STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0011	Carolyn Boone Lewis Health Care A. BUILDING _____ B. WING _____	09/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Center, "CBL", is filing this

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L 000	Initial Comments A Licensure survey was conducted on September 4, 2012 through September 11, 2012. The deficiencies are based on observation, record review, resident and staff interviews for 37 sampled residents	L 000	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.	
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: A. Based on record review and staff interview for two (2) of 37 sampled residents, it was determined that the nursing facility failed to accurately code the Minimum Data Set (MDS) for weight loss for one (1) resident and restorative programs for one (1) resident. Residents #62 and #156. The findings include: 1. The facility staff failed to accurately code the MDS, Section K- Swallowing/Nutritional Status for the Resident's #62. A review of the annual MDS with an Assessment Reference Date (ARD) of July 18, 2012 revealed that Section K0300 (Weight Loss) was coded as " No " indicating that Resident #62 had no weight loss of 10% or more in the last 6 months. According to a dietary note dated May 24, 2012 at 4:16 PM, " Nutrition Diagnosis/Assessment: Weight loss of 10% in 180 days. "	L 001	3200.1 Nursing Facilities 1. The MDS for resident #62 and #156 was corrected at the time of survey. 11/01/12 2. An audit was completed of resident receiving restorative services and with weight loss and corrective actions implemented as needed. 10/26/12 3. A review of the weight loss and restorative nursing policy and process was reviewed with the MDS Coordinators. Random audits of the MDS will be completed by the ADON monthly for proper coding. 10/26/12 4. A report of the results of the above audits will be provided to the CQI committee by the ADON quarterly. The CQI Committee will determine the need for further audits. 11/02/12 On going	

Denise Chadwick Wright — TITLE Administrator — (X6) DATE 11/2/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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L 001	Continued From page 1 A face-to-face interview was conducted on September 7, 2012 at approximately 2:30 PM with Employees #7 and #15. After reviewing the record; the weight loss sustained by Resident #62 was not coded on the MDS. . The clinical record was reviewed on September 7, 2012. 2. The facility staff failed to code the MDS Section O - Restorative programs for Resident #156. A review of Residents #156 ' s clinical record revealed that he/she was admitted to the facility on June 5, 2012 with diagnoses which included Cerebrovascular Accident (CVA), Hypertension (HTN), and Dementia, Obesity, Gout and Non Hemorrhage-stroke. Physician ' s order dated July 7, 2012 at 1:10 PM directed, " D/C resident from skilled PT services, Restorative nursing to follow through FMP [functional maintenance Program] for strengthening for 6x/ wk x 90 days in AM shift. " Another order dated July 14, 2012 at 1:45 PM directed, " Restorative to follow up with FMP for strength and conditioning 6x wk x 30 days " A review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of July 15, 2012 revealed Section O - Special Treatments and Procedures, Part O-0500 Restorative Nursing Programs was coded " 0, indicative that no restorative services were provided." There was no evidence that facility staff failed coded the MDS to include restorative services provided for Resident #156.	L 001		

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L 001	Continued From page 2 A face-to-face interview was conducted on September 6, 2012 at approximately 10:00 AM with Employee #11. He/she acknowledged the findings. The record was reviewed September 6, 2012. B. Based on record review and staff interview of two (2) of 32 sampled resident, it was determined that the nursing facility failed to ensure that one (1) resident was informed about his/her wheelchair being broken and the availability of alternative measures for the resident to get out of bed and failed to ensure that the established communication log for both the facility and dialysis center was recorded consistently for one (1) resident. Residents #27 and #54. The findings include: 1. Facility staff failed to document that Resident #27 was informed about his/her wheelchair being broken and record the alternative measures available for the him/her to get out of bed and attend activities. A face-to-face interview was conducted with Resident # 27 on September 4, 2012 at approximately 1:50 PM. He/she stated, " They (facility staff) took my wheelchair. They said it was broken. They didn ' t ' t leave me another one (wheelchair). I ' m stuck in this bed and they haven ' t said anything about when the wheel chair would be back. I guess in a few weeks, I hope it won ' t be that long. I don ' t like being stuck in this bed. " The resident was observed in bed from 1:50 PM	L 001		

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L 001	Continued From page 3 to 5:00 PM. Also during this time the writer heard the resident place three calls to the nurses ' station and ask " When am I going to get up (out of the bed)." A face-to-face interview was conducted with Employee #9 on September 4, 2012 at approximately 2:00 PM. He/she stated, " The resident had a seizure yesterday. I was told that the wheelchair broke at that time and it was sent for repair. I don ' t know how long it will take to be repaired, because it is a special chair. " A nurses note dated September 3, 2012 at 12:33 PM revealed, " ...apparent seizure activity Grad Mal, time lasted activity unsure of time. The seizure was of such force the back of [his/her] wheel chair was observed broken. " A nurse ' s note dated September 4, 2012 at 11:49 PM revealed, " Wheel chair broken. Down for repairs. Resident concerned about getting up. PT (physical therapy) notified for alternate wheelchair. " A face-to-face interview was conducted on September 5, 2012 at 12:00 PM with Employee #24. He/she stated, " The facility is trying to get a wheel chair for the resident. Resident #27 requires a special wheel chair. " According to the rehabilitation note dated September 5, 2012 [no time indicated], Occupational Therapy Screen Form revealed, "Pt (patient) seen for w/c (wheel chair) consult secondary to pt's current w/c requires repair. Pt has custom chair second to hx (history) of seizures... OT recommends standard w/c with	L 001		

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L 001	Continued From page 4 seat belt as a temporary chair for pt ..." A review of the 24-Hour Report, the Social Services notes and the Nursing Progress notes for September 3 - 5, 2012 at 1:00 PM revealed that there was no documented evidence that the resident and/or his/her representative was informed about his/her wheelchair being broken, how long it was going to take to repair the wheelchair and alternative measures to be taken for the resident to get out of bed and attend activities and dining outside of the resident ' s room. A face-to-face interview was conducted with Employee #9 on September 10, 2012 at approximately 11:00 AM. He/she acknowledged that the resident and/or his/her representative was not informed about his/her wheelchair being broken, how long it was going to take to repair the wheel chair and alternative measures to be taken for the resident to get out of bed and attend activities and dining outside of the resident ' s room. The record was reviewed September 10, 2012 2. Facility staff failed to ensure that the established communication log for coordination of services between the facility and the dialysis center was consistently recorded for Resident #54. A review of the medical record revealed that Resident #54 received dialysis treatments on Monday, Wednesday and Friday during the afternoon shift.	L 001		

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L 001	Continued From page 5 A review of the dialysis communication book revealed pre and post dialysis weights, dry weight, the amount of fluid removed, nurse signature and date, labs drawn, medication(s) administered and post dialysis nursing assessments were not consistently documented for the period of May 25, 2012 to September 7, 2012. A face-to-face interview was conducted September 7, 2012 at 10:00 AM with Employee #11. He/she acknowledged that the findings. The record was reviewed September 7, 2012. C. Based on observation, record review and staff interview for 70 of 70 sampled records it was determined that the nursing facility failed to maintain electronic and active clinical record information in a systematically organized and readily accessible manner. The findings include: Throughout the survey period of September 4, 2012 through September 11, 2012 the survey team made requests of facility staff for current computerized information, active clinical records and thinned record information. The requests included but were not limited to: progress notes, nursing assessments sheets, care plans, skin measurements sheets, physician order sheets, medication administration records, treatment administration records and the like. Staff were not able to readily access the information and there were significant delays in obtaining the requested documents.	L 001		

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L 001	Continued From page 6 A face-to-face interview was conducted with Employees #1, #2 on September 11, 2012 at approximately 2:00 PM. A query was made regarding measures to be implemented to allow for efficient access to the medical records and needed information regardless of the format. After review of the above Employee #1, and #2 acknowledged the findings and indicated that the facility implemented the electronic medical records system beginning in January 2012 for nursing documentation, social services, dietary and activity records, and that other departments information will be introduced in phases until all of the medical record is computerized. Employee #2 also acknowledged that staff will be re-inserviced on handling the medical record information in a more systematic manner.	L 001	Continued From page 6 3210.4 Nursing Facilities	
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff	L 051	1. Corrections were made to the care plans for residents #5, #16, #23, #87, #99, #107, #125, #152, #156 and#179. 2. An audit will be completed of resident care plan to assure that all diagnosis have been addressed. Corrective actions have been implemented as indicated. 3. Education has been completed with the unit managers by the educator regarding completion of the care plan. An audit of care plans will be completed by the ADON monthly. 4. Results of the above audits will be provided to the CQI committee quarterly of problems identified and corrective actions implemented. The CQI committee will determine the need for further audits.	10/31/12 11/02/12 10/26/12 11//2/12 On going

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L 051	Continued From page 7 for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record review and staff interview for 10 of 37 sampled residents, it was determined that the charge nurse failed to develop care plans with goals and approaches to address: Anticoagulant therapy for two (2) residents; medication allergies for two (2) residents; polypharmacy for one (1) resident; integrated hospice planning for one (1) resident; visual impairment for resident two (2) residentsRestorative Care for two (2) residents. Residents #5, #16,#23, #87, #99, #107, #125, #152, #156 and#179. The findings include: 1. The charge nurse failed to initiate a a care plan for Resident #5 to address the care and services associated with the use of an anticoagulant medication, Coumadin. A physician ' s order, dated August 8 2012 (originated June 21, 2012) directed, " Warfarin Sodium (Coumadin) 5mg tablet via GT (Gastrostomy Tube) [every day] at 6 PM-[Diagnosis-Deep Vein Thrombosis].	L 051		

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L 051	Continued From page 8 According to the August 2012 Medication Administration Record, Coumadin 5 mg was administered daily at 6 PM as evidenced by staff signatures in the allotted spaces [indicating that the medication was administered]. The clinical record lacked evidence that a care plan with goals and approaches was initiated to address the use of Coumadin. A face-to-face interview was conducted with Employee #10 on September 7, 2012 at approximately 4:30 PM. After reviewing the chart, both acknowledged the aforementioned findings. The clinical record was reviewed on September 7, 2012. 2. The charge nurse failed to initiate a care plan to address Resident #16 ' s use of eyeglasses and the use of ophthalmic medications. A face-to-face interview was conducted with the Responsible Party for Resident #16 on September 6, 2012 at 11:48 AM. He/she stated, "He/ she can see very well and he/she needs someone to feed him/her. " On September 7, 2012 at approximately 9:30 AM the resident was observed resident being fed breakfast by the facility staff. The resident was observed without eye glasses on September 5, 2012 at approximately 12:20 PM; September 6, 2012 at approximately 11:48 AM and on September 7, 2012 at approximately 3:00 PM. A face-to-face interview was conducted with	L 051		

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L 051	Continued From page 9 Employee s# 25 and #26 on September 7, 2012 at approximately 3:00 PM. He/she stated, "The resident doesn ' t want to wear the glasses. We offer them to him/ her but he/she doesn ' t want to wear them. His/her eye glasses are in the drawer. " A review of the ophthalmology "Report of Consultation " dated June 4, 2012 revealed, " Report- Diagnosis: Pseudophakia os (left eye) ... Recommendations: Continue Tobradex, Prednisolone Acetate and ...qid (four times a day) for a total of 1 month post op (operative). To office at 6 weeks post op (operative) for refractum. " A review of the ophthalmology " Report of Consultation " dated July 9, 2012 revealed, " Recommendations: " Cont (continue present glasses. F/u (follow up) in 6 mos (months). " According to the physician ' s orders signed and dated August 1, 2012, "Continue present glasses, follow-up in 6 months. Remove eye pad shield in AM and wear dark sunglasses. " A review of the "Report of Consultation" dated August 9, 2012 revealed, " Findings: Left eye sore difficulty opening eye lids in AM.Diagnosis: Ectropion left lower lid ...Recommendations: To [hospital] for plastic surgery on lower lid to correct Ectropion. D/c Tobradex drops after a total use for 7 days. " A review of the care plan section of the active clinical record revealed that there was no care plan initiated with goals and approaches to	L 051		

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L 051	Continued From page 10 address the resident ' use of eyeglasses and the use of ophthalmic medications. A face-to-face interview was conducted with Employee # 3 on September 7, 2012 at approximate 4:30 PM. He/she acknowledged that there was no care plan initiated to address the resident ' use of glasses, the use of ophthalmic medications, and impaired vision related to diagnoses. The record was reviewed on September 7, 2012. 3. The charge nurse failed to initiate a care plan for the use of the anticoagulant medication, Lovenox for Resident #23. A review of the Physician ' s Order Sheet and Plan of Care, dated August 31, 2012 directed: " Lovenox 40mg Sub-Q (subcutaneous) daily for DVT (Deep Venous Thrombosis) prophylaxis. " According to the August 2012 Medication Administration Record, Resident #23 received Lovenox daily. A review of the clinical record lacked evidence that a care plan was initiated with goals and approaches to address the use of Lovenox. A face-to-face interview was conducted with Employees #3 and #7 on September 7, 2012 at approximately 4:00 PM. After reviewing the active clinical record, both employees acknowledged the aforementioned findings. The clinical record was reviewed on September 7, 2012.	L 051		

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L 051	Continued From page 11 4. The charge nurse failed to initiate a care plan with goals and approaches to address Resident #87 ' s history of a medication allergy to Pneumovax. An " Admitting Evaluation History " dated May 5, 2012 revealed: " Allergies: Pneumovax. " According to a " Physician ' s Order Form " dated and signed by the physician on August 1, 2012 directed, " Immunizations: No Pneumovax [secondary] to Allergy." A review of Resident #87 ' s care plans lacked evidence that a care plan with goals and approaches was initiated to address the allergy to Pneumovax. A face-to-face interview was conducted with Employee #10 on September 10, 2012 at approximately 12 Noon. He/she acknowledged that there was no care plan in place to address the resident ' s allergy to Pneumovax. The record was reviewed September 10, 2012. 5. The charge nurse failed to initiate a care plan with goals and approaches for restorative care for Resident #99. A review of the medical record revealed that Resident #99 was admitted to the facility on April 12, 2012 with diagnoses of Hypertension, Diabetes Mellitus, Cerebrovascular Accident, Osteoporosis, and Dementia, History of left ankle fracture s/p (status post) -ORIF (Open Reduction Internal Fixation) April 5, 2012.	L 051		

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L 051	Continued From page 12 Physician ' s orders dated August 23, 2012 at 4:00 PM directed, " D/C [discontinue] OT [occupational therapy] services. Begin FMP [functional Maintenance program] for August 24, 2012 5x/wk x 90 days." A review of the "Therapy Follow-up Recommendations " revealed an " x " next to Restorative... " maintain current functional strength and endurance, maintain B/L [Bilateral] UE [upper extremities] strength... 5x/wk x 90 days; wheelchair mobility: self propel w/c [wheelchair] 50' [50 feet] or down one (1) hallway 1-2xs, Transfer: from chair to chair or bed to chair 1-2xs (times). " There was no evidence in Resident # 99 ' s chart that a care plan with goals and approaches for Restorative Care was initiated. A face-to-face interview was conducted on September 7, 2012 at approximately 10:30 AM with the Employee #11. He/she acknowledged the findings. The record was reviewed on September 7, 2012. 6. The charge nurse failed to initiate a care plan with goals and approaches to address Resident #107 ' s medication allergy to Penicillin. Physician ' s orders signed and dated August 23, 2012 revealed, " Allergy History: Penicillin. " The resident ' s care plan initiated July 19, 2012, lacked evidence that a care plan with goals and approaches was initiated to address the resident ' s medication allergy. A face-to-face interview was conducted on	L 051		

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L 051	Continued From page 13 September 10, 2012 with Employee #10 at approximately 11:34 AM. He/she acknowledged that there was no care plan for Penicillin allergy for Resident #107. The record was reviewed September 10, 2012. 7. The charge nurse failed to develop a comprehensive care plan to address visual impairment for Resident #125. A review of the annual Minimum Data Set (MDS) for Resident #125 with an Assessment Reference date of October 11, 2011 and the subsequent quarterly MDS assessments dated March 26 and June 19, 2012, revealed that the resident was identified as being visually impaired in Section B, B1000 (Vision). A review of Section V [Care Area Assessment] of the annual MDS dated October 13, 2011 showed that " Vision Function " triggered as a care area that will be addressed in the care plan. The IDT (interdisciplinary team) note from the meeting dated March 27, 2012 (where Resident #125 was present and the responsible party (RP) participated via a telephone conference) revealed that Resident #125 refused to see the ophthalmologist. However, a care plan for " Vision " was not initiated to address the resident's refusal to see an ophthalmologist. An interview was conducted with Resident #125 at 12:50 PM on September 10, 2012. When the resident was asked if he/she had seen the eye doctor, Resident #125 replied, " No. " When	L 051		

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L 051	Continued From page 14 asked if he/she wanted to go see an ophthalmologist, the resident stated, " The only place I want to go is home. That's where I was born. " When asked if he/she had trouble seeing he/she answered, " I can see out of one eye, the other one is blurred " as he/she covered his/her right eye and reiterated that he/she did not want to see an eye doctor or a dentist. A face-to-face interview was conducted with Employee #11 on September11, 2012 at approximately 9:30 AM. After review of the above he/she acknowledged findings. The record was reviewed on September 11 2012. 8. The charge nurse failed to develop a care plan for nine (9) or more medications to address the potential for adverse drug interactions for Resident #152. A review of the resident ' s Physician Order Form dated and signed by the physician on August 3, 2012 revealed that the resident is on the following medications: Amiodarone, Amlodipine, Aspirin, Carbidopa, Enalapril, Furosemide, Levothyroxin, Mapap, Methocarbamol, Potassium Chloride, Sertraline, Warfarin, Oxycodone, Enoxaparin, Albuterol. Review of the residents care plans last update August 16, 2012 lacked evidence of a care plan to address the potential for adverse drug interactions associated with the use of nine (9) or medications. A face-to-face interview was conducted with	L 051		

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L 051	Continued From page 15 Employee #9 on September 11, 2012 at approximately 11:00 AM. After review of the above he/she acknowledged findings. 9. The charge nurse failed to develop a care plan with appropriate goals and approaches for Resident #156 who was receiving Restorative Care. A review of the medical record revealed that Resident #156 was admitted to the facility June 5, 2012 with diagnoses which included Cerebrovascular Accident (CVA), Hypertension (HTN), and Dementia, Obesity, Gout and Non Hemorrhage -Stroke. A review of the physician ' s order dated July 7, 2012 at 1:10 PM, directed, " D/C resident from skilled PT [physical therapy] services, Restorative nursing to follow through FMP [functional maintenance program] for strengthening for 6x/ wk x 90 days in AM shift. " Another order dated July 14, 2012 at 1:45 PM directed, "Restorative to follow up with FMP for strength and conditioning 6x wk x 30 days." A review of the " Therapy Follow-up Recommendations " revealed an " x " next to Restorative. Under overall goals " UE [upper extremities] conditioning functional maintenance ...Tricep Press #07 wt [weight] plate Height 4-5, 4 sets x10 reps. Compound Row #07 wt plate 4 sets x10 reps. For 60 days x 6 day [days]. " There was no evidence in Resident # 156 ' s chart that a care plan with goals and approaches for Restorative Care was initiated.	L 051		

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L 051	Continued From page 16 A face-to-face interview was conducted on September 6, 2012 at approximately 10:00AM with the Employee #11. He/she acknowledged the findings. The record was reviewed on September 6, 2012. 10. The charge nurse failed to develop a care plan with goals and approaches for Resident #179 who was receiving Hospice services. Physician ' s orders dated May 2, 2012 at 1:10 PM directed," Admitted to Hospice Service: Hospice to provide comfort care. " " May 14, 2012 at 2:10 PM directed, " Hospice CNA [Certified Nursing Assistant] Orders: Hospice CNA 3-5 times week to assist with ADL [Activities of Daily Living] care " " May 15, 2012 at 11:59 AM directed, " Change primary Hospice Diagnosis from Alzheimer to Adult Failure to Thrive. " A review of the resident ' s care plans last updated on September 4, 2012 lacked evidence that an integrated Hospice care plan was initiated to identify needed services to include measureable goals, objectives and approaches to provide comprehensive care to Resident #179. A face-to-face interview was conducted with Employee #21 on September 7, 2012 at approximately 11:30 AM. A query was made regarding where he/she documents the plan of	L 051		

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L 051	Continued From page 17 care given to the resident while he/she is in the facility. Employee #21 indicated that once information is loaded into his/her hand held device, it is then down loaded to the hospice facility computer, the information is then printed out on a care plan and placed in the medical record. Employee #21 was unsuccessful in locating the care plan for the resident. He/she then placed a call to the Hospice RN [Registered Nurse] who indicated that he/she would be in to the facility within the hour. A face-to-face interview was conducted with Employee #20 on September 7, 2012 at approximately 12:30 PM. He/she acknowledged that a Hospice care plan was not in the medical record, and proceeded to place a copy in the medical record. The record was reviewed on September 7, 2012. B. Based on record review and staff interview for one (1) of 37 sampled residents, it was determined that the charge nurse failed to update the care plan for 9 or more medications to address the potential for adverse reactions for Resident # 62. The findings include: A review of the clinical record for Resident #62 lacked evidence that the charge nurse updated the care plan with goals and approaches for the use of nine (9) or more medications and an antidepressant medication. A review of the August 2012 physician 's orders	L 051		

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L 051	Continued From page 18 revealed the resident ' s medication regimen included : Fosamax 70mg every week; Aspirin 81mg daily; Colace 10ml twice daily; Enulose 30ml 2 (two) times a week; Lisinopril 20mg every day; Remeron 7.5mg every day; Oscal + D 500mg-200mg twice daily; Zoloft 100mg every day; Zocor 40mg every day and Multi-Vitamin 1 (one) tablet every day. The comprehensive care plan dated March 22, 2011 included the problems " 9 or more medications and Depression related to Antidepressant Use " and goals and approaches were developed, however; there was no evidence that the care plan was revised since that date. A face-to-face interview was conducted with Employee #10 on September 7, 2012 at approximately 10:15 AM. He/she acknowledged the care plan was not updated since March 22, 2011. The record was reviewed September 7, 2012. C. Based on record review and interview of three (3) of 37 sampled residents, it was determined that the charge nurse failed to 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 as evidenced by a failure to: obtain a hospice evaluation per physician's orders for one (1) resident; obtain a hemoglobin A1C as per the physicians order for one (1) resident; and follow a physician's order for weekly weights for one (1) resident with weight loss. Residents #107, #148, and #197.	L 051		

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L 051	Continued From page 19 The findings include: 1. The charge nurse failed to obtain a hospice evaluation for Resident #107 in accordance with the physician ' s order. An " Admitting Evaluation History " dated July 22, 2012 included diagnoses of Hypertension, Asthma/ [Chronic Obstructive Pulmonary Disease] and Metastatic Prostate Cancer. " A physic ian ' s "Interim Order " dated July 24, 2012 directed, "Do Not Resuscitate, No Chest Compression, No Intubation, No Cardiac Shock... DX (Diagnosis) Metastatic Prostate Cancer, Admit to hospice Service. " According to the Social Service note dated July 29, 2012, " Purpose for Note: Late entry for July 26, 2012 Initial Assessment-the resident is a DNR (Do Not Resuscitate) and the physician has already signed the order. Resident is posing no behavior problems at this time. " An IDT [Interdisciplinary Team] note dated July 26, 2012 at 5:20 PM revealed, " ... Resident is a DNR. Responsible party will clarify about hospice status. " A review of the clinical record including the Nursing Notes lacked evidence that facility staff followed through on physician ' s orders for hospice services for Resident #107. A face-to-face interview was conducted with Employees #10 and #23 on September 10, 2012 at approximately 11:00 AM. Employee #23 stated, " Resident ' s name] was on home	L 051		

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L 051	Continued From page 20 hospice before he/she was admitted to the hospital. I called [name of hospice service], but they never called me back. Also, the facility does not have a contract with that particular hospice." Employees #10 and #23 acknowledged they did not follow up with coordination of hospice services for the resident. The clinical record was reviewed on September 10, 2012. 3. The charge nurse failed to obtain a hemoglobin A1C (HGA1C) as per the physician ' s order for Resident #148. The physician ' s orders signed and dated September 7, 2012 directed, " HGA1C every 3 months May/Aug/Nov/Feb " A review of the active clinical record revealed the following: February 2012- no laboratory results found; May 2012 =HGA1C results=6.0; August 2012 HGA1C results=5.9 There was no evidence that the facility ensured that the laboratory tests were conducted as per the physician ' s orders. A face-to-face interview was conducted on September 9, 2012 at 1:33 PM with Employee #11. He/she acknowledged that the laboratory test was not conducted as per the physician ' s order. The record was reviewed on September 9, 2012. 3. The charge nurse failed to follow a physician's order to obtain weekly weights for Resident #197.	L 051		

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L 051	Continued From page 21 The Physician's order sheet and plan of care dated July 24, 2012 directed, "Weight on admission, then 72 hours thereafter. An interim physician's order dated August 22, 2012 at 12 Noon directed, "Weekly weight x 4 [times four]." According to weight record retrieved from the electronic medical record, the resident's weight history was as follows: July 23, 2012 - 126 pounds (admission weight) August 9, 2012 - 116 pounds (10 pounds less from admission weight - 7.9% loss weight loss within 30 days) September 3, 2012 - 114 pounds (12 pounds less from admission weight - 9.5% weight loss) According to the " Weekly Weight Flow Sheet " book located on the nursing unit, the resident ' s weight history was as follows: July 23, 2012- 126 pounds July 26, 2012 - 124 pounds August 6, 2012- 116 pounds (10 pounds less from admission weight- 7.9% weight loss within 30 days) August 13, 2012- 116 pounds There was no evidence that facility staff obtained weekly weights after August 22, 2012 for Resident #197 in accordance with the physician ' s order. Additionally, A review of the facility ' s policy " Weight Loss/Gain Protocol " revised February 3, 2011 revealed: " 3. If resident has a 5% (percent) weight loss resident will be reweighed with the charge nurse and unit manager present to verify weight. 8. The disciplines	L 051		

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L 051	Continued From page 22 responsibilities are as follows: a. Nursing- Put resident on weekly weights x4 (times 4) on Mondays. Appendix II- Any resident with a weight variance will be assessed by the Dietitian." The facility failed to follow its policy regarding a weight change. Resident #197 ' s weight loss was greater than 7.9%; but there was no evidence that the resident was reweighed and that weekly weights were obtained according to the physician ' s order. A review of the electronic dietary progress notes revealed the following: July 27, 2012- Late entry for July 26, 2012- Assessment Type: Initial- Weight 126 lbs. Increased need for protein; disease process Dysphagia. Goals: Provide adequate nutrition and hydration, no weight loss; gain least 2-4 pounds in 90 days. Intervention: Change formula to Glucerna1.5- start at 30 ml/hour; increase as tolerated to goal of 55 ml/hr. August 7, 2012- Dietary progress notes: tolerating tube feeding well, resident receiving Glucerna 1.5 @ 55 ml/ hr x 18 hours. August weight: No new weight available at this time; July admission weight 126 pounds. Discussed with [Employee #10 name] today. Will continue to monitor weight trends. Plan: continue tube feeding regimen as tolerated. August 16, 2012- Weekly weight/wound note: current weight: 116 pounds. Date: 08/03/2012; Diet: Jevity 1.5 @ 55 ml/hr x 18 hours. Weight concerns triggers for: weight loss 8.0% in 30 days. Intervention: Increased tube feeding from Jevity 1.2 to Jevity 1.5 @ 55 ml/hr. August 28, 2012- Weekly Weight/Wound note:	L 051		

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L 051	Continued From page 23 Follow-up; current weight: (8/6) 116 [pounds] re-weight- none; Supplements: Prosource No Carb 30 ml [twice a day]. Weight concerns trigger for: significant weight loss. Interventions: Decrease Prosource; No carb to 30 ml via GT (Gastrostomy tube) daily. Change TF to Glucerna 1.5 @ 55 ml/hr. Current [tube feeding] increased to 65 ml/hr of Jevity for unplanned weight loss, etiology?? Glucerna 1.5 at 55 per hour hanging at this timed ...Closely monitoring intake and weight. " A face-to-face interview was conducted with Employees # 3 and #7 on September 10, 2012 at approximately 4:00 PM. After reviewing the chart, both acknowledged that the weights were not recorded as ordered. A telephonic interview was conducted with Employee #15 on September 13, 2012 at approximately 10:00 AM. Employee # 15 stated that he/she spoke to Employees #10 and #28 regarding the weight not being recorded. I was told by Employee #28 that the resident was currently on weekly weights. Employee #15 stated Resident #197 ' s weight did trigger and interventions were put in place. I am not in the facility everyday; but I communicate with the staff and the nurse practitioner/doctors closely regarding residents who are having weight issues. The record was reviewed September 10, 2012. D. Based on record review and staff interview for five (5) of 19 sampled residents, it was determined that the charge nurse failed to ensure that residents with pressure sores receive necessary treatment and services to promote healing as evidenced by eight residents noted to not have a documented assessment of the	L 051		

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L 051	Continued From page 24 wound at least weekly. Resident ' s # 8, #50, #82, #117 and #149. The findings include: The policy entitled: " Wound Care Program " Policy and Procedure number 1000, revised 7/29/10 stipulated: " Procedure for Breaks in Skin Integrity- 6. The charge nurse will complete weekly documentation of all wounds Skin breakdown, (abrasions, lacerations, rashes, surgical), stasis, non-pressure wound or pressure report sheets. " 1. The charge nurse failed to measure wounds at least every seven days from August 2012 through September 2012 for Resident #8. A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the resident ' s skin impaired areas were measured on the following dates: Left Buttock Stage IV- August 2, 16, and 30, 2012 There was no evidence that facility staff measured the resident ' s aforementioned wound at least every seven (7) days. 2. The charge nurse failed to measure wounds at least every seven days from June 2012 through September 2012 for Resident #50.	L 051		

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L 051	Continued From page 25 A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the residents skin impaired areas were measured on the following dates: Lower Sacrum Unstageble due to necrosis- June 2, 8, 21, and 28, 2012 Lower Sacrum Stage IV- July 12, 26, August 16, 23, and September 6, 2012 There was no evidence that facility staff measured the residents aforementioned wound at least every seven (7) days. 3. The charge nurse failed to measure wounds at least every seven days from June 2012 through September 2012 for Resident #82. A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the resident ' s skin impaired area was measured on the following dates: Lower Sacrum Stage III- June 14, 28, August 16, 23, and September 6, 2012 There was no evidence that facility staff measured the residents aforementioned wound at least every seven (7) days. 4. A review of Resident # 117 ' s record revealed that the charge nurse failed to measure wounds at least every seven days from April 2012	L 051		

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L 051	Continued From page 26 through Sept 2012. A review of the " Wound Care Specialist Evaluation " form from April 26, 2012 through September 6, 2012 revealed the resident ' s skin impaired areas were measured on the following dates: Lower Coccyx Stage IV - June 8, 28 July 12, 26, August 9, 23, and September 6, 2012 Right Hip- Stage IV- June 8, 28, July 12, 26, August 9, 23, and September 6, 2012 There was no evidence that facility staff measured the resident ' s aforementioned wounds at least every seven (7) says. 5. The charge nurse failed to measure a wound at least every seven days from June 2012 through September 2012 for Resident #149. A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the resident ' s skin impaired area was measured on the following dates: Medial Sacrum Stage IV- June 28, July12, 26, August 16, 30, 2012 There was no evidence that facility staff measured the resident ' s aforementioned wound at least every seven (7) days. A face-to-face interview was conducted with Employees #2 and # 29 on September 11, 2012 at approximately 11:00 PM. They acknowledged	L 051		

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L 051	Continued From page 27 the findings.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating;	L 052		

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L 052	Continued From page 28 (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A. Based on record review and staff interview for two (2) of 37 sampled residents, it was determined that sufficient nursing time was not given to ensure that facility staff acted on a Pharmacy recommendation to evaluate the need for the combined use of both Plavix, and Aspirin for one (1) resident, and failed to act upon the recommendation to obtain hemoglobin A1c (HGA1C) for one (1) resident. Residents #57, and #134. The findings include: 1. Sufficient nursing time was not given to ensure that facility staff acted on a Pharmacy recommendation to evaluate the need for the combined use of both Plavix, and Aspirin for Resident #57. A review of the " Consultation Report " for the pharmacist dated August 14, 2012 revealed: " Comment: ... receives Aspirin and Clopidogrel (Plavix) concomitantly. "	L 052	3211.1 Nursing Facilities 1. The milk on the test tray was replaced at the time of survey. 2. A test tray audit will be completed weekly by the dietician/Dietary Manager for the next 30 days and corrective actions implemented as indicated. 3. Staff training has been completed by the Dietary Manager with dietary staff regarding timeliness of tray service completion and temperature monitoring of food items on the tray line. 4. A report of the above audits will be provided to the facility administrator weekly of problems identified and corrective actions implemented. The administrator will determine the need for further actions.	9/11/12 10/26/12 9/7/12 10/26/12

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L 052	Continued From page 29 " Recommendation: Please re-evaluation the continued use of this combination. " " Rationale for Recommendation: Literature suggest an increased risk of moderate-to-severe bleeding events with combined aspirin/clopidogrel use in individuals with recent ischemic stroke or transient ischemic attack (TIA) and in individuals with clinically evident cardiovascular disease or multiple risk factors for cardiovascular disease without a recent history of acute coronary syndrome. If the therapy is continued, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences such as bleeding and bruising. " A review of the Consultation Report dated August 14, 2012 lacked a signature and date indicating that the recommendation was reviewed and acted upon. According to the September 2012 Medication Administration Record, Resident # 57 received both Plavix and Aspirin from August 14 through September 6, 2012. A face-to-face interview was conducted with Employee #9 on September 7, 2012 at approximately 3:30 PM. A query was made regarding whether the Consultation Report was addressed. Employee #9 referred to Employee	L 052		

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L 052	Continued From page 30 #2. Employee #2 was unable to identify if the report was addressed or acted upon. Facility staff failed to act upon a pharmacy recommendation to re-evaluate the continued use of this combination. The chart was reviewed on September 7, 2012. 2. Sufficient nursing time was not given to ensure that facility staff acted on a Pharmacy recommendation to obtain Hga1c for Resident #134. The physician ' s order form signed and dated August 3, 2012 directed, " HGBA1C every 3 months Jan/Apr/Jul/Oct- Dx: IDDM (Insulin Dependent Diabetes Mellitus)." A review of the active clinical record revealed that January and July 2012 HGA1C laboratory results were available. A review of the Drug Regimen Review conducted on August 14, 2012 revealed: Comment: " ...has orders for labs to be drawn, but at the time of this review they were not available in the residents record. The missing lab values include: A1c due April, July " Recommendation: "Unless otherwise indicated, Please follow up with the lab and have results forwarded to the facility." On August 31, 2012 [no time indicated],	L 052		

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L 052	Continued From page 31 Employee # 2 responded to the recommendation by documenting, " July A1c in the chart; will obtain April 2012 report. " There was no evidence that the April 2012 HgbA1c results were obtained. A face-to-face interview was conducted with Employee #2 on September 10, 2012 at 10:00 AM. He/she acknowledged that the laboratory results were not available. The record was reviewed on September 10, 2012. B. Based on an observation for one (1) of 32 sampled residents, it was determined that sufficient nursing time was not given to promote care for Resident #77 in a manner that maintains or enhances his/her dignity and respect in full recognition of his/her individuality as evidenced by the resident being observed without appropriate footwear. The findings include: On September 4, 2012 at approximately1:00 PM Resident #77 was observed being transported via wheel chair from the second floor dining room to the second floor day room. The resident was observed with a black shoe on right foot and burgundy slipper on the left foot. The burgundy slipper was missing parts of the insole and outsole (the part of the shoe that comes in direct contact with the ground) exposing the resident ' s right toes. The writer asked the resident did he/she want to wear his/her shoes like this. The resident looked down at his/her feet and replied, " No. I want to	L 052		

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L 052	Continued From page 32 go home. " At the time of this observation the writer asked the licensed staff assigned to the resident why he/she had on two different shoes. Employee #19 replied, " The certified nurse aide that dressed the resident went home for the day. I passed medication to him/her but he/she was in the room in the bed. I didn ' t see him/her when they brought him/her in the dayroom. " A staff person went to the laundry and got a new pair of sneakers. When the resident was asked about this pair of shoes, he/she said, " I like them." According to the quarterly Minimum Data Set last completed August 3, 2012 the resident was coded as requiring extensive physical assistance with one (1) person for Bed mobility, Transferring, Dressing, Personal Hygiene and Toilet Use. Facility staff failed to enhance Resident #77 ' s dignity as evidenced by the use of mismatched and damaged footwear.	L 052		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: A. Based on a review of the facility ' s Infection Control Program and through staff interview, it	L 091		

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L 091	Continued From page 33 was determined that the facility failed to ensure the implementation of an infection control program that included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. The findings include: A review of the facility ' s infection control surveillance documentation, " Infection Control Log, "lacked evidence of a methodology to consistently collect, analyze, interpret and disseminate data related to infections in the facility. The log lacked evidence of the organism type, source of acquisition (whether community or facility acquired), predisposing factors, treatment and/or date of resolution. A Line Listing of the facility ' s infections for the past six (six) months was requested. The facility presented documentation for August 2012 and gave a verbal report for January, February and June 2012. The August 2012 report failed to indicate the mode of treatment for the infections, as well as any predisposing factors and the date of resolution of the infections. The verbal reports for January, February and June 2012 failed to include the source of acquisition (whether community or facility acquired), identify the infecting organism, predisposing factors, the treatment and/or the date of resolution of the infections. All of the reports were incomplete. They lacked all of the necessary components of a Line Listing as aforementioned. A face-to-face interview was conducted with Employee #2 at approximately 11:50AM. The employee acknowledged that the Line Listing	L 091	Continued From page 33 3217.6 Nursing Facilities **L91 A** 1. The facility is unable to correct data for the previous months. 2. An audit of the September line listing has been completed by the ADON and the corrections have been made as indicated. 3. A review of the facility Infection Control policy has been completed with the staff by the educator. An audit of the infection control line listing will be completed by the Administrator monthly. 4. A report of the above audits and any problems identified will be reported the CQI committee by the administrator. The CQI committee will determine the need for further audits. **L91 B** 1. Staff was educated at the time of survey. No corrections can be done for resident #5 at this time. 2. An audit of residents on contact isolation has been completed and a medication observations to these resident has been completed by the ADON. Corrective actions implemented as indicated. 3. Staff education regarding the proper procedures for managing the medication administration for residents on Isolation has been completed by the educator. An audit medication pass of residents on isolation will completed weekly by the educator.	10/15/12 10/31/12 11/2/12 On going 10/15/12 10/31/12

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L 091	Continued From page 34 was incomplete. The employee also stated, " We are in the process of changing our documentation system. We documented on paper previously and are now in the process of documenting electronically. " The facility failed to ensure the implementation of an infection control program that included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. B. Based on observation and staff interview for one (1) of 37 sampled residents, it was determined that the facility failed to ensure that acceptable Infection Control standards were utilized during Gastrostomy tube managment. Resident #5. The findings include: An observation of a Medication Administration was conducted on September 6, 2012 at approximately 9:15 AM with Employee # 14. The observation was of Resident #5 who was currently on contact isolation. Employee# 14 sanitized his/her hands, prepared the medications to be administered to the resident, donned protective personal equipment, knocked on the Resident 's door and awaited a response. He/she then entered the room, washed his/her hands and placed the silver tray containing medications to be administered on the over-the	L 091	Continued From page 34 4. A report of findings for the audits audits will be provided to the DON by the educator weekly and a report to the CQI committee monthly of problems identified and corrective actions implemented.	11/2/12 On going

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L 091	Continued From page 35 bed table. The employee disconnected the enteral feeding and checked the resident ' s Gastrostomy tube (g-tube) for placement. Upon doing so Employee #14 assessed that the tube was clogged. The employee left the room to get a " Declogger " [a device used to clear a Gastrostomy tube]. Upon return, Employee #14 opened the package and inserted the yellow " Declogger " into Resident #5 ' s Gastrostomy tube and manipulated it to clear the obstruction. He/she then removed the yellow declogger and placed it uncovered on top of a paper towel and the silver tray which contained medications to be administered to the resident. The nurse then manipulated the resident ' s Gastrostomy tube and reinserted the Declogger into Resident #5 ' s Gastrostomy tubing and again attempted to clear the tubing. The nurse then removed the Declogger from the Gastrostomy tubing; rinsed it off at the sink in the resident ' s room and placed it back on the paper towel and silver tray uncovered. He/she repeated this sequence of events three more times. At this time, Employee # 3 entered the room to assist Employee #14 with clearing the Gastrostomy tube. Employee #3 told Employee #14 to continue passing medications (to the other residents) and that he/she would assign another nurse to clear the Gastrostomy tube. Employee # 14 disposed of the medications by pouring them into the sink in the resident's room, he/she rinsed the silver tray with water and wiped it dry with a paper towel, washed his/her hands	L 091		

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L 091	Continued From page 36 and left the room with the tray. When the writer queried Employee #3 as to the type of isolation the resident was on. He/she replied, " MRSA (Methicillin-resistant Staphylococcus Aureus) at the g-tube site. " There was no evidence that the staff practiced appropriate infection control standards while attempting to clear Resident #5 ' s Gastrostomy tube. The Declogger apparatus was not properly contained during the procedure and the silver medication tray was intended for reuse after contamination. Employees # 3 and #14 acknowledged the findings at the time of the observation.	L 091	Continued From page 36	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made during a tour of Dietary Services on August 4, 2012 at approximately 9:30 A.M. and on August 7, 2012 at approximately 9:05 A.M.it was determined that the facility failed to store, prepare and serve food under sanitary conditions as evidenced by: tray line, freezer, refrigerator and dishwashing machine temperature logs that were incomplete; the observation of soiled equipment such as four (4) convection ovens, one (1) tilt skillet, one (1) grill and one (1) gas oven. The findings include:	L 099	3219.1 Nursing Facilities **L099** 1. Corrections for the temperature documentation is not possible at this time. 2. An audit of temperatures was completed by Dietary Manager and corrective actions implemented as needed. 3. Staff training has been completed by the Dietary Manager with the staff regarding dietary policy on cleaning equipment. An of equipment will completed daily by the dietary manager/designee. 4. A report of the above audits will be provided to the facility administrator weekly of problems identified and corrective actions implemented. The administrator will determine the need for further actions.	9/4/12 9/7/12 9/7/12 9/11/12 On going

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L 099	Continued From page 37 1. Food temperatures from the tray line, temperatures for one (1) of one (1) freezer, one (1) of one (1) walk-in refrigerator and one (1) of one (1) dishwashing machine were not consistently documented for the months of February 2012 through September 2012. 2. Equipment such as four (4) of four (4) convection ovens, one (1) of one (1) tilt skillet, one (1) of one (1) grill and one (1) of one (1) gas oven were soiled. These observations were made in the presence of employee # 17 who acknowledged the findings.	L 099	Continued From page 37 3220.2 Nursing Facilities **L108** 3. The milk on the test tray was replaced at the time of survey. 4. A test tray audit will be completed weekly by the dietician/Dietary Manager for the next 30 days and corrective actions implemented as indicated. 3. Staff training has been completed by the Dietary Manager with dietary staff regarding timeliness of tray service completion and temperature monitoring of food items on the tray line. 4. A report of the above audits will be provided to the facility administrator weekly of problems identified and corrective actions implemented. The administrator will determine the need for further actions.	9/11/12 10/26/12 9/7/12 10/26/12
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations made on August 7, 2012 at approximately 1:40 PM it was determined that the facility failed to serve food under sanitary conditions as evidenced by one (1) of one (1) half-pint carton of 2% milk from the lunch meal test tray that measured at 48.4 degrees Fahrenheit (F). The findings include: One (1) of one (1) half-pint of 2% milk from the test tray exceeded 41 degrees F and was measured at 48.4 degrees (F) on August 7, 2012	L 108		

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L 108	Continued From page 38 at approximately 1:40 PM. These observations were made in the presence of employee # 17 who acknowledged the findings.	L 108	Continued From page 38	
L 113	3220.7 Nursing Facilities The dietitian preparing the therapeutic diet shall have access to the resident's medical record and shall document each observation, consultation and instruction regarding the resident's acceptance and tolerance of his or her prescribed diet. This Statute is not met as evidenced by: Based on record review and staff interview, it was determined that the dietician failed to fully assess the nutritional status for one (1) of 37 sampled residents as evidenced by a failure to act on weight variances indicative of significant weight change. Resident #106. The findings include: Resident #106 was admitted to the facility on June 15, 2012. According to a " History and Physical " dated June 19, 2012; resident ' s diagnoses included CVA (Cerebral Vascular Accident), Hypertension, Renal Insufficiency and Congestive Heart Failure. Progress note dated July 12, 2012 revealed: " [Patient] is to go home soon; had short rehab in [facility]. CVA [with] left weakness. " According to the medical record; resident was discharged home July 15, 2012 with home health services. A review of Resident #106 ' s clinical record revealed an " Electronic Weight Record " which revealed the following documentation:	L 113	3220.7 Nursing Facilities **L113** 1. Corrections cannot be made for resident #106. Resident was discharged 7/15/12. — 7/15/12 2. An audit of resident's weights over the past 30 days has been completed by the dietician and corrective actions implemented as indicated. — 10/26/12 3. A review of the facility Weight Policy has been completed with the dieticians by the educator. An audit of resident weights will be completed weekly by the food service manager. — 10/31/12 4. A report will be provided to the DON of problems identified and corrective actions. The DON will determine the need for further action. — 11/02/12 On going	

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L 113	Continued From page 39 06/15/2012 - Weight (lbs): 195 (Admission) 06/18/2012- Weight (lbs) - 152 06/26/2012 - Weight - 171.3 lbs. There was a documented 42 pound weight loss 72 hours post admission; and a documented 19.3 pound weight gain 8 days later.. According to the June 2012 Medication Administration Record: June 15, 2012- 195 lbs (pounds) June 18, 2012 - 182.5 lbs (72 hours after admission) June 22, 2012- 191 lbs. (8.5 lbs weight gain) June 26, 2012- 171.3 lbs (17.7 lbs weight loss) There was a 12.5 lbs weight loss 72 hours post admission; and a 24 lbs weight loss 15 days from admission. A review of the facility ' s policy " Weigh Loss/Gain Protocol " revised February 3, 2011, " If resident has a 5 lb or 5% weight loss, resident will be reweighed with the charge nurse and unit manager present to verify weight. If resident continues to lose weight ... weight gains that are not planned will be evaluated for edema or change in condition. ..the IDT (Interdisciplinary Team) will need to write a note in their section of the chart regarding weight and what is being done or changed and the residents response to their interventions. Appendix II Weight Protocol: Any resident with a weight variance will be assessed by the Dietitian. " A review of progress notes lacked evidence that the resident ' s weight variances were monitored and assessed in accordance with facility policy. A face-to- face interview was conducted with Employee #7 on September 10, 2012 at approximately 5:00 PM. In response to a query regarding the documented weight variations,	L 113		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 113	Continued From page 40 he/she acknowledged the variations. It was stated that the variations recorded in the electronic record and medication administration record were likely errors. A telephonic conversation was conducted with Employee #3 on September 13, 2012 at approximately 10:00 AM. After further review of the clinical record; he/she stated that " it appears that there is possibly an error in documenting his/her weight. The dietitian who assessed the resident is no longer employed at the facility. " The dietitian failed to act on a significant weight variance indicative of a significant weight change for Resident #106. The record was reviewed on September 10, 2012.	L 113	Continued From page 40	
L 292	3243.3 Nursing Facilities Each ramp, stairway,and corridor that is used by a resident shall be equipped with firmly secured handrails or banisters on each side. This Statute is not met as evidenced by: Based on observations made during an environmental tour, it was determined that the facility failed to ensure that handrails were firmly secured as evidenced by loose handrails on the three (3) of three (3) residents care units. The findings include: Handrails were not secured in as the following locations: a. On the first floor next to the service elevator	L 292	3243.3 Nursing Facilities **L292** 1. Corrections for the hand rails were completed at the time of survey. 9/7/12 2. A physical assessment has been completed by the maintenance staff of handrails. Corrective actions implemented as needed. 10/26/12 3. A physical assessment of hand rails will be completed weekly as part of environmental care rounds by a designated department director/designee. 10/26/12 4. The results of the above environmental care rounds will be provided to the Administrator of problems identified and corrective actions implemented. The Administrator will determine the need for further action. 10/26/12 On going	

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	HFD02-0011	A. BUILDING _____ B. WING _____	09/11/2012

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L 292	Continued From page 41 b. Between rooms #113 and #114 c. Outside of rooms #115 and room #117 d. Across from room #142 e. Outside of rooms #222, #227, #229 and #322. These observations were made in the presence of Employee #18 who acknowledged the findings.	L 292		
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 7, 2012 between 11:00 AM and 4:00 PM, it was determined that the facility failed to ensure that call bells were functioning properly in three (3) of 40 residents rooms as evidenced by one (1) call bell pull cord that was wrapped around a grab bar in the bathroom of room #230, one (1) call bell	L 306		

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L 306	Continued From page 42 cord that was too short in the bathroom of room #223 and a non-functioning call bell in room #318. The findings include: 1. The call bell in the bathroom of room #230 was wrapped around the grab bar in one (1) of 40 residents rooms. 2. The call bell cord was too short in one (1) of 40 residents room (#223). 3. The call bell in room #318 did not activate when tested in one (1) of 40 resident's rooms. These observations were made in the presence of Employee #18 who acknowledged the findings.	L 306	Continued From page 42 3245.10 Nursing Facilities **L306** 1. Corrections for the call bells were completed at the time of survey. 2. An audit has been completed by the maintenance director of call bells. Corrective actions implemented as indicated. 3. During weekly environment of care rounds (EOR) of call bells will be checked to ensure they are operable by the Unit manager,/ADON/ departmental director/designee, 4. The results of the above environmental care rounds will be reported to the Administrator on a monthly basis with problems identified and corrective actions implemented. The Administrator will determine the need for further action	9/7/12 10/26/12 10/26/12 10/26/12 On going
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour on September 7, 2012 between 11:10 AM and 4:00 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: two (2) of	L 410		

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L 410	Continued From page 43 40 resident rooms were malodorous; marred walls in four (4) of 40 resident rooms; a damaged wall in one (1) of three (3) dayrooms; broken baseboard tiles in two (2) of 40 resident rooms; a broken clock and a stained and malfunctioning toilet in one (1) of 40 resident bathrooms; a missing cover to the ceiling light in (1) of 40 resident bathrooms and a broken curtain rod in one (1) of 40 resident rooms. The findings include: 1. An offensive, unclean odor was evident in two (2) of 40 resident rooms including room #230 and #335. 2. Walls were marred in four (4) of 40 resident rooms including rooms #111, #135, #145 and #220. 3. There was a hole in the wall under the window in one (1) of three (3) dayrooms specifically the 2nd floor dayroom. 4. Baseboard tiles were broken in two (2) of 40 resident rooms including room #114 and #230. 5. The wall clock was no longer functioning and the toilet was stained and did not flush properly in Room #127. 6. The cover to the bathroom ceiling light was missing in Room #135. 7. The curtain rod was completely detached from the wall Room #238. These observations were made in the presence	L 410	Continued From page 43 3256.1 Nursing Facilities **L410** 1. The corrections were made in each of the identified rooms at the time of survey. 2. A review was completed of other resident's rooms corrections were made as indicated. 3. Housekeeping and maintenance staff were educated on the facility policy of reporting broken and items in disrepair in resident's room. Weekly rounds will be completed by a departmental director as part of Environmental Care rounds (EVC). 4. Results of the rounds will be reported to the CQI committee monthly of problems identified and corrective action implemented. The CQI committee will determine the need for further audits.	9/7/12 10/26/12 10/26/12 10/26/12 On going

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L 410	Continued From page 44 of Employee #18 who acknowledged the findings.	L 410	Continued From page 44	
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made during the survey and during a tour of the Dietary Services on August 4, 2012 at approximately 9:30 A.M. and on August 7, 2012 at approximately 9:05 AM, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects observed in five (5) of 40 resident rooms and in the kitchen on two (2) of two (2) occurrences. The findings include: 1. Flying insects were seen in resident rooms #111, #125, #324, #325 and #342. 2. Flying insects were seen in dietary services on two (2) of two (2) occasions on August 4 and August 7, 2012. These observations were made throughout the survey.	L 426	3257.3 Nursing Facilities **L426** 4. Corrections for the hand rails were completed at the time of survey. — 9/7/12 5. A physical assessment has been completed by the maintenance staff of handrails. Corrective actions implemented as needed. — 10/26/12 6. A physical assessment of hand rails will be completed weekly as part of environmental care rounds by a designated department director/designee. — 10/26/12 4. The results of the above environmental care rounds will be provided to the Administrator of problems identified and corrective actions implemented. The Administrator will determine the need for further action. — 10/26/12 On going	
L 442	3258.13 Nursing Facilities The facility shall maintain all essential	L 442		

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L 442	Continued From page 45 mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations made during a tour of Dietary Services on August 4, 2012 at approximately 9:30 A.M. and on August 7, 2012 at approximately 9:05 A.M., it was determined that the facility failed to maintain essential equipment in safe, operating condition as evidenced by one inoperable refrigerator and Two (2) of four (4) convection ovens were not functioning as intended. The findings include: 1. One (1) of one (1) reach-in refrigerator used for produce storage was inoperative. 2. Two (2) of four (4) convection ovens were not functioning as intended. One was completely inoperative and the double doors to another would not remain fully closed. These observations were made in the presence of Employee #18 who acknowledged the findings.	L 442	Continued From page 45 3258.13 Nursing Facilities **L442** 1. The equipment identified has been serviced and parts have been ordered and scheduled to be installed by 11/6/12. 2. An audit of dietary equip has been completed by the administrator and corrective actions implemented as indicated. 3. Review of the facility policy regarding equipment in disrepair has been completed by the administrator with the Dietary Manager. The Dietary Manager will complete an audit of equipment weekly. 4. The results of the above audits will be provided to the administrator weekly and the CQI committee monthly of problems identified and corrective actions implemented. The CQI committee will determine the need for further action.	9/14/12 9/17/12 9/14/12 9/14/12 10/26/12