Deanwood
The Dean's
REHABILITATION & WELLNESS CENTER

May 11, 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 updated and revised 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. All deficiencies have been responded to with a date of compliance of May 12, 2015.

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

5000 Nannie Helen Burroughs Avenue N.E., Washington, DC 20019
TEL 202-399-7504 | FAX 202-399-0881

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	02/20/2015

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

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F 000	INITIAL COMMENTS A Recertification Quality Indicator Survey (QIS) and a complaint investigation for C-15-024, DC- 2945 was conducted at your facility on February 5, 2015 through February 20, 2015. The following deficiencies are based on observations, record reviews, 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)	F 000	Please begin typing your responses here:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rose Cellar	Administrator	5/11/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury 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	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.	F 156	F-Tag 156 (1,2) & F-Tag 514 (6) 1.The admissions 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.	

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F 156	Continued From page 2 The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending	F 156	F-Tag 156 (1,2) & F-Tag 514 (6) cont. 2. All other admissions packets were reviewed for 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. 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. An in-service was conducted by the administrator with admissions and business office staff on 4/7/15. 4.The admissions department will report on a monthly basis to the QAPI committee any deficient practices.	5/12/15

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F 156	Continued From page 3 down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: 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 available services in the facility and the charges	F 156		

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F 156	Continued From page 4 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	F 156		

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F 156	Continued From page 5 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	F 156		

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F 156	Continued From page 6 listed were blank.There was no evidence that 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.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157	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.	

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F 157	Continued From page 7 regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 51 sampled residents, it was determined that facility staff 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.	F 157	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 by the Staff Development 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. The DON wrote a protocol for nursing staff to call the physician in the event we do not receive medications timely.	

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F 157	Continued From page 8 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 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.	F 157	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 F-Tag 176 1.Resident # 211 did not experience any negative outcome related to residents ability to self administer medications in a safe manner. Resident was assessed for safe administration of medication. Resident educated and care plan updated.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 51 sampled residents, it was determined that the interdisciplinary team failed to assess one (1) resident's ability to self administer medications in a safe manner. Resident #211. The findings include:	F 176	2. All residents that wish to self medicate some or all of their medications have the potential to be affected by the practice of not being first assessed by the interdisciplinary team for safe medication administration. Nursing management will review all residents to identify those that are administering their own medications and/or desire to do so. All residents identified will have a self administration evaluation completed. Results of this evaluation will be shared with the nursing management team and the attending physician will be notified for an order to self administer if appropriate. Care-plans will be updated to reflect any changes.	

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F 176	Continued From page 9 On February 19, 2015 at approximately 11:50AM a Xopenex [bronchodilator] inhaler was observed on the resident's over-bed table. In response to the question, Why is the inhaler in your room? The resident responded, " I use it when I am wheezing or short of breath. I used to have some eye drops too. They [staff] took that away but I wasn't going to let them take this inhaler. I need it." A review of the physician's order dated January 3, 2015 revealed the following: "Resident may administer Xopenex Inhaler every 4 (four) hours and keep at bedside as per resident's request." A face-to-face interview was conducted with Employee #12 at approximately 12:00PM on February 19, 2015. In response to the question whether he/she was aware that the resident had the inhaler in his/her room? He/she responded, "Yes." In response to the question whether the Inter Disciplinary Team (IDT) had assessed the resident for self administration of medications, and whether a care plan was initiated to ensure safe administration of the medication, the employee responded, "No" to both questions. The record was reviewed on February 19, 2015.	F 176	3. The Policy/procedure for self administration was reviewed by the nursing management team. Licensed Staff will be in serviced by the Staff Development/ Nursing Management on assessing residents for self administration of medication on admission, quarterly and/or after a significant change, using the assessment tool in PCC by 5/12/15. Training will also include how to educate the resident on the correct process for self administration of their medication(s), safe storage of these medications, and the documentation of self administered medications. On a quarterly basis and/or after a significant change, licensed nursing staff will re-assess the resident's ability to self administer medications. Care-plans will be put in place to reflect the residents self administering of medications. Any changes in the residents ability to self administer medications will be discussed during morning clinical review with the nursing management team. 4. Nursing management will audit the process of resident self administering of medication monthly. Audit will include: current assessment, care-plan, storage of medication, and documentation of administration when necessary. Audits will be reviewed by the DON and QAPI nurse and brought to the monthly QAPI meeting to ensure compliance. Education will be provided as needed and Performance improvement plans if indicated. 5/12/15	
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224		

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F 224	Continued From page 10 This REQUIREMENT 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 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	F 224	F-Tag 224 1. Resident 259 was assessed and did not experience any physical side effects 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. Additional staff have been hired. 2. All residents have the potential to be affected by the deficient practice. 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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F 224	Continued From page 11 (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, "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.	F 224	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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F 224	Continued From page 12 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 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."	F 224		

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F 224	Continued From page 13 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 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 224		

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: 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 ... "	F 226	F-Tag 226 1. Resident # 49 was assessed and did not have any negative physical outcome related to the allegation regarding employees lack of providing ADL care to the resident. Employee is no longer employed by the facility therefore this could not be addressed with employee. 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.	

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F 226	Continued From page 15 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	F 226	3. All managers were educated on the policy for the prevention of abuse and neglect by the Director of Social Services by 5/12/15. 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. 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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F 226	Continued From page 16 suspended and according to Employee #2, will remain suspended pending the outcome of the 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	F 226		

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F 226	Continued From page 17 information: Action Plan: Time Frame 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	F 226		

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F 226	Continued From page 18 blank [no data was entered in this section]. Additional information that was at the bottom of the form revealed the following: "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 "	F 226		

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F 226	Continued From page 19 Nothing was checked to indicate whether the training was successfully completed, ongoing or not completed. 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.	F 226	F-Tag 241 1a. Resident #162 treatments/assessments are now completed in areas that promote resident's dignity and well being. Staff identified had been educated on the importance of maintaining privacy and dignity when providing treatments/ assessments. Lighting was also checked in resident's room to ensure it was adequate. 1b. Resident #185 urinal was immediately emptied when brought to staff's attention. CNA was counseled on the importance of maintaining dignity and cleanliness for residents. Care-plan was updated to include frequent checks of resident's urinal to maintain dignity and cleanliness. 1c. Resident #211 did not have negative outcomes related to the deficient practice of facility staff failing to enter resident's room without knocking on the door and awaiting permission to enter the room. Staff identified with this deficient practice were immediately counseled and educated on resident's rights and dignity.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241		

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F 241	Continued From page 20 Based on observation and staff interviews for three(3) of 51 sampled residents, it was determined that the facility staff failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect as evidenced by: performing treatment in an open area for one (1) resident; a filled urine receptacle in close proximity of a resident during lunch consumption of one (1) resident; and entering a resident's room without knocking and without permission for one (1) resident. Residents' #162, 185, and 211. The findings include: 1.Facility staff failed to enhance Resident #162's dignity by performing the resident's rehabilitative treatment in an open/common area, in view of visitors, staff and other residents who were present. On February 12, 2015 at approximately 12:30PM, Employee #48 was observed performing an assessment/a treatment on Resident #162 in the hallway outside of his/her room and adjacent to the dining area. The resident was seated in a Geri chair [geriatric chair] and several residents and staff who were present in the area. When asked why he/she was performing the session in the open area, the employee responded, "The lighting is not good in the room and I needed good lighting in order to evaluate the [resident's] responses and I also needed assistance to pull him/her up in the chair" In	F 241	2. All residents have the potential to be affected by the deficient practices of staff failing to promote care for residents in a manner and environment that maintains or enhances each resident's dignity and respect. Residents will be interviewed monthly during resident council meeting to identify any further concerns in relation to dignity and respect. Any concerns will be addressed by the appropriate dept head. 3. Staff development/Social Services will in-service licensed staff on resident's rights, privacy and dignity. Rehab Staff will also be in-service that treatment procedures will not be provided to residents in common areas. Trainings will be completed by 5/12/15. ADON's/Nursing Supervisors will round on their floors daily to identify areas of concern and promote quality of care by recognizing examples of excellence provided during care. Employee appreciation programs will recognize staff monthly that consistently promotes respect and dignity while providing care for residents.	

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F 241	Continued From page 21 response to whether anyone had been informed of the poor lighting in the room, he/she responded, " No, but I will inform them." The employee also stated, "I am very sorry. It will not happen again." Facility staff failed to enhance Resident #162's dignity by performing the resident's treatment in an open area, where staff and residents were present. 2. Facility staff failed to promote dignity to Resident #185 as evidenced by having a filled urinal receptacle in close proximity of resident during [his/her] lunch consumption. A dining observation was conducted on February 5, 2015 at approximately 12:50 PM on Unit North. At this time Resident #185 was observed sitting on his/her bed preparing to consume lunch. A receptable filled with urine was placed on the night stand next to the left of his/her bed. The Resident stated that he/she moved the urinal from the over bed table to the night stand when the CNA [Certified Nursing Assistant] placed his/her lunch tray on the table. Facility staff failed to promote dignity to Resident #185 as evidenced by having a filled urinal receptacle in close proximity of resident during lunch consumption. Employee #12 was present at the time of the observation. 3. Facility staff failed to treat Resident #211 in a manner that enhanced his/her dignity. On February 19, 2015 at approximately 12:30 PM, Employee #44 was observed entering the	F 241	4 Random audits will be done by dept heads during ambassador rounds. Results will be trended and reported monthly through the QAPI process. Results of resident council identified concerns will be report in monthly QAPI to identify areas of improvement and further education needed. Compliance will be monitored monthly the QAPI process for the next six months. 5/12/15	

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F 241	Continued From page 22 resident's room without knocking on the door and awaiting permission to enter the room. When asked why he/she had entered the resident's room without knocking on the door and awaiting the resident's permission to enter, the employee responded, "Oh, he/she is my buddy." The employee acknowledged that he/should have knocked on the resident's door and waited for a response before entering the room.	F 241	F-Tag 246 (1) 1.The call bells in rooms 329 bed A and C Were repaired on February 26, 2015. 2.All other call bells 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 call bells 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 call bells for all residents. Nursing staff was in serviced not to wrap call bell cords around rails or hand assist bars. 4.Monthly reporting will be done by the director of maintenance or designee. Any deficient practices will be brought to QAPI committee.	5/12/15
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: A. Based on observation, resident interview, and staff interview for four (4) of 51 sampled residents, it was determined that facility staff failed to ensure that the resident's Call System was connected and functioning for two (2) residents; provide towels for resident's morning baths, clean linens to ensure that the sheets on the resident's bed were changed before lunch was served, and to empty the resident's bedside commode after use for one (1) resident; and failed to ensure that the bathroom call bell was accessible for one (1) resident. Residents' #163, 211 239, and 322.	F 246		

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F 246	Continued From page 23 The findings include: 1. Facility staff failed to ensure that the Resident #163's Call System was connected and functioning. A review of the resident's Quarterly Minimum Data Set (MDS) dated October 4, 2014 revealed the following: Under Section I - Active Diagnoses included Anemia, Peripheral Vascular Disease, Hypertension, Diabetes, and Chronic Obstructive Pulmonary Disease. Under Section G, Functional Status - the resident required extensive assistance with bed mobility, transfer, was totally dependent for toilet use and bilateral lower extremity impairment. On February 6, 2015 at approximately 2:00 PM during a face-to-face interview with Resident #163, the resident voiced concerns that his/ her call bell was not working on January 28, 2015, so he/she wrote a note to the facility's Administrator requesting assistance. The resident further stated that on repeated occasions he/she had pressed the call bell to call for help from the facility staff, but after a while, noticed that no one came. He/she could not specifically recall the actual dates or times of these occurrences, but added that as a result, he/she waited for long periods before receiving the help he/she needed.	F 246	F- Tag 246 (2,3 &4) 1.The DON met with Residents #163 and #322 and assured them that their call bells will be answered timely and apologized to them for her staff. Maintenance checked to make sure Call bell for this room was back on line and functioning. Staff on unit were counseled regarding the importance of maintaining a functioning call bell system. Resident #239 length of call bell was changed to ensure it was long enough to be accessible to residents. Staff were educated to keeping call bell cords accessible and to report in Reqqer when a call bell cord is not long enough for resident to access. Residents #211 commode was emptied and given linens. CNA's were educated to provide linens to resident #211 daily and report to charge nurse immediately when more linen are needed on the unit.	

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F 246	Continued From page 24 A face-to face interview was conducted with Employee #4 on February 9, 2015 at approximately 11:00 AM. When queried regarding the functioning of the resident's Call System, he/she stated that the visual indicator is usually illuminated above the door of the resident's room and accompanied by a sound from the nurses' station, when the call bell is activated. He/she added that when the call bell is activated, the visual indicator and the audible alarm should be seen and heard by staff. On February 9, 2015 at approximately 12:33 PM, a face-to face interview was conducted with Employee #36 regarding his/her awareness of the malfunctioning of the call bells; he/she provided the following information: " ... I did my investigation in why the call bell in [Room] 329 beds A and C was [were] not working on January 28, 2015. The reason is after investigating, maintenance found that the nurses locked out the call bell in room 329 from the system at the nurse's [] station so that the resident[s] cannot call them every few minutes." Employee #4 acknowledged the aforementioned findings. Facility staff failed to ensure that the residents' Call System was connected and functioning. The record was reviewed on February 6, 2015. 2. Facility Staff failed to provide towels for Resident #211's morning baths and clean linens to ensure that the sheets on the resident's bed were changed before lunch was served	F 246	2.All residents have the potential to be affected by the practice of call bells not being readily accessible to residents and call bells not connected and functioning clean linens available when needed, and staff failing to empty residents bedside commode timely. All Call bells were checked by maintenance to ensure they were of adequate length to be accessible and were functioning correctly. Call Bell system was updated to ensure it could not be disarmed or turned off by other staff. Healthcare Services was contacted and par levels of linens/towels were checked and then adjusted as needed to meet the needs of the community. Extra linens/towels were ordered to ensure there was enough on hand for all shifts and to replace any that were torn or stained. 3.Protocols regarding call bell response, accessibility for the resident, and the responsibility of answering call bells were reviewed and shared with all staff on (insert date). CNA's and Licensed Nurses were in-serviced on Call Bell response, Accessibility of the Call Bell to the resident, requesting of linen, and the requirement to ensure the system is functioning and report when it is not to the maintenance dept. In-service was provided by the Staff Development Coordinator/ Nursing Management on (insert date). Maintenance staff will perform preventative maintenance audits daily for visibility and audio. Results are logged and any deficiencies corrected.	

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F 246	Continued From page 25 (approximately 12:30PM daily), and to empty the resident's bedside commode after use. On February 12, 2015 Resident #211 requested an interview. During a face-to-face interview at approximately 3:00PM, on that day, the resident complained that he/she performed his/her own baths; was never able to get any linens (wash cloths, towels etc.) until around 11:00AM. That made him/her late for PT (physical therapy). He/she did not get his/her bed changed until the afternoon, due to a shortage of linen. The resident also complained that nursing staff did not empty his/her bedside commode after use, but someone from therapy came by to check on him/her and emptied the commode, at the same time. Urine was observed in the commode at approximately 5:00PM on February 12, 2015, 9:00 AM on February 13, 2015, and 3:00PM on February 13, 2015. The observation on February 13, 2015 at 3:00PM was witnessed by Employee #5. The employee acknowledged the findings. A face-to-face interview was conducted with Employee #41 at approximately 10:00AM on February 18, 2015. The employee acknowledged emptying the resident's commode on several occasions. The resident's bathroom was closed for renovation. 3. Facility staff failed to ensure the bathroom call bell was accessible for Resident #239. During a resident's room observation conducted on February 6, 2015 at approximately 3:48 PM, the following was observed: One (1) of two (2) call bells/pull cords located in Resident #239's	F 246	4.Call Bell response audits will be completed weekly for 3 months by Dept Heads and QAPI Nurse. Results of the audit will be reviewed monthly through the QAPI process to identify any opportunities for improvement and education. Maintenance Dept will review their Preventative Maintenance Audits and report findings monthly through the QAPI process. 5/12/15	

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F 246	Continued From page 26 bathroom/shower room area was tied up in a knot, that prevented the bell from hanging freely. When untied, the (pull cord) was too short and inaccessible to the resident. The observation was made in the presence of Employee #4 and Employee #49. Both employees acknowledged the finding. 4. Facility Staff failed to ensure that Resident #322's Call System was connected and functioning. A review of the 'Admission Record' revealed that the resident was admitted to the facility on June 7, 2014 with diagnoses that included Cerebral Vascular Disease with Hemiplegia, Deep Venous Thrombosis, Idiopathic Peripheral Neuropathy, and Chronic Pain. A review of the Quarterly Minimum Data Set (MDS) dated January 9, 2015, under Section G, Functional Status revealed that the resident required extensive assistance with bed mobility, transfer, dressing, personal hygiene, and was totally dependent for toilet use. Section G, Functional limitations and range of motion revealed that the resident had upper and lower extremity impairment on one side. On February 6, 2015 at approximately 10:30 AM during a face-to-face interview with Resident #322, he/she stated that his/ her concerns regarding the call bell started approximately one	F 246		

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F 246	Continued From page 27 (1) month ago. He/she stated that he/she pressed the call bell for help, but after a while noticed that no one came. A face-to face interview was conducted with Employee #4 on February 9, 2015 at approximately 11:00 AM. When queried regarding the functioning of the resident's Call System, he/she stated that the visual indicator is usually illuminated above the door of the resident's room and accompanied by a sound from the nurses' station, when the call bell was activated. He/ she added that when the call bells are activated, the visual indicator and the audible alarm should be seen and heard by staff. On February 9, 2015 at approximately 12:33 PM, a face-to face interview was conducted with Employee #36 regarding his/her awareness of the malfunctioning of the call bells; he/she provided the following information: " ... I did my investigation in why the call bell in [Room] 329 beds A and C was [were] not working on January 28, 2015. The reason is after investigating, maintenance found that the nurses locked out the call bell in room 329 from the system at the nurse's ['] station so that the resident[s] cannot call them every few minutes." Employee #4 acknowledged the aforementioned findings.	F 246	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 into Maintenance tracking system, Reqqer. 4. monthly reporting will be done by the director of maintenance. All deficient practices will be brought to the QAPI Committee.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		5/12/15

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F 253	Continued From page 28 This REQUIREMENT 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 necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by wall clocks in four (4) of 53 residents' rooms that failed to display the correct time and window blinds in three (3) of 53 residents' rooms that were soiled with dust. The findings include: 1. Wall clocks failed to display the correct times in rooms # 512, # 513, # 436 and # 309, four (4) of 53 residents' rooms surveyed. 2. Window blinds were soiled with dust in three (3) of 53 residents' rooms including rooms # 233, # 513 and # 528. These observations were made in the presence of Employees #18 and 36 who confirmed the findings.	F 253	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
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272	F-tag 272 (1) 1.MDS with ARD Section E, question E0200, for resident # 139 was corrected and resubmitted to reflect accurate coding of behaviors. No other resident was found to be affected by this deficient practice. 2. All current residents most recent OBRA MDS were audited for the accurate coding of Section E, question E0200, per RAI instructions. Corrections to the MDS were made accordingly.	

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F 272	Continued From page 29 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: 0Based on clinical record review and staff interviews for two (2) of 51 sampled residents, it was determined that the facility staff failed to	F 272	3. Education was provided to Social Services on the coding of Section E, E0200, via the RAI manual. Social Services will continue to review progress notes and care tracker documentation to code resident's behaviors. 4. Social services will complete audits to include all OBRA monthly to ensure compliance is achieved. Audits and findings will be reported monthly QA Committee. 5/12/15 F-Tag 272 (2) 1. MDS with ARD of 1-3-15 Section O, question O0100J, for resident # 322 was corrected and re-submitted to reflect accurate coding of dialysis status. 2. All current dialysis resident's most recent OBRA MDS were audited for the accurate coding of section O question O0100J per RAI instructions. Corrections to the MDS were made accordingly. 3. Education was provided to the MDS coordinators on the coding of Section O, question O0100J, via the RAI manual. MDS coordinators will review nursing admission assessment, physician documentation, physician orders, and interview staff to determine resident's dialysis status. 4. MDS coordinators will complete audits to include all OBRA assessments weekly, and monthly. Audits and findings will be reported monthly to QA Nurse. 5/12/15	

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F 272	Continued From page 30 code the Minimum Data Set [MDS] to reflect the behavioral status of one (1) resident and the dialysis status for one (1) resident. Resident's #132 and 322. The findings include: 1. Facility staff failed to code Resident #139's quarterly MDS for behaviors. Review of Resident #132's quarterly MDS dated December 20, 2014, revealed that the resident was admitted to the facility on December 16, 2013 with diagnoses that included Cerebrovascular Accident, Hemiplegia or Hemiparesis, Depression, Hypertension, Muscle Weakness, and Abnormal Gait. Review of the social services note dated December 15, 2014 and timed at 3:08 PM revealed the following, " ...Also, nursing states the resident will not allow staff to shave him and continues to have verbal outburst towards nursing staff ... " Review of the Quarterly MDS dated December 20, 2014, under Section E Behavior, E0200. Behavioral Symptoms - Presence and Frequency revealed "0" in the available boxes, which indicated no physical, verbal or other behaviors were exhibited by the resident. On February 12, 2015 at approximately 4:20 PM, a face-to-face interview was conducted with Employees #15 and 16 regarding the aforementioned findings. Employee #16 stated, "The social worker is responsible for completing the behavior section on the MDS, and the nurse is responsible for ensuring each section is	F 272		

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F 272	Continued From page 31	F 272		

complete." Both employees confirmed that behavior symptoms were not coded on the MDS for the resident.

On February 12, 2015 at approximately 4:20 PM, a face-to-face interview was conducted with Employee #17 who acknowledged the aforementioned findings.

Facility staff failed to code the Minimum Data Set [MDS] to reflect the resident's behavioral status. The clinical record was reviewed on February 12, 2015.

2. Facility staff failed to code Section O for dialysis on the Quarterly MDS 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 quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of January 9, 2015 Section O: Special Treatments, Procedures, and Programs : O0100 (other): J Dialysis: (1) While not a resident and (2) while a resident was not coded.

A face-to-face interview was conducted on

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F 272	Continued From page 32 February 11, 2015 at approximately 11:30 AM with Employee #49. After review of the above, Employee #49 acknowledged the finding and stated, "It had to be due to an error in clicking the button, because the resident did not receive any transfusions, which is the box above dialysis that was checked." Facility staff failed to accurately code Section O for dialysis on the Quarterly MDS. The clinical record was reviewed on February 11, 2015.	F 272	F-Tag 279 (1-5) 1a. Resident #16's 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's a care-plan was developed to address the goals, interventions, and needs related to his/her behavior of "hoarding". 1d. Resident #392 no longer resides at the facility. 1e. Resident #322s a care-plan was developed to address the goals and intervention related to the residents tooth extraction and oral dental care.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		

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F 279	Continued From page 33 by: Based on observations, record review and interviews for five (5) of 51 sampled residents, it was determined that the facility staff 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. The findings include: 1. Facility staff 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. Facility staff failed to develop a care plan with appropriate goals and approaches for	F 279	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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F 279	Continued From page 34 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 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."	F 279	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 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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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

3. Facility staff 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

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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.

Facility staff failed to initiate a care plan with goals and approaches for one resident described as a " hoarder. "

4. Facility staff 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. 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

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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."

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. Facility staff 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

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F 279	Continued From page 38 "(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 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. Facility staff failed to develop a care plan with goals and approaches that reflected the residents current oral dental care needs.	F 279		

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F 280	Continued From page 39	F 280		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 51 sampled residents, it was determined that facility staff 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.	F 280	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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F 280	Continued From page 40 The findings include: 1. Facility staff failed to review and revise the care plan to include dialysis treatments days 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. Facility staff 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.	F 280	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. Education to licensed nurses related to Dialysis Care was provided by the Staff Development Coordinator/Nursing Management. 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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F 280	Continued From page 41 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. Facility staff failed to review and revise 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. Facility staff 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]	F 280		

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F 280	Continued From page 42 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 (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. Facility staff 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	F 280		

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F 280	Continued From page 43 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 ...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. Facility staff 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]	F 280		

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F 280	Continued From page 44 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 findings. The record was reviewed on February 11, 2015.	F 280	F-Tag 309 (A-D) A1. Resident # 286 no longer resides at Deanwood. A2. Resident #177 Resident Pain management plan of care was reviewed by the 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. The 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. 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.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: A. Based on observations, record review and interviews for two (2) of 51 sampled residents, it was determined that the facility staff failed 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, facility staff failed to develop a coordinated interdisciplinary Hospice	F 309		

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F 309	Continued From page 45 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: 1. Facility staff failed 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, facility staff failed 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 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	F 309	B2. Resident # 135, was assessed to ensure the resident did not have any negative 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. B3. 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. B4. Resident # 291 Resident no longer in the facility	

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F 309	Continued From page 46 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 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,	F 309	C1. Resident # 99 no longer resides at the facility. C2.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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F 309	Continued From page 47 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 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	F 309	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 no longer resides at the facility. 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 is no longer at the facility and has expired.	

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F 309	Continued From page 48 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 [guaze] 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 [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	F 309	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 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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F 309	Continued From page 49 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 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] " .	F 309	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 of 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. Meeting was conducted With hospice and QA nurse and protocol developed to ensure compliance with regulatory requirement.	

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F 309	Continued From page 50 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 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 Unit Manager. He/she stated, " The resident has a g-tube and a permacath on [his/her] left side. The resident did not have any	F 309	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. We now have 2RNs in staff development that are doing pre-tests, post-tests, competencies and return demonstration. 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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F 309	Continued From page 51 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 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].	F 309	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. The DON contacted APS to inform them if they cannot come in a timely manner we will send residents out, and staff were in-serviced. 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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F 309	Continued From page 52 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 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	F 309	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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F 309	Continued From page 53 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 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 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. "	F 309		

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F 309	Continued From page 54 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 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 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:	F 309		

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· 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 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

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F 309	Continued From page 56 [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. 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,	F 309		

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F 309	Continued From page 57 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] 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.	F 309		

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F 309	Continued From page 58 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 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.	F 309		

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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]. "

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

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F 309	Continued From page 60 [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 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-	F 309		

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F 309	Continued From page 61 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. [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	F 309		

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F 309	Continued From page 62 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. 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	F 309		

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F 309	Continued From page 63 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] 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	F 309		

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F 309	Continued From page 64 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 (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	F 309		

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F 309	Continued From page 65 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 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	F 309		

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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 wasconducted 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 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

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F 309	Continued From page 67 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 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.	F 309		

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F 309	Continued From page 68 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 the Tecfidera until the [attending physician] spoke with the pharmacy. The attending physician made visits on December 31, 2014 and January 31, 2015. There was no evidence that the physician addressed any discussion with pharmacist or pharmacy	F 309		

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F 309	Continued From page 69 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 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)	F 309		

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F 309	Continued From page 70 B. Based on observations, record review and interviews for five (5) of 51 sampled residents, it was determined that the facility staff failed 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 failed to manage a glycemic reaction sustained by one (1) resident in accordance with physician ' s orders. Residents' # 16, 135, 211, 291 and 352. The findings include: 1. Facility staff failed to administer medication(s) to Resident #16 on his/her assigned dialysis treatment days. A review of the Physician's orders signed and 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	F 309		

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F 309	Continued From page 71 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 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	F 309		

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F 309	Continued From page 72 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 #16 on days that dialysis treatment was rendered. The record was reviewed on February 20, 2015. 2A. Facility staff failed 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." 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:	F 309		

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F 309	Continued From page 73	F 309		

· 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."

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

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F 309	Continued From page 74 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 discontinue Rozerem and continue Ambien, as ordered by the physician. The clinical record was reviewed on February 11, 2015. 2B. Facility staff failed 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. " 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	F 309		

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F 309	Continued From page 75 [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 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	F 309		

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F 309	Continued From page 76 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 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 follow physician ' s order to administer an anticoagulant (Xarelto) for 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".	F 309		

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F 309	Continued From page 77 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 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 [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;	F 309		

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F 309	Continued From page 78 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. 5B. Facility staff failed to manage a glycemic reaction sustained by Resident #352 in accordance with physician' s orders. Resident #352 ' s diagnoses included Diabetes Mellitus [Insulin Dependent] according to the History and Physical examination signed by the physician October 5, 2014. A Review of physician's orders signed and dated October 21, 2014 at 23:33 [11:33 PM] directed the following: "Check Blood sugar every 2 hours x 12 hours. If BS [blood sugar] < 60 give Glucagon [anti-hypoglycemic medication] and send patient to the nearest emergency room for further evaluation of diabetes " Resident #352 sustained a hypoglycemic reaction [low blood sugar] [normal blood glucose range: 70 - 100 mg/dl; milligrams per deciliter according to Mosby's Diagnostic and Laboratory test reference] as	F 309	F-Tag 309 5B 1.Resident #352 has been discharged from the facility and no longer resides here. Nothing could be done subsequently for this resident. All residents have the potential to be affected by this deficient practice. 2. All residents with the diagnosis of IDDM Type II diabetes with orders for finger sticks and insulin coverage were assessed and there were no negative outcomes to any resident. 3.alll professional licensed staff and all new hires will be in-serviced on assessment and management of diabetic residents. Policy and procedures were reviewed and revised. 4. Weekly audits of glucometer administration records will be done by ADONs and random checks will be done by DON. All findings will be brought monthly to the QAPI Committee.	5/12/2015

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F 309	Continued From page 79 evidenced by the following nurse's entry dated October 22, 2014 at 5:23 AM: " Resident had hypoglycemic event at about 12:00AM finger stick was 57mg/dl [milligrams per deciliter], orange juice ...and orange sherbet ice cream was given, blood sugar was 76mg/dl, resident was alert and responsive at this time, at 1:40am finger stick was rechecked and it was 47mg/dl, orange juice was given and was vomited back immediately at this time resident appeared lethargic and diaphoretic, Glucagon was given subq [subcutaneously], [attending physician] was notified and stated to send the resident out for recurrent hypoglycemia, recheck in 15 minutes [blood glucose level] came up to 76mg/dl, [attending physician] was notified still want [ed] resident to go to emergency room to be checked, resident was transferred to [Hospital Named], family member notified. " According to the sequence of interventions recorded in the nurse ' s note listed above, it was evident that licensed staff failed to manage Resident #352 ' s hypoglycemic episode in accordance with physician ' s orders. The resident's blood glucose level was assessed at 57 mg/dl (<60) at 12 AM and Glucagon was not administered as prescribed. Additionally, the resident was not sent to the "nearest emergency room "in accordance with physician orders. Instead, licensed staff administered orange juice and sherbet as opposed to the prescribed Glucagon and EMS (emergency medical services - 911) was not activated for greater than two (2) hours (after 1:40 AM) after the onset of Resident #352 ' s glycemic symptoms. A face-to-face interview was conducted with on February 20, 2014 at 12:00 PM with Employee #28. He/she acknowledged the findings. C. Based on observations, record review and interviews for two (2) of 51 sampled residents, it was determined that the facility staff failed to assess pain and vital signs for one (1) resident as prescribed	F 309		

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F 309	Continued From page 80 and to accurately assess the status of Hemodialysis access sites for one (1) resident. Residents # 99 and 259. 1C.Facility staff failed to assess pain and vital signs 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. 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. B. Facility staff failed 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 reviewed February 10, 2015.	F 309		

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F 309	Continued From page 81 2C. Facility staff failed 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" Review of the TAR dated February 2015 revealed the following: "Assess graft site for bleeding every shift, Order date May 8, 2014"	F 309		

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F 309	Continued From page 82 " 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 aforementioned findings. Facility staff failed to demonstrate accurate knowledge of the dialysis access site	F 309		

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F 309	Continued From page 83 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 the facility staff failed 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 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 [End Stage Renal Disease Dialysis Dependent]. Review of the Resident's MDS [Minimum Data	F 309		

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F 309	Continued From page 84 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 [Certified Nursing Assistant] might have removed it from the bedside during resident care."	F 309		

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F 309	Continued From page 85 Facility staff failed to follow physician orders to keep a dialysis emergency kit by the bedside. 2.Facility staff failed 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 ordered ... " A review of the care conference notes dated June	F 309		

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F 309	Continued From page 86 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 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] of January 14, 2015 revealed the resident was coded in Section I Active Diagnoses: (J) End Stage Renal Disease.	F 309		

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F 309	Continued From page 87 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 follow physician orders to keep a dialysis emergency kit by the bedside. 4.Facility staff failed to ensure that Resident #223 ' s diagnostic study results were obtained. Resident #223 was admitted to the facility on October 10, 2014 with diagnoses which included: Congestive heart failure, cardiomyopathy, Hyperlipidemia, end stage renal disease,	F 309		

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F 309	Continued From page 88 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. The record was reviewed on February 12, 2015. 5.Facility staff failed to ensure that Resident #283	F 309		

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F 309	Continued From page 89 ' s PICC (peripherally inserted central catheter) line was removed 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], " ...PICC line flushed with normal saline followed by heparin for maintenance ... " September 14, 2014 at 21:37 [9:37 PM], "	F 309		

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F 309	Continued From page 90 ...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 to the left side and drooling from [his/her] mouth. Resident was lying in the bed in supine position,	F 309		

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F 309	Continued From page 91 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] ... "	F 309		

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F 309	Continued From page 92 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	F 309		

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F 309	Continued From page 93 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. "	F 309		

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F 309	Continued From page 94 A review of the Dialysis Communication Sheet 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 Resident #292 received a scoop mattress as order 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 ... "	F 309		

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F 309	Continued From page 95 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 obtain daily weights for the management of a cardiac disorder (congestive heart failure) for Resident #352 as per the physician's order.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	02/20/2015

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

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F 309	Continued From page 96	F 309		

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

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F 309	Continued From page 97 assisted with ADL ' s care. Resident gains weight from 233lb to 246lb. [Physician] notified and 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.	F 309		

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 51 sampled residents, it was determined that facility staff failed to ensure that one (1) resident received necessary services to maintain good grooming, and personal hygiene as evidenced by Resident #292 who was found lying in bed saturated with urine. The findings include: A review of the facility's incident reports revealed that on February 19, 2015 the Resident was found hanging halfway out of bed with head on the floor and the bed was saturated with urine. A review of the quarterly Minimum Data Set dated October 11, 2014, revealed that 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.] 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). There were	F 312	F-Tag 312 1. Resident # 292 was assessed and plan of care was reviewed and revised. Staff was in-serviced on the plan of care and providing appropriate ADL care. Resident's plan of care for falls prevention was also reviewed by the IDT team member to ensure the interventions recommended is in place. 2. Residents who are dependent on staff for ADLs have the potential to be affected by this deficient practice. Residents requiring Assistance with ADLs will be assessed by the staff to ensure the Care plan is reviewed to address care needs. Residents with History of falls will also be assessed to ensure the plan of care and interventions is being followed thru on the unit. Staff will continue to make every two hours rounds. The CNA care card will indicate any special fall prevention interventions need to be followed.	

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F 312	Continued From page 99 no observed signs that the resident was incontinent at the time of this observation. Nursing Notes: The nursing note dated February 19, 2015 revealed, " resident is alert and oriented to person. Resident status post fall and three [3] day[s] [of] neurological assessment continues ... " A review of the ADL (activities of daily living) care plan initiated on September 10, 2014 revealed, " Toilet Use: the resident is totally dependent on staff for toilet use. Total incontinent of bladder and bowel. " There was no evidence that facility staff updated the ADL care plan to address the resident ' s increase in urinary incontinence frequency and the staff ' s approach to toileting the resident. Interviews: A face-to-face interview was conducted February 20, 2015 at 3:15 PM with Employee # 39, Evening shift CNA. When asked about the care provided to the resident Employee #39 stated that he/she takes care of the resident about 10 times a month. He/she stated that recently the Resident started moving the top of [his/her] body and reaching with [his/her] arms. The employee stated that he/she noticed the movement about three (3) weeks ago so the half side rails are always up. A face-to-face interview was conducted on February 20, 2015 at 3:55 PM with Employee # 9. When asked about the falls the resident had recently sustained, he/she stated that the Resident had a fall eight (8) days ago. [He/she] wiggles and can move [his/her] upper body fairly	F 312	3. Staff Development will in service CNA's and nursing staff on Care and Management of residents requiring assistance with ADL's. All IDCP team and nursing staff will be in serviced on Falls prevention and management of residents at risk for falls. All new hires will be in serviced. Annually all staff will be in serviced on care of residents requiring assistance with ADLs and falls prevention. Policy and Procedure on ADLs and falls prevention will be reviewed and revised. All accident and incident reports will be reviewed by the IDT members the following day to ensure appropriate interventions is recommended for the resident. The plan of care will be updated and the CNA care card will be revised. The IDT will meet weekly to review all frequent fallers to ensure implementation of intervention is effective. The IDT will review quarterly all residents during care plan meeting to ensure the interventions implemented is working for the resident or necessary changes need to be made.	