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
	095031	A. BUILDING ____ B. WING ____	01/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	2131 O STREET NW WASHINGTON, DC 20037

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F 000	INITIAL COMMENTS A Quality Indicator Survey (QIS) recertification survey was conducted at your facility on January 5 through January 12, 2015. The following deficiencies are based on observations, record reviews, resident and staff interviews for 37 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status g-tube Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - Emergency Medical Services (911) HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA Certified Nurse Aide DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L - Liter Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of	F 000	Please begin typing your responses here:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 2/13/2015

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 mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury POS - physician ' s order sheet Prn - As needed TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- discontinue Rp, R/P- responsible party PO- By Mouth	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156		

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F 156	Continued From page 2 items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification	F 156	1. No resident suffered any harm from this deficient practice. 2. All other units were checked and those found with this deficient practice were immediately corrected. State agency contacts have been posted on each floor. 3a. All staff were in-serviced on 1/31/15 on posting of names, addresses and phone numbers of state agency. 3b. QA/Designee will conduct a bi-weekly rounds for ninety days to ensure postings are displayed in the facility. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	2/12/15

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F 156	Continued From page 3 agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation of five (5) of five (5) residential care units and staff interviews, it was determined that facility staff failed to include a written description of legal rights as evidenced by the absence of a posting of names, addresses and telephone numbers of the State survey and certification agency and a statement that the resident may file a complaint with the agency. The findings include: On January 5, 2015 at approximately 10:00 AM, a tour conducted on the 4th floor of the facility	F 156		

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F 156	Continued From page 4 revealed there was no evidence of a posting with State Agency contact information made available to the residents on the floor. On January 5, 2015 at approximately 10:50 AM, a face- to -face interview was conducted with Employee #3 who acknowledged the aforementioned findings. On January 5, 2015 at approximately 11:00 AM, a tour conducted on the 5th floor of the facility revealed there was no evidence of a posting with State Agency contact information made available to the residents on the floor. On January 5, 2015 at approximately 11:55 AM, a face- to -face interview was conducted with Employee #7 who acknowledged the aforementioned findings. On January 7, 2015 at approximately 4:00 PM, tours conducted of the 2nd and 3rd floors lacked evidence of a posting with State Agency contact information. On January 7, 2015 at approximately 4:30 PM AM, a face- to -face interview was conducted with Employee #4 who was asked to show the location of where the State Agency contact information was posted. He/she acknowledged that it was not present on the unit, but stated, "It might be posted the first floor lobby." On January 8, 2015 at approximately 5:00 PM, a tour conducted on the first floor and lobby of the facility revealed there was no evidence of a posting with State Agency contact information made available to the residents on the floor.	F 156		

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F 156	Continued From page 5 On January 9, 2015, at approximately 4:30 PM, a face- to -face interview was conducted with Employee #2 who acknowledged the aforementioned findings. Facility staff failed to post State Agency Contact information in the facility.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview for 1 (one) of 37 sampled residents it was determined that facility staff failed to promote an environment that enhanced dignity as evidenced by the observation of Resident #167 lying supine in bed on a mattress without linens. The findings include: On January 5, 2015 at approximately 12:35 AM, Resident #167 was observed lying in bed on a mattress without linens. Resident #167 was clothed lying supine with his/her head lying atop the vinyl/plastic surface of the bare mattress. Resident #167 replied " Hi " to a greeting. In response to a query, " how are you, " he/she nodded affirmatively. The resident was not communicative to additional conversation.	F 241	1. Resident#167 was immediately identified and bed was made with linens. 2. All other residents rooms were checked and none was noted with this deficient practice. 3a. All nursing staff were in-serviced on 1/31/15 on making beds with AM care. 3b. QA/Designee will conduct bi-weekly rounds for ninety days to ensure residents have their beds made with AM care. 4. Further findings in this matter will be discussed in the weekly, monthly and quarterly QA meeting for six months.	2/12/15

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F 241	Continued From page 6 A review of the Quarterly Minimum Data Set [MDS] dated December 15, 2014 under Section C, Cognitive Patterns revealed that; Resident #167 was coded as "severely impaired" cognitively. Face-to-face interviews were conducted with Employees #13 and 18 at the time of the observation on January 5, 2015 at approximately 12:40 PM. In response to a query as to why Resident #167 was lying in bed without linens, Employee #13 proceeded to assist the resident out of bed and Employee #18 stated that the bed linens were wet and that he/she was trying to locate a mechanical lift sling to transfer the resident out of bed. Facility staff failed to enhance dignity for Resident #167 as evidenced by allowing the resident to occupy a bed without linens.	F 241		
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 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 observation, record review, resident interview and staff interviews, for one (1) of 37 sampled residents, it was determined that the facility staff failed to honor one (1) resident's	F 246	1. Resident #86 did not suffer any harm from this deficient practice. Resident #86 blanket was replaced on 2/3/15. 2. All other residents were checked and none noted with the deficient practice. 3a An in-service was conducted for nursing staff on 2/3/15 regarding honoring of residents preferences in general and handling of laundry in particular. 3b QA/Designee will conduct bi-weekly rounds for ninety days to ensure compliance. 4. Further findings of this matter will be discussed in the weekly, monthly and quarterly QA meeting for six months.	2/12/15

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F 246	Continued From page 7	F 246		

preference to launder his/her own clothing/linen as evidenced by staff sending the resident's blanket to the facility's laundry department. Resident #86.

The findings include:

An observation of Resident #86's room was made on January 6, 2015 at approximately 11:59 AM. A blue sign was observed posted on the resident's left closet door indicating the following: "Family does laundry [resident's name and room number]. Please put all clothes in the hamper in the closet."

On January 6, 2015 at approximately 11:57 AM, a face-to face interview was conducted with Resident #86 and a family member. When asked if the resident had any missing personal items, the resident's family member stated, "Yesterday, he/she [the resident] had an appointment. He/she called me crying because when they brought [resident's name] back from the appointment, his/her blanket was missing. They [staff] took his/her personal blanket (seashore scenery blanket) with tassels and sent it downstairs to the laundry; although the blue sign on the door [pointing to the resident's closet] said family will do laundry." The family member continued to say he/she spoke to [named facility staff member], "the head CNA [certified nursing assistant]," who stated, "They took the blanket by mistake to the laundry." The resident stated that [facility staff] admitted that he/she had accidentally sent the blanket downstairs to the laundry.

A telephone interview was conducted with Employee #14 on January 9, 2015 at approximately 2:00 PM. The employee was

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F 246	Continued From page 8 asked to explain his/her encounter on January 5, 2015 with Resident #86. He/she stated. "I worked as a floater on the floor that day and helped to prepare the resident for his/her appointment. I knew that the family did the resident's laundry. I did not see the blue blanket. I just gathered the linens as I stripped the bed, so it was possible that the blue blanket may have been under the white blanket [referring to the facility's blanket]. " The employee added that the resident had told him/her that the [facility staff] had rolled the blanket up with the facility's linen. The employee further added that he/she had called the head of laundry [person's name] to see if he/she could recover the blanket. He/she admitted that the incident was not reported to anyone else when it occurred. On January 9, 2015 at approximately 3:00 PM, a face-to-face interview was conducted with Employee #7, who communicated that the family member had informed him/her of the incident on January 6, 2015. He/she also stated that the facility staff [staff name] had taken care of Resident #86 previously. He/she acknowledged that he/she was aware that the facility staff had accidently sent the resident's blanket downstairs to the laundry. Facility staff failed to honor the resident's preference to handle his/her own laundry. The clinical record was reviewed on January 9, 2015.	F 246		
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.	F 253		

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F 253	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations made on January 8, 2015 between 11:00 AM and 4:30 PM and on January 9, 2015 at approximately 9:30 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by soiled bathroom vents in five (5) of 44 residents' rooms surveyed and one (1) of two (2) damaged over-bed table in one (1) of 44 resident's room surveyed. The findings include: 1. Bathroom vents were soiled with dust particles in five (5) of 44 residents' rooms Rooms #518, #505, # 405, # 319 and # 308. 2. One (1) of two (2) over-bed table in room #320 was worn at the seams and needed to be replaced in one (1) of 44 resident's room surveyed. These observations were made in the presence of Employee #11 and Employee #12.	F 253	1. Soiled exhaust vents in rooms 518, 505, 405,319,and 308 were cleaned on 1/11/15. Exhaust vents were blown and/or vacuumed as indicated. 2a Exhaust vents in all residents rooms were checked by the Director of Maintenance and none was noted with this deficient practice. 2b Exhaust vents throughout the facility will be checked daily during AM rounds 3a All maintenance staff were in-serviced on the cleaning of soiled exhaust vents on 1/8/15. 3b. Director of Maintenance/Designee will conduct bi-weekly rounds for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meeting six months.	2/12/15
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		

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F 253	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations made on January 8, 2015 between 11:00 AM and 4:30 PM and on January 9, 2015 at approximately 9:30 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by soiled bathroom vents in five (5) of 44 residents' rooms surveyed and one (1) of two (2) damaged over-bed table in one (1) of 44 resident's room surveyed. The findings include: 1. Bathroom vents were soiled with dust particles in five (5) of 44 residents' rooms Rooms #518, #505, # 405, # 319 and # 308. 2. One (1) of two (2) over-bed table in room #320 was worn at the seams and needed to be replaced in one (1) of 44 resident's room surveyed. These observations were made in the presence of Employee #11 and Employee #12.	F 253	1. Damaged over bed table in room 320 was immediately retrieved and replaced on 1/9/2015. 2. All over the bed tables in all residents rooms were checked by the Director of Maintenance and none noted with this deficient practice. 3a All over bed tables will be checked weekly during AM grand to ensure compliance. 3b All maintenance staff were in-serviced on 1/12815 on over bed table protocol. 3c Director of Maintenance/Designee will conduct bi-weekly rounds for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	2/12/15
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		

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F 272	Continued From page 10 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 37 sampled residents, it was determined that the facility staff failed to accurately code the Minimum Data Set [MDS]	F 272	1. Resident #189 was identified and the admission MDS was modified on 1/17/15 to include section M and surgical wound was correctly coded. 2a All other resident's MDS were reviewed on 1/7/15 for inaccurate coding and none was found with this deficient practice. 2b QA/Regional MDS coordinator will conduct bi-weekly audits for ninety days to ensure compliance. 3a The MDS coordinator upon completion will review source of information to ensure accurate coding. 3b QA/regional MDS coordinator in-serviced MDS coordinators on 1/13/15 on appropriate coding in general and resident with wound in particular. 3c QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance. 4. Further findings of this matter will be discussed in weekly, monthly and quarterly QA meetings for 6 months.	2/12/15

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under Section M -Skin Conditions for Resident #189 to include surgical wound(s) of the lower extremities.

The findings include:

A review of the Admission MDS for Resident #189 completed on November 16, 2014 revealed that the resident was admitted to the facility on November 4, 2014 with diagnoses that included: [International Statistical Classification of Diseases - ICD-9 codes] 707.10 [Ulcer of Lower Limb], 730.06 [Osteomyelistis, Lower Leg], 728.11 [Progressive Myosistis Ossificans], 338.19 [Other Acute Pain, and 782.3 [Edema] according to Section I, Active Diagnoses.

Section M, Skin Conditions of the Admission MDS dated November 16, 2015was coded as " none " indicative of no pressure ulcers, vascular ulcers and/or other wounds.

Physician ' s orders dated December 12, 2015 revealed the following wound treatment plan:

' Dressing change ' ....clean left leg skin graft site very gently pat dry apply mepital iodosorb, alginate then wrap with bulky guaze weekly and as needed.

' Clean ' donor site [left hip] with nss [normal saline solution] pat dry apply mepital, 4x4 [gauze dressing], every 3 days.

' Clean ' right leg with normal saline, dry wrap with bulky gauze then elastic gauze once a week.

Review of the resident's wound care notes

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F 272	Continued From page 12 revealed the following: November 7, 2014 at 2:00 PM - " Lt [left] Leg noted with surgical ulcer that measures 9.0x7.0x0.5 cm [centimeters]...Rt [right] Leg with 0 [no] ulcer but double layer wrap recommended ... " November 12, 2014 at 5:00 PM - " Resident now has Pico (vac) [negative pressure vacuum used to promote wound healing] to Left leg ulcer ...Left Thigh donor site intact with 0 drainage noted. " November 13, 2014 at 11:00 AM - Lt. Thigh donor site noted soak [soaked] with serous sanguineous drainage, dressing changed as per MD [physician] order ... " On January 8, 2015 at approximately 2:50 PM, a face-to-face interview was conducted with Employee #16, who stated Resident #189 was admitted with surgical wounds of the lower extremities, The wounds were originally vascular but the resident underwent surgical intervention, therefore categorized as ' surgical. ' On January 8, 2015 at approximately 3:30 PM, a face-to-face interview was conducted with Employee #17 who acknowledged the aforementioned findings. Facility staff failed to accurately code the admission MDS to under Section M, Skin Condition for Resident #189. The clinical record was reviewed on January 8, 2015.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 13 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. 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 record review and staff interviews for one (1) of 37 sampled residents, it was determined that facility staff failed to initiate a coordinated plan of care for Hospice and the Nursing home. Resident #104. The findings include: The facility staff failed to initiate a coordinated plan of care for both providers [hospice and the nursing home] for Resident #104. A review of the physician's order dated February 11, 2013 revealed the following: "Admit Resident to Hospice Care (Name of Agency). Dx. [Diagnosis] COPD [Chronic Obstructive	F 279	1. An integrative care plan was immediately put in place for resident #104 to reflect all IDT members and plan of care of resident on hospice. 2. Care plans for all other residents on hospice were reviewed on1/14/15 and none was found with this deficient practice. 3a. All RCC's/Nurse manager were in-serviced on 1/14/15 on the implementation of an integrative care plan for hospice residents 3b.QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	2/12/15

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F 279	Continued From page 14 Pulmonary Disease]." A review of the Resident #104's plan of care revealed the following entry: " [Resident's name] has a h/o [history of] Diabetes. No finger sticks r/t [related/to] hospice care." Further review of the plan of care failed to reveal any additional documentation regarding the resident's hospice care. The plan of care also failed to identify the respective functions of which services the nursing facility and hospice would provide in order to be responsive to the unique needs of the resident and the expressed desire for hospice care. A face-to-face interview was conducted with Employee #2 at approximately 10:00AM on January 12, 2015. The employee reviewed the record and acknowledged the finding. The facility staff failed to initiate a coordinated plan of care for both providers [hospice and the facility] for Resident #104. The record was reviewed on January 9, 2014.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	1. The falls care plan was amended to Include a bed/chair alarm intervention. 2. Care plans for all other residents on bed/ chair alarm were reviewed on 1/15/15 and none was noted with this deficient practice. 3a All nurse Managers/RCC's were in-serviced on 1/30/15 on the implementation of fall risk/bed chairs alarm care plan.	

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F 280	Continued From page 15 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews for one (1) of 37 sampled residents, it was determined that facility staff failed to revise the comprehensive care plan to include prescribed precautions [bed/chair alarm] for fall prevention for Resident #167. The findings include: Physician ' s orders dated January 2, 2015 [initiated 9/10/14] directed: "Precautions- fall ...every shift special instructions: bed and chair alarm for safety. " A review of Resident #167 ' s care plan initiated September 11, 2014 and updated December 9, 2014 revealed the interdisciplinary team (IDT) identified the focus area " Risk for Falls. " The goal was to reduce the incident of falls over the next 90 days. The list of interventions failed to include the use of a bed/chair alarm for fall precautions as prescribed by the physician. Resident #167 was observed seated in his/her wheelchair in the common room on January 7,	F 280	3b QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meeting for six months.	2/12/15

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F 280	Continued From page 16 2015 at approximately 1:30 PM. A chair alarm was observed applied to the resident and affixed to the chair. On January 9, 2015 at approximately12:00 PM a face-to-face interview was conducted with Employee #3 who acknowledged the care plan lacked evidence of the bed/chair alarm as a fall precaution. The record was reviewed January 8, 2015.	F 280		
F 286 SS=E	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of five (5) Residential care Units; it was determined that facility staff failed to ensure the MDS (Minimum Data Set) assessments were readily accessible to all professional staff members (including consultants and easily accessible for review by the State Survey Agency and Centers for Medicare and Medicaid Services [CMS]. Units #2, #3, #4, and #5. The findings include: According to Chapter 2.3 of the MDS 3.0 RAI Manual " In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated	F 286	1. No resident was hurt or affected by this occurrence or deficient practice on unit #2, #3, #4, and #5. 2. All other charts were reviewed and those noted with this deficient practice were immediately corrected. 3a. QA/Regional MDS coordinator in-serviced MDS coordinators on 1/13/15 on making residents assessment accessible. 3b. QA/Regional MDS coordinator will audit bi-weekly for ninety days to ensure compliance. 4. Further findings of this matter will be discussed in weekly, monthly and quarterly QA meetings six months.	2/12/15

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F 286	Continued From page 17 CAA(s) [Care Area Assessment] completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record. Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident." During a review of clinical records on the 3rd floor Residential Care Unit on January 7, 2015 at approximately 10:00 AM, Employee #6 was asked regarding the location to review residents' MDS assessments, as they were not observed in the active clinical record. Employee #6 stated that the MDS assessments were maintained electronically and required a special access code that was maintained by the MDS Coordinator. He/she stated that he/she did not have access to the assessments and proceeded to contact the MDS Coordinator to obtain the MDS assessments. A face-to-face interview was conducted with Employee #6 on January 7, 2015 at approximately 2:30 PM regarding the accessibility and availability of MDS assessments. He/she acknowledged that MDS assessments were not accessible to clinical staff in the residential care areas. He/she stated that he/she was unable to readily provide it and would have to request a print out from the MDS Coordinator. A follow up face-to-face interview was conducted with Employee #4 on January 9, 2015 at	F 286		

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F 286	Continued From page 18 approximately 1:30 PM regarding the accessibility and availability of MDS assessments on the 2nd floor Residential Care Unit. He/she acknowledged that MDS assessments were not accessible to clinical staff in the residential care areas. He/she stated that he/she was unable to readily provide it and would have to get it from the MDS Coordinator. A face-to-face interview was conducted with Employee #3 on January 9, 2015 at approximately 11:30 AM. He/ she was asked to provide the MDS assessments for residents on the 4th floor Residential Care Unit. He/she stated that he/she would have to obtain them from the MDS coordinator. a face-to-face interview was conducted with Employee #7 on January 9, 2015 at approximately 1:30 PM regarding the accessibility and availability of MDS assessments on the 5th floor Residential Care Unit. He/she acknowledged that MDS ' were not accessible to clinical staff in the residential care areas. There was no evidence that facility staff maintained MDS assessments on the active clinical records or in a manner where they were accessible and readily available for professional review. Facility staff failed to ensure the MDS assessments were readily available and easily accessible to professional staff members.	F 286		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	Continued From page 19 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review for five (5) of 37 sampled residents, it was determined that the facility staff failed to provide the necessary care and services for the residents to attain or maintain the highest practicable physical, mental, and psychosocial well- being as evidenced by failure to: clarify the route of administration for aspirin prescribed by the physician for three (3) residents; ensure that one (1) resident received hospice care as ordered by the physician and collaborate with hospice to coordinate the necessary care and services for one (1) the resident. Residents' #65, 103, 104, 146, and 159. The findings include: 1. Facility staff failed to clarify the oral method (chew or swallow) of administration for aspirin prescribed by the physician for three (3) residents. Residents #65, 103, and 146. On January 9, 2015 at approximately 10:00 AM, a review of resident clinical records revealed the following: A. A review of the clinical record for Resident #65 revealed the following physician ' s order dated January 2, 2015: "aspirin oral tablet	F 309	1. Residents #65, #103 and #146 did not suffer any harm from this deficient practice. 2. All residents on chewable Asprin were identified and clarification of orders to administer the medication chewed or swallowed was established. 3a.All licensed nurses were in-serviced on 1/31/15 on the administration of chewable medication. 3b.QA/Designee will conduct weekly audits for ninety days to ensure that all medications are administered per order. 4 Further findings of this matter will be discussed in the weekly, monthly and quarterly QA meeting for six months.	2/12/15

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F 309	Continued From page 20 chewable 81mg 1 tablet po [by mouth] 1 time a day 10 am, special instructions: dx [diagnosis]: prophylaxis." B. A review of the clinical record for Resident #103 revealed the following physician ' s order dated January 2, 2015: "aspirin oral tablet chewable 81mg 1 tablet po 1 time a day 10 am special instructions: dx: stroke." C. A review of the clinical record for Resident #146 revealed the following physician ' s orders dated January 2, 2015: "aspirin oral tablet chewable 81mg 1 tablet po 1 time a day 10 am special instructions: dx: cva [cerebral vascular accident] prophylaxis." The clinical record lacked evidence that facility staff clarified the aspirin orders to provide unequivocal direction on whether to administer the aspirin to be chewed or swallowed. A face-to-face interview was conducted on January 9, 2015 at approximately 11:30 AM with Employee #13 and Employee #3 regarding the above mentioned orders for aspirin. When queried regarding how the aspirin was to be administered, Employee #13 stated he/she would administer the medication by mouth to be swallowed by the resident. Employee #3 stated he/she would administer the medication by mouth to be chewed by the resident. Both acknowledged the aforementioned findings. Facility staff failed to clarify the oral method of administration for aspirin prescribed for the residents. The clinical record was reviewed on January 9, 2015.	F 309		

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2. Facility staff failed to ensure that Resident #104 received hospice care as ordered by the physician.

According to the documentation in the clinical record, the physician ordered the following treatment for the resident on February 11, 2013: "Admit Resident to Hospice Care (Name of Agency). Dx. [Diagnosis] COPD [Chronic Obstructive Pulmonary Disease]." Current physician ' s orders dated January 2, 2015 includes an order for continued Hospice services.

A review of Resident #104 ' s clinical record lacked evidence of hospice nursing assessments and/or progress notes. Further review of a "Hospice Visit Frequency Grid" in the clinical record also failed to reveal any consistent documentation of the hospice nurses' visits.

A face-to-face interview was conducted with Employee #2 at approximately 10:00AM on January 12, 2015. The employee was queried regarding the lack of hospice nursing documentation in the clinical record. He/she responded that hospice had its own chart and that I should look in the hospice chart for their nursing documentation.

A review of the hospice chart [a binder stored on the residential unit with records of residents receiving hospice services] failed to reveal nursing documentation or evidence of nurse visits for Resident #104. When queried about the absence of documentation in the hospice record, Employee #2 stated, "They keep their notes in their office [at another location]. Would you like me to have them faxed over here?" I responded,

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F 309	Continued From page 22 " No " and informed the employee that the aforementioned information needed to be readily available and accessible. The employee was also unable to determine the frequency of hospice nurse visits based on an assessment of the resident ' s needs. The record was reviewed on January 9, 2015. Facility staff failed to ensure that Resident #104 received hospice care as ordered by the physician. 3. Facility staff failed to collaborate with hospice to coordinate the necessary care and services for Resident #159. The Annual Minimum Data Set dated October 20, 2014 revealed that Resident #159 was admitted to the facility on October 14, 2013 with diagnoses including Anemia, Deep Venous Thrombosis, Hearth Failure, Hypertension, and Non-Alzheimer 's Dementia. Additional diagnoses included Speech Disturbance, Vitamin B deficiency, and Encounter for Palliative Care. Review of the October 14, 2013 Interim Order Form, timed 10:00 PM, revealed an order that directed the following: " Patient admitted to [company name] Hospice with a dx of Dementia ..." Review of the November 13, 2014 physician progress notes revealed the following: "Continue supportive hospice care." On January 8, 2014, at approximately 12:18 PM, a face-to-face interview was conducted with Employee #13 who was asked to explain how the facility coordinates care with the hospice provider	F 309	1. Resident #104 and #159 did not suffer any harm from this deficient practice. 2. Review of all medical records of hospice residents was conducted and none was noted with this deficient practice. 3a An in-service was conducted on 1/31/15 with facility and hospice staff on coordination and collaboration of care. 3b QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	2/12/15

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to care for Resident #159. Employee #13 stated that hospice attendants come to assist with ADL's [Activities of Daily Living] and care; hospice provides music therapy and a pastor visits the resident. When asked how the facility staff and the hospice nurse coordinate care, Employee #13 provided no answer. When asked to provide the hospice notes, he/she stated, "The hospice care plans and notes are not in the resident's chart." He/she admitted that he/she didn't know where they were.

On January 8, 2014, at approximately 12:30 PM, a face-to-face interview was conducted with Employee #4 who was asked to provide the hospice care plans and notes for review. Employee #4 communicated that he/she would call the hospice manager to assist. At approximately 2:30 PM, Employee #4 provided the hospice binder for review.

Review of the hospice "Visit Frequency Grid," indicated the following:

November 11, 2014 - The resident was to receive planned visits by the nurse once a week. December 3, 2014 - The resident was to receive planned visits by the nurse twice a week. December 23, 2014 - The resident was to receive planned visits by the nurse once a week.

Review of the hospice sign in sheet revealed the following:

November 2014- no printed name with credentials or signed names with credentials of the hospice nurse.
December 2014-December 20, 2014, there was one printed and signed name with credentials of

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F 309	Continued From page 24 hospice nurse. Review of the clinical record lacked documented evidence of hospice nursing assessments and notes from November 12, 2014 to January8, 2014. January 2014- no printed name with credentials or signed names with credentials of the hospice nurse. The clinical record lacked documented evidence that the facility staff collaborated with hospice to provide the necessary care and services to the resident. On January 8, 2014, at approximately 2:40 PM, a face-to-face interview was conducted with the hospice representative who acknowledged the above mentioned findings. When asked if visits were made by the hospice nurse during the above mentioned dates, he/she stated although they did not sign in, he/she knew they made visits. When asked to provide the hospice nursing assessments and notes for the resident from November 12, 2014 to January 8, 2014, he/she could not provide the information. He/she communicated that the assessments and notes were in the hospice office. On January 8, 2014, at approximately 3:00 PM, a face-to -face interview was conducted with Employee #3 who acknowledged the aforementioned findings. Facility staff failed to collaborate with hospice to coordinate the necessary care and services for the resident. The clinical record was reviewed on January 8, 2015.	F 309		

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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. This REQUIREMENT is not met as evidenced by: Based on an isolated observation and interview, facility staff failed to promote safety for one (1) resident who was observed lying in bed unsupervised with the bed positioned at an elevated height and without the prescribed safety device (bed alarm); additionally, the resident was assessed as a ' fall ' risk. Resident #167. The findings include: Resident #167 was observed lying supine in bed on January 5, 2015 at 12:30 PM. The bed was positioned at an elevated height and bilateral quarter rails were observed in the " up " position proximal to the resident ' s head. Resident #167 wore a red colored band around his/her wrist that read, " Fall risk. " The resident was alone and unsupervised at the time of the observation. A review of physician ' s orders dated January 2, 2015 (originated 9/10/14) read, " Bed side rails: ¼ bed side rails for bed mobility ...Fall precautions: bed and chair alarm for safety. " A face-to-face interview was conducted with Employees #2 and 3 on January 5, 2015 at	F 323	1. Resident #167 was identified and the bed immediately lowered to the floor. The resident was transferred to the social room for direct supervision. 2. All other rooms were checked and none noted with this deficient practice. 3a All nursing staff were in-serviced on 1/31/15 on safety precautions and placement of beds in the lowest position. 3b.QA/Designee will conduct bi-weekly rounds for ninety days to ensure compliance. 4. Further findings of this matter will be discussed in the weekly monthly and quarterly QA meetings for six months.	2/12/15

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F 323	Continued From page 26 approximately 12:40 PM. It was acknowledged that Resident #167 was a fall risk and that the bed should have been positioned at a lower level. Facility staff failed to promote safety precautions for resident #167 as it related to the potential for falls. The prescribed bed alarm was not in-use and the bed was positioned at an elevated height when the resident was observed unsupervised in bed on January 5, 2015 at approximately 12:30 PM.	F 323		
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.	F 329	la. Resident #10 did not suffer any harm from this deficient practice. 1b. Clarification of Cogentin was done to Include its indication of use. 2. All other residents on Cogentin (Benzo Tropine) were reviewed and none was noted with this deficient practice. 3a All nurse managers and charge nurses were in-serviced on 1/31/15 to include appropriate indication of medication use. 3b QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance. 4. Further findings of this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	2/12/15

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F 329	Continued From page 27	F 329		

This REQUIREMENT is not met as evidenced
Based on clinical record review and staff interviews for 1 (one) of 37 sampled residents it was determined that the facility staff failed to clarify a medication order to include an accurate indication for the use of Benzotropine (Cogentin) [an Anticholinergic medication used to treat symptoms of involuntary movement]. Resident #110.

The findings include:

Mosby ' s Nursing Drug Reference 2014
Cogentin - an Anticholinergic /Antiparkinsonian medication to control extrapyramidal [neurological network that causes involuntary reflexes and movements] disorders.

Facility staff failed to clarify a medication order to include an accurate indication for the use of Cogentin (Benzotropine) for Resident #110.

Initial physician ' s order: July 22, 2014, 10:27 AM, " Start Cogentin 0.5 mg [milligrams] po [by mouth] BID [twice a day] for psychosis/agitation. "

Current physician ' s order: January 2, 2015, Cogentin (Benztropine) Oral Tablet 0.5mg 1 Tablet PO 2 [two] Times a day 9am, 5pm special instructions: for psychosis/agitation. "

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F 329	Continued From page 28 On January 9, 2015 at approximately 2:30 PM, a face-to-face interview was conducted with Employee #4 who acknowledged the findings. Facility staff failed to clarify a medication order to include an accurate indication for the use of Cogentin (Benzotropine). The clinical record was reviewed on January 9, 2015.	F 329		
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 January 8, 2015, it was determined that the facility failed to store, prepare and distribute food under sanitary conditions as evidenced by dented food service equipment such as one (1) of one (1) round pan and one (1) of one (1) half-size deep pan, five (5) of five (5) one-quarter size pans that were stored wet and dented, and low final rinse temperatures from the dishwashing machine that were sporadically documented and not acted upon for nine (9) of 13 months in 2014 and 2015. The findings include:	F 371	1. All dented pans were immediately Identified, removed and discarded on 1/30/15. 2. Director of Food Service checked all pots and pans and none was noted with this deficient practice. 3a All Food Services staff were in-serviced on 1/31/15 on the identification and disposal of dented pans. 3b Food Service Director/Designee will conduct random audits bi-weekly for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meeting six months.	2/12/15

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F 371	Continued From page 29 1. One of one round pan was dented. 2. Five of five one-quarter size pans were stored wet and dented. 3. One of one half-size deep pan was dented. 4. Final rinse temperatures for the dishwashing machine were documented at less than 180 degrees Fahrenheit on numerous occasions for 9 of 13 months in 2014 and 2015. A review of the dishwashing machine logs revealed that final rinse temperatures, which are recorded once in the morning and once in the afternoon, were below the expected minimum temperature of 180 degrees Fahrenheit during the following instances. Three (3) times in January 2015 Twenty-two (22) times in December 2014 Six (6) times in November 2014 Twice (2) in October 2014 Fourteen (14) times in August 2014 Three (3) times in July 2014 Three (3) times in June 2014 Seven (7) times in May 2014 Three (3) times in February 2014. There was no evidence that the low temperatures noted above were acted upon. During a face to face interview with Employee #10 on January 8, 2015 at approximately 9:30 AM, he/she confirmed the findings and stated that some of the newer staff members needed to be re-educated about the dishwashing machine logs. He/she stated that the dishwashing machine had been operating normally and the low temperatures that were sporadically documented	F 371	1. All five one quarter size pans were identified and immediately rewashed and air dried. 2. Dietary department checked all pans on 1/15/15 and none was noted with this deficient practice. 3a Director of Food Services in-serviced all dietary staff on 1/31/15 on proper air drying and storage of pans. 3b Director of Food Service / Designee will conduct weekly audits for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly monthly and quarterly QA meetings for six months. 1. No resident was harmed by this deficient practice. 2. The dish machine temperature log book was immediately checked and no other deficient practice was noted. 3a Director of Food Services in-serviced all dietary staff on 1/31/15 on the accuracy of proper temperature range and documentation in the temperature log book. 3b. The food service director will conduct daily audit of the temperature log book for ninety days to ensure accuracy and compliance.	2/12/15 2/12/15

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F 371	Continued From page 30 above were incorrect. These observations were made in the presence of Employee #10 who acknowledged the findings.	F 371	4. Further findings of this matter will be discussed in the weekly, monthly and quarterly QA meeting for six months.	2/12/15
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program 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	F 441	1. The handheld TV remote control was identified and cleansed with germicidal wipes. 2. All other TV remote controls were assessed and none noted to be with this deficient practice. 3a All nursing staff were in-serviced on cleansing remote control retrieved from trash can 3b QA designee will conduct bi-weekly audits for ninety days to ensure all TV remote controls are clean. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	2/12/15

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F 441	Continued From page 31 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 an observation and staff interviews for one (1) of 37 sampled residents, it was determined that the facility staff failed to maintain a sanitary environment as to prevent the spread of infection as evidenced by failure to cleanse a remote control apparatus that was retrieved from the trash can, prior to returning it to the resident for use. Resident #191. The findings include: An observation was made on January 8, 2015 at approximately 12:00 PM. Employee #13 was observed placing Resident #191 ' s food tray on the bedside table and the television remote control accidentally fell into the trash can. Employee #13 retrieved the remote control apparatus from the trash can and placed it on the resident ' s bedside table for use, without first cleaning it. On January 8, 2015, at approximately 12:05 PM, a face-to-face interview was conducted with Employee #13, who acknowledged the findings. On January 8, 2015 at approximately 12:10 PM, a face-to-face interview was conducted with Employee #2. He/she was apprised of the aforementioned findings and was queried regarding the availability of cleaning equipment. He/she demonstrated the availability of surface	F 441		

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F 441	Continued From page 32 [germicidal] wipes on the medication cart and in the supply closet for staff access. Facility staff failed to cleanse a hand held television remote control device after retrieving it from the trash can and prior to returning it to the resident for use.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made on January 8, 2015 between 11:00 AM and 4:30 PM, it was determined that the facility failed to maintain the resident's call bell system in good working condition, as evidenced by call bells in six (6) of 44 residents' rooms that did not emit an alarm when tested. The findings include: Resident call bells did not operate when triggered in six (6) of 44 residents' rooms including rooms #507, #508, #513B, #518B, #517A and #207. These observations were made in the presence of Employee #11 and Employee #12.	F 463	1. Call cords in rooms 507, 508, 513B, 517A and 207 were identified and immediately replaced and tested for proper operation on 1/8/15. 2. All call lights in the facility were checked and none was noted with this deficient practice. 3a. All maintenance staff were in-serviced on 1/12/15 on proper functioning of call bells. 3b. The Director of Maintenance//Designee will check call bell daily for ninety days to ensure proper functioning. 4. Further findings on this matter will be discussed in the weekly, monthly and daily QA meetings for six months.	2/12/15
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest	F 469		

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F 469	Continued From page 33 control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations made during the survey period, it was determined that the facility failed to maintain an effective pest control program as evidenced by crawling and flying insects observed in the facility. The findings include: 1. A large flying insect was observed in the area of rooms #415 A and B and #415 C and D on January 7, 2015 at approximately 1:00 PM. 2. On January 8, 2015, at approximately 3:00 PM, multiple crawling insects were observed crawling atop and in the crevices of a chair located in [room #420] one (1) of 44 residents' rooms surveyed. Food [crackers] was stored under the seat of the chair. The chair was immediately removed from the resident's room according to Employee #12. 3. A second observation of flying insects were observed in the proximity of the nursing station on the fourth (4th) floor on January 8, 2015 at approximately 3:15 PM. 4. These observations were made in the presence of Employee #11 and Employee #12 during the environmental tour.	F 469	1. Rooms 415A, 415B, 415C, 415D and the nursing station were treated for pest by Western Pest Control Company on 2/2/15 2a The entire building was treated and checked by Western Pest Control and none noted with this deficient practice. 3a. All Environmental Staff were in-serviced on 1/31/15 on Pest control and the login book located on all units. 3b. The Director of Environmental service or designee will conduct daily checks for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months. 1. The chairs in room 420 was immediately Identified and removed from the resident's room and discarded. 2a All chairs located in residents rooms in the entire building were checked and none noted with this deficient practice. 2b All environmental service staff were in-serviced on 1/22/14 on pest control. 3 The Director of Environmental service or designee will conduct daily rounds for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	2/16/15 2/12/15
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD	F 492		

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F 492	Continued From page 34 The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observations made on January 8, 2015 between 11:00 AM and 4:30 PM and on January 9, 2015 at approximately 9:30 AM, it was determined that the facility failed to maintain water temperatures in five (5) of 44 resident's rooms in accordance with Title 22b District of Columbia Municipal Regulations, Chapter 32, Section 3236, Water Supply and Distribution. The findings include: 1. Water temperatures in five (5) of 44 residents' rooms surveyed were less than 95 degrees Fahrenheit (F) as required by Title 22b DCMR, Chapter 32. The water temperatures were as follows: Room # 403 = 92.8 degrees F Room # 402 = 84.0 degrees F Room # 303 = 93.4 degrees F Room # 302 = 90.3 degrees F Room # 203 = 84.0 degrees F These observations were made in the presence of Employee #11 and Employee #12 during the tour.	F 492	1a Cold water temperatures in rooms 403, 402, 303, 302 and 203 were Immediately restored to compliance between 95-110 degrees by replacing the gas valve by American Boiler on 1/8/15. 2. All other rooms in the facility were checked and none noted with this deficient practice. 3a. The Director of Maintenance in-serviced the staff on 1/31/15 on the accuracy of water temperature per regulation. 3b. Director of Maintenance/Designee will conduct daily rounds for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	2/12/15
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		

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F 514	Continued From page 35 LE 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 interview for three (3) of 37 sampled residents, it was determined that the facility's staff failed to maintain complete, accurate, and organized clinical records in accordance with accepted professional standards and practices as evidenced by failure to ensure that documentation related to Advanced Beneficiary Notice of Non-coverage was incorporated into the closed clinical records for three (3) residents. Residents #42, #51, and #61. The findings include: 1. The facility's staff failed to ensure that Advanced Beneficiary Notices were incorporated into the closed clinical record for Resident #42. A review of Resident #42' s clinical record revealed that the resident was admitted to the facility on August 29, 2014 with diagnoses which	F 514	1. Resident 42, 51 and61 ABN/denial letters were placed in their charts. 2. All other resident charts were checked and none noted with this deficient practice 3a. All social workers were in-serviced on 1/15/14 on the placement of ABN forms/denial letters in residents charts. 3b.QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	2/12/15

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F 514	Continued From page 36 included End Stage Renal Disease, Hemiparesis, Generalized Muscle Weakness Diabetes Mellitus, and Depression. Additional review of the clinical record revealed that Resident #42 was discharged from the facility on September 11, 2014. Resident #42 ' s closed clinical record lacked documented evidence that he/she received notice of his/her appeal rights once the provider determined that skilled nursing or rehabilitation services may be denied. A face-to-face interview was conducted with Employee #9 on January 12, 2015, at approximately 11:40 AM. He/she acknowledged the findings and stated that copies of the Advanced Beneficiary Notices/ Notice of Medicare Non-coverage forms were not kept in the residents' closed records but were kept in a binder in the Social Service's office. The record was reviewed on January 12, 2015. Facility staff failed to ensure that documentation related to Advanced Beneficiary Notice was incorporated into the closed clinical record for Resident #42. 2. Facility staff failed to ensure that Advanced Beneficiary Notices were incorporated into the closed clinical record for Resident #51. A review of Resident #51's clinical record on January 12, 2015, revealed that he/she was admitted to the facility on July 10, 2014. Further review of the clinical record revealed the resident was discharged from the facility on	F 514		

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
	095031	A. BUILDING ______ B. WING ______	01/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 37 August 29, 2014. Resident #51 ' s closed clinical record lacked documented evidence that he/she received notice of his/her appeal rights once the provider determined that skilled nursing or rehabilitation services may be denied. A face-to-face interview was conducted with Employee #9 on January 12, 2015 at approximately 10:29 AM. He/she acknowledged the findings and stated that copies of the Advanced Beneficiary Notices/ Notice of Medicare Non-coverage forms were not kept in the resident's closed records but were kept in a binder in the Social Service's office. The record was reviewed on January 12, 2015. Facility staff failed to ensure that documentation related to Advanced Beneficiary Notices were incorporated into the closed clinical record for Resident #51. 3. Facility staff failed to ensure that Advanced Beneficiary Notices were incorporated into the closed clinical record for Resident #61. A review of Resident #61's clinical record on January 12, 2015, revealed that he/she was admitted to the facility on July 28, 2014 and was discharged from the facility on September 9, 2014. Resident #61 ' s closed clinical record lacked documented evidence that he/she received notice of his/her appeal rights once the provider determined that skilled nursing or rehabilitation services may be denied.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING ______ B. WING ______	01/12/2015

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F 514	Continued From page 38 A face-to-face interview was conducted with Employee #9 on January 12, 2015 at approximately 10:29 AM. He/she acknowledged the findings stating that copies of the Advanced Beneficiary Notices/ Notice of Medicare Non-coverage forms were not kept in the resident's closed records but were kept in a binder in the Social Service's office. The record was reviewed on January 12, 2015. Facility staff failed to ensure that documentation related to Advanced Beneficiary Notices were incorporated into the closed clinical record for Resident #61.	F 514		