SPECIALTY HOSPITAL of WASHINGTON

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August 29, 2014

Cassandra Kingsberry, RN
Supervisory Nurse Consultant
Health Care Facilities Division
District of Columbia Department of Health (DOH)
Health Regulation and Licensing Administration
899 North Capitol Street, NE, 2nd Floor
Washington, DC 20002

Dear Ms. Kingsberry:

Subject: Survey Plan of Correction

Enclosed is the plan of correction for Specialty Hospital of Washington – Capitol Hill Nursing Center addressing the deficiencies found during the annual licensure survey conducted on July 8 through July 18, 2014. We are alleging compliance as of September 12, 2014.

If you have any question, please don't hesitate to contact me at (202) 527-0901 or 202-629-5464.

Sincerely,

Maria Allen
Nursing Home Administrator
Enclosure (3)

cc.: Susan Bailey, SHW-Capitol Hill
Sharon W. Lewis, DHA, RN-BC, CPM, DOH-HRLA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING _____ B. WING _____	07/18/2014

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F 000	INITIAL COMMENTS	F 000		

A recertification Quality Indicator Survey (QIS) was conducted on July 8 through July 18, 2014. The deficiencies are based on observation, record review, resident and staff interviews for 36 sampled residents and eight (8) of 40 supplemental residents.

Responses begins on page 3

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

Abbreviations
AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
D/C discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - emergency medical services (911)
g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning
FU/FL Full Upper /Full Lower
ID - Intellectual disability
IDT - interdisciplinary team
INR - International Normalised Ratio
L - Liter
Lbs - pounds (unit of mass)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mara Adler	Nursing Home Administrator	8/29/201

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 MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MRR- Medication Regimen Review Neuro - Neurological NP - Nurse Practitioner OBRA - Omnibus Budget Reconciliation Act PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- responsible party RAI- Resident Assessment Instrument ROM- Range of Motion TAR - Treatment Administration Record CAA- Care Assessment Area QAA- Quality Assessment and Assurance	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the	F 156	Refer to page 4 for response F156	

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F 156	Continued From page 2 notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a	F 156	Refer to page 4 for response F156	

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F 156	Continued From page 3 couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by:	F 156	Refer to page 4 for response F156	

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F 156	Continued From page 4 Based on record review and staff interview for one (1) of 36 sampled residents, it was determined that facility staff failed to ensure that the " Notice of Medicare Non-coverage " letter was provided to Resident #57. The findings include: According to a " History and Physical " dated January 22, 2014 revealed; Resident #57 was admitted to the facility with diagnoses which included: " Congestive Heart Failure, Coronary Artery Disease, and Status Post Coronary Artery Bypass Graft [times 3]. According to an interim physician ' s order dated February 26, 2014 directed, " Resident may be [discharged] home on Friday February 28, 2014 with nursing for medication management, home health aide, OT (Occupational therapy), PT (Physical Therapy) for safety evaluation ... " Physician ' s order dated January 22, 2014 directed, " Rehabilitation Screen: PT (Physical Therapy), OT (Occupational Therapy) and Speech Therapy ... may evaluate and treat as indicated. " A review of the clinical record revealed Resident #57 was started on skilled services on January 23, 2014 and was discharged from physical therapy on February 3, 2014, speech therapy on February 5, 2014 and occupational therapy on February 7, 2014. A review of the clinical record lacked evidence that a " Notice of Medicare Non-coverage " letter was provided to Resident #57 to give	F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 1. Resident #57 no longer resides in the facility, therefore; no further measures could be taken. 2. Business Office Coordinator will audit residents discharged from Medicare to ensure “Notice of Medicare non-coverage” has been provided. 3. Business Office Coordinator or designee will audit monthly Medicare discharges to ensure “Notices of Medicare non-coverage” have been provided. 4. Business Office Coordinator or designee will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	9.12.2014

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F 156	Continued From page 5 notification when the last day of skilled services. Additionally, there was no documented evidence in the clinical record that verbal notification was provided. A face-to-face interview was conducted with Employees #7 and #22 on July 17, 2014 at approximately 1:00 PM regarding the aforementioned concerns. Both stated that they were not given the information regarding the resident ' s discontinuation of skilled services. The clinical record was reviewed on July 17, 2014. Facility staff failed to ensure that the " Notice of Medicare Non-coverage " letter was provided to Resident #57.	F 156		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on July 10, 2014 at approximately 10:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by: air control fans that failed to blow air in six (6) of 46 resident's rooms, window blinds with missing slats in three (3) of 46 resident's rooms, soiled shower floors on three (3) of three (3) floor	F 253	Refer to page 7 for response F253	

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F 253	Continued From page 6 levels, burnt ceiling lights in five (5) of 46 resident's rooms, a broken light cover in one (1) of 46 resident's rooms, marred entrance doors in seven (7) of 46 resident's rooms, marred walls in nine (9) of 46 resident's rooms and in two (2) of three (3) activity rooms and leaky hot water faucets in two (2) of 46 resident's rooms. The findings include: 1. Air control fans were not functioning in six (6) of 46 resident's rooms including rooms #6153, #6144, #6143, #6128, #6112, #5144. 2. Window blinds were missing slats in four (4) of 46 resident's rooms (#6128, # 6112, #5127, #4143). 3. Shower room floors on the fourth, fifth and sixth floor level were soiled and discolored in several areas. 4. Ceiling lights would not illuminate in the following resident's rooms: Two (2) of three (3) in room #6142, two (2) of two (2) in the bathroom of room #6143, two (2) of three (3) in room #6133 and one (1) of two (2) in the bathroom of room #6128. 5. The wall light located in the bathroom of room #5119 was out and its cover was cracked. 6. The entrance door to several resident's rooms were marred including rooms	F 253	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES **Response to #1-8** 1. Air control fans have been fixed in rooms #6153, #6144, #6143, #6128, #6112, #5144. Window slats have been replaced in rooms #6128, #6112, #5127, #4143; Shower room floors on the fourth, fifth and sixth floor will be stripped and waxed by housekeeping. Ceiling lights have been replaced in rooms #6142, #6143, #6133, #6128; The wall light and cover in room #5119 will be replaced; The entrance door to resident's rooms #5116, #5110, #5102, #4150 and #4106 will be painted; The walls in resident's rooms #6143, #6104, #5147, #5133, #4155, #4146, #4133, #4104 will be painted. The walls in the activity rooms in the 4th and 5th floor, and the walls in the bathroom in room #4116 will be fixed; The hot water faucet in rooms #6129 and #4121 have been fixed. 2. Maintenance Director or designee will conduct an environmental round to identify any issues with air control fans, window blinds, floors, ceiling lights, entrance doors, walls, and faucet leaks. 3. Environmental rounds will be conducted monthly by a work group including Maintenance Director or designee, Housekeeping Director or designee, Administrator or designee, Resident Care Coordinator or designee to identify any maintenance or housekeeping issues. Maintenance a binder on each floor to ensure staff can document maintenance needs. 4. Maintenance Director will document findings and present to the Quality Assurance Committee for review, evaluation and recommendations monthly for a period of three months.	**9.12.2014**

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F 253	Continued From page 7 #5116, #5110, #5102, #4157, #4150 and #4106. 7. Walls in resident's rooms were marred including rooms #6143, #6104, #5147, #5133, #4155, #4146, #4133, #4104, the activity room on the fifth floor, the activity room on the fourth floor and the bathroom in room #4116. 8. The hot water faucet in rooms #6129 and #4121 leaked when in use. These observations were made in the presence of Employee #1 and Employee #15 who acknowledged the findings.	F 253	Refer to page 7 for response F253	
F 272 SS=F	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;	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 8 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: A. Based on record review and staff interview for nine (9) of 36 sampled residents and eight (8) of 40 supplemental residents, it was determined that facility staff failed to identify the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A] for nine (9) residents: Residents #38, #42, # 48, #55, #58, #95, #111, #113, #134, and eight (8) supplemental residents: S16, S26, S40, S50, S65, S83, S119, S123. The findings include: According to Chapter 4 of the MDS 3.0 Users ' Manual, " for each triggered care area, indicate the date and location of the CAA documentation...CAA documentation should	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 9 include information on the complicating factors, risks and any referrals for the resident for this care area ... " 1. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #38. A review of Resident #38's significant change Minimum Data Set dated June 18, 2014 revealed the Care Areas and 'addressed ' in Care Plan triggered for #2 Cognitive Loss, #3 Visual Loss, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #15 Dental Care and #16 Pressure Ulcers. The record revealed that the location and date of CAA information [for care areas # 2, 3, 6, 11, 12, 15, and 16] was blank. There was no evidence that the facility staff documented the location in the clinical record regarding information related to the CAA ' s. The clinical record lacked evidence of documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the	F 272	483.20(b)(1) COMPREHENSIVE ASSESSMENTS **Response to A#1-17** 1. MDSs for residents #38, #42, #48, #58, #95, #111, #134 , S50, S65, S83, S119 will be corrected. Residents #55, #113, S123, S16, S26 no longer resides in the facility, therefore; no further measures could be taken. 2. MDS coordinator will audit residents' MDSs to ensure V-section is complete. 3. MDS coordinator or designee will audit MDSs on a monthly basis for completion. 4. MDS coordinator will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	**9.12.2014**

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F 272	Continued From page 10 information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 2. Facility staff failed to document on the Care Area Assessment (CAA) Summary the location and date where information related to the CAA was obtained. Resident #42. A review of Resident #42's annual Minimum Data Set dated February 3, 2014 revealed that Care Areas and 'addressed ' in Care Plan triggered for, #3 Visual Function, #4 Communication, #5 ADL (Activities of Daily Living) /Functional Status,, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Nutrition, #15 Dental Care, and #16 Pressure Ulcers. The record revealed that the location and date of CAA information [for care areas #3, 4, 5, 6, 11, 12, 15, and 16] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 11 regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 3. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #48. A review of Resident #48's significant change Minimum Data Set dated February 14, 2014 revealed the Care Areas and ' addressed ' in Care Plan triggered for #1 Delirium, #2 Cognitive Loss, #3 Visual Loss, #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #14 Dehydration/Fluid Maintenance, #16 Pressure Ulcers, and #17 Psychotropic Medication Use. The record revealed that the location and date of CAA documentation information [for care areas # 1, 2, 3, 5, 6, 11, 12, 14, 16, and 17] were blank. There was no evidence that the facility staff documented the location in the clinical record regarding information related to the CAA's.	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 12 The clinical record lacked evidence of documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 4. Facility staff failed to accurately code Resident #58 ' s Minimum Data Set (MDS) under Section " V, " Care Area Assessment (CAA) Summary to include the location and date where information related to triggered care areas could be located on the clinical record. A review of Resident #58's admission Minimum Data Set with an ARD (Assessment Reference Date of April 3, 2014 revealed that Care Areas and 'addressed ' in Care Plan triggered for, #2 cognitive Loss/Dementia, #3 Visual function, #4 Communication, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Nutrition Status, #15 Dental Care, and #16 Pressure Ulcers. The record revealed that the location and date of	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 13 CAA information [for care areas #2, #3, 4, 6, 11, 12, 15, and 16] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to document on the Care Area Assessment (CAA) Summary the location and date where information related to the CAA was obtained. 5. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the annual Minimum Data Set [MDS] for Resident #55. A review of Resident #55's significant change Minimum Data Set dated June 18, 2014 revealed	F 272	Refer to page 10 for response F272	

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the Care Areas and 'addressed ' in Care Plan triggered for #2 Cognitive Loss, #4 Communication, #6 Urinary Incontinence and Indwelling Catheter, #7 Psychosocial Well-being, #10 Activities, #11 Falls, #12 Nutritional Status, #13 Feeding Tube(s), #14 Dehydration/Fluid Maintenance, and #16 Pressure Ulcers.

The record revealed that the location and date of CAA information [for care areas # 2, 4, 6, 7, 10, 11, 12, 14, and 16] was blank.

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

The clinical record lacked evidence of documentation regarding complicating factors, risks and any referrals related to the triggered care areas.

A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014.

Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A].

6. Facility staff failed to identify the location and

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F 272	Continued From page 15 date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary" of the annual Minimum Data Set [MDS] for Resident #95. A review of Resident #95 's annual Minimum Data Set dated December 28, 2013 revealed that Care Areas and 'addressed' in Care Plan triggered for, #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Nutrition, #16 Pressure Ulcers, and #17 Psychotropic Medication Use. The record revealed that the location and date of CAA information [for care areas # 5, 6, 11, 12, 16, and 17] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 16 date of Care Area Assessment [CAA] information on Minimum Data Set (MDS) under Section V [V0200A]. 7. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the annual Minimum Data Set [MDS] for Resident #111. A review of Resident #111's admission Minimum Data Set with an ARD (Assessment Reference Date of April 7, 2014 revealed that Care Areas and 'addressed ' in Care Plan triggered for, #2 cognitive Loss/Dementia, #3 Visual function, #4 Communication, #6 Urinary Incontinence /Catheter, #12 Nutrition Status, #13 Feeding Tube, #14, dehydration/fluid Maintenance, #15 Dental Care, and #16 Pressure Ulcers. The record revealed that the location and date of CAA information [for care areas #2, #3, 4, 6, 12, 13, 14, 15, and 16] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not	F 272	Refer to page 10 for response F272	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 17 documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 8. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #113. A review of Resident #113's Admission Minimum Data Set dated December 27, 2013 revealed the Care Areas and ' addressed ' in Care Plan triggered for #2 Cognitive Loss, #3 Visual Loss, #4 Communication, #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence and Indwelling Catheter, #7 Psychosocial Well-being, #10 Activities, #12 Nutritional Status, # 13, Feeding Tube (s), #14 Dehydration/Fluid Maintenance, # 15 Dental Care, and #16 Pressure Ulcers. The clinical record revealed that the location and date of CAA documentation information [for care areas #2, 3, 4, 5, 6, 7, 10, 12, 13, 14, 15, and 16] was blank. There was no evidence that the facility staff documented the location in the clinical record information related to the CAA's.	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 18 The clinical record lacked evidence of documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. On July 17, 2014 at approximately 3:20 PM, a face to face interview was conducted with Employee #2 regarding the aforementioned missing information on the Care Area Assessment (CAA) Summary, under CAA Results. He/she acknowledged the findings. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 9. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A],"Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #134. A review of Resident #134's significant change Minimum Data Set dated March 20, 2014 revealed that Care Areas and ' addressed ' in Care Plan triggered for #5 ADL (Activities of	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 19 Daily Living) Functional Status, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #14 Dehydration/Fluid Maintenance, #16 Pressure Ulcers, and # 17 Psychotropic Medication Use. The clinical record revealed that the location and date of CAA information [for care areas #, 5, 6, 11, 12, 14, 16, and 17] was blank. There was no evidence that the facility staff documented the location in the clinical record information related to the CAA's. The clinical record lacked evidence of documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 10. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 20 Assessment Summary " of the Minimum Data Set [MDS] for Resident #S-16. A review of Resident #S16's significant change Minimum Data Set dated February 1, 2014, revealed that Care Areas and 'addressed ' in Care Plan triggered for, #2 Cognitive Loss/Dementia, #4 communication, #6 Urinary Incontinence /Catheter, #7 Psychosocial well being, #10, #11 Falls, Activities, #12 Nutritional Status, #16 Pressure Ulcer. The record revealed that the location and date of CAA information [for care areas #2, 4, 6, 7, 10, 11, 12, 16] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 21 [V0200A]. 11. Facility staff failed to accurately code Resident #S-26 ' s Minimum Data Set (MDS) under Section " V, " Care Area Assessment (CAA) Summary to include the location and date where information related to triggered care areas could be located on the clinical record. A review of Resident #S-26's significant change Minimum Data Set dated March 14, 2014 revealed that Care Areas and 'addressed ' in Care Plan triggered for, #1 Delirium, #2 Cognitive Loss/Dementia, #3 Visual Function, #4 communication, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Nutritional Status, #15 Dental Care, #16 Pressure Ulcer, #17 Psychotropic Drug Use. The record revealed that the location and date of CAA information [for care areas #1, #2, 3, 4, 6, 11, 12, 15, 16, 17] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 22 documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 12. Facility staff failed to accurately code Resident #S-40 ' s Minimum Data Set (MDS) under Section " V, " Care Area Assessment (CAA) Summary to include the location and date where information related to triggered care areas could be located on the clinical record. A review of Resident #S-40's significant change Minimum Data Set dated December 11, 2013, revealed that Care Areas and 'addressed ' in Care Plan triggered for, #2 Cognitive Loss/Dementia, #3 Visual Function, #4 communication, #6 Urinary Incontinence /Catheter, #7 Psychosocial well being, #10 Activities, #12 Nutritional Status, #13 Feeding Tube, #14 Dehydration, #16 Pressure Ulcer, #19 Pain. The record revealed that the location and date of CAA information [for care areas #2, 3, 4, 6, 7, 10, 12, 13, 14, 16, 19] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 23 care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 13. Facility staff failed to accurately code Resident #S-50 ' s Minimum Data Set (MDS) under Section " V, " Care Area Assessment (CAA) Summary to include the the location and date where information related to triggered care areas could be located on the clinical record. A review of Resident #S-50's significant change Minimum Data Set dated May 21, 2014, revealed that Care Areas and 'addressed ' in Care Plan triggered for, #2 Cognitive Loss/Dementia, #3 Visual Function, #4 communication, #5 ADL Function/Rehabilitation Potential, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Nutritional Status, #16 Pressure Ulcer. The record revealed that the location and date of CAA information [for care areas #2, 3, 4, 5, 6, 11,12, 16.] was blank.	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 24 There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 14. Facility staff failed to accurately code Resident #S-65 ' s Minimum Data Set (MDS) under Section " V, " Care Area Assessment (CAA) Summary to include the location and date where information related to triggered care areas could be located on the clinical record. A review of Resident #S-65's significant change Minimum Data Set dated April 12, 2014 revealed that Care Areas and 'addressed ' in Care Plan triggered for, #2 Cognitive, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Nutritional Status, #14 Dehydration/Fluid Maintenance, , #16 Pressure Ulcer.	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 25 The record revealed that the location and date of CAA information [for care areas #2, 6, 11, 12, 14, 16,] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 15. Facility staff failed to accurately code Resident #S-83 ' s Minimum Data Set (MDS) under Section " V, " Care Area Assessment (CAA) Summary to include the location and date where information related to triggered care areas could be located on the clinical record. A review of Resident #S-83's significant change	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 26 Minimum Data Set dated June 20, 2014 revealed that Care Areas and 'addressed ' in Care Plan triggered for, #2 Cognitive, #Visual Function, #5 ADL [Activities of Daily] functional/Rehabilitation Potential, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Nutritional Status, #14 Dehydration/fluid Maintenance, #16 Pressure Ulcer, #17 Psychotropic Drug Use. The record revealed that the location and date of CAA information [for care areas #2, 5, 6, 11, 12, 13, 14, 15, 16, 17] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 16. Facility staff failed to accurately code Resident #S-119 ' s Minimum Data Set (MDS)	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 27 under Section " V, " Care Area Assessment (CAA) Summary to include the location and date where information related to triggered care areas could be located on the clinical record. A review of Resident #S-119's significant change Minimum Data Set dated November 19, 2013 revealed that Care Areas and 'addressed ' in Care Plan triggered for, #2 Cognitive, #5 ADL [Activities of Daily] functional/Rehabilitation Potential, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Nutritional Status,# 13 Feeding tube, #14 Dehydration/fluid Maintenance, #15 Dental Care, #16 Pressure Ulcer, #17 Psychotropic Drug Use. The record revealed that the location and date of CAA information [for care areas #2, 5, 6, 11, 12, 13, 14, 15, 16, 17] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA	F 272		

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F 272	Continued From page 28 information was entered. The clinical record was reviewed on July 14, 2014. . Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. 17. Facility staff failed to accurately code Resident #S-123 ' s Minimum Data Set (MDS) under Section " V, " Care Area Assessment (CAA) Summary to include the location and date where information related to triggered care areas could be located on the clinical record. A review of Resident #S-123 ' s significant change Minimum Data Set dated January 15, 2014 revealed that Care Areas and 'addressed ' in Care Plan triggered for, #2 Cognitive Loss/Dementia, #3 Visual Function, #4 communication, #6 Urinary Incontinence /Catheter, #7 Psychosocial well being, #10 Activities, #12 Nutritional Status, #16 Pressure Ulcer. The record revealed that the location and date of CAA information [for care areas #2, 3, 4, 6, 7, 10, 12,16] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. There were no " CAA worksheets " available for review. The clinical record lacked evidence of documentation regarding complicating factors,	F 272	Refer to page 10 for response F272	

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F 272	Continued From page 29 risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the " system " [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A]. B. Based on record review and staff interview for three (3) of 36 sampled residents it was determined that facility staff failed to accurately code Minimum Data Sets [MDS] for: one (1) resident ' s Oral/Dental status under Section L, one (1) resident ' s use of splint devices under Section O - Special Treatments and Procedures and one (1) resident ' s vision under Section B. Residents #44, 136 and 140. The findings include: 1. Facility staff failed to accurately code Resident # 44's annual Minimum Data Set (MDS) dated July 5, 2014 under Section L - Oral/Dental Status for lack of natural teeth. During a face-to-face interview with Resident #44 conducted on July 10, 2014 at approximately	F 272	483.20(b)(1) COMPREHENSIVE ASSESSMENTS **Response to B1-3** **Residents #44, 136, 140** 1. MDSs for residents #44, and #136s will be corrected. Resident # 140 has been discharged. 2. MDS coordinator will audit Section L, Section O, and Section B for accuracy. 3. MDS coordinator or designee will audit MDSs on a monthly basis for completion. 4. MDS coordinator will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	**9.12.2014**

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F 272	Continued From page 30 10:00AM he/she was queried, " Do you have any chewing or eating problems (could be due to no teeth, missing teeth, and oral lesions, broken or loose teeth)? The resident responded, "Yes. " The resident added that he/she had difficulty chewing and opened his/her mouth to reveal gums and no teeth (edentulous). A review of the clinical record revealed Dental Care Notes dated October 23, 2013 the dentist documented the following statement: "Annual exam [examination]. Edentulous, oral cancer screening is negative. " A review of Section L (Oral/Dental Status) of the resident ' s annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of July 5, 2014 revealed that option " Z " , none of the above was coded and Section L0200B (No natural teeth or tooth fragment(s) (edentulous) was blank. A face-to-face interview was conducted with Employee #7 at approximately 2:00PM on July 15, 2014. After reviewing a copy of the completed MDS, the employee acknowledged that Section L of the MDS (Oral/Dental Status) was not coded to reflect that the resident was edentulous. The employee then stated, "We will make the corrections. The record was reviewed on July 14, 2014. Facility staff failed to accurately code one (1) resident ' s MDS for lack of natural teeth. 2. Facility staff failed to accurately code Resident #136 ' s quarterly Minimum Data Set (MDS) under Section O - [Special Treatments and	F 272	Refer to page 30 for response F272B	

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F 272	Continued From page 31 Procedures] for splints or brace assistance. Review of Resident #136 's Quarterly MDS with an Assessment Reference Date (ARD) of June 6, 2014 revealed that under Section O [Special Treatments and Procedures] O0500 Resident #136 was coded as " 0 " indicative that the resident did not receive "Splint or brace assistance." A review of the restorative nursing flow sheets revealed: May 27, 2014 ROM/Splint/Brace application; May 28, 2014 ROM Splint/Brace application; May 29, 2014 ROM/Splint/Brace application; May 30, 2014 ROM Splint/Brace application; June 2, 2014 ROM/Splint/Brace application; June 3, 2014 ROM Splint/Brace application; June 4, 2014 ROM Splint/Brace application The "Restorative Nursing Programs" section that the facility utilized for recording Resident #136's number of days and technique performed was reviewed for the ARD period of May 27, 2014 through June 04, 2014. It was determined that facility staff recorded seven (7) days of restorative splint and brace assistance and application. There was no evidence that the comprehensive MDS dated June 4, 2014 was accurately coded to include special treatment and procedures. A face-to-face interview was conducted with Employee #7 on July 12, 2014 at approximately 3:15 PM. After review of findings, he/she acknowledged that the Quarterly MDS was incorrectly coded. The record was reviewed on	F 272	Refer to page 30 for response F272B	

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F 272	Continued From page 32 July 12, 2014. 3. Facility staff failed to accurately code Resident #140 ' s MDS for vision. According to Chapter 3 of the MDS 3.0 Users ' Manual page B-10 " ...special population: If the resident is unable to communicate or follow your directions for testing vision. Observe the resident ' s eye movements to see if his or her eyes seem to follow movement of objects or people. These gross measures of visual acuity may assist you in assessing whether or not the resident has any ability. For residents who appear to do this, code 3 highly impaired." According to the clinical record, Resident #140 was admitted with diagnoses that included: Chronic Respiratory Failure, Cerebral Vascular Accident, Diabetes Mellitus Type 2, Coronary Artery Disease, [status post] Coronary Artery bypass Graft and Hypotension. According to the 5-day PPS (Prospective Payment System) assessment dated March 8, 2014 Section B0100: Vision, Resident #140 was coded as (1) Impaired - sees large print, but not regular print in newspapers/books and B1200. Corrective Lenses (corrective lenses - contact, glasses, or magnifying glass) used was coded " No." A face-to-face interview was conducted with Employee #7 on July 15, 2014 at approximately 2:00 PM. A query was made regarding the coding related to vision. Employee #7 stated, the physician did not indicate that the resident was blind. Upon assessing the resident, the	F 272	Refer to page 30 for response F272B	

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F 272	Continued From page 33 resident would blink his/her eyes. I did not shine a light, but he/she seem to have vision. So " adequate was the proper choice for vision, he/she did not wear glasses. Facility staff failed to accurately code one (1) resident for vision.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 36 sampled residents, it was determined that facility staff failed to conduct the required admissions RAI (Resident Assessment Instrument) OBRA (Omnibus Budget Reconciliation Act) admissions for one (1) resident. Resident #140 Facility staff failed to conduct the required admissions RAI (Resident Assessment Instrument) OBRA within 14 days of Resident #140 ' s admission. According to the Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument User ' s Manual	F 273	Refer to page 35 for response F273	

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F 273	Continued From page 34 Version 3.0 October 2013, page 2-18: 01. Admission Assessment (A0310A=1). The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: this resident is the resident ' s first time in this facility, OR the resident had been in this facility previuously and was discharged prior to completion of the OBRA Admission assessment OR, this resident has been admitted to this facility and was discharged return not anticipated, OR, the resident has been admitted to this facility and was discharged returned anticipated and did not return within 30 days of discharge. A review of the clinical records revealed that Resident #140 was admitted to the facility on February 20, 2014; discharged to an acute care facility on February 22, 2014 and returned on March 4, 2014. The resident expired on March 26, 2014. According to the MDS (Minimum Data Set) tracking records, Resident #140 had an MDS (Minimum Data Set), Section A0310: Type of Assessment: F. Entry/discharge reporting coded (01) Entry record; A1600. Entry Date (date of this admission/reentry into the facility): 3/4/2014 (March 4, 2014), A1700. Type of Entry (2) Reentry. MDS, Section A0310: type of Assessment: 2000. Discharge Date 20140326 (March 26, 2014), A2100. Discharge Status (08). Deceased. The resident was in the facility from March 4,	F 273	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT 1. Resident #140 expired; therefore, no further measures could be taken. A review of the MDS transmission summary shows that resident #140's 14-day assessment was initially completed on 2/22/2014 as he was admitted on 2/20/2014 and was treated as a short stay resident. Enclosed is the transmission record to document latter statement (See attachment A) 2. MDS coordinator will audit Medicare MDSs to ensure that the 14 day MDS has been completed. 3. MDS coordinator or designee will audit Medicare MDSs monthly to ensure 14 day MDS has been completed. 4. MDS coordinator will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	9.12.2014

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F 273	Continued From page 35 2014 until discharge of March 26, 2014 without an Admissions MDS.	F 273		
F 279 SS=D	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, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 36 sampled residents, it was determined that facility staff failed to develop a care plan with goals and approaches to address one (1) resident who received continuous oxygen therapy for shortness of breath. Resident #136. The findings include:	F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 1. Immediately upon notification of this deficiency, a care plan was initiated for resident #136 to indicate use of continues oxygen use 2. An audit will be conducted by RCC's or designee on residents on oxygen to ensure that they have a care plan for continues oxygen use. 3. RCC's/ designee will audit care plans of residents on oxygen use monthly. 4. Reports of the audits will be reported to the risk management committee weekly and then to QA monthly for a period of 3 months for review, evaluation, and recommendations.	9.12.2014

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F 279	Continued From page 36 1. Facility staff failed to develop a care plan for Resident #136 who was receiving continuous oxygen therapy for shortness of breath. According to the admission's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) date of March 13, 2014, Section J: Health Condition; J1100 Shortness of Breath (dyspnea) was coded (C) trouble breathing when lying flat and under Section O: Special Treatments, Procedures, and Programs O 0100 [Respiratory Treatments] was coded as receiving oxygen therapy while a resident. According to the quarterly MDS with an ARD date of June 04, 2014 revealed that Resident #136 was shortness of breath or trouble breathing when lying flat, under Section J1100 [Shortness of Breath] and under Section O 0100 [Respiratory Treatments] coded as receiving oxygen therapy while a resident. A review of Resident #136 ' s care plan updated July 15, 2014 lacked evidence of problem identification, goals and approaches to manage the resident ' s respiratory status. The resident's medication regimen included continuous oxygen for shortness of breath. A face-to-face interview was conducted on July 11, 2013 at 12:30 PM with Employee #3. After review of the above, He/she acknowledged the aforementioned findings. The record was reviewed on July 15, 2014.	F 279	Refer to page 36 for response F279	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

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F 280	Continued From page 37 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 36 sampled residents, it was determined that facility staff failed to amend Resident #42 ' s care plan to include aspiration precautions and application of functional ROM [range of motion] braces. Resident #42 The findings include: A. Facility staff failed to amend Resident #42 ' s care plan to include application of functional ROM braces. According to an interim physician ' s order dated June 4, 2014 directed, " Discontinue skilled	F 280	Refer to page 39 for response F280	

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F 280	Continued From page 38 [Physical Therapy] services at this time [secondary to] [patient] at maximum functional level. (2) Functional maintenance program for donning/doffing BLE ROM [bilateral lower extremities Range of Motion] braces. On at 9:00 AM, Off at 3:00 PM, On at 5:00 PM, Off at 10:00 PM. " The comprehensive care plan dated April 28, 2014 included the following problems: " Decline in Range of Motion, Interventions included, " use aids/supportive devices provide passive ROM to bilateral lower extremities; however, there was no evidence that the care plan was revised to include the schedule for application of the ROM braces. A review of the June, 2014 Treatment Administration Record (TAR) revealed nurses ' initials in the allotted spaces that the ROM braces were being applied as directed by physical therapy from June 5 - June 30, 2014 and July Functional maintenance Program for donning BLE ROM [bilateral lower extremity- Range of Motion] on at 9:00 AM, off at 3:00 PM, on at 5:00 PM, off at 10:00 PM A review of the clinical record lacked evidence that the care plan was revised to include goals and interventions to specify the various application times of the ROM braces. Facility staff failed to amend Resident #42 ' s care plan to include the application of functional	F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP **Response to #A & #B** 1. Resident #42's care plan was updated/amended to include application of functional ROM braces and aspiration precautions 2. Audit will be conducted on residents receiving functional ROM braces and on those that are on aspiration precautions to ensure that their care plans and Physicians orders are up to date. 3. RCC's or designee will audit Physician orders and care plans of residents that are on functional ROM braces to ensure that they are cared planned appropriately Care plans of residents needing Aspiration precautions will be audited monthly to ensure that the care plans are amended/ updated as needed. 4. RCC's will document findings of the audit monthly for a period of 3months and report findings to QA monthly for review , evaluation, and recommendations.	**9.12.2014**

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F 280	Continued From page 39 ROM braces. A face-to-face interview was conducted with Employee #3 on July 11, 2014 at approximately 10:30 AM. After reviewing the clinical record; he/she acknowledged that the care plan did not incorporate the application of ROM braces. The clinical record was reviewed on July 11, 2014. B.Facility staff failed to amend Resident #42 ' s care plan to include aspiration precautions. According to an interim physician ' s order dated June 11, 2014 at 11:40 AM directed, " Speech skilled services discontinue 6/11/14- Continue with current diet puree with thin liquids. Follow strict aspiration precautions. Please follow aspiration precautions when feeding- small bites/sips via straw, seated upright for meals, alternate liquids and solids. " . The comprehensive care plan dated April 28, 2014 included the following problems: Alteration in Nutritional Status related to chewing problem as evidenced by altered feeding ability, Approach Plan-Monitor: PO (by mouth) intake; Provide PO diet per order ... " A review of the clinical record lacked evidence that the care plan was amended to include the strict aspiration precautions. Facility staff failed to amend Resident #42 ' s care plan to include aspiration precautions.	F 280	Refer to page 39 for response F280	

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F 280	Continued From page 40 A face-to-face interview was conducted with Employee #3 on July 11, 2014 at approximately 10:30 AM. After reviewing the clinical record; he/she acknowledged that the care plan was not amended to include the aspiration precautions. The clinical record was reviewed on July 11, 2014.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews for three (3) of 36 sampled residents, it was determined that facility staff failed to: follow physician orders for the application of antiembolism stockings for one (1) resident with pedal edema, administer anticoagulant medication, Lovenox in accordance with physician's orders; obtain a psychiatric consultation in accordance with physician's orders for one (1) resident and clarify a diet order for one (1) resident. Residents' #44, #127 and #134. The findings include: 1. Facility staff failed to follow a physician ' s	F 309	Refer to page 42 for response F309	

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F 309	Continued From page 41 order for Resident #44 to apply Ted stockings daily for Pedal Edema. A review of the resident ' s clinical record revealed a Physician ' s Order Sheet (POS) with an initial order date of December 13, 2013 which directed, " Ted Stockings daily for Pedal Edema. " The order was last signed by the physician on July 8, 2014. The resident was observed sitting in a wheel chair in his/her room and in the Day Room (without Ted stockings) wearing socks from approximately 9:00AM to 12:00PM on July 15, 2014. A face-to-face interview was conducted with the assigned CNA Employee #29 at approximately 12:30PM on July 15, 2014 The employee was queried whether he/she applied Ted stockings for his/her assigned residents. He/she responded "Yes, as long as they have an order." The employee was then queried why Resident #44 was not wearing Teds. The employee stated, " They were probably discontinued. I did not see any [Teds] in the room. I will check and if they are not discontinued I will put them on. " The record was reviewed on July 15, 2014. Facility staff failed to follow a physician ' s order to apply Ted stockings daily for Pedal Edema. 2. Facility staff failed to administer Resident #127's Lovenox in accordance to physician ' s orders. According to a " History and Physical " dated January 27, 2014 revealed Resident #127's	F 309	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP **Response to #1, 2, 3a, 3b** **Resident: #44, #127, #134** 1. Resident #44's Ted Stockings was applied on the resident immediately on 7/15/2014 after the RCC was notified by the surveyor; Resident #127 no longer has a physician's order for Lovenox; (a) Resident # 134 was seen by the Psychiatrist on 7/16/2014; (b) A telephone order was obtained on 7/14/2014 to reflect resident #134's current diet of Mechanical soft diet with Thin Liquids. 2. Residents with TED Stockings order will be observed by the RCC or designee to ensure compliance to Physicians Orders. RCC's or designee will audit POS/MAR & Medication carts to ensure compliance with physician orders for residents receiving Lovenox; RCC or designee will audit physician orders to ensure psychiatrist consults are scheduled in accordance with the physician's orders; RCC or designee to audit dietary recommendations to ensure physician's orders are written according to the dietician recommendations. 3. RCC's or Designee will audit POS's monthly to ensure compliance with applying TED stockings, Administration of Lovenox and obtaining psychiatrist consults. 4. Reports of the audits will be reported to the risk management committee weekly and then to QA monthly for a period of 3 months for review, evaluation, and recommendations.	**9.12.2014**

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F 309	Continued From page 42 diagnoses included: " Left hemiplegia, Chronic Respiratory Failure, Bilateral Pulmonary Embolism, Intracranial Hemorrhage and Hypertension. " An interim order dated January 28, 2014 at 4:00 PM directed: " Lovenox 30mg SQ (subcutaneously) QD (everyday). Dx Anticoagulation Tx (Treatment). " A review of the January 2014 Medication Administration Record (MAR) lacked evidence that Lovenox 30mg was administered on January 29, 20 and 31. A review of the February 2014 MAR revealed nurses ' initials were in the allotted spaces which indicated the resident was administered Lovenox 30 mg SQ daily at 9:00 AM on February 1, 2, and 3, 2014. There was no evidence in the clinical record that the staff administered the Lovenox from January 29 through January 31. There were no untoward effects to the resident. A face-to-face interview was conducted with Employees #5 and #6 on July 11, 2014 at approximately 2:00 PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on July 11, 2014. 3a. Facility staff failed to obtain a psychiatric consultation in accordance with physician's orders for Resident #134. A review of the History and Physical dated February 9, 2014 revealed the following	F 309	Refer to page 42 for response F309	

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F 309	Continued From page 43 diagnoses: Cerebral Vascular Accident (stroke) 2008, Pontine Hemorrhage 2013, Left Hemiplegia, Hypertension, Obstructive Sleep Apnea, Tracheostomy, Peg [feeding tube]. A review of the clinical record revealed a psychiatric consultation note dated February 11, 2014 with recommendations to start the resident on Zoloft [Sertraline] 50mg [milligrams] for depression. A physician ' s order dated March 1, 2014 directed, " psychiatric re-evaluation of Sertraline." On July 14, 2014 at approximately 11:40 AM, a face-to-face interview was conducted with Employee #3, who was asked to provide the follow-up psychiatry note. He/she was unable to produce the document from the clinical record and acknowledged that there was no progress note from the psychiatrist since the initial consultation [February 11, 2014]. On July 14, 2014, at approximately 3:15 PM, a face-to-face interview was conducted with Resident #134 to discuss the approximate day he/she was visited by the psychiatrist. He/she explained that he/she had not spoken to the psychiatrist. There was no evidence that facility staff followed the physician's order for Resident #134 to have a psychiatric consultation. 3b. Facility staff failed to follow through on a dietitian ' s recommendation for a dietary texture	F 309	Refer to page 42 for response F309	

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F 309	Continued From page 44 modification for Resident #134. The History and Physical dated February 9, 2014 revealed the following diagnoses: Cerebral Vascular Accident (stroke) 2008, Pontine Hemorrhage 2013, Left Hemiplegia, Hypertension, Obstructive Sleep Apnea, Tracheostomy, Peg Tube [feeding tube]. A review of the clinical record revealed dietary recommendations on the 'Quarterly Nutrition Review' dated May 28, 2014 for "mechanical soft thin liquids." A review of the 'Physician's Order Form' dated May 28, 2014 revealed a diet order that directed the following: "NAS [No Added Salt] diet order related to dx [diagnosis] of HTN [hypertension]." The July 2014 'Physician's Order Form' revealed the following diet orders: February 28, 2014 - " Diagnosis, PT [patient] eating po [by mouth] food, good intake" and May 28, 2014 - "No added salt diet." On July 14, 2014 at approximately 9:40 AM, mechanical soft foods were observed on the tray at Resident #134's bedside. On July 14, 2014 at approximately 9:45 AM, a face-to-face interview was conducted with Employee #3 regarding the resident's diet. He/she acknowledged that the resident's diet was mechanical soft with thin liquids and there was no physician's order for the mechanical soft diet. Facility staff failed to follow through on a dietitian ' s recommendation for a dietary texture	F 309	Refer to page 42 for response F309	

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F 309	Continued From page 45 modification for Resident #134.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A.Based on an observation made during an environmental tour of the facility on July 10, 2014 at approximately 10:00 AM, it was determined that facility staff failed to maintain the area free of accident hazards as evidenced by one (1) of one (1) unlocked door to the sprinkler control room where various mechanical equipment are located. The findings include: 1. The door to the sprinkler control room on the sixth floor was unlocked and accessible to residents. 2. Floor tiles located in front of the shower room access door on the fourth floor were loose, damaged and wet and presented a tripping and/or a slipping hazard.	F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES **Response to #A1, 2** 1. Immediately upon notification of this deficiency the sprinkler control room door was locked. The Maintenance Director is obtaining bids to repair the tiles and leaky pipes. 2. Maintenance Director will conduct an environmental sound to identify and address hazardous conditions. 3. Environmental rounds will be conducted monthly by a work group including Maintenance Director or designee, Housekeeping Director or designee, Administrator or designee, Resident Care Coordinator or designee to identify any hazardous conditions or unlocked medication/treatment carts. Maintenance will have a work order binder on each floor to ensure other staff document maintenance needs. 4. Maintenance Director will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendation monthly for a period of three months.	**9.12.2014**

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F 323	Continued From page 46 These observations were made in the presence of Employee #1 and Employee #15 who acknowledged the findings. B. Based on observation and staff interviews for one (1) of 36 sampled residents, it was determined that the facility staff failed to maintain medications under safe and secure storage and limited access to minimize loss or diversion of all medications as evidenced by the wound cart (containing prescribed meds) observed unattended outside of Resident #42' s door during a wound care treatment. The findings include: On July 15, 2014 at approximately 9:45 AM, a wound care observation was conducted. The wound cart was observed outside of Resident #42 ' s door unlocked and unattended, while Employee #23 was inside the room performing the dressing change. The wound cart contained the following medications: Drawer #1 and Drawer #2: Scissors, Clotrimazole 1% Cream, Risanue Ointment (multiple tubes), ten (10) Arzol - Silver Nitrate Applicators (Silver Nitrate - 75%/Potassium Nitrate 25%). The front of the tube was labeled " POISON " in red. Drawer #3: Ammonium Lactate cream 12% Drawer #4: Ketoconazole cream 2% (anti fungal cream), enema supplies, and xeroform pads	F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES **Response to #B** **Resident #42** 1. Immediately upon notification of this deficiency the medication cart was locked. 2. Administrator will conduct a round to ensure treatment carts are maintained locked. 3. Environmental rounds will be conducted monthly by a work group including Maintenance Director or designee, Housekeeping Director or designee, Administrator or designee, Resident Care Coordinator or designee to identify any hazardous conditions or unlocked medication/treatment carts. Maintenance will have a work order binder on each floor to ensure other staff document maintenance needs. RNs/LPNs will be re-in-serviced to lock treatment and medication carts. 4. The Administrator will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendation monthly for a period of three months.	**9.12.2014**

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F 323	Continued From page 47 Drawer #5: Optifoam dressing supplies On July 15, 2014 at approximately 9:45 AM, a face-to-face interview was conducted with Employee # 3 and Employee # 23 regarding the findings. Both employees acknowledged the aforementioned findings. Facility staff failed to maintain medications under safe and secure storage and limited access to minimize loss or diversion.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Refer to page 48 for response F329	

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F 329	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 36 sampled residents, it was determined that facility staff failed to ensure a gradual dose reduction (GDR) was attempted for the use of an anti-depressant medication. Resident #95. The findings include: Facility staff failed to ensure that a gradual dose reduction [GDR] was attempted for the use of an antidepressant medication, Prozac for Resident #95. A review of the physician ' s orders revealed that Resident #95 was prescribed the antidepressant medication Prozac 10 mg everyday for depression (originated April 2, 2013). An interim physician ' s order dated May 23, 2014 at 9:00 PM directed, " Prozac 20 mg po [by mouth every] am (morning) for depression. The psychiatry consultation dated April 1, 2014 revealed, " Report requested regarding: Follow up on Alpraolam (Xanax- anti anxiety) ... [He/she] denies being depressed, suicidal or homicidal... Medication Psych- Xanax 0.25mg BID, Prozac 10 mg po q am for depression. Plan: Continue Prozac order, [Decrease] Xanax 0.25mg po qd. " A review of the pharmacy " Drug Regimen Review " revealed the following:	F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS **Response to Resident #95** 1. Resident #95 will be started on a gradual dose reduction of the anti-depressant Prozac. 2. RCCs will conduct an audit of pharmacist's recommendations to ensure gradual dose reduction per recommendation. 3. RCCs or designee will conduct monthly audits of pharmacist's recommendations. 4. RCCs will document findings and report to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	**9.12.2014**

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F 329	Continued From page 49 " March 18, 2014- See report for any noted irregularities and/or recommendations April 18, 2014- See report for any noted irregularities and/or recommendations. " A review of the pharmacy consultation reports revealed the following: "February 19, 2014 - [Resident #95] has received alprazolam 0.25mg daily since 4/2013. Please consider a gradual dose reduction, perhaps decreasing to 0.25 mg at bedtime ... Physician ' s response: I accept the recommendations above with the following modification(s): [Follow-up] with psychiatry. Signed by Nurse Practitioner." "April 18, 2014 revealed, Comment: [Resident #95] has received Fluoxetine (Prozac) 10mg for management of depressive symptoms since 4/2013. Recommendation: Please consider a gradual dose reduction, perhaps decreasing to Fluoxetine (Prozac) 10mg every other day, while concurrently monitoring for re-emergence of depressive and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated. Physician ' s response: Resident seen by Psychiatrist on 4/1/14. See [his/her] note. Wanted to continue current dose. Signed by Employee #30. " The clinical record lacked evidence that a gradual dose reduction for the anti-depressant medication Prozac. A face-to-face interview was conducted with Employee #30 on July 17, 2014 at approximately 3:30 PM regarding the aforementioned findings. He/she stated that although the pharmacy	F 329	Refer to page 48 for response F329	

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F 329	Continued From page 50 recommendation was dated April 18, 2014, "The psychiatrist had already evaluated the resident on April 1, 2014 and wrote a note stating [he/she] wanted the resident to continue on the same dose of Prozac. " A face-to-face interview was conducted with Employee #17 on July 18, 2014 at approximately 12:45 PM regarding the consultation report dated April 18, 2014 recommending the GDR for Prozac. He/she stated, " The nurse practitioner did document [his/her] comments; however, the psychiatrist needs to address the GDR and indicate response to accept or decline with rationale. " The clinical record was reviewed on July 18, 2014. Facility staff failed to ensure that a gradual dose reduction [GDR] was attempted for the use of an antidepressant medication.	F 329	Refer to page 48 for response F329	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on July 11, 2014 at approximately 10:00 AM, it was determined	F 371	Refer to page 52 for response F371	

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F 371	Continued From page 51 that the facility failed to store and prepare food under sanitary conditions as evidenced by one (1) of one (1) hotel pan of cooked pasta that was stored uncovered on the code production table, a half-full 16 ounces bottle of apple juice that was stored inside one (1) of one (1) ice machine, dented and/or soiled cooking utensils such as one (1) of one (1) braser, two (2) of two (2) four-inch deep third pans, four (4) of four (4) six-inch deep third pans, five (5) of five (5) six-inch deep half pans, one (1) of two (2) soiled air curtain from the dishwashing machine and a soiled and blemished kitchen floor. The findings include: 1. One (1) of one (1) hotel pan of cooked pasta was stored uncovered on the code production table. 2. A half-full bottle of apple juice was observed inside the ice machine in the kitchen. 3. Cooking utensils such as one (1) of one (1) braser and two (2) of two (2) four-inch deep third pans were dented and needed to be replaced. 4. Cooking utensils such as four (4) of four (4) six-inch deep third pans and five (5) of five (5) six-inch deep half pans were soiled and dented. 5. One (1) of two (2) air curtain from the dishwashing machine was soiled with food debris and needed to be cleaned. 6. The entire kitchen floor was marred with	F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY **Response to #1-6** 1. Immediately upon notification, the pasta was covered, the bottle of apple juice was discarded and Ice machine emptied, clean and sanitized on 7/18/2014. The dented braser and 4' deep pans were discarded and replaced. The dented soiled cooking utensils have been replaced. The air curtain was cleaned. The kitchen floor was stripped, cleaned and waxed. The kitchen floor tiles will be changed as necessary. 2. Dietary staff were reeducated on 7/24/2014 on the importance of following sanitation/infection control practices within the dietary area. Director of Dietary will conduct an environmental round to ensure sanitary conditions. 3. Director of Dietary or designee will conduct environmental rounds on a monthly basis. 4. Director of Dietary will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	**9.12.2014**

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	095027	A. BUILDING _____ B. WING _____	07/18/2014

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F 371	Continued From page 52 accumulated stained spots and discolored tiles. These observations were made in the presence of Employee #12 and Employee #1 who acknowledged the findings.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 36 sampled residents, it was determined that the medical team failed to review the total program of care as it relates to anticoagulation therapy for Resident #127 whose therapeutic anticoagulant goal was consistently subtherapeutic. The findings including A review of the clinical record for Resident #127 revealed the medical team failed to implement measures to maintain the desired therapeutic range for anticoagulation therapy. According to a " History and Physical " dated	F 386	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS **Response to #1-6** 1. Resident # 27 is no longer receiving Lovenox. Resident #27 is receiving Coumading and his PT/INR levels are within therapeutic range. 2. RCCs will review residents on anticoagulants to ensure PT/INR levels are within therapeutic range. 3. Nursing has implemented a new Coumadin Tracking form. Staff Development nurse will in-service RNs and LPNs on the use of this tracking form. Resident Care Coordinators will audit tracking form on a monthly basis. 4. RCCs will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	**9.12.2014**

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F 386	Continued From page 53 February 11, 2014 revealed Resident #127 ' s diagnoses included: " Left hemiplegia, Chronic Respiratory Failure, Bilateral Pulmonary Embolism, Deep Vein Thrombosis, Anemia, Intracranial Hemorrhage and Hypertension. " A review of physician ' s orders revealed the resident ' s medication regimen included anticoagulant therapy as follows: Physician ' s orders signed June 20, 2014 [initiated April 30, 2014] directed Warfarin sodium (Coumadin) 6mg tablet daily for pulmonary embolism. Physician orders signed June 20, 2014 [initiated May 12, 2014] directed: " Please check PT/INR [Prothrombin Time and International Normalized Ratio] Monday-Wednesday-Friday until PT/INR is consistently greater than 2.0. Notify [Medical Doctor] regarding INR result. Once INR is greater than 2.0 then check PT/INR every week then D/C (discontinue) Lovenox." [Note: physician ' s orders for May - July 2014 lacked evidence of an order for Lovenox] Consulting physician [Pulmonologist] progress notes included the following: May 11, 2014 at 9:40 AM, " ...INR remains subtherapeutic, must adjust Coumadin [to] get INR consistently greater than 2.0 to 3.0. May 12, 2014, " Needs therapeutic INR (last 5/7/14 subtherapeutic). Continue Lovenox until INR [greater than] 2.0 and less than 3.0. May 19, 2014 at 7PM, " ...Remains	F 386	See page 53 for response to F386	

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F 386	Continued From page 54 subtherapeutic with Coumadin ...continue Lovenox ... " May 28, 2014, " Status post PE (pulmonary embolism)/history of Deep Vein Thrombosis (DVT) ...get INR greater than 2.0 - 3.0 ... " July 10, 2014 10 AM, " ...remains subtherapeutic with INR [for approximately] 30 days! Need to keep INR greater than 2.0 and less than 3.0 ....adjust Coumadin to keep INR greater than 2.0 and less than 3.0 [history of pulmonary embolism/Deep Vein Thrombosis] " Progress notes recorded by the primary care physician (team) included: July 11, 2014, " Family meeting ... [assessment & plan] pulmonary embolism on Coumadin PT/INR checks [Pulmonologist named] to decide the length of Rx [medication regimen (anticoagulant)] ... " A review of physician ' s interim orders for the months of May - July 2014 revealed that the resident ' s Coumadin dosages were modified. However; the resident ' s PT/INR levels (June - July) remained subtherapeutic [below target goal of greater than 2.0 - 3.0] as follows: June 2, 2014- INR 1.3; June 4, 2014- INR 1.3; June 6, 2014- INR 1.7; June 9, 2014- INR 1.8; June 11, 2014- INR 1.7; June 18, 2014- INR 1.4; June 25, 2014 - INR 1.4; June 27, 2014- INR 1.6; June 30, 2014 - 1.7; July 2, 2014 - INR 1.5; July 7, 2014 - INR 1.5; July 10, 2014 - INR 1.3. A face-to-face interview was conducted with	F 386	See page 53 for response to F386	

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F 386	Continued From page 55 Employee #30 [Nurse Practitioner] on July 16, 2014 at approximately 2:30 PM. He/ she stated that the pulmonologist was spoken with regarding the INR being greater than 2.0 and less that 3.0 because of the resident ' s history of bilateral pulmonary embolism. A telephone interview was conducted with the pulmonologist on July 16, 2014 at approximately 5:00 PM regarding the aforementioned sub-therapeutic lab values. He/she stated that the resident ' s INR should be maintained between 2.0-3.0 because the resident had bilateral pulmonary embolism. Further stated; he/she has talked Employee #30 regarding this repeatedly. A follow-up telephone conversation was conducted with Employee #16 [primary care physician] on July 17, 2014 at approximately 1:00 PM regarding the aforementioned concerns. He/she stated the INR should be maintained between 2.0-3.0 and the pulmonologist had been writing notes repeatedly regarding maintaining the INR range between 2.0 and 3.0. Facility staff failed to review the resident ' s total program of care to ensure the desired therapeutic goal for anticoagulant therapy was obtained. The medical team documented directives [orders and progress notes] related to an anticoagulant medication, Lovenox that was not included in the resident ' s current medication regimen.The clinical record was reviewed on July 17, 2014.	F 386	See page 53 for response to F386	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	F 412		

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F 412	Continued From page 56 The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews for two (2) of 36 sampled residents, it was determined that facility staff failed to provide recommended dental services for two (2) residents. Residents' #44 and #95. The findings include 1. Facility staff failed to follow-up and/or provide recommended dental services for Resident #44. During a face-to-face interview with Resident #44 on July 10, 2014 at approximately 10:40AM the resident was asked the following question, " Do you have any chewing or eating problems[could be due to no teeth, missing teeth, oral lesions, broken or loose teeth]? He/she responded, " Yes. " The resident opened his/her mouth widely, pointed to his/her gums and said, " No teeth and I would like to have some dentures." The resident was queried whether his/her gums hurt and he/she responded, yes." A review the of the Dental Records revealed the	F 412	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS **Response to #1 & 2** **Resident #44, #95** 1. Resident #44 was seen by dentist on 7/17/14 who determined that she is not a good candidate for dentures as she does not follow commands due to her dementia. Resident #95 has been scheduled for appointment with the oral surgeon on 9/11/14. 2. RCCs will review consult folder and dentist's progress notes to identify residents who need follow-up. 3. RCCs or designees will review consult folder and dentist's progress notes monthly to ensure additional services are followed through 4. RCCs will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	**9.12.2014**

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F 412	Continued From page 57 following: On September 16, 2011, comments from the initial exam were, "Edentulous, oral cancer screening is negative." Under "Recommendations" the following statement was documented; "If patient has Medicaid, will attempt to fabricate FU/FL, (full upper/full lower) dentures. On October 11, 2011 the dentist wrote, "Patient is not interested in dentures at this time. [He/she] states that he/she has never had false teeth and ate alright w/o [without] them. Will call RP. [Responsible Party]. " There was no documentated information from the dentist in 2012. On October 23, 2013 the dentist wrote, "Annual exam. Edentulous. Oral cancer screening is negative." No additional documentation from dentist noted on the resident's clinical record. There was no documented evidence that the dentist followed up with the responsible party regarding the residents oral status from October 2011 to present. A face-to-face interview was conducted with the resident's RP at approximately 3:00PM on July 14, 2014. The RP was queried whether he/she had discussed the possibility of dentures for his/her relative with anyone. He/she responded, " Yes " and added that "It was a long time ago [does not remember exact time" The RP added that he/she wanted the dentures but was told it was not really needed because the resident was eating okay without them.	F 412	See page 57 for response to F412	

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F 412	Continued From page 58 Review of the dietary records revealed that the resident receives a Regular, Mechanical Soft diet and that his/her weight is stable. A face-to-face interview was conducted with Employee #4 at approximately 12:00PM on July 14, 2014. In response to a query regarding the resident ' s complaint of sore gums and a need for dentures the employee stated that neither the resident nor the RP had advised him/her of the problem. The employee added, " If I was aware, I would have asked the dentist to see the resident." A telephone interview was conducted with Employee #32 at approximately 3:30PM on July 14, 2014. The employee stated that he/she was unaware of the resident ' s complaint of soreness/pain to the gums and of the RP ' s desire for the resident to have dentures. The employee added, " I will evaluate the resident ' s gums and will speak to the RP regarding the dentures." The record was reviewed on July 14, 2014. The facility staff failed to follow-up and/or provide recommended dental services for one resident. 2. Facility staff failed to provide follow-up dental care in a timely manner for Resident #95. During a resident interview on July 9, 2014 at approximately 12:14 PM, Resident #95 was queried, " Do you have any chewing or eating	F 412	See page 57 for response to F412	

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F 412	Continued From page 59 problems (could be due to: no teeth, missing teeth, oral lesions, broken or loose teeth? He/she responded, " Yes, because of missing teeth. The dentist came in October and [I] was fitted... and had to be readjusted... [I] still has not received the dentures. " Resident further stated when asked if he/she had any tooth problems, gum problems, mouth sores, or denture problems, he/she responded, " Yes. " Stated, " I have a cavity in my front tooth... going across the gum line. " Proceeded to query resident if she/he had any mouth/facial pain with no relief? He/she responded, " No. " Review of Resident #95's clinical record revealed an annual history and physical dated April 6, 2014 which included diagnoses of COPD (Chronic Obstructive Pulmonary Disease), Pulmonary Hypertension, Diabetes and Hypertension.. The physician ' s monthly summary note dated July 22, 2013 at 9:00 AM revealed, " [male/female] with stable COPD, Pulmonary hypertension. Declined trach - on BIPAP (Bi-Level Positive Airway Pressure) 24 hours. " A review of the dental notes revealed the following:	F 412	See page 57 for response to F412	

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F 412	Continued From page 60 August 13, 2013- Took 1 PA [periapical radiograph] # #23, 25. PAP [periapical panaramic], abscess no discomfort. Patient has abscess near #23. Discussed with patient need for possible extraction. Patient doesn ' t want RCT [root canal treatment]. Rx [prescription]: Amoxicillin 500mg, 1 tablet every 8 hours x 7 days. August 22, 2013 revealed, " Trying PU/PL (Partial Upper/Partial Lower). Will need to reset teeth. May need to schedule extraction. Patient on Aspirin . A physician ' s order dated June 26, 2014 at 9:30 AM directed, " Dental consultation for resident with toothache. " A review of the physician ' s notes from August 2013 to present did not indicate that the resident had any dental concerns. A nurses ' note dated June 26, 2014 at 1:45 PM revealed, denies pain or discomfort .... New orders given for consult with dental for complain of toothache. " Successive nurses ' notes revealed resident denied any pain or discomfort. The clinical record lacked evidence that the resident had received any dental visits between	F 412	See page 57 for response to F412	

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F 412	Continued From page 61 August 22, 2013 and July 16, 2014. A review of the unit ' s appointment scheduling log revealed the nurse called the dentist office on July 1, 2014 and noted " office will place on list. " A face-to-face interview was conducted with Employees #6 and #5 on July 14, 2014 at approximately 12:45 PM regarding the aforementioned concerns. Employee #5 contacted Employee #32 regarding the concerns. According to a nurses ' note dated July 14, 2014 at 1:35 PM revealed, " Spoke with Employee #32 in reference to dental consult ordered on 6/26/14 and called to dentist on 7/1/14. Resident not seen by dentist, dentist in facility 7/10/14. Spoke with dentist who reported that it is difficult to see resident secondary to BIPAP, and that resident should be referred to oral surgeon at [hospital named]. Appointment is being scheduled ...Employee #32 was informed that [she/he] last saw resident in 8/13 and there was no follow up. Employee #32 informed me that she would fax a note in regards to [his/her] consultation done in 8/13. Employee #32 has ordered for resident to start on Clindamycin 150mg po [times] 7 days for toothache. Resident presently is not complain of pain or discomfort at this time ... Resident #95 updated on plan and is in agreement to go out to [named hospital] earliest appointment 8/11/14. "	F 412	See page 57 for response to F412	

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F 412	Continued From page 62 Prior to telephone discussion and documentation noted on July 14, 2014, the clinical record lacked evidence that an oral surgeon appointment was warranted secondary to resident being on BIPAP. On July 17, 2014 a follow-up visit was conducted by Employee #32. His/her dental note revealed, " 7/17/14 consult: Refer patient to [hospital named] for evaluation and treatment of necrotic and abscessed teeth including #23, 25. Rx: Clindamycin 150mg po (by mouth) q (every) 8 hours [times] 7 days ... " There was no evidence that the facility acted with timeliness on an order for a dental consultation for Resident #95 who had a " toothache " . In addition, there was no evidence the dentist made provisions/arrangements for follow-up on Resident #95 ' s dentures. A face-to-face interview was conducted with Employee #32 on July 18, 2014 at approximately 11:00 AM. He/she stated, no one called him/her nor informed him/her that the resident was having any tooth pain. It was further stated that the resident had an abscess before and was treated and there was no harm to the resident. The clinical record was reviewed on July 18, 2014.	F 412	See page 57 for response to F412	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	Continued From page 63 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: A. Based on observations, record review and staff interview, it was determined that facility staff failed to consistently monitor and ensure medication refrigerator temperatures were between 36-46 degrees fahrenheit on one(1)	F 431	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 1. The refrigerator in the 5th floor medication storage room was replaced. 2. RCCs will check refrigerator temperatures in medication storage rooms to ensure temperatures remain at 36-46 degrees Fahrenheit. 3. Environmental rounds will be conducted monthly with the Resident Care Coordinator or designee, Maintenance Director or designee, Housekeeping Director or designee, and Administrator or designee. Staff Development Nurse will re-in-service RNs and LPNs on the need to monitor the temperatures in the medication refrigerators to maintain temperatures at 36-46 degrees Fahrenheit. 4. RCCs will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	9.12.2014

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F 431	Continued From page 64 nursing unit. The findings include: An observation of a medication refrigerator in the 5th floor medication storage room was done on July 15, 2014 at approximately 4:00PM. A review of the " Refrigerator Storage Log " for July 15, 2014 revealed the temperature was recorded as 32 degrees F (Fahrenheit). After further review of the Refrigerator Temperature log revealed the following recorded temperatures: January 10, 2014 - 30 degrees F; January11, 2014 - 30 degrees F; January 15, 2014- 34 degrees F; January 24, 2014- 42 degrees F; January 31, 2014- 32 degrees F; February 10, 2014- 32 degrees F; February 27, 2014- 32 degrees F; March 6, 2014- 30 degrees F; April 20, 2014- 34 degrees F; May 1, 2014 -34 degrees F; June 2, 2014- 32 degrees F; June 7, 2014- 34 degrees F; June 15, 2014- 34 degrees F; June 18, 2014- 34 degrees F; June 26, 2014 -32 degrees F; June 28, 2014- 32 degrees F; June 29, 2014- 30 degrees F; July 1, 2014 - 34 degrees F; July 2, 2014- 32 degrees F; July 4, 2014- 34; degrees F; July 5, 2014- 32 degrees F; July 6, 2014- 34 degrees F; July 9, 2014- 32 degrees F; July 10, 2014 -30 degrees F; July15, 2014 -32 degrees F"	F 431	Refer to page 64 for response F431	

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F 431	Continued From page 65 There was no evidence that facility staff notified the maintenance department when the refrigerator items were below 36 degrees Fahrenheit as directed on refrigerator log. A face-to-face interview was conducted with Employees #2 and #20 on July 15, 2014 at approximately 4:15 PM. After reviewing the 'Refrigerator Temperature Log" form, Both employees acknowledged the aforementioned findings. The observation was conducted July 15, 2014.	F 431	Refer to page 64 for response F431	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	Refer to page 67 for response F441	

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F 441	Continued From page 66 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations made on July 11, 2014 at approximately 10:00 AM, it was determined that the facility failed to store and prepare food under sanitary conditions as evidenced by a half-full 16 ounces bottle of apple juice that was stored inside one (1) of one (1) ice machine. The findings include: A half-full bottle of apple juice was observed inside the ice machine in the kitchen. These observations were made in the presence of Employee #12 and Employee #1 who acknowledged the findings.	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. Immediately upon notification, the apple juice bottle stored inside the ice machine was discarded. 2. Re-education of dietary staff was conduced on 7/24/2014 reiterating the importance of following proper sanitization procedures. 3. Director of Dietary will conduct monthly environmental rounds identifying any infection control violations. 4. Director of Dietary will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	9.12.2014
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		

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F 463	Continued From page 67 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on an observation made during an environmental tour of the facility on July 10, 2014 at approximately 3:00 PM, it was determined that facility staff failed to maintain resident's call system in good working condition as evidenced by a non-functional call bell in one (1) of 15 resident's rooms on the fifth floor. The findings include: The call bell in resident room #5105 would not reset after it was activated in one (1) of 15 resident's rooms. These observations were made in the presence of Employee #1 and Employee #15 who acknowledged the findings.	F 463	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. The call bell in room #5105 was repaired. 2. Maintenance Director or designee will conduct environmental rounds to ensure call bells in rooms and bathrooms are working. 3. Maintenance Director or designee, Director of Housekeeping or designee, Administrator or designee, Resident Care Coordinator or designee will conduct monthly rounds. Maintenance will have a work order system on each unit for staff to document maintenance needs. 4. Maintenance Director will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	9.12.2014
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 469		

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F 469	Continued From page 68 Based on observations made throughout the survey period from July 8 2014 through July 14, 2014, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects seen on the fourth, fifth and sixth floor. The findings include: Flying insects were seen several times in resident's areas located on the fourth, fifth and sixth floor. These observations were made throughout the survey period from July 8, 2014 through July 14, 2014.	F 469	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM 1. Pest control measures will be implemented to control flying insects on the fourth, fifth, and sixth floor. 2. Maintenance Director will conduct an environmental round to ensure pest control issue related to flying insects has been resolved. 3. Environmental rounds will be conducted with a work group including Director of Maintenance or designee, Director of Housekeeping or designee, Resident Care Coordinator or designee, and Administrator or designee monthly. The Pest Control company will be required to communicate with maintenance and nursing staff prior to doing rounds. 4. Director of Maintenance will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514		9.12.2014

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F 514	Continued From page 69 A. Based on record review and staff interview for one (1) of 36 sampled residents, it was determined that facility staff failed to maintain clinical records in a complete; accurately documented; readily accessible; and systematically organized manner, as evideced by wound sheets not readily accessible for an active clinical record. Resident #42 The findings include: A review of the physician's orders directed: May 2, 2014- " Right Heel: Cleanse with normal saline, pat dry, apply santyl ointment mixed with mupirocin ointment followed by maxorb and roller gauze every day and prn (as needed)" June 17, 2014 at 5:01 PM-" D/C (Discontinue) previous santyl + 2% Muprocin TX (treatment) for [right] heel wound treatment secondary to non-covered by insurance. Right heel wound-Cleanse with [Normal Saline Solution], Pat dry then apply santyl ointment with dry dressing QD (every day) and prn (as needed). " On July 15, 2014 at approximately 12:30 PM the State Agency Representive reviewed the active clinical record for Resident #42. During the reveiw, wound and skin sheets from April 30, 2014 to June 3, 2014 were not located on the active clincial record. At this time Employees #3 and #8 were queried as to the wereabouts of the wound and skin sheets. Employee #3 the retrieve the wound and skin shets from his/her computer and placed in them active clinical record.	F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 1. Resident #42 has the wound and skin sheets on the chart Resident #42 has the wound treatments documented on the wound skin treatment sheets. Resident #95 will have showers documented on the log sheet. Resident #127 is no longer receiving Lovenox. Resident #134's order for nutritional supplements was discontinued. 2. Resident Care Coordinators or designee will audit resident charts, to ensure wound and skin sheets are in the charts Resident Care Coordinators or designee will audit Treatment Administration Records, Medical Administration Records, to ensure wound treatments are documented on the wound skin treatment sheets, and that Lovenox orders are transcribed to the MAR Resident Care Coordinators or designee will audit shower logs and dietitian's consult folder to ensure showers are documented and dietitian's recommendations are followed through 3. Staff Development nurse will re-in-service CNAs on the use of shower logs. Staff Development nurse will re-in-service RNs/LPNs on transcription of orders and on following consultant's recommendations. Resident Care Coordinators or designee will audit resident charts, MARs, TARs, shower logs, and dietitian's consult folder monthly. 4. Resident Care Coordinators will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendation monthly for a period of three months.	9.12.2014

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F 514	Continued From page 70 Employee #3 was queried, " What is the process of maintaining the wound sheets in the active clinical record? " He/she responded, " The wound team rounds every week. The wound nurse measures and assess the wound. Afterwards, the charge nurse dress the resident ' s wound. The wound and skin care sheet is completed by the wound nurse and e-mailed to the clinical managers and director of nursing usually one-two days. The clinical manager prints it from the computer and places it in the resident ' s chart. Facility staff failed to maintain complete and systematically organized medical records as evidence by wound and skin sheets were not readily available on the active clinical record. B. Based on a resident interview, staff interviews and clinical record review for four (4) of 36 sampled residents, it was determined that the facility staff failed to accurately document one (1) resident's wound treatment onto the wound skin treatment sheets; failed to consistently document one (1) resident's baths and showers onto the the log sheet; failed to transcribe a physician's order for Lovenox onto the Medication Administration Record (MAR) for one (1) resident; and failed to transcribe an order to discontinue nutritional supplements on to the June 2014 and July 2014 Medication Administration Records for one (1) resident. Residents' #42, #95, #127 and #134. The findings include:	F 514	Refer to page 70 for response F514	

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F 514	Continued From page 71 1. Facility staff failed to accurately document Resident #42 ' s prescribed wound treatment onto the wound treatment sheets. The physician ' s order dated June 17, 2014 at 5:01 PM directed, " D/C (Discontinue) previous Santyl + 2% Muprocin TX (treatment) for [right] heel wound treatment secondary to non-covered by insurance. Right heel wound- Cleanse with [Normal Saline Solution], Pat dry then apply Santyl ointment with dry dressing QD (every day) and prn (as needed). " A dressing change observation was conducted on July 14, 2014 at approximately 9:45 AM. At this time the State Agency Reprehensive observed Santyl ointment being applied to right heel. A review of the " Wound and Skin Care Progress Note " sheets from June 18, 2014 to July 9, 2014 revealed, " Location: Right heel; Stage/ Etiology- unstageable, Treatment: Continue Santyl + 2% Mupirocin TX (Treatment) as per order. " A face-to-face interview was conducted with Employee #24 on July 15, 2014 at approximately 12:15 PM regarding the aforementioned findings. He/she stated, "We continued to write the treatment as Santyl and 2% Mupirocin because we thought the resident was receiving the same treatment. No one informed us (wound team) that the treatment has changed." The clinical record was reviewed on July 15, 2014.	F 514	Refer to page 70 for response F514	

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F 514	Continued From page 72 Facility staff failed to accurately document Resident #42 ' s prescribed wound treatment onto the wound and skin care progress notes. 2. Facility staff failed to consistently document resident ' s bath and showers on log sheet for Resident #95. During a resident interview conducted on July 9, 2014 at approximately 11:58 AM, when queried, " Do you choose whether you take a shower, tub, or bed bath? He/she responded, " No. " He/she further stated; " I suppose to get a shower on Tuesday and Fridays on evening shift, but it is not consistent. " A review of the resident ' s " bath/shower log " revealed resident ' s shower days were Tuesdays and Fridays on 3PM-11PM shift. However, from February to July 2014 the resident received bed baths on designated shower days. A face-to-face interview was conducted with Employee #5 on July 14, 2014 at approximately 11:45 AM. He/she acknowledged the aforementioned findings. He/she further stated, " When a bed bath was given, there should have been documentation that a shower was offered and if resident refused. " The clinical record was reviewed on July 14, 2014. There was no evidence that facility staff consistently documented the resident ' s bath and showers on log sheet. 3.Facility staff failed to transcribe a physician ' s	F 514	Refer to page 70 for response F514	

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F 514	Continued From page 73 order for Lovenox onto the Medication Administration Record (MAR) for Resident #127. The "History and Physical "dated January 24, 2014 revealed that Resident #127 ' s diagnoses included: " Left hemiplegia, Chronic Respiratory Failure, Bilateral Pulmonary Embolism, Intracranial Hemorrhage and Hypertension. " A physician's interim order dated January 28, 2014 directed, " Lovenox 30mg SQ (subcutaneously) QD (everyday) - Dx (Diagnosis) - Anticoagulation Tx (Treatment). " A review of the January 2014 Medication Administration record lacked evidence that the order to administer Lovenox 30 mg SQ was transcribed onto the MAR. A face-to-face interview was conducted with Employees #5 and #6 on July 16, 2014 at approximately 2:30 PM. Both employees acknowledged the aforementioned findings. The clinical record was reviewed on July 16, 2014. Facility staff failed to transcribe a physician ' s order for Lovenox onto the Medication Administration Record. 4. Facility staff failed to transcribe an order to discontinue nutritional supplements on to the June 2014 and July 2014 Medication Administration Records for Resident #134. The History and Physical dated February 9, 2014 for Resident #134 included the following diagnoses: Cerebral Vascular Accident (stroke) 2008, Pontine Hemorrhage 2013, Left	F 514	Refer to page 70 for response F514	

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F 514	Continued From page 74 Hemiplegia, Hypertension, Obstructive Sleep Apnea, Tracheostomy, Peg Tube [feeding tube]. A telephone order dated May 28, 2014 directed, " D/C [discontinue] Beneprotein [nutritional supplement] related to wound healing, D/C [discontinue] Juven [nutritional supplement]." A review of the June 2014 and July 2014 'Physician's Order Forms' revealed the following orders dated April 28, 2014: " Juven 7G[gram]-7G [gram] - 1.5G [gram] packet, 1 packet dissolved in liquid by mouth twice daily ...and Resource Beneprotein 7GM [gram] packet, 1 packet dissolved in liquid by mouth twice daily..." On July 14, 2014 at approximately 9:45 AM, a face-to-face interview was conducted with Employee #3 regarding the resident's discontinued orders. He/she confirmed that although the supplements were actively on the 'Physician's Order Forms,' the resident was no longer receiving the supplements. The April 2014 Medication Administration Record [MAR] documentation indicated they were discontinued as evidenced by the following markings beside the Juven and Resource Beneprotein, " D/C [discontinue] May 28, 2014 ". A review of the June and July 2014 MARs revealed that here were no nursing initials in the designated areas to indicate that the supplements were given. Facility staff failed to transcribe an order to discontinue nutritional supplements on to the June 2014 and July 2014 Medication Administration Records.	F 514	Refer to page 70 for response F514	

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F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for nine (9) of 36 sampled residents and eight (8) of 40 supplemental residents, it was determined that the facility ' s Quality Assessment and Assurance (QAA) Committee failed to develop, implement, and /or revise appropriate corrective actions for the identified deficient practice as necessary. Residents #38, #42, # 48, #55, #58,	F 520	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 1. MDSs for residents #38, #42, #48, #58, #95, #111, #134 , S50, S65, S83, S119 will be corrected. Residents #55, #113, S123, S16, S26 no longer resides in the facility, therefore; no further measures could be taken. 2. MDS coordinator will audit residents' MDSs to ensure V-section is complete. 3. MDS coordinator or designee will audit MDSs on a monthly basis for completion. Quality Assurance Coordinator will in-service Quality Assurance Committee members as to the need to address concerns to the committee 4. MDS coordinator will document findings and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of three months. Quality Assurance Coordinator will prompt members to address any concerns during quality assurance committee monthly for a period of three months	9.12.2014

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F 520	Continued From page 76 #95, #111, #113, #134, and eight (8) supplemental residents: S16, S26, S40, S50, S65, S83, S119, S123. The findings include: During the survey, the following area of concern was identified: Facility staff failed to ensure that the Minimum Data Sets were accurately coded under Section V, Care Area Assessment. On July 17, 2014 at approximately 3:20 PM, the Interim Director of Nursing was interviewed regarding their QAA Committee ' s identification of the concern listed above. It was stated that the committee members had not identified concerns related to the MDS-CAA summary. Upon notification of the concern, the system problem was corrected immediately. There was no evidence that the Quality Assurance Committee identified and developed corrective measures to address the aforementioned concern prior to the start of the QIS survey (July 8, 2014).	F 520	Refer to page 76 for response F520	