April 16, 2015

Ms. Sharon Williams Lewis
Program Manager
Government of the District of Columbia
Department of Health
Health Regulations Administration
899 North Capitol St., N.E. 2ND Floor
Washington, D.C. 20002

Dear Ms. Lewis:

Enclosed is the Plan of Correction for the deficiencies cited during our annual survey from February 4, 2015 through February 20, 2015 by surveyors here at Deanwood Rehabilitation and Wellness Center for L-Tags.

Should you have any questions, please feel free to contact me at (202) 399-7504, ext. 535.

Respectfully submitted,

Rose Marie Gilliam, BS, MHSA, LNHA
Administrator

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: _____ B. WING _____	02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

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L 000	Initial Comments A Licensure Survey was conducted on February 5, 2015 through February 20, 2015. The following deficiencies are based on observations, record review, resident and staff interviews for 51 sampled residents. 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 DCMR- District of Columbia Municipal Regulations 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 ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass)	L 000	Please begin typing your responses here:	

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: L Coellan | TITLE: Administrator | (X6) DATE: 4/16/15

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L 000	Continued From page 1 mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury Neuro - Neurological NP - Nurse Practitioner 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 Sol- Solution TAR - Treatment Administration Record Trach - Tracheostomy Vent - Ventilator	L 000	L001(A1, A2) same as F-Tag 156 (1&2) 1.The department had the resident's family come in and sign an updated form and informed the family which services are covered / not covered. The admission department provided information about Deanwood's bed-hold policy to the other resident's family. Admissions has also added that name that was missing from the financial document.	
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: A. Based on record review, family, and staff interviews for two (2) of 51 sampled residents, it was determined that the facility staff failed to inform the resident and/or RP [Responsible Party] of costs and services that he/she would or would not be charged for, as evidenced by the staff's failure to inform the resident and/or RP of	L 001	2. All other admissions packets were reviewed or completeness and no other contracts were found to have these same deficient practice upon admission, all residents/responsible parties will receive accurate information of covered, and non-covered services as well as information on the bed-hold policy. All admission documents will be reviewed to ensure all information is accurately been inserted. All residents/ responsible parties will sign documents acknowledging receipt of the information given.	

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L 001	Continued From page 2 available services in the facility and the charges for those services for one (1) resident and failed to obtain documented evidence to demonstrate receipt of explanation for the bed hold policy for one (1) resident. Residents' #156 and #388. The findings include: 1. A review of the admission record revealed that the resident was admitted to the facility on January 1, 2015. On February 6, 2015 at approximately 11:30 AM, a family interview was conducted for Resident #156. The question was asked, "If the resident is on Medicaid, did the staff give her/him (or you), a list of services and items that you would and would not be charged for? The family member responded, "No, they didn't." On February 12, 2015 at approximately 2:30 PM, a face-to-face interview was conducted with Employee #21. He/she was asked to provide a list of services and items that the resident would or would not be charged for. He/she stated that the services and items have variable prices, so the exact prices could not be written. The employee continued to explain that general prices were discussed upon admission, and the list of prices was in the admission package or with the activities director. He/she did not find the list in the admission package, and could not produce the requested price list(s). On February 13, 2015 at approximately 10:30 AM, a face-to-face interview was conducted with Employee #35 regarding the price list for services and items that the resident would or would not be charged for. He/she stated, "We don't provide costs on the list in the admission packets	L 001	3. The admissions department will conduct an audit all resident files to ensure all residents have received information regarding costs of covered and non- covered services as well as information regarding bed-hold policy. All signed information will be reviewed to ensure that information regarding the residents name and signatures have been properly inserted. The admission department will also track receipt of this information via spreadsheet and all future admissions to ensure timely delivery of information. 4.The admissions department will report on a monthly basis to the QAPI committee any deficient practices.	5/12/15

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L 001	Continued From page 3 because costs change from time to time." On February 13, 2015 at approximately 10:50 AM, a face-to-face interview was conducted with Employee #20 regarding the price list for services and items that the resident would or would not be charged for. He/she stated, "The only lists of costs given to the residents, during orientation, from the activities department are for beauty and barber services." Employee #21 acknowledged the aforementioned findings. The clinical record was reviewed on February 12, 2015. 2. Facility staff failed to obtain documented evidence to demonstrate that Resident #388 ' s responsible party was in receipt of and received an explanation of the facility ' s rules and regulations for the bed hold policy. A family interview was conducted with Resident #388 ' s responsible party on February 6, 2015 at approximately 11:28 AM. When asked, " Have your relative/friend been discharged to a hospital within the past several months? " He/she responded, " Yes. " " Were you notified of the facility policy permitting him/her[Resident #388 ' s] to return? " He/she stated, " No. " A review of the clinical record for Resident #388 revealed that he/she was initially admitted to the facility on January 9, 2015. The resident's name was printed on the signature line of the admission documents. The RP [Responsible Party] name was documented as being the designated representative. The lines next to each of the seven documents listed were blank.There was no evidence that	L 001		

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L 001	Continued From page 4 Resident #388 ' s responsible party initialed the allotted spaces to attest that the documents and/or an explanation of the document(s) were received for the bed hold policy. A face-to-face interview was conducted with Employee # 21 on February 10, 2015 at approximately 10:00 AM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on February 10, 2015. B. Based on record review and staff interviews for one (1) of 30 census sampled residents who were interviewed in a total sample of 51 residents, it was determined that the facility staff failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, as evidenced by failure to ensure that an employee who was accused of abusing a resident(s) completed a plan of action that was developed to correct his/her behavior. Resident #49. The findings include: A review of facility policies: Abuse Prohibition Policy - Social Services [no date recorded] revealed the following: " This policy is aimed at promoting the rights of residents to be free from verbal, sexual, physical and mental abuse ...depending on the facts of the investigation, appropriate action will be taken against the offender, as determined by the Director of Nursing or the Administrator ...all alleged violations, substantiated incidents; corrective actions depending on the results of the investigation are reported verbally within 48 hours (8 hours if harm) and in writing ... "	L 001	L001B same as F-Tag 226 1. Resident # 49 was assessed and did not have any negative outcome related to the allegation regarding employee #31 lack of providing ADL care to the resident. Employee #31 is no longer employed by the facility. 2. All residents have the potential of being affected by the facilities failure to properly implement and follow their policy on the prevention of abuse and neglect. The manager involved was educated on the correct use of the disciplinary form, writing a performance improvement plan for another employees work performance and the follow through required. The Social worker interviewed all residents on employee #31 assignments to ensure no other concerns were identified with her work performance and care of her residents. 3. All managers were educated on the policy for the prevention of abuse and neglect by the Director of Social Services. Education also included the correct use of the disciplinary form, writing a performance improvement plan for another employees work performance and the follow through required. All allegations of a abuse will be reviewed by the Administrator to ensure the process was followed as outlined in the policy and discipline up to and including termination is completed as indicated.	

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L 001	Continued From page 5 Abuse Prohibition Policy - Administration [no date recorded] " ....each resident has the right to be free from abuse, corporal punishment and involuntary seclusion ...Supervisor/Department Head will immediately initiate an investigation and give an oral report to the administrator ...the employee will be placed on administrative leave pending results of the facility investigation of the alleged abuse ...the employee will be notified of the findings and disciplinary action will follow, which may include termination ...if the findings are substantiated, a report will be submitted to the Department of Health ... " Facility staff failed to fully implement its policy for abuse prohibition when its investigation determined that a resident ' s allegation of mistreatment by Employee #31 was substantiated. A subsequent allegation of mistreatment related to failure to provide assistance with activities of daily living was verbalized against the same employee during a face-to-face interview with Resident #49 on February 6, 2015 at approximately 11:43AM. During an interview with Resident #49 on February 6, 2015 at approximately 11:43AM, he/she stated that employees often refuse to change [his/her] incontinent brief, when requested. The resident stated that employee(s) usually respond by saying "I just changed you. I'm not changing you again." The complaint was reported to the facility. The Social Worker who investigated the complaint and the resident identified the employee [Employee #31] who allegedly failed to provide incontinent care. The employee was then suspended and according to Employee #2, will remain suspended pending the outcome of the	L 001	4. All disciplines and employee performance improvement plans will be reviewed by HR and the manager prior to meeting with the staff. Identification of a planned follow up will be noted by HR and the manager. The Director of HR will monitor and track disciplines to ensure follow up has been completed and ensure a progressive discipline process when needed. Results of this audit will be reported through the QAPI process.	5/12/15

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L 001	Continued From page 6 investigation. A review of Employee #31's personnel file revealed that the employee was identified in a former abuse allegation related to "Resident/s alleged that he/she exhibited unsatisfactory work and attitude, inappropriate behaviors, and disorderly conduct" on March 25, 2014. The facility ' s investigation of the March 25, 2014 allegation was substantiated and the employee was suspended; reassigned and placed on a performance improvement plan. A review of the ' Performance Improvement Plan' developed by the facility for Employee #31 revealed the following: The form instructed, " Check one " and there were three (3) asterisked areas that identified each area. The areas were *Competency, *Policy and *Procedure Improvement. None of the areas were checked. The form further instructed to " Describe below the specific situation in detail. " The descriptions were documented as follows: " 1. Resident/s alleged that you exhibited unsatisfactory work and attitude, in appropriate behaviors, Disorderly conduct. 2. You did not follow chain of command. 3. Resident/s alleged that you have used abusive language. 4. Residents alleged intimidation or coercing [coercion] by you. " The ' Action Plan ' form revealed the following information: Action Plan: Time Frame	L 001		

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L 001	Continued From page 7 Completed 1. You will exhibit a professional and positive attitude at all times. 14 days 2. You will be respectful to residents, their families and staff. 14 days 3. You will exhibit an orderly conduct at all times. 14 days 4. You will perform your job duties and responsibilities as required. 14 days 5. You will not use abusive language while on duty caring for residents. 14 days 6. You will follow the chain of command at all times. 14 days 7. You will now be transferred to [named] unit effective immediately. 14 days 8. You will not be paid for the days you were suspended. 14 days The area designated "Completed" remained blank [no data was entered in this section]. Additional information that was at the bottom of the form revealed the following:	L 001		

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L 001	Continued From page 8 "This action plan is being given to you so you will have an opportunity to correct the performance deficiency discussed with you. Your Nurse Manager will meet with you in 14 days to discuss with you any improvement or failure to correct the deficiencies addressed in this Action Plan. Failure to adhere to the terms of the Performance Improvement Plan will lead to immediate termination." The following statement was written beneath the preceding passage: "You are to attend in-services on Mental Health, Abuse Prohibition." Another statement followed [on page 2]: "I have read and understand the above Action Plan and have discussed it with my supervisor. I am aware of the rules and requirements involved." The statement was signed by the employee and dated March 25, 2014. There was a statement that indicated that a follow-up meeting would be on or about April 9, 2014. The document was signed and witnessed by two (2) supervisors. The next section on the form addressed the follow-up and revealed the following: "Follow-up meeting: completed ...Plan of Correction: *Successfully Completed ... *Ongoing: *Not completed " Nothing was checked to indicate whether the training was successfully completed, ongoing or not completed.	L 001		

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L 001	Continued From page 9 The areas on the form designated for the supervisor's signature and date were left blank. The employee ' s signature was present in the designated area, but the area for the date was left blank. A face-to-face interview was conducted with Employee #2 on February 19, 2015 at approximately 4:00 PM. He/she stated that the ' Plan of Action ' was completed. However, Employee #2 could not explain the incomplete documentation, omission of signatures and dates, and could not provide evidence that Employee #31 satisfactorily completed the performance improvement plan. There was no evidence that the facility followed its abuse prohibition policy as it relates to corrective actions/disciplinary actions. A performance improvement plan was developed to address Employee #31 ' s behaviors but not followed through. C. Based on record review, resident and staff interview for two (2) of 51 sampled residents, it was determined that the facility failed to provide routine drugs to its residents as evidenced by failure to ensure that the pharmacy delivered prescribed medications in a timely manner to meet the needs of two (2) residents. Residents #211 and 352. The findings include: Review of the facility contract provided to the State Agency Representative with [Pharmacy	L 001	L001 C1 &C2 same as F-Tag 425 (1&2) 1.Resident #211, and #352was assessed by unit managers. Residents did not experience any ill outcome related to facilities failure to obtain prescribed medications from the pharmacy timely. All residents have the potential to be effected by this deficient practice. 2. All other residents charts were audited to ensure that no other residents were affected by this same deficient practice. 3.Facility has developed a new process to ensure all new residents medications will be delivered to the facility timely by pharmacy, including late hours fax and medication prep for delivery. Dedicated telephone with supervisor on duty to ensure prompt communication to pharmacy. Back up pharmacy will also be utilized in the event of weather related conditions that could delay the delivery of meds from pharmacy. The backup med box in the facility was updated to include a larger list of meds. Policy and procedure for medication availability was revised. Staff development will in-service all license staff on new procedure. Policy and procedure for medication availability was revised. Staff development will in-service all license staff on new procedure. 4. Results of monthly audits will be reviewed monthly through the QAPI process to identify any opportunities for improvement and education.	5/12/15

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L 001	Continued From page 10 Name] signed by the facility on October 28, 2014 but not signed by the pharmacy stipulates in Article1.3 titled 'Methods of providing services', Section C: "The Pharmacy will deliver Medication and provide services to the Facility seven (7) days a week, 365 days a year, with modified schedules during national holidays based on daily delivery schedule mutually determined by the Facility and the Pharmacy. Emergency delivery of Medications will be done by the pharmacy during normal business hours, except for circumstances beyond the Pharmacy's reasonable control and emergency services will be available after hours through an answering service with a pharmacist on call." 1. Facility staff failed to obtain prescribed medications from the pharmacy for Resident #211. A review of the resident's clinical record revealed that the resident was discharged to an area hospital on February 6, 2015 and returned to the facility on February 10, 2015 with prescriptions which included: Spiriva Hand Inhaler Capsules 18mcg [micrograms] 1 puff inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease) with a start date of February 11, 2015 and Xarelto tablet 20mg Give one (1) tablet one time a day for DVT (Deep Vein Thrombosis) prophylaxis. Start date February 11, 2015. A face-to-face interview was conducted with the resident at approximately 3:00 PM on February	L 001		

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L 001	Continued From page 11 13, 2015. He/she informed this writer that he/she had not received some of his/her medications for two (2) days on February 11 and 12, 2015. A review of the Medication Administration Record (MAR) revealed that the nurse's signature was circled in the designated area to indicate that the Spiriva Hand Inhaler and Xarelto were not administered as ordered on February 11, and February 12, 2015. A face-to-face interview was conducted with Employee #12 at approximately 4:00 PM on February 13, 2015. The employee was asked why the resident had not received his/her medications as ordered by the physician. The employee responded: "The medications were not given because they were not received from the pharmacy. They are here now and the resident received them today". The employee acknowledged the finding. The record was reviewed on February 13, 2015. 2. The facility's contract pharmacy failed to deliver medications in a timely manner for Resident #352. A review of the Physician's Order signed and dated by the physician on October 5, 2014 revealed: " Bidil [antihypertensive] 20-37.5mg [milligrams] BID [two times a day] take one tab PO [by mouth] BID - Hypertension " On the back of the MAR documentation revealed: "10/06/2014 0900 meds not given. Pharmacy did not send the meds. Pharmacy was called and	L 001		

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L 001	Continued From page 12 they said the meds will be send [sent] tomorrow"; "10/06/2014 1800 Bidil 20-37.5mg not given , medication not available pharmacy notified" A Physicians Order signed and dated by the physician on October 5, 2014 revealed: "Coreg (Carvedilol)[antihypertensive] oral 6.25mg BID [two times a day] Take 1 tab PO BID - HTN " " Wellbutrin (Bupropion Hcl)[antidepressant] - Oral By mouth Dose 150mg BID two times a day Take 1 tab PO BID depression " " Lisinopril [antihypertensive] - Dose 5 mg Take 1 tab PO Daily Hypertension " " Plavix (Clopidogrel Bisulfate)[anti-platelet] Take 1 tab PO Daily CHF " " Abilify (Aripiprazole)[antidepressant] 15mg Take 1 tab PO daily - depression " On the back of the MAR documentation revealed, "10/06/2014 0900 Meds were not given - pharmacy did not send it. Pharmacy was called and they said it will be sent tomorrow " The Physicians Order signed and dated by the physician on October 5, 2014 revealed: " Glipizide[anti-diabetic] 5mg Take 1 tab PO daily Diabetes Mellitus " On the back of the MAR documentation revealed, " 10/06/2014 0900 Meds were not given - pharmacy did not send it. Pharmacy was called and they said it will be sent tomorrow " " Lipitor (atorvastatin) [anti-cholesterol] 40mg bed time hs take 1 tab PO daily - hyperlipidemia " On the back of the MAR documentation revealed,	L 001		

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L 001	Continued From page 13 " 10/06/2014 2100 Lipitor not given, medication not available pharmacy notified " " Glipizide [anti-diabetic] ER tablet Extended Release 24 hour 2.5mg Give 2.5mg by mouth one time a day for diabetes " On the back of the MAR documentation revealed: "10/11/2014 0900 Pharmacy did not send Glipizide 2.5mg. Pharmacy was called and it will be send tomorrow; 10/12/2014 0900 Glipizide was not send as promised by pharmacy. Nurse has called pharmacy and fax the order; 10/18/2014 0900 Pharmacy did not send Glipizide 2.5mg. Pharmacy was informed " A face-to-face interview was conducted with Employee #53 on February 11, 2015 at approximately 1:30 PM. He/she acknowledged the aforementioned findings. Facility staff failed to obtain Resident #352' s prescribed medications for administration from the contract pharmacy. The record was reviewed on February 11, 2015. D. Based on observation, record review, and interviews for one (1) of 51 sampled residents, it was determined that Employee #3 failed to demonstrate knowledge of one (1) resident ' s respiratory care needs and the medical respiratory equipment utilized for the management of Resident #99 ' s respiratory condition. The findings include:	L 001	L001 D 1. Retrospectively nothing can be done as Resident # 99 no longer resides at the facility. 2. All residents have the potential to be affected by the deficient practice of staff failing to demonstrate the knowledge of residents respiratory care needs and medical respiratory equipment utilized for the management of respiratory needs. All Licensed staff will be in-serviced on the knowledge of residents respiratory care needs and the management of respiratory equipments. In-services will be provided by staff Development and the respiratory therapist. 3. Competencies will be conducted on all Licensed Nurses by Staff Development and Respiratory Therapist. Regional Respiratory Therapist will also be available to conduct in-service education. 4. Results of the competencies will be forwarded to the Administrator and the D.O.N. Results will be discussed in the monthly QAPI meeting. Identified area of concern will be forwarded for education and compliance.	5/12/15

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L 001	Continued From page 14 Title 17 DCMR Chapter 54, 5414.1, stipulates: " The practice of registered nursing means the performance of acts requiring substantial specialized knowledge, judgment, and skill based upon the principles of the biological, physical, behavioral, and social sciences ... " An initial tour was conducted on the 2nd Floor on February 5, 2015 at approximately 10:00 AM. When asked about the characteristics of the resident population on the floor, Employee #3 stated there was one resident [Resident #99] with a trach [tracheostomy] and vent [ventilator]. Upon observation, Resident #99 was observed with a tracheostomy collar connected to an oxygen compressor, which was located on top of the bedside stand, proximal to resident ' s left side. The resident was not observed using a ventilator. Resident #99 was admitted to the facility on December 27, 2014. A physician ' s history and physical dated December 30, 2104 revealed medical diagnoses that included: " Laryngeal Neck Mass, Status Post Laryngectomy, Bilateral Neck Dissection and Status Post Pectoralis Flap. " Review of the physician ' s orders signed and dated December 28, 2014 directed the following: " Tracheostomy care to be performed every shift and as needed. Every shift for tracheostomy tube. " Further review of the physician ' s orders signed and dated February 2, 2015 directed: " Change oxygen circuit once a week, one time a day every Wednesday for oxygen concentrator. " Review of the Admission MDS (Minimum Data Set) dated January 3, 2015 under Section O	L 001		

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L 001	Continued From page 15 (Special Treatments and Programs - Respiratory Treatments) revealed that the resident was coded for oxygen therapy, suction and tracheostomy care. On February 5, 2015 at approximately 3:15 PM, a follow-up face-to -face interview was conducted with Employee #3 regarding Resident #99 ' s respiratory care needs. He/she acknowledged that the resident had a tracheostomy and was not connected to a ventilator. The observation and clinical record review was conducted on February 5, 2015.	L 001		
			L024 same as F-Tag 492 (1)	
L 024	3206.3 Nursing Facilties Policies shall be reviewed by the committee at least annually with written notations, signatures, and dates of review. This Statute is not met as evidenced by: Based on clinical record review, resident interview, and staff interviews for one (1) of 51 sampled residents, it was determined that the facility staff failed to comply with applicable federal, state, and local laws and regulations, as evidenced by staff's failure to provide evidence that facility policies were reviewed annually. The findings include: On February 18, 2015 at approximately 3:15 PM, during a policy review, it was revealed that the policies in the policy manual list numbered "NSD04-001 to NSD04-160" had blank areas in the "Date Reviewed," "Date Revised," and "Date Approved " spaces allotted for facility documentation. The policies lacked evidence of	L 024	1.The annual review form for the Nursing policy and procedure manual has been revised. 2.A copy of the annual review form for the nursing policy and procedure manual will be turned into the Administrator upon the day of review. 3.The D.O.N will ensure that the Nursing policy and procedure review form will be updated annually and turned into the Administrator for review. 4. This will be brought through the QAPI process annually to ensure compliance.	5/12/15

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L 024	Continued From page 16 documented notations, signatures, and dates of review. On February 18, 2015 at approximately 3:30 PM, a face-to -face interview was conducted with Employee #1 regarding the aforementioned findings. He/she explained that they have a signature page in the original policy book that was signed and dated. He/she provided the signature page for review. When asked about the written notations and revisions, he/she did not provide the requested information. Facility staff failed to provide evidence that facility policies were reviewed annually. The policies were reviewed on February 18, 2015.	L 024	L027 same as F-Tag 492 (B2) 1. Resident # 392 no longer resides in the facility. Resident #148 was assessed. There was no ill effect noted from the deficient practice of physician not completing the H & P timely (72hrs). Retrospectively nothing can be done. 2. All residents have the potential to be affected by the deficient practice of physician H & P not done timely. (72hrs). 3.An audit was created to track physician visits within 72 hours. Medical records will complete a monthly audit to ensure compliance. A new system was developed by Administration for physician assignment to new admission for compliance. 4. Audits will be turned in to the MD, Administrator and DON to ensure compliance. Results will be present in the monthly QAPI meeting. Areas of concern will be discussed and follow up by Medical Director.	5/12/15
L 027	3207.2 Nursing Facilities The Medical Director shall: (a)Coordinate medical care in the facility; (b)Implement resident care policies; (c)Develop written medical bylaws and medical policies; (d)Serve as liaison with attending physician physicians to ensure the prompt issuance and implementation of order; (e)Review incidents and accidents that occur on the premises to identify hazards to health and safety; (f)Ensure that medical components of resident care policies are followed;	L 027		

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L 027	Continued From page 17 (g)Assist the Administrator in arranging twenty-four (24) hours of continuous physician services a day for medical emergencies and in developing procedures for emergency medical care; and (h)Ensure that attending medical professionals who treat residents in the facility have current District of Columbia licenses, U.S. Drug Enforcement Agency and D.C. Controlled Substance registration on file in the facility, along with initial and annual certification of their freedom from communicable diseases. This Statute is not met as evidenced by: Based on clinical record review and staff interview for one (1) of 51 sampled residents, it was determined that the facility staff failed to comply with applicable federal, state, and local laws and regulations, as evidenced by the physician ' s failure perform the resident's history and physical assessment within 72 hours of admission. Resident #392. The findings include: According to 3207.2 of the District of Columbia Municipal Regulations, " The Medical Director shall: (i) Ensure that each resident is seen by a physician within seventy-two (72) hours after admission and that the physician has included in the record information identified in sub-section 3231.12. A review of the admission record revealed the resident was admitted to the facility on February 9, 2015.	L 027		

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L 027	Continued From page 18 A review of the clinical record lacked documented evidence of a history and physical. A review of the February 2015 'Order Summary Report' lacked documented evidence of the resident's admitting diagnoses. On February 19, 2015 at approximately 9:30 AM, a face-to-face interview was conducted with Employees #11 regarding the aforementioned findings. He/she acknowledged the absence of the history and physical on the clinical record, and stated that he/she would place a call to the physician regarding the matter. On February 19, 2015 at approximately 4:00 PM, Employee #11 provided a history and physical for Resident #392, dated February 13, 2015. He/she stated that he/she "found the physician who just completed the history and physical. The physician stated he/she had performed a history and physical prior to this one, but it must have been lost." The clinical record was reviewed on February 19, 2015.	L 027	L036 1. Resident #148 was admitted to the facility on 12/12/2014. The resident was examined by the attending physician on 12/13/14, and a history and physical was completed. 2. All other residents H&P were checked to ensure compliance. All residents have the potential to be affected by this deficient practice. 3. The Medical Director was notified of the findings. The Medical Director communicated to all other physicians. Medical Records Coordinator will ensure that all residents' active records are in the active chart order. Audits will be conducted by the unit secretaries monthly and all findings shared with physicians. 4. Results of the audits will be turned into the D.O.N for review and discussed in the monthly QAPI meeting for compliance. Any potential need for education will be identified and followed through.	
L 036	3207.11 Nursing Facilities Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. This Statute is not met as evidenced by: Based on clinical record review and staff interview for one (1) of 51 sampled residents, it was determined that the facility staff failed to comply with applicable federal, state, and local	L 036		

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L 036	Continued From page 19 laws and regulations, as evidenced by staff's failure to conduct a comprehensive medical examination and evaluation of the resident's health status at least every twelve (12) months and document it in the medical record. Resident #148. The findings include: According to 3207.11 of the District of Columbia Municipal Regulations, "The Medical Director shall: Ensure that each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. A review of the medical record was conducted on February 10, 2015 at approximately 2:30 PM. There was no evidence of an annual history and physical in the medical record for last year 2014 and or 2015, if required at this time. A face-to-face interview was conducted on February 12, 2015 at approximately 11:00 AM with Employee #9. A query was made regarding if there was an annual history and physical conducted. Employee #9 stated, "I will check medical records to make sure that it was not thinned." Employee #9 was unsuccessful in locating the document and stated, "I will place a call to the Primary Medical Doctor and inform him/her."	L 036		

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L 051	Continued From page 20 3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on observations, record review and interviews for five (5) of 51 sampled residents, it was determined that the charge nurse failed to develop care plans with appropriate goals and approaches to address: care needs for one (1) resident who received dialysis; one (1) resident who required tracheostomy care; one (1) resident who was described as a "Hoarder;" for oral dental care needs for one (1) resident; and care of the hemodialysis access site for one (1) resident. Residents' #16, 99, 185, 322 and 392.	L 051	L051 (A1-5) same as F-Tag 279 (1-5) 1a. Resident #16- a care-plan was developed to address the goals, interventions and needs related to Dialysis treatment. 1b. Resident #99- no longer resides in facility. 1c. Resident #185- a care-plan was developed to address the goals, interventions, and needs related to his/her behavior of "hoarding". 1d. Resident #392- a care-plan was developed to address the goals and interventions related to the assessment and care of the dialysis access site. 1e. Resident #322- a care-plan was developed to address the goals and intervention related to the residents tooth extraction and oral dental care. 2. All residents have the potential to be affected by the practice of not initiating care plans with appropriate goals and approaches to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The Care-plans of all residents will be reviewed to ensure there are appropriate goals and interventions in place to meet needs identified in all assessments and orders.	

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L 051	Continued From page 21 The findings include: 1. The charge nurse failed to develop a care plan with goals and approaches to address care needs for Resident #16 who received dialysis. A Physicians order signed and dated February 6, 2015 directed, " Dialysis Monday, Wednesday, & Friday one time a day every Mon [Monday], Wed [Wednesday], Fri [Friday]. " A face-to-face interview was conducted with Employee #25 on February 13, 2015 at 11:00am. The employee stated that Resident #16 has dialysis on Monday, Wednesday, and Friday at 9:15 AM. Review of the care plan section of the clinical record reveled that there was no plan of care developed to address the resident receiving dialysis treatment. 2. The charge nurse failed to develop a care plan with appropriate goals and approaches for tracheostomy care for one resident with a trach. Resident #99 A review of physician's history and physical progress note dated January 9, 2015, under physical examination at the section Neck: revealed, "Tracheostomy site." A review of an interim order sheet for January, 2015 revealed a physician's order that read, "Tracheostomy care to be performed every shift and as needed every shift for tracheostomy tube; Shiley [Laryngectomy tube] size 8 uncuffed one time a day for tracheostomy tube; Suction every	L 051	3. Protocols for Care-plan development, review and revision were reviewed to ensure compliance with requirements related to care-planning for residents. The Staff development coordinator provided care plan education on these protocols to licensed nurses by 5/12/15. All new and readmission residents will be reviewed by the ADONs to ensure appropriate care-plans are in place. Care-plan review and revisions will be completed quarterly and updated as needed to reflect residents' current goals, interventions and health needs. ADONs and Unit Managers will check care-plans prior to the quarterly care-plan meetings to ensure they have been updated. Nursing Management will monitor care-plan review schedules through daily dash board review in the Morning clinical review meeting. 4. A monthly audit will be conducted by the QAPI nurse on 10% of current residents' care-plans to ensure compliance with care-plan review and revision. Sample will be increased if concerns are identified. Results of the audit will be brought through the QAPI process to identify any further need for education or performance improvement plans.	5/12/15

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L 051	Continued From page 22 shift and as needed every shift for tracheostomy tube, Keep emergency equipments at bedside one time day for respiratory difficulty, At 4 liters continuous O2 [oxygen] via trach mask for shortness of breath one time a day and Start oxygen weaning as tolerated every shift related to tracheostomy status." A review of the careplan, under problem, revealed, "Resident has tracheostomy related to surgery;" under goal revealed, "The resident will have clear and equal breath sounds bilaterally;" under interventions revealed, "Administer humidified oxygen as prescribed, Ensure that trach ties are secured at all times; monitor/document for restlessness, agitation, confusion, increase heart rate (tachycardia) and Bradycardia [decreased heart rate]. Monitor/document level of consciousness, mental status and lethargy PRN [as necessary], Monitor/document respiratory rate, depth and quality; Provide paper and pencil if needed, work with resident to develop communication system that will work in a emergency." There was no evidence found in the developed care plan that included goals and approaches to perform tracheostomy care, maintenance of bedside emergency equipment, and oxygen weaning, as prescribed by the physician for Resident #99. A face-to-face interview was conducted with Employee #3 on February 10, 2015 at approximately 1:30 PM. After examining the care plan records, he/she acknowledged the aforementioned findings. The record was reviewed on February 10, 2015	L 051	L051 B1,2a-b;3;4a-b same as F-tag 280(1-4) 1a. The Care-plan for Resident #16 was reviewed and revised to include the dialysis treatment days. 1b. The Care-plan for Resident #93 was revised to include the dialysis treatment days and to include approaches/interventions for care needs related to pre and post dialysis treatment. 1c. The Care-plan for Resident #322 was reviewed and revised to include the dialysis treatment days. 1d. The Care-plans for Resident #388 was reviewed and revised to include goals and approaches for suicidal ideation. A review and revision was also completed to reflect resident's hospitalization from January 16-27, 2015 for evaluation of COPD. 2. All residents have the potential to be effected by this deficient practice of failing to review/revise care-plans to reflect residents' current needs and health status. Care-plans for all residents will be reviewed and revised by the nursing management team to ensure they reflect the residents' current goals, interventions and healthcare status.	

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L 051	Continued From page 23 3. The charge nurse failed to initiate a care plan with goals and approaches for one resident described as a " hoarder. " Resident #185. A review of Resident #185 ' s history and physical dated October 2, 2014, under problems included: " Hypertension, Congestive Heart Failure, History of Renal Failure, General Debility and a new problem described as a " Hoarder. " On February 5, 2015 at approximately 9:15 AM, Resident #185 was observed in his/her assigned room lying in his/her bed. Observed were bags of clothes piled up on his/her chair located next to the window. There was no evidence that a care plan was initiated to include goals and approaches to address Resident #185 ' s new problem described as a " Hoarder. " A face-to-face interview was conducted on February 11, 2015 at approximately 4:07 PM with Employee # 11. The employee acknowledged the findings. He/she further stated; "The resident is resistant to letting staff re-arrange his/her belongings. " The record was reviewed on February 11, 2015. The charge nurse failed to initiate a care plan with goals and approaches for one resident described as a " hoarder. " 4.The charge nurse failed to develop a care plan to include the comprehensive assessment for Resident #392's hemodialysis access site. According to the facility's policy titled, 'Dialysis,' " Shunt site will be monitored every shift by palpating for thrill and auscultating for bruit.	L 051	3. Protocols for Care-plan development, review and revision were reviewed to ensure compliance with requirements related to care-planning for residents. The Staff development coordinator provided care plan education on these protocols to licensed nurses on (insert dates). Education to licensed nurses related to Dialysis Care was provided by the Staff Development Coordinator/Nursing Management by 5/12/15.. All new and readmission residents will be reviewed by the ADONs to ensure appropriate care-plans are in place. Care-plan review and revisions will be completed quarterly and updated as needed to reflect residents' current goals, interventions and health needs. ADONs and Unit Managers will check care-plans prior to the quarterly care-plan meetings to ensure they have been updated. 4. A monthly audit will be conducted by the QAPI nurse on 10% of current residents' care-plans to ensure compliance with care-plan review and revision. Sample will be increased if concerns are identified. Results of the audit will be brought through the QAPI process to identify any further need for education or performance improvement plans.	5/12/15

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L 051	Continued From page 24 Physician will be notified of the absence of a thrill or bruit." A review of the admission record revealed the resident was admitted to the facility on February 9, 2015. A review of the physician's history and physical dated February 13, 2015, but provided for chart review on February 20, 2015 revealed that the resident's diagnoses included Hypertension, Diabetes Mellitus, Pacemaker, End Stage Renal Disease/Hemodialysis, Chronic Anemia, Altered Mental Status, Atrial Fibrillation, Congestive Heart Failure, and Cardiovascular Disease. Review of the February 2015 Treatment Administration Record (TAR) revealed the following: "Assess graft site [vascular access device for hemodialysis] for bleeding every shift." "Assess site for bruit [a whooshing sound made when blood flows through a vessel] & thrill [the rhythmic vibration over the vascular access] -document presence of bruit & thrill every shift." "Evaluate dialysis catheter site on return from dialysis center & every shift for bleeding, redness, or signs of infection." Review of the care plan created on February 9, 2015 revealed the following: "Do not draw blood or take B/P [blood pressure] in arm with graft Right upper arm." "Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis (MWF) [Monday, Wednesday, and Friday]." "Monitor for dry skin and apply lotion as needed." "Monitor right upper arm dialysis fistula [vascular access for hemodialysis]for bruit/thrill."	L 051		

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L 051	Continued From page 25 The care plan lacked comprehensive assessment of the dialysis access site, as described in the facility policy and TAR. On February 19, 2015 at approximately 9:30 AM, a face-to-face interview was conducted with Employees #5 and Employee #11 regarding the aforementioned findings. Both acknowledged the findings. The clinical record was reviewed on February 19, 2015. 5. The charge nurse failed to develop a care plan with goals and approaches for Resident #322 that reflected the residents current oral dental care needs. A review of the nursing progress notes revealed the following: December 23, 2014 23:14 [11:14 PM] revealed "(Dentist name) extracted 1 [one] teeth [tooth] and ordered Penicillin V potassium 500mg [antibiotic] every 6 hrs [hours] times 7 days for dental infection. Resident complained of dental pain scale 6 (six)/10 and Tramadol 2 tabs administered at 6:00 PM. Resident re-evaluated at 7:00 PM and denied any pain. Resident remains stable no dental bleeding noted.... " ; December 24, 04:40 PM revealed: "Resident had tooth extraction on previous shift, some bleeding noted ..." A review of the residents care plan lacked evidence of a focus area with goals and approaches to address the tooth extraction and	L 051		

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L 051	Continued From page 26 oral dental needs. A face-to-face interview was conducted with Employee #4 on February10, 2015 at approximately 12:22 PM. A query was made regarding the resident's tooth extraction and goals and approaches that were in place to address the oral dental concern. After review of the care plan, Employee #4 acknowledged the resident's care plan lacked evidenced of a focus area to reflect the tooth extraction and oral dental care needs. The charge nurse failed to develop a care plan with goals and approaches that reflected the residents current oral dental care needs. B. Based on record review and staff interview for four (4) of 51 sampled residents, it was determined that the charge nurse failed to review and revise the residents care plans as evidenced by: failure to revise the care plan to include the dialysis treatment days for two (2) residents; to address the resident care needs pre and post dialysis for one (1) resident, and to revise the care plan to address one (1) resident' s suicidal ideations and hospitalization. Residents' #16, #93, #322, and #388. The findings include: 1. The charge nurse failed to review and revise the care plan to include dialysis treatments days	L 051		

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L 051	Continued From page 27 for Resident #16. A review of the Physicians order signed and dated February 6, 2015 directed, " Dialysis Monday, Wednesday, [and] Friday one time a day every Mon, Wed, Fri." A review of the care plan section of the clinical record lacked evidence of the dialysis treatment days for Resident #16. A face-to-face interview was conducted with Employee #25 on February 13, 2015 at approximately 11:00 AM. After review of the above he/she acknowledged the findings. The record was reviewed on February 13, 2015. 2a. The charge nurse failed to review and revise the care plan to include dialysis treatment days for Resident #93 A review of the Physician ' s Orders signed and dated January 21, 2015 directed, " Dialysis Monday, Wednesday, and Friday. " A review of the care plan section of the clinical record lacked evidence of the dialysis treatment days for Resident #93. A face-to-face interview was conducted with Employee #25 on February 13, 2015 at approximately 11:00 AM. After review of the above he/she acknowledged the findings. The record was reviewed on February 13, 2015. 2b. The charge nurse failed to review and revise	L 051		

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L 051	Continued From page 28 the care plan to include approaches/interventions to address the resident's care needs pre and post dialysis for Resident #93. A review of " The resident has, renal failure r/t [related to] End Stage disease " care plan revealed that there were no approaches/interventions to address care needs such as, pre and post dialysis assessments. A face-to-face interview was conducted with Employee #25 on February 13, 2015 at approximately 11:00 AM. After review of the above he/she acknowledged the findings. The record was reviewed on February 13, 2015. 3. The charge nurse failed to review and revise the residents care plan to include dialysis treatment days for Resident #322. Resident #322 was admitted to the facility on June 7, 2014 with diagnoses which included ESRD [End Stage Renal Disease]. Review of the Resident ' s MDS [Minimum Data Set] with an ARD [Assessment Reference Date] of January 9, 2015 revealed the resident was coded in Section I Active Diagnoses: (F) chronic Kidney disease; (G) Renal Dialysis Status. A review of the Order Summary Report [Physician ' s Orders] signed and dated by the physician on February 2, 2015 revealed: Order summary; Active; order date September 6, 2014: Dialysis on Tuesday, Thursday, and Saturday. A review of the residents care plan revealed a focus area: " The resident needs, dialysis	L 051		

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L 051	Continued From page 29 (specify type hemo [hemodialysis/peritoneal) r/t [related/to] Renal Failure. Date initiated: June 8, 2014 with a goal/target date of December 29, 2014. There was no evidence that the care plan was reviewed and revised to include the resident ' s dialysis days on Tuesday, Thursday, and Saturday. A face-to-face interview was conducted with Employee #4 on February 13, 2015 at approximately 11:00 AM.. After review of the above he/she acknowledged the findings. The record was reviewed on February 13, 2015. 4a. The charge nurse failed to review and revise the care plan to include interventions to manage suicidal ideations verbalized by Resident #388. An Electronic Nurses Note dated January 16, 2015 at 03:15 revealed, "Late documentation for January 15, 2015; Resident alert and confused. ... [He/she] verbalized [he/she] want to kill [himself/herself], [he/she] need a knife to harm self, that [his/her] child is been taken and no one love [him/her]. [She/he] was seen by the psychiatrist and some new orders were given. Resident has been placed on 1:1[one to one] supervision. " A Psychiatry Consult dated January 15, 2015 revealed: "Spoke with the staff, spoke with the patient, recommended admit ... Patient appears to be confused secondary to underlying Dementia Diagnosis that can be exacerbated by infection and disorientation. Plan: Medical workup recommended, 1:1 [one to one] supervision	L 051		

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L 051	Continued From page 30 ...Give patient Haldol/Cogentin ..." A review of care plan revealed that the care plan was not reviewed and revised to include goals and approaches for Resident#388 ' s suicidal ideations on January 15, 2015. There was no evidence that the care plan was amended to include Resident #388 ' s suicidal ideations. A face-to-face interview was conducted on February 11, 2015 at approximately 4:07 PM with Employee # 11. He/she acknowledged the findings. The record was reviewed on February 11, 2015. 4b. The charge nurse failed to review and revise the care plan to include Resident #388 ' s hospitalization. Resident #388 was initially admitted to the facility on January 9, 2015 with diagnoses that included Status Post Acute Exacerbation of COPD (Chronic Obstructive Pulmonary Disease), Hypertension, Diabetes, and Debility. An interim physician order dated January 16, 2015 at 6:30 PM directed: "Transfer resident to [hospital named] under [medical doctor named] care for evaluation COPD (Chronic Obstructive Pulmonary Disease) exacerbation and electrolyte imbalance." The resident was readmitted back to the facility on January 27, 2015. A review of care plan revealed that the careplan was not reviewed and revised to include goals and approaches for resident#388 ' s hospitalization on January 16, 2015. There was no evidence that the care plan was amended to include Resident #388 ' s hospitalization. A face-to-face interview was conducted on February 11, 2015 at approximately 4:07 PM with Employee # 11. He/she acknowledged the	L 051		

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L 051	Continued From page 31 findings. The record was reviewed on February 11, 2015. C. Based on record review and staff interview for one (1) of 51 sampled residents, it was determined that the charge nurse failed to notify the attending physician that two (2) prescribed medications could not be administered to the resident because they were unavailable. Resident #211. The findings include: The physician ' s order dated February 10, 2015 directed, " Spiriva Hand inhaler Capsule 18Mcg 1 puff inhale orally one time a day for COPD to begin on February 11, 2015; and Xarelto Tablet 20mg one (1) tablet one (1) time a day for DVT (deep vein thrombosis) prophylaxis to begin on February 11, 2015 " . A review of the Medication Administration Record (MAR) for February 2015 revealed that Spiriva was not administered on February 11 and 12, 2015; and Xarelto was not administered on February 11 and 12, 2015. A further review of the nursing documentation failed to reveal any evidence that the physician was notified that the resident had not received the medications as ordered. A face-to-face interview was conducted with Employee #12 on February 13, 2015 at approximately 11:00AM. The employee stated	L 051	L051 (C) Same as F-Tag 157 1.Resident #211 was assessed and had no negative outcomes related to the deficient practice. 2.All residents have the potential to be affected by the deficient practice of medication not being delivered timely from the pharmacy. A meeting was held with pharmacy and facility administration regarding the timely delivery of medications, back up pharmacy protocols, and the availability of medications through the Omnicell. Protocols were updated and a system has been implemented for the ordering of medications for new admissions/readmissions. 3.Nursing staff will be in serviced on the process and protocols for ordering medications, cut off times for ordering, and medications available in the Omnicell for new admissions and readmissions 5/12/15 by the Staff Development Coordinator and/or Nursing Management. The protocols for ordering medications will be included in orientation of all new hires. A new cell phone was also provided to Nursing Supervisors to better facilitate communication with the pharmacy. Unit Managers/Nursing Supervisors will verify medication delivery daily and follow up with MD and Pharmacy if meds are not delivered timely. All new and readmission orders will be reviewed and the availability of meds in the facility by ADON on a daily basis and reported to DON during morning clinical review.	

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L 051	Continued From page 32 that the medications were not administered to the resident because they were not received from the pharmacy and they were not available in the Pyxis (automated medication storage and dispensing unit). Employee #12 acknowledged the aforementioned findings. There were no untoward effects to the resident. The record was reviewed on February 13, 2015.	L 051	4.Audits will be completed by the ADONs/ Nursing Management on all new admissions weekly to monitor compliance. Compliance with follow through will be monitored monthly by DON/QA Nurse through the QAPI process to identify need for further education, performance improvement plans, and/or modifications to the protocols.	5/12/15
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;	L 052	L052 1A,1B, 2 B1-2A-B,3a-b 4,C, D1-8 1. Resident # 286 no longer resides at Deanwood. Resident #177 Resident Pain management plan of care was reviewed by his/her Physician and plan of care was revised. Pain medications were adjusted after assessment of pain scale. Physician reviewed Neurology recommendations and patients MS meds to provide the most effective management of his/her MS symptoms. Care-plan was updated to reflect this. The delay in communication from staff to pharmacy and to the Neurologist office was a past event and could not be rectified at this moment.	

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L 052	Continued From page 33 (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A. Based on observations, record review and interviews for two (2) of 51 sampled residents, it was determined that sufficient nursing time was not given: To implement measures to safeguard the integrity of one (1) resident ' s central venous catheter [Permacath] from unintentional dislodgement and trauma. For the same resident, sufficient nursing time was not given to develop a coordinated interdisciplinary Hospice plan of care that guides both providers [hospice and the nursing facility] to meet the assessed needs for the resident. Facility staff failed to effectively manage pain and a chronic disorder of the Central Nervous System [Multiple Sclerosis] for one (1) resident. Residents' #286 and 177. The findings include:	L 052	B1. Resident # 16 Medications times were adjusted to account for dialysis treatment times. Review of record found there were no ill effects noted from not administering the ordered medications to resident. Nursing was in-serviced on the need to administer medications as ordered and to receive orders to adjust medication to account for dialysis times. Resident # 135, was assessed to ensure the resident suffered no ill effects from receiving both Rozerem and Ambien. Physician was notified and a med error assessment was completed. Medications times were adjusted to account for dialysis treatment times. A nursing assessment found there were no ill effects noted from not administering the ordered medications to resident. Employee # 25 was counseled and in-serviced, to call MD/ NP for clarification of orders when not clear. Nursing was in-serviced on the need to administer medications as ordered and to receive orders to adjust medication to account for dialysis times. Resident # 211 Medications for this resident were received from pharmacy. Review of record found there were no ill effects noted from not receiving medications as ordered. Nursing staff was in-serviced and counseled on protocols for when medications are not delivered timely or unavailable. Resident # 291 Resident no longer in the facility	

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L 052	Continued From page 34 1. Facility staff failed to ensure sufficient nursing time was given to implement measures to safeguard the integrity of one (1) resident ' s central venous catheter [Permacath] from unintentional dislodgement and trauma. For the same resident, sufficient nursing time was not given to develop a coordinated interdisciplinary Hospice plan of care that guides both providers [hospice and the nursing facility] to meet the assessed needs for Resident #286. A. Facility staff failed to ensure sufficient nursing time was given to implement measures to safeguard the integrity of Resident #286's central venous catheter [Permacath] from unintentional dislodgement and trauma. " A venous catheter is a tube inserted into a vein in the neck, chest, or leg near the groin, usually only for short-term hemodialysis. The tube splits in two after the tube exits the body. The two tubes have caps designed to connect to the line that carries blood to the dialyzer and the line that carries blood from the dialyzer back to the body," (National Kidney and Urologic Diseases Information Clearinghouse). http://kidney.niddk.nih.gov/KUDiseases/pubs/vascularaccess/index.aspx Resident #286 was admitted to the facility on September 24, 2014 with no known allergies and a past medical history that included: Candidiasis, Unspecified Pruritic Disorder, Aphasia, End Stage Renal Disease, Secondary Parkinsonism, and Essential Hypertension. The quarterly Minimum Data Sets dated November 25, 2014 and January 19, 2015 were	L 052	C1. Resident # 99 Orders for q shift pain assessment was verified with the physician and continues. Resident # 99 was not assessed q shift for Vital signs as ordered by the MD. Record review was completed in relation to previous vital sign orders to ensure no ill effects were noted by the lack of monitoring. Education provided to staff on importance of monitoring for pain and vital signs. Resident # 259 The Bruit and Thrill were assessed to ensure graft site was functioning when deficiency noted. Staff members identified were educated on this assessment and provided return demonstration of this ability. D1.Resident # 93 was assessed and emergency kit was placed at resident bed. Resident did not experience any negative outcome related to failure to keep dialysis emergency kit by bedside. D2. Resident #115 was assessed and did not experience any negative outcome related to failure to follow up with resident RP request for ophthalmologist consult. Appoint will be arranged for resident to see the Ophthalmologist. Facility has also set up more access for optical services for all their residents.	

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L 052	Continued From page 35 reviewed. Under Section B [Hearing, Speech and Vision] the resident was coded as having no speech. Under Section C [Cognitive Skills] the resident was coded as being severely impaired. Under Section E [Behaviors] the resident was coded as having no behavioral issues. Under Section G [Functional Status] the resident was coded as totally dependent in bed mobility, transfers, dressing, eating, personal hygiene and toilet use. The resident was coded as having no impairment in upper extremity range of motion, (shoulders, elbow wrist and hand) in Section G0400 [Functional Limitation in Range of Motion]. Under Section O [Special Treatments, Procedures, and Programs] the resident was coded as receiving Hemodialysis. A review of the nursing notes revealed: December 8, 2014 at 15:19 [3:19 PM] " Resident alert and responsive. Left chest permacath dry and intact, no bleeding noted." December 9, 2014 at 08:19 [AM] " Resident ' s left chest permacath observed coming out, no bleeding noted. Nursing supervisor made aware, said to send resident to dialysis. Call placed to [physician] and message left. Dialysis nurse [sent] resident back to the floor and said to [send] [him/her] to [the] hospital. [Physician] returned call and spoke with the supervisor and ordered to send resident to [Outpatient Medical Center] for permacath replacement. [Outpatient Medical Center] was called and not open till 8:00 AM. Next shift handed over to observe resident for bleeding and follow up with appointment ... " December 9, 2014 at 11:47 [AM] " Resident alert	L 052	D3. Resident # 135 was assessed and emergency kit was placed at resident bed. Resident did not experience any negative outcome related to failure to keep dialysis emergency kit by bedside. D4.Resident #223 Facility failed to obtain results of the Chest x-ray results timely and failed to relay results to the Physician. Results were obtained and placed in resident record at the time deficiency noted. Employees were in serviced on the policy and procedure of notification and or follow up timely to obtain results. Record review found no further respiratory concerns due to lack of follow up. D5. Resident #283 no longer resides at the facility. D6. Resident #291 no longer resides at the facility. D7.Resident #292.was given a scoop mattress as ordered by MD and IDT members. Care-plan was updated to reflect new mattress. D8.Resident # 352 daily weights were not obtained as per MD order. MD was notified of the omission. Dietitian continues to monitor residents weights routinely and nursing continues with plan of care to manage the r residents CHF.	

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L 052	Continued From page 36 and responsive. No bleeding noted from old access site left upper chest. V/S (vital signs) 98.0 [temperature], 78 [pulse], 20 [respirations], 160/90 [blood pressure]. Call placed to [physician at the Outpatient Medical Center] for appt [appointment] for permacath replacement. Resident needs a referral from dialysis to go to [Outpatient Medical Center], dialysis made aware. " December 9, 2014 at 14:01 [2:01 PM] " Resident responsive to stimuli, V/S (vital signs) 97.9 [temperature], 60 [pulse], 18 [respirations], 130/60 [blood pressure]. Resident left the unit at 1:50 PM via 911 to [hospital name] for left chest permacath replacement ... " December 9, 2014 at 22:41 [10:41 PM] " Resident admitted at [hospital name] ... " December 10, 2014 at 01:03 [AM] " Late entry note for 12/9/14: Supervisor was called at 6:45 AM that resident permacath was dangling, resident was assessed and noted that the permacath was out [more] than usual and was dangling, no bleeding noted at the site. Resident is [non] verbal and unable to explain ...resident was put in [geri] chair and took down to dialysis to also co-assessed by the charge nurse, the change nurse was not available, and at 7:05 AM the charge call supervisor that the permacath was completely out, but no bleeding or drainage noted. Supervisor immediately [covered] the site with 4x4 [gauze] and opsite [dressing cover] to prevent air embolism ... " On December 11, 2014 at 15:14 [3:14 PM] " Resident #286 was [re-admitted] from the	L 052	2. All residents have the potential to be affected by areas identified in this deficient practice. Areas of concern identified were- Implementing safety measures for residents that may dislodge a permacath or any other vascular access site, Pain management, hospice integration of plan of care, Administering medications as ordered, completing accurate assessments in relation to pain, vital signs and dialysis, and following physician orders. Nursing management met together to determine the best plan of action for these identified concerns. Systems and protocols were reviewed and their investigation and due diligence identified the root cause(s) that allowed the deficient practices to occur. Education, monitoring and follow through were identified as areas for improvement. Complete audits have been put in place and continue to identify any other potential residents that may have been affected by the lack of providing care and services to promote a residents' highest well being.	

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L 052	Continued From page 37 [hospital] ... S/P (status post) left upper chest perma cath replacement... " January 7, 2015 at 19:58 [7:58 PM] " Resident alert and responsive. Left chest permacath intact no bleeding noted or swelling noted ... " January 8, 2015 at 08:39 [AM] " The writer was called to resident room at 7:15 AM, left chest permacath was dislodged and observed on [his/her] body. No bleeding observed, no distress noted. Supervisor made aware, site covered with dry dressing. [Attending physician] paged and message left. 911 was called and came in at 7:31 AM. Resident left the unit at 7:41 AM ... " January 13, 2015 at 16:19 [4:19 PM] " Resident re-admitted from [hospital] ...patient had newly placed permacath on the right thigh [groin] which is double lumen and properly secured ...skin is warm to touch, dry, and noted with multiple scars on the left neck, bilateral upper chest, right ankle, and scratch marks all over the body ...Peri-wound is noted with discoloration and multiple scratch wounds, right buttocks noted with scratch wound measuring (1.0 cm x 0.5 cm x 0.1 cm) ...Resident was seen scratching self, fingernails trimmed ... " January 13, 2015 at 20:14 [8:14 PM] " Left buttock scratch wound instead of right. " January 14, 2015 at 00:30 [12:30 AM], " Resident is re-admitted from [hospital name] permacath replaced to right femoral ... " February 7, 2015 at 13:38 [1:38 PM] " Resident is responsive. Right femoral catheter is dry and intact, no bleeding noted ... " February 7, 2015 at 18:19 [6:00 PM] " Supervisor	L 052	2 continued. In addition: All residents on dialysis treatment were given an emergency kit to be placed at bed side. Complete audit of all charts to ensure orders for consults or diagnostic testing were followed. Medications for dialysis residents were reviewed and adjusted to ensure they are scheduled around dialysis services times. All residents with PICC lines were reviewed for continued need and/or orders for removal. Residents with orders for daily and/or weekly weights were reviewed for compliance. 3. A. All residents on dialysis will be assessed for potential pulling off the Permacath and/or AV shunt causing dislodgement and complications resulting from that. Appropriate interventions and care plans will be reviewed and revised as indicated. B. All residents on Hospice care will be assessed to ensure appropriate care plans and interventions are in place. Hospice providers will be invited and encouraged to participate in the Care-plan meetings and review and revisions of the residents Plan of Care. Medical records pertaining to Hospice will remain in the resident's active chart at the facility.	

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L 052	Continued From page 38 call by Safety for a resident being sent out of dialysis center. Supervisor went to 1st floor to find a resident [on] a stretcher in ambulance. Dialysis staff narrated that resident pulled [his/her] right femoral dialysis access and therefore 300 ml [milliliters] of blood in the dialyzing line was unable to return to the system and therefore wasted. Per dialysis staff, this event occurred and hour towards the end of treatment. Resident taken to [hospital name] at 15:00 [3:00 PM] by ambulance ...charge nurse call [hospital] at 6:22 PM to verify resident ' s status and [he/she] was informed that resident will be admitted. " The Dialysis Communication forms from November 2014 through February 7, 2015 were reviewed. It was noted that sections of the forms were incomplete/or left blank. For example: Part I- " comments or questions " , " glucose [level] " , " did the patient eat before dialysis " , " time taken " , " problems noted and/or resident complaints " , " nurse signature " ; Part III- " patient status " , glucose [level] " . It was determined that facility staff failed to consistently complete sections of the forms, to communicate pertain information regarding the resident ' s clinical status and care needs. A review of the care plan section of the active clinical record revealed that there was no care plan initiated with goals and approaches to address the resident ' s dislodging of the perm-a-cath. In addition there was no evidence that facility staff initiated a care plan to address the residents	L 052	C. Pain evaluations will be performed every shift on all residents to identify effective pain management and when PRN medications are administered. Residents on pain medications will be assessed by MD/NP and their medications will be reviewed to ensure efficacy of the medication is met. D. Follow up on consults will be reviewed by the Nursing management daily in the morning stand up meeting. All physicians 'orders will be reviewed by Unit managers on a daily basis to ensure compliance is met. E. Licensed Nurses will be in serviced on these following Policy and Procedure: • Care and management of dialysis residents, • Care and management of CHF residents., • Care and management of Residents with PICC line. • Timely carrying out of MD orders. • Timely carrying out of Lab, diagnostic orders& follow up on results by notifying md/np timely. • Care and Management of residents on pain management. • Assessing resident pain scale and taking vital signs as ordered by MD. • Care and management of Hospice resident's. • Communication with Pharmacy and follow up. All new hires will be in serviced on all of the above and annually for all staff thereafter. Policy and procedures for above topics will be reviewed and included in training protocols.	

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L 052	Continued From page 39 scratching of his/her skin until January 4, 2015, however this concern was first observed in July 2014. Interviews: A face-to-face interview was conducted on February 11, 2015 at approximately 11:00 AM with Employee #56 Occupational Therapist. He/she stated, " The resident did not participate in therapy. [He/she] did not show purposeful movement, but [he/she] could not follow commands. The resident ' s fingers were not contracted but both of [his/her] wrists were stiff. The resident was receiving occupational therapy for positioning and range of motion. " A face-to-face interview was conducted on February 11, 2015 at approximately 4:20 PM with Employee #11. He/she stated, " The resident has a g-tube and a permacath on [his/her] left side. The resident did not have any behavioral issues. [He/she] itches. He/she took the permacath out twice [from the chest]. After the second time [the catheter was pulled out] it was put in [his/her] thigh [groin] and [he/she] took it out. [He/she] is at the hospital now and [he/she] is Hospice. The resident ' s nails were short. Employee #11 was asked if the resident had dermatology consult due to the resident itching. He/she replied, " No. " The employee was then asked what measures were put in place to address the resident's scratching. He/she replied, " The resident was prescribed Benadryl [anti-itch medicine] cream and Hospice nurse ordered something for the itching. We also monitored the resident and checked [his/her] vitals. [He/she] pulled at [his/her] clothes and	L 052	F. Protocol for PICC Line removal updated to include: NP or qualified RN onsite will be contacted to complete the PICC removal, if unavailable IV services will be called in to schedule removal, if delays are indicated the NP/MD will be notified for further orders. If required, resident will be sent to the ER for removal. G. All labs logs book will be reviewed by Nursing Leadership at end of day to ensure results and follow thru was done. H. A new ophthalmologist was hired to ensure all consult orders are followed thru timely. I. All new dialysis resident's will be reviewed by nursing to individualize and adjust the medication times so that the medications are not omitted. J. The 24 hour progress notes will be reviewed daily by Nursing and IDT members in clinical meeting to ensure all items noted in the shift report is followed through by Nursing / IDT members. At stand down meeting daily, all items for follow thru will be checked for completion by DON. All medication and Treatment orders for past 24 hours will be printed and reviewed by ADON's/ unit managers to ensure the orders are carried appropriate, accurately and timely. This will also be reported at Stand down meeting every day.	

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L 052	Continued From page 40 scratched." In addition, the employee acknowledged that the communication forms were not consistently completed and there was no information recorded on the forms regarding the resident pulling on his/her clothing and scratching him/herself. In summary, Resident #286 dislodged his/her chest permacatheter on December 9, 2014. The resident was first transported to the first floor to the dialysis center to seek assistance. The resident was then returned to the nursing unit. The facility staff attempted to make an appointment with an Outpatient Medical Center to have the permacatheter reinserted. Approximately five (5) hours later the resident was sent from the facility to the hospital via 911. The resident was admitted to the hospital. On December 11, 2014 Resident #286 was readmitted to the facility from the [hospital]. During the resident ' s stay, a left upper chest permacatheter replacement occurred. There was no evidence that facility staff implemented measures to help prevent future removal or dislodgement of the catheter. January 8, 2015 the resident was observed with his/her left chest permacatheter dislodged and observed on his/her body. The resident was sent to the hospital via 911. January 13, 2015 the Resident was re-admitted from [hospital] ...patient had a newly placed permacatheter on the right groin. The resident also presented with scratch marks all over his/her	L 052	A new staffing coordinator was hired. HR continues to recruit for all positions. Interviews conducted by Nursing Leadership. Orientation held twice a month. The daily PPD ratio is being projected a day in advance. Staffing coordinator was given expectations to have weekly schedule printed and to identify vacancies and fill vacancies in advance. ADON, Nurse Manager on the house continues to meet with staffing coordinator daily to review the schedule to ensure staffing is scheduled as required to meet federal and state guidelines. Daily PPD is now be discussed at Morning stand up meeting. 4. Nursing Administration will audit weekly MAR Binders for: • pain management • Assessing access site q shift • Labs ordered are done as scheduled • Discontinued central lines were done timely • Daily weights are being taken as ordered. • Review if Ophthalmology consult/ and any other consults was completed timely and follow up of recommendation carried out. • Mar review for omission and meds availability. All medication and Tx orders for past 24 hours will be printed and reviewed by ADONs/unit managers to ensure the orders are carried appropriate, accurately and timely. Trends will be reported to QA committee monthly to address any identified concerns or need for further education or enhanced monitoring.	5/12/15

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L 052	Continued From page 41 body and the peri-wound was noted with multiple scratch wounds, right buttocks noted with scratch wound measuring (1.0 cm x 0.5 cm x 0.1 cm). It was also recorded that the resident was seen scratching his/herself and the resident ' s fingernails were trimmed. Through record review and staff interview, there was no evidence that the facility staff communicated with the dialysis staff on the "communication forms" regarding the resident's itching, scratching and the resident dislodging the permacatheter. After the second occurrence of the permacatheter being dislodged, there was no evidence that facility staff implement approaches to help prevent the resident from dislodging/removing the permacatheter or the femoral catheter. Subsequently, on February 7, 2015 it is recorded that while receiving a dialysis treatment the resident pulled [his/her] right femoral dialysis access and therefore 300 ml [milliliters] of blood in the dialyzing line was unable to be return to the resident resulting in blood loss. The Resident was taken to the hospital and admitted. The record was reviewed on February 11, 2015. 1B. Facility staff failed to ensure sufficient nursing time was given to develop a coordinated interdisciplinary Hospice plan of care that guides both providers [hospice and the nursing facility] to meet the assessed needs for Resident #286. A review of the physician ' s order dated January 17, 2015 at 18:50 [6:50 PM] directed, " Evaluate	L 052		

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L 052	Continued From page 42 and admit to hospice, Diagnosis: Anoxic Encephalopathy " The quarterly Minimum Data Sets January 19, 2015 was reviewed. Under Section O [Special Treatments, Procedures, and Programs] the resident was coded as receiving Hospice. Review of the " Hospice " care plan dated January 23, 2015 under " Focus " states, " Resident family agree for resident to be hospice due to [his/her] prognosis. Resident was admitted into hospice care on 01/23/2015 [January, 23, 2015]. The " Goal " states, " Residents family wishes will be respected with regards to hospice care through the review date. The " Interventions " include " Continue quarterly care conference with all members of the team to address resident/family need, " and " Coordinate care with [Outside provider] hospice. " Resident #286 ' s electronic record and paper chart revealed that there were no hospice notes/information related to care of the resident (i.e. the initial and ongoing assessments, the interdisciplinary plan of care) available for review. A face-to-face interview was conducted with Employee #11 on February 11, 2015 at 12:45 PM. He/she stated, " I will call Hospice and ask them for the notes." Employee #11 the picked up the phone and called the hospice organization in the presence of the surveyor. Employee #11 then stated, " The notes will come within an hour per hospice." Employee #11 further acknowledged the findings. There was no evidence that a coordinated interdisciplinary Hospice plan of care that guides both providers [hospice and the nursing facility] to	L 052		

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L 052	Continued From page 43 meet the assessed needs for Resident #286 was not readily available in the active clinical record. A face-to-face interview was conducted with Employee #11 on February 11, 2015 at 12:45 PM. He/she acknowledged the findings. The record was reviewed on February 11, 2015. 2. Facility staff failed to ensure sufficient nursing time was given to implement an effective pain management regimen and address the neurologist ' s recommendations in a timely manner for Resident #177. A family interview with Resident #177 ' s Responsible Party (RP) was conducted on February 11, 2015 at approximately 2:00 PM. The Responsible Party voiced the following concerns: · Regarding Resident #177 ' s medication- " This is extremely pressing for me. [Resident #177] had an appointment with the neurologist secondary to swallowing issues. He/she [the nurse] was unable to administer the medication (Tecifidera- medication for multiple sclerosis) secondary to resident ' s swallowing deficit. " The RP found out within "the last month or so" that the resident ' s old medication had been discontinued. · Regarding Resident #177's pain - The RP verbalized that [he/she] is unsure if the pain medication is strong enough because the resident moves from side to side and/or grips the bedrail when [he/she] is in pain. Visited Resident #177 four (4) days ago in the evening. " When I arrived, [he/she] was in pain. [He/she] was	L 052		

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L 052	Continued From page 44 holding the side rails. I asked the evening nurse about [his/her] pain medication. He/she looked at the medication record and nothing was recorded that [he/she] received anything for pain. " · Regarding nursing staffing - The RP stated that at times there are only two (2) CNA ' s [Certified Nursing Assistants] on evenings and weekends. An annual physician history and physical dated January 31, 2015 revealed Resident #177 ' s medical diagnoses included: " Multiple Sclerosis/Rule out Contractures, Chronic Pain, GERD (Gastro Esophageal Reflux Disease, Gastrostomy Tube Status, Neurogenic Bladder and Depression. " The quarterly MDS (Minimum Data Set) dated October 12, 2014 revealed that Under Section G [Functional Status] the resident was coded as totally dependent in bed mobility, transfers, dressing, eating, personal hygiene and toilet use. The resident was coded as having bilateral lower extremity impairment and impairment to one side in the upper extremity (shoulders, elbow wrist and hand) in Section G0400 [Functional Limitation in Range of Motion]. Under Section J (Health Conditions) revealed that Resident #177 was on a scheduled pain medication regimen and receiving PRN pain medications. The resident was also coded as having a numeric rating scale of " 06 " (the Numeric Rating Scale was from " 0-10 " for pain intensity. During an observation conducted on February 11, 2015 at approximately 4:45 PM, the resident was observed lying on [his/her] back in the bed and covered with a white sheet. [His/her] head was positioned towards the left of the bedside rail.	L 052		

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L 052	Continued From page 45 He/she was instructed to blink [his/her] eyes once for " yes " and twice for " no. " When queried if [he/she] was in pain, [he/she] nodded [his/her] head and blinked [his/] eyes one time. The writer informed Employee # 67 that the resident was in pain. An annual physician history and physical dated January 31, 2015 revealed Resident #177 ' s medical diagnoses included: " Multiple Sclerosis/Rule out Contractures, Chronic Pain, GERD (Gastro Esophageal Reflux Disease, Gastrostomy Tube Status, Neurogenic Bladder and Depression. " The quarterly MDS (Minimum Data Set) dated October 12, 2014 revealed that Under Section G [Functional Status] the resident was coded as totally dependent in bed mobility, transfers, dressing, eating, personal hygiene and toilet use. The resident was coded as having bilateral lower extremity impairment and impairment to one side in the upper extremity (shoulders, elbow wrist and hand) in Section G0400 [Functional Limitation in Range of Motion]. Under Section J (Health Conditions) revealed that Resident #177 was on a scheduled pain medication regimen and receiving PRN pain medications. The resident was also coded as having a numeric rating scale of " 06 " (the Numeric Rating Scale was from " 00-10 " for pain intensity. During an observation conducted on February 11, 2015 at approximately 4:45 PM, the resident was observed lying on [his/her] back in the bed and covered with a white sheet. [His/her] head was positioned towards the left of the bedside rail. He/she was instructed to blink [his/her] eyes once for " yes " and twice for " no. " When queried if [he/she] was in pain, [he/she] nodded [his/her]	L 052		

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L 052	Continued From page 46 head and blinked [his/] eyes one time. The writer informed Employee # 67 that the resident was in pain. A review of the signed physician ' s orders directed the following: "October 6, 2014 - Marinol [man-made form of cannabis- also known as marijuana] 5mg capsule- 1 (one) cap [capsule] twice a day for pain control. "October 6, 2014 - Tecfidera [medication used for the treatment of patients with relapsing forms of multiple sclerosis] capsule delayed release 240mg oral two times a day -MS (multiple sclerosis) "October 6, 2014 -Tylenol [analgesic- pain reliever] -650 mg tablet enteral pain - [route] rectum prn for pain. October 20, 2014- 3:00 PM- Tramadol [narcotic -like pain reliever] 50mg via GT (Gastrostomy Tube) Q (every) six (6) hours prn (as needed) pain. [Please] assess resident for pain and medicate as prescribed. " December 21, 2014- 1520 (3:20 PM) - Hold Tecfidera until pharmacy gives an alternative [medication] [to be given] IM [Intramuscular injection]. January 3, 2015 Monthly Physician ' s Orders directed: " Assess resident for pain every shift on a scale from 0 to 10 every shift; Diet Orders: Aspiration Precaution: Hold Tecfidera until pharmacy gives an alternative every shift; Acetaminophen (Tylenol- analgesic- pain reliever) 650mg rectal- prn pain every 6 (six) hours; Neurontin (Gabapentin)- [therapeutic class: Anticonvulsant, also used for migraine prophylaxis and tremor associated with multiple	L 052		

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L 052	Continued From page 47 sclerosis] capsule 400mg three times a day- 1 cap via G-tube tid [three times a day] for neuropathic pain; Tramadol HCL (hydrochloride) - [analgesic]-tablet 50mg - Give 1 (one) tablet via G-tube every 6 (six) hours as needed for pain ... " A review of the October, November and December, 2014, January and February 2015 MARs revealed that Resident #177 did not receive Marinol. A review of the October, November and from December 1 - 21, 2014 the resident was administered the Tecfidera. From December 22, 2014 to February 19, 2015 the resident did not receive the Tecfidera. Notes: A review of the " Physician ' Progress Notes " revealed the following: October 9, 2014- 16:10 (4:10 PM) - " Resident was assessed by speech and pleasure feeding discontinued. Resident is NPO (nothing by mouth) MD [medical doctor] was notified and marinol held until NPO status is discontinued ... RP aware ... " October 20, 2014- 15:07- (3:07 PM) - Type: SOAP (Subjective, Objective, Assessment, Plan) Note-Nurse Practitioner- " Resident with history of neurogenic bladder, MS (Multiple Sclerosis) and advanced immobility, and depression seen today for evaluation. [His/her] [Responsible party named], [his/her] [responsible party] states resident is having pain and would like [him/her] to have pain medication because Tylenol is not working for [him/her]. Resident nods when asked if [he/she] is having pain. Plan: Tramadol 50mg [milligram] q [every] 6 [six] prn [as needed]. "	L 052		

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L 052	Continued From page 48 November 3, 2015- 15:12 (3:12 PM) - Type: SOAP Note- Nurse Practitioner- " Subjective: Resident with history of ... MS and advanced immobility ... seen today for evaluation. [Relative named] reported that resident was not getting pain medication as needed, [he/she] saw that [he/she] was gripping the bed rail which shows that [he/she] is in pain, explained to [him/her] that the nurses assess the resident for pain which [he/she] is able to nod yes or no. Plan: Continue plan of care. Nurses to assess for pain and offer pain medication. " November 18, 2014- 15:45 (3:45 PM) - Type: SOAP Note- Nurse Practitioner- " ... Resident is currently on tube feedings. Unit manager states [he/she] was evaluated about a month ago, with results being unsafe for resident to have food by mouth. Plan: SLP [Speech Language Pathology] evaluation and treatment for possible pleasure foods. " " November 25, 2014 - Physical Examination- Attending Physician - " Have Pain: " N ", Plan/Recommendations- Hold Tecfidera, Continue current management, Aspiration Precautions " December 11, 2014- 15:56 (3:56 PM) - Type: Nurses Note- " ...Tecfidera 240mg was not given because medication cannot be crushed. A call was placed to the MD [Medical Doctor] and MD instructed that a call be placed to pharmacy to get a substitute for the medication. MD said [his/her] phone number [will] be sent to pharmacy for them to call [him/her] so that they can come out with a cheaper substitute. MD suggested Avonex [medication used to treat relapsing multiple sclerosis] MCG [microgram] IM Q [every] week. A call was placed to pharmacy and all information	L 052		

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L 052	Continued From page 49 given, MD number. " December 21, 2015 15:25 [3:25 PM], " Nurses Notes: ...Resident was seen by [attending physician] and new order to hold Tedfidera 240 mg until MD talks to the pharmacy ... " January 5, 2015 at 16:16 [4:16 PM] - " Nurses Notes:...Tecfidera to be discontinued due to resident is unable to swallow. Medication cannot be crushed ...Pleasure feeding discontinued by the speech therapist. Responsible party informed ... " January 31, 2015- Physical Examination- Physician ' s Note: " Have Pain: " N " ; Plan/Recommendations: Neurology f/u [follow up] for MS [Multiple Sclerosis] meds [medications] and start via G-Tube (Gastrostomy Tube) or IM. " February 16, 2015- 15:12 (3:12 PM)- Type: SOAP Note- Subjective: " ...seen today for evaluation- states [he/she] had pain, tried to point to [his/her] head. Nurse administered pain medication right away. Plan- Seroquel [Atypical anti-psychotic] decreased to 50mg q hs [hour of sleep] - On Gabapentin 600mg [milligram] tid [three times a day]. " Neurology Consultation: A neurology consult dated January 20, 2015 revealed: " From Wellness notes, patient is on Tecfidera 240mg twice per day along with adjunct medications of neurontin, seroquel and oxybutynin [drug for urinary tract anti-spasmodic]. Off Marinol of which [resident ' s responsible party] is not sure why. According [to] [Responsible Party], patient has verbalized pain sensation as well as observed non-verbal cues. [He/she] points to [his/her] headache and body.	L 052		

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L 052	Continued From page 50 [He/she] does receive as needed APAP (Tylenol-pain analgesic). [He/she] is off Marinol. Most pressuring issues today to [his/her] [Responsible Party] are: (1) worsening dysphagia- [patient] can no longer swallow Tecfidera (oral delayed-released capsules used for the treatment of patients with relapsing forms of Multiple Sclerosis) and new DMT (Dimethyltryptamine) is needed and (2) [patient] continues to have pain- she [sees] [him/her] crying at times. Patient Instructions: Problem #1: [History] of Multiple Sclerosis, Progressive/Relapsing- The patient has presented with chronic progressive MS. [He/she] has been on Tecfidera for several months. Unfortunately, because the Tecfidera capsules cannot be crushed and given to [him/her] via G-tube, we have to switch the patient to AUBAGIO (teriflunomide)- [used to reduce flare-ups in people with relapsing multiple sclerosis] at an initial dose of 7mg once a day daily for about 3 months, then switch to the 14mg/day dose[enrollment form was completed today). TB [Tuberculin] test will be required. Liver function will have to be checked monthly for the first 6 (six) months of therapy. (2) We suggest increasing the daily dose of Gabapentin [neurontin] from 400 up to 600mg three times a day (for pain, including headache). Problem #2: Headache- Since the patient has presented with apparent headache, we ordered a CT to rule out hydrocephalus or subdural hematoma. Order- CT Head (Computerized Tomography) or Brain without Contrast. " A review of the Pain Management Flow sheets for November 2014 through February 11, 2014 revealed the following: " Pain Rating Scale Legend: 0- No Hurt; 2- Hurts Little Bit; 4- Hurts Little More; 6- Hurts Even More; 8- Hurts Whole Lot and 10- Hurt Worst.	L 052		

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L 052	Continued From page 51 Location of Pain was " general " with a behavior of " restlessness " exhibited prior to med (medications) for some of the occurrences. The Resident ' s pain scale prior to the administration of Tramadol 50mg PRN revealed the following quantitative pain intensity assessments: During the month of November 2014 the resident ' s experienced pain daily that ranged from four (4) to seven (7) out of 10 as follows: 4/10- 1 time 5/10- 5 times 6/10- 34 times 7/10- 3 times During the month of December 2014 the resident ' s experienced pain daily that ranged from five (5) to eight (8) out of 10 as follows: 5/10- 5 times 6/10- 37 times 7/10- 1 time 8/10- 1 time During the month of January 2015 the resident ' s experienced pain daily that ranged from four (4) to six (6) out of 10 as follows: 4/10- 1 time 5/10- 29 times 6/10- 23 times On January 20, 2015 the resident ' s Neurontin was increased from 400mg to 600mg three (3) times a day. During the month of February 2015 the resident ' s experienced pain daily that ranged from five (5) to six (6) out of 10 as follows: 5/10- 8 times 6/10- 15 times The Medication Administration Records [MARs]	L 052		

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L 052	Continued From page 52 for December 2014 through February 2015 revealed that the nurses signed their initials in the allotted spaces, which indicated that [Resident #177] was assessed for, pain every shift and was administered Tramadol 50mg every six (6) hours as directed for pain prn. Also, Neurotin 600mg was administered three times a day for neuropathy pain, including headache. A review of the Nurse Practitioner ' s Communication book located on the unit revealed the following entry: " December 19, 2014- Don ' t think the pain medication is working. Have nurse practitioner review medication. " There was no evidence that the nurse practitioner addressed the aforementioned nursing communication. The following interviews were conducted regarding Resident #177 ' s pain management and multiple sclerosis medication: A face-to-face interview was conducted on February 12, 2015 at approximately 2:45 PM with Employee #58 in regards to Resident #177 ' s pain management and the initiation of the new drug. [He/she] stated, they [medical doctors] have to be very careful with switching research drugs and it takes time to get them approved. [He/she] further stated the neurologist increased the resident's Neurontin and [he/she] would talk to the attending doctor regarding the resident ' s pain. A face-to- face interview was conducted on February 12, 2015 at approximately 3:30 PM with Employee #4 regarding Resident #177 ' s multiple sclerosis and pain management medication. [He/she] called Employee #55 regarding the " granules " of Tecfidera - having difficulty administering through the resident ' s GT	L 052		

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L 052	Continued From page 53 (Gastrostomy tube) instructed by Employee #55 to ask the Pharmacist to get an alternate medication. Employee #55 recommended Avonex IM. Employee #4 was informed by the pharmacist that there was no alternate medication for Tecfidera and the doctor was informed. [He/she] further stated that the physician wanted to talk to the pharmacist. The pharmacist telephone number was given to the doctor to call. Also, Employee #4 stated that the resident ' s pain was assessed and [he/she] can verbalize or nod if [he/she] is in pain. We look at " facial expressions and grimaces. " In September 2014 [he /she] seem like [he/she] " was in more pain. " They only wanted to prescribe Tramadol. On December 21, 2014, " I was transferred to another floor to assume another position " . A face-to-face interview was conducted on February 12, 2015 at approximately 3:10 PM with Employee # 6. He/she stated when [he/she] was looking at the MAR (Medication Administration Record), [he/she] noticed that the medication (Tecfidera) was circled in red and immediately informed the nurse that " we cannot hold medication. " Employee #6 proceeded to tell the nurse to call the mother and inform [him/her]. The [responsible party] made the appointment for the resident to see the neurologist. An order was written on December 21, 2014 to hold the medication. A face-to-face interview was conducted on February 12, 2015 at approximately 3:15 PM with Employee #14 regarding the Purified Protein Derivative (PPD) results. He/she stated he/she faxed the first PPD results to the neurologist nurse practitioner on January 23, 2015 and the second one on February 5, 2015. [He/she] called	L 052		

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L 052	Continued From page 54 on February 6, 2015 to follow up on if the fax was received. However, did not get a voicemail. So [he/she] left a message for [him/her] to return [his/her] call. Further stated, he/she made a follow-up call on February 9, 2015; left another message for a return call. Another call was placed on February 12, 2015; informed he/she was not available. I then asked to speak to the " next person in charge. " At that time, the nurse practitioner " picked her line up to talk. When queried about the resident ' s pain; Employee #14 stated, " I go in frequently to assess [him/her]. All the nurses are aware of this. Also, Employees #2 and #6 had in-services with the nurses on all three shifts regarding frequent monitoring (every two hours) of resident. On December 19, 2014, I documented in the NP ' s [Nurse Practitioner ' s] communication book about the resident ' s pain medication being reviewed. A face-to-face interview was conducted with Employee #41 on February 17, 2015, who stated, Resident #177 ' s diet was tapered to pureed pleasure feedings. However, evaluation for October through November 2014, the resident was not safely tolerating anything by mouth. The medication for [his/her] multiple sclerosis could not be crushed to go through the gastrostomy tube. A telephone interview was conducted on February 12, 2015 at approximately 5:25 PM with Employee #55 (Attending Physician). He/she stated; the resident is always in pain regardless. Further stated, anytime you ask him, [he/she] is in pain. With the resident taking Neurontin and Tramadol, it puts [him /him] in a semi-comatose state. Employee #55 acknowledged [he/she] talked to the neurologist after the resident ' s appointment. However, did not document any	L 052		

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L 052	Continued From page 55 notes in the resident ' s clinical record regarding the discussion and plan. He/she further stated there are very few medications that will work with [him/her] (Resident #177) at this stage of [his/her] Multiple Sclerosis. We are waiting for the neurologist to prescribe the medication. It takes a long time to get it approved by the insurance. A follow-up face-to-face interview was conducted with Employee #55 (Attending Physician) on February 13, 2015 at approximately 1:00 PM. He/she stated that the [responsible party of Resident #177] has multiple complaints. [He/she] wants the resident to be on 1:1 (one-to-one), which is not possible and have " selective nurses " to work with [him/her]. I have seen the [responsible party] in the facility multiple times and [he/she] has not complained to me. Further stated, " The patient is not suffering. " Employee # again re-iterated that the problem with Tramadol and Neurontin is it can cause the resident to be in a semi-comatose state. You have to be very careful when you are using experimental drugs with other medications. The insurance has to approve the drug. I will let the neurologist handle that. The mother will get an appointment with the neurologist. [He/she] is the expert. I will have to evaluate [his/her] pain medications and [he/she] (neurologist) can refer [him/her] to pain management. A query was made about the Marinol for pain. He/she stated that the insurance was not paying for it. He/she further stated the Marinol was not for pain; it was to help [his/her] appetite. Now that the resident has the gastrotomy tube, it is not needed and was discontinued. A face-to-face interview was conducted with Employee #71 on February 19, 2015 at approximately 2:00 PM. When queried about the entry dated [December 19, 2014] in the nurse	L 052		

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L 052	Continued From page 56 practitioner ' s communication book. He/she stated that [he/she] did not know about the entry. Further stated, [he/she] does not have a set scheduled to see certain residents. When [he/she] goes to the units, [he/she] deal with acute issues. The nurses usually inform them what the concerns are. A telephone interview was conducted with Employee #54 on February 19, 2015 at approximately 2:30 PM. When queried about the order written for pharmacist to recommend an alternative medication for the Tecfidera. He/she stated that the contractor, the one who manufactures the drug has to be called. Further stated that the [facility ' s contracted pharmacy] has no documentation regarding being called by anyone to discuss the issue of an alternate medication. Also, no fax was received for the order. A face-to-face interview was conducted with Employee #68 on February 20, 2015 at approximately 1:30 PM. When asked how she assesses resident for pain? He/she replied, " I guess when [he/she] grits [his/her] teeth, and he does say ouch sometimes. " Employee #68 shared within that week, when [he/she] works- " seen him grit teeth almost every day. One of [his/her] hands is contracted and [he/she] says it hurts him. I ask if [he ' s/she] in pain, and [he/she] can verbalize it. [He/She] will tell me and I let the charge nurse know. " In conclusion, the Marinol [prescribed on October 6, 2014 for pain control] was held on October 7, 2014 and to date [February 19, 2015] had not been administered. December 21, 2014- an order was written to hold	L 052		

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L 052	Continued From page 57 the Tecfidera until the [attending physician] spoke with the pharmacy. The attending physician made a visit on December 31, 2014. There was no evidence that the physician addressed any discussion with pharmacist or pharmacy representative for an alternative medication for Tecfidera [prescription medication used to treat relapsing multiple sclerosis] prior to the neurology appointment on January 20, 2015. At the time of this review Resident #177 had not received the Tecfidera for approximately 54 days [from the date of discontinuance to February 19, 2015] On January 20, 2015 the resident was seen by a neurologist. At this time it was recommended that the resident begin an alternative medication to treat MS. However, before starting the medication the resident was required to have a TB [Tuberculosis test]. Once the facility staff conducted the test the results were faxed to the Neurologist office. According to facility staff the representatives ' from the neurologist office never acknowledged receipt of the TB test results. There was no documented evidence that the responsible party, physician and/or the director of nursing were notified that there were delays in a response to the next step in treatment. The physician and facility staff failed to follow through on the availability of the prescribed alternative medication for the resident's diagnosis of multiple sclerosis. At the time of this review there was no evidence that measures were implemented to treat the resident ' s symptoms associated with MS. Subsequently, the resident ' s treatment for Multiple Sclerosis was delayed and the pain	L 052		

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L 052	Continued From page 58 management regimen was ineffective. The clinical record was reviewed on February 19, 2015. The RP ' s [Responsible Party] concern related to Insufficient nursing staff was addressed in CFR 483.75 (F492) B. Based on observations, record review and interviews for six (6) of 51 sampled residents, it was determined that the facility staff failed to ensure sufficient nursing time was given to administer medications in accordance with physician ' s orders as evidenced by failure to: administer medications as prescribed to three (3) residents ' whose scheduled medications were to be administered at the same time of dialysis treatments; administer antibiotics (amoxicillin) as prescribed for one (1) resident; modify dosages of psychotropic medications (Rozerem and Ambien) in accordance with physician ' s orders for one (1) resident; administer anticoagulant medication (Xarelto) and a bronchodilator (Spiriva) as prescribed for one (1) resident; and to administer an insulin antagonist medication (Glucagon) as prescribed to manage a glycemic reaction for one (1) resident. Residents ' # 16, 135, 211, and 291. The findings include: 1. Facility staff failed to ensure sufficient nursing time was given to administer medication(s) to Resident #16 on his/her assigned dialysis treatment days. A review of the Physician's orders signed and	L 052		

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L 052	Continued From page 59 dated February 6, 2015 directed: "Ascorbic Acid [vitamin supplement] 250 mg [milligrams] give 1 tablet by mouth daily for supplementation; Aspirin [anticoagulant] give 81 mg by mouth daily for prophylaxis; Finasteride [androgen hormone inhibitor] 5 mg give 1 tablet by mouth daily for hypertrophy prostate without urinary obstruction... Nephrocaps [B-Complex C-Folic Acid] 1mg give 1 capsule by mouth daily for supplement; Pravastatin Sodium [anti-cholesterol] 20 mg give two (2) tablets by mouth daily for Hyperlipidemia. " A review of the February 2015 MAR revealed that on Monday, February 2, 2015; Wednesday, February 4, 2015; Friday, February 6, 2015; Monday, February 9, 2015; and Wednesday, February 11, 2015 the facility staff initials were circled in the designated boxes. This indicated that the resident's medications were not given. A review of the MAR lacked evidence that Ascorbic Acid, Aspirin, Finaseride, Nephrocaps, and Pravastatin Sodium were administered, as ordered by the physician on five (5)] of eight [8] days that the resident received dialysis. There was no documentation that the resident suffered adverse effects. A face-to-face interview was conducted with Employee #25 on February 13, 2015 at 11:00	L 052		

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L 052	Continued From page 60 AM. He/she stated that Resident #16 has dialysis on Monday, Wednesday, and Friday at 9:15 AM. A face-to-face interview was conducted with Employees ' #4 and #5 (Assistant Directors of Nursing) on February 20, 2015 at approximately 1:30 PM. They acknowledged the findings. Through staff interview and review of the clinical record it was determined that the facility staff failed to ensure sufficient nursing time was given to administer medications to Resident #16 on days that dialysis treatment was rendered. The record was reviewed on February 20, 2015. 2A. Facility staff failed to ensure sufficient nursing time was given to discontinue Rozerem (hypnotic medication) and continue Ambien (hypnotic medication) as ordered for Resident #135. A review of the Quarterly Minimum Data Set (MDS) dated October 14, 2014 revealed that the resident's diagnoses included End Stage Renal Disease, Insomnia, Cerebrovascular Disease, Diabetes Mellitus, Gastroparesis, Hypertension, Anemia, Depressive Disorder, and Dysphagia, and Hyperlipidemia. The medication orders for February 2015 revealed the following: "Rozerem 8 mg tablet, give 8 mg by mouth at bedtime for insomnia. Administer 30 mins [minutes] before bedtime" "Zolpidem Tartrate give one tablet 10 mg by mouth every evening at bedtime."	L 052		

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L 052	Continued From page 61 The physician ' s order dated February 4, 2015 and timed 5:30 PM directed, " D/C [Discontinue] Rozerem (on Ambien) ... " A review of the February 2015 Medication Administration Record revealed: · Rozerem 8 mg was administered as prescribed February 1 through February 10. However, the medication was discontinued on February 4, 2015. The facility staff administered six (6) additional doses of the medication. · Zolpidem Tartrate tablet 10 mg was administered from February 1, 2015 to February 5, 2015. The medication was " D/C " [discontinued] thereafter. There was no documented evidence of an order to discontinue the Zolpidem tartrate. However, the facility discontinued the medicine on February 5, 2015. On February 11, 2015 at approximately 12:15 PM, a face-to-face interview was conducted with Resident #135. He/she was asked if he/she had experienced any changes in his/her sleep pattern or orientation status over the past week? He/she replied, "No." On February 11, 2015 at approximately 12:20 PM, a face-to-face interview was conducted with Employees #25. He/she was asked to explain the order on February 4, 2014. He/she stated, " It says to discontinue the Rozerem on Ambien." When asked what that meant? He/she stated, " It ' s unclear, but the Ambien was discontinued." The employee was then asked to display the order to discontinue the Ambien. He/she stated, " I don't see the order to discontinue the Ambien." The employee was asked if there was an order to continue the Rozerem? He/she stated, " No."	L 052		

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L 052	Continued From page 62 On February 11, 2015 at approximately 12:25 PM, a face-to-face interview was conducted with Employees #4. He/she was asked to explain the order on February 4, 2014. He/she stated, " It reads to discontinue the Rozerem on Ambien."When asked what that meant? He/she stated, " It means to discontinue the Rozerem." When asked if the order was to discontinue the ambien, he/she replied, "No." When asked if the resident was receiving the Ambien, as ordered? He/she stated, "No, I will clarify the order with the nurse practitioner." He/she acknowledged the aforementioned findings and later stated, "It was a misunderstanding, and the resident should be receiving the Ambien, not the Rozerem." Facility staff failed to ensure sufficient nursing time was given to discontinue Rozerem and continue Ambien, as ordered by the physician. The clinical record was reviewed on February 11, 2015. 2B. Facility staff failed to ensure sufficient nursing time was given to administer medication to Resident #135 on dialysis days. Primary medical history-Gastroparesis, Dysphagia, Shortness of Breath, End Stage Renal disease on dialysis, Diabetes type 1, hypertension, Cerebrovascular disease, esophageal reflux, hemiplegia affecting dominant side. Physicians' orders signed and date February 6, 2015 directed, " Dialysis treatment on Tuesdays, Thursdays, and Saturday.	L 052		

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L 052	Continued From page 63 " Amiodarone HCL [antiarrhythmic] Tablet 200 mg [milligrams] give 200mg by mouth daily; Aspirin [antiplatelet] tablet delayed release 81 mg oral (By mouth) once daily prophylaxis 81mg Po [by mouth] Begin 1/23/2014; Plavix [anti-platelet] tablet 75 mg give 1 tablet by mouth daily for cerebral vascular accident." Lactulose [laxative] Solution 20 gm [grams]/30ML [milliliter] oral by mouth daily for constipation. A review of the February 2015 MAR revealed the following: Saturday February 7, 2015, Tuesday February 10, 2015, Thursday February 12, 2015 initials in the designated boxes were circled indicating that the residents ' medications were not given at 1400 [2:00pm]. The reverse side of the February 2015 MAR revealed nursing entries as follows: " 2/7/15 1400 Amiodarone not given resident on dialysis; 2/10/15 Morning and afternoon medication not given resident in dialysis; 2/12/15 afternoon pills not given resident on dialysis. " There was no evidence that Amiodarone, Aspirin, Lactulose and Plavix, were administered as ordered by the physician on the aforementioned days that the resident received dialysis. A face-to-face interview was conducted with Employee #25 on February 13, 2015 at 11:00 AM. He/she stated that Resident #135 has dialysis on Tuesday, Thursday, and Saturday at	L 052		

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L 052	Continued From page 64 9:15 AM. A face-to-face interview was conducted with Employees ' #4 and #5 (Assistant Directors of Nursing) on February 20, 2015 at approximately 1:30 PM. They acknowledged the findings. Through staff interview and review of the clinical record it was determined that the facility staff failed to administer medications to Resident #135 on days that dialysis treatment was rendered. The record was reviewed on February 20, 2015. 3. Facility staff failed to ensure sufficient nursing time was given to follow physician ' s order to administer a bronchodilator (Spiriva) for Chronic Obstructive Pulmonary Disease (COPD and to administer an anticoagulant (Xarelto) for deep vein thrombosis. Resident #211. 3a) Facility staff failed to follow physician ' s order to administer Spiriva to Resident #211who has a diagnosis of COPD. The physician ' s order dated February 10, 2015 directed, " Spiriva Hand inhaler Capsule 18Mcg 1 puff inhale orally one time a day for COPD to begin on February 11, 2015 " . A review of the Medication Administration Record (MAR) for February 2015 revealed that Spiriva was not administered on February 11 and 12, 2015. 3b) Facility staff failed to ensure sufficient nursing time was given to follow physician ' s order to administer an anticoagulant (Xarelto) for	L 052		

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L 052	Continued From page 65 prevention of deep vein thrombus. The physician ' s order dated February 10, 2015 directed, " Xarelto Tablet 20mg one (1) tablet one (1) time a day for DVT (deep vein thrombosis) prophylaxis to begin on February 11, 2015 " . A review of the MAR for February 2015 revealed that Xarelto was not administered on February 11 and 12, 2015. A face-to-face interview was conducted with Employee #12 on February 13, 2015 at approximately 11:00AM. The employee acknowledged that the medications were not administered to the resident as ordered because they were not received from the pharmacy and were not available in the Pyxis (Medication Storage System). The employee then added, "The medications came in today [February 13, 2015] and were given to the resident. Employee #12 acknowledged the finding. The record was reviewed on February 13, 2015. 4. Facility staff failed to ensure sufficient nursing time was given to administer medications on dialysis days for Resident #291. A review of physician ' s orders signed and dated February 6, 2015 directed the following: " Amlodipine Besylate [antihypertensive] Tablet 10mg [milligrams]Give 1 Tablet orally one time a day for HTN [hypertension] hold for SBP [systolic blood pressure] less than 110 hr [heart rate] less than 60 " " Aspirin [anticoagulant] tablet chewable 81mg give 1 tablet orally one time a day for cva	L 052		

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L 052	Continued From page 66 [cerebral vascular accident] Prophylaxis " " Glipizide [antidiabetic] ER [extended realease] tablet extended release 24 hour 5 mg give 1 tablet orally one time a day for diabetes mellitus" A review of the MAR dated February 2015 revealed the following: Tuesday February 3, 2015, Saturday February 7, 2015, Tuesday February 10, 2015, and Thursday February 12, 2015 initials in the designated boxes were circled, which indicated that the residents ' medications were not given. On the back of the MAR documentation revealed, " 2/3/2015 Morning Pills not given resident in dialysis; 2/7/2015 Morning pills not given resident in dialysis; 02/10/2015 Morning pills not given resident on dialysis " A review of the clinical record lacked documented evidence to indicate that medications ordered one time a day, on specific dialysis days were omitted and not given to the resident on that day. A face-to-face interview was conducted on February 13 at 11:00AM with Employee #25 who stated that Resident #291 has dialysis on Tuesday, Thursday, and Saturday at 9:15AM. When asked where he/she documented that the once daily medications were given upon the resident ' s return from dialysis, he/she stated that the medications were not given. A face-to-face Interview was conducted with Employees ' #4 and #5 Assistant Directors of Nursing on February 20, 2015 at approximately 1:30PM regarding medications being held on dialysis days. They acknowledged the findings. The record was reviewed on February 20, 2015.	L 052		

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L 052	Continued From page 67 C. Based on observations, record review and interviews for two (2) of 51 sampled residents, it was determined that the facility staff failed ensure sufficient nursing time was given to assess pain and vital signs for one (1) resident as prescribed, and to accurately assess the status of Hemodialysis access sites for one (1) resident. Residents ' # 99 and 259. The findings include: 1A.Facility staff failed to ensure sufficient nursing time was given to use the numerical pain assessment scale " 0 to 10 " as per the physician's order to assess pain for Resident #99. A review of an " Interim Order Form" dated December 27, 2014 directed, " Assess resident for pain every shift on a scale from 0 to 10 every shift." A review of Resident #99 's MAR dated from December 2014, January 2015, and February 2015 revealed, "Assess resident for pain every shift on a scale from 0 to 10 every shift." On the following shifts, the pain assessments were not conducted as ordered: December 28 and 31, 2014 evening shift and December 31, 2014 day shift, January 3, 2015 day and night shift and January 31, 2015 on evening shift February 7, 9, and 10, 2015 day shift.	L 052		

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L 052	Continued From page 68 A face-to-face interview was conducted on February 10, 2015 at approximately 1:30 PM with Employee # 3. He/she acknowledged the findings. The record was reviewed February 10, 2015. There was no evidence that facility staff assessed the resident's pain, as per the physician's order. 1B.Facility staff failed to ensure sufficient nursing time was given to perform vital sign assessment as per the physician ' s order for Resident #99. A review of Resident #99 ' s " Treatment Administration Record " [TAR] dated December 2014 revealed an order that directed, "Vital signs every shift [times] three days. " that was left blank (indicating it was not done) on the day shift dated December 28, 2014. A review of Resident #99 ' s clinical record revealed an " Interim Order Form " that included an order dated December 27, 2014 that directed " Vital signs every shift x three days. " The December 2014 TAR lacked evidence that facility staff performed Resident # 99 vital signs assessment every shift [times] three days per the physician ' s order as evidenced by lack of initials in the space allotted for signature left blank on the day shift of December 28, 2014. A face-to-face interview was conducted on February 10, 2015 at approximately 1:30 PM with Employee # 3. He/she acknowledged the aforementioned findings. The record was	L 052		

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L 052	Continued From page 69 reviewed February 10, 2015. 2. Facility staff failed to ensure sufficient nursing time was given to demonstrate accurate knowledge of the dialysis access site assessment for Resident #259. According to Lippincott Nursing Center, " the nurse should assess to ensure that the resident has a continuous audible bruit and a palpable thrill at the AV [arteriovenous (connection between the artery and the vein)] fistula or graft. It may be assessed by performing the following: Listening for a continuous, low-pitched bruit [a whooshing sound made when blood flows through a vessel] over the access site with a stethoscope, and palpating for a thrill (pulsation) or "buzzing" sensation by lightly placing the hand at the distal anastomosis site. " According to the facility ' s policy titled, ' Dialysis,' " Shunt site will be monitored every shift by palpating for thrill and auscultating for bruit. Physician will be notified of the absence of a thrill or bruit. " A review of the admission record revealed that the resident was admitted on September 27, 2013 with diagnoses that included Atrial Fibrillation, Acute Venus Embolism, Type II Diabetes Mellitus, Hypertension, Depressive Disorder, End Stage Renal Disease, Anemia, and Lower Limb Amputation. Review of the 'Order Summary Report' dated February 2015 revealed the following: " Assess graft site for bleeding every shift " " Assess site for bruit & thrill -document presence or bruit & thrill every shift "	L 052		

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L 052	Continued From page 70 Review of the TAR dated February 2015 revealed the following: " Assess graft site for bleeding every shift, Order date May 8, 2014 " " Assess site for bruit & thrill -document presence or bruit & thrill every shift, Order date April 16, 2014 " The allotted spaces for signatures to indicate that this task was performed were signed up until February 19, 2015, night shift. On February 19, 2015 at approximately 12:30 PM, a face-to-face interview was conducted with Employees #42. When asked if he/she ever performed and documented the assessment of the bruit & thrill on Resident #259, he/she replied, " Yes." When asked how to perform the assessment? He/she stated, " I feel [demonstrated touching the arm] for the bruit, and I auscultate the thrill. When asked what sound he/she auscultated for? He/she stated, " The sound is dumm dumm for the thrill." On February 19, 2015 at approximately 12:40 PM, a face-to-face interview was conducted with Employees #43. When asked if he/she ever performed and documented the assessment of the bruit & thrill on any dialysis residents? He/she responded, " Yes." When asked how to perform the assessment? He/she stated, "I feel the graft for the thrill, and I use my stethoscope to auscultate the bruit." When asked what sound he/she auscultated for? He/she stated, "I do it, but I don't pay attention to the sound." On February 19, 2015 at approximately 12:50 PM, a face-to-face interview was conducted with Employees #28 who acknowledged the	L 052		

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DEANWOOD REHABILITATION AND WELLNESS	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

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L 052	Continued From page 71 aforementioned findings. Facility staff failed to demonstrate accurate knowledge of the dialysis access site assessment. The clinical record was reviewed on February 19, 2015. D. Based on observations, record review and interviews for eight (8) of 51 sampled residents, it was determined that sufficient nursing time was not given to follow physician ' s orders to: discontinue a venous access device [PICC line] for one (1) resident; maintain a dialysis emergency kit proximal to the bedside for two (2) residents; obtain daily weights as prescribed for the management of a cardiac disorder for one (1) resident; obtain and implement prescribed adaptive equipment [scoop mattress] to promote safety from falls for one (1) resident; obtain diagnostic study reports for one (1) resident; follow-up on an ophthalmology consult for one (1) resident and obtain diagnostic laboratory specimens as prescribed for one(1) resident. Residents ' # 93, 116, 135, 223, 283, 291, 292, and 352. The findings include: 1. Facility staff failed to ensure sufficient nursing time was given to follow physician orders to keep a dialysis emergency kit by the bed side for Resident #93. Resident #93 was admitted to the facility on May14, 2013 with diagnoses that included ESRD	L 052		

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L 052	Continued From page 72 [End Stage Renal Disease Dialysis Dependent]. Review of the Resident's MDS [Minimum Data Set] with an ARD [Assessment Reference Date] of December 10, 2014 revealed that the resident was coded with the diagnosis of Renal Dialysis under Section I (Active Diagnoses). A review of the clinical record revealed a telephone order signed and dated by the physician on February 3, 2015 that directed, " Dialysis emergency kit at bedside at all times every shift. " A review of the February 2015 Treatment Administration Record revealed that on February 11 a signature indicating that the dialysis emergency kit was at the resident's bedside. A review of the resident's care plan revealed a focus area initiated July 27, 2014, " The resident has, renal failure r/t [related/to] End Stage Disease " and interventions to include: "check dialysis emergency kit every shift." A resident room observation was conducted on February 11, 2015 at approximately 10:30 AM with Employee's #9 and #17. There was no evidence that a dialysis emergency kit was kept at the bedside. A face-to-face interview was conducted with Employee's #9 and #17. At the time of the observation, Employee #17 stated, " The CNA	L 052		

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L 052	Continued From page 73 [Certified Nursing Assistant] might have removed it from the bedside during resident care." Facility staff failed to ensure sufficient nursing time was given to follow physician orders to keep a dialysis emergency kit by the bedside. 2. Facility staff failed to ensure sufficient nursing time was given to follow-up on Resident # 115's responsible party's request for ophthalmology consults. The annual MDS (Minimum Data Set), dated October 7, 2014 revealed under Section I (Active Diagnoses) that Resident #115 diagnoses included Diabetes Mellitus and Glaucoma, Cataracts or Macular Degeneration. A physician order summary report dated February 2, 2015 directed: " Travatan [eye drop medication used to treat glaucoma] 0,004% Ophthalmic every evening at bedtime - one drop in both eyes [for] Glaucoma, Dorzolamide (HCL- Hydrochloride) [eye drop medication used to treat glaucoma] Solution 2% Ophthalmic every eight hours- 1 (one drop) in both eyes [for] Glaucoma. " A review of Resident #115 ' s comprehensive care plan revealed; " Focus: The resident has impaired visual function [related to] Cataracts, Glaucoma, uses glasses. Interventions: Administer eye drops as ordered ... Arrange consultation with eye care practitioner as required, Ophthalmology/Optometrist consult as	L 052		

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L 052	Continued From page 74 ordered ... " A review of the care conference notes dated June 9, 2014 and January 28, 2015 revealed that the responsible party requested an eye exam for Resident #115. There was no documented evidence of any ophthalmology consult in the clinical record. A review of the clinical record lacked evidence that ophthalmology consult was obtained. A face-to-face interview was conducted with Employee #11 and Employee # 57 on February 10, 2015 at approximately 12:56. Employee #57 stated because the resident is a diabetic, he/she is suppose to see an ophthalmologist every year. It is a standing physician ' s order. The clinical record was reviewed on February 10, 2015. 3. Facility staff failed to ensure sufficient nursing time was given to follow physician orders to keep a dialysis emergency kit by the bedside for Resident #135. Resident #135 was admitted to the facility on May14,2013 with diagnoses which included ESRD [End Stage Renal Disease Dialysis Dependent]. Review of the Resident's MDS [Minimum Data Set] with an ARD [Assessment Reference Date]	L 052		

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L 052	Continued From page 75 of January 14, 2015 revealed the resident was coded in Section I Active Diagnoses: (J) End Stage Renal Disease. A review of the clinical record revealed a telephone order signed and dated by the physician on February 3, 2015: Order summary: Dialysis emergency kit at bedside at all times every shift. A review of the resident's Treatment Administration Record for February 1, 2015 through February 28, 2015 revealed a signature in box for February 11, 2015 which indicated that the dialysis emergency kit was by the bedside. A resident room observation was conducted on February 11, 2015 at approximately 10:30 AM with Employees' #9 and #17. There was no evidence of a dialysis emergency kit kept at the bedside. A face-to-face interview was conducted with Employee ' s #9 and #17 at the time of the observation. Employee #17 stated, " The CNA [Certified Nursing Assistant] might have removed it from the bedside during resident care. " Facility staff failed to ensure sufficient nursing time was given to follow physician orders to keep a dialysis emergency kit by the bedside. 4. Facility staff failed to ensure sufficient nursing time was given to obtain Resident #223 ' s diagnostic study results.	L 052		

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L 052	Continued From page 76 Resident #223 was admitted to the facility on October 10, 2014 with diagnoses which included: Congestive heart failure, cardiomyopathy, Hyperlipidemia, end stage renal disease, Hypertension, Human Immunodeficiency Virus A review of an interim order dated October 15, 2015 at 0915 [9:15 AM] directed, " Obtain chest x-ray ap/lat (anteroposterior/lateral position) today second to sob (short of breath), with coarse b.s. (breath sounds) to r/o (rule out) infiltrates. " A review of the clinical notes from October 15, 2014 to November 5, 2014 lacked evidence that the physician and facility staff follow up to obtain the results of the diagnostic study. A further review of the clinical record lacked evidence that results /findings of the chest x-ray was maintained on the active clinical record. A face-to-face interview was conducted with Employee # 3 on February 12, 2015 at approximately 12:30 PM. He/she acknowledged that the results of the chest x-ray were obtained. At this time the State Agency Representative was given a copy of the final radiology report with a date/time stamp of February 12, 2015 at 11:39 AM. A review of the radiology report electronically signed and dated October 15, 2015 at 8:45 PM revealed, " Conclusion: 1. Modest cardiomegaly with slight pulmonary venous congestion. 2. Modest right lower lobe infiltrates and/or right pleural effusion " . There was no evidence that facility staff obtained the results of the chest x-ray for Resident # 223.	L 052		

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L 052	Continued From page 77 The record was reviewed on February 12, 2015. 5.Facility staff failed to ensure that sufficient time was given to remove Resident #283 ' s PICC (peripherally inserted central catheter) line in accordance with the physician ' s order. A review of the PICC Catheter [protocol] signed and dated by the attending or designee on September 10, 2014 at 11:30 AM directed, " Unused lumens-Non-valved catheters Flush Q 12 hours each lumen ... Measure eternal catheter length on admission, weekly with each dressing change and PRN ... Flushes PICC line Q (every) 12 hours with normal saline, [followed] by heparin for maintenance until removed. Orders: A review of the physician ' s order dated September 10, 2014 at 12:20 PM directed, " D/c (discontinue) PICC (peripherally inserted central catheter) Line (if not in use). A review of the September 2014 PICC Line Catheter form revealed that the resident arm circumference above the midline insertion site was 26 [inches] on September 9, 2014. After September 9, there were no weekly measurements obtained as per the physician ' s order. The nursing notes revealed: September 10, 2014 at 22:12 [10:12 PM], Resident PICC line flushed for maintenance. Physician called to have PICC line discontinued. Advance PICC Specialist Inc [APS]. Called at 9PM [9:00 PM]. Waiting on return call ... " September 11, 2014 at 21:47 [9:47 PM], " ...PICC line flushed with normal saline followed by heparin for maintenance ... " September 12, 2014 at 15:03 [3:03 PM], "	L 052		

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L 052	Continued From page 78 ...PICC line flushed with normal saline followed by heparin for maintenance ... " September 14, 2014 at 21:37 [9:37 PM], " ...PICC line flushed with normal saline followed by heparin for maintenance ...Awaiting call back from APS for d/c picc line. " September 15, 2014 at 21:57 [9:57 PM], " ...PICC line flushed with normal saline followed by heparin for maintenance ...Awaiting call back from APS for d/c picc line. " September 16, 2014 at 16:51 [4:51 PM], " ...PICC line flushed with normal saline followed by heparin for maintenance ...Awaiting call back from APS for d/c picc line. " September 17, 2015 at 08:01 [8:01 AM], " B/p [blood pressure] 148/100, P [Pulse]- 85, R [respiration] -20 ...Resident has a diagnoses of lung cancer, He had an episode of SOB (short of breath) this morning, supervisor notified [doctor name] ... ordered O2 (oxygen) to be increased to 4 liters via nasal cannula continuous and if patient wishes to go to the hospital [he/she] should be transferred to the nearest ER (emergency room). Resident verbalized [he/she] feels better and refused to go to the hospital. Resident is resting in [his/her] room. " September 17, 2014 at 20:25 [8:25 PM] called Apex at 8:25 PM to follow up [on] removal of picc line. Spoke with [name]; stated IV [intravenous] nurse will soon arrive at facility. " September 17, 2014 at 21:44 [9:44PM], " Resident was give Enoxaparin Sodium (lovenox) subcutaneous at 8:55 [PM] with nebulizer treatment (albuterol), nurse stayed with resident for 2 minutes to see how the neb treatment is being tolerated. Charge nurse left the room to attend to another resident and came back in the room at 9:00 PM to check on resident. Upon getting to room nurse noticed resident was tilted	L 052		

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L 052	Continued From page 79 to the left side and drooling from [his/her] mouth. Resident was lying in the bed in supine position, skin was warm but not responsive, upon further assessment unable to obtain pulse oxymetery and blood pressure and patient was without respiratory effort. Patient is DNR. Patient was 70 years old ...diagnoses of lung cancer and bladder cancer ... " There was no evidence that a representative from APS arrived at the facility to remove the PICC line from Resident #283 as ordered by the physician. A telephone interview was conducted on March 11, 2015 at approximately 10:45 AM. He/she acknowledged the findings. 6.Facility staff failed to obtain Hemoglobin and Hematocrit [blood count values], stat [immediately] laboratory values CBC [complete blood count] to evaluate anemia of ckd [chronic kidney disease] and stool for occult blood x 3 for anemia as ordered by the physician; and failed to administer medications on dialysis days for Resident #291. A review of a nursing note dated January 14, 2015 at 1720 [5:20 PM] revealed, " 4:20 PM dialysis called unit about resident abnormal lab result of Hgb [Hemoglobin] of 5.9 and Hct [Hematocrit] 19.3 MD paged. 4:30 PM order for resident to be transferred to the ER [Emergency Room] for transfusion [order] given at dialysis by nephrologist. Lifestar called for resident transportation... " A review of a nursing note dated January 21, 2015 at 08:03 [8:03 AM] revealed " Resident is a readmission post blood transfusion due to low H&H [Hemoglobin and Hematocrit] ... "	L 052		

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L 052	Continued From page 80 A review of the physician ' s orders dated January 20, 2015 directed: " H/H [Hemoglobin and Hematocrit] every Wednesday one time a day every Wed," A review of the clinical record revealed that there was no Hemoglobin and Hematocrit drawn on Wednesdays (January 21, 28, February 4, 2015) between January 20, 2015 and February 4, 2015 by the facility. On February 3, 2015 monthly labs were drawn at the dialysis center that included a CBC study. On February 4, 2015 a Hemoglobin result of 5.5 [normal reference range 14.0 - 18.0] and Hematocrit result of 16.5 [normal reference range 42.0 - 52.0]. A review of the nursing note dated February 4, 2015 at 22:29 [10:29 PM] revealed, " Resident remain alert and verbally responsive, assisted with due care, medicated as ordered and well tolerated. Received paperwork from dialysis unit with hemoglobin level of 5.5. Call placed to MD, who said [his/her] NP [nurse practitioner] is in the building. NP notified, came to the unit and assessed resident. Wrote order for stat CBC, call placed to [lab] was told there was no one to come in for a draw. Supervisor notified, attempted to draw blood but was not successful. Call placed to MD who said lab should be drawn in the morning. No signs of acute distress noted. No bleeding noted. New order for Stool occult x 3 [three times]. " A review of the physician ' s order signed and dated February 4, 2015 at 4:30 PM directed the following: A "Stat lab: CBC [complete blood count] evaluate	L 052		

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L 052	Continued From page 81 anemia, CKD [chronic kidney disease] ...Stool for occult blood x 3 [three times] for anemia." A review of the clinical record lacked evidence that the Stat blood work was obtained for Resident #291. A review of a Nurse Practitioner ' s note dated February 6, 2015 revealed, " Resident seen today for f/u [follow up] of anemia. Stat CBC requested on 02/04/2015. Results still pending at this time. On evaluation today, pt [patient] is asymptomatic. [He/she] stated [he/she] had dialysis today and had some lab work done. Pt. continues to state [he/she] does not want to be sent to the ER [emergency room] for transfusion ...In [he/she] presently on Feso4 [ferrous sulfate is use to treat patients with low blood levels] and Aranesp for anemia of CKD. Will review labs once they are available. Pt [patient] is stable at this time. Stool for occult blood pending. No change in plan of care. " A face-to-face interview was conducted on February 13, 2015 at approximately 3:00PM. In addition, Employee #4 submitted a written statement, regarding the aforementioned findings, to the State Agency Representative on February 14, 2015 at 12:54 AM. The employee stated, " ...Concerning weekly H/H resident refused labs being drawn by phlebotomist on the unit and lab requisition and vacu-containers were sent for labs to be drawn from dialysis and picked up by phlebotomist as is our practice in [facility] for dialysis patients who do not want blood draw on the unit. According to the nurse [name], dialysis stated that the specimens were not picked up by any phlebotomist. " A review of the Dialysis Communication Sheet	L 052		

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L 052	Continued From page 82 dated February 5, 2015 indicates " NO " in the field " Labs Drawn today " . There was no documentation in the ' Pre-dialysis ' section of the form indicating that labs were to be drawn nor was there written communication to inform the dialysis center staff that the resident was in possession of blood tubes to obtain/collect blood samples. A review of the clinical record lacked documentation to support that there was a physician ' s order for labs to be drawn in dialysis, evidence of physician notification that the resident refused to have labs drawn in the facility, evidence that the residents refusal was documented in the plan of care, and evidence on the dialysis communication forms that indicated the resident was in possession of the containers used for obtaining blood samples. Subsequently, Resident #291 was sent to the hospital on February 13, 2015 to receive a blood transfusion. 7. Facility staff failed to ensure that sufficient nursing time was given to receive a scoop mattress for Resident #292 as ordered by the physician. A review of the nursing notes revealed, " November 15, 2014 at 15:41[3:41PM], Resident was observed on the floor on a laying position, upper extremities was on the floor while his/her lower extremities remained on the bed. At that time, bed was [in] a lower position ... " December 8, 2014 at 10:49 AM, " Resident was found on floor at noon ...upon assessment no bruise or laceration found ... "	L 052		

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L 052	Continued From page 83 A review of the February 19, 2015 incident report revealed, " Resident found hanging halfway out of bed with head on the floor. Bed was saturated with urine. " The physician ' s order last signed and dated February 19, 2015 directed, " Scoop mattress for bed secondary to hanging off at bedtime provide safety precautions order dated November 17, 2014, start date November 18, 2014. Observation: Resident #292 was observed lying in bed on February 20, 2015 at approximately 3:10 PM. The resident was lying on an air mattress (without a scooped edge). The bed was in a low position, the privacy curtain was in the closed position, and a gray mat was observed on the floor on the right side of the bed. The red call light/pad was on the night stand. A telephone interview was conducted with Employee #9 on March 4, 2015 at 12:28 PM. He/she stated, " I do not see an order for an air mattress. The resident is not on a scoop mattress. That order was discontinued on February 27, 2015. " There was no evidence that facility staff followed up on the physician ' s order to obtain a scoop mattress for Resident #292 who was observed with his/her head hanging off the bed and onto the floor and on the floor. The record was reviewed on February 20, 2015. 8. Facility staff failed to ensure sufficient nursing time was given to obtain daily weights for the management of a cardiac disorder (congestive heart failure) for Resident #352 as per the physician's order.	L 052		

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L 052	Continued From page 84 Resident #352 had a primary medical history of Congestive Heart failure, diabetes mellitus, hypothyroidism, coronary artery disease, hyperlipidemia, cardiomyopathy with a pacemaker, renal insufficiency, EF of 15%. A review of the nursing admission note dated October 5, 2014 revealed, " Resident is a 58 year old ...Admitting diagnosis include: CHF [Congestive Heart Failure], CAD [Coronary Artery Disease], H/O [history of], DM [Diabetes Mellitus]. Hypothyroidism, hyperlipidemia, ...Lungs clear to auscultation [auscultation], Heart rate regular; pacemaker noted on left side of the chest ...Lower extremities with 1+pitting edema. Central line removal side on right upper chest with clean dressing on. " The physician's order signed and dated October 6, 2014 directed the following, " Discontinue Lasix 40 mg, fluid restriction 1500 mls in 24 hrs, Lasix 20 mg po qd CHF, Dietary Consult, Daily Weights - CHF notify [physician] if >3lbs in 1 day or >5lbs in 3 days " A review of the weight summary in the clinical record revealed that the resident ' s weight was obtained on the following dates: October 4, 2014 - Weight = 233.2 Lift Scale Manual October 23, 2014- Weight = 246.0 Lift Scale Manual October 24, 2014 - Weight =230.1 Standing Manual A review of the nursing note dated October 23, 2014 stated, " ...Resident is alert and verbally responsive. All due meds were given and assisted with ADL ' s care. Resident gains weight from 233lb to 246lb. [Physician] notified and	L 052		

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L 052	Continued From page 85 ordered Lasix 20 mg po BID [twice a day] and cardiology consult. No discomfort and no distress noted at this time. " A review of the dietary note dated October 23, 2014 stated 10/23/2014 stated, " Resident visited and seen this day due to new weight of #246 done today. This weight indicate gain of #12.8 since admitted on 10/4/2014. Nursing notified to update physician on weight gain for further direction. Nursing to also repeat performance for verification. Will adjust dietary care as needed as per physician direction " A review of the dietary note dated October 24, 2014 stated, " Resident weight performed and supervised today at #230 [230 pounds] (standing). This weight indicate performance done 10/23/14 may be inaccurate and should be disregarded. Appearance consistent with weight range but significant change is questioned. Resident remains alert and communicative at this time. Physician is made aware of weights values and will adjust as directed. Will also follow up with repeat performance for consistency. " A face-to-face interview was conducted with Employee #40 on February 11, 2015 at 2:50 pm. When queried about the daily weights ordered for Resident #352. He/she stated, " If the weights aren't on the MAR/TAR on in the system then they weren't done. " A review of the clinical record lacked evidence that facility staff obtained daily weights for the management of a cardiac disorder as per the physician's order. E. Based on clinical record review, resident interview, and staff interviews for one (1) of 51	L 052	L052 E Same as F-Tag 224 1. Resident 259 was assessed and did not experience any ill effect from staff's failure to provide ADL. Immediate in-service to Nursing staff on a team approach with regards to providing ADL care on all shifts. 2. All residents have the potential to be affected by the deficient practice. No other resident were affected. All residents will be monitored on a daily basis to ensure ADL care is provided by staff. Facility will continue to interview and hire appropriate staff to fill all open positions. 3. All clinical staff was educated on team approach for providing ADL. Nursing staff will round during their shift to ensure resident's ADL care was provided. New staffing coordinator was hired on 4/6/15. The facility continues to recruit and schedule orientation until such time all open positions are filled.	

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L 052	Continued From page 86 sampled residents, it was determined that the facility staff failed to ensure sufficient nursing time was given to prohibit neglect of the resident, as evidenced by the staff's failure to provide Activities of Daily Living [ADL] care to Resident #259. The findings include: A review of the admission record revealed the resident was admitted on September 27, 2013 with diagnoses that included Atrial Fibrillation, Acute Venus Embolism, Type II Diabetes Mellitus, Hypertension, Depressive Disorder, End Stage Renal Disease, Anemia, and Lower Limb Amputation. A review of the resident's quarterly Minimum Data Set [MDS] dated January, 1, 2015 revealed under Section G [Functional Status], that the resident required extensive assistance with at least one (1) person assistance in personal hygiene, dressing, and toileting. The resident also required extensive assistance in bathing, bed mobiltiy and transfering, with two persons physical assist. The resident had functional limitations in range of motion to bilateral lower extremities. In Section H [Bladder and Bowel] the resident was coded as frequently incontinent of urine and bowel. A review of the care plans dated December 24, 2014 revealed the resident had an "ADL self-care performance deficit" that required "one (1) staff participation with bathing." On February 20, 2015 at approximately 2:45 PM, a face-to-face interview was conducted with Resident # 259, regarding a complaint that was made on February 15, 2015. The resident stated,	L 052	4. Administration will review all concern forms and interview resident's to ensure compliance is being met. Ambassador rounds will be done weekly by Directors as assigned. The findings will be analyzed and trended for pattern. Projections for next day staffing will be reviewed by ADON and designee and plan to staff the facility to meet the required PPD. PPD's will be calculated daily by staffing coordinator. Weekly schedule to be provided and reviewed by staffing coordinator and Nursing leadership to identify staffing needs to ensure adequate staffing daily. Open house started immediately and ongoing.	5/12/15

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L 052	Continued From page 87 "On Sunday [February 15, 2015] it was only two (2) Certified Nursing Assistants [CNA's] on the floor. The only time I saw a CNA is when they brought my tray in for lunch. I waited after lunch for someone to service me. At 2:55 PM, a CNA came in the room. I don't know [his/her] name, and it's not my job to give names. The CNA said, [resident's sir name], because of the workload we have, I'm not able to get to you on this shift. I will relay this to the next shift to take care of you. A little after 3:00 PM, the charge nurse came in the room, and I told the charge nurse. The charge nurse said, I know. I just don't have the people to work the floors. I apologize. I will let the next shift know to definitely clean you up. These nurses are so frustrated and they don't want to confront management because they are afraid their jobs are in jeopardy. I got cleaned up after 4:00 PM. I told the social worker on February 17, 2015 that I wanted to speak to administration [named personnel]. On February 18, 2015, they both [facility and nursing administration] came up to my room. I explained the situation. I didn't bite my tongue. I told them that management is doing a poor job providing us quality service. I told them it's no way to give quality service with two CNA's covering 35 people. I told [administration] that the blame is on them. I told them that we are paying residents and we demand quality services and I'm tired of hearing excuses." When asked what happened thereafter, he/she stated they [administration] apologized. On February 20, 2015 at approximately 3:15 PM, a face-to-face interview was conducted with Employee #34. When asked who provided ADL care to the resident, he/she stated, "I gave [resident's name] a complete bath, at approximately 4:00 PM or so." He/she stated, "The CNA that was assigned on the day shift	L 052		

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L 052	Continued From page 88 gave shift report that he/she [CNA] wasn't able to get to [resident's name] because they only had two CNA's that morning. He/she was giving care to the resident in the 'D bed', when I came in." On February 20, 2015 at approximately 3:35 PM, a face-to-face interview was conducted with Employee #19 regarding the complaint. He/she stated, "I am aware of a complaint about the floor only having two CNA's. I received a grievance form from the nurse manager. It was a complaint by [resident's name]. I spoke to [resident's name] on the 17th [February 17, 2015] to see what happened. He/she reported that they only had two] CNA's on the day shift this weekend. He/she stated that management doesn't care about the residents, its poor management, and he/she was going to report this to the state [State Agency], when they come in tomorrow. He/she asked to speak to administration. I met with him/her on February 18, 2015. I spoke to him/her the day before yesterday. He/she told me that [administration] came to talk to him/her." On February 20, 2015 at approximately 3:55 PM, a face-to-face interview was conducted with Employee #28. He/she acknowledged the aforementioned findings. He/she stated, "We know that [Employee #37's name] did not bathe the resident, and he/she was suspended for five days." A review of the Certified Nursing Assistants [CNA's] assignment(s) for February 15, 2015 revealed that Employee #37 was assigned to care for Resident #259 from 7:00 AM - 3:00 PM. A review of Employee #37's written statement revealed the following: "I was floated to 5S [5 South] from 4S [4 South] over the weekend. We working 2 [two] CNA's. I	L 052		

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L 052	Continued From page 89 realized [resident's sir name] did not get ADL care. I informed [resident] I will let the next shift know because I didn't have enough time, I still had 2 [two] other residents to care for." According to 3211.5 of the District of Columbia Municipal Regulations, Nursing personal and required daily average staffing levels are as follows: Registered Nurses 0.6 Total Staffing 4.1 A review of the facility staffing on February 15, 2015 revealed the following: Registered Nurses 0.42 Total Staffing 2.82 The staffing results listed above reveal that the facilty failed to provide sufficient numbers of personnel to provide nursing care to the resident. Subsequently, facility staff neglected to provide ADLs care such as, personal hygiene, dressing, bathing, toileting for Resident #259. On February 20, 2015 at approximately 5:00 PM, a face-to-face interview was conducted with Employee #2 regarding the aforementioned findings and staffing. He/she acknowledged the aforementioned findings. The clinical record was reviewed on February 20, 2015. F. Based on observations, record review and staff interviews for four (4) of 51 sampled residents, it was determined that facility staff failed to maintain a safe environment for one (1) resident who sustained a bump to the head secondary to being hit by an unattended object; failed to supervise two (2) residents who each sustained a fall without injury; failed to implement measures and	L 052	L052 F1,2a-b,3,4 Same as F-Tag 323 (A1, 2a-b,3,4) 1. Residents # 148, 25,292, and #115 were all assessed and did not have any negative outcome related to the deficient practice of the facility's failure to maintain a safe environment. Resident Number 25 , care plan was revised to address that resident will not be left alone in the bathroom. Resident Number 148 care plan was reviewed and revised to include rest periods after dialysis tx. The Maintenance staff was in-serviced not to keep any items on top of the paper dispenser to avoid such items from falling on residents. Resident number 292 care plan was reviewed and revised to include all interventions recommended by the Team. (scoop mattress provided, bed alarm on bed when resident is laying in bed, Curtain will be drawn open) Resident number 115, care plan was reviewed and revised by IDT members.Team also met to discuss discharge plan as residents wandering behavior is not easily redirected. Staff continues to monitor resident closely to prevent from entering into other residents rooms.	

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L 052	Continued From page 90 or provide adequate supervision to help ensure that (one (1) resident did not fall out of bed; and failed to consistently supervise one (1) resident who was observed walking on and off the unit and entering other residents' rooms without permission. Residents' #148, 25, 292 and 115. The findings include: 1. Facility failed to maintain a safe environment for Resident #25 who was left unsupervised in the bathroom which resulted in a fall without injury. According to the annual MDS (Minimum Data Set) dated February 4, 2015, Under Section C, (Cognitive Patterns), the BIMS [Brief Interview for Mental Status] score was 3, which indicated the resident was cognitively impaired. Section I [Active Diagnoses] included Anemia, Cerebrovascular Accident (CVA), End Stage Renal Disease, Altered Mental Status, Pulmonary Embolism [and] Infarction, Unspecified Hypotension. Section G [Functional Status] revealed the resident required extensive assistance of one person for toilet use and extensive assistance of two (2) persons for transfers between wheelchair to a standing position. A face-to-face interview was conducted with Employee #12 on February 6, 2015 at approximately 11:48 AM. He/she was asked; " Has the resident had a fall and/or sustained a fracture within the last 30 days? The employee replied, " Yes. " The resident fell in the bathroom on February 4, 2015 on the (7AM-3PM shift). " He/she further stated the resident did not sustain	L 052	2. All residents' potential to be affected by the deficient practice will be assessed by the IDT members. Care plans will be reviewed and revised to address appropriate interventions to reduce falls. The team will review all A and I's post fall to ensure appropriate measures are implemented and addressed in care plan. 3. Falls Prevention program policy and procedure was reviewed by the team. All new admission, readmission, quarterly and after a fall , a fall risk assessment will be completed . Staff Development will in-service staff on falls prevention, and protocol. All new hires will be in serviced on fall prevention program. Team will evaluate and assess root cause analysis for falls. Licensed nursing staff, C.N.A's and Rehab staff will be in serviced on fall prevention and management program. All new hires will also be in-serviced. A new staffing coordinator was hired. HR continues to recruit for all positions. Interviews conducted by Nursing Leadership. Orientation held twice a month. The daily PPD ratio is being projected a day in advance. Staffing coordinator was given expectations to have weekly schedule printed and to identify vacancies and fill vacancies in advance. ADON, Nurse Manager on the house continues to meet with staffing coordinator daily to review the schedule to ensure staffing is scheduled as required to meet federal and state guidelines. Daily PPD is now be discussed at Morning stand up meeting.	

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L 052	Continued From page 91 an injury and the last time [he/she] was seen prior to the fall, " [he/she] was sitting on the toilet. " A review of the nurses ' note revealed the following: " February 4, 2015 - Alert and verbally responsive. At 8:30 AM resident was found on the floor of the restroom lying on [his/her] right side. Fall was not witness. MD [Medical Doctor] notified and was told the position resident was found. MD ordered x-ray of the skull, and the right side of the body to rule out fracture ... resident was assessed head to toe. Resident denied pain, all extremities moveable, no bruise or skin tear noted. Ate lunch in dining room and left for dialysis. Neurocheck in progress. Left arm graft site dry/intact no bleeding noted. (+-positive) bruit/thrill present. V/S [Vital Signs] - 100/66 [Blood Pressure], [Pulse]-54, [Temperature] - 97.7, [Respirations] -18. February 4, 2015 - Resident is pleasantly confused with dx [diagnosis] of senile dementia. [He/she] has poor safety awareness/impaired judgment. Denies pain or any kind of discomfort upon assessment. [He/she] enjoyed a back rub during assessment. Staff has been [educated] not to leave [him/her] on the toilet by [him/herself]. [He/she] is alert, able to self propel in wheelchair on the unit and neuro checks in progress. February 4, 2015 - 14:25 (2:25 PM) - CNA (Certified Nursing Assistant) was educated on the importance of safety and not to leave residents on the toilet unattended if they are not capable to be left alone. " A review of the Rehabilitation Notes revealed the following: " Occupational Therapy - Therapy Progress	L 052	4. The QAPI coordinator will trend all falls monthly. Share findings with staff on all shifts. Results of the findings will be shared at the QA committee.	5/12/15

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L 052	Continued From page 92 Report " with dates of service from January 29, 2015 through February 4, 2015 revealed: " STG#3.0- Short Term Goal- Goal Met - Upgrade- Resident will safely perform toileting tasks using standard commode with Mod (A) [moderate assist] with good safety awareness. Baseline- January 29, 2015- Max (A) [maximum assist]; Previous (February 2, 2015) - Max (A) and Current (February 4, 2015) - Mod (A). STG #3.1- New Goal: Patient will safely perform toileting tasks using standard commode with Min (A) - (Minimum Assistance) with good safety awareness. Physical Therapy- PT (Physical Therapy) Evaluation [and] Plan of Treatment- Start of care January 29, 2015 - Risk Factors: Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for falls, further decline in function, increased dependency upon caregivers and decrease in level of mobility. Functional Mobility Assessment- Gait- Level Surfaces = Moderate Assist- ... Deviations: Patient exhibits forward lean of trunk and inadequate knee extension which are associated with the underlying causes of muscle paresis/weakness, lack of /impaired coordination and lack of selective control. Gait Pattern: The patient exhibits the following characteristics during gait: decreased accuracy of movements, decreased velocity, uneven step length and wide base of support. " A review of the care plan revealed the following: "Focus- The resident has an alteration in neurological status [related to] Syncope and Collapse, CVA with hemiplegia- Interventions- PT [Physical Therapy], OT[Occupational Therapy],	L 052		

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L 052	Continued From page 93 ST[Speech Therapy] evaluate and treat as ordered... Focus - The resident has an ADL (Activities of Daily Living) Self Care Performance Deficit [related to] Dementia, Impaired balance secondary to CVA with hemiplegia, Interventions: ...Transfers: The resident is able to stand, weight bear, pivot, use arms to support, take steps during transfer. Resident is receiving intermittent assistance. Toilet Use: The resident is able to toilet self, wash hands, hold grab bars, wipe self, and adjust clothing during toileting. " Facility failed to maintain a safe environment for Resident #25 who was left unsupervised in the bathroom which resulted in a fall without injury. A face-to-face interview was conducted with Employee #12 on February 12, 2015 at approximately 10:55 AM regarding the aforementioned findings. He/she stated that he/she was walking down the hallway, when he/she saw the CNA assisting the resident; he/she went into the room to assist him/her because the resident was unsteady and was " wobbly. " He/she further stated; he/she heard the CNA tell the resident to " pull the call bell when [he/she] is done. " A face-to-face interview was conducted with Employee #60 on February 13, 2015 at approximately 12:40 PM. He/she stated prior to Resident #25's fall, the resident was currently on the occupational therapist caseload. He/she further stated, "The resident required moderate assistance with transfers from bed to chair and from wheelchair to toilet. Sometimes [he/she] was maximum assist. " Employee #60 stated the rehabilitation recommendations are	L 052		

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L 052	Continued From page 94 communicated to staff in the IDT [Interdisciplinary Team] meeting. Also, every week PT discusses recommendations with the nurses who update the care plan. A face-to-face interview was conducted with Employee #37 on February 17, 2015 at approximately 10:20 AM. He/she stated, " I assisted [Resident #25] out of the bed into his/her wheelchair. I pushed the wheelchair to the bathroom door, after locking the wheelchair brakes, I assisted [him/her] from the wheelchair onto the toilet seat. The bathroom rail was on the left. I instructed [him/her] to pull the call bell string when [he/she] was done. The charge nurse assisted me when getting the resident from the wheelchair onto the toilet. " He/she further stated that the resident did not complain of being dizzy and [he/she] did not recall if the resident ' s gait was unsteady. He/she left the room to attend to another resident. The record lacked evidence that the staff ensured that Resident #25 was transferred from the toilet seat as stipulated in the MDS and in accordance to the recommendations from the rehabilitation team. Facility staff failed to maintain a safe environment for Resident #25 who was left unsupervised in the bathroom. The clinical record was reviewed on February 12, 2015. 2a. Facility staff failed to ensure the environment was free from potential accident hazards as evidenced by a resident who sustained an injury	L 052		

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L 052	Continued From page 95 from a fire alert apparatus that was improperly placed on a paper towel dispenser. Subsequently, the apparatus fell and struck Resident #148 in the head. A review of the facility ' s " Incident Report " dated December 31, 2014 5:00 PM " According to the patient [resident] there was a fire drill and after that, one of the maintenance staff came into the room and removed [his/her] fire alarm because [he/she] wanted to fix it. [He/she] left the fire alarm on top of the shelve [shelf] where the paper towel was. [A] few minutes later, the patient washed [his/her] hands, and when [he/she] tried to reach and get the paper towel to wipe [his/her] hands, the fire alarm fell on [his/her] face and as a result [he/she] has a bump on [his/her] right forehead ... Immediate action taken: Assessment was done for any pain; ice pack was applied at the site and MD [Medical Doctor] was notified about the incident; Medical Treatment Necessary: No " Nursing Entry: January 5, 2015 [no time indicated] revealed " Incident reviewed; hematoma to forehead present. Resident denies pain or discomfort at site, Incident determined to be accidental due to unintentional improper placement of object ... Nursing Entry: January 15, 2015 [no time indicated] revealed: "Resident hit by fire alarm left unattended, director of maintenance consulted to educate staff on the incident... "	L 052		

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L 052	Continued From page 96 A face-to-face interview was conducted with Employee #36 on February 20, 2015 at approximately 11:30 AM. A query was made regarding the incident and outcome of staff education related to leaving the unattended object in the resident's room. Employee #36 indicated that the in-service was not conducted and that another department [security] might have taken them [smoke detector] down. Employee #36 provided an in-service titled " Resident Safety " sheet signed by staff on February 18, 2015 after the surveyor brought this issue to his/her attention. Facility staff failed to ensure safe practice in the resident's care area secondary to leaving an object unattended that subsequently fell and hit the resident on the head whereby the resident sustained a bump to the right side of his/her forehead. 2b. Facility staff failed to ensure adequate supervision for Resident #148 who sustained a fall following dialysis. A review of the clinical record revealed the following: "Progress Note dated January 10, 2015 18:09 [6:09 PM] Supervisors were called at 12:40 PM by Safety [Security] for a resident that fell in the dining room floor. Resident observed on the floor in a sitting position in front of his/her wheelchair. Resident assessed, no bruises/injuries noted at this time. Range of motion performed, resident moved all extremities	L 052		

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L 052	Continued From page 97 and denies pain. No s/s [signs/symptoms] of acute distress noted. Resp [respirations] even unlabored, pupils equal round reactive to light. Resident alert and oriented ....Resident stated to Supervisor...I did not stand up, I felt the chair moving under me and I sat down on the floor. I did not hit my head, resident RP [Responsible Party] notified at 13:20 [1:20 PM] and [Physician named] notified 13:30, no new orders received, resident on neuro [neurological] checks... " ; January 10, 2015 18:09 [6:09 PM] ...Resident is status post fall. No signs of acute distress/discomfort noted and no complaints, assessment done as per facility policy during the shift, will continue with plan of care... " A review of the " Facility Incident Report " dated January 10, 2015 12:30 PM, "Location: first floor main dining room: Description: Supervisors were called at 12:40 PM by Safety [Security] for a resident that fell in the dining room floor. Resident was observed on the floor in a sitting position in front of [his/her] wheelchair. Resident assessed, no bruises/injuries noted at this time. Range of motion performed, resident moved all of [his/her] extremities and denies pain. No s/s [signs/symptoms] of acute distress noted. Resp [respirations] even unlabored, pupils equal round reactive to light. Resident alert and oriented x3 ....Resident stated to Supervisor...I did not stand up, I felt the chair moving under me and I sat down on the floor. I did not hit my head, resident RP [Responsible Party] notified at 13:20 [1:20 PM] and [Physician named] notified 13:30, no new orders received, resident on neuro [neurological] checks... Page 1 of 4 of the incident report revealed,	L 052		

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L 052	Continued From page 98 "Resident Description: Resident said [he/she] was trying to sit on the wheelchair and it slid away from [him/her] and [he/she] decided to sit on the floor because [he/she] was tired after coming from dialysis... Page 4 of 4 of the incident report revealed the following dated "January 19, 2015 Resident ambulates, fell due to weakness after dialysis...staff to monitor and assist resident to rest after dialysis ... " A review of the Facility ' s Dialysis communication Sheet, dated January 10, 2015 revealed that the resident returned to the unit at 11:00 AM. There was no evidence in the clinical record to reflect that facility staff put measures in place to supervise and or monitor the resident following dialysis. A face-to-face interview was conducted with Employee #9 on February 13, 2015 at approximately 1:00 PM. A query was made regarding if the resident requires assistance when going to and coming from dialysis treatments. Employee #9 indicated that the resident is alert and oriented [he/she] is ambulatory, but when [he/she] goes to dialysis we take [him/her] down in a wheelchair and bring [him/her] back in a wheelchair. A face-to-face interview was conducted with Resident #148 on February 13, 2015 at approximately 4:30 PM. A query was made	L 052		

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L 052	Continued From page 99 regarding the above incident. Resident #148 stated " I was not coming from dialysis, I do not know what happen. " A face-to-face interview was conducted on February 19, 2015 at approximately 1:00 PM with Employee #51. A query was made regarding the above incident. Employee #51 stated " I observed [Resident #148] as [he/she] finished eating lunch, [he/she] stood up from [his/her] wheelchair, the chair was not locked and the chair rolled from under [him/her], [he/she] fell on the floor. " There was no evidence that the facility had measures in place to monitor the resident following dialysis. Facility staff failed to ensure adequate supervision for Resident #148 who sustained a fall following dialysis. 3. Facility staff failed to implement measures and or provide adequate supervision to help ensure that Resident #292 did not fall out of the bed. A review of the quarterly Minimum Data Set dated October 11, 2014, Resident #292 was coded as totally dependent in bed mobility, and toilet use under Section G [Functional Status] The resident was coded as being frequently incontinent of urine and always incontinent of bowel under Section H [Bladder and Bowel]. A review of the nursing notes revealed, "	L 052		

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L 052	Continued From page 100 November 15, 2014 at 15:41[3:41PM], Resident was observed laying on the floor, upper extremities was on the floor while [his/her] lower extremities remained on the bed. At that time, bed was [in] a lower position ... " December 8, 2014 at 10:49 AM, " resident was found on floor at noon ...upon assessment no bruise or laceration found ... " A review of the February 19, 2015 incident report revealed, " Resident found hanging halfway out of bed with head on the floor. Bed was saturated with urine. " A review of the care plan revealed the following interventions: December 8, 2014- the resident had actual fall with no injury, poor safety awareness. Intervention: Bed alarm will be monitored and maintained by nursing staff to assist with injury prevention. Resident referred to skilled rehab for bed mobility and communication training. Staff will provide education and teach proper techniques for safety, such as call light use and communicating needs. Interventions: as on February 11, 2015. "Curtain to be drawn back at all times to ensure visual of resident. Neurochecks per facility protocol. Position resident bed alarm at shoulder height to alert staff of changing in position, referral to therapy." February 19, 2015: resident had an actual fall, found leaning halfway out of bed with head resting on floor. Interventions: as on February 19, 2015. Bed in the lowest position at all times when resident in bed. Fall mats alongside bed. Neurochecks per facility protocol.	L 052		

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L 052	Continued From page 101 The physician's order last signed and dated February 19, 2015 directed, " Scoop mattress for bed secondary to hanging off at bedtime provide safety precautions." The order was dated November 17, 2014, with a start date of November 18, 2014. Observation: Resident #292 was observed lying in bed on February 20, 2015 at approximately 3:10 PM. The resident was lying on an air mattress (without a scooped edge). The bed was in a low position, the privacy curtain was in the closed position, and a gray mat was observed on the floor on the right side of the bed. The red call light/pad was on the night stand. There was no evidence that facility staff followed up on the physician ' s order to obtain a scoop mattress for Resident #292 who was observed with his/her head hanging off the bed and onto the floor and on the floor. The record was reviewed on February 20, 2015. The facility staff acknowledged the finding. 4. Facility staff failed to consistently supervise Resident #115, who was observed walking about the unit entering residents' rooms without permission and wandering off the unit. During the survey period the following incidents were observed: February 9, 2015 10:30 AM -Resident #115 [Resident's room was located on Unit 4 North] was observed ambulating without walker and unsupervised. He/she went into a female resident ' s room [Room 429 on Unit 4 South] (Unit 4 South). The resident shouted, " Nurse." The	L 052		

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L 052	Continued From page 102 resident was removed from the room by a staff member. February 9, 2015- 10:45 AM- Resident #115 was ambulating without a walker and was unsupervised. He/she went into the female resident's room [located on 4 South]. Female resident shouted,, " Nurse." The resident was escorted out of the room by the activity coordinator. February 9, 2015 -10:51 AM- The resident was ambulating without a walker and supervision to the door of Room 429. Immediately [he/she] was redirected by the activity coordinator. He/she; stated; " [Resident ' s Name], do not go in that room. Ladies are in there. " The resident turned around and walked down the hallway corridor. February 10, 2015 - 11:48 AM- The resident exited [his/her] room. He/she was neatly groomed and ambulated with a walker down the hallway, without supervision. February 10, 2015 - 11:55 AM- The resident was sitting in the lounge area (walker by his side), located proximal to the nursing station. He/she abruptly got up from the sofa and preceded to the activities area without his/her walker. The resident removed graham crackers from a table and began eating them. A staff member gave the resident his/her walker and stated, " [Resident Name], you know you cannot walk around without your walker. " February 10, 2015 - 11:56 AM- The resident left the activities area and ambulated with walker to the corridor double doors without supervision. February 10, 2015 -12:00 PM- Resident #115	L 052		

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L 052	Continued From page 103 returned to activity area. He/she was ambulating with a walker, but without supervision when he/she bumped into a resident. The resident was sitting in a wheelchair with his/her right leg extended on the foot rest. The resident was redirected by the activity coordinator. The resident left the unit again without supervision. February 10, 2015 - 12:05 PM- Resident returned to the unit without his/her walker. The staff looked for the resident's walker which was found on Unit 4 South) On February 10, 2015 at 12:30 PM, Employee # 11 was asked about the facility ' s system for monitoring residents who wander. He/she stated the resident has a wandergard. The nurse proceeded to the resident ' s room to show the surveyor that the resident was wearing a wandergard. The resident was neither in his /her room nor in the area of the nursing station. Staff proceeded to look for the resident. The resident returned to the nursing station without his/her walker and no supervision at 12:32 PM. A quarterly MDS [Minimum Data Set] dated January 7, 2015 Under Section G (Functional Status), the resident required limited assistance for walking in the room, corridor and locomotion on and off [unit] with one person physical assist. A review of the physician ' s notes revealed the following: " September 4, 2014- 20:14 [8:14 PM]- Type: Psychiatrist- Patient has been seen in [his/her] room. [He/she] is in [his/her] bed and relaxing after dinner, covered with bed spread. Patient is still quite symptomatic. [He/she] is depressed, suspicious, anxious, and guarded. Patient was	L 052		

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L 052	Continued From page 104 spending a lot of [his/her] time walking around of the unit tirelessly using [his/her] walker ..." December 9, 2014- 19:31 [7:31 PM] - Type: Psychiatrist- "Patient continues to walk around of the units with [his/her] walker. At times [his/her] behavior is quite bizarre. Patient presented self with substantial cognitive impairment. On other occasions [he/she] is attempting [his/her] walks without walker and poses risk for fall." January 13, 2015 - 20:01 [8:01PM] - Type: Psychiatrist- "Patient has been seen for follow up in the day room. [He/she] is receptive to visit and cooperative. Patient has been constantly walking around sometimes without walker and is very reluctant to cooperate with staff at times. [He/she] is still quite sad, anxious, guarded, and inappropriate." A review of the nurse ' s notes revealed the following: January 8, 2015- 16:31 [4:31PM]- Type: Social Services- Quarterly review: "Resident is alert and oriented x1[times one]... [He/she] ambulates throughout the unit daily with a walker. [He/she] frequently requires redirection." January 10, 2015 - 11:23[AM] - Type: Activities- "... [Resident #115] is alert orient x2 [times two], verbally responsive. Resident uses a walker for mobility around the unit. [Resident #115] shows signs of confusion and needs redirection from staff. Resident is a wanderer and needs supervision on and off the unit. However, [Resident #115] is out in the day room 4-5x (four to five times) per week, at times when directed [he/she] joins the morning daily chronicle readings and group discussion. [Resident] like to walk around on and off the unit so staff at times	L 052		

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L 052	Continued From page 105 walks with [him/her] to monitor and sometimes assist in redirecting." January 20, 2015 - 17:05 [5:05PM] - Type: Nurses Note-" Resident was walking with walker and tumble on the chair where another resident [was], then staff member help ease resident to the floor." January 20, 2015 - 16:30 (4:30 PM) - Type: Nurses Note- "Resident was walking without walker and tumble on the chair where other resident was sitting in the day room at 2:15 PM. Staff member help resident and ease [him/her] to the floor. No injury noted. V/S [Vital Signs]- [Temperature]- 98, [Pulse]-88, [Respirations-20, [Blood Pressure]-114/74. MD [Medical Doctor] paged, RP [Responsible Party] notified. " A review of Resident #115 ' s care plan , updated February 4, 2015 revealed: " The resident is an elopement risk/wanderer [as evidenced by] resident wanders aimlessly. Impaired safety awareness. Disoriented to place. Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, Wander guard bracelet at all times and monitor placement and function. Resident was walking without [his/her] walker and [he/she] slipped and fell over another resident who was sitting on the couch. Interventions: Check on resident more frequently. Ensure resident have [his/her] walker at all times. Staff will check on resident more frequently. Monitor resident when moving around and ensure that [he/she] has [his/her] walker with [him/her]. " There was no evidence that facility staff provided adequate supervision for Resident #115 who	L 052		

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L 052	Continued From page 106 exhibited repetitive locomotion and unsafe wandering; who was observed walking about the unit entering resident ' s rooms without permission and wandering off the unit; and facility staff failed to consistently supervise and monitor to ensure that the resident had [his/her] walker at all times as indicated in the plan of care. A face-to-face interview was conducted with Employees #11 on February 10, 2015 at approximately 1:00 PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on February 10, 2015.	L 052	L056 Same as F-Tag 353 1. All residents identified with this deficient practice were assessed and had the potential to be affected by the deficient practice of the facility failing to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The Administrator, HR and DON meet weekly and Bi-weekly with corporate via phone to discuss plans for staffing. We discussed open house for staffing. We have had and are having orientation twice a month at minimum and we have hired a new staffing coordinator. 2. All residents have the potential to be affected by the deficient practice of the facility failing to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Facility continues to recruit and schedule orientation in order to meet the correct daily Nursing PPD. All residents identified in the POC were assessed audits completed to ensure that other residents were not affected by the deficient practice.	
L 056	3211.5 Nursing Facilities Nursing personnel, licensed practical nurses, nurse aides, orderlies, and ward clerks shall be assigned duties consistent with their education and experience and based on the characteristics of the patient load. This Statute is not met as evidenced by: Based on observations, policy/record review, and interviews, it was determined that the facility staff failed to comply with applicable federal, state, and local laws and regulations, as evidenced by the staff's failure to: ensure sufficient nursing staff was available to provide nursing and related services to attain/maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 16 of 16 days. Facility staff failed to ensure sufficient nursing staff was available to provide nursing and related services to attain/maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 16 of 16 days. The facility failed to ensure that there was	L 056		

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L 056	Continued From page 107 sufficient registered nurse staffing and total nursing staffing from January 31, 2014 to February 15, 2015, as indicated below: Registered Nurse Staffing Total Nursing Staff January 31, 2014 0.46 2.66 February 1, 2015 0.46 2.80 February 2, 2015 0.43 3.09 February 3, 2015 0.35 2.83 February 4, 2015 0.40 3.09 February 5, 2015 0.44 2.80 February 6, 2015 0.57 3.22 February 7, 2015 0.27 3.15 February 8, 2015 0.38 3.50 February 9, 2015 0.52 3.11 February 10, 2015 0.50 3.28 February 11, 2015 0.38 3.50 February 12, 2015 0.36 2.68 February 13, 2014 0.36 2.61 February 14, 2015 0.50 2.70 February 15, 2015 0.42 2.82	L 056	3. A new staffing coordinator was hired. HR continues to recruit for all positions. Interviews conducted by Nursing Leadership. Orientation held twice a month. The daily PPD ratio is being projected a day in advance. Staffing coordinator was given expectations to have weekly schedule printed and to identify vacancies and fill vacancies in advance. ADON, Nurse Manager on the house continues to meet with staffing coordinator daily to review the schedule to ensure staffing is scheduled as required to meet federal and state guidelines. Daily PPD is now be discussed at Morning stand up meeting. 4. Daily staffing PPD to be review by DON to ensure compliance. Staffing report will be brought through the monthly QAPI process to ensure compliance and identify area for improvement. HR department continues to report monthly on staff vacancies.	5/12/15

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DEANWOOD REHABILITATION AND WELLNESS	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 108 A review of the facility's nursing staffing ratios from January 31, 2014 to February 15, 2015. revealed an average of 0.46 for registered nurse staffing and 2.9 for overall direct nursing care. On February 20, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employee #2 regarding the aforementioned findings. After review of the above he/she acknowledged the findings. Facility staff failed to ensure that sufficient nursing staff was available to provide nursing and related services to all residents within the facility. Cross referenced in 483.13 (c), F224.	L 056	L099 same as F-Tag 371 1. Anusal head were all cleaned immediately by FSD. No residents were affected from this deficient practice. 2. A weekly audit tool will be use to check and clean all anusal heads. No residents were affected by this deficient practice. 3. A weekly audit tool was developed by FSD to check and ensure that all anusal heads are free of debris. Staff were in-serviced on cleaning all ansul heads and completing the audit tool. 4. The audit tool will be brought through QAPI committee monthly to report any deficient practices.	5/12/15
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations that were made during on February 5, 2015, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by two (2) of six (6) fire suppression outlets located above the grill that were soiled with dust. The findings include: 1. Two (2) of six (6) fire suppression outlets were visibly soiled with dust and needed to be cleaned.	L 099		

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L 099	Continued From page 109 This observation was made in the presence of Employee #32 who acknowledged the findings.	L 099	L108 Same as F-Tag 364 1.Retrospectively no changes could be accomplished for those residents identified with this deficient practice.	
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations made on February 10, 2015 at approximately 1:40 PM, it was determined that the facility failed to serve food at the proper temperature as evidenced by hot foods that tested below 140 degrees Fahrenheit and cold food that tested above 40 degrees Fahrenheit (F) from two (2) test trays. The findings include: Food temperatures from test trays tested as follows: Regular diet Grilled chicken = 110 degrees Fahrenheit Rice = 120 degrees F Green beans = 120 degrees F Milk = 44 degrees F Ice cream = 31 degrees F Puree diet	L 108	2. All residents have the potential to be affected by this deviant practice if food temperatures are not correct due to staff failure to serve food timely or food services staff getting trays to units timely. 3. FSD made adjustment to thermostat in all plate warmer and the pallets warmers are now being turned at least 1 hour prior to meal service time. Food Services staffs were in-service on plating food and ensuring that each food service truck gets to unit within 10 minutes. Staff on units with assistance of ambassadors will ensure trays are given to residents in a timely manner. FSD devised tools to monitor and track compliance. 4. FSD will continue to monitor and track any and all deficient practices and provide monthly reports to QAPI committee.	5/12/15

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L 108	Continued From page 110 Grilled chicken = 120 degrees Rice = 136 degrees F Broccoli = 136 degrees F Bread = 122 degrees Milk = 44 degrees F Ice cream = 32 degrees F These observations were made in the presence of Employee #32 who acknowledged the findings.	L 108	L214 (1-4) same as F-Tag 323 (B1-4) 1. The door closer cap missing in room 320 was repaired on February 11th 2015. The door closer cover in room 202 was repaired on February 11th 2015. Empty boxes from dialysis supplies, seven chairs and a ladder were in double doors unlocked easy access residents were emptied on February7th 2015. All resident wardrobes were secured on February 28/29 By facility contractors. 2. All other storage rooms, door closures, door caps and wardrobes were checked by the Director of Maintenance. No other rooms were found to have this deficient practice. 3. A monthly storage room audit tool was created to check for improperly stored items, missing door cap, door closure covers . Maintenance staff after conducting monthly tours will provide audit tools to the director who will check findings and address. Maintenance staff were in serviced on door closer caps, door closer covers, clean and orderly storage areas. 4. The Director of Maintenance will report monthly on any deficient findings after audits are conducted and provide findings to QAPI Committee.	5/12/15
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: A. Based on observations made during initial tour on February 5, 2015 and on February 11, 2015 between 10:30 AM and 3:00 PM, it was determined that the facility failed to ensure that it was free of accident hazards as evidenced by a missing door cap to a door closure in one (1) of 53 resident's rooms surveyed; a missing cover to a door closure in one (1) of 53 resident's room surveyed and an unlocked, accessible area that was littered with trash such as empty boxes, chairs and a ladder. The findings include: 1. The door cap from the door closure in resident room # 320 was missing, exposing electrical	L 214		

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L 214	Continued From page 111 wires to residents in one (1) of 53 resident's rooms surveyed. 2. The whole cover to the door closure in room # 202 was missing and mechanical and electrical parts to the door closure were accessible to residents in one (1) of 53 resident's rooms surveyed. 3. Numerous empty boxes of dialysis supplies, seven (7) chairs and a ladder were scattered in an area accessible through an unlocked double door with a sign that read "DANGER, CONSTRUCTION AREA, KEEP OUT". The area was located on the first floor next to the Admission department and was easily accessible to residents, visitors and staff. The first and second observations were made in the presence of Employee #18 and Employee #36 who confirmed the findings. 4. Facility staff failed to ensure that the wardrobes in residents' rooms were secured. On February 20, 2015 at approximately 3:30 PM, a tour of all residents' rooms on 2North, 2South, 3North and 3South nursing units was conducted. It was determined that the wardrobes [furniture for residents to store personal belongings] in residents' rooms were unsecured presenting a potential hazard to residents. The observations of the 3rd floor were made in the presence of Employee # 9. A face-to-face interview was conducted with the Employee # 70 on February 20, 2015 at 4:50 PM. He/she stated, "The contractors are coming on	L 214		

Health Regulation & Licensing Administration

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L 214	Continued From page 112 Sunday [February 22, 2015] to secure the wardrobes to the walls. " Facility staff failed to ensure that the wardrobes in resident rooms were secured.	L 214	L306 same as F-Tag 463 (A) 1. The call bells were fixed immediately by Maintance staff. All call bells were unwrapped immediately. 2 call bells in the 5th floor shower room were repaired immediately on February 6th 2015 by maintenance staff. Facility contractor Fine Wire Solutions were asked to come in and fix call bell system per unit. 2. All other call bells were checked by the Director of Maintenance to ensure no other residents were affected by this deficient practice. Fine Wire Solutions fixed the call bells on all units to ensure staff could no longer turn off call lights at nursing station. Contractor also placed enunciator panels in the front of each nurse's station to ensure they can hear when call bells sounds. 3. A daily room audit check list to include call bells will continue to be used to ensure call lights are operational. Maintenance staff after conducting daylily tours will provide audit tools to the director who will check findings and address. Maintenance was in serviced on the importance of functional and operational call bells for all residents. Nursing staff was in serviced to respond to call lights immediately and to place any issues with call lights in Reqqer maintenance system immediately and not to wrap call bells around railings in resident rooms or bathrooms. 4. Maintenance Director and nursing will report all and any deficient findings to monthly QAPI Committee.	5/12/15
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations made during initial tour on February 5, 2015 and on February 11, 2015 between 10:30 AM and 3:00 PM, it was determined that the facility failed to maintain resident ' s call bell system in good working condition as evidenced by call bells in four (4) of 53 resident ' s rooms that did not emit an alarm when tested and two (2) of three (3) call bells in the female bathroom on the fifth floor that were wrapped around the grab bar and failed to initiate an alarm when tested.	L 306		

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L 306	Continued From page 113 The findings include: Resident call bells did not operate as intended in four (4) of 53 resident ' s rooms including rooms ' # 320C, 335A, # 507A and # 520A, B, D. Two (2) of three (3) call bells located in the female bathroom on the fifth floor were wrapped around the grab bar and failed to initiate an alarm when tested. These observations were made in the presence of Employee #18 and Employee #36 who confirmed the findings.	L 306	L314 same as F-Tag 460 1. Both privacy curtains that were too short were replaced immediately by housekeeping staff. 2. All other rooms' privacy curtains were inspected to ensure that no others were found to be too short. No other residents were affected by this deficient practice. 3. Housekeeping manager will do weekly checks of privacy curtains with his audit tool to ensure no other curtains are inappropriately placed in wrong rooms. All housekeeping staff were in-serviced on the importance of having appropriate privacy curtains in residents rooms. 4 The audit tool will be brought through monthly to QAPI committee and all deficient practices reported by housekeeping manager.	5/12/15
L 314	3246.5 Nursing Facilities If the room is not for single occupancy, each bed shall have flameproof ceiling suspended curtains which extend around each bed in order to provide the resident total visual privacy, in combination with adjacent walls and curtains. This Statute is not met as evidenced by: Based on observations made on February 11, 2015 at approximately10:30 AM, it was determined that the facility failed to equip a resident's bedroom with curtains designed to provide full visual privacy for each resident as evidenced by privacy curtains in one (1) of 53 resident's rooms that were too short to provide full visual privacy when fully extended. The findings include: 1. Two (2) of two (2) privacy curtains in room #	L 314		

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L 314	Continued From page 114 528 were too short to provide full privacy to residents. These observations were made in the presence of Employee #18 and Employee #36 who confirmed the findings.	L 314	L389 same as F-Tag 493 (3) F-Tag 492 (3) 1. Retrospectively nothing could be done as the facility did not have 3 pars of linen in the building. We placed an order for additional linens on March 1st.	
L 389	3254.5 Nursing Facilities The linen supply shall be at least three (3) times the amount that is needed for the licensed occupancy. This Statute is not met as evidenced by: Based on obervations, clinical record review, resident interview, and staff interviews for two (2) of 51 sampled residents, it was determined that the facility staff failed to comply with applicable federal, state, and local laws and regulations, as evidenced by staff's failure to ensure linen was at least three times the amount needed for licensed occupancy. The findings include: According to 3254. 5 of the District of Columbia Municipal Regulations, "The linen supply shall be at least three (3) times the amount that is needed for the licensed occupancy." The Resident Council Meeting Minutes dated December 10, 2014 revealed the following: "Issue/Discussion - Noted that the units are not getting enough wash towels and linen sent to the unit." On February 12, 2015 at approximately 12:15	L 389	2. All other residents had the potential to be affected by this deficient practice until 3 pars of linen are in the building. 3. Regional Housekeeping manager assured administrator that bimonthly purchases will be made to ensure we have a continuous flow of linen into the facility. The administrator did request for an additional 3 par to be purchased by housekeeping contractor. 4. A linen audit will be brought through monthly QAPI committee to ensure any deficient practices reported by housekeeping manager.	5/12/15

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L 389	Continued From page 115 PM, the linen room shelves were observed in the presence of Employee#18 to have no washcloths or towels, a couple of blankets, six (6) pillows, and a box of blankets was stored in the corner. There was no evidence of emergency linen stocked. On February 12, 2015 at approximately 12:15 PM, a face-to-face interview was conducted with Employee #18 regarding the linen par level. The employee stated, "The bed capacity is 300 and our par level is two. We send linen to the floor three times a day .The emergency linen is sent in. We make a purchase every two weeks and we recycle the linen on all three shifts." When queried regarding the handling and purchasing process, he/she replied, "Every two weeks we order 50-60 dozen washcloths, 20 dozen towels, 10 dozen flat and fitted sheets. We circulate the linen, as needed. The issue is that we are not getting the linen back to be cleaned." On February 12, 2015 at approximately 3:20PM a face-to-face interview was conducted with a resident [who requested anonymity] and requested that his linen concern be addressed. He/she stated, "Usually two times a month, they don't have enough towels, sheets, or laundry. About a month ago, two weeks went by before my bed linen was changed. [Named the director of laundry] is aware and he/she said he/she is trying to address the shortage of linen. A resident said he/she witnessed his/her roommate being cleaned with paper towels because they had no linen. This was said in the resident council meeting last year." On February 12, 2015 at approximately 4:00PM a face-to-face interview was conducted with Resident #259 who stated he filed a complaint	L 389		

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L 389	Continued From page 116 about the linen shortage to the manager on the 5 South unit. He/she stated, "I had a bowel movement and called the CNA at 10:30PM and asked her to change me. She said that she didn't have any problems cleaning me, but that she had no wash cloths or anything to clean me with. I asked her to at least change my diaper, and she did change my diaper. I waited until the next morning to be cleaned." On February 13, 2015 at approximately 11:30 AM, a face-to-face interview was conducted with Employee #14 who acknowledged the aforementioned findings. He/she added, "I went downstairs on February 11, 2015 and spoke with the supervisor in laundry. He/she showed me the carts that were being filled and he/she showed me how laundry is delivered on the 3-11 PM shift. He/she explained that staff tends to hoard linen, they do have a shortage on wash cloths, and they are being ordered." Facility staff failed to ensure linen was at least three times the amount needed for licensed occupancy. The record was reviewed on February 13, 2015.	L 389	L410 (1) same as F-Tag 253 (1) 1.The following wall clocks in rooms 512,513, 436 and 309 had all batteries were replaced immediately. 2. All other wall clocks were checked by the Director of Maintenance. No other rooms were found to have this deficient practice. 3. A daily room audit check list to include wall clocks will continue to be used. Maintenance staff after conducting daylily tours will provide audit tools to the director who will check findings and address. Maintenance was in serviced on the importance of functional and operational of the wall clocks for all residents. Nursing staff was in serviced if you see a clock not functioning place the item in to Reqqer. 4. monthly reporting will be done by the director of maintenance. All deficient practices will be brought to the QAPI Committee.	5/12/15
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made on February 11, 2015 between 10:30 AM and 3:00 PM, it was determined that the facility failed to provide housekeeping and maintenance services	L 410		

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L 410	Continued From page 117 necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by wall clocks in four (4) of 53 resident's rooms that failed to display the correct time and window blinds in three (3) of 53 resident's rooms that were soiled with dust. The findings include: 1. Wall clocks down in rooms # 512, # 513, # 436 and # 309, four (4) of 53 resident's rooms surveyed. 2. Window blinds were soiled with dust in three (3) of 53 resident's rooms including rooms # 233, # 513 and # 528. These observations were made in the presence of Employee #18 and Employee #36 who confirmed the findings.	L 410	L410 (2) same as F-Tag 253(2) 1. Housekeeping staff immediately cleaned the soiled window blinds in rooms 233, 513 and 528. No residents were affected by this deficient practice. 2. Window other blinds were inspected in all other rooms and if found soiled were cleaned immediately. No other residents were affected by this deficient practice. 3. An audit tool was created by housekeeping manger. Housekeeping manager will do weekly checks of random units. All housekeeping staff were in-serviced on the importance of keeping window blinds clean. 4. The audit tool will be brought through monthly to QAPI committee and all deficient practices reported by housekeeping manager.	5/12/15