS Coordinators will perform weekly audits, reviewing findings during the IDT meeting. A monthly summary of the audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months.	11.10.2015

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F 272	Continued From page 31	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS**	

Nutrition, #13 Feeding Tube, #14 Dehydration/fluid Maintenance, #16 Pressure Ulcers.

The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #2, #3, #4, #6, #7, #10, #11, #12, #13 #14, #16] was not included in the documentation line for the corresponding triggered care area.
There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA ' s.

A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated " No matter how much information I [Employee #7] write in the area of " Location and Data of CAA documentation ' , the program defaults to only stating " CAA 3.0 9/16/15 (which is today ' s date.)

Facility staff failed to provide date and location of Care Area Assessment [CAA] information on the MDS under Section V [V0200].

2. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. " Care Area Assessment Summary " of the quarterly minimum data set for Resident #6.

A review of Resident #6 ' s admission ' s MDS dated February 15, 2015 revealed the Care Areas and ' addressed ' in Care Plan triggered for #2 Cognitive Loss, #3 Visual Function, #4

Response to #1 - #17
Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.

Refer to page 31 for response.

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F 272	Continued From page 32 Communication, #5 ADLs [Activity of Daily Living]/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, #16 Pressure Ulcers. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #2, #3, #4, #5, #6, #11, #12, #16] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA ' s. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated " No matter how much information I [Employee #7] write in the area of " Location and Data of CAA documentation ' , the program defaults to only stating " CAA 3.0 9/16/15 (which is today ' s date.) Facility staff failed to provide date and location of Care Area Assessment [CAA] information on the MDS under Section V [V0200]. 3. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. " Care Area Assessment Summary " of the admissions minimum data set for Resident #9. A review of Resident #9 ' s admission ' s MDS dated May 21, 2015 revealed the Care Areas and	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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F 272	Continued From page 33 ' addressed ' in Care Plan triggered for #5 ADLs [Activity of Daily Living]/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, #14 Dehydration/fluid Maintenance, #16 Pressure Ulcers and #17 Psychotropic Medication Use. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #5, #6, #11, #12, #14, #16, #17] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA ' s. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated " No matter how much information I [Employee #7] write in the area of " Location and Data of CAA documentation ' , the program defaults to only stating " CAA 3.0 9/16/15 (which is today ' s date.) Facility staff failed to provide date and location of Care Area Assessment [CAA] information on the MDS under Section V [V0200]. 4. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], ' Care Area Assessment Summary ' of the Annual Minimum Data Set [MDS] for Resident #27.	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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F 272	Continued From page 34 A review of Resident #27's Annual MDS with an Assessment Reference Date (ARD) of September 4, 2015 lacked evidence of the location in the clinical record where the information related to the triggered care areas could be found. A face-to-face interview was conducted with Employee #7 on September 16, 2015 at approximately 10:50 AM. He/she acknowledged the findings. The records were reviewed September 16, 2015. 5. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. " Care Area Assessment Summary " of the admission ' s minimum data set for Resident #41. A review of Resident #41 ' s admission ' s MDS dated November 25, 2014 revealed the Care Areas and ' addressed ' in Care Plan triggered for #2 Cognitive Loss, #4 Communication, #6 Urinary Incontinence/Catheter, #7 Psychosocial Well-being, #10 Activities, #11 Falls, #12 Nutrition, #13 Feeding tube(s), #14 Dehydration/Fluid Maintenance, #16 Pressure Ulcers and #18 Physical Restraints. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #4, #5, #6, #11, #12, #14, #16, #17, #18] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING ______ B. WING ______	09/23/2015

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F 272	Continued From page 35 regarding information related the CAA ' s. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated " No matter how much information I [Employee #7] write in the area of " Location and Data of CAA documentation ' , the program defaults to only stating " CAA 3.0 9/16/15 (which is today ' s date.) Facility staff failed to provide date and location of Care Area Assessment [CAA] information on the MDS under Section V [V0200]. 6. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], ' Care Area Assessment Summary ' of the Annual Minimum Data Set [MDS] for Resident #43. A review of Resident #43's Annual MDS with an Assessment Reference Date (ARD) of March 8, 2015 lacked evidence of the location in the clinical record where the information related to the triggered care areas could be found. A face-to-face interview was conducted with Employee #7 on September 16, 2015 at approximately 10:50 AM. He/she acknowledged the findings. The records were reviewed September 16, 2015. 7. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], ' Care Area Assessment	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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 272	Continued From page 36 Summary ' of the Admissions Minimum Data Set [MDS] for Resident #46. Admission Minimum Data Set dated April 11, 2015 revealed the Care Areas and the Care Planning Areas triggered for Cognitive Loss, Communication, Urinary Incontinence/Catheter, Psychosocial Well-being, Activities, Falls, Nutrition, Feeding Tube(s), Dehydration/ Fluid Maintenance, Dental Care, and Pressure Ulcers. The medical record revealed the following documentation in the space for the location and date of the CAA information: Psychosocial Well-being and Activities as " CAA 3.0 04/16/15 " and Cognitive Loss, Communication, Urinary Incontinence/Catheter, Falls, Nutrition, Feeding Tube(s), Dehydration/ Fluid Maintenance, Dental Care and Pressure Ulcers as " CAA 3.0 04/17/15 " Further review of the CAA Worksheet provided by the facility staff revealed that the facility staff did not document the date and location for the aforementioned care areas in the medical record related to the Care Area Assessment. A face to face interview was conducted with Employee #7 on September 15, 2015 at approximately 10:30 AM regarding the completion of the Care Area Assessment information on the Minimum Data Set under Section V0200. S/he stated that the computer software does not allow for the documentation into the " Location and Date of CAA Documentation " field of the Minimum Data Set. The information is entered on the CAA Worksheet. The findings were reviewed, discussed, and acknowledged that the location	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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 272	Continued From page 37 and/or date were not documented in the medical record. 8. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], ' Care Area Assessment Summary ' of the Annual Minimum Data Set [MDS] for Resident #49. A review of Resident #49' s Annual MDS with an Assessment Reference Date (ARD) of March 15, 2015 lacked evidence of the location in the clinical record where the information related to the triggered care areas could be found. A face-to-face interview was conducted with Employee #7 on September 16, 2015 at approximately 10:50 AM. He/she acknowledged the findings. The records were reviewed September 16, 2015. 9. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], ' Care Area Assessment Summary ' of the Annual Minimum Data Set [MDS] for Resident #51. A review of Resident #51' s Annual MDS with an Assessment Reference Date (ARD) of April 20, 2015 lacked evidence of the location in the clinical record where the information related to the triggered care areas could be found. A face-to-face interview was conducted with Employee #7 on September 16, 2015 at approximately 10:50 AM. He/she acknowledged	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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F 272	Continued From page 38	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS**	

the findings. The records were reviewed September 16, 2015.

10. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], ' Care Area Assessment Summary ' of the Annual Minimum Data Set [MDS] for Resident #79.

A review of Resident #79's Annual MDS with an Assessment Reference Date (ARD) of July 3, 2015 lacked evidence of the location in the clinical record where the information related to the triggered care areas could be found.

A face-to-face interview was conducted with Employee #7 on September 16, 2015 at approximately 10:50 AM. He/she acknowledged the findings. The records were reviewed September 16, 2015.

Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], ' Care Area Assessment Summary ' of the Annual Minimum Data Set [MDS] for Resident #64.

11.Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], ' Care Area Assessment Summary ' of the Significant Change in status Minimum Data Set [MDS] for Resident #64

Response to #1 - #17
Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.

Refer to page 31 for response.

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F 272	Continued From page 39 A Significant Change in Status Assessment (SCSA) dated August 9, 2015 revealed the Care Areas and Care Planning Decisions triggered for Visual Function, ADLs/ Functional Status, Urinary Incontinence/ Catheter, Falls, Nutrition, Feeding Tube(s), Dehydration/ Fluid Maintenance, Dental Care, and Pressure Ulcers. The medical record review revealed the following documentation in the space for location and date of the CAA documentation: Nutrition, Feeding Tube(s), and Dehydration/ Fluid Maintenance as " CAA 3.0 08/03/15 " ; and Visual Function, ADLs/ Functional Status, Urinary Incontinence/ Catheter, Falls, Dental Care, and Pressure Ulcers as " CAA 3.0 08/11/2015. Further review of the CAA Worksheet provided by the facility staff revealed that the facility staff did not document the date and location for the aforementioned care areas in the medical record related to the Care Area Assessment. A face-to-face interview was conducted with Employee #7 on September 15, 2015 at approximately 10:30 AM regarding the completion of the Care Area Assessment information on the Minimum Data Set under Section V0200. S/he stated that the computer software does not allow for the documentation into the " Location and Date of CAA Documentation " field of the Minimum Data Set. The information is entered on the CAA Worksheet. The findings were reviewed, discussed, and acknowledged that the location and/or date were not documented in the medical record.	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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 272	Continued From page 40 12. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], ' Care Area Assessment Summary ' of the Annual Minimum Data Set [MDS] for Resident #80 Annual Minimum Data Set (MDS) dated April 2, 2015 revealed the Care Areas and the Care Planning Areas triggered for Cognitive Loss, Communication, Urinary Incontinence/Catheter, Activities, Falls, Nutrition, Feeding Tube(s), Dehydration/ Fluid Maintenance, Dental Care, and Pressure Ulcers. The medical record review revealed the following documentation in the space for location and date of the CAA documentation for all the aforementioned Care Areas as: " CAA 3.0 04/20/2015 " Further review of the CAA Worksheet provided by the facility staff revealed that the facility staff did not document the date and location for the aforementioned care areas in the medical record related to the Care Area Assessment. A face to face interview was conducted with Employee #7 on September 15, 2015 at approximately 10:30 AM regarding the completion of the Care Area Assessment information on the Minimum Data Set under Section V0200. S/he stated that the computer software does not allow for the documentation into the " Location and Date of CAA Documentation " field of the Minimum Data Set. The information is entered on the CAA Worksheet. The findings were reviewed, discussed, and acknowledged that the location and/or date were not documented in the medical	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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F 272	Continued From page 41 record. 13. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. "Care Area Assessment Summary " of the admissions minimum data set for Resident #86. A review of Resident #86 ' s admission ' s MDS dated June 5, 2015 revealed the Care Areas and ' addressed ' in Care Plan triggered for #4 communication, #5 ADLs [Activity of Daily Living]/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, and #16 Pressure Ulcers. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #4, #5, #6, #11, #12, #16] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA ' s. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated " No matter how much information I [Employee #7] write in the area of " Location and Data of CAA documentation ' , the program defaults to only stating " CAA 3.0 9/16/15 (which is today ' s date.)	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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F 272	Continued From page 42	F 272		

Facility staff failed to provide date and location of Care Area Assessment [CAA] information on the MDS under Section V [V0200].

14. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. "Care Area Assessment Summary " of the significant change minimum data set for Resident #122.

A review of Resident #122 ' s significant change MDS dated July 27, 2015 revealed the Care Areas and ' addressed ' in Care Plan triggered for #3 Visual Function, #5 ADLs [Activity of Daily Living]/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, and #16 Pressure Ulcers and #17 Psychotropic Medication Use.

The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #3, #5, #6, #11, #12, #16, #17] was not included in the documentation line for the corresponding triggered care area.

There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA ' s.

A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated " No matter how much information I [Employee #7] write in the area of " Location and Data of CAA documentation ' , the program defaults to only stating " CAA 3.0 9/16/15 (which is today ' s

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F 272	Continued From page 43 date.) Facility staff failed to provide date and location of Care Area Assessment [CAA] information on the MDS under Section V [V0200]. 15. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. " Care Area Assessment Summary " Admissions Minimum data set for Resident #129. Admission Minimum Data Set dated July 15, 2015 revealed the Care Areas and the Care Planning Areas triggered for Cognitive Loss, Visual Function, Communication, Urinary Incontinence/Catheter, Psychosocial Well-Being, Activities, Falls, Feeding Tube(s), Dehydration/ Fluid Maintenance, and Pressure Ulcers. The medical record review revealed the following documentation in the space for location and date of the CAA documentation for Dehydration/ Fluid Maintenance and Feeding Tube(s) as " CAA 3.0 07/08/2015 " ; Psychosocial Well-Being and Activities as " CAA 3.0 07/15/2015 " ; and Cognitive Loss, Visual Function, Communication, ADLs/Functional Status, Urinary Incontinence/ Catheter, Falls, and Pressure Ulcers as " CAA 3.0 07/23/2015 " . Further review of the CAA Worksheet provided by the facility staff revealed that the facility staff did not document the date and location for the aforementioned care areas in the medical record related to the Care Area Assessment. A face to face interview was conducted with	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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F 272	Continued From page 44 Employee #7 on September 15, 2015 at approximately 10:30 AM regarding the completion of the Care Area Assessment information on the Minimum Data Set under Section V0200. S/he stated that the computer software does not allow for the documentation into the "Location and Date of CAA Documentation " field of the Minimum Data Set. The information is entered on the CAA Worksheet. The findings were reviewed, discussed, and acknowledged that the location and/or date were not documented in the medical record. 16. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. "Care Area Assessment Summary" Admissions Minimum data set for Resident #132. Admission Minimum Data Set dated May 28, 2015 revealed the Care Areas and the Care Planning Areas triggered for Cognitive Loss, Visual Function, Communication, Urinary Incontinence/Catheter, Psychosocial Well-Being, Activities, Falls, Nutrition, Feeding Tube(s), Dehydration/ Fluid Maintenance, and Pressure Ulcers. The medical record review revealed the following documentation in the space for location and date of the CAA documentation for Nutrition, Feeding Tube(s), and Dehydration/Fluid Maintenance as " CAA 3.0 05/22/2015 " ; Cognitive Loss, Psychosocial Well-Being, and Activities as " CAA 3.0 05/27/2015 " ; Visual Function, Communication, ADLs/ Functional Status, Falls, and Pressure Ulcers as " CAA 3.0 06/09/2015 " .	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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F 272	Continued From page 45 Further review of the CAA Worksheet provided by the facility staff revealed that the facility staff did not document the date and location for the aforementioned care areas in the medical record related to the Care Area Assessment. A face to face interview was conducted with Employee #7 on September 15, 2015 at approximately 10:30 AM regarding the completion of the Care Area Assessment information on the Minimum Data Set under Section V0200. S/he stated that the computer software does not allow for the documentation into the "Location and Date of CAA Documentation " field of the Minimum Data Set. The information is entered on the CAA Worksheet. The findings were reviewed, discussed, and acknowledged that the location and/or date were not documented in the medical record. 17.Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. "Care Area Assessment Summary " of the admission ' s minimum data set for Resident #141. A review of Resident #141s admission ' s MDS dated July 27, 2015 revealed the Care Areas and ' addressed ' in Care Plan triggered for #4 Communication, #5 ADLs [Activity of Daily Living]/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, and #14 Dehydration/Fluid Maintenance, #16 Pressure Ulcers and #17 Psychotropic Medication Use, and #19 Pain. The record revealed that the location and date	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	

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F 272	Continued From page 46 including information on the complicating factors, risks, and any referrals for this resident [for care areas #4, #5, #6, #11, #12, #14, #16, #17, #18] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA 's. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated " No matter how much information I [Employee #7] write in the area of " Location and Data of CAA documentation ' , the program defaults to only stating " CAA 3.0 9/16/15 (which is today ' s date.) Facility staff failed to provide date and location of Care Area Assessment [CAA] information on the MDS under Section V [V0200].	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to #1 - #17** **Residents' #5, #6, #9, #27, #41, #43, #46, #49, #51, #63 #79, #80, #86, #122, #129, #132 and #141.** Refer to page 31 for response.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	**483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **Residents' #21, #64 and #122.** Refer to page 49 for response	

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
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F 279	Continued From page 47 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview for three (3) of 55 sampled residents, it was determined that facility staff failed to initiate a care plan with goals and approaches for visual function for two (2)) residents and one (1) resident with pressure ulcers. Residents' #21, #64 and #122 The findings include: 1. Facility staff failed to initiate a care plan with goals and approaches to address visual function for Resident #21. A history and physical dated January 30, 2015 revealed Resident #21 diagnoses included Hypertension, [Status Post] Left Total Hip Replacement and Dementia. A review of the residents annual Minimum Data Set (MDS) with a Assessment Reference Date of September 1, 2015 revealed in Section B1000 (Vision) the resident was coded " 1 " for Impaired - sees large print, but not regular print in	F 279	**483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **Residents' #21, #64 and #122.** Refer to page 49 for response	

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F 279	Continued From page 48 newspapers/books; Section B1200 Corrective Lenses (contact, glasses, or magnifying glass) used in completing B1000, vision was coded " 0 " No. Further review of the annual MDS identified that Visual Function care area triggered and Care planning decision was checked indicating that the care area would be addressed in the care plan. A review of the comprehensive care plans updated August 15, 2015 lacked evidence of problem identification, goals and approaches to manage the resident ' s visual function. Facility staff failed to initiate a care plan with goals and approaches for Resident #21 for visual function. A face-to-face interview was conducted with Employee #12 on September 14, 2015 at approximately 3:00 PM regarding the aforementioned findings. He/she acknowledged the findings. The clinical record was reviewed on September 14, 2015. 2. Facility staff failed to develop an individualized care plan with goals and approaches for Resident #64's pressure ulcers. Resident #64 was admitted on May 4, 2015 with diagnoses which included Surgical Wound, Sacral Wound, and Nutritional Deficit with Deconditioning. Medical record review revealed physician orders on the September 2015 Physician Order Form for	F 279	**483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **Response to #1 - #3** **Residents' #21, #64 and #122** 1. An individualized care plan, to include care interventions and goals, for visual function was implemented for resident #21 immediately upon notification of this deficiency. Physician assessed resident #122 vision and appointment scheduled for follow-up and ophthalmologist care plan updated. A comprehensive pressure ulcer care plan, to include care interventions and goals, was developed and implemented for resident #64. 2. The Resident Care Coordinators (RCC) performed an audit of all residents who triggered for impaired vision and pressure ulcers in the previous quarter. Findings were reviewed and corrected as needed. 3. Standardize documentation for care planning to create an integrated interdisciplinary care plan that will identify the problem, measureable goals and interventions/approaches. The DON/Administrator will in-service the Interdisciplinary Team on the care planning process. The MDS Coordinator will re-educate the department managers on the process to electronically view MDS care area triggers for all residents. 4. MDS Coordinators will perform weekly audits to ensure discussions related to trigger CAAs are reviewed and addressed by the IDT during care planning meetings. A monthly summary of the audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months.	11.10.2015

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F 279	Continued From page 49 the following sacral wound treatments: Calmoseptine " apply to affected area sacral/ perineal area after each incontinence care with original order date May 5, 2015; and " Sacrum Wound: Cleanse with Normal Saline, pat dry, then soak Kerlix with Dankin ' s Solution [Half Strength] every shift " with original order date May 8, 2015. The medical record contains no further order changes relative to the treatment of sacral wound. Review of the care plan dated May 6, 2015 through September 6, 2015 listed Pressure Ulcer: Sacral Stage IV with potential for delay healing due to multiple contributors as a problem. An entry dated May 6, 2015 stated the goal as: " Ulcer will be healed without complication; Ulcer will be clean and free of odor " . Nursing interventions to this problem include " Wound status: size of wound: measurements of depth and width, skin color, surrounding skin tissue assessment weekly, complaints of pain, effectiveness of pain medication per MD order; Apply medicated ointment per MD order; Apply dressing per MD order (space for order specific is blank); keep Dietary informed of wound status: Freq: PRN; Notify physician of wound status of change in or deterioration in status of wound; and Air mattress to promote wound healing " . The sections for Dietary, Social Services, and Activities intervention were blank with no interventions indicated. Nurse 's notes and Nutrition Risk Assessment dated May 5, 2015 documented the presence of a 16 X 18 X 3 centimeter Stage 4 pressure ulcer on sacrum. The presence ulcer was documented as present on admission May 4, 2015. The most recent wound assessment was documented as	F 279	**483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **Residents' #21, #64 and #122.** Refer to page 49 for response.	

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F 279	Continued From page 50 15 X 16 X 3.5 centimeters on August 31, 2015 with the " narrative: 08/31/15 unable to assess Resident. {She} said she is sick, pain though pain med has been given & N/V (and nausea and vomiting). Nurse aware" . The care plan did not include information on individualized interventions, or changes to plan of care to promote healing of pressure, and/or measurable goals for present on admission pressure ulcer to sacrum. The facility staff failed to develop a care plan with measureable goals and/or interventions to promote healing for Resident #64. A face-to-face interview with Employee #11 was conducted on September 16, 2015 at approximately 10:14 AM. S/he stated that family is very involved in the care and new orders were obtained the day prior to transfer to the hospital. He/she was unable to provide any further insight into omission to develop a care plan with measureable goals and interventions related to the pressure ulcer. The clinical record was reviewed on September 16, 2015 3. Facility staff failed to initiate a care plan with goals and approaches for Resident #122's visual function. A review of the residents Admission 's sheet indicated that the resident was admitted to the facility on April 16, 2015. According the History and Physical the resident has the following diagnoses which included: "Multiple CVA 's (Cerebral Vascular Accidents), Chronic Respiratory Failure - Off Vent [Ventilator], Asthma	F 279	**483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **Residents' #21, #64 and #122.** Refer to page 49 for response.	

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F 279	Continued From page 51 ..." A review of the residents Admissions Minimum Data Set (MDS) dated April 23, 2015 and Significant Change MDS dated July 27, 2015 revealed in Section B1000 Vision the resident was coded " 1 " for Impaired - sees large print, but not regular print in newspapers/books; Section B1200 Corrective Lenses (contact, glasses, or magnifying glass) used in completing B1000, vision was coded " 0 " No. An observation and interview was conducted with Resident #122 on September 21, 2015 at approximately 11:00 AM. The resident indicated that he/she wears glasses, and that the glasses were on the dresser, however I prefer different glasses. The resident also stated that he/she could see out of the right eye and not the left eye. Further review of the admissions and significant change MDS identified that #Visual Function care area triggered and Care planning decision was checked indicating that the care area would be addressed in the care plan. There was no evidence in the clinical record that a care plan was initiated to address Resident #122's visual function. A face-to-face interview was conducted on September 21, 2015 with Employee #10 at approximately 11:30 AM. After review of the above he/she acknowledged the findings. The clinical record was reviewed on September 21, 2015. Facility staff failed to initiate a care plan with goals and approaches for Resident #122's visual	F 279	**483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **Residents' #21, #64 and #122.** Refer to page 49 for response.	

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F 279	Continued From page 52 function.	F 279		
F 282 SS=K	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 observation, clinical record review, review of employee personnel files and staff interviews, it was determined that the facility failed to ensure that 20 of 20 licensed nurses assigned to provide ventilator services for 12 of 12 ventilator dependent residents were qualified and competent as evidenced by a lack of documentation in personnel records of training, experience and competencies to verify qualifications in ventilator management, and staff failure to identify the way the ventilator delivers a breath to the resident, if the resident initiated breaths on the ventilator, if the ventilator delivered a set breathing rate, and how the ventilator assisted the resident ' s breathing (mechanics of ventilation). Resident #98. Subsequently, Residents #13, 37, 80, 98, 100, 111, 134, 135, 137, 138, and 142 also had the potential to be effected by this deficient practice. The findings include: An Immediate Jeopardy (IJ) was identified at CFR 483.20 Resident Assessment; F282 (Failure to ensure that licensed nurses assigned to provide	F 282	**483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** Residents' #98. Refer to page 59 for response	

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F 282	Continued From page 53	F 282	**483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN**	

ventilator services were qualified and competent). The facility's Administrator provided a letter noting a corrective action plan and the IJ was removed on September 25, 2015 at 6:00 PM. Subsequently, the deficiency was identified at a scope and severity of "E."

Facility staff failed to ensure that licensed nurses assigned to provide ventilator services were qualified and competent.

During the survey period interviews conducted with licensed nursing staff assigned to provide ventilator services to residents revealed a lack of knowledge in the mechanics of ventilation, ventilator function and its correlation to the resident's respiratory status. An example to reflect this determination is delineated in the deficiency documented for Resident #98.

Facility Policies:

The facility policy dated May 15, 2015, titled ' Ventilator Management and Nursing Care Respiratory Education ' detailed the following information: " care of the tracheostomy tube...modes of ventilation...alarms and common causes...breath sounds assessment...weaning, and patient suctioning. " [This document was provided to the State Agency on September 22, 2015 by the Facility Administrator [Employee #1].

The policy entitled, ' Ventilator Settings Definitions ' (no initiated or revised date) included the following information: "Mode: The way a breath is delivered, Assist Control: A/C,

Residents' #98.

Refer to page 59 for response

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F 282	Continued From page 54 Synchronized Intermittent Ventilation: SIMV, Continuous Positive Airway Pressure CPAP Rate: (bpm- breath per minute), usually set at 8-12 breaths per minute, Tidal Volume: The amount of volume inhaled in the lungs. The ventilator delivers a pre-set volume of gas with each breath, Fi02: fraction of inspired oxygen [percent of oxygen a patient is inhaling], and Positive End Expiratory Pressure [PEEP]: Special setting on the ventilator that keeps the lungs expanded to help get oxygen from the lungs into the bloodstream. " [This policy was provided to the State Agency on September 22, 2015 by the Nurse Educator]. ? The facility policy #CP.603, last revised June 17, 2015, titled, ' Ventilator Weaning Protocol stipulates, " II. Policy: Protocol will be applied per physician's written order of Wean per protocol." On September 21, 2015 at approximately 9:30 AM, a review of the admission record revealed that Resident #98 was admitted on July 8, 2015 to the facility with a diagnosis that included Respiratory Failure. Physician's Orders: ? A physician's order dated July 8, 2015 revealed for the resident to have a mechanical ventilator [a mechanical machine that assists or replace spontaneous breathing] programmed at the following settings: A/C, Rate 10, Tidal Volume [VT] 500, Fi02 30%, and PEEP 5. ? A physician's order dated August 13, 2015 directed the following, "Initiate ventilator weaning protocol." [Defined by the National Institutes of	F 282	**483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** Residents' #98. Refer to page 59 for response	

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F 282	Continued From page 55 Health as the gradual withdrawal of ventilatory support through utilization of a variety of ventilator modes, periods of total spontaneous ventilation, and appropriate rest periods for muscle unloading [Respiratory therapy was responsible for initiating weaning]. <http://clinicalcenter.nih.gov/ccmd/cctrcs/pdf_docs/Ventilator%20Management/02-Ventilator%20Weaning.pdf> On September 21, 2015 at approximately 9:40 AM an observation of the ventilator settings for Patient #98 was noted as follows: A/C, Rate 12 VT 500 Fi02 40% PEEP 5 On September 21, 2015 at approximately 9:42 AM a review of the 'Ventilator Flow Sheet' completed by respiratory therapy [who adjusted the ventilator settings as per weaning protocol] during the period of September 1, 2015 to September 21, 2015 revealed the following documented ventilator settings: A/C Rate - 12 VT - 500 Fi02 - 40% PEEP - 5 Review of the "Nursing Respiratory Flow " sheet revealed the following recorded ventilator settings for the period of September 1, 2015 to September 21, 2015: A/C Rate - 10 VT - 500	F 282	**483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** Residents' #98. Refer to page 59 for response	

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F 282	Continued From page 56	F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Residents' #98. Refer to page 59 for response	

Fi02 - 30%
PEEP - 5

The documented assessment of ventilator settings recorded by the nursing staff on September 21, 2015 failed to correlate with the actual settings that reflected the respiratory status of the resident, as observed. Additionally, from September 1, 2015 to September 21, 2015, the documented assessment of ventilator settings recorded by the nursing staff failed to correlate with the actual settings documented by the respiratory therapist.

Interviews:

On September 21, 2015 at approximately 9:45 AM, a face-to-face interview was conducted with Employee #16, the registered nurse (RN) who was assigned to care for Resident #98. Employee #16 also confirmed that his/her assignment included the care of Residents #37, 98, 111, 134, 137, 138, who were all ventilator dependent. She was interviewed at the bedside of Resident #98, at the site of the ventilator. He/she was asked to observe Resident #98 and the ventilator, confirm the ventilator settings, describe the mode, the set rate, the resident's rate, and the resident's response to the ventilator. Employee #16 stated the rate was 12; but could not explain his/her documentation of a rate of 10 and Fi02 30% or describe the remaining requested information related to the nursing care for the specialized ventilator services.

On September 21, 2015 at approximately 10:30 AM a face-to-face interview was conducted with Employee #42, the licensed practical nurse (LPN)

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F 282	Continued From page 57 who was assigned to care for residents requiring ventilator services. Employee #42 was asked to observe Resident #98 and the ventilator, confirm ventilator settings, and describe the mode, the set rate, the resident's rate, and the resident 's response to the ventilator. Employee #42 explained the set rate of 12; however, he/she could not further describe the requested information related to the nursing care for the specialized ventilator services. On September 21, 2015 at approximately 10:45 AM a face-to-face interview was conducted with Employee #10, the nurse manager for the unit, regarding the aforementioned findings. He/she acknowledged the findings, stating that the respiratory therapy staff would hold an in-service for the nursing staff. On September 22, 2015 at approximately 9:30 AM a face-to-face interview was conducted with Employee #6, the Staff Development Coordinator, regarding ventilator management training provided to staff and the corresponding documented competencies. He/she stated, "I have no knowledge of ventilators, and I made administration aware of that when I took the job. I know the staff spends one day with a Respiratory Therapist." On September 22, 2015 at approximately 10:00 AM a face-to-face interview was conducted with Employee #31, regarding ventilator management training provided to staff and the corresponding documented competencies. He/she stated, "The nursing staff shadows a respiratory therapist for one day. I do not have a checklist or competencies for their training. That is the	F 282	**483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** Residents' #98. Refer to page 59 for response	

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F 282		F 282		

Continued From page 58
responsibility of the nursing department."

Employee Record Review:

On September 22, 2015 at approximately 1:00 PM, a review of 20 personnel records of staff, confirmed by Employee #10, who had taken care of residents requiring ventilator services lacked evidence that they were trained and/or had documented demonstration of competency in ventilator management. The following is a list of employee personnel records that were reviewed:

Registered Nurses

Employee #9
Employee #35
Employee #10
Employee #36
Employee #13
Employee #37
Employee #17
Employee #38
Employee #18
Employee #39
Employee #32
Employee #40
Employee #33
Employee #41
Employee #34

Licensed Practical Nurses

Employee #24
Employee #44
Employee #42
Employee #45

483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
Response to #A

1. Immediately upon notification of this deficiency a review of the competencies confirmed findings, however no adverse event occurred to resident #98.

   On 9/22-9/26, 10/7, all Registered and Licensed Practical Nurses assigned to the 6th floor ventilator unit by Respiratory Department were In-serviced on ventilator mechanics, to include ventilator settings function and their correlation to respiratory function was performed for all.

   The scope of practice for RN and LPNs were reviewed with nursing staff, as well as the implications for daily practice.

2. A review of the retrospective review of the medical records for all residents on vent weaning protocol was performed by the Resident Care Coordinator. Results of the audit found all residents were in compliance.

3. Continual skills and competency assessment related to vent management and airway maintenance, as well as the mechanics of the ventilator has been included in the annual requirements for all nursing staff and new hires.

   Residents on weaning protocol will be entered on 24-hour report to ensure communication of residents' status and order changes.

   Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. The Nursing Ventilator Flowsheet was revised and nursing instructed on the new format.

4. The RCCs will perform weekly audits of the nursing ventilator flowsheet to ensure settings reflect respiratory therapy ventilator flowsheet and audit the 24-hour report to ensure appropriate protocol related to residents' change in condition are followed.

   Results of the audits will be reported weekly to the Risk Management Subcommittee for any actions plans/recommendations if deemed necessary.
   A quarterly summary will be reported to the Quality Assurance Committee until 100% is consistently maintained for three (3) months.

Completion date: 11.10.2015

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	095027	A. BUILDING ______ B. WING ______	09/23/2015

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F 282	Continued From page 59 Employee #43 A review of the personnel records of licensed nursing staff assigned to provide ventilator services lacked evidence that the staff were adequately trained and/or had documented experience and competence in ventilator care services and airway management. Additional Interviews: ? On September 18, 2015 at approximately 3:30 PM, a face-to-face interview was conducted with Employee #4 (Assistant Director of Nursing) regarding the aforementioned findings. He/she was unaware that there was a problem regarding the nurses' knowledge and competence of care and treatment for ventilator dependent residents. On Tuesday September 22, 2015 at approximately 2:20 PM a face-to-face interview was conducted at approximately 2:28 PM with Employees' #2, #3, and #4. The employees made the following responses related to the quality concerns identified during the survey: ? On September 22, 2015 at approximately 2:20 PM Employee #3 stated that he/she was aware that a potential problem could arise, as a result of the knowledge deficit regarding the care and treatment of ventilator dependent residents. He/she stated it seemed very hard to make the necessary changes. ? On Tuesday September 22, 2015 at approximately 2:20 PM, Employees #3 and #4 acknowledged that Employee #6 [Staff Development Coordinator] had a knowledge	F 282	**483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** **Residents' #98.** Refer to page 59 for response.	

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F 282	Continued From page 60 deficit related to ventilator services and management, and he/she failed to ensure that nursing personnel assigned to care for residents that required the ventilator services received the education and training necessary to ensure proper care and treatment related to specialized ventilator services. In Summary: · Pursuant to the facility's practice and policy [last reviewed and signed by facility administration May 2015] nursing staff is required to demonstrate proficiency in Ventilator Management, Respiratory Care and Specialized services such as, care of the tracheostomy tube, modes of ventilation, alarms and common causes, breath sounds assessment, weaning, and patient suctioning. ? There was no evidence that nursing staff assigned to care for residents who required ventilator services received a comprehensive on-going in-service education/training related to ventilator management; and there was no documented evidence of competencies in the specialized area of ventilator management. ? There was no evidence that the Staff Development Coordinator was qualified and experienced in the area of ventilator management. ? There was no evidence that each nurse who was assigned to care for residents requiring	F 282	**483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** **Residents' #98.** Refer to page 59 for response.	

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F 282	Continued From page 61 ventilator services were trained in areas to address the resident's special health care needs.	F 282		
F 309 SS=J	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: A. Based on observations, record review and staff interview for five (5) of 55 sampled residents, it was determined that facility staff failed to provide the necessary care and services to ensure residents attain or maintain the highest practicable physical, mental, and/or psychosocial well-being as evidenced by facility staff ' s failure to: consistently assess and monitor the status of one (1) resident who exhibited a change in status as manifested by low blood pressure, increased respirations and tachycardia [rapid heart rate] and failed to administer a bronchodilator treatment [Duoneb] as ordered for the same resident; failed to perform an accurate assessment for one (1) resident who sustained a change in condition to include elevated heart rate, increased respirations, and decreased oxygen saturation; to consistently assess and monitor one (1) resident who was ventilator dependent and experienced tachycardia; assess and identify the need for one (1) resident who had an accumulated white coating on his/ her tongue; and failed to ensure	F 309		

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F 309 Continued From page 62

that one (1) resident wore protective head gear and that the head circumference was measured in accordance to physician's orders. Residents #145 (is affiliated with the immediate jeopardy scope and severity), #37, #5, #104 and #143.

An Immediate Jeopardy (IJ) was identified at 42 CFR 483.25; F309 Provide Care/ Services for Highest Well Being for Failure to prevent neglect: Lack of supervision for individuals with known special needs and Failure to monitor and intervene for serious medical conditions. The notification of the IJ was made on September 22, 2015 (Tuesday) at 2:20 PM.

The facility's Administrator provided a letter noting a corrective action plan inclusive of staff training on multiple aspects of the provision of respiratory care to licensed nursing staff and respiratory therapists. A review of the IJ action plan was removed on September 25, 2015 at 6:00 PM. Subsequently, the deficiency was identified at a scope and severity of "E."

The findings include:

1. Facility staff failed to identify, comprehensively assess and monitor Resident #145 when he/she demonstrated change in status as evidenced by repeated complaints of shortness of breath, refusal of respiratory treatments [CPAP - Continuous Positive Airway Pressure - breathing treatment] and alteration in level of arousal.

The resident began complaining of shortness of breath on August 29, 2015, refused CPAP treatments beginning August 28, 2015 and

F 309

483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Response to #A1-3, 5 Resident #145, #37, #5, #104

1. Immediately upon notification of this deficiency, the medical records for resident #145 and #5 were reviewed to verify findings. On 9/16/15, 1:1 education of the Respiratory staff involved was held on the timeliness of completing respiratory orders.

2. Nursing conducted a retrospective review of the 24-hr report for indications of status change, cross- referencing the medical record to ensure the physician is notified of any change in the resident's condition. The audit results found all medical records in compliance.

   Respiratory Therapist conducted medical record audits to identify new/changed orders and indications of missed orders. Those found out of compliance were addressed with the attending physician.

3. The clinical nursing staff were educated 9/22-9/26, 10/7 and ongoing by the Respiratory Department on the weaning protocol and related comprehensive assessment and interventions.

   The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable).

   The Respiratory staff were re-educated on 9/25/2015 related to the recognition of changes in resident's status, notification to physician and timeliness of completing physician orders,

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F 309	Continued From page 63 demonstrated an alteration in the level of arousal on August 31, 2015. On August 31st at approximately 9:03 PM, Resident #145 sustained low blood pressure, increased respirations and tachycardia. Subsequently, the resident was transferred to the nearest emergency room (ER) and was hospitalized in intensive care. Resident #145 was admitted on August 24, 2015. According to the admitting history and physical examination signed by the physician August 25, 2015, Resident #145 ' s diagnoses included Chronic Respiratory Failure, Status Post Tracheotomy-Continue on [Ventilator], Quadriplegia [secondary] to cervical spine injury, Non-Ischemic Cardiomyopathy, Congestive Heart Failure, Major Depression with Anxiety and Diabetes Mellitus Type II. According to clinical record entries documented by respiratory therapy; in S-BAR format [situation/background/assessment/recommendation] the following was revealed: [August 28, 2015 to] August 29, 2015 - " 7PM-7AM-Shift Report - " Patient refused CPAP trails last night; Sat = 99% [oxygen saturation], [Heart Rate] 79, [Respiratory Rate] 24. Alert [and] stable. Patient has a lot of thick tan to white (oral) secretions. Continue to encourage patient to get weaned ...CPAP 5/10 x10[minutes], back on AC [assist control] due to patient complaining of SOB [shortness of breath] " August 30, 2015 - " 7AM-7PM- Shift Report - " Received [patient] on AC mode, [nebulization treatment] given as ordered. [Patient]... (Illegible writing). [oxygen saturation] -99%, HR (illegible	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #A1-3, 5 Resident #145, #37, #5, #104** 3. Residents on weaning protocol will be entered on the 24 hour report to ensure notification of residents' status and order changes are communicated across shift. Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. 4. The Resident Care Coordinator (RCC) will perform weekly audits of the 24 hour report to ensure appropriate protocol related to residents' change in condition are followed per policy. Results of the audits will be reported weekly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months. The Respiratory Department will conduct monthly audits to respiratory orders. A monthly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months.	11.10.2015

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F 309	Continued From page 64 writing), Will continue to monitor patient. Special procedures done ...Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp [complaining] of SOB [shortness of breath], anxious. Placed back on AC [Assist Control] mode to rest. " [August 30, 2015 to] August 31, 2015- " 7PM-7AM- S- [Patient] is on AC 15/[Tidal Volume]-500, [Fractioned of Inspired Oxygen-45%, [Peep]-5, B- Respiratory Failure, A- Pt stable throughout shift- Sat-98%. HR-79, RR (Respiratory Rate) -21. Pt complains of being unable to breathe but in no apparent distress. Continue to monitor for changes. " August 31, 2015- " 7AM-7PM- S- Pt remains on AC mode, O [No] active weaning do [due] to pt being less arousable in PM. B- Respiratory failure, A- Alert [male/female], HR-84- RR-25, Sat-98%, small thin pale secretions, BS (breath sounds) clear, R- Will continue to monitor. " August 31, 2015 " Ventilator Flow Sheet " [recorded by respiratory therapist] revealed the following " Rate Set/Total " on the A/C mode: [Rate Set/Total defined: 15/34 - "15" reflects ventilator preset respiratory rate and " 34" reflects - resident breaths above the set rate] 0130 (1:30 AM) - 15/34 - [Oxygen] Saturation[normal range 95 - 100%] - 97%, Heart Rate- 87 0425 (4:25 AM) - 15/33 - [Oxygen] Saturation- 98%, Heart Rate-93 0855 (8:55 AM) - 15/32 - [Oxygen] Saturation-98%, Heart Rate-87 1230 (12:30 PM) - 15/33 - No Oxygen Saturation	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #A1-3, 5 Resident #145, #37, #5, #104** Refer to page 63 for response	

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F 309	Continued From page 65 and Heart Rate documented in the allotted space. [1700] 5:00 PM - 15/29 - [Oxygen] - 98%, Heart Rate-80 2045 (8:45 PM) - 15/23, Saturation 96%, Heart Rate- 158. " The nurse practitioner documented a change in Resident #145 as follows: August 31, 2015 [no time indicated] - Certified Registered Nurse Practitioner ... Initial " Psych [psychiatric] and Mental Status Exam: Information obtained from staff/chart/resident [not] easily arousable ... [Patient] not arousable and does not answer questions at this time. Staff reports resident Alert and Oriented x3- [time, person and place], but just received pain meds. Concerns/Findings: Per staff resident normally [Alert and oriented x3], responds to questions asked. On exam, resident responding to painful stimuli but not easily arousable and [he/she] opens eyes to name but does not answer question, (-) Insomnia, " + " [Positive] Anxiety, " + " mood and affect [secondary to medical complications/conditions per staff. Plans: Monitor for safety and fall precautions, monitor for worsening anxiety, [Follow-up] in one (1) week to reassess mood/and anxiety. " The record revealed that nursing staff communicated to the nurse practitioner that the resident was "not arousable " due to " just received pain medication ". However, a review of the August 2015 Medication Administration Record [MAR] revealed Tylenol 500mg 2 caplets were administered 30 minutes prior to wound treatment during the 7AM - 3PM shift on August 31, 2015. The specific time was not noted.	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5, #104 Refer to page 63 for response	

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F 309	Continued From page 66 Further review of the MAR revealed that Resident #145 received Tylenol 500mg 2 caplets 30 minutes prior to wound treatment during the period of August 25th through August 30, 2015. There was no documented evidence that Resident #145 sustained " lack of arousal " associated with any preceding dosages of Tylenol administration or " just received pain medication. " Nursing Notes: August 28, 2015 3:13 PM - " ...V/S [vital signs]: [b/p-blood pressure] 108/58; [P-pulse] 99; [R-respirations] 18 ... no acute distress noted " August 29, 2015 3:00 AM - " ... [b/p] 116/62; [P] 78, [R] 20 ... " August 31, 2015- 12:35 PM - Resident remain alert and responsive. Vent [ventilator] dependent AC mode for respiratory support. Suction PRN (as needed) ...V/S- [Blood Pressure] - 134/74, 98.9 [Temperature]-, 74, 100 [two (2) different heart rates] no respirations documented... S-BAR (Situation-Background-Assessment-Recommendation) /Acute Change in Condition Report: Situation- Date: August 31, 2015, Time: 9:39 PM [of note, this is the successive nursing note to the August 31st 12:35 PM entry] ... low B/P- 77/53, P-153, R-24, lethargy [and] gasping for breath, although on vent. Background: Respiratory Failure, Temp: 98.6, B/P- 77/53, RESP: 24, Pulse: 153, Lung sounds: Crackles, Pulse ox: 93% ventilator ... Resident was noted [with] [decreased] B/P 77/53, elevated pulse rate. House officer notified who ordered to transport	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #A1-3, 5 Resident #145, #37, #5, #104** Refer to page 63 for response	

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F 309	Continued From page 67 resident to [hospital] for further evaluation and treatment. " There was no evidence that licensed nursing and respiratory staff identified that Resident #145 exhibited progressive change in status (respiratory and mental) that warranted monitoring and/or intervention before the resident became obtunded, unresponsive with agonal breathing requiring transfer to higher level of care. August 31, 2015- 2103 (9:03 PM) - Hospitalist [physician] Note: I was called to evaluate [Resident #145] b/c (because) of hypotension, tachycardia, [and] acute AMS gradually since few hours ago. [His/her] HR (heart rate) has been elevated to 150 ' s [and] B/ P as low as 77/53. As per nurse even to earlier today [he/she] was A&O (alert and oriented), but currently [he/she] is obtunded (diminished arousal and awareness) [and] unresponsive with agonal (gasping) breathing. [He/she] is quadriplegic. Assessment/Plan: Acute AMS [and] hypotension- unknown cause ([he/she] finished [his/her] IV (Intravenous) Cipro (antibiotic) yesterday [and] Diflucan (anti-fungal medication) was discontinued). Transfer to nearest ER (Emergency Room). " The clinical record lacked evidence that nursing notified the physician regarding the resident's progressive complaint of having shortness of breath, refusing CPAP trials, alteration in the level of arousal from August 28, 2015 to August 31, 2015 until 9:03PM when the resident was obtunded and with agonal breathing. Interviews	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #A1-3, 5 Resident #145, #37, #5, #104** Refer to page 63 for response	

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F 309	Continued From page 68 A face-to-face interview was conducted with Employee #14 [on-coming day-shift team member, August 31, 2015 7AM - 7PM] September 18, 2015 at approximately 2:00 PM regarding the above aforementioned concerns. He/she said that the off-going team member [night shift August 30th 7PM through August 31, 2015 7AM] stated that the resident was calling all night, using the type of call bell one blows into. Employee #14 further stated the off-going therapist and the nurse was in and out of the resident ' s room all night. Employee #14 acknowledged the physician should have been informed of the resident's restlessness, complaint of having shortness of breath and refusal of CPAP treatments. A review of records obtained from the acute care facility that the resident was transferred to revealed the following physician ' s entry dated 8/31/15: " ...[Resident #145] presented to the ED (Emergency Department) from NH (Nursing Home) with acute AMS (Altered Mental Status), hypotension, tachycardia and fever of 107. In ED, [Temperature] - 41.7(Celsius- converted to Fahrenheit- 107.6 degrees); [Heart Rate-85]; Respirations-16; Blood Pressure (Systolic/Diastolic) 87/48. " The clinical record was reviewed September 18, 2015. Cross referenced 483.25(k) F328; 483.20(k)(3)(ii) F282; 483.30(a) F353; 483.10(b)(11) F157 2. Facility staff failed to perform an accurate assessment for Resident #37 that experienced a	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #A1-3, 5 Resident #145, #37, #5, #104** Refer to page 63 for response	

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F 309	Continued From page 69 documented change in condition. The respiratory therapy staff assessment was inconsistent with the resident's status as reflected in the nurse's and physician ' s assessments on September 18, 2015 at 5:00 PM and 5:30 PM; respectively. Resident #37 was admitted on July 22, 2015 with diagnoses to include Chronic Respiratory Failure, Coronary Artery Disease, and Sacral Decubitus. Medical record review was conducted on September 21, 2015 at 9:40 AM. The review of clinical notes revealed inconsistencies in the assessment of Resident #37 status on September 18, 2015 at 5:00 PM as it relates to entries documented by medical staff, nursing staff, and respiratory staff. The inconsistencies are as follows: Review of the Ventilator Flow Sheet dated September 18, 2015 revealed the respiratory therapy staff documented pre- treatment assessment at 5:00 PM which indicated the heart rate- 89 beats per minute, respiratory rate- 19 breaths per minute, and oxygen saturation- 98 percent; and post-treatment assessment at 5:15 PM indicating heart rate was 90 beats per minute, respiratory rate 16 breaths per minute and oxygen saturation of 98%. The nursing staff documented an ' Acute Change in Condition Report ' dated September 18, 2015 at 5:00 PM secondary to resident with elevated irregular heart rate of 166 beats per minute and oxygen saturation of 81% while on the ventilator with FiO2 of 40%.	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5, #104 Refer to page 63 for response	

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F 309	Continued From page 70 Physician Progress note from September 18, 2015 at 5:30 PM revealed the Attending Physician was requested by the nursing staff to evaluate the resident with changes in mental status, tachycardia, and hypoxia. According to the medical staff assessment, the resident was noted to have a heart rate of 166 beats per minute, blood pressure of 125/56 millimeter of Mercury. Although the medical and nursing staff assessed Resident #37 to have experienced a change in condition to include elevated heart rate, increased respirations, and decreased oxygen saturation, the respiratory therapy staff documented an assessment with the heart rate, respiratory, and oxygen saturation consistent with Resident #37 ' s baseline physical assessments. Resident #37 was subsequently transferred via Emergency Medical Services to a local emergency department. A face to face interview was conducted with Employee #31 on September 21, 2015 at approximately3:30 PM. S/he confirmed that the respiratory assessment was inconsistent with the change of condition at the time of assessment. The findings were reviewed, discussed, and acknowledged. 3. Facility staff failed to consistently assess and monitor Resident #5 who was ventilator dependent and experienced an increase in heart rate and was subsequently sent out 911 [Emergency Services]. A review of Resident #5 ' s quarterly MDS (Minimum Data Set) with an Assessment	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #A1-3, 5 Resident #145, #37, #5, #104** Refer to page 63 for response	

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F 309	Continued From page 71 Reference Date (ARD) of April 22, 2015 revealed diagnoses in Section I (Active Diagnoses) included: Hypertension, Tracheostomy, Respiratory Failure, and Ventilator. According to physician ' s orders dated May 9, 2015 directed; " Vent [Ventilator] Settings: AC (Assist Control) Mode- Rate-10, VT- 400 [Tidal Volume]- FIO2 [Fraction Inspired Oxygen]- 40% Physician ' s Progress Notes: Pulmonary Note - June 1, 2015 at 1:45 PM revealed " Patient [resident] remains on vent. Responds to stimuli, no purposeful movements. Vent settings AC [mode of Assist Control] 10, VT [tidal volume] 500, PEEP [positive expiratory end pressure] +5, Fi02 [room air] 40%. Exam: vitals 104/72, P 69, R 18, T 97.9; CTA-[clear to auscultation bilaterally no wheezes; CVS [cardiovascular] no murmurs; Abd [abdomen] + [positive] bs [bowel sounds]; Ext [extremities] no edema ...A/P Assessment/Plan (1) chronic Respiratory Failure; (2) Encephalopathy secondary CVA [Cerebral Vascular Accident] - Continue on vent support - no weaning - supportive care. " MD [Medical Doctor] Acute Note - June 2, 2015 at 08:50 AM revealed " Responding to " Rapid Response. " Patient [Resident] identified with tachycardia with HR [140], SBP [systolic blood pressure 110, RR [respiratory rate] 20s-30s; SAT [Saturation] 96%, 100% Fi02 with ambu bagging. Emesis, tube feeding witnessed; lung (+)	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #A1-3, 5 Resident #145, #37, #5, #104** Refer to page 63 for response	

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F 309	Continued From page 72 Rhonchi, R [right] CTA [clear to auscultation] left. CVS: tachycardia ...ABD: distended...hypo [hypoactive] bowel sounds; ENT [Ear, Nose, Throat] edema BUE [bilateral upper extremities], R [right] > [greater than] L [left]. Warm extremities; A/P [Assessment/Plan] : Respiratory Distress, R/O aspiration/sepsis. Will send to ER [Emergency Room] v [by] 911. " A review of the nursing notes revealed the following: " May 31, 2015 4:50 AM - " Resident is alert and responsive. AM care given, vs [vital signs] 98.4 temperature, P [pulse] 77 R[respirations] 16, BP [blood pressure]127/68, Pulse OX [oximetry] 96%. No evidence of pain noted. IS Care given will continue to monitor ... " May 31, 2015 6:30 PM - " Resident is alert and responsive due medications given as ordered. No abnormal findings noted. Vs T 98.2, P 86 R 20, BP 133/78. Pulse Ox 96%. Will continue to monitor. " June 1, 2015 4:00 PM - " Resident is alert and responsive PM care given. Vs T 98.6, P 87, R 20, BP 130/77 Pulse OX 98%. Turned and repositioned, due meds give. " June 2, 2015 5:00 AM - " Resident is alert. On vent [ventilator] dependent for support. Trach [tracheostomy] and suction care provided. Total	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5, #104 Refer to page 63 for response	

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F 309	Continued From page 73 care with ADL [Activities of Daily Living]. Enteral Feeding in progress. Peg [percutaneous endoscopic gastrostomy] tube patent and flushed well. Will monitor. Vs [BP] 131/72, [P] 76, [R] 18, [T] 98.3. June 2, 2015- 8:35 AM- SBAR [Situation, Background, Assessment, Recommendation]/Acute change in condition. Resident was noted with respiratory distress and an elevated HR [heart rate] of 140 [bpm/beats per minute]. Resident was bagged by RT [Respiratory Therapy] while Rapid Response was called. Rapid Response team responded ....In house officer gave new order to transfer resident via [by] 911 [Emergency]. Emesis [vomiting] noted x [times] 1 [one] during bagging with seizure like activity. Resident was then transferred via 911 to [local hospital]. " Respiratory Therapy Notes: A review of the Respiratory Ventilator Flow Sheet for June 2, 2015 revealed the following: "Date: June 2, 2015 Time: 0025 [12:25 AM] Mode: AC Fi02: 40% PEEP: 5 Saturation: 97% Heart Rate: 70 Date: June 2, 2015 Time: 0345 [3:45 AM] Mode: AC Fi02: 40%	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #A1-3, 5, Resident #145, #37, #5, #104** Refer to page 63 for response	

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PEEP 5
Saturation: 98%
Heart Rate: 121

Date: June 2, 2015
Time: 08:20 [8:20 AM]
Mode: AC
Fi02: 40%
PEEP: 5
Saturation: 99%
Heart Rate: 129

There was no documented evidence that the physician was notified in regards to Resident #5 ' s increased heart rate from June 2, 2015 (3:45 AM) to June 2, 2015 (08:20 AM), which is indicative of approximately 4 hours.

A review of the respiratory therapy shift note revealed:

June 2, 2015 - 7pm-7am shift note revealed:
S: Pt on A/C mode
B: Respiratory resident
A: Sat 98% HR 71, RR 18 BS [breath sounds] Rhonchi/clear, sxn [suction] moderate yellow suction, no distress.
R: monitor

June 2, 2015 -7AM- 7PM Shift- no documentation under shift report; indicated on flow sheet- " PT [Patient] transferred to area Hospital. "

The clinical record lacked evidence that facility staff assessed and monitored Resident #5 when

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F 309	Continued From page 75 the resident ' s heart rate increased. The physician was not notified when the resident ' s became tachycardia (increased heart rate) , which was first documented on June 2, 2015 at 3:45 AM to be 121. The resident ' s condition declined as evidenced by increased tachycardia (HR elevated to 129). A rapid response was called and resident was subsequently transferred to the Emergency room via 911 [Emergency Medical Services] according to the SBAR at the time of transport the residents heart rate of 140. A face-to-face interview was conducted on September 21, 2015 at approximately 10:30 AM with Employees #18 and #47. Employee #18 state that his/her shift is 7:00AM to 7:00PM. Employee #18 also state, when he/she first saw the resident with the heart rate 129 is when the rapid response [When a resident's condition changes (based on predetermined criteria) and requires an assessment by a physician to stabilize his/her condition and prevent further deterioration] was called at approximately 8:20AM, the resident vomited when he/she was bagged. Employee #47 stated when he/she was conducting rounds from the rooms assigned he/she was called to the rapid response by Employee #18 who stated that the rapid response took over, and that the resident had vomited when he/she was bagged and then the resident was sent out 911 with a heart rate at 140. The night shift nurse was not available for interview. The clinical record was reviewed on September 21, 2015.	F 309		

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F 309	Continued From page 76 4. Facility staff failed to assess and identify the need for medical intervention for Resident #104, who had accumulated white colored lesions on his/her tongue. A review of documentation related to Activities of Daily Living [ADL] performed on behalf of Resident #104 and through staff interview, it was determined that oral care was consistently provided each shift by facility staff. However, there was no evidence that facility staff identified the need for medical intervention to address the white substance on the resident 's tongue. Following the survyeor's query, the resident was examined by the medical team and subsequently diagnosed with oral Candidiasis and prescribed antifungal treatment. According to, " The Lippincott Manual of Nursing Practice, " Ninth Edition-2010, pp 613, revealed: " Conditions of the Mouth and Jaw .... Candidiasis- Candidiasis is a fungal infection commonly caused by Candida albicans. It usually occurs in the mouth ... Candidiasis can become a source of systemic dissemination, particularly in high-risk persons, Clinical Manifestations: (1.) Oral discomfort, burning, altered taste, erythema, (2) White, raised, painless plaques, loosely adherent, (3) Possible spread to the esophagus with pain on swallowing and chest pain Management: Topical antifungal agents in oral rinses, troches, or creams, such as Mycelex or Nystatin ... Analgesics for pain ..., Nursing Assessment: Assess extent of lesions and inflammation in mouth ... 2. Assess level of pain ... Patient Education and Health Maintenance: (2) Instruct high-risk patients about daily oral	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #A4, Resident #104** 1. On 9/15/15 interventions were put in place by nursing for resident #104 per NP assessment. 2. All residents dependent in activities of daily living (ADL) were reassessed and an appropriate care plan updated. . 3. All clinical staff were reeducated regarding assessment, and documentation of ADLs emphasizing the mouth care policy and the importance of oral health care. The RCCs or designee will perform daily clinical rounds with nursing staff to review resident care needs. An in-service will be scheduled for CNAs and licensed staff by Medline on mouth care/oral hygiene and the current products used in the facility. 4. The Resident Care Coordinators (RCC) or designee will perform weekly rounds on each unit and documentation audits of the CNA flowsheet to ensure ADLs are performed per care plan for dependent residents. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is consistently obtained for three (3) months.	11.10.2015

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examination and signs and symptoms to observe (3). Encourage good oral hygiene .... "

An observation of the Resident #104 during the survey period revealed the following:

On September 10, 2015 at approximately 4:28 PM- Resident #104 ' s tongue was observed completely coated with a white substance.

A second attempt was made on September 14, 2015 at approximately 12Noon to visualize Resident #104 ' s oral cavity with Employee #15. A visualization of the resident ' s oral cavity was unsuccessful because the resident rejected the employee ' s attempt to open his/her mouth. This surveyor conveyed to Employee #15 the concern related to the observation of the white substance on the resident ' s tongue. Employee #15 informed the Nurse Practitioner who evaluated the resident and diagnosed him/her with Oral Candidiasis as follows:

Nurse Practitioner note dated September 14, 2015 at 4:10 PM read: " Asked to evaluate resident with c/o [complaint of] whitish coating on tongue. Resident is bedbound and clamps mouth close [with] difficulty to adequately view oral cavity. Assessment done [with] aid of primary nurse, " = " whitish coating on tongue. Attempted to clear tongue with mouth care kit [without] any effect on mouth/tongue coating. [No] distress. A [Assessment]:- Oral Candidiasis (Thrush). Plan: Nystatin solution 100,000 units/ml. Apply 5 ml (millimeters) to tongue and clean tongue QID (four times a day) [times] 14 days. Reassess for any adverse changes. "

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Facility staff failed to assess and identify the need for medical intervention for Resident #104 whose tongue was observed coated with a white substance.

Resident #104 was totally dependent and facility staff must anticipate the resident 's needs as evidenced by the annual Minimum Data Set [MDS] assessment dated August 14, 2015. Section B, Hearing, Speech, and Vision was coded that Resident 104 was unable to speak and was rarely/never understood. Under Section C, Cognition, the resident was coded as severely cognitively impaired and never/rarely made decisions, Section I (Active Diagnoses) included: Seizure Disorder, Traumatic Brain Injury, Tracheostomy, Craniotomy, Dysphagia. Section G (Functional Status) revealed the resident was coded as being totally dependent with one person for physical assist and personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth ...).

Physician 's order dated August 25, 2015 directed: " Mouth care every shift. "

A review of clinical documentation [ADL sheets and Treatment Administration Records] for the months of August and September 2015 revealed staff documented that oral care was provided every shift.

An interim physician 's order [subsequent to the surveyor ' s observation] dated September 14, 2015 at 4:00 PM directed; " Nystatin (Anti-fungal

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medication) Oral Suspension 100,000 units per ml. Apply 5 ml (millimeters) to tongue and clean tongue QID (four times a day) [times] 14 days for thrush. "

A review of the resident ' s " CNA [nursing assistant] Charting " flow sheets from September 7, 2015 through September 15, 2015 revealed, " Personal Hygiene: Resident required one person physical assist to provide all hygiene tasks [oral care included], with no self-performance. "

The comprehensive care plan updated August 11, 2015 included the following problem: " Alteration in ADL (Activities of Daily Living) function [secondary] to diagnosis of Anoxic Brain Injury, Approaches included, ... Staff to provide oral, hair and nail care qd (every day) and prn (as needed) ... "

There was no evidence that facility staff provided oral care consistent with the resident's need.

A face-to-face interview was conducted with Employees #15 and #17 on September 14th at approximately 1:00 PM. When queried about how the resident ' s mouth care is performed and the frequency, he/she stated; " It is done every day, and an oral swab is used and s/he stated there was no white coating on the resident ' s tongue. He/she further stated sometimes white secretions

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F 309	Continued From page 80 are in his/her mouth but they are suctioned out, and the mouth and tongue is cleaned every shift. The clinical record was reviewed on September 15, 2015. 5. Facility staff failed to ensure that Resident #143 wore protective head gear and underwent head circumference measurements weekly in accordance with physician ' s orders. On September 16, 2015 at approximately 11:45 AM and 2:00 PM, Staff was observed sitting in chair, near the window at the foot of Resident # 143 ' s bed. The resident was observed asleep, lying in bed on his/her back. A white mitten was observed on the right hand. He/she was covered with a white sheet. A helmet was positioned on the foot board. A face to face interview was conducted with Employee #48 at the time of the observation. Employee #48 was queried about the scheduled times the resident was supposed to wear the helmet. He/she stated; " He/she is supposed to wear the helmet when he/she is out of bed. Employee #48 further stated that the resident was on one to one (1:1) observation. A physician's order dated August 27, 2015 directed; " Helmet to be worn Q [every] shift for safety to protect craniotomy site. Remove every 2 (two) hours to check skin integrity. Document in chart. Measure head circumference weekly. Report increase in size to MD (Medical Doctor). " A review of the clinical record [Medication and Treatment Administration records MAR/TAR and nurse's notes] for the period of August 27, 2015	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #A5, Resident #143** 1. Resident #143 suffered no adverse event. The head circumference was re-measured and found consistent with previous measurements. The attending was contacted and care plan updated to include interventions related to managing resident with a craniotomy. 2. There were no other residents with an order for a helmet; therefore, no other resident was affected. 3. Staff re-educated of the standards of practice related to execution of physician orders. RCC or designee will perform random audits of the medical record to ensure physician orders are followed per policy. Results of the audits will be reported the Quality Council until 100% compliance is consistently maintained for six (6) months.	11.10.2015

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F 309	Continued From page 81 through September 16, 2015 lacked evidenced that Resident #143 ' s head circumference was measured weekly in accordance with physician's orders and there was no documented evidence that staff consistently applied the helmet as directed by the physician. A face-to-face interview was conducted with Employee #18 on September 16, 2015 at approximately 2:31 PM. He/she acknowledged the aforementioned findings. The observation and clinical record was conducted on September 16, 2015. B. Based on record review and staff interview for seven (7) of 55 sampled residents, it was determined the facility staff failed to: conduct comprehensive pain assessments to include characteristics such as intensity, type, pattern of pain, location, frequency and duration of pain for seven (7) residents; consistently assess two (2) residents response to pain intervention. Residents ' #64, #108, #107, #142, #80, #43 and #49. The findings include: Facility ' s Policy -Pain Assessment and Management policy Copyright 2001 MED_PASS, INC (Revised October 2010) stipulates " Steps in the Procedure Recognizing Pain: 1. Observe the resident (during rest and movement) for physiologic and behavioral (non-verbal) signs of pain ...Assessing Pain: 1. During Comprehensive pain assessment gather the following information as indicated from the resident (or legal representative): a. History of pain and its treatment ...b. Characteristics of pain: (1)	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** 1. Immediately upon notification of this deficiency, a comprehensive pain assessment for residents #64, #107, #142, #80, #43 and #49 was completed. Resident #108 was discharged therefore no further actions could be taken. 2. A chart audit was conducted on all residents on pain management program. Audit findings determined no other resident potentially affected by the same deficient practice. 3. All clinical staff were reeducated on 10/15, 10/25 and ongoing by the Interim Administrator/DON on the revised Pain Assessment and Management policy and the Omnicare Pharmacy Pain Flowsheet. The Omnicare Pharmacy Pain Flowsheet will be implemented 11/1/15 for pain monitoring and documentation of assessment, intensity and effectiveness. The RCCs will perform a random sample audit of the pain flowsheet weekly to ensure compliance. 4. Results of the audit findings will be reported weekly to the Risk Management Subcommittee three (3) months. A monthly summary of the audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a three (3) months.	11.10.2015

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F 309	Continued From page 82 Intensity of pain (as measured on a standardized pain scale); (2) Descriptors of pain; (3) Pattern of pain (e.g. constant or intermittent); (4) Location and radiation of pain; (5) Frequency, timing and duration of pain; c. Impact of pain on quality of life; d. Factors that precipitate or exacerbate pain; e. Factors and strategies that reduce pain; and f. Symptoms that accompany pain (e.g. nausea, anxiety) ...Identifying the Causes of Pain ...Define Goals and Appropriate Interventions ...Implement Pain Management Strategies1. Non-pharmacological interventions ...; 2. Pharmacological interventions ...; 4. The physician and staff will establish a treatment regimen based on consideration of the following a. The resident ' s medical condition; b. Current medication regimen; c. Nature, severity and cause of the pain; d. Course of the illness; and e. Treatment goals ...6. Implement the medication regimen as ordered, carefully documenting the results of the interventions ...Monitoring and Modifying Approaches ...Documentation 1. Document the resident ' s reported level of pain with adequate details (i.e. enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. 2. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident 's medical record. " 1. Facility staff failed to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for resident #64	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 83 A review of the medical record revealed Resident #64 was admitted on May 4, 2015 with diagnoses which included Surgical Wound, Sacral Wound, and Nutritional Deficit with Reconditioning. Resident #64 was transferred out to a local emergency department on September 1, 2015 to manage " change in mental status " . Review of medical record conducted on September 14, 2015 revealed Resident #64 has a documented community-acquired Stage IV sacral pressure ulcer present on admission which last measured 15 X 16.5 X 3.5 centimeters according to the Wound and Skin Care Progress Note dated August 31, 2015. According to the Physician ' s Orders, the medical staff documented the following medication orders relative to pain: July 15, 2015- Tramadol 50 milligrams via G-tube (gastrostomy tube) three times a day prior to wound care August 24, 2015 at 2:10 PM- Discontinue Tramadol 50 milligrams; Start Tramadol 100 milligram by mouth 30 minutes prior to wound treatment three times per day then one (1) by mouth every eight (8) hours as needed pain August 31, 2015 at 1:00 PM- Discontinue Tramadol order; Start Oxy IR (Immediate Release) 5 milligram by mouth one tab 30 minutes prior to wound treatment every shift and every eight (8) hours as needed for pain September 1, 2015 at 3:15 PM- Discontinue Oxy IR (Immediate Release)order; start Neurontin 100 milligram three times daily by	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 84 mouth for neuropathic pain; Tylenol ES [Extra Strength] 500 milligrams by mouth three times daily 30 minutes prior to wound treatment every shift for pain Review of the Physician ' s Progress Notes from June 22, 2015 through September 1, 2015 revealed the medical staff documented assessment of Resident #64 on June 22, 2015, July 28, 2015; August 20, 2015 and September 1, 2015. On August 20, 2015, Resident #64 was seen for significant weight loss. The medical record lacked documentation relative to pain during this visit. On September 1, 2015 at 3:20 PM, the medical staff had a discussion with Resident #64 's family member about " ...many questions related to issues of pain, wound care and weight loss and recurrent UTI (Urinary Tract Infections) ...We discussed pain medications being used Oxy IR which was started yesterday ' p ' (symbol for after) discontinuing Tramadol but resident is more drowsy today. Will discontinue all narcotics ..." The medical record lacked documented evidence to provide insight into the reason for adjusting the pain medication regimen prior to wound care from August 24, 2015 through September 1, 2015. Nurse ' s Notes from August 22, 2015 through September 1, 2015 revealed Resident #64 was medicated prior to wound care; however, the medical record lacked documented evidence the facility staff performed comprehensive pain assessments before and after the administration of pain medication. In addition, the medical record lacked documented evidence of unresolved or worsening pain to warrant an adjustment in the resident ' s pain medication regimen.	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 85 On September 1, 2015 at 11:30 PM, the facility staff documented a " SBAR [Situation Background, Assessment and Response]/ Acute Change In Condition Report " which " detailed reason for evaluation ...change in mental status, lethargic " . The sections reserved for the documentation of " Things that make the problem worse; Pertinent recent medical history; Mental status; Change in intake/hydration; and Labs in the past 30 days " were left blank. According to the narrative contained in the SBAR: Resident #64 was "noted very sleepy but arouse to touch and verbal commands " at around 9:00 PM. The resident 's family was in the room at the time of the observation. S/he informed the facility staff "that resident sleep deeply and not communicating with her " . SicThe attempt to start an intravenous line was unsuccessful secondary to poor vein. Resident #64 's respirations were also " noted " to be shallow with a change in vital signs. The vital signs were documented as follows: temperature- 97.3 degrees Fahrenheit, blood pressure- 125/55 millimeters of Mercury; respirations- 28 breaths per minute, and heart rate 120 beats per minute. The resident was subsequently transferred to the hospital via Emergency Medical Services. Subsequent review of the August 2014 Medication Administration Record (MAR) revealed the facility staff documented the administration of Tramadol 50 milligrams prior to wound care from August 1-24, 2015 and on August 25- 31, 2015 Tramadol 100 milligram, was administered three times a day. The Medication Administration Record did not contain specific time of each dose of pain medication administered and/or the time wound treatment was completed. Medication administration times	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 86 were documented according to the shift, i.e. "7-3; 3-11; 11-7". Furthermore, the MAR lacked documentation of comprehensive pain assessment before and after medication administration to determine the presence of pain and/or effective of the pain medication. Review of Nurse ' s Notes from August 19, 2015 through September 1, 2015 revealed the facility staff documented the pain medication administration prior to wound care. According to the note documented on August 20, 2015 at 11:00 PM, the Resident #64 was " medicated x1 with Tramadol as ordered prior to wound care for breakthrough pain with positive outcomes " , there was no documentation to provide enough description of pain to include intensity, descriptors, pattern, location and radiation, and a frequency. In addition, there were additional nurse ' s notes on August 22, 23, 24, 26, and 28, 2015 that indicated that pain medication was administered prior to wound care with " good " or " + " (positive) effects. However, the aforementioned nurse 's notes lacked documented evidence of a pain assessment before and after the administration of the pain medication to include location, intensity, and descriptors. On August 24, 2015 at 11:00 [no indication of am or pm documented], the facility staff documented the " resident was asked if the pain medicine ... gets is effective enough for [his/her] with [him/her] wound care, resident said yes but if [s/he] can get more, it will make [his/her] more comfortable " . The medical staff was notified and pain medication was increased. Review of the subsequent nursing notes failed to	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 87 reveal the facility staff performed monitoring for effectiveness and/or adverse consequences relative to pain. On September 1, 2015 at 1:00 PM the facility staff was called to the resident ' s room because the resident was observed " drowsy " and had been unable to " be taken to therapeutic recreation this morning. " According to the September 1, 2015 at 1:00 PM note, " Resident was given Oxycodone 5mg IR and the nurse getting ready to do ... wound care. " The family at bedside and responsible party via telephone was notified Resident #64 " has a new order for Oxy IR but will have the NP (Nurse Practitioner) review this med [medication] since resident is drowsy " . Oxy IR was last administered on September 1, 2015 during the " 7-3 " shift; the specific time was not documented. It is unclear if the responsible party had been notified of the medication change at the time of the order. The medical record lacked documented evidence the nursing staff performed a comprehensive assessment when a change in condition was identified at 1:00 PM. It was at 9:00 PM on September 1, 2015 that the family "complained that resident sleep deeply and not communicating with her, resident opened her eyes then close it still responds to touch " . A call was placed to the house officer at 9:30 PM. The medical record lacked documented evidence the facility staff continued to assess and monitor Resident #64 ' s condition with ensure s/he received necessary care and treatment to prevent and/or readily identify acute changes in status at the earliest time possible. The " Pain " care plan initiated for the period of	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 88 May 6, 2015 through September 6, 2015 revealed the facility staff documented the " Problem/Need Related To " as: " Other, specify generalized " ... " Resulting In: Complaints of pain less than daily " ... " Strengths To Draw On: Able to communicate needs, Able to express level of pain " with Goal(s) identified as: " will be free of pain complaints; Will display signs of comfort, no grimacing; Will report pain resolved with pain medication and other interventions " . The " Target Review date: 5/6/15-9/6/15 " . The " Interventions " for " Nursing " include " Assess symptoms of pain on occurrence and document location and pain scale as reported by the resident; Provide quiet environment; Offer calming music, TV per resident request; Offer back rub, warm blanket; Provide pain medications as prescribed; Check vital signs: Freq. Per order and Notify Physician if: Pain persists despite intervention; vital signs are out of normal range along with pain persistence. " The sections reserved for intervention to be documented by dietary, social services, and activities were left blank. On the reverse side of the care plan for " pain " , there were three (3) entries as follows: " 5/11/15- Cont. c [line noted above the letter ' c '] (with) POC (Plan of Care) x 90 days " " 8/24/15- Pain reevaluated, need for increase in pain med noted CRNP (Certified Registered Nurse Practitioner) notified, Tramadol increased to 100 mg. Will cont. to monitor resident. " " 8/31/15- Resident is started on Oxy IR 5 mg to be given prior to wound care. Will monitor resident. Tramadol dc 'd [discontinued]. " The medical record lacked documented evidence the facility staff consistently followed the plan of care to demonstrate assessment, monitoring, and provision of necessary care and treatment in	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 89 accordance with standards of practice relative to the treatment of resident with complaints of pain. Review of Significant Change in Status Assessment Minimum Data Set (MDS) dated August 9, 2015 revealed the following coding for Section J Health Conditions: J0100 Pain Management A. Been on a scheduled pain medication regimen?- " 1. Yes " ; B. Received PRN pain medications OR was offered and declined? - " 0. No " ; C. Received non-medication intervention for pain?- " 1. Yes " ; Section J0300- " Have you had pain or hurting at any time in the last 5 days? " - " 1.- Yes " ; 0J0400. Pain Frequency: " How much of the time you experience pain or hurting over the last 5 days?- " 3- Occasionally " ; and J0600 Pain Intensity A. Numeric Rating Scale (00-10)- Please rate your worst pain over last 5 days on a zero to ten scale with zero being no pain and ten as the worst pain you can imagine- " 05 " . Further review of the medical record revealed Resident #64 experienced a significant weight loss since admission to the facility from May, 2015 through August, 2015. The weights were documented as: May 11, 2015- 186.8 pounds; May, 2015 (day of month unknown) - 177 pounds; June, 2015- 163 pounds; July, 2015- 150 pounds; and August, 2015- 141 pounds. As a result of the documented weights the resident triggered for a significant weight loss for 30 days according to the Nutritional Care Progress notes on June 17, 2015, July 20, 2015, and August 19, 2015. The medical record lack documented evidence that the interdisciplinary team evaluated the potential impact the resident ' s complaints of pain may have on his/her nutritional status.	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 90 Although the facility staff continued to administer pain medication routinely prior to wound care, the facility staff failed to assess and reassess Resident #64 in enough details and frequency to ensure management and prevention of pain consistent with the comprehensive assessment, plan of care, and accordance with current clinical standards of practice, resident ' s goals and preferences. A face-to-face interview was conducted with Employee #11 on September 21, 2015 at approximately 9:40 AM regarding the management of pain for Resident #64. When queried about the facility ' s policy relative to pain management and assessments, s/he stated that it is expected that the nursing staff assess the pain when the medication is given and afterwards. S/he further provided a Medication Administration Record and pointed out where the documentation would be located. The reverse of the Medication Administration record for Resident #64 was reviewed, discussed, and acknowledged. Facility staff neglected to conduct comprehensive pain assessments and reassessment before and after the administration of pain medication as is consistent with current clinical standards of practice. There was no evidence the resident was consistently monitored when pain medications were adjusted and when the resident demonstrated a change in clinical status [e.g. lethargy], there was no comprehensive nursing assessment. On September 1, 2015, the resident demonstrated " drowsiness, " at 1:00 PM however; facility staff did not intervene for several hours [approximately 9:30 PM] until the resident '	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #49 Refer to page 82 for response	

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F 309	Continued From page 91 s symptoms worsened and required emergency transport out of the facility.	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**	
	2. Facility staff failed to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #80.		**Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	
	A review of the medical record revealed Resident #108 was admitted on December 19, 2014 with diagnoses which include Congestive Heart Failure with EF (Ejection Fraction) 20%, Cerebrovascular Accident Status post Craniotomy, Hypertension, and Diabetes Mellitus.			
	Medical record review conducted on September 13, 2015 revealed a Physician Order dated August 17, 2015 for Acetaminophen with Codeine 300 mg/30 mg one tab via g-tube (gastrostomy tube) every 6 (six) hours as needed for pain and on August 28, 2015 at 12:00 PM- " ...Roxanol 20 mg/ml 0.25 ml [milliliter] (5mg) SL [sublingual] q3° [every three hours] PRN [as needed] severe pain/ SOB [shortness of breath] " .			
	A review of the September 2015 Medication Administration Record (MAR) revealed Acetaminophen with Codeine was administered for pain on the following occasions: September 3, 2015 at 11:00 AM; September 8, 2015 at 8:00 AM, September 9, 2015 at 8:00 PM, September 10, 2015 at 9:30 AM, September 11, 2015 at 11:30 AM, September 12, 2015, September 13, 2015 at 9:00 AM, and September 14, 2015 at			

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F 309	Continued From page 92 9:00 AM. The reverse side of the September 2015 MAR revealed the details of the Acetaminophen with Codeine administered for pain as follows: September 3, 2015 at 11:00 AM- No documented evidence of the date/hour, medication, reason or result September 8, 2015 at 8:00 AM- No documented evidence of the date/hour, medication, reason or result September 9, 2015 at 8:00 PM- No documented evidence of intensity relative to reason and result was documented as " effective " no intensity documented or time of reassessment September 12, 2015 at 9:00 PM- Reason documented as " c/o pain " (no location documented); Result documented as " effective " - no intensity or time of reassessment documented September 13, 2015 at 9:00 AM- Result documented as " effective " - no intensity or time of reassessment documented September 14, 2014 at 9:00 AM- Reason documented as " c/o pain " - no location documented; Result was left blank- no reassessment documented In addition, Roxanol 0.25 milliliter administration was documented on the September 2015 MAR	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 93 on September 1, 2015 at 11:00 AM; September 5, 2015 at 12:30 PM; and September 6, 2015 at 7:00 PM. The three (3) occasions lacked documentation of the descriptors relative to pain to include intensity before and after the administration of the Roxanol 0.25 milliliter. In each instance, the facility staff documented " effective " in the section reserved for the result. In addition, the result did not contain the time of the reassessment. There was no evidence that the facility staff consistently conducted pain assessments that included the intensity of the pain (e.g. numeric scale) before and after the administration of Acetaminophen with Codeine and Roxanol. 3. Facility staff failed to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #80 A review of the medical record revealed that Resident #107 was admitted on December 5, 2014 with diagnoses to include Sacral Osteomyelitis, Arrhythmia, Debility, and Status post Right Above Knee Amputation. Medical record review conducted on September 18, 2015 at 2:35 PM revealed Physician Orders date and signed by the physician on September 4, 2015 with the original order date of June 16, 2015 for Acetaminophen 325 milligrams two (2) tabs by mouth every six (6) hours as needed for pain or temperature greater than 101; and	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 94 Acetaminophen 500 milligrams two (2) caplets by mouth every day 30 minutes prior to wound care for pain management. Review of the Medication Administration Record (MAR) for August and September 2015 revealed the following: Acetaminophen 325 milligram two tablets were administered as follows: August 6, 2015 at 2:10 (no indication of AM or PM); August 10, 2015 at 1:30 PM; August 14, 2015 at 11:30 (no indication of AM or PM); August 18, 2015 at 7:00 PM; August 20, 2015 at 7:00 PM; and August 25, 2015 at 9:00 AM; and Acetaminophen 500 milligram two caplets every day prior to wound care was administered daily during the month of August and September 1 through 18, 2015. Subsequent review of the reverse side of the MAR revealed the following documentation relative to administration of Acetaminophen 325 milligrams and Acetaminophen 500 milligrams: August 6, 2015 at 2:10 (no indication of AM or PM)- No documented evidence of the date/hour, medication, reason or result August 10, 2015 at 1:30 PM- Reason- " general pain " no documentation of intensity; Result- " effective " no documentation of intensity or time of reassessment August 14, 2015 at 11:30 (no indication of AM or PM)- No documented evidence of the date/hour, medication, reason or result August 18, 2015 at 7:00 PM- Reason- " general pain " no documentation of intensity; Result- " effective " no documentation of	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 95 intensity or time of reassessment August 20, 2015 at 7:00 PM- Reason- " general pain " no documentation of intensity; Result- " effective " no documentation of intensity or time of reassessment August 25, 2015 at 9:00 AM- No documented evidence of the date/hour, medication, reason or result In addition, the medical record lacked a documented pain assessment relative to the administration of Acetaminophen prior to wound care in accordance with the facility ' s pain policy of at least weekly for chronic pain. There was no evidence that the facility staff consistently conducted pain assessments that included the intensity of the pain (e.g. numeric scale) before and after the administration of Acetaminophen. 4. Facility staff failed to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #142. A review of the medical record revealed that Resident #142 was admitted on September 4, 2015 with diagnoses to include dysphagia, respiratory failure, and Guilliare-Barre Syndrome. Review of the medical record on September 16, 2015 at approximately 12:45 PM revealed Physician Orders for Tylenol 650 milligram via PEG (Percutaneous Endoscopic Gastrostomy)	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 96 tube every six (6) hours as needed for pain dated September 4, 2015; and Tylenol 650 milligrams via PEG 30 minutes prior to wound care. Review of the September 2015 Medication Administration Record (MAR) revealed the facility staff documented the administration of the daily Tylenol 650 milligrams prior to wound care. In addition on September 15, 2015 at 6:00 PM, Resident #142 received Tylenol 650 milligrams for " pain- 4/10 " no location and/or other descriptors were documented and " 1/10- effective " upon reassessment (no time of reassessment documented). The medical record lacked documented evidence the facility staff consistently conducted pain assessment for a newly admitted resident to assess the effective of the pain management regimen relative to pre-medication for pain prior to wound care and/or weekly for according to the facility ' s policy for residents with chronic pain. The facility staff failed to consistently conduct comprehensive pain assessments that include the intensity for resident with complaints of pain. 5. Facility staff failed to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #80. A review of the medical record revealed that Resident #80 was admitted with diagnoses to include Amyotrophic Lateral Sclerosis, Anemia,	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 97 Stage IV Sacral Ulcer, and Respiratory Failure. Medical record review conducted on September 16, 2015 at approximately 3:20 PM revealed Physician Order for Acetaminophen 650 milligram via G-tube (Gastrostomy tube) 30 minutes prior to wound care for pain management signed and date September 4, 2015. Review of the Medication Administration Record for September 2015 revealed Acetaminophen 650 milligrams were administered once a day from September 1- 16, 2015. The medical record lacked documented evidence of a pain assessment before and after the administration of Tylenol for pain prior to wound care. Furthermore, the medical record lacked documented evidence of a weekly pain assessment for a resident with chronic pain. The facility staff failed to consistently conduct comprehensive pain assessments that include the intensity for resident with complaints of chronic pain in accordance with the facility 's policy. 6. Facility staff failed to consistently assess Resident #43 's response to pain interventions. a. On September 18, 2015 at approximately 12:15 PM, a review of the admission note revealed that Resident #43 was initially admitted to the facility on April 22, 2011. A review of the physician 's history and physical dated May 1, 2015 revealed the resident ' s diagnoses included a Stage 3 sacral ulcer and Immobility.	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1-** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response	

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F 309	Continued From page 98 Review of the physician ' s orders signed and dated August 31, 2015 revealed a daily order for Percocet [narcotic analgesic] 30 minutes prior to wound care treatment for pain. Review of the Medication Administration Record [MAR] dated September 2015 revealed that the staff administered Percocet daily from September 1-17, 2015 between the 3-11PM-work shifts. Further review of the nursing notes and clinical record revealed that the staff failed to assess the resident 's response to pain 7 (seven) of 17 days that the pain medication was administered. On September 18, 2015 at approximately 12:15 PM, a face-to-face interview was conducted with Employee #21 regarding the aforementioned findings. He/she reviewed the record and acknowledged the findings. The record was reviewed on September 18, 2015. b. Facility staff failed to re-assess the effectiveness of wound care interventions for Resident #43. On September 18, 2015 at approximately 12:15 PM, a review of the admission record revealed that Resident #43 was initially admitted to the facility on April 22, 2011. A review of the physician 's history and physical dated May 1, 2015 revealed the resident ' s diagnoses included a Stage 3 sacral ulcer and Immobility.	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B6b, Residents #43** 1. There was no adverse effect to the wound healing process because the 'actual' treatment being done was saline. The error was in the report submitted by the wound consultant physician. 2. A review of wound care orders were audited finding all orders in compliance. 3. Careful review of treatment orders during end of month review and reconciliation to ensure accuracy. Review reports submitted by consulting wound physician with signed physician order in medical record. 4. The RCCs or designee will audit the TAR to ensure all orders are documented and implemented. The audit findings will be reported to Risk Management Subcommittee for three (3) months and a quarterly summary to Quality Assurance Committee until 100% compliance is demonstrated for three (3) months	11.10.2015

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F 309		F 309		

Continued From page 99

Review of the physician's orders signed and dated August 31, 2015 revealed an order that directed the following: "Cleanse sacral ulcer wound with normal saline, pat dry with gauze. Apply Maxorb [wound care dressing] Ag [silver] and cover with dry dressing daily. "

Further review of the weekly wound documentation from April 2015 to September 10, 2015 revealed the following monthly wound information relative to the resident ' s sacral wound:

April 30, 2015 Stage 4 2.8 [length] x 2.5 [width] x1.8 [depth]

May 21, 2015 Stage 4 2.2 x 1.7 x1

June 25, 2015 Stage 4 1.7 x 1.5 x 2

July 23, 2015 Stage 3 2.0 x 2.5 x 1.0

August 28, 2015 Stage 3 2.9 x 2.0x 1.5

September 10, 2015 Stage 3 2.0 x 1.5 x 0.8

The resident 's wound advanced to a Stage 4 ulcer and the record lacked documented evidence that the staff re-assessed the effectiveness of the wound care interventions.

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F 309	Continued From page 100 On September 18, 2015 at approximately 12:40 PM, a face-to-face interview was conducted with Employee #12 regarding the wound care interventions and how the staff re-assessed the effectiveness of the treatment plan. He/she provided no answer. The record was reviewed on September 18, 2015. 7. Facility staff failed to assess the effectiveness of pain medication that was administered to Resident #49. On September 18, 2015 at approximately 1:45 PM, a review of the admission note revealed that Resident #49 was initially admitted to the facility on January 26, 2011 with diagnoses that included Traumatic quadriparesis with thoracic, lumbar, and left acetabulum fractures, Diabetes Mellitus, and Hypertension. Review of the physician's orders signed and dated September 2015 revealed a daily order for Percocet [narcotic analgesic] for chronic pain. Review of the Medication Administration Record [MAR] dated September 2015 revealed that the staff administered Percocet daily from September 1-18, 2015 at 08:00 AM. Further review of the clinical record lacked documented evidence that the facility staff assessed the resident ' s response to the administered pain medication on September 3, 5, 6, 7, 8, 10, 11, 12, and 15, 2015.	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1- 6a, 7** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response.	

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F 309	Continued From page 101 On September 18, 2015 at approximately 12:15 PM, a face-to-face interview was conducted with Employee #20 regarding the aforementioned finding. He/she was asked to provide the documentation that the resident was assessed for the effectiveness of the daily pain medicine on the aforementioned dates. He/she reviewed the clinical record, could not provide the requested documentation, and acknowledged the findings. The record was reviewed on September 18, 2015.	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **Response to #B1- 6a, 7** **Residents #64, #108, #107, #142, #80, #43 and #49** Refer to page 82 for response.	
F 312 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for one (1) of 55 sampled residents, it was determined that facility staff failed to ensure the resident received necessary services to maintain good oral hygiene as evidenced by: one (1) resident who was observed with an accumulation of white colored substance on his/her tongue. Resident #104. The findings include: Facility staff failed to assess and identify the need for medical intervention for Resident #104, who	F 312		

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F 312	Continued From page 102 had accumulated white colored lesions on his/her tongue. A review of documentation related to Activities of Daily Living [ADL] performed on behalf of Resident #104 and through staff interview, it was determined that oral care was consistently provided each shift by facility staff. However, there was no evidence that facility staff identified the need for medical intervention to address the white substance on the resident 's tongue. Following the survyeor's query, the resident was examined by the medical team and subsequently diagnosed with oral Candidiasis and prescribed antifungal treatment. According to, "The Lippincott Manual of Nursing Practice, " Ninth Edition-2010, pp 613, revealed: " Conditions of the Mouth and Jaw .... Candidiasis- Candidiasis is a fungal infection commonly caused by Candida albicans. It usually occurs in the mouth ... Candidiasis can become a source of systemic dissemination, particularly in high-risk persons, Clinical Manifestations: (1.) Oral discomfort, burning, altered taste, erythema, (2) White, raised, painless plaques, loosely adherent, (3) Possible spread to the esophagus with pain on swallowing and chest pain Management: Topical antifungal agents in oral rinses, troches, or creams, such as Mycelex or Nystatin ... Analgesics for pain ..., Nursing Assessment: Assess extent of lesions and inflammation in mouth ... 2. Assess level of pain ... Patient Education and Health Maintenance: (2) Instruct high-risk patients about daily oral examination and signs and symptoms to observe (3). Encourage good oral hygiene .... "	F 312	**483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** **Response to #1 Resident #104** 1. The care needs for resident #104 was assessed and an appropriate care plan was developed immediately upon notification of this deficiency. A schedule for resident #80 to be out of bed was also created. 2. ADL needs for dependent residents on each unit were reassessed and an appropriate care plan with specific interventions was developed. 3. All clinical staff were re-educated regarding assessment, and documentation of ADLs emphasizing the mouth care policy and the importance of oral health care. Create quarterly care plan review of all ADL dependent residents. 4. The Resident Care Coordinators (RCC) or designee will perform weekly rounds on each unit and documentation audits ensure ADLs are performed per care plan for dependent residents. Audit findings will be reported weekly to the Risk Management Subcommittee for three (3) months. The Respiratory Department will conduct monthly audits to respiratory orders. A monthly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months.	11.10.2015

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F 312	Continued From page 103 An observation of the Resident #104 during the survey period revealed the following: On September 10, 2015 at approximately 4:28 PM- Resident #104 ' s tongue was observed completely coated with a white substance. A second attempt was made on September 14, 2015 at approximately 12Noon to visualize Resident #104 ' s oral cavity with Employee #15. A visualization of the resident 's oral cavity was unsuccessful because the resident rejected the employee ' s attempt to open his/her mouth. This surveyor conveyed to Employee #15 the concern related to the observation of the white substance on the resident 's tongue. Employee #15 informed the Nurse Practitioner who evaluated the resident and diagnosed him/her with Oral Candidiasis as follows: Nurse Practitioner note dated September 14, 2015 at 4:10 PM read: " Asked to evaluate resident with c/o [complaint of] whitish coating on tongue. Resident is bedbound and clamps mouth close [with] difficulty to adequately view oral cavity. Assessment done [with] aid of primary nurse, " = " whitish coating on tongue. Attempted to clear tongue with mouth care kit [without] any effect on mouth/tongue coating. [No] distress. A [Assessment]:- Oral Candidiasis (Thrush). Plan: Nystatin solution 100,000 units/ml. Apply 5 ml (millimeters) to tongue and clean tongue QID (four times a day) [times] 14 days. Reassess for any adverse changes. "	F 312	**483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** **Response to #1 Resident #104** Refer to page 103 for response	

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F 312	Continued From page 104 Facility staff failed to assess and identify the need for medical intervention for Resident #104 whose tongue was observed coated with a white substance. Resident #104 was totally dependent and facility staff must anticipate the resident ' s needs as evidenced by the annual Minimum Data Set [MDS] assessment dated August 14, 2015. Section B, Hearing, Speech, and Vision was coded that Resident 104 was unable to speak and was rarely/never understood. Under Section C, Cognition, the resident was coded as severely cognitively impaired and never/rarely made decisions, Section I (Active Diagnoses) included: Seizure Disorder, Traumatic Brain Injury, Tracheostomy, Craniotomy, Dysphagia. Section G (Functional Status) revealed the resident was coded as being totally dependent with one person for physical assist and personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth ...). Physician 's order dated August 25, 2015 directed: " Mouth care every shift. " A review of clinical documentation [ADL sheets and Treatment Administration Records] for the months of August and September 2015 revealed staff documented that oral care was provided every shift. An interim physician ' s order [subsequent to the surveyor ' s observation] dated September 14, 2015 at 4:00 PM directed; " Nystatin (Anti-fungal medication) Oral Suspension 100,000 units per ml. Apply 5 ml (millimeters) to tongue and clean	F 312	**483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** **Response to #1 Resident #104** Refer to page 103 for response	

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F 312	Continued From page 105 tongue QID (four times a day) [times] 14 days for thrush. " A review of the resident ' s " CNA [nursing assistant] Charting " flow sheets from September 7, 2015 through September 15, 2015 revealed, " Personal Hygiene: Resident required one person physical assist to provide all hygiene tasks [oral care included], with no self-performance. " The comprehensive care plan updated August 11, 2015 included the following problem: " Alteration in ADL (Activities of Daily Living) function [secondary] to diagnosis of Anoxic Brain Injury, Approaches included, ... Staff to provide oral, hair and nail care qd (every day) and prn (as needed) ... " There was no evidence that facility staff provided oral care consistent with the resident's need. A face-to-face interview was conducted with Employees #15 and #17 on September 14th at approximately 1:00 PM. When queried about how the resident ' s mouth care is performed and the frequency, he/she stated; " It is done every day, and an oral swab is used and s/he stated there was no white coating on the resident ' s tongue. He/she further stated sometimes white secretions are in his/her mouth but they are suctioned out, and the mouth and tongue is cleaned every shift.	F 312	**483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** **Response to #1 Resident #104** Refer to page 103 for response	

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F 312	Continued From page 106 The clinical record was reviewed on September 15, 2015.	F 312		
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 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 observation, record review and staff interviews for two (2) of 55 sampled residents, it was determined that the facility staff failed consistently provide the necessary services and treatment to manage pressure ulcers as evidenced by failure to perform an accurate assessment to identify the appropriate stage of a sacral ulcer for one (1) resident; and implement measures to promote healing such as bed surfaces, nutritional status and pain management for one (1) resident. Residents #64 and #91. The findings include: 1. The facility staff failed to provide treatment and services to promote healing of the Stage IV pressure ulcer on Resident #64 's sacrum.	F 314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Response to #1, 2, Resident #64, #91 Refer to page 108 for response.	

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BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

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F 314	Continued From page 107 Resident #64 was admitted on May 4, 2015. According to the History and Physical examination documented by the physician May 4, 2015, Resident #64 ' s diagnoses included Surgical Wound, Stage IV Sacral Wound, and Protein Malnutrition and Deconditioning. According to Section M, Skin Conditions, of the Admission Minimum Data Set (MDS) dated May 11, 2015, Resident #64 was coded as having two (2) Stage IV sacral ulcers, one (1) Stage 3 pressure ulcer and Moisture Associated Skin Damage (MASD). Section K, Nutritional status, revealed Resident #64 received 51% or more of his/her nutrition and hydration via feeding tube and orally via mechanically altered diet. A Significant Change MDS dated August 9, 2015 under Section M; Skin Conditions revealed Resident #64 was assessed with one (1) Stage IV and two (2) Stage 2 pressure ulcers. Medical record review revealed physician orders on the September 2015 Physician Order Form for the following sacral wound treatments: Calmoseptine " apply to affected area sacral/ perineal area after each incontinence care with original order date May 5, 2015; and " Sacrum Wound: Cleanse with Normal Saline, pat dry, then soak Kerlix with Dakin ' s Solution [Half Strength] every shift " with original order date May 8, 2015. The medical record contains no further order changes relative to the treatment of sacral wound. Review of the care plan dated May 6, 2015	F 314	**483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** **Response to #1, #2, Resident #64 and #91** 1. Immediately upon notification of this deficiency, the most recent comprehensive assessment was reviewed to determine triggers and care-planning needs for residents #64 and #91. A focus interdisciplinary care plan meeting was held, to include wound care team, to determine the appropriate plan of care. Resident #91 medical record was reviewed to address staging and concluded as indicated. 2. The Interdisciplinary Team reassessed residents with community acquired wounds and appropriate plan of care implemented. An audit of residents identified with a pressure ulcer were reviewed to ensure accuracy in staging. 3. The DON and Wound Care Nurse re-educated the Interdisciplinary Care Planning Team on 11/3/2015 regarding avoidable/unavoidable pressure ulcer assessment and reassessment of treatment and criteria for staging. 4. The Resident Care Coordinators (RCC) or designee will audit the MDS, wound reports and TAR to ensure MDS triggers are treatments are followed and documented per order. The audits will be reported weekly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is consistently obtained for three (3) months.	11.10.2015

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F 314	Continued From page 108 through September 6, 2015 listed Pressure Ulcer: Sacral Stage IV with potential for delay healing due to multiple contributors as a problem. An entry dated May 6, 2015 stated the goal as: "Ulcer will be healed without complication; Ulcer will be clean and free of odor " . Nursing interventions to this problem include " Wound status: size of wound: measurements of depth and width, skin color, surrounding skin tissue assessment weekly, complaints of pain, effectiveness of pain medication per MD order; Apply medicated ointment per MD order; Apply dressing per MD order (space for order specific is blank); keep Dietary informed of wound status: Freq: PRN; Notify physician of wound status of change in or deterioration in status of wound; and Air mattress to promote wound healing " . The sections for Dietary, Social Services, and Activities intervention were blank with no interventions indicated. Nurse's notes and Nutrition Risk Assessment dated May 5, 2015 documented the presence of a 16 X 18 X 3 centimeter Stage 4 pressure ulcer on sacrum. The presence ulcer was documented as present on admission May 4, 2015. The most recent wound assessment was documented as 15 X 16 X 3.5 centimeters on August 31, 2015 with the " narrative: 08/31/15 unable to assess Resident. {She} said she is sick, pain though pain med has been given & N/V (and nausea and vomiting). Nurse aware". A face to face interview was conducted with Employee #25 on September 18, 2015 at approximately 11:45 AM; s/he stated that there were occasions when weekly wound assessments could not be performed secondary to complaint of pain and not feeling well. S/he	F 314	**483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** **Response to #1, 2, Resident #64, #91** Refer to page 108 for response.	

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F 314	Continued From page 109 recalled that recently on August 31, 2015 Resident #64 had complaints of not feeling well and was sent out to the hospital. The medical record lacked documented evidence of pain assessment and/or physician notification relative to complaint of pain with attempt to perform wound assessment. According to Employee #25, each time the resident declines a wound assessment, the primary nurse is made aware. The employee acknowledged that the measurement (size of the wound) recorded on the August 31, 2015 ' Wound and Skin Care Progress Note ' was actually assessed on August 24, 2015 and not characteristic of the status of the wound on August 31, 2015. Additional documentation reviewed included nurse's notes for notification of change in condition, comprehensive assessment performance, weight, and nutritional status from May 4, 2015 through September 1, 2015. Resident #64 was noted to have significant weight loss, poor nutritional intake, and a persistent Stage IV sacral decubitus ulcer. The medical record lacked documented evidence to support the notification of the physician and/or revision of interventions until August 20, 2015. On August 20, 2015, the medical staff documented that they were asked to evaluate resident for significant weight loss Admission weight in May, 2015 was documented as 177 pounds and August, 2015 weight was documented as 141 pounds. The assessment documents the following relative to skin- " sacral decub [decubitus] Stage IV ". The plan on August 20, 2015 was to follow recommendations from	F 314	**483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** **Response to #1, 2, Resident #64, #91** Refer to page 108 for response.	

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F 314	Continued From page 110 dietician to increase tube feeding and encourage oral intake until goal is met for ideal weight and start Vitamin C and Zinc supplements for wound healing. On September 1, 2015 at 3:20 PM, the medical staff discussed the plan of care with the resident ' s responsible party according to the documentation had " many questions related to issues of pain wound care and weight loss and recurrent UTI (urinary tract infection). The plan on September 1, 2015 was to discontinue all narcotics due to increase drowsiness, start Neurontin and Tylenol for pain, Marinol for appetite stimulation, and schedule an appointment with Wound Care Surgeon. The facility staff was unable to fully implement the plan secondary to "change in mental status " noted at 11:30 PM on September 1, 2015. Resident #132 was transferred out to acute care facility for evaluation and treatment. Review of the Significant Change in Status Assessment Minimum Data Set dated August 9, 2015 revealed Section K0200B- Weight: 150 pounds; K0300 Weight Loss- "Loss of 5% or more in the last month or loss 10% or more in the last 6 moth " : 2.- Yes, not on physician-prescribed weight-loss regimen. Although the facility was aware of the resident ' s weight loss, persistent Stage IV sacral pressure ulcer, and continued to routinely administer pain medication prior to wound care, they failed to consistently reassess and/or modify wound treatment regimen; and/or document rationale for	F 314	**483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** **Response to #1, 2, Resident #64, #91** Refer to page 108 for response.	

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F 314	Continued From page 111	F 314	**483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES**	

continuing the present treatment despite little healing as the resident was continued on Dakin ' s without change. In addition, there was no evidence the facility staff explored whether or not the resident was could benefit from specialty consultation (e.g. wound consult) and/or a variation in support surface.

September 17, 2015 at approximately 11:55 AM a face to face interview was conducted with Employee #4. The findings were reviewed, discussed, and acknowledged.

2. Facility staff failed to identify the appropriate stage of a sacral ulcer for Resident # 91.

According to the MDS [Minimum Data Set] 3.0, pressure ulcer stages and characteristics are noted as follows:

" Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence ... "

" Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister serum-filled blister. "

A review of the clinical record for Resident #91 revealed an 'Acute Change in Condition Report' dated September 3, 2015 and timed at 0:200 AM that indicated the resident was discovered to have a " new sacral open area " that measured 0.5 cm [length] x 0.5 cm [width]. The ' Weekly

Response to #1, 2, Resident #64, #91

Refer to page 108 for response.

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F 314	Continued From page 112 Wound Documentation ' sheet revealed the following: September 3, 2015 that the resident had a Stage 1 ulcer to the sacrum that measured 0.5 cm x 0.5 cm with scant serous drainage; and on September 9, 2015 the ulcer was staged as a " 1, " measuring 0.2 cm x 0.5 cm, with scant serous drainage. A review of the physician ' s interim order form revealed an order dated September 3, 2015 that directed the following, " ...Cleanse sacral opening with NSS [Normal Saline Solution], pat dry, apply calmoseptine each shift and prn [as necessary]. " On September 17, 2015 at approximately 10:00 AM, a wound care observation was conducted with Employee # 17 for resident #91. Resident #91 was observed, in the presence of Employee #10 to have a Stage 2 (open) wound on his/her sacrum. Employee #10 acknowledged and confirmed the finding. Facility staff failed to identify the appropriate stage of the sacral ulcer; according to the pressure ulcer staging described in MDS. The record was reviewed on September 14, 2015.	F 314	**483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES** **Response to #1, 2, Resident #64, #91** Refer to page 108 for response.	
F 323 SS=D	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.	F 323		

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F 323	Continued From page 113 This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 14, 2015 at approximately 2:30 PM and on September 16, 2015 at approximately 10:00 AM, it was determined that facility staff failed to maintain the area free of accident hazards as evidenced by two (2) of two (2) surge protectors observed on the floor of one (1) of 42 resident's rooms surveyed and one (1) of one (1) surge protector observed on top of the dresser in one (1) of 42 resident's rooms surveyed, nails that were sticking out of the top of the closet door in one (1) of 42 resident's rooms surveyed, an unlocked and accessible utility closet with cleaning chemicals on one (1) of three (3) resident's care unit and an unlocked and accessible oxygen storage room on one (1) of three (3) resident care units. The findings include: 1. Two (2) of two (2) surge protectors were not mounted and were observed on the floor of room #6138, and a surge protector was observed on top of a dresser in room #6104, two (2) of 42 resident's rooms surveyed.	F 323	**483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **Response to #1-4** 1. Immediately upon notification, the surge protectors were secured, the nails sticking out of the top of the closet door were removed and closet door repaired in the identified areas. The utility closet on 5th floor and oxygen storage room on 6th floor was securely locked. 2. Facilities Supervisor and Interim Administrator performed Environment of Care (EOC) rounds on each unit focusing on surge protector location, resident closet doors and utility closet on each unit. Those found out of compliance were repaired and/or placed on a maintenance repair schedule. 3. Environmental Surveillance Rounds will continue to include Facilities Director, Maintenance Supervisor and EVS Supervisor. An electronic work order system was established to submit and track completion. An Environment of Care Committee (EOC) was formed to monitor maintenance/repair activities based on findings from the surveillance rounds and electronic work order system 4. The Facilities Director or designee will audit the work order system and surveillance round findings to ensure EOC activities are addressed. A monthly compliance summary will be reported to the EOC Committee and Quality Assurance Committee.	11.10.2015 & ongoing

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F 323	Continued From page 114 2. Four nails were observed protruding from the top of a broken closet door in room #4132, one (1) of 42 resident's rooms surveyed. 3. The utility closet on the fifth floor where housekeeping cleaning chemicals are stored, was unlocked and accessible to residents and visitors. 4. The oxygen storage room located on the sixth floor was unlocked and accessible to residents and visitors. These observations were made in the presence of Employee #8 who acknowledged the findings.	F 323		
F 328 SS=J	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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for	F 328		

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Continued From page 115

four (4) of 55 sampled residents, it was determined that the facility staff failed to ensure that residents received the necessary care and treatment relative to ventilator services as evidenced by failure to: recognize, assess and monitor potential complications for one (1) ventilator dependent resident who demonstrated symptoms of respiratory dysfunction for greater than 24 hours; and was subsequently transferred via 911 to an emergency department and hospitalized in intensive care; failure recognize, assess and monitor potential complications for one (1) resident who was ventilator dependent and experienced an increase in heart rate [tachycardia] and was subsequently transferred via 911 to an emergency department ; accurately assess the respiratory status of one (1) resident requiring ventilator services and perform an accurate assessment of one (1) resident with a known change in condition. Residents #145 (is affiliated with the immediate jeopardy scope and severity), 37, 5, and 98.

An Immediate Jeopardy (IJ) was identified at 42 CFR 483.25(k); F328 Special Needs; ensure that residents receive proper treatment and respiratory care for Failure to prevent neglect: Lack of supervision for individuals with known special needs and Failure to monitor and intervene for serious medical conditions. The notification of the IJ was made on September 22, 2015 (Tuesday) at 2:20 PM.

The facility's Administrator provided a letter noting a corrective action plan inclusive of staff training on multiple aspects of the provision of respiratory care to licensed nursing staff and respiratory therapists. A review of the IJ action plan was removed on September 25, 2015 at 6:00 PM.

F 328

483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

Response to #A1-3, Resident #145, #37, #5, #98

1. Immediately upon notification of this deficiency, the medical records for resident #145 and #5 to verify findings. On 9/16/15, 1:1 Education of the Respiratory staff involved was held on the timeliness of completing respiratory orders and enhance accountability.

2. Nursing conducted a retrospective review of the 24-hr report for indications of status change, cross- referencing the medical record to ensure the physician is notified of any change in the resident's condition. The audit results found all medical records in compliance.

   Respiratory Therapist conducted medical record audits to identify new/changed orders and indications of missed orders. Those found out of compliance were addressed with the attending physician.

3. The clinical nursing staff were educated 9/22-9/26, 10/7 and ongoing by the Respiratory Department on the weaning protocol and related comprehensive assessment and interventions.

   The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable)

   The Respiratory staff were re-educated on 9/25/2015 related to the timeliness of completing physician orders, notification to physician, and the use of the communication binder.

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F 328	Continued From page 116 Subsequently, the deficiency was identified at a scope and severity of "E." The findings include: Facility staff failed to recognize and assess factors that placed Resident #145, who was ventilator dependent, at risk for complications as evidenced by the resident ' s repeated complaints of shortness of breath, refusal of respiratory treatments [CPAP - Continuous Positive Airway Pressure - breathing treatment] and alteration in level of arousal. The resident began complaining of shortness of breath on August 29, 2015, refused CPAP treatments beginning August 28, 2015 and demonstrated an alteration in the level of arousal on August 31, 2015. On August 31st at approximately 9:03 PM, Resident #145 sustained low blood pressure, increased respirations and tachycardia. Subsequently, the resident was transferred to the nearest emergency room (ER) and was hospitalized in intensive care. Resident #145 was admitted on August 24, 2015. According to the admitting history and physical examination signed by the physician August 25, 2015, Resident #145 ' s diagnoses included Chronic Respiratory Failure, Status Post Tracheotomy-Continue on [Ventilator], Quadriplegia [secondary] to cervical spine injury, Non-Ischemic Cardiomyopathy, Congestive Heart Failure, Major Depression with Anxiety and Diabetes Mellitus Type II. According to clinical record entries documented by respiratory therapy; in S-BAR format [situation/background/assessment/recommendati	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-3, Resident #145, #37, #5, #98 (Cont'd)** 3. Residents on weaning protocol will be entered on the 24 hour report to ensure notification of residents' status and order changes are communicated across shift. Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. 4. The Resident Care Coordinator (RCC) will perform weekly audits of the 24 hour report to ensure appropriate protocol related to residents' change in condition are followed per policy. Results of the audits will be reported weekly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months. The Respiratory Department will conduct monthly audits to respiratory orders. A monthly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months.	11.10.2015

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F 328	Continued From page 117 on] the following was revealed: [August 28, 2015 to] August 29, 2015 - " 7PM-7AM- Shift Report - " Patient refused CPAP trails last night; Sat = 99% [oxygen saturation], [Heart Rate] 79, [Respiratory Rate] 24. Alert [and] stable. Patient has a lot of thick tan to white (oral) secretions. Continue to encourage patient to get weaned ...CPAP 5/10 x10[minutes], back on AC [assist control] due to patient complaining of SOB [shortness of breath] " August 30, 2015 - " 7AM-7PM- Shift Report - " Received [patient] on AC mode, [nebulization treatment] given as ordered. [Patient]... (Illegible writing). [oxygen saturation] -99%, HR (illegible writing), Will continue to monitor patient. Special procedures done ...Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp [complaining] of SOB [shortness of breath], anxious. Placed back on AC [Assist Control] mode to rest. " [August 30, 2015 to] August 31, 2015- " 7PM-7AM- S- [Patient] is on AC 15/[Tidal Volume]-500, [Fractioned of Inspired Oxygen-45%, [Peep]-5, B- Respiratory Failure, A- Pt stable throughout shift- Sat-98%. HR-79, RR (Respiratory Rate) -21. Pt complains of being unable to breathe but in no apparent distress. Continue to monitor for changes. " August 31, 2015- " 7AM-7PM- S- Pt remains on AC mode, O [No] active weaning do [due] to pt being less arousable in PM. B- Respiratory failure, A- Alert [male/female], HR-84- RR-25, Sat-98%, small thin pale secretions, BS (breath sounds) clear, R- Will continue to monitor. " August 31, 2015 " Ventilator Flow Sheet "	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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F 328	Continued From page 118 [recorded by respiratory therapist] revealed the following " Rate Set/Total " on the A/C mode: [Rate Set/Total defined: 15/34 - "15" reflects ventilator preset respiratory rate and " 34" reflects - resident breaths above the set rate] 0130 (1:30 AM) - 15/34 - [Oxygen] Saturation[normal range 95 - 100%] - 97%, Heart Rate- 87 0425 (4:25 AM) - 15/33 - [Oxygen] Saturation- 98%, Heart Rate-93 0855 (8:55 AM) - 15/32 - [Oxygen] Saturation-98%, Heart Rate-87 1230 (12:30 PM) - 15/33 - No Oxygen Saturation and Heart Rate documented in the allotted space. [1700] 5:00 PM - 15/29 - [Oxygen] - 98%, Heart Rate-80 2045 (8:45 PM) - 15/23, Saturation 96%, Heart Rate- 158. " Nursing Notes: August 28, 2015 3:13 PM - " ...V/S [vital signs]: [b/p-blood pressure] 108/58; [P-pulse] 99; [R-respirations] 18 ... no acute distress noted " August 29, 2015 3:00 AM - " ... [b/p] 116/62; [P] 78, [R] 20 ... " August 31, 2015- 12:35 PM - Resident remain alert and responsive. Vent [ventilator] dependent AC mode for respiratory support. Suction PRN (as needed) ...V/S- [Blood Pressure] - 134/74, 98.9 [Temperature]-, 74, 100 [two (2) different	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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 328	Continued From page 119 heart rates] no respirations documented... S-BAR (Situation-Background-Assessment-Recommendation) /Acute Change in Condition Report: Situation- Date: August 31, 2015, Time: 9:39 PM [of note, this is the successive nursing note to the August 31st 12:35 PM entry] ... low B/P- 77/53, P-153, R-24, lethargy [and] gasping for breath, although on vent. Background: Respiratory Failure, Temp: 98.6, B/P- 77/53, RESP: 24, Pulse: 153, Lung sounds: Crackles, Pulse ox: 93% ventilator ... Resident was noted [with] [decreased] B/P 77/53, elevated pulse rate. House officer notified who ordered to transport resident to [hospital] for further evaluation and treatment. " There was no evidence that licensed nursing and respiratory staff identified that Resident #145 exhibited progressive change in status (respiratory and mental) that warranted monitoring and/or intervention before the resident became obtunded, unresponsive with agonal breathing requiring transfer to higher level of care. August 31, 2015- 2103 (9:03 PM) - Hospitalist [physician] Note: I was called to evaluate [Resident #145] b/c (because) of hypotension, tachycardia, [and] acute AMS gradually since few hours ago. [His/her] HR (heart rate) has been elevated to 150 ' s [and] B/ P as low as 77/53. As per nurse even to earlier today [he/she] was A&O (alert and oriented), but currently [he/she] is obtunded (diminished arousal and awareness) [and] unresponsive with agonal (gasping) breathing. [He/she] is quadriplegic. Assessment/Plan: Acute AMS [and] hypotension-	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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F 328	Continued From page 120 unknown cause ([he/she] finished [his/her] IV (Intravenous) Cipro (antibiotic) yesterday [and] Diflucan (anti-fungal medication) was discontinued). Transfer to nearest ER (Emergency Room). " The clinical record lacked evidence that nursing and respiratory staff recognized and communicated to the physician, the resident's progressive complaint of having shortness of breath, refusing CPAP trials, alteration in the level of arousal from August 28, 2015 to August 31, 2015 until 9:03PM, when the resident was obtunded and with agonal breathing. Interviews A face-to-face interview was conducted with Employee #14 [on-coming day-shift team member, August 31, 2015 7AM - 7PM] September 18, 2015 at approximately 2:00 PM regarding the above aforementioned concerns. He/she said that the off-going team member [night shift August 30th 7PM through August 31, 2015 7AM] stated that the resident was calling all night, using the type of call bell one blows into. Employee #14 further stated the off-going therapist and the nurse was in and out of the resident ' s room all night. Employee #14 acknowledged the physician should have been informed of the resident's restlessness, complaint of having shortness of breath and refusal of CPAP treatments. A review of records obtained from the acute care facility that the resident was transferred to revealed the following physician ' s entry dated 8/31/15: " ...[Resident #145] presented to the ED (Emergency Department) from NH (Nursing	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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F 328	Continued From page 121 Home) with acute AMS (Altered Mental Status), hypotension, tachycardia and fever of 107. In ED, [Temperature] - 41.7(Celsius- converted to Fahrenheit- 107.6 degrees); [Heart Rate-85]; Respirations-16; Blood Pressure (Systolic/Diastolic) 87/48. " The clinical record was reviewed September 18, 2015. Cross referenced 483.25 F309; 483.30(a) F353; 483.10(b)(11) F157 2. Facility staff failed to perform an accurate assessment for Resident #37 that experienced a documented change in condition. The respiratory therapy staff assessment was inconsistent with the resident's status as reflected in the physician and nurse's assessment on September 18, 2015 at 5:30 PM and 5:00 PM; respectively. Resident #37 was admitted on July 22, 2015 with diagnoses to include Chronic Respiratory Failure, Coronary Artery Disease, and Sacral Decubitus. Medical record review was conducted on September 21, 2015 at 9:40 AM. The review of clinical notes revealed inconsistencies in the assessment of Resident #37 status on September 18, 2015 at 5:00 PM as it relates to entries documented by medical staff, nursing staff, and respiratory staff. The inconsistencies are as follows: Physician Progress note from September 18, 2015 at 5:30 PM revealed the Attending	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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F 328	Continued From page 122 Physician was requested by the nursing staff to evaluate the resident with changes in mental status, tachycardia [rapid heart rate], and hypoxia. According to the medical staff assessment, the resident was noted to have a heart rate of 166 beats per minute, blood pressure of 125/56 millimeter of Mercury. The nursing staff documented an ' Acute Change in Condition Report ' dated September 18, 2015 at 5:00 PM secondary to resident with elevated irregular heart rate of 166 beats per minute and oxygen saturation of 81% while on the ventilator with FiO2 of 40%. Review of the Ventilator Flow Sheet dated September 18, 2015 revealed the respiratory therapy staff documented pre- treatment assessment at 5:00 PM which indicated the heart rate- 89 beats per minute, respiratory rate- 19 breaths per minute, and oxygen saturation- 98 percent; and post-treatment assessment at 5:15 PM indicating heart rate was 90 beats per minute, respiratory rate 16 breaths per minute and oxygen saturation of 98%. Although the medical and nursing staff assessed Resident #37 to have experienced a change in condition to include elevated heart rate, increased respirations, and decreased oxygen saturation, the respiratory therapy staff documented an assessment with the heart rate, respiratory, and oxygen saturation consistent with Resident #37 ' s baseline physical assessments. Resident #37 was subsequently transferred via Emergency Medical Services to a local emergency	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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F 328	Continued From page 123 department. A face to face interview was conducted with Employee #31 on September 21, 2015 at approximately3:30 PM. S/he confirmed that the respiratory assessment was inconsistent with the change of condition at the time of assessment. The findings were reviewed, discussed, and acknowledged. 3. Facility staff failed to recognize and assess factors that potentially placed Resident #5, who was ventilator dependent, at risk for complications as evidenced by failure assess and monitor the resident when he/she experienced an increase in heart rate and subsequent compromise in respiratory function. The resident was subsequently sent out 911 [Emergency Services]. A review of Resident #5's quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of April 22, 2015 revealed diagnoses in Section I (Active Diagnoses) that included: Hypertension, Tracheostomy, Respiratory Failure, and Ventilator. Physician's orders dated May 9, 2015 directed; " Vent [Ventilator] Settings: AC (Assist Control) Mode- Rate-10, VT- 400 [Tidal Volume]- FIO2 [Fraction Inspired Oxygen]- 40% Physician ' s Progress Notes: Pulmonary Note - June 1, 2015 at 1:45 PM revealed " Patient [resident] remains on vent. Responds to stimuli, no purposeful movements.	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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F 328	Continued From page 124	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS**	

Vent settings AC [mode of Assist Control] 10, VT [tidal volume] 500, PEEP [positive expiratory end pressure] +5, Fi02 [room air] 40%. Exam: vitals 104/72, P 69, R 18, T 97.9; CTA-[clear to auscultation bilaterally no wheezes; CVS [cardiovascular] no murmurs; Abd [abdomen] + [positive] bs [bowel sounds]; Ext [extremities] no edema ...A/P Assessment/Plan (1) chronic Respiratory Failure; (2) Encephalopathy secondary CVA [Cerebral Vascular Accident] - Continue on vent support - no weaning - supportive care. "

MD [Medical Doctor] Acute Note - June 2, 2015 at 08:50 AM revealed " Responding to " Rapid Response. " Patient [Resident] identified with tachycardia [rapid heart rate] with HR [heart rate] 140, SBP [systolic blood pressure] 110, RR [respiratory rate] 20s-30s; SAT [Saturation] 96%, 100% Fi02 with ambu bagging. Emesis, tube feeding witnessed; lung (+) Rhonchi, R [right] CTA [clear to auscultation] left. CVS[Cerebrovascular system]: tachycardia ...ABD: distended...hypo [hypoactive] bowel sounds; ENT [Ear, Nose, Throat] edema BUE [bilateral upper extremities], R [right] > [greater than] L [left]. Warm extremities; A/P [Assessment/Plan] : Respiratory Distress, R/O [rule out] aspiration/sepsis. Will send to ER [Emergency Room] via [by] 911. "

A review of the nursing notes revealed the following:

" May 31, 2015 4:50 AM - " Resident is alert and responsive. AM care given, vs [vital signs] 98.4 temperature, P [pulse] 77 R[respirations] 16, BP [blood pressure]127/68, Pulse OX [oximetry] 96%. No evidence of pain noted. Care given will

Provider's Plan of Correction (F 328):

Response to #A1-4, Resident #145, #37, #5, #98

Refer to page 116 for response.

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F 328	Continued From page 125 continue to monitor ... "	F 328	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS Response to #A1-4, Resident #145, #37, #5, #98 Refer to page 116 for response.	

May 31, 2015 6:30 PM - " Resident is alert and responsive, due medications given as ordered. No abnormal findings noted. Vs T 98.2, P 86 R 20, BP 133/78. Pulse Ox 96%. Will continue to monitor. "

June 1, 2015 4:00 PM - " Resident is alert and responsive PM care given. VS [vital signs] T [temperature] 98.6, P [pulse] 87, R [respirations] 20, BP [blood pressure] 130/77 Pulse OX [oximetry] 98%. Turned and repositioned, due meds given. "

June 2, 2015 5:00 AM - " Resident is alert. On vent [ventilator dependent] for support. Trach [tracheostomy] and suction care provided. Total care with ADL [Activities of Daily Living]. Enteral Feeding in progress. Peg [percutaneous endoscopic gastrostomy] tube patent and flushed well. Will monitor. Vs [BP] 131/72, [P] 76, [R] 18, [T] 98.3.

June 2, 2015- 8:35 AM- SBAR [standardized communication in healthcare - S = Situation, B = Background, A = Assessment, R = Recommendation]/Acute change in condition note read: " Resident was noted with respiratory distress and an elevated HR [heart rate] of 140 [bpm/beats per minute]. Resident was bagged by RT [Respiratory Therapy] while Rapid Response was called. Rapid Response team responded ....In house officer gave new order to transfer resident via [by] 911 [Emergency]. Emesis [vomiting] noted x [times] 1 [one] during bagging with seizure like activity. Resident was then transferred via 911 to [local hospital]. "

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F 328	Continued From page 126	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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Respiratory Therapy Notes:

A review of the Respiratory Ventilator Flow Sheet for June 2, 2015 revealed the following:

"Date: June 2, 2015
Time: 0025 [12:25 AM]
Mode: AC
Fi02: 40%
PEEP: 5
Saturation: 97%
Heart Rate: 70

Date: June 2, 2015
Time: 0345 [3:45 AM]
Mode: AC
Fi02: 40%
PEEP 5
Saturation: 98%
Heart Rate: 121

Date: June 2, 2015
Time: 08:20 [8:20 AM]
Mode: AC
Fi02: 40%
PEEP: 5
Saturation: 99%
Heart Rate [HR]: 129

There was no documented evidence that the physician was notified in regards to Resident #5's increased heart rate from June 2, 2015 (3:45 AM) to June 2, 2015 (08:20 AM), which is indicative of approximately 4 hours.

A review of the respiratory therapy shift notes revealed:

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F 328	Continued From page 127	F 328	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	

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June 2, 2015 [notes beginning June 1, 2015 7PM - 11:59 PM thru June 2, 2015 12 Midnight - 7AM] - 7pm-7am shift note revealed:
S: Pt on A/C mode
B: Respiratory resident
A: Sat 98% HR 71, RR [respiratory rate] 18 BS [breath sounds] Rhonchi/clear, sxn [suction] moderate yellow suction, no distress.
R: monitor

June 2, 2015 -7AM- 7PM Shift- " PT [Patient] transferred to area Hospital. "

The clinical record lacked evidence that facility staff assessed and monitored Resident #5 when the resident ' s heart rate increased which was first documented on June 2, 2015 at 3:45 AM, heart rate - 121. The resident ' s condition declined as evidenced by increased tachycardia [rapid heart rate - elevated to 129 beats per minute]. A rapid response [a team of health care providers that responds to intervene when a resident shows signs of clinical deterioration to prevent respiratory of cardiac arrest] was called and the resident was subsequently transferred to the Emergency room via 911 [Emergency Medical Services] according to the SBAR at the time of transport the resident's heart rate was 140.

A face-to-face interview was conducted on September 21, 2015 at approximately 10:30 AM with Employees #18 and #47. Employee #18 stated that his/her shift was 7:00AM to 7:00PM. Employee #18 also stated, when he/she first saw the resident with the heart rate 129 is when the rapid response was called at approximately 8:20AM, the resident vomited when he/she was bagged [manually resuscitated using a bag valve

Provider's Plan of Correction (F 328):

483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

Response to #A1-4, Resident #145, #37, #5, #98

Refer to page 116 for response.

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F 328	Continued From page 128 mask]. Employee #47 stated when he/she was conducting rounds from the rooms assigned when he/she was called to the rapid response by Employee #18 who stated that the rapid response [team] took over, and that the resident had vomited when he/she was bagged and then the resident was sent out 911 with a heart rate at 140. The night shift nurse was not available for interview. The record was reviewed September 21, 2015. 4. Facility staff failed to accurately assess the respiratory status of Resident #98 who required ventilator services. The facility policy dated May 15, 2015, titled ' Ventilator Management and Nursing Care Respiratory Education ' detailed the following information: " care of the tracheostomy tube, modes of ventilation, alarms and common causes, breath sounds assessment, weaning, and patient suctioning. " [This document was provided to the State Agency on September 22, 2015 by the Facility Administrator [Employee #1]. The policy entitled, ' Ventilator Settings Definitions ' (no initiated or revised date) included the following information: "Mode: The way a breath is delivered, Assist Control: A/C, Synchronized Intermittent Ventilation: SIMV, Continuous Positive Airway Pressure CPAP Rate: (bpm- breath per minute), usually set at 8-12 breaths per minute, Tidal Volume: The amount of volume inhaled in the lungs. The ventilator delivers a pre-set volume of gas with each breath, Fi02: fraction of inspired oxygen [percent of oxygen a patient is	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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F 328	Continued From page 129 inhaling], and Positive End Expiratory Pressure [PEEP]: Special setting on the ventilator that keeps the lungs expanded to help get oxygen from the lungs into the bloodstream." [This policy was provided to the State Agency on September 22, 2015 by the Nurse Educator]. The facility policy #CP.603, last revised June 17, 2015, titled, ' Ventilator Weaning Protocol ' stipulates, " II. Policy: Protocol will be applied per physician ' s written order of Wean per protocol." On September 21, 2015 at approximately 9:30 AM, a review of the admission record revealed that Resident #98 was admitted on July 8, 2015 to the facility with a diagnosis that included Respiratory Failure. A physician's order dated July 8, 2015 directed that the resident have a mechanical ventilator [a mechanical machine that assists or replace spontaneous breathing] programmed at the following settings: A/C, Rate 10, Tidal Volume [VT] 500, Fi02 30%, and PEEP 5. A physician's order dated August 13, 2015 directed the following, "Initiate ventilator weaning protocol." [Defined by the National Institutes of Health as the gradual withdrawal of ventilatory support through utilization of a variety of ventilator modes, periods of total spontaneous ventilation, and appropriate rest periods for muscle unloading [Respiratory therapy was responsible for initiating weaning]. <http://clinicalcenter.nih.gov/ccmd/cctrcs/pdf_docs/Ventilator%20Management/02-Ventilator%20Weaning.pdf>] On September 21, 2015 at approximately 9:40	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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F 328

Continued From page 130

AM, an observation of the ventilator settings for Patient #98 was noted as follows:

A/C, Rate 12
VT 500
Fi02 40%
PEEP 5

On September 21, 2015 at approximately 9:42 AM, a review of the 'Ventilator Flow Sheet' completed by respiratory therapy [who adjusted the ventilator settings as per weaning protocol] during the period of September 1, 2015 to September 21, 2015 revealed the following documented ventilator settings:

A/C Rate - 12
VT - 500
Fi02 - 40%
PEEP - 5

Review of the "Nursing Respiratory Flow " sheet revealed the following recorded ventilator settings for the period of September 1, 2015 to September 21, 2015:

A/C Rate - 10
VT - 500
Fi02 - 30%
PEEP - 5

The documented assessment of ventilator settings recorded by the nursing staff on September 21, 2015 failed to correlate with the actual settings that reflected the respiratory status of the resident, as observed. Additionally, from September 1, 2015 to September 21, 2015, the documented assessment of ventilator settings recorded by the nursing staff failed to correlate

F 328

483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

Response to #A1-4, Resident #145, #37, #5, #98

Refer to page 116 for response.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING ______ B. WING ______	09/23/2015

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F 328	Continued From page 131 with the actual settings documented by the respiratory therapist. On September 21, 2015 at approximately 9:45 AM, a face-to-face interview was conducted with Employee #16, the registered nurse who was assigned to care for Resident #98. Employee #16 also confirmed that his/her assignment included the care of Residents #37, 98, 111, 134, 137, 138, who were all ventilator dependent. He/she was interviewed at the bedside of Resident #98, at the site of the ventilator. Employee #16 was asked to observe Resident #98 and the ventilator, confirm the ventilator settings, and describe the mode, the set rate, the resident's rate, and the resident's response to the ventilator. Employee #16 stated the rate was 12; but could not explain his/her documentation of a rate of 10 and Fi02 30% or describe the remaining requested information related to nursing care for the specialized ventilator services. On September 21, 2015 at approximately 10:30 AM a face-to-face interview was conducted with Employee #22, who was assigned to care for residents requiring ventilator services. Employee #22 was asked to observe Resident #98 and the ventilator, confirm ventilator settings, and describe the mode, the set rate, the resident's rate, and the resident's response to the ventilator. Employee #22 explained the set rate of 12; however, he/she could not further explain the requested information related to nursing care for the specialized ventilator services. On September 21, 2015 at approximately 10:45 AM a face-to-face interview was conducted with Employee #10, the nurse manager for the unit, regarding the aforementioned findings. He/she	F 328	**483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS** **Response to #A1-4, Resident #145, #37, #5, #98** Refer to page 116 for response.	

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F 328	Continued From page 132 acknowledged the findings, stating that the respiratory therapy staff would hold an in-service for the nursing staff. The record was reviewed on September 21, 2015.	F 328		
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 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 record review and staff interview for one (1) of 55 sampled residents, it was determined that facility staff failed to ensure that	F 329	**483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** **Response to Resident #94** 1. Immediately upon notification of this deficiency, the medical records for resident #94 was reviewed and identified no adverse effects. The attending physician was notified and confirmed the need for Vitamin C for wound healing. A complete order was obtained to include dose, frequency and route of administration and transcribed on the MAR. 2. An audit of the MAR for September was reviewed on each unit and were brought into compliance where indicated. 3. The nursing staff were re-educated on 10/16, 10/30 and ongoing regarding the standards of practice as it relates to administration of medication (the Five Rights) and the process of reconciliation of monthly orders. The Medical Director will send a memo to the medical staff on the standards of practice related to complete medication orders. 4. The RCCs or designee will continue to perform monthly audits of the MAR to ensure accuracy per physician order. Results of the audits will be reported weekly to the Risk Management Subcommittee for four (4) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is consistently demonstrated for three (3) months.	11.10.2015

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F 329	Continued From page 133 Resident #94 was free of unnecessary medications as evidenced by failure to ensure the resident received only those medications ordered by the physician, as clinically indicated. The findings include: On September 16, 2015 at approximately 12:30 PM, a review of the admission record revealed that Resident #94 was admitted to the facility on October 10, 2014. Review of the physician's history and physical dated October 10, 2014 revealed the resident ' s diagnoses included Deconditioning and Decubitus Ulcers. On September 16, 2015 at approximately 12:32 PM, a review of the July and September 2015 physician ' s order sheets lacked documented evidence of an order for Vitamin C to be administered to the resident. Review of the Medication Administration Record [MAR] dated July 2015 revealed the following: " Vitamin C 500mg [milligrams] po [by mouth] BID [twice a day] for wound healing. " The staff had signed the allotted signature boxes twice a day from July 1-31, 2015 which indicated the medication was given to the resident. Review of the Medication Administration Record [MAR] dated September 2015 revealed the following: " Vitamin C. " The order was incomplete, lacking the dose, frequency, route of	F 329	**483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** **Response to Resident #94** Refer to page 133 for response.	

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F 329	Continued From page 134 administration, and use. The staff had signed the allotted signature boxes twice a day from September 1-16, 2015 which indicated the medication was given to the resident. The staff failed to ensure the resident was free from unnecessary medications as evidenced by the administration of Vitamin C to the resident for 16 days in September and 31 days in July, without a physician ' s order. On September 18, 2015 at approximately 12:40 PM, a face-to-face interview was conducted with Employee #4 regarding the aforementioned findings. He/she reviewed the records and acknowledged the findings. The record was reviewed on September 16, 2015.	F 329		
F 353 SS=K	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.	F 353	**483.30(a) SUFFICIENT 24 HR NURSING STAFF** Refer to page 137 for response.	

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F 353	Continued From page 135 Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and resident outcomes, it was determined that the facility failed to provide sufficient nursing staff to ensure the delivery of nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as evidenced by failure to have sufficient staff in both numbers and/or qualifications to meet the needs of 21 of 55 sampled residents. An Immediate Jeopardy (IJ) was identified at a scope and severity of " J " in the areas of CFR 483.25 Quality of Care, F-309 Failure to ensure that each resident attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care - specifically, Resident #145 and 11 additional ventilator dependent residents that have the potential to be affected by this deficient practice; F-328 Failure to ensure that residents receive the necessary care and treatment relative to ventilator services - specifically, Resident #145 and 11 additional ventilator dependent residents that have the potential to be affected by this deficient practice; a scope and severity of " K " was identified at F-353 Failure to have sufficient staff in both numbers and/or qualifications to meet the needs of residents, specifically, deficient practices related to the provision of needed care	F 353	**483.30(a) SUFFICIENT 24 HR NURSING STAFF** Refer to page 137 for response.	

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F 353	Continued From page 136 for residents identified in the regulatory groupings of quality of care and quality of life and 483.20 Resident Assessment; F-282 Failure to ensure that licensed nurses assigned to provide ventilator services were qualified and competent - specifically, Residents #98, 145, and 11 additional ventilator dependent residents that have the potential to be affected by this deficient practice. The facility's Administrator provided a letter noting a corrective action plan [see letter attached] and the IJ was removed on September 25, 2015 at 6:00 PM. Subsequently, the Immediate Jeopardy was lowered to a scope and severity of " E " for each of the tags, F-282, F-309, F-328 and F-353. The findings include: Example(s) of care deficits caused by insufficient quantity and/or quality of nursing staff include: A review of the nurse staffing assignment indicative of the provision of nursing care for residents residing on the 6th floor nursing unit who require special care needs such as ventilator, tracheostomy and respiratory related services revealed the absence of Registered Nurse (RN) staff during the day-shift [7:00 AM - 3:30 PM] on August 30, 2015. The configuration of the resident population on August 30, 2015 included 12 residents dependent on mechanical ventilators for adequate breathing, 15 residents who had tracheostomies [a surgically created hole through the front of the neck and into the windpipe (trachea) that provides an air passage for breathing], four (4) residents requiring BIPAP therapy [Bi-level	F 353	**483.30(a) SUFFICIENT 24 HR NURSING STAFF** 1. See immediate corrective actions for all areas of concern sited. The staffing records for nursing and respiratory were reviewed to verify findings. 2. A lookback of the staffing records identified this event ass an isolated incident, therefore no other resident was found to be affected. 3. The Respiratory Department will develop a staffing plan based on patient census and care needs. Policy 112 Respiratory Staffing will be developed to outline minimum staffing requirements and contingency plans for staffing variances. BridgePoint Hospital Respiratory staff will assist with providing respiratory services to Bridgepoint Subacute in the event of staffing shortages. RT staff will notify the hospital and subacute nursing supervisors, and the RT Department Director immediately with reference to staffing shortage. Nursing Supervisors and RT Department Director will assist staff with contingency strategies to meet the care needs. The staffing plan, to include the Ventilator Care Unit will be reviewed on 11/2/15 and ongoing with the Staffing Coordinator, RCCs and nursing supervisors by the interim Administrator/DON. All registered nurses and licensed nurses were in-serviced 9/22-9/26, 10/7, 10/25-10/28 and ongoing regarding ventilator management care and weaning protocol to increase the number of qualified staff assigned to 6th floor. HR will implement plans to actively recruit respiratory therapists and qualified registered nurses to fill department vacancies and hire supplemental staff (i.e., PRN). 4. Staffing utilization will be tracked daily by the Director of Respiratory. Results are reported to the Administrator and DON daily. The nursing Staffing Coordinator will continue to provide a daily staffing report to the Administrator and/or DON. Staffing utilization, including the use of supplemental staff, per diem and PRN will be analyzed and reported to Executive Leadership monthly. Human Resources Department will report recruitment efforts daily in the Operations Meeting and monthly to the Quality Assurance Committee.	11.10.2015 & ongoing

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F 353	Continued From page 137 Positive Airway Pressure - a non-invasive mechanical pressure support ventilation], 2 (two) residents requiring Hi-Flow therapy [High flow nasal cannula oxygen therapy], 55 residents who required nebulization treatments and four (4) residents whose plan of care included ventilator weaning services. The staffing assignment for August 30, 2015 included four (4) Licensed Practical Nurses (LPNs) on duty during the day shift and one (1) respiratory therapist on duty during the period of 7:00 AM - 7:00 PM [12 hour-shift]. The absence of Registered Nursing staff on duty [8/30/15 day shift] for the provision of direct care services to residents and/or supervision of LPN practice, would allow residents on the 6th floor nursing unit to be subject to practices inconsistent with State requirements as follows: The scope of practice for LPNs, According to District of Columbia Municipal Regulations for Practical Nursing under Title 17, Chapter 55, Section 5514 " The practice of practical nursing means ...the performance of actions of preventive health care, health maintenance, and the care of persons who are ill, injured or experiencing alteration in health processes at the direction of the delegating or supervisory registered nurse ....shall include: (a) Participating in the performance of the ongoing comprehensive nursing assessment process of the client ' s biological, physiological, and behavioral health, including the client ' s reaction to an illness, injury, and treatment regimens by collecting data and performing focused nursing assessments; (b) Recording and reporting the findings and results of the ongoing nursing assessment process ... "	F 353	483.30(a) SUFFICIENT 24 HR NURSING STAFF Refer to page 137 for response.	

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

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F 353	Continued From page 138 In contrast ... The scope of practice for RNs According to District of Columbia Municipal Regulations for Registered Nursing under Chapter 54, Section 5414 " The practice of registered nursing means the performance of acts requiring substantial specialized knowledge, judgment, and skill based upon principles of the biological, physical, behavioral and social sciences in the following: (a) The observation, comprehensive assessment, evaluation and recording of physiological and behavioral signs and symptoms of health, disease and injury including the performance of examinations and testing and their evaluation for the purpose of identifying the needs of the client and family Additionally, care deficits caused by insufficient quantity and/or quality of nursing staff are delineated in this survey report under the regulatory groupings of Resident Rights, Resident Assessment and Quality of Care and cross referenced as follows: Cross referenced 483.10(b)(11) F157; 483.20(k)(3)(ii) F282; 483.25 F309; 483.25(a)(3)F312; 483.25(c)F314; 483.25(i)F325; 483.25(k) F328 Resident Rights - 483.10(b)(11) F157 Nursing staff failed to notify the physician when two (2) ventilator dependent residents who demonstrated a compromise in respiratory function and two (2) residents experienced a weight loss that exceeded five (5) percent in 30 days. Residents' #145 and #64 and #6, #5.	F 353	483.30(a) SUFFICIENT 24 HR NURSING STAFF Refer to page 137 for response.	

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F 353	Continued From page 139 Resident Assessment - 483.20(k)(3)(ii) F282 Facility failed to ensure that 20 of 20 licensed nurses assigned to provide ventilator services for 12 of 12 ventilator dependent residents were qualified and competent as evidenced by a lack of documentation in personnel records of training, experience and competencies to verify qualifications in ventilator management, and staff failure to identify the way the ventilator delivers a breath to the resident, if the resident initiated breaths on the ventilator, if the ventilator delivered a set breathing rate, and how the ventilator assisted the resident ' s breathing (mechanics of ventilation). Resident #98. Subsequently, Residents #13, 37, 80, 98, 100, 111, 134, 135, 137, 138, and 142 also had the potential to be effected by this deficient practice. Quality of Care - 483.25 F309 Nursing staff failed to provide the necessary care and services to ensure residents attain or maintain the highest practicable physical, mental, and/or psychosocial well-being as evidenced by failure to: consistently assess and monitor the status of one (1) who exhibited an acute change in status as manifested by low blood pressure, increased respirations and tachycardia; to perform an accurate assessment for one (1) resident who experience a documented change in condition; to consistently assess and monitor one (1) resident who was ventilator dependent and experienced tachycardia; assess and identify the need for one (1) resident who had accumulated white colored substance on his/ her tongue; and failed to ensure that one (1) resident wore protective head gear and that the head circumference was measured in accordance to physician's orders. Residents ' #145, #37, #5, #104 and #143.	F 353	483.30(a) SUFFICIENT 24 HR NURSING STAFF Refer to page 137 for response.	

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F 353	Continued From page 140 Additionally, facility staff failed to conduct comprehensive pain assessments to include characteristics such as intensity, type, pattern of pain, location, frequency and duration of pain for seven (7) residents and consistently assess two (2) residents response to pain intervention. Residents ' #64, #108, #107, #142, #80, #43 and #49. Quality of Care - 483.25(a)(3)F312 Nursing staff failed to ensure one resident received necessary services to maintain good oral hygiene as evidenced by one (1) resident who was observed with an accumulation of white colored substance on his/her tongue. Resident #104. Quality of Care - 483.25(c), F-314 Nursing staff failed consistently provide the necessary services and treatment to manage pressure ulcers as evidenced by failure to perform an accurate assessment to identify the appropriate stage of a sacral ulcer for one (1) resident; and implement measures to promote healing such as bed surfaces, nutritional status and pain management for one (1) resident. Residents #64 and #91 . Quality of Care - 483.25(k), F-328 Nursing staff failed to ensure that residents received the necessary care and treatment relative to ventilator services as evidenced by staff failure to: consistently assess and monitor one (1) ventilator dependent resident who demonstrated symptoms of respiratory dysfunction for greater than 24 hours in the absence of close monitoring, supervision and/or physician notification,	F 353	**483.30(a) SUFFICIENT 24 HR NURSING STAFF** Refer to page 137 for response.	

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F 353	Continued From page 141 subsequently was transferred to ER via 911; consistently assess and monitor one (1) resident who was ventilator dependent and experienced an increase in heart rate and was subsequently sent out 911 [Emergency Services]; accurately assess the respiratory status of one (1) resident requiring ventilator services and perform an accurate assessment of one (1) resident with a known change in condition. Residents' #145, #37 #5, and # 98.	F 353		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on September 9, 2015 at approximately 9:20 AM, it was determined that the facility failed to prepare food under sanitary conditions as evidenced two (2) of two (2) soiled grease fryers and a kitchen floor that was marred in several areas. The findings include:	F 371	**483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE SANITARY** **Response to #1 and #2** 1. Immediately upon notification of this deficiency, grease fryer in prep area was cleaned. The marred kitchen floors throughout the department will be replaced. 2. The Dietary Director conducted environmental rounds. Any sanitary or environmental issues were addressed immediately or submitted to maintenance through the electronic work order system. No residents were impacted by this deficiency. 3. The Dietary Director or designee will conduct monthly kitchen inspections to identify and correct sanitary or environmental issues. An equipment cleaning schedule will be developed and implemented by the Dietary Director. The Dietary staff were re-educated on the cleaning process of the grease fryers. The Dietary Director or designee will report audit findings monthly to the Environment of Care Committee and quarterly to the Quality Assurance Committee.	11.10.2015 & ongoing

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 142 1. Two (2) of (2) grease fryers were soiled with leftover food residue. 2. The kitchen floor was marred in several areas. These observations were made in the presence of Employee #5 who acknowledged the findings.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 55 sampled residents, it was determined that the physician failed to review the total program of care as it relates to weights, labs, wound status and pain for a resident that experienced a weight loss that exceeded five (5) percent in 30 days for one (1) resident and visual function for one (1) resident. Residents #64 and #122. The findings include:	F 386		

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	095027	A. BUILDING ______ B. WING ______	09/23/2015

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F 386	Continued From page 143	F 386	**483.40(b) PHYSICIAN VISITS REVIEW CARE/NOTES/ORDERS**	

1. The physician failed to review the total program of care for Resident #64 to include weights, labs, wound status and pain for a resident that experienced a weight loss that exceeded five (5) percent in 30 days.

A review of the medical record revealed that Resident #64 was admitted on May 4, 2015 with diagnoses to include Sacral decubitus ulcer, Urinary Retention, Hypertension, Lymphedema Bilateral Lower Extremities, and Bilateral Lower Extremity Venous Stasis, and " Chief Complaint: Nutritional Deficient with deconditioning " as documented on the History and Physical dated May 4, 2015. Resident underwent a Percutaneous Endoscopic Gastrostomy on May 8, 2015 for Dysphagia and poor oral intake.

Medical record review conducted on September 16, 2015 at 10:00 AM revealed the following documented weights: May 11, 2015- 186.8 pounds; May, 2015 (date of month unknown) - 177 pounds; June, 2015- 163 pounds; July, 2015- 150 pounds; and August, 2015- 141 pounds.

Review of the Physician ' s Progress Notes from June 22, 2015 through September 1, 2015 revealed the medical staff documented notification of significant weight loss on August 20, 2015. The medical record lacked documented evidence that the medical staff assessed the resident to identify the nature of the problem, possible causes, and/or tailored interventions to Resident #64 ' s specific situation i.e. monitoring of labs, specialty consults, frequent monitoring of weights.

Response to #1, Resident #64

1. Immediately upon notification of this deficiency a review of the medical record for resident #6 to verify findings.
2. The Assistant Director of Clinical Nutrition performed a retrospective audit of the monthly weights on 10/1/2015 to ensure that all residents with significant weight changes were addressed and communicated to the attending physician.
3. Assessment and Intervention policy will be revised to reflect the Registered Dietitian (RD) as responsible for notifying the attending physician or NP of a confirmed significant weight change within 48 hours. The RD will call the attending physician or NP to inform about the significant weight change via phone and email. The RD will keep a record of physician/NP significant weight notification including date, time, and mode of communication. The RD will continue to communicate weekly to the Interdisciplinary Risk Management Subcommittee of interventions related to significant weight changes based on clinical collaborations. — Completion date: 11.10.2015 & ongoing

   The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and is ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable)
4. The Assistant Director of Clinical Nutrition will perform monthly audits of the physician significant weight change notification record. The audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months

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F 386	Continued From page 144 A face-to-face interview conducted with Employee #27 at 10:38 AM on September 16, 2015 revealed that Resident #64 was admitted as "obese". According to Employee #27, after it was determined the resident was not eating, the plan was changed to adjust the tube feeding because of volume intolerance and oral intake. When queried about labs, s/he stated the labs were not available and it was assumed the albumin was low because of the sacral wound and weight loss. Juven was started for 2 weeks and then changed to Beneprotein. Although the dietician continued to make adjustment to the tube feeding order and the physician authenticated the order as evidence by a signature. The medical record lacked documented evidence the physician reviewed Resident #64 ' s total program of care to include possible cause of the significant unplanned weight variance, labs, wound status and pain prior to August 20, 2015. As of August 20, 2015, the resident had loss approximately 45.2 pounds since original weight of 186.8 pounds documented on May 11, 2015. The findings were discussed, reviewed and acknowledged by Employee # 11. 2. The physician failed to review the total program of care to implement measures for one (1) resident with Visual Function Deficits. Resident #122 According the History and Physical dated April 17, 2015 the resident had the following diagnoses	F 386	**483.40(b) PHYSICIAN VISITS REVIEW CARE/NOTES/ORDERS** **Response to #2, Resident #122** 1. Physician assessed resident #122 vision and appointment scheduled for follow-up and ophthalmologist care plan updated. 2. The Resident Care Coordinators (RCC) performed an MDS audit of all residents who triggered for vision impairment in the previous quarter finding no other residents affected. 3. Standardize documentation for care planning to create an integrated interdisciplinary care plan that will identify the problem, measureable goals and interventions/approaches. The DON/Administrator will in-service the Interdisciplinary Team on the care planning process. The MDS Coordinator will re-educate the department managers on the process to electronically view MDS care area triggers for all residents. 4. MDS Coordinators will perform weekly audits to ensure discussions related to trigger CAAs are reviewed and addressed by the IDT during care planning meetings. A monthly summary of the audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months.	11.10.2015

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F 386	Continued From page 145 which included: "Multiple CVA ' s (Cerebral Vascular Accidents), Chronic Respiratory Failure - Off Vent [Ventilator], Asthma ..." A review of the resident's Admission Minimum Data Set (MDS) dated April 23, 2015 and Significant Change MDS dated July 27, 2015 revealed in Section B1000Vision that the resident was coded " 1 " for Impaired - sees large print, but not regular print in newspapers/books; Section B1200 Corrective Lenses (contact, glasses, or magnifying glass) used in completing B1000, vision was coded " 0 " No. An observation and interview was conducted with Resident #122 on September 21, 2015 at approximately 11:00 AM. The resident indicated that he/she wears glasses, and that the glasses were on the dresser, however I prefer different glasses. The resident also stated that he/she could see out of the right eye and not the left eye. A review of the physician ' s progress notes lacked evidence an assessment related to the residents visual function deficits. A face-to-face interview was conducted on September 21, 2015 with Employee #10 at approximately 11:30 AM. After review of the above he/she acknowledged the findings, and indicated that an eye appointment would be arranged. The physician failed to review the total program of care to implement measures for one (1) resident with Visual Function Deficits.	F 386	**483.40(b) PHYSICIAN VISITS REVIEW CARE/NOTES/ORDERS** **Response to #2, Resident #122** Refer to page 145 for response.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 146 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews for six (6) of 55 sampled residents, it was determined	F 431	**483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** **Response to #1-6, Resident #16, 17, 31, 91,108, and 140** Refer to page 148 for response.	

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F 431	Continued From page 147 that the facility staff failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles as evidenced by: Five (5) vials of opened medications stored without notation of the resident ' s names on the vials or date they were opened; one (1) expired medication was stored in the refrigerator and one (1) expired medication was stored in the medication cart, accessible for use. Residents ' #16, 17, 31, 91,108, and 140. The findings include: 1. On September 14, 2015 at approximately 3:30 PM, a medication storage observation was conducted on the 4th floor with Employee #49. The following medications were observed opened and without notation of the resident ' s names on the vials or the date the vials were opened: · One Novolog [insulin-aspart] unlabeled vial in a box for Resident #16. · Two Humalog [insulin-lispro] unlabeled vials in a box for Residents #31 and 140. · Additionally, one (1) of one (1) vial of Tuberculin Purified Protein Derivative (lot#762019) was open and without notification of the date the vial was first opened. On September 14, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employee #12. He/she acknowledged the aforementioned findings. 2. On September 16, 2015 at approximately	F 431	**483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** **Response to #1-6, Resident #16, 17, 31, 91,108, and 140** 1. Immediately upon notification, the vials for residents #16, 17, 31, 108, and 140 were relabeled using the information affixed to the containers. The expired medication was removed from supply and discarded. The residents were not impacted by this deficient practice. 2. All medication carts and storage areas were checked to ensure all medications had appropriate labels to include resident's name and date medication/vial was opened. The checks also ensured expired medications were removed if noted. No other resident was affected. 3. The DON re-educated licensed staff on 9/16, 9/18, and is ongoing the regarding proper storage and labeling of medications and process to remove expired medications. The contracting pharmacy will performed monthly scheduled audits of the Medication carts and storage areas. RCCs or designee will perform daily checks of medication carts and refrigerated vials to ensure proper labeling. 4. Pharmacy will provide a monthly report to the RCCs and DON, and a quarterly summary to Quality Assurance Committee until 100% compliance is demonstrated for a minimum of three (3) months. RCCs or designee will report quarterly summary of nursing audit findings to Quality Assurance Committee until 100% compliance is demonstrated for a minimum of three (3) months.	11.10.2015

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F 431	Continued From page 148 12:20 PM, a medication storage observation was conducted on the 5th floor with Employee #49. The following medications were observed opened and without notation of the date the vials were opened and were expired: · Lorazepam [anti- anxiety medication], 1ml vial - (lot # 083352) for Resident #17, with an expiration date of August 8, 2015. · Vitamin C (23 tablets-Lot# 0105326) for Resident #91, with an expiration date of July 31, 2015. · Additionally, one (1) of one (1) bottle of Morphine Sulfate for Resident #108 was open, without notification of the resident ' s name and the date the vial was first opened. On September 16, 2015 at approximately 12:30 PM, a face-to-face interview was conducted with Employee #4. He/she acknowledged the aforementioned findings.	F 431		
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	F 441	**483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **Response to #1-2,** Refer to page 150 for response.	

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F 441	Continued From page 149 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility 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 observations and staff interview for two (2) of 55 sampled residents, it was determined that facility staff failed to help prevent the development and transmission of disease and infection as evidenced by: staff walking on the floor mat, while administering care to one (1) resident; and staff failed to maintain and perform good hygienic practices, as evidenced by placing the glucometer on the resident ' s bed, then returning it to storage in the medication cart, without first cleaning the glucometer.	F 441	**483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **Response to #1-2** 1. Immediately upon notification, the direct caregiver involved was educated of the violation in infection control practice. 1:1 re-education of Employee #48 and #51 was held on 9/16 and 9/23 respectively, by the DON on the standards of infection control practice, including use of PPE, cleaning equipment and hand hygiene. 2. Direct observations of staff during care process was performed by RCCs. Just-in-time education was performed if non-compliant practices were observed. 3. The Interim Administrator/DON re-educated the staff on 10/27, 10/28 and is ongoing regarding the standards of infection control practice, to include cleaning of medical equipment, removal of floor mats during bedside care and prevention of cross-contamination. 4. RCCs or designee will perform random infection prevention surveillance weekly, providing a monthly summary to the Infection Control Committee and Quality Assurance Committee until 100% compliance is demonstrated for a minimum of three (3) months.	11.10.2015 & ongoing

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F 441	Continued From page 150 The findings include: 1. Facility staff failed to maintain and perform good hygienic practices. On September 16, 2014 at approximately 11:45 AM and 2:00 PM, Employee #48 was observed walking on the floor mat, while administering care to a resident in room #6122. The observation was made in the presence of Employee #18 who acknowledged the finding. 2. Facility staff failed to staff failed to maintain and perform good hygienic practices. On September 21, 2015 at approximately 12:36 PM, a medication observation was conducted on the 5th floor, with Employee #51. During the observation, Employee #51 performed a finger stick on Resident #77, who was in room 5131, to check the blood glucose. After the test was completed, Employee #51 placed the glucometer on the resident ' s bed, left the room using one gloved hand to open the door, and went into room 5138 to use the hand sanitizer. He/she returned, retrieved the glucometer, and returned it to storage in the medication cart, without first cleaning the glucometer. On September 21, 2015 at approximately 12:45 PM, a face-to-face interview was conducted with Employee #51 who acknowledged the aforementioned findings.	F 441	**483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **Response to #1-2,** Refer to page 150 for response.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		

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F 456	Continued From page 151 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on September 9, 2015 at approximately 9:20 AM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of three (3) garbage disposals with a torn gasket and missing slats from air curtains located in one (1) of one (1) walk-in refrigerator and one (1) of one (1) walk-in refrigerator/freezer. The findings include: 1. One (1) of three (3) garbage disposals located in the prep area had a torn splash guard. 2. Air curtains from one (1) of one (1) walk-in refrigerator and one (1) of one (1) walk-in refrigerator/freezer were missing slats. These observations were made in the presence of Employee #5 who acknowledged the findings. B. Based on observation and staff interview made during tour of the sixth floor on September 9, 2015 at approximately 12:20 PM and September 16, 2015 at approximately 1:15 PM, it	F 456	**483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION** **Response to #A1-2** 1. Immediately upon notification, the splash guard in the prep area was replaced. A work order was submitted to repair the air curtain and slats in the walk-in refrigerator. 2. The Dietary Director conducted environmental rounds. Any sanitary or environmental issues were addressed immediately or submitted to maintenance through the electronic work order system. No residents were impacted by this deficiency. 3. The Dietary Director or designee will conduct monthly kitchen inspections to identify and correct sanitary or environmental issues. 4. The Dietary Director or designee will report audit findings monthly to the Environment of Care Committee and quarterly to the Quality Assurance Committee.	

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F 456	Continued From page 152 was determined that the facility failed to maintain essential equipment as evidence by the external ventilator alarm monitor for one (1) of eleven ventilator alarm monitors on multiple days. The findings include: 1. On September 16, 2015 at 12:15 PM during a tour of the ventilator unit revealed the external ventilator monitor for Resident #37 was observed to be turned off as evidenced by the lack of digital display on the screen. A face to face interview was conducted with Employee #30on September 16, 2015 at approximately at 12:20 PM. S/he stated rounds for the external ventilator alarm monitors are conducted once every shift to ensure proper functioning as a part of the ventilator checks. The external ventilator alarm monitors are battery-operated. The battery for the aforementioned alarm was observed to be low and continued to shut off when inspected by the respiratory therapist. There was not documented evidence to support that the facility staff monitored the proper functioning of the external ventilator alarm monitors as stated in the interview. 2. On September 16, 2015 at approximately 1:15 PM during a resident and unit observations on the ventilator unit, the external ventilator alarm monitor was observed to be off as evidenced by	F 456	**483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION** **Response to #B1-2** 1. The battery was immediately replaced by the respiratory therapist on 9/16. Immediate follow-up was conducted with the individual respiratory staff to enhance accountability. Respiratory therapy staff were reeducated on the process for checking ventilator external alarms. 2. External alarm check was performed on all patients that were on mechanical ventilation. Based on the review this was an isolated incident, resident #37, was not harmed by this deficiency. No other resident were found to be affected by this deficiency. 3. Daily rounding will be conducted at the beginning of each shift. Ventilator External Alarm Check List – All external alarms will be checked at the beginning of the shift. Effective 9/25/15, the Respiratory Therapist assigned to Subacute will record the following at the beginning of each shift: Alarm working properly and battery changed date. A running log will be maintained 4. The Director of Respiratory or designee will monitor the ventilator alarm log daily, providing a monthly summary to Quality Assurance Committee until 100% compliance is consistently demonstrated for three (3) months.	

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F 456	Continued From page 153 the lack of a digital display on the screen. Upon further inspection by the respiratory therapist, the battery was observed to be missing from the monitor. A face -to- face interview conducted with Employee #30 on September 16, 2015 at approximately 1:35 PM revealed the battery had been removed from the alarm at approximately 12:15 PM because of " low battery ". When queried about the battery replacement delay, he/she stated that he/she was distracted by another resident that required assistance. There was no documented evidence to support that the staff monitored the proper functioning of the external ventilator alarm monitors. A subsequent interview was conducted with Employee #31 on September 21, 2015 at approximately 3:30 PM. Employee #31 stated the external ventilator alarms only serve as a back-up to the manufacturer 's internal ventilator alarms on each ventilator. These observations were confirmed, and acknowledged by Employee #31 at the time of each incident.	F 456		
F 463 SS=D	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.	F 463		

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F 463	Continued From page 154 This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 14, 2015 at approximately 2:30 PM and on September 16, 2015 at approximately 10:00 AM, it was determined that facility staff failed to maintain resident's call system in good working condition as evidenced by a call bell in the bathroom of room #6146 that missing the pull cord. The findings include: 1. The call bell in the bathroom of room #6146 was missing a pull cord, one (1) of 41 resident's rooms surveyed. These observations were made in the presence of Employee #8 who acknowledged the findings.	F 463	**483.70(f) RESIDENT CALL SYSTEM ROOMS/TOILET/BATH** 1. Immediately upon notification, the call bell light was repaired and the call bell cord of room 6146 bathroom was replaced. 2. Maintenance Supervisor and 6th Fl RCC conducted environmental rounds to ensure the call bells in resident rooms and bathrooms were functioning. All rooms were in compliance. 3. Environmental rounds will be conducted bi-weekly on a rotational schedule by a work group to include Maintenance Supervisor or designee, Housekeeping Supervisor or designee, Clinical Care Coordinator or designee, and Administrator or designee. The work group will utilize the electronic work order system to ensure tracking and just-in-time status report of any outstanding environmental concerns identified. The staff was in-serviced on 9/27, 9/30 and is ongoing regarding the work order process by the Maintenance Supervisor. 4. Results of ongoing quality monitoring, findings, and actions taken during inspections will be reported to EOC Committee monthly and Quality Assurance Committee at least quarterly.	11.10.2015
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations made on September 9, 2015 at approximately 9:30 AM, it was	F 469		

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F 469	Continued From page 155 determined that the facility failed to maintain an effective pest control program as evidenced by a crawling insect seen in the garbage disposal located in the prep area and flying insects seen throughout the facility during the survey. The findings include: 1. A crawling insect was observed in one (1) of three (3) the garbage disposal located in the prep area 2. Flying pest were observed throughout the facility on the fourth, fifth and sixth on numerous occasions during the survey. The first observation was made in the presence of Employee #5 who acknowledged the finding.	F 469	**483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM** **Response to #1, 2** 1. Immediately upon notification, pest control measures have been implemented to control flying insects on the fourth, fifth, and sixth floor. 2. Environmental rounds were conducted on 9/23 by Environmental Services Supervisor and Administrator to ensure pest control issue related to flying insects has been resolved. 3. Environmental rounds will be conducted bi-weekly on a rotational schedule by a work group to include Maintenance Supervisor or designee, Environmental Services Supervisor or designee, Clinical Care Coordinator or designee, and Administrator or designee. Environmental Services Supervisor will implement routine cleaning schedule for trash and deep cleaning schedule for residents' rooms as part of the pest control program. Pest Control Company will be required to communicate with the EVS Supervisor and nursing staff prior to doing rounds to ensure all locations are addressed. A logbook of Pest Control visit will be maintained and monitored by EVS Supervisor. 4. Results of ongoing quality monitoring, findings, and actions taken during inspections will be reported to EOC Committee monthly and Quality Assurance Committee quarterly.	11.10.2015
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 observations, clinical record reviews and staff interviews, it was determined that the Administration failed to develop, implement, and/or revise appropriate corrective actions: to notify the physician when there was a change in the resident's condition; to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; to	F 490		

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F 490	Continued From page 156 ensure that resident assessments were accurate, to initiate and revise care plans as necessary; to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident ' s written plan of care; to ensure that each resident received and the facility provided the necessary care and services to attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care; to ensure the necessary services were provided to maintain good hygiene and to carry out activities of daily living; to ensure provision of necessary care and treatment to promote healing of wound(s); to ensure that the resident environment remains as free of accident hazards as is possible; ensure that a resident receives proper treatment and care for respiratory care; to ensure that sufficient staff was available to provide quality care and services; to post nurse staffing information on a daily basis to include all components per the regulation; to ensure that medications were properly labeled and stored; to ensure all essential resident care equipment was in safe operating condition; to ensure that the resident call system was maintained in a safe and operating condition; to ensure that the facility maintained an effective pest control program; to ensure that location and date of Care Area Assessment information on the Minimum Data Sets (MDS) under Section V was complete; to comply with state and local laws and regulations; and to maintain clinical records in accordance with accepted professional standards. The findings include:	F 490	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL BEING Refer to page 158 for response.	

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F 490	Continued From page 157 During the recertification survey from September 9 - 21, 2015, the following areas of concern were identified: · Failure to ensure that facility staff notified the attending physician when a resident did not receive a vaccine as ordered.. Cross reference CFR 483.10, F157 · Failure to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Cross reference CFR 483.15, F253 · Failure to ensure that resident assessments were accurate. Cross reference 483.20, F272 · Failure to ensure that facility staff developed care plans with appropriate goals and approaches to address care needs of residents. Cross reference CFR 483.20, F279 · Failure to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident ' s written plan of care. Cross reference 483.20 (k) (3) (ii), F282 · Failure to ensure that each resident received and the facility provided the necessary care and services to attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Cross reference 483.25, F309 · Failure to ensure the necessary services was provided to maintain good hygiene and to carry out activities of daily living. Cross reference CFR 483.25(a) (3), F312 · Failure to ensure provision of necessary care and treatment to promote healing of wound (s). Cross reference CFR 483.25(c), F314	F 490	**483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL BEING** 1. The facility administrative staff addressed all areas of immediate concern related to care of all residents (equipment safety, staff qualification, and competencies with special focus on competencies and skills required to care for residents with Special Care Needs. Environmental hazards were immediately abate 2. Any resident impacted by these deficiencies were addressed immediately 3. The Nursing Leadership Team assessed systems process and outcomes to determine effectiveness in meeting daily management and operations of facility. The Interim Administrator/DON in collaboration with HR and Education Department will work on the selection of personnel with required qualification skills and competencies to ensure the highest practicable well-being of each resident The Director of QA in partnership with the DON will continue ongoing assessment of education and training of staff The Director of QA, Interim Administrator/DON will revise the Quality Assurance program that will identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan and continuously monitor effectiveness of interventions. 4. Ongoing communication with Executive Team during daily operations meeting, monthly managers' meeting and Managers Operations Review at the executive level.	11.10.2015 & ongoing

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F 490	Continued From page 158 · Failure to ensure that the resident environment remains as free of accident hazards as is possible. Cross reference CFR 483.25, F323 · Failure to ensure that a resident receives proper treatment and care for respiratory care. Cross reference 483.25(k) , F328 · Failure to ensure that sufficient staff was available to provide quality care and services. Cross reference 483.30 (a), F353 · Failure to ensure that medications were properly labeled and stored. Cross reference 483.60 (b), (d), (e), F431 · Failure to ensure all essential resident care equipment was in safe operating condition. Cross reference CFR 483.70, F456 · Failure to ensure that the call bell system was maintained in good working condition. Cross reference CFR 483.70, F463 · Failure to ensure that the facility maintained an effective pest control program. Cross reference 483.70(h)(4), F469 · Failure to ensure that clinical records were maintained in accordance with accepted professional standards. Cross reference CFR 483.75, F514. * Failure to ensure that location and date of Care Area Assessment information on the Minimum Data Sets (MDS) under Section V was complete. CFR 483.20, F272 · Failure to ensure that the Quality Assurance Committee identified and developed corrective measures to address the concerns identified during the survey process. Cross reference CFR 483.75, F520. On Tuesday September 22, 2015 at	F 490	**483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL BEING** Refer to page 158 for response.	

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

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F 490	Continued From page 159 approximately 2:20 PM a face-to-face interview was conducted at approximately 2:28 PM with Employee ' s #2, #3, and #4. The employees made the following responses related to the quality concerns identified during the survey: · Employee #4 stated that during the Quality and Assessment and Assurance Review Committee conference conducted on September 18, 2015 that he/she was not aware that there was a problem regarding the residents who are vent dependent. · Employee #3 stated that he/she was aware that a potential problem could arise as a result of his/her current knowledge regarding the care and treatment of ventilator dependent residents, it seem very hard to make necessary changes. As a result of the Immediate Jeopardy (IJ) a plan of correction was developed regarding physical assessment and documentation of the respiratory system and In-services were conducted by the Respiratory therapist and the Nurse Practitioner in order to increase the knowledge base of staff and safety of the residents who are ventilator dependent. · Employee #3 and #4 acknowledged that Employee #6 did not have the required skills to identify and educate the nursing personnel needed to staff ventilator dependent residents in the facility. · Employee #3 acknowledged that the duties and responsibilities of the facility staff should be outlined more clearly to define when a Rapid Response is called for a resident in the facility	F 490	**483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL BEING** Refer to page 158 for response.	

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F 490	Continued From page 160 and by who and what documentation should be completed. · Employee #2 and #7 acknowledged that the Resident Care Area Assessment is a computer program problem since MDS 3.0 came into effect, and that the program no longer will allow for information to populate into the area that requires the date and location of where information could be found. · Employee #3 acknowledged that at present time there is one (1) wound doctor that covers Medicare A residents and that they are in the process of exploring hiring a another physician to join the wound team. · Employee #31 acknowledged that the external alarms for ventilator residents did not have a battery or that the battery was low, and stated that the respiratory therapists that is assigned to that particular resident will check the external ventilator alarms once a shift, and that the internal ventilator alarms are checked every four (4) hours. · Employee #2 and #3 acknowledged that the facility was under renovation in some areas. · Employee #3 acknowledged that staff did not document nor assess residents prior to and after the administration of pain medication. At this time, it was determined that the Administrator, the Director of Nursing and Educator failed to provide necessary care and	F 490	**483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL BEING** Refer to page 158 for response.	

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F 490	Continued From page 161 services and lacked supervision for residents who required ventilator services; failed to ensure that the nursing staff accurately assessed and monitored residents who received ventilator services, failed to notify the physician when the resident experienced acute changes, failed to assess and monitor residents with pain concerns; and failed to intervene on serious conditions related to the care of residents receiving ventilator services, failed to ensure that staff who worked with resident requiring special needs and ventilator received education and training to help provide quality care and services and failed to ensure that CAAs were accurately coded. It was determined that the Administration failed to recognize and identify the necessary care concerns and services needed to provide safe and competent care to residents; and developed and implement appropriate plans of action to correct identified quality deficiencies.	F 490		
F 493 SS=E	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by:	F 493	**483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN** 1. See immediate corrective actions for all areas of concerns cited. The governing body ensure(d) that there is an administrator who is duly licensed in the District of Columbia. The governing body holds (held) the administrator accountable for the proper management of the facility in accordance with federal regulations and DC licensure requirements. 2. The governing body convened all department heads, managers, and committee chairs and directed each person to implement immediate corrective action to abate any immediate threat and/or hazard to residents' well-being and safety. These corrective actions included staff education and training, and documentation of skills and competencies specific to the care of residents with special needs. Hired contractors to provide all office related services. 3. Under the direction of the Interim Administrator/DON and Dir. QA: • Undertake a review of resident care policies and procedures by department heads including the medical director. • Assess Quality Improvement Program and establish systems and processes that recognize and identify the necessary care concerns and services needed to provide safe and competent care to residents. 4. All quality assessment findings and status/outcomes of action plans will be reported to Executive Team and Governing Body at scheduled intervals to ensure Nursing Center is operating and maintaining substantial compliance with all Federal regulations, DCMR chapter 32, and other related professional standards	11.10.2015 & ongoing

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F 493	Continued From page 162 Based on observations, clinical record reviews and staff interviews, it was determined that the Governing Body failed to develop, implement, and/or revise appropriate corrective actions: to notify the physician when there was a change in the resident's condition; to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; to ensure that resident assessments were accurate, to initiated and revised care plans as necessary; to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident ' s written plan of care; to ensure that each resident received and the facility provided the necessary care and services to attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care; to ensure the necessary services were provided to maintain good hygiene and to carry out activities of daily living; to ensure provision of necessary care and treatment to promote healing of wound(s); to ensure that the resident environment remains as free of accident hazards as is possible; ensure that a resident receives proper treatment and care for respiratory care; to ensure that sufficient staff was available to provide quality care and services; to post nurse staffing information on a daily basis to include all components per the regulation; to ensure that medications were properly labeled and stored; to ensure all essential resident care equipment was in safe operating condition; to ensure that the resident call system was maintained in a safe and operating condition; to ensure that the facility maintained an effective pest control program; to ensure that location and date of Care Area Assessment information on the Minimum Data	F 493	**483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN** Refer to page 162 for response.	

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F 493	Continued From page 163 Sets (MDS) under Section V was complete; to comply with state and local laws and regulations; and to maintain clinical records in accordance with accepted professional standards. The findings include: During the recertification survey from September 9 - 21, 2015, the following areas of concern were identified: · Failure to ensure that facility staff notified the attending physician when a resident did not receive a vaccine as ordered. Cross reference CFR 483.10, F157 · Failure to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Cross reference CFR 483.15, F253 · Failure to ensure that resident assessments were accurate. Cross reference 483.20, F272 · Failure to ensure that facility staff developed care plans with appropriate goals and approaches to address care needs of residents. Cross reference CFR 483.20, F279 · Failure to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident ' s written plan of care. Cross reference 483.20 (k) (3) (ii), F282 · Failure to ensure that each resident received and the facility provided the necessary care and services to attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Cross reference	F 493	**483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN** Refer to page 162 for response.	

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F 493	Continued From page 164 483.25, F309 · Failure to ensure the necessary services was provided to maintain good hygiene and to carry out activities of daily living. Cross reference CFR 483.25(a) (3), F312 · Failure to ensure provision of necessary care and treatment to promote healing of wound (s). Cross reference CFR 483.25(c), F314 · Failure to ensure that the resident environment remains as free of accident hazards as is possible. Cross reference CFR 483.25, F323 · Failure to ensure that a resident receives proper treatment and care for respiratory care. Cross reference 483.25(k) , F328 · Failure to ensure that sufficient staff was available to provide quality care and services. Cross reference 483.30 (a), F353 · Failure to ensure that medications were properly labeled and stored. Cross reference 483.60 (b), (d), (e), F431 · Failure to ensure all essential resident care equipment was in safe operating condition. Cross reference CFR 483.70, F456 · Failure to ensure that the call bell system was maintained in good working condition. Cross reference CFR 483.70, F463 · Failure to ensure that the facility maintained an effective pest control program. Cross reference 483.70(h)(4), F469 · Failure to ensure that clinical records were maintained in accordance with accepted professional standards. Cross reference CFR 483.75, F514. * Failure to ensure that location and date of Care Area Assessment information on the Minimum Data Sets (MDS) under Section V was complete. CFR 483.20, F272 · Failure to ensure that the Quality Assurance	F 493	**483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN** Refer to page 162 for response.	

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F 493	Continued From page 165 Committee identified and developed corrective measures to address the concerns identified during the survey process. Cross reference CFR 483.75, F520. On Tuesday September 22, 2015 at approximately 2:20 PM a face-to-face interview was conducted at approximately 2:28 PM with Employee ' s #2, #3, and #4. The employees made the following responses related to the quality concerns identified during the survey: · Employee #4 stated that during the Quality and Assessment and Assurance Review Committee conference conducted on September 18, 2015 that he/she was not aware that there was a problem regarding the residents who are vent dependent. · Employee #3 stated that he/she was aware that a potential problem could arise as a result of his/her current knowledge regarding the care and treatment of ventilator dependent residents, it seem very hard to make necessary changes. As a result of the Immediate Jeopardy (IJ) a plan of correction was developed regarding physical assessment and documentation of the respiratory system and In-services were conducted by the Respiratory therapist and the Nurse Practitioner in order to increase the knowledge base of staff and safety of the residents who are ventilator	F 493	**483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN** Refer to page 162 for response.	

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	095027	A. BUILDING ______ B. WING ______	09/23/2015

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F 493	Continued From page 166 dependent. · Employee #3 and #4 acknowledged that Employee #6 did not have the required skills to identify and educate the nursing personnel needed to staff ventilator dependent residents in the facility. · Employee #3 acknowledged that the duties and responsibilities of the facility staff should be outlined more clearly to define when a Rapid Response is called for a resident in the facility and by who and what documentation should be completed. · Employee #2 and #7 acknowledged that the Resident Care Area Assessment is a computer program problem since MDS 3.0 came into effect, and that the program no longer will allow for information to populate into the area that requires the date and location of where information could be found. · Employee #3 acknowledged that at present time there is one (1) wound doctor that covers Medicare A residents and that they are in the process of exploring hiring a another physician to join the wound team. · Employee #31 acknowledged that the external alarms for ventilator residents did not have a battery or that the battery was low, and stated that the respiratory therapists that is assigned to that particular resident will check the external ventilator alarms once a shift, and that the internal ventilator alarms are checked every four (4) hours.	F 493	**483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN** Refer to page 162 for response.	

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F 493	Continued From page 167 · Employee #2 and #3 acknowledged that the facility was under renovation in some areas. · Employee #3 acknowledged that staff did not document nor assess residents prior to and after the administration of pain medication. · Employee #3 acknowledged that the facility staff were not following the facility policy regarding weights for residents with significant unplanned weight loss. And stated that the new scales might be the reason for some of the discrepancy. At this time, it was determined that the Administrator, the Director of Nursing and Educator failed to provide necessary care and services and lacked supervision for residents who required ventilator services; failed to ensure that the nursing staff accurately assessed and monitored residents who received ventilator services, failed to notify the physician when the resident experienced acute changes, failed to assess and monitor residents with pain concerns; and failed to intervene on serious conditions related to the care of residents receiving ventilator services, failed to ensure that staff who worked with resident requiring special needs and ventilator received education and training to help provide quality care and services and failed to ensure that CAAs were accurately coded. It was determined that the Governing Body failed to recognize and identify the necessary care concerns and services needed to provide safe and competent care to residents; and developed	F 493	483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN Refer to page 162 for response.	

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F 493	Continued From page 168 and implement appropriate plans of action to correct identified quality deficiencies.	F 493		
F 514 SS=E	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 staff interviews for Four (4) of 60 sampled residents, it was determined that the facility staff failed to maintain clinical records in accordance with accepted professional standards and practices as evidenced by: the physician failed to document the accurate intervention for wound care treatment for one (1) resident; failed to ensure the correct spelling of two (2) residents ' names were accurately documented in the clinical records and to document one (1) resident's change in condition, and subsequently a rapid response was called. Residents # 43, #108, #138, #132. The findings include:	F 514	483.75(l)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE Response to #1, Residents 43 Refer to page 170 for response	

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F 514	Continued From page 169 1. The physician failed to document accurate intervention for wound care treatment for Resident #43. On September 18, 2015 at approximately 12:15 PM, a review of the admission note revealed and revealed that Resident #43 was admitted to the facility on April 22, 2011. A review of the physician ' s history and physical dated May 1, 2015 revealed the resident ' s diagnosis included a Stage 3 sacral ulcer and Immobility. Review of the physician ' s orders signed and dated August 31, 2015 revealed an order that directed the following: " Cleanse sacral ulcer wound with normal saline, pat dry with gauze. Apply Maxorb [wound care dressing] Ag [silver] and cover with dry dressing daily. " Review of the ' Wound Care Specialist Evaluation ' records revealed that the resident was not receiving dressing changes with Normal Saline as per physician ' s order; instead, the following wound care documentation observed in the ' Assessment & Plan ' section of the August 20, 2015 and September 10, 2015 notes described the following: " Continue dry protective dressing once daily, silver absorbing agent -prn [as needed], Dakin ' s Solution- once daily cleanse. " On September 18, 2015 at approximately 4:26 PM, a telephone interview was conducted with Employee #9 regarding the aforementioned documentation and treatment. He/she explained, " The resident should be receiving dressing changes with saline, as the physician ordered. I	F 514	**483.75(l)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE** **Response to #1, Residents 43** 1. There was no adverse effect to the wound healing process because the 'actual' treatment being done was saline. The error was in the report submitted by the wound consultant physician. 2. A review of wound care orders were audited finding all orders in compliance. 3. Careful review of treatment orders during end of month review and reconciliation to ensure accuracy. Review reports submitted by consulting wound physician with signed physician order in medical record. 4. The RCCs or designee will audit the TAR to ensure all orders are documented and implemented. The audit findings will be reported to Risk Management Subcommittee for three (3) months and a quarterly summary to Quality Assurance Committee until 100% compliance is demonstrated for three (3) months.	11.10.2015

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F 514	Continued From page 170 meant to switch my notes to saline. " The record was reviewed on September 18, 2015. 2. Facility staff failed to ensure the correct spelling of two residents' names were accurately documented in the clinical records for Residents' #108 and 138. A. On September 16, 2015 at approximately 12:30 PM, a review of the admission note revealed that Resident #108 was admitted to the facility on December 19, 2014 with diagnoses that included Respiratory Failure. Review of the Admission Record and physician ' s history revealed documentation that the resident ' s name was spelled one way. A review of the ' Controlled Medication Record ' and Medication Administration Record [MAR] revealed documentation that the resident ' s name was spelled differently. The resident ' s name was spelled two different ways in the clinical record. On September 16, 2015 at approximately 1:20 PM, a face-to-face interview was conducted with Employees #4 and #50. Both reviewed the records and acknowledged the findings. The record was reviewed on September 16, 2015. B. On September 10, 2015 at approximately 1:30 PM, a review of the admission note revealed that Resident #138 was admitted to the facility on August 14, 2015 with diagnosis that included Chronic Respiratory Failure. Review of the Admission Record and physician ' s history revealed documentation that the resident ' s name was spelled one way. A review of the '	F 514	**483.75(l)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE** **Response to #2A, 2B, Residents 108 and 138** 1. Immediately upon notification, the names of resident #108 and #138 were corrected within the medical record. 2. An audit of the medical records was reviewed and none were found to have been affected. 3. The MDS Audit Tool was revised, to include verification of the spelling of residents' names A full review of each residents' name will be done during admission, utilizing all available information by the MDS Coordinator. 4. Results of the MDS audit will be reported to Risk Management Subcommittee for three (3) months and a quarterly summary to Quality Assurance Committee until 100% compliance is demonstrated for three (3) months.	11.10.2015

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F 514	Continued From page 171 Controlled Medication Record ' and Minimum Data Set [MDS] dated August 23, 2015 revealed the resident ' s name was spelled differently. The resident ' s name was spelled two different ways in the clinical record. On September 16, 2015 at approximately 1:40 PM, a face-to-face interview was conducted with Employees #7 regarding the aforementioned findings. He/she reviewed the records and acknowledged the findings. The record was reviewed on September 10, 2015. 3. Facility staff failed to document the events of Resident #132 ' s change in condition, subsequently a rapid response was called. According to the facility ' s policy " Rapid Response in Nursing Center, Policy #: 3.11, date revised: 9/2013 stipulates: " D. Expectations of the SNF Staff Nurse: 1. Anyone on the unit can bring the Emergency Cart to the resident ' s room. 2. Resident ' s chart must be brought to the resident ' s room-anyone can bring. 3. The Charge Nurse who noted the change will give report to the house physician about the events leading up to the rapid response. 4. The SNF Supervisor will record on the rapid response emergency form and direct staff traffic. 5. The SNF Charge Nurse will complete the following: a. Change in Condition Nurse ' s notes to include the disposition of the resident, b. Document on the 24 hour report to include the disposition of the resident, c. SNF Supervisor document on supervisor ' s report. " A review of the medical record revealed that Resident #132 was admitted on May 20, 2015	F 514	**483.75(l)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE** **Response to #2, B, Residents #108 and #138** Refer to page 171 for response.	

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F 514	Continued From page 172 with diagnoses to include Anoxic Brain Injury, Coronary Artery Disease Status post Acute Myocardial Infarction (AMI), Diabetes Mellitus, Sacral Decubitus Ulcer and Sepsis. [This was a closed record review] A Physician ' s Order Form dated June, 2015, directed: " Yes- CPR [Cardiopulmonary Resuscitation]. " A review of the nursing notes revealed the following: " June 17, 2015 3:30 AM, " Remains clinically stable, trach [tracheostomy] colar intact, care provided, suction by the RT [Respiratory Therapist] [without] s/s [signs or symptoms of respiratory distress observed. Skin dry and warm to touch. TNRP [turn and repositioned] q [every] 2 h [hours] for pressure relief. Mouth care provided, v/s [vital signs] 99 degrees [temperature], 102 or 100 [pulse/ difficult to interpret], 116/67 [blood pressure], 02 sat 96% [oxygen saturation]. " June 17, 2015 6: AM ...Upon arrival to the unit, The Nursing Supervisor met CPR in progress by nursing staff. A call was placed to the " 911 crew " at 5:20 AM and the House officer was also called to the unit for further evaluation. The Emergency Medical Services team arrived at 5:30 AM and took over CPR. Resident #132 was not transported by Emergency Medical Services due to " asystole (indicates the heart has stopped beat and there is no electrical activity in the heart) status ... "	F 514	**483.75(l)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE** **Response to #2, B, Residents #108 and #138** Refer to page 171 for response.	

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F 514	Continued From page 173 June 17, 2015 7:35 AM Rounds were made as per facility ' s protocol, every 2 hr [hours] and PRN [as needed] from the start of the shift. At 4AM the writer made rounds on the patient and observed [his/her] indwelling catheter leaking. Call placed to {physician ' s name] to get an order to change the foley size 16F [French] to 18F, but no call back yet. At 4:30AM, the CNA [Certified Nursing Assistant] started [his/her] AM rounds, [He/she] washed and bathed [him/her] in bed. [He/she] finished at 5AM. The writer went to [him/her] at 5:10 AM and took the finger stick and result was 246 mg/dl [milligrams/deciliter], coverage 2 units was administered of Novolog, no s/s of hyperglycemia observed. At approximately 5:15AM, the writer went to hanf [his/her] G [gastrostomy]-tube feeding, then found the resident unresponsive. The Supervisor was notified right away, CPR initiated, in-house doctor notified and [he/she] was at the scene, 911 called and they arrived on time, along with the police officers. V/s during CPR were B/P 73/49, 144 and 66/42, 133, no respiration observed. 911 came and took over the CPR, but unable to take resident with them secondary asystole [indicates the heart has stopped beat and there is no electrical activity in the heart) status. The EMS [Emergency Medical System] left, leaving the corpes of the resident at the facility. Resident was pronounced death by the house officer at 5:35AM. The Supervisor contacted the family members. Detective [name] came at approx. [approximately] 6AM and asked the writer some questions. Spoke with the medical examiner at 7:15AM. " There was no evidence that the nursing	F 514	**483.75(l)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE** **Response to #2, B, Residents #108 and #138** Refer to page 171 for response.	

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F 514	Continued From page 174 supervisor documented Resident #132 ' s change in condition and the rapid response events as specified in the facility ' s policy. Facility staff failed to document Resident #132 ' s change in condition, and subsequently a rapid response was called. A face-to-face interview was conducted with Employees #2 and #3 on September 21, 2015 regarding the aforementioned findings. He/she acknowledged the findings. The clinical record was reviewed on September 21, 2015.	F 514		
F 520 SS=E	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.	F 520	483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS Refer to page 176 for response.	

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F 520	Continued From page 175 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews and staff interviews, it was determined that the facility's Quality Assessment and Assurance (QAA) Committee failed to develop, implement, and/or revise appropriate corrective actions: to notify the physician when there was a change in the resident's condition; to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; to ensure that resident assessments were accurate, to initiated and revised care plans as necessary; to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident ' s written plan of care; to ensure that each resident received and the facility provided the necessary care and services to attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care; to ensure the necessary services were provided to maintain good hygiene and to carry out activities of daily living; to ensure provision of necessary care and treatment to promote healing of wound(s); to ensure that the resident environment remains as free of accident hazards as is possible; ensure that a resident maintains acceptable parameters of nutritional status, such as body weight; ensure that a resident receives proper treatment and care for respiratory care; to ensure that sufficient staff was available to provide quality care and	F 520	**483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS** 1. See immediate corrective actions for all areas of concerns cited 2. A preliminary meeting was held with department managers responsible for areas of concern to review existing systems and processes; identify breakdown in systems and processes; determine effectiveness of current protocols and, policies and procedures. 3. The Dir. Of Quality Assurance will revise the QA program to: Identify root causes for areas of concerns cited; Determine resources needed for data collection, analyses, monitoring; Develop action plans relevant to process and systems to ensure sustainability; and facility-wide education on QAPI process. 4. All quality assessment findings and status/outcomes of action plans will be reported to Executive Team and Governing Body at scheduled intervals to ensure Nursing Center is operating and maintaining substantial compliance with all Federal regulations, DCMR chapter 32, and other related professional standards.	11.10.2015 & ongoing

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F 520	Continued From page 176 services; to post nurse staffing information on a daily basis to include all components per the regulation; to ensure that medications were properly labeled and stored; to ensure all essential resident care equipment was in safe operating condition; to ensure that the resident call system was maintained in a safe and operating condition; to ensure that the facility maintained an effective pest control program; to ensure that location and date of Care Area Assessment information on the Minimum Data Sets (MDS) under Section V was complete; to comply with state and local laws and regulations; and to maintain clinical records in accordance with accepted professional standards. The findings include: During the recertification survey from September 9 - 23, 2015, the following areas of concern were identified: · Failure to ensure that facility staff notified the attending physician when a resident did not receive a vaccine as ordered. Cross reference CFR 483.10, F157 · Failure to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Cross reference CFR 483.15, F253 · Failure to ensure that resident assessments were accurate. Cross reference 483.20, F272 · Failure to ensure that facility staff developed care plans with appropriate goals and approaches to address care needs of residents. Cross reference CFR 483.20, F279	F 520	483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS Refer to page 176 for response.	

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F 520	Continued From page 177 · Failure to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident ' s written plan of care. Cross reference 483.20 (k)(3) (ii), F282 · Failure to ensure that each resident received and the facility provided the necessary care and services to attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Cross reference 483.25, F309 · Failure to ensure the necessary services was provided to maintain good hygiene and to carry out activities of daily living. Cross reference CFR 483.25(a) (3), F312 · Failure to ensure provision of necessary care and treatment to promote healing of wound (s). Cross reference CFR 483.25(c), F314 · Failure to ensure that the resident environment remains as free of accident hazards as is possible. Cross reference CFR 483.25, F323 · Failure to ensure that a resident maintains acceptable parameters of nutritional status, such as body weight. Cross reference 483.25 (i), F325 · Failure to ensure that a resident receives proper treatment and care for respiratory care. Cross reference 483.25(k) , F328 · Failure to ensure that sufficient staff was available to provide quality care and services. Cross reference 483.30 (a), F353 · Failure to ensure that medications were properly labeled and stored. Cross reference 483.60 (b), (d), (e), F431 · Failure to ensure all essential resident care equipment was in safe operating condition. Cross reference CFR 483.70, F456 · Failure to ensure that the call bell system was	F 520	**483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS** Refer to page 176 for response.	

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BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(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 520	Continued From page 178 maintained in good working condition. Cross reference CFR 483.70, F463 · Failure to ensure that the facility maintained an effective pest control program. Cross reference 483.70(h)(4), F469 · Failure to comply with state and local laws and regulations. Cross reference CFR 483.75, F492 · Failure to ensure that clinical records were maintained in accordance with accepted professional standards. Cross reference CFR 483.75, F514. * Failure to ensure that location and date of Care Area Assessment information on the Minimum Data Sets (MDS) under Section V was complete. CFR 483.20, F272 On Tuesday September 22, 2015 at approximately 2:20 PM a face-to-face interview was conducted at approximately 2:28 PM with Employee ' s #2, #3, and #4. The employees made the following responses related to the quality concerns identified during the survey: · Employee #4 stated that during the Quality and Assessment and Assurance Review Committee conference conducted on September 18, 2015 that he/she was not aware that there was a problem regarding the residents who are vent dependent. · Employee #3 stated that he/she was aware that a potential problem could arise as a result of his/her current knowledge regarding the care and treatment of ventilator dependent residents, it	F 520	**483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS** Refer to page 176 for response.	

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 520	Continued From page 179 seem very hard to make necessary changes. As a result of the Immediate Jeopardy (IJ) a plan of correction was developed regarding physical assessment and documentation of the respiratory system and In-services were conducted by the Respiratory therapist and the Nurse Practitioner in order to increase the knowledge base of staff and safety of the residents who are ventilator dependent. · Employee #3 and #4 acknowledged that Employee #6 did not have the required skills to identify and educate the nursing personnel needed to staff ventilator dependent residents in the facility. · Employee #3 acknowledged that the duties and responsibilities of the facility staff should be outlined more clearly to define when a Rapid Response is called for a resident in the facility and by who and what documentation should be completed. · Employee #2 and #7 acknowledged that the Resident Care Area Assessment is a computer program problem since MDS 3.0 came into effect, and that the program no longer will allow for information to populate into the area that requires the date and location of where information could be found. · Employee #3 acknowledged that at present time there is one (1) wound doctor that covers Medicare A residents and that they are in the process of exploring hiring a another physician to join the wound team. · Employee #31 acknowledged that the	F 520	**483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS** Refer to page 176 for response.	

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F 520	Continued From page 180 external alarms for ventilator residents did not have a battery or that the battery was low, and stated that the respiratory therapists that is assigned to that particular resident will check the external ventilator alarms once a shift, and that the internal ventilator alarms are checked every four (4) hours. · Employee #2 and #3 acknowledged that the facility was under renovation in some areas. · Employee #3 acknowledged that staff did not document nor assess residents prior to and after the administration of pain medication. · Employee #3 acknowledged that the facility staff were not following the facility policy regarding weights for residents with significant unplanned weight loss. And stated that the new scales might be the reason for some of the discrepancy. At this time, it was determined that the Administrator, the Director of Nursing and Educator failed to provide necessary care and services and lacked supervision for residents who required ventilator services; failed to ensure that the nursing staff accurately assessed and monitored residents who received ventilator services, failed to notify the physician when the resident experienced acute changes, failed to assess and monitor residents with pain concerns; and failed to intervene on serious conditions related to the care of residents receiving ventilator services, failed to ensure that staff who worked with resident requiring special needs and ventilator received education and training to help	F 520	**483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS** Refer to page 176 for response.	

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

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F 520	Continued From page 181 provide quality care and services and failed to ensure that CAAs were accurately coded. It was determined that the Quality Assessment and Assurance Committee failed to recognize and identify the necessary care concerns and services needed to provide safe and competent care to residents; and developed and implement appropriate plans of action to correct identified quality deficiencies.	F 520	483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY/PLANS Refer to page 176 for response.	