STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	09/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE CENTER	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 was conducted on September 16 through September 24, 2013. The deficiencies are based on observations, record review, resident and staff interviews for 40 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 DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner BID - Twice- a-day B/P - Blood Pressure L - Liter Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MDS - Minimum Data Set Mg - milligrams (metric system unit of mass)	F 000	Carolyn Boone Lewis Health Care Center, "CBL", is filing this Plan of Correction in accordance with the compliance requirements for federal and state regulations. This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction does not constitute admission of facts or conclusions cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mona J. Wesson	Interim Administrator	Dec. 3, 2013

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 mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter 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 mm/Hg - millimeters of mercury D/C discontinue	F 000		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for three (3) of 40 sampled residents, it was determined that facility staff failed to ensure residents were free from physical restraints as evidenced by: one (1) resident who was observed seated in a wheelchair equipped with a seat belt which the resident was unable to release and two (2) residents who were observed in bed with bilateral full side rails observed in the upright position. Residents #23, #153, and #173.	F 221		

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F 221	Continued From page 2 The findings include: The Facility's Policy and Procedure No.1035 - Restraint Policy: effective 09/10/00 revised 07/29/10 stipulated the following: " Restraint use in our facility will only be considered to treat a medical symptom/condition that endangers the physical safety of the resident and under the following conditions: 1. As a last measure after trial period where less restrictive measures have been taken and proven unsuccessful; 2. With a physician's order; 3. With the consent of the resident (or legal representative); 4. When benefits for the restraint outweigh the identified risks. If a restraint use is deemed necessary, the goal will be to use the least restrictive type of restraint for the shortest period of time possible." 1. Facility staff failed to maintain Resident #23 free from physical restraints. Resident #23 was observed seated in a wheel chair in a dining room on the third floor with a self-release seat belt around his/her waist at approximately 10:30 AM on September 19, 2013. The resident did not respond to a request from the surveyor to release the seat belt. A face-to-face interview was conducted with Employee #8 immediately after the observation on September 19, 2013. A query was made to determine if the resident could release his/her seat belt. Employee #8 stated, "The seat belt is	F 221	Continued From page 2 **#1 Resident #23** 1. Resident # 23 had a restraint assessment and an updated consent form the seatbelt completed 9/27/13. The MDS is unable to be re-coded for the specific time period. An update was entered for resident. 2. A 100% review of resident's restraint/ side rail assessment was conducted to determine the need for side rail use. 3. The Charge Nurse/Team Leader will monitor the resident(s)' need for restraint use and communicate findings to the Unit Manager/IDT team for development of clinical care plan. This will be monitored weekly and reported the DON/designee monthly x3. 4. The results of the monitoring will be reported to the monthly Quality Assessment and Performance Improvement (QAPI) Committee meetings monthly. The committee, based on the results of the audit will determine the need and future plans for continued monitoring and follow up.	9/27/13 11/1/13 12/3/13 & Weekly Monthly & Ongoing

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F 221	Continued From page 3 not a restraint because it is a self-release belt and it can be released by the resident." The employee was informed that the resident had failed to release the seat belt when instructed to do so. Employee #8 then stated, "[He/she] will not release the belt when requested, but always releases it when [he/she] is angry." A review of a physician's order on the Interim Order Form dated May 3, 2013 directed, "EZ [Easy] release w/c [wheelchair] belt. Resident unable to release belt. Seat belt to be released q [every] two [2] hours for 15 minutes for repositioning." Resident #23 was observed with a seat belt attached around his/her waist while seated in a wheelchair. There was no evidence that the resident was able to voluntarily release the seatbelt. The clinical record lacked evidence that the medical team identified a symptom for the use of the seatbelt and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to the use of the seatbelt device. There was no evidence that the facility staff assessed the seatbelt as the least restrictive device prior to implementing its use. The record was reviewed on September 19, 2013. Facility staff failed to maintain Resident #23 free from physical restraints. 2. Facility staff failed to maintain Resident #153 free from physical restraints.	F 221	Continued From page 3	

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F 221	Continued From page 4 A face- to- face interview was conducted with Resident #153 on September 16, 2013 at approximately 4:40 PM. The resident was observed lying in bed with both side rails in the upright position. When asked why the side rails were used, the resident stated "I guess to keep me from falling " A face- to- face interview was conducted with Employee #16 on September 17, 2013 at approximately 10:50 AM, he/she stated "The resident has bed side rails up for turning and repositioning." A review of Section G, Functional Status of the Quarterly MDS (Minimum Data Set) dated August 23, 2013 revealed Resident #153 was coded as requiring extensive assistance of two (2) persons for transfer and bed mobility. A face-to-face interview was conducted with Employee #30 on September, 23 2013 at approximately 1:00 PM. In response to a query regarding the Rehabilitation (Rehab.)Department's role in the use of side rails, the employee stated " Rehabilitation is not involved with the use of bed side rails in the facility." He/she further stated, " On the units it 's the nursing department that determines the need for and use of bed side rails." When asked if the rehab department assesses the rails for safety and effectiveness he/she replied, " No " . Resident #153 was observed lying in bed with uninterrupted side rails that extended the length of the bed in the upright position. There was no evidence that the medical team identified a	F 221	Continued From page 4 **#2.** 1. Resident #153 assessment for restraints was completed 9/26/13. 2. A 100% review of residents was conducted to determine the need for restraint/side rail use. 3. The Charge Nurse / Team leaders will monitor resident's need for restraint use and communicate findings to the Unit Manager / IDT team for the development of clinical care plan. This will be monitored and reported to DON/designee monthly x3. 4. The results of the monitoring, including problems identified and corrective actions taken, will be reported at the monthly Quality Assessment and Performance Improvement (QAPI) Committee meetings. The QAPI committee, based on the evaluation of the results of the audit will determine the need to continue to monitor and follow up.	9/26/13 11/6/13 11/6/13 Ongoing

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F 221	Continued From page 5 medical symptom for the use of the full side rails, nor was there evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to their use. The clinical record lacked evidence that facility staff explained the risks/benefits for the use of full side rails to the resident and/or responsible party. Facility staff implemented the use of full side rails for Resident #153 that had the potential for prohibiting freedom of movement. A face-to-face interview was conducted with Employee #8 on September 20, 2013 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. Facility staff failed to maintain Resident #153 free from physical restraints. 3. Facility staff failed to maintain Resident #173 free from physical restraints. A face-to-face interview was conducted with Employee #17 on September 17, 2013 at approximately 10:40 AM. He/she stated "the bed side rails are used by this resident for turning and repositioning." A face-to-face interview was conducted with Resident #173 on September 18, 2013 at approximately 1:30 PM. The Resident was observed lying in bed with both side rails in the upright position. When queried regarding why side rails were used, the resident stated " I don ' t know " In response to a query as to whether or	F 221	Continued From page 5 **#3.** 1. Resident #173 had the side rail removed on 9/18/13. On 10/18/13 upon readmission to the facility an order was written for partial side rails. 9/18/13 2. A 100% review of residents was conducted to determine the need for restraint/side rail use. 11/6/13 3. The Charge Nurse / Team leaders will monitor resident's need for restraint use and communicate findings to the Unit Manager / IDT team for the development of clinical care plan. This will be monitored and reported to DON/designee monthly x3. 11/6/13	

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F 221	Continued From page 6 not he/she was able to get out of bed when the side rails are raised, the resident responded "no." The Resident was alert, oriented and observed ambulating during the survey period. A face- to- face interview was conducted with Employee #30 on September, 23 2013 at approximately 1:00 PM. When questioned he/she stated " The Rehabilitation Department is not involved with the use of bed side rails in the facility. He/she further stated, " On the units it's the nursing department that determines the need for and use of bed side rails. A review of Section G, Functional Status of the Admission MDS (Minimum Data Set) dated July 1, 2013 revealed Resident #173 was coded as independent for transfer, bed mobility and locomotion. Resident #173 was observed lying in bed with uninterrupted side rails that extended the length of the bed in the upright position. There was no evidence that the medical team identified a medical symptom for the use of the full side rails, nor was there evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to their use. The clinical record lacked evidence that facility staff explained the risks/benefits for the use of full side rails to the resident and/or responsible party. Facility staff implemented the use of full side rails for Resident #173 that prohibited him/her from voluntarily getting out of bed.	F 221	Continued From page 6 4. The results of the monitoring, including problems identified and corrective actions taken, will be reported at the monthly Quality Assessment and Performance Improvement (QAPI) Committee meetings. The QAPI committee, based on the evaluation of the results of the audit will determine the need to continue to monitor and follow up.	Ongoing

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F 221	Continued From page 7 Facility staff failed to maintain Resident #173 free from physical restraints. The record was reviewed on September 23, 2013. .	F 221	Continued From page 7 **F 253** **#1.**	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 18, 2013, between 11:40 AM and 2:15 PM, 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 privacy curtains that were partially detached from hooks in four (4) of 40 residents ' s rooms surveyed, A stained ceiling tile in one (1) of 40 residents' rooms, clutter in two (2) of 40 residents' rooms and marred furniture in five (5) of 40 residents' rooms. The findings include: 1. Privacy curtains were partially detached from the hooks in rooms #242, #329, #338 and #341 in four (4) of 40 residents ' rooms observed. 2. A ceiling tile was fully stained in one (1) of 40 resident ' s rooms (#145).	F 253	1. Privacy curtains in rooms #242, #329, and #341were corrected and hung properly. 2. A review was completed of other resident's rooms and corrections were made as indicated. 3. Environmental Services staff were in-services by Director on partially detached privacy curtain hooks. 4. Weekly rounds will be completed by the EVS Department Director/supervisor using monitoring tool. Results of rounds will be reported monthly to the QAPI Committee. The QAPI Committee will determine the need for further audits. **#2.** 1. Stained ceiling tile was removed and replaced with new tile. 2. Maintenance staff will check resident's rooms for stained ceiling tiles and correct or replace tiles. 3. Maintenance staff were in-serviced by Director of Maintenance, monitor resident room ceiling monthly to ensure compliance..	9/18/13 9/18/13 11/25/13 9/18/13 Ongoing 9/30/13 11/29/13 11/29/13 On going

Continued From page 7
F 253

4. Finding and corrections of the ceiling tiles will be reported to the monthly QAPI Committee, following monthly monitoring by the Maintenance Manager utilizing monitoring tool.	11/29/13

 # 3

1. Room # 146 (A side) and Room # 238 (A side) have been de-cluttered. We have had discussion with the residents and families and the excess clothing, newspaper, and boxes have been removed from both rooms.	11/6/13
2. Environmental Services Director, Maintenance /Building Service Manager have conducted observations of all residents' rooms to identify rooms that are cluttered and they have been corrected.	12/2/13
3. Department Directors and managers will incorporate observations of cluttered resident rooms in their Daily Environment of Care Rounds. Results of the daily rounds will be provided to the Nurse Managers and Environmental Services Director for corrective action. Reports also will be provided to Director of Social Services for communication with families.	12/2/13 & Ongoing
4. Results of the EOC rounds will also be presented to the QAPI Committee monthly for analysis. Based on the results of the monthly reports, the committee will make a decision on the pattern and frequency of continuous monitoring.	Monthly & Ongoing

#4.

1. Marred baseboard was removed and replaced with new baseboard and the area was corrected.	11/25/13
2. Maintenance department will monitor resident room(s) baseboard as directed by Maintenance Director to identify resident room(s) that may be affected.	11/29/13
3. Baseboards to be included as a part of the Monthly Preventative Maintenance Program to ensure compliance.	11/29/13
4. Finding and corrective actions will be reported to QAPI Committee following monthly monitoring by manager utilizing monitoring tool.	11/29/13 & Monthly

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F 253	Continued From page 8 3. Rooms #146 (A side) and room #238 (A side) were cluttered with clothing, newspapers and boxes piled up on top of each other. 4. The baseboard was marred in room #141, the bedside tables were marred in room #143 and #145, two (2) of two (2) night tables were marred in room #137 and one (1) of two (2) closets and the walls were marred in room #222, five (5) of 40 residents ' rooms observed. These observations were made in the presence of Employee #13 who confirmed the findings.	F 253	Continued From page 8	
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;	F 272		

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F 272	Continued From page 9 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 interview for three (3) of 40 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for one (1) resident who sustained a fall w/o injury and was observed with a wheelchair seatbelt that restricted freedom of movement and two (2) residents that were observed in bed with full side rails in the upright position that prohibited freedom of movement. Residents #23, 153 and 173. The findings include: 1(a).Facility staff failed to accurately code Resident #23's Quarterly MDS dated March 22, 2013 under Section J, Health Conditions. A review of Resident #23 ' s clinical record	F 272	Continued From page 9	

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F 272	Continued From page 10 revealed that he/she sustained a fall without injury on February 13, 2013. A review of the resident ' s quarterly MDS with an Assessment Reference Date (ARD) of March 22, 2013 revealed that the MDS was coded " No " , in response to the question in Section J 1800 [Falls since Admission] " Has the resident had any falls since admission or the prior assessment, whichever is more recent? " A face-to-face interview was conducted with Employee #15 at approximately 11:00 AM on September 20, 2013. After reviewing the MDS, the employee acknowledged that the resident ' s MDS was not coded for the fall sustained on February 13, 2013. The record was reviewed on September 19, 2013. The facility ' s staff failed to accurately code Resident #23's March 22, 2013 quarterly MDS for a fall history. 1 (b). Facility staff failed to accurately code Resident #23 ' s quarterly MDS under Section P, Restraints. Resident #23 was observed seated in a wheel chair in a dining room on the third floor with a seat belt attached around his/her waist at approximately 10:30 AM on September 19, 2013. The resident did not respond to a request from the surveyor to release the seat belt. The quarterly MDS dated September 9, 2013	F 272	Continued From page 10 **1(a) & 1(b)** 1. The MDS is unable to be recoded for resident #23 for fall for the specific time period. A modified MDS assessment was submitted on 11/26/13 addressing the resident' seatbelt use for quarterly MDS. 2. A 100% review of residents to determine the need for restraint/side rail use was conducted from 11/6-11/27/13. 3. The Charge Nurse/Team Leader will monitor the resident(s)' need for restraint use and communicate to the IDT for care plan/MDS assessment and report to the DON/designee. 4. The findings, problems identified and corrective actions implemented for the restraint/side rails audit will be reported to the QAPI Committee monthly for three (3) months. The committee will evaluate and determine the pattern and need for further monitoring and frequency of audits	12/3/13 Monthly & Ongoing

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F 272	Continued From page 11 was coded as " 0, not used " under Section P, Restraints. A face-to-face interview was conducted with Employee #8 immediately after the observation on September 19, 2013. A query was made to determine if the resident could release his/her seat belt. Employee #8 stated, "The seat belt is not a restraint because it is a self-release belt and it can be released by the resident." The employee was informed that the resident had failed to release the seat belt when instructed to do so. Employee #8 then stated, "[He/she] will not release the belt when requested, but always releases it when [he/she] is angry." A review of a physician's order on the Interim Order Form dated May 3, 2013 directed, "EZ [Easy] release w/c [wheelchair] belt. Resident unable to release belt. Seat belt to be released q [every] two [2] hours for 15 minutes for repositioning." Resident #23 was observed with a seat belt attached around his/her waist while seated in a wheelchair. There was no evidence that the resident was able to voluntarily release the seatbelt. The clinical record lacked evidence that facility staff identified the seatbelt as a restraint device that restricted freedom of movement for Resident #23. There was no evidence that the facility staff accurately coded the MDS to include the seatbelt as a trunk restraint. The record was reviewed on September 19, 2013.	F 272	Continued From page 11	

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F 272	Continued From page 12 2. Facility staff failed to accurately code Resident #153 ' s quarterly MDS under Section P, Restraints. A face- to- face interview was conducted with Resident #153 on September 16, 2013 at approximately 4:40 PM. The resident was observed lying in bed with both side rails in the upright position. When asked why the side rails were used, the resident stated "I guess to keep me from falling " A face- to- face interview was conducted with Employee #16 on September 17, 2013 at approximately 10:50 AM, he/she stated "The resident has bed side rails up for turning and repositioning." The quarterly MDS dated August 23, 2013 was coded as " 0, not used " under Section P, Restraints. A face-to-face interview was conducted with Employee #30 on September, 23 2013 at approximately 1:00 PM. In response to a query regarding the Rehabilitation (Rehab.)Department's role in the use of side rails, the employee stated " Rehabilitation is not involved with the use of bed side rails in the facility." He/she further stated, " On the units it 's the nursing department that determines the need for and use of bed side rails." When asked if the rehab department assesses the rails for safety and effectiveness he/she replied, " No " . Resident #153 was observed lying in bed with	F 272	Continued From page 12 **#2.** 1. Resident #153 MDS for 8/23/13 was modified and recoded to include use of side rails for positioning and movement on 11/26/13. 2. A 100% review of residents to determine the need for restraint/side rail use was conducted from 11/6-11/27/13. 3. The licensed nursing staff was educated on the use of side rail and restraint use documentation. 4. The findings, problems identified and corrective actions implemented for restraint/side rail audit will be reported to the QAPI Committee monthly x3. The QAPI Committee will evaluate and determine the pattern and need for further monitoring and frequency of audits.	11/26/13 11/27/13 11/26/13 Monthly & Ongoing

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F 272	Continued From page 13 uninterrupted side rails that extended the length of the bed in the upright position. Facility staff implemented the use of full side rails for Resident #153 that had the potential for prohibiting freedom of movement. There was no evidence that the facility staff accurately coded Section P of the MDS to include the side rails as a restraint. A face-to-face interview was conducted with Employee #8 on September 20, 2013 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. 3. Facility staff failed to accurately code Resident #173 ' s admission MDS under Section P, Restraints. A face-to-face interview was conducted with Employee #17 on September 17, 2013 at approximately 10:40 AM. He/she stated "the bed side rails are used by this resident for turning and repositioning." A face-to-face interview was conducted with Resident #173 on September 18, 2013 at approximately 1:30 PM. The Resident was observed lying in bed with uninterrupted bilateral side rails that extended the length of the bed in the upright position. When queried regarding why side rails were used, the resident stated " I don ' t know. " In response to a query as to whether or not he/she was able to get out of bed when the side rails are raised, the resident responded "no." A face- to- face interview was conducted with	F 272	Continued From page 13 **#3** 1. Resident #153 MDS for 8/23/13 was modified and recoded to include use of side rails for positioning and movement on 11/26/13. 2. A 100% review of residents to determine the need for restraint/side rail use was conducted from 11/6-11/27/13. 3. The licensed nursing staff was educated on the use of side rail and restraint use documentation. 4. The findings, problems identified and corrective actions implemented for restraint/side rail audit will be reported to the QAPI Committee monthly x3. The QAPI Committee will evaluate and determine the pattern and need for further monitoring and frequency of audits.	11/26/13 1/27/13 10/10/13 Monthly & Ongoing

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F 272	Continued From page 14 Employee #30 on September, 23 2013 at approximately 1:00 PM. When questioned he/she stated " The Rehabilitation Department is not involved with the use of bed side rails in the facility. He/she further stated, " On the units it's the nursing department that determines the need for and use of bed side rails. A review of Section G, Functional Status of the Admission MDS (Minimum Data Set) dated July 1, 2013 revealed Resident #173 was coded as independent for transfer, bed mobility and locomotion. Section P, Restraints was coded as " 0, not used." There was no evidence that the facility staff accurately coded Section P of the MDS to include the side rails as a restraint. The record was reviewed on September 23, 2013.	F 272	Continued From page 14	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		

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F 278	Continued From page 15 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to accurately code the discharge assessment Minimum Data Set [MDS] under Section K, Nutritional Status Resident #65. This was a closed record review. The findings include: Resident #65 was admitted to the facility on May 20, 2013 for skilled [Physical Therapy and Occupational Therapy] post hospitalization and was discharged home on June 18, 2013 with home health services. An " Admission Assessment " dated May 21, 2013 " revealed that the resident ' s weight was 199.5 pounds. An assessment conducted on June 1, 2013 recorded a weight of " 166 pounds (bed scale). " A review of the discharge MDS assessment dated June 18, 2013 revealed that Section K,	F 278	Continued From page 15 1. Resident #65 discharge MDS cannot be addressed at this time. He/she was discharged from facility in June 2013. 2. A 100% review of the weights for all admission and discharge residents for 9/24/13 – 11/27/13 was conducted. 3. An educational update was held with the following staff members (dieticians, MDS coordinators, Unit Managers and RN Charge Nurse) to discuss the action plan for weight management and documentations. A weekly audit of new admission charts will be conducted for four (4) weeks. 4. The findings, problems identified and corrective actions implemented for the residents weights will be reported to the QAPI Committee monthly meetings. The committee will evaluate to determine frequency of continuous monitoring.	11/27/13 11/27/13 Monthly & Ongoing

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F 278	Continued From page 16 Nutritional Status was coded as " no or unknown " in Section K 0300 [weight Loss] in response to the query, " loss of 5% or more in the last month ... " There was no evidence that the discharge MDS was coded to reflect the resident's significant weight variance of greater than 5% in 30 days. The resident ' s recorded weight history revealed a weight loss of approximately 33 pounds between May 21, 2013 and June 13, 2013. A face-to-face interview was conducted with Employee #15 on September 20, 2013 at approximately 10:15 AM. He/she acknowledged that the MDS was not coded to reflect the resident ' s significant weight loss. Facility staff failed to accurately code the discharge MDS for weight loss. The record was reviewed on September 20, 2013.	F 278	Continued From page 16	
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. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental,	F 279		

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F 279	Continued From page 17 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 observations, record reviews, and staff interviews for six (6) of 40 sampled residents, it was determined that facility staff failed to initiate care plans with goals and approaches to address: one (1) resident whose behaviors included public sexual acts; functional maintenance needs of one (1) resident referred for restorative care; one (1) resident for a medication allergy; one (1) resident who engaged in unauthorized alcohol consumption; impaired vision for one (1) resident and resistance of care for one (1) resident. Residents #14 , #85, #104, #153, # 171 and #173. The findings include: 1. Facility staff failed to initiate a care plan with goals and approaches to address Resident #14 ' s behaviors that included public sexual acts. On September 19, 2013 at approximately 10:00AM, while a face-to-face interview was being conducted in the Day Room, Resident #14 unzipped his/her pant and fondled his/her genitalia. Facility staff intervened and redirected the resident. On September 20, 2013 the resident was	F 279	Continued From page 17 **#1, #2, #3, #4, #5, #6, & #7** 1. Resident # 14's care plan was updated to include behaviors and sexual acts conducted in public. The resident was also evaluated by the psychiatrist Resident # 85's care plan was updated to include Restorative strengthening of muscle. Resident # 104's care plan was updated to include approaches for allergy to Clonidine Resident # 153's care plan was updated to include approaches for diagnosis of Astigmatism when diagnosis was received. Resident # 171's care plan was updates to include alcohol consumption with potential for falls and injury due to intoxication. Resident # 194's care plan was updated to include behaviors for refusal of care.	9/26/13 11/29/13 9/23/13 10/26/13 11/25/13 9/25/13

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F 279	Continued From page 18 observed seated in a wheel chair on the second floor hallway masturbating and again on September 23, 2013 at approximately 5:00 PM in the dining room on the first floor. A face-to-face interview was conducted with Employee #9 at approximately 4:00PM on September 20, 2013. The employee was queried whether he/she was aware of the resident ' s behavior and whether approaches were in place to address the behavior. The employee acknowledged awareness of the behavior, however; responded, " No " [regarding approaches] and stated whenever we [staff] see [him/her] displaying the behavior we usually put [him/her] in [his/her] room. " A review of the demographic information in the clinical record revealed that the resident resides in a semi-private room with another resident. The resident ' s roommate was not available to be interviewed. Facility staff failed to initiate a care plan with goals and approaches to address Resident #14 ' s behavior of public sexual acts. The record was reviewed on September 19, 2013. 2. Facility staff failed to initiate a care plan with goals and approaches for Restorative Care for Resident #85. On September 23, 2013 at approximately 10:30 AM Resident #85 was observed seated in a chair in his/her room. The resident was queried why he/she was still in the room. The resident responded, "I am waiting for someone to take me	F 279	Continued From page 18 2. A 100% review of residents' care plans was conducted to ensure the care plan includes contains goals and approaches that reflect the resident's current and potential care needs. 3. A class/in-service on care planning resident care issues will be conducted by the MDS Director. All MDS staff will conduct monthly reviews of care plans and report the findings to the Director of Nursing & Assistant Director of Nursing or Designee. 4 The Director of Nursing or Designee will report to the Quality Assessment and Performance Improvement (QAPI) Committee the findings, and problems identified and interventions based on the results of the audit. The QAPI Committee will determine the need for further interventions, continued monitoring and follow up.	11/29/13 10/10/13 Monthly & Ongoing

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F 279	Continued From page 19 to therapy." A review of Resident #85's clinical record revealed that the resident was referred to Restorative Care in July, 2013. A review of the care plan section of the record revealed a care plan in place for physical therapy, however; there was no evidence of a functional maintenance plan to address the restorative care needs of the resident. A face-to-face interview was conducted with Employee #8 on September 23, 2013 at approximately 11:00 AM. After reviewing the resident's record he/she acknowledged that the record lacked a care plan for restorative care. Facility staff failed to initiate a care plan with goals and initiatives for Restorative Care. The record was reviewed September 23, 2013. 3. Facility staff failed to initiate a care plan with goals and approaches for allergy to Clonidine for Resident #104. An annual physician ' s " Admitting Evaluation History " dated August 28, 2013 revealed the following: " Allergies: Clonidine causes excessive drowsiness and bradycardia. " The resident ' s care plan which was updated July 13, 2013 lacked evidence that a care plan with goals and approaches was developed to address the resident ' s adverse response to Clonidine. A face-to-face interview was conducted with Employees #10 and #15 on September 23, 2013	F 279	Continued From page 19	

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F 279	Continued From page 20 at approximately 10:30 AM. After reviewing the clinical record, both employees acknowledged the aforementioned findings. Facility staff failed to initiate a care plan with goals and approaches to address the resident ' s allergy and/or adverse response to Clonidine. The clinical record was reviewed on September 23, 2013. 5 Facility staff failed to develop a care plan with goals and approaches to address the visual needs of Resident #153 who was assessed with visual impairment. A review of admission Minimum Data Set [MDS] Assessment Reference Date (ADR) December 19, 2012 revealed that Resident #153 was coded as " 1 " visually impaired under section B [Hearing, Speech, and Vision] B1000. A review of the quarterly [MDS] with (ADR) August 23, 2013 revealed that under section B [Hearing, Speech, and Vision] B1000 Resident #153 was coded as " 1 " indicating the resident was "visually impaired" . Observations of the resident during the survey period lacked evidence that the resident utilized corrective lenses or other visual aids to manage the visual impairment. A review of the comprehensive care plan dated August 30, 2013 lacked evidence of goals and approaches to manage the resident ' s visual impairment. There was no evidence that a care plan was initiated to address the resident ' s visual	F 279	Continued From page 20	

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impairment.

A face-to-face interview was conducted with Employee #8 on September 20, 2013 at approximately 3:00 PM. He/she acknowledged the findings. The record was reviewed on September 20, 2013.

6. Facility staff failed to develop a care plan with goals and approaches to address Resident #171 ' s behavior of unauthorized alcohol consumption.

A review of the medical record revealed that Resident #171 was admitted to the facility on February 1, 2013 with diagnoses which included Anemia, Hyperlipedemia, Pancreatic Disease, Hypertension (HTN) and Adjustment Disorder.

A review of the physician ' s order dated August 26, 2013 at 2:15AM directed " Transfer resident to ER [emergency room] for evaluation of frequent falls, unsteady gait, changes in mental status secondary to possible alcohol consumption. "

A review of an area hospital's Medical Center Emergency Department Discharge instructions record dated August 26, 2013 at 9:37AM revealed a discharge diagnoses of falling, alcohol intoxication and left hand scratch.

During a face-to-face interview conducted with Employee #2 on September 20, 2013 at approximately 2:00PM, he/she stated that" ... [Resident #171] attends every outing plus goes out with family members and takes those opportunities to buy alcohol. On one trip [resident name] was observed by staff leaving

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F 279	Continued From page 22 the function they were attending at a department store. The staff followed the resident who was found in a nearby liquor store and observed purchasing alcohol . Staff advised the resident return the alcohol. Housekeeping also reported finding rum flasks in the resident's trash can and between the resident's head board and bed. [Resident name] was questioned concerning the liquor bottles found in the room [resident name] denied it. Moving forward [resident name] now has staff escort at every outing, to the doctor and all appointments." A review of the Social Worker's note dated July 25, 2013 revealed the following: " Recently resident was found to have a bottle of alcohol in [his/her] room. [He/she] was sent out to the ER [emergency room] due to a fall on July 20, 2013 and the bottle was discovered afterwards. Resident stated that [he/she] had the bottle for several weeks and had been sipping out of it from time to time. [Resident name] goes out of facility with [his/her] spouse on occasion. Counseling was provided on July 23, 2013 during a visit to SW ' s [social worker ' s] office." The Social Worker's progress note dated August 11, 2013 stated " This writer learned of an incident that occurred on a recent outing resident made while being out with Therapeutic Recreation. Apparently [resident name] left the group from [facility's name] (they had gone to a name of store) and had gone next door to purchase some liquor. [Employee name] happened to follow him/her and witnessed this. [He/she] was asked to return the bottle and got [his/her] money back."	F 279	Continued From page 22	

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F 279	Continued From page 23 Social Worker's Progress note dated September 6, 2013 stated " On August 26, 2013 was made aware that resident had an incident in which [he/she] fell or tripped over [his/her] shoes in [his/her] room and cut [his/her] fingers. The Nurse Manager explained that another bottle of alcohol (vodka) was found in the resident ' s room. [Resident/s name] went out to the hospital on the 25th of August regarding the fall. It was found that [resident's name] alcohol level was high. Resident, the nurse manager and SW [social worker] met in social worker ' s office. Resident stated that the alcohol does not make [him/her] unsteady on [his/her] feet and got very upset that we had to discuss this with [him/her] again " . Social Worker Progress note dated September 9 2013 stated " Social worker located a phone number for the private organization of Alcohol Anonymous [phone number]. The contact person informed this writer that anyone can walk into their meeting places, all over the city, as long as they have transportation " A face-to-face interview was conducted with Employee # 2 and Employee #9 on September 20, 2013 at approximately 2:45 PM. Both employees acknowledged the findings. The record was reviewed September 20, 2013. The facility failed to develop a care plan with goals and approaches to address Resident #171 ' s behavior of unauthorized alcohol consumption. 7. Facility staff failed to initiate a care plan to address behaviors of resistance of care for Resident #194.	F 279	Continued From page 23	