STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: _____ B. WING _____	3.The facility QAPI 03/07/2014

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team has developed a

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L 000	Initial Comments The Annual Licensure Survey was conducted at your facility on February 18, 2014 through March 7, 2014. 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 D/C discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - emergency medical services (911) g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of	L 000	L001 1.Retrospectively all residents had the potential to be affected by this deficient practice. The Administrator developed a plan with Corporate approval to ensure the integration, coordination, and monitoring of the center's practices related to resident care and safety to ensure that each resident attains or maintains the highest practicable physical, mental and psychosocial well-being; ensure that the program is designed to provide a safe and sanitary, comfortable environment and help prevent the healing of pressure ulcers and prevent transmission of disease and infection and provide a program for quality assessments and assurance that implements plans of action to correct identified deficiencies. Corporate will respond more timely to requests from the Administrator. 2.For each deficient practice identified in the POC a total audit (100%) was completed for all other residents to ensure no other residents were affected by the deficient practice. 3.The Administrator has been writing policies And procedures for each disciplines and other policies and policy and procedures were updated, protocols and guidelines written.	

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L 000	Continued From page 1 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 TAR - Treatment Administration Record	L 000	We wrote a policy for Ambassador Rounds to incorporate all leaders in the building to do room rounds for each resident with a check list and the Administrator/DON will follow-up at morning meetings. We are hiring 4 ADONs to have strategic, educational, tracking, trending and overall oversight and monitoring of all 4 floors. We are also bringing on another Nurse Practitioner (NP) to assist with education and training on the units with all licensed nurses. We hired a new Certified Wound Care NP to assist the Wound Team. A policy and protocol was written for all clinicians to do survey preparedness/chart audits per unit. A new RN Director of Staff Development was hired. The facility QAPI team has developed a QAPI plan to outline the structure of QAPI in the facility using data to not only identify our quality issues, but to also identify, opportunities for improvement, and setting priorities for action. Data that will be routinely monitored has been identified and will be organized and interpreted into meaningful reports that can be used for performance improvement. Performance Improvement Plans have been developed for resident assessments related to respiratory status, management of central line catheters, skin/wound monitoring and, care planning, following, physician orders, pharmacy services, MDS coding; and staffing consistency levels. QA Nurse will be sent to several QAPI training, the next training will be May 7, 2014.	
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on observations, record review and staff interview, it was determined that the facility Administration and Governing Body failed to integrate, coordinate and monitor the facility ' s practices related to the residents care and safety as evidenced by a failure to ensure that residents attain or maintain the highest practicable physical, mental and psychosocial well-being; ensure that a program designed to provide a safe, sanitary and comfortable environment and to help promote the healing of Pressure Ulcers	L 001		

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L 001	Continued From page 2 and prevent the development of new ulcers and prevent the transmission of disease and infection; and provide a program for quality assessments and assurance that implements plans of action to correct identified quality deficiencies. Cross reference CFR §483.75 and §483.75(d) The findings include: The facility Administration and Governing Body failed to: Ensure that residents attain or maintain the highest practicable physical, mental and psychosocial well-being. Cross reference CFR 483.25, F309, Provide Care/Services for Highest Well being Ensure that a program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Cross reference CFR 483.25, F314 Pressure Ulcers Ensure a that a program for quality assessments and assurance implements plans of action to correct identified quality deficiencies. Cross reference CFR 483.75, F520 QAA Committee-Members/Meet Quarterly/Plans	L 001	4.QAPI tool was developed to monitor the Performance Improvement Plans and identify areas for improvement, the need for continued monitoring, and the need for further education. A QAPI steering committee will be developed and each team member will take responsibility to study the issue, analyze the data, and recommend corrective actions. They will then prioritize opportunities for more intensive improvements. Changes or corrective actions will only be implemented in order to improve or reduce the chance of the event recurring. The goal will be to make changes that will result in a lasting improvement. This will be achieved through the new monthly QAPI process. L051 1.Resident #401 and 402 no longer resides in facility. Resident # 290 has been seen by Nephrology, Podiatry, and The Wound Care Consultant. An appointment has been made with Infectious Disease MD. Skin sweep sheets are in place for resident and the primary care physician has addressed recommendations by consultants. A turning and repositioning schedule has been put in place and staff has been in-serviced on addressing and documenting the care needs of this resident. Resident #290 Facility amended care plans to reflect specific intervention for a right arm splint and refusal of dental treatments.	5/13/14
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical	L 051		

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L 051	Continued From page 3 and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on observation, record review and interviews for four (4) of 51 sampled residents, it was determined that the charge nurse failed to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being as evidenced by failure to: consistently assess, monitor and report to the physician the respiratory status of one (1) resident who subsequently expired; consistently conduct skin assessments for one (1) resident who subsequently developed a facility acquired dry gangrene of the toe; consistently assess, monitor and manage a peripherally inserted central catheter (PICC) for one (1) resident who subsequently sustained an infection at the site;	L 051	Resident #316 is no longer receiving Antibiotics and no longer has a PICC line in place. The Central line protocol and documentation will be reviewed for all residents receiving medication/fluids through this device to ensure protocols were followed and identify any areas of education needed. Resident #50 Upon assessment, Dialysis site is patent and bruit and thrill are present. No sign or symptoms of redness/infection or bleeding noted. Employee #8 was educated regarding the pre and post assessment of the dialysis access site. Dialysis Care-plan was updated to reflect appropriate goals and approaches, including assessment and follow up care of dialysis access site, pre and post dialysis. Care-plans were also updated to reflect resident's dependent dining status, and bilateral hand splinting needs. Resident #384 did not have negative outcomes related to the deficient practice of the facility not reviewing and revising residents care plan to reflect resident's current continent voiding status. All concerns were addressed with the specific residents. Resident #121- Dialysis Care Plans were initiated with appropriate goals and approaches, including assessment and follow up care of dialysis access site, pre and post dialysis. Poly-Pharmacy Care Plans were also initiated with appropriate goals and approaches addressing the potential for drug interaction. Resident# 222- Care-plans were updated to reflect the Restorative Nursing Programs for AROM and Ambulation Program Resident # 265- Care plans were developed to address resident's refusal for the use of a nicotine patch.	

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L 051	Continued From page 4 act with timeliness on physician ' s orders for one (1) resident to undergo a nephrology consultation; turn and reposition one (1) resident with altered skin integrity in accordance with the comprehensive plan of care and consistently assess the respiratory status of one (1) resident prior to and post the administration of respiratory treatments. Residents' # 402, 290, 316, 80 The findings include: 1. The charge nurse failed to consistently assess, monitor and report to the physician, the status of Resident #402 ' s condition at the time admission.. The resident was assessed with respiratory wheezing, use of accessory muscles to breathe and cyanosis of fingers and toes at the time of admission. He/she was assessed with unresponsiveness and expired within twelve (12) hours of admission to the facility. Resident #402 was admitted to the facility on February 18, 2014 at 7:15 PM from an acute care hospital. According to the " Discharge/Transfer Summary " from the hospital, the resident ' s discharge diagnoses included " Mycardial Infarction, Congestive Heart Failure exacerbation, Acute on Chronic Kidney Disease, Dehydration, Atrial fibrillation, Hypertension, moderate Pulmonary Hypertension, Hypoalbuminemia and Supratherapeutic INR [International Normalized Ratio]. " According to the Certificate of Death noted in the clinical record, the resident expired on February 19. 2014 at 6:20 AM; cause of death " Fatal Cardiac Arrhythmia due to or as a consequence of Non Valvular Atrial Fibrillation. " Nursing Notes:	L 051	2.All residents have the potential to be affected by the deficient practice of not initiating care plans with appropriate goals and approaches and have the potential to be affected by the failure to ensure the residents have received necessary care and services to attain or maintain the highest practicable well being. Charts will be reviewed to address all concerns identified and education to be provided as applicable. All Residents have the potential to be affected by the deficient practice of not notifying both the physician and responsible party of changes in condition. Nursing Management will review resident's records to ensure that both the physician and responsible party will be notified of changes in condition. Care Plan Education has been provided to License Nursing staff by Nursing Administration and Staff Development. A.Nursing Management and Restorative Nursing will review resident's records to ensure that Restorative Nursing Care Plans address splinting devices, as appropriate and identify areas of education as needed. B.Nursing Management will review resident's records to ensure that ADL Care Plans addresses resident's needs for assistance with feeding, make updates as necessary, and identify areas of education as needed to ensure that staff are aware, and adhering to plan of care. C.Nursing Management will review residents records to ensure that dialysis care plans are initiated with appropriate goals and approaches, including assessment and follow up care of dialysis access site, pre and post dialysis.	

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L 051	Continued From page 5 The Admission Note written on February 18, 2014 at 23:49 [10:49 PM] revealed, " [Resident #402] arrived at the facility from an area hospital at 7:15 PM on February 18, 2014 ... " On admission resident is alert and oriented x 3[times], on [continuous] oxygen for SOB [Shortness of Breath], no acute distress or discomfort noted ...Lung sounds noted with expiratory wheezing, noted with barrel chest, resident is hyperventilating and [he/she] was using accessory muscles to breathe with respiration of 22. Resident is on oxygen 3l/min [three liters per minute] via NC [nasal cannula] for SOB. Skin is warm to touch skin is tinted, bi lateral hand and all fingers are cyanotic, both feel are shinny [and] toes are cyanotic. All meds (medications) clarified with [attending physician] and faxed to pharmacy. Emergency contact was in the unit. V/S (vital signs) 129/66 [blood pressure], Pulse 94, temp (temperature) 98.8, rr (respiratory rate) 22, SPO2 [Saturation Percentage of Oxygen] 97% with 02 (oxygen) 3l/min and wt (weight) 110 lbs (pounds). " The nursing note dated February 19, 2014 at 02:55 AM revealed, " Writer went to give the resident PPD [Purified Protein Derivative]. Resident was sleeping. Writer attempt[ed] to wake [the] resident. [The] roommate stated, 'Do not wake [him/her] up. ' Supervisor made aware. Will follow up in the morning." The nursing note dated February 19, 2014 at 08:44, revealed, " Writer called to the room ... to find the resident unresponsive with the charge nurse performing CPR (Cardiopulmonary resuscitation). The EMS [Emergency Medical Services] team came to the resident's room [and] performed EKG (electrocardiogram) with result	L 051	D.Nursing Management will review resident's record to ensure that Poly-Pharmacy Care Plans are initiated with appropriate goals and approaches addressing the potential for drug interaction. Care Plans will be updated as necessary and education to be provided as needed. E.Nursing Management will review resident's records to ensure care plans are developed to address resident's refusal to the use of nicotine patch. Social work, Medical and Nursing will provide education to residents regarding the benefits of the nicotine patch. Make updates as necessary and identify areas of education as needed. Nursing Management will review all care plans on residents with PICC line on proper documentation including goals and approaches, to manage focused areas of a PICC line. Updates will be made when necessary and education to be provided as needed. The Central Line protocol and documentation will be reviewed for all residents receiving medication/fluids through this device to ensure protocols were followed and identify any areas of education needed. F. Facility will review protocols for completing the weekly skin observation sheets, make updates as necessary, and identify areas of education needed. G. Nursing Management will review all residents' records for care plan initiation, which have an order for a CPM machine and proper documentation to include the daily use and management of the CPM machine.	

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L 051	Continued From page 6 showing asystole (that the resident expired). [He/she] was pronounced dead at 06:20 AM ... " A face-to-face interview was conducted with Employee #35 on March 5, 2014 at approximately 3:30PM. During the interview the employee acknowledged writing the aforementioned statement [nurse ' s note February 19, 2014 at 2:55 AM]. He/she also stated that the resident was awake and verbally responsive while the supervisor was admitting [him/her]. The employee also stated that the resident was asleep when he/she was attempting to administer the PPD. The employee was queried at what time [he/she] had attempted to administer the PPD. He/she stated, " It was around 2:00AM. " A face-to-face interview was conducted with Employee #34 at approximately 9:00AM on March 5, 2014. The employee stated that he/she was the supervisor on duty when the resident expired. The employee was queried regarding the events that led up to the resident ' s death. He/she stated that the report he/she received was that there were two admissions to the facility. One admission had been completed by the evening supervisor and one needed to be completed by him/her. He/she became involved with the admission of the assigned resident and was unaware of the expired resident ' s respiratory problems until he/she was called to the unit at around 6:00AM on February 19, 2014. A face-to-face interview was conducted with Employee #33 at approximately 4:30PM on February 27, 2014. The employee was queried whether he/she was the nurse who documented the following information [nurse ' s note February	L 051	3A. Nursing Management provided in-servicing on care planning to Licensed Nurses and Restorative Nursing. Residents care plans have been initiated to reflect appropriate goal and approaches for the use of splinting. Care Plans to be audited by Restorative Nursing to ensure completion and compliance. B.Care Plans have been initiated with appropriate goals and approaches to include assessments and follow up care of dialysis access site pre and post dialysis. Care Plans to be audited by Nursing Management weekly to ensure completion and compliance. C.ADL Care Plans have been developed with appropriate goals/approaches to address assistance with feeding to dependent residents. Education was provided to License Nurses on care plan development and updates. ADL Care Plans will be audited by Nursing Management weekly to ensure completion and compliance. D.Poly Pharmacy Care Plan was initiated with appropriate goals/approaches to address the potential for adverse drug interactions. Medication review done by the Physician and Pharmacy Consultants and recommendation as appropriate. Nursing Management to conduct weekly audits for completion and compliance, make updates as necessary, and provide education as needed. E.Care Plan initiated to address residents refusal to the use of the nicotine patch. Nicotine patch was discontinued by the Physician due to resident's refusal. Educated resident on the importance of cessation. Nursing Management to conduct audit weekly to ensure appropriate documentation and completion.	

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L 051	Continued From page 7 18, 2014 at 10:49 PM]: " Lung sounds noted with expiratory wheezes, barrel chest, hyperventilating and using accessory muscles to breathe; utilizing O2 at 3l/min [three liters per minute] via NC [nasal cannula] for SOB [Shortness of Breath.] Bilateral hands and all fingers were cyanotic, both feet were shiny and toes cyanotic. " The employee was asked whether the resident ' s condition (as described by him/her) warranted immediate medical attention. The employee did not respond to the question. A review of the record lacked documented evidence of an assessment for the resident between the time of admission 7:15 PM on February 18, 2014 and the time that the resident was pronounced dead at 6:20AM on February 19, 2014. The Admission Assessment documented by the nurse revealed that Resident #402 was experiencing respiratory difficulty upon arrival to the facility as evidenced by the following note: " Lung sounds noted with expiratory wheezes, barrel chest, hyperventilating and using accessory muscles to breathe; utilizing O2 at 3l/min via NC for SOB. Bilateral hands and all fingers were cyanotic, both feet were shiny and toes cyanotic. " The nurse ' s note also indicated that the nurse spoke with the attending physician regarding the resident ' s medication regimen; however, there was no evidence that the resident ' s condition, assessed at the time of admission was conveyed to the primary care provider. The only vital signs recorded in the clinical record prior to assessing the resident as unresponsive were obtained at the time of	L 051	F.Policy and procedures and documentation for central lines were reviewed by Nursing Administration. All residents with central line care plans were reviewed by Nursing Administration for proper documentation including goals and approaches to manage focused areas of PICC Line. Audits will be performed weekly by Nursing Management to ensure proper documentation, completion and compliance. G.Care Plan for CPM machine was initiated which addressed daily used and management of the CPM machine. Education was given to nursing staff by the Therapy Department on the daily use and management of the CPM machine. Continued education will be given to Licensed Nursing staff prior to any prospective admission to the facility with an order of the application and use of a CPM machine. Audits will be performed weekly by Nursing Management when there is an order for the use and application of a CPM machine to ensure compliance. H.Weekly skin check policy was reviewed and updated as necessary. Licensed staff will be in-serviced by the Staff Development Coordinator regarding protocols and documentation requirements for weekly skin checks. 4. Audits will be reviewed by Nursing Administration on a weekly basis. Compliance with follow through will be monitored monthly through the QADI process by the QAPI Department/ Nurse Education will be provided as needed.	5/13/14

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L 051	Continued From page 8 admission at 7:15 PM on February 18, 2014. There was no evidence that facility staff consistently assessed and monitored Resident #402 once he/she was assessed with respiratory difficulty at the time of admission. The primary care physician was not informed regarding the respiratory status of the resident. The record was reviewed on February 27, 2014. 2. The charge nurse failed to consistently conduct skin assessments on Resident #290, who subsequently developed a facility acquired dry gangrene of the toe; failed to obtain a nephrology consultation with timeliness and failed to turn and reposition the resident in accordance with the comprehensive plan of care. A. Facility staff failed to consistently conduct skin assessments on Resident #290, who was subsequently diagnosed with dry gangrene of the toe. The Facility ' s Procedure Policy: " Skin and Wound Management " [no date indicated] stipulates: " Each resident is evaluated by the interdisciplinary team to determine his or her risk for skin compromise or the presence of wounds and/or pressure ulcers. A plan of care is developed and implemented based on this evaluation with ongoing review. Procedure: 3. Residents will be monitored weekly for skin integrity and documentation will be completed on the Weekly Skin Assessment form. " According to a re-admission history and physical dated June 5, 2013, Resident #290 ' s diagnoses included: " Seizure Disorder, Hypertension, [Status Post] PEG (Percutaneous Endoscopic	L 051		

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L 051	Continued From page 9 Gastrostomy) and Diabetes Type II. " MDS: According to the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of January 17, 2014, Resident #209 was coded in Section G as being totally dependent requiring one person physical assist in personal hygiene. Under Section M (Skin Conditions) the resident was coded as having no venous and arterial ulcers and no foot problems; however, he/she was coded as being at risk of developing pressure ulcers. Care Plan: The care plan entitled ADL [Activities of Daily Living] Self Care Performance Deficit [related to] stroke, Musculoskeletal Impairment, Limited Mobility last updated on December 17, 2013 revealed: Interventions: Skin Inspection- The resident requires skin inspection [every] shift. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse. The care plan entitled Diabetes Mellitus Type II last updated December 17, 2013 revealed... Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. Physician ' s Orders: The Physician ' s Order Sheet dated December 31, 2013 revealed, " Skin Checks by Licensed Nurse twice a week on Shower Days Tuesdays and Fridays (3pm-11pm) " Interim order dated February 7, 2014 at 3:30 PM, directed, " Arterial Doppler- [Rule out] PAD/BLE (Peripheral Arterial Disease - Bilateral Lower	L 051		

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L 051	Continued From page 10 Extremities). " Interim order dated February 10, 2014 directed, "Apply skin prep to left 2nd toe gangrene. " Interim order dated February 14, 2014 at 2:46 pm, directed, " Schedule vascular consult with a vascular doctor for a plan of treatment to lt [left] foot 2nd toe gangrene. " A radiology report dated February 10, 2014 revealed the following: Procedure: Arterial Duplex Doppler to lower extremities- " Impression: No evidence of significant stenos is within either lower extremity arterial tree. " Skin Reports: The "Bath [and] Skin Report" revealed the following: January 13, 2014- Bed Bath Given- Skin intact-No documentation on the sheet. No charge nurse signature January 16, 2014- Bed Bath Given- Skin intact- No charge nurse signature. " The " Skin Sweeps" sheets revealed the following: " November 9, 2013- No new skin impairment- signed by licensed practical nurse December 7, 2013- No new skin impairment- signed by licensed practical nurse December 12, 2013- No new skin impairment- signed by licensed practical nurse January 5, 2014- No new skin impairment- signed by licensed practical nurse	L 051		

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L 051	Continued From page 11 January 12, 2014- No new skin impairment-signed by licensed practical nurse. " The " Non-Pressure Ulcer Skin Conditions Sheet " dated February 10, 2014 at 13:01 revealed, " Date of Onset: February 8, 2014, Origin of Wound: Facility Acquired, Type of Evaluation: Initial Onset, Site of Skin Condition: Left 2nd (second) toe, Type of Skin Condition: Other: Dry Gangrene, Document Measurement in centimeters: Length: 3.6, Width: 4.9, Depth: 0, Presence of Pain: No, Progress: A dry gangrene. Black and dry with no drainage. Treatment: - Apply skin prep daily, Physician Notified of Change: - Yes. Vascular consult was scheduled for February 19, 2014; resident refused to go. Guardian made aware. Appointment rescheduled for March 9, 2014. " The clinical record lacked evidence that skin assessments were consistently conducted on shower days in accordance with the physician's orders and the facility ' s policy. Additionally, there were no skin sweep sheets nor bath and skin report sheets in Resident #209 ' s record for the month of February 2014. The Physician's Progress Notes revealed the following: December 11, 2013- Section C: Physical Examination: Check below [check mark] if normal and [+] if abnormal. Under Skin: check mark was placed after no rash. Extremities: No edema. Under skin care section - there was no documentation indicating there was no skin alteration. January 13, 2014- Skin-check mark [no rash];	L 051		

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L 051	Continued From page 12 Extremities: no edema, no documentation under skin care section. Plan/Recommendations: IV (Intravenous Fluids) - Continue [water] through PEG, Repeat electrolytes. January 31, 2014- Skin- check mark placed- [no rash], no documentation under skin care section. Plan/Recommendations: IV fluids. February 7, 2014 at 3:15 PM- Resident [with] Diabetes Mellitus, Seizure Disorder, Hypertension, [Status Post] PEG and Paranoid Schizophrenia seen today for evaluation of abnormal labs ... [Extremities]- No edema, [left] foot 2nd toe necrotic. Assessment/Plan: [Left] foot 2nd toe necrotic- Arterial Doppler- [Rule out] PAD- (Peripheral Arterial Disease.) " According to a " Patient Podiatric Service report " dated January 13, 2014 revealed: " Assessment, Procedures Performed & Plan of Treatment: Professional treatment is required of [check in box for] toe nails to prevent exposing patient to medically significant risk related to wound healing, complications and possible loss of limbs, due to : Diabetic and/or Peripheral Vascular Disease; Follow-Up- Patient should be treated in 60 days for foot care due to systemic conditions or sooner should complications arise. " There was no evidence that the physician included the podiatrist follow-up recommendations in his/her plan of care prior to February 7, 2014, when the " gangrene toe " was discovered. Nursing Notes:	L 051		

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L 051	Continued From page 13 January 18, 2014-12:53 PM - ADL (Activities of Daily Living) care provided by assigned CNA (Certified Nursing Assistant). Skin assessment done, no new skin issue. February 5, 2014 at 12:18 PM - Skin warm and dry to touch. February 6, 2014 at 07:35 AM - ADLs- total care given. February 7, 2014 at 09:19 AM- ADLs, total care given. February 7, 2014 at 19:50 PM- Resident has an order for bilateral lower extremities, Arterial Doppler study [related to] dark disco orated left second. " February 8, 2014 at 16:52 PM - Arterial Doppler study to [rule out] PAD (Peripheral Artery Disease) of bilateral lower extremities. Skin warm and dry to touch. February 9, 2014 at 08:06- Skin dry and warm to touch. AM ADL care given. February 10, 2014 at 12:20- Note Text- Resident was transferred from [unit and bed named]. Was noted with black dry gangrene on left 2nd toe- 3.6 x 4.9 x 0 x 0 cm. This was reported to [attending doctor named] on February 8, 2014 who ordered arterial Doppler to rule out peripheral artery disease. Doppler was scheduled for [February 10, 2014] by [radiology company]. In the meantime skin prep to left 2nd toe daily. February 10, 2014 at 17:05- Note Text- Late	L 051		

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L 051	Continued From page 14 entering for resident. On February 7, 2014, resident was noticed with darkness on left second toe. [Nurse Practitioner] was notified and an order for arterial Doppler- [Rule out bilateral lower extremities] was given. Will continue to monitor. February 10, 2014 17:10- Note Text: Resident was transferred from [room number written] to [room number written] at 14:00 (2:00 PM). No sign of distress noted. [Vital Signs]:104/70 [Blood Pressure], 66, [Pulse] 18 [Respiration], 97.4 [Temperature]. The clinical record lacked evidence that skin assessments were consistently conducted twice a week in accordance with physician ' s orders and facility policy. A review of the 24 hours nursing report from February 7, 2014 through February 10, 2014 lacked evidence that Resident #290 had any type of alteration in skin integrity. Consulted with Employee #41 telephonically on February 28, 2014 at approximately 4:20 PM regarding the necrotic toe. When queried regarding the necrotic toe on assessments; he/she stated, "The necrotic toe was discovered and I was informed. They stated that he/she had a vascular appointment. " A face-to-face interview was conducted with Employee #7 on February 28, 2014 at approximately 3:00 PM regarding the weekly skin assessments. After reviewing the skin sheets; he/she acknowledged the aforementioned findings. The clinical record was reviewed on February 28, 2014.	L 051		

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L 051	Continued From page 15 Facility staff failed to consistently conduct skin assessments on Resident #290, who subsequently developed a " facility acquired dry gangrene " of the left 2nd toe. B. Facility staff failed to act with timeliness on an order to reschedule a nephrology appointment for Resident #290, who exhibited abnormal renal laboratory values. Greater than seven (7 months) lapsed before the order was acted upon. According to a re-admission history and physical dated June 5, 2013 revealed, Resident #209 ' s diagnoses included: " Seizure Disorder, Hypertension, [Status Post] PEG (Percutaneous Endoscopic Gastrostomy), Diabetes Type II and Bili (Biliary) Non obstructing Renal Calculi. " According to an interim physician ' s order dated August 9, 2013 [unable to read time] directed; " [Follow up with] Nephrology [specialist physician named] ASAP (As Soon As Possible) for renal insufficiency. " A nurses note dated August 28, 2014 at 14:02 (2:02PM) read: " Note Text: Resident was scheduled for nephrology appt with [nephrologists ' named] at [hospital named] at 10:30 AM. At 8:45 AM ... from [ambulance company] called and stated that they will come around 9:30 AM to pick the resident [up] for the appointment. At 9:45 AM, the writer called ambulance company], the operator stated that they are running behind schedule. That they will come around 10:10 AM and that they will call the doctor ' s office first to find out if they will still see the resident if they get him/her there late. Later the operator returned call and stated that they	L 051		

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L 051	Continued From page 16 are cancelling the pick up because the doctor ' s office said they will not see the resident if he is late. Responsible party made aware. [Appointment] to be rescheduled " [SIC]. An interim physician ' s order dated August 29, 2013 directed; " Reschedule resident for Nephrology with [specialist named] secondary [to] elevated BUN (Blood Urea Nitrogen) and Creatinine. " [Normal Range- BUN-8-23, BUN/Creatinine- 3.60-50.0] A review of the doctor ' s progress notes revealed the following: " August 8, 2013 at 1:30 PM- [chief complaint] - [follow-up] labs .... Resident labs came back and NP [nurse practitioner] for review: BUN/Creatinine-89/1.90; Assessment/Plan: [Diagnosis] - Renal Insufficiency, Diabetes 2, [Status Post] PEG Placement secondary to poor po [by mouth] intake ..... Increase GT flushes to 500 cc [times] 72 hours then [every] 6 hours [times] 24 hours. Repeat labs after flushes. Follow up with nephrology for renal insufficiency ... Signed Nurse Practitioner August 13, 2013- 1:40 PM- ... CC follow up labs ... BMP (Basic Metabolic Panel) with BUN/Creat 75/1.80 improving as compared to last labs-89/1.90, Assessment/Plan: ... Renal Insufficiency, DM 2, Follow-up Nephrology appointment. Repeat BMP [every] month .... Signed Nurse Practitioner August 17, 2013- Problem List (New) - Dehydration ..., BUN-75, Crt-1.8. Plan/Recommendations: [Increase] flushes, Repeat BMP. Signed: Attending Physician.	L 051		

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L 051	Continued From page 17 August 20, 2013 at 7:00 PM- CC- follow up labs .... BMP with BUN/Creat 72/1.60; Assessment/Plan: Renal Insufficiency, Diabetes .... Signed by Nurse Practitioner. September 18, 2013- ... Lab Tests: BUN/Crt= 73/1.8; Plan/Recommendations: Push Fluids, Repeat BMP. Signed: Attending Physician. October 4, 2013- Lab work: ... BUN -72/ Crt- 1.7; Assessment: Dehydration; Plan: Start IV fluids- ½ [normal saline] 50 ml/hour; Repeat BMP- Signed: Attending Physician October 8, 2013-.. Lab work- BUN-70, Crt- 1.4- Continue flushes and IV (Intravenous Fluid) fluids; Assessment: Dehydration, P- Continue IV fluid [increase] rate- Continue water flushes. Signed: Attending Physician. October 16, 2013- 3:00 PM- CC- follow up labs- ... BMP- BUN/Crt- 55- improved from 76, Creat 1.6, Assessment Plan: DX (Diagnosis) - Renal Insufficiency; Continue GT flushes, Completed IVF (IV Fluids). Signed- Nurse Practitioner. November 4, 2013- ...No lab values documented. Plan/Recommendations: Please resend Urology, Repeat Lab. Signed: Attending Physician. December 11, 2013- ...No lab values documented. Plan/Recommendations: Surgery Consult- Distended Gallbladder... Signed: Attending Physician. January 13, 2014- Problem List (New) - Dehydration, Renal Insufficiency, and	L 051		

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L 051	Continued From page 18 Plan/Recommendations: IV fluids- Continue [water] through PEG, Repeat Electrolytes. Signed: Attending Physician. January 31, 2014- ... BUN/CRt- 76/1.70, Plan/Recommendations: IV fluids. Signed: Attending Physician According to a request form for consults and/or appointments form dated February 26, 2014 revealed; " Type of Appointment: Nephrology; Reason for Appointment: for high BUN that has not been responding to treatments. Consults and /or Appointments Arranged: Date of Appointment: March 12, 2014; Time: 11:30 AM. There was no evidence in the clinical record that Resident #290 had an appointment scheduled prior to March 12, 2014. There was no evidence that the physician or the nurse practitioner included the resident ' s nephrology consultation in his/her total plan of care. A review of the medical record revealed that the attending physician made visits on September 18, October 4, October 8, November 4, December 11, 2013 and January 13 2014 and January 31, 2014. There was no evidence that the physician addressed the request for nephrology consultation. A face-to-face interview was conducted on February 26, 2014 at approximately 1:00 PM with Employee #7. When queried if the nephrology appointment had been rescheduled per physician ' s orders prior to the state agency inquiry; he/she stated that the appointment was	L 051		

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L 051	Continued From page 19 not rescheduled as ordered and that he/she would investigate what happened. A face-to-face interview was conducted on February 28, 2014 at approximately 1:30 PM with Employee #40. When he/she was queried; " What is the facility ' s process on scheduling appointments and arranging transportation for residents? " He/she stated; " I make transportation arrangements after the unit secretary schedules the appointment. The unit secretary schedules the appointment and the referral with the appointment date and time is faxed to me. Upon receiving the fax; transportation is arranged. I record the information in the referral/transportation log book. " Facility staff failed to act with timeliness on a physician ' s order for Resident #290 to undergo a nephrology consultation. The resident renal laboratory values were abnormal. Greater than seven (7 months) lapsed before the order was acted upon. C. Facility staff failed to turn and reposition Resident #290 in accordance to the comprehensive plan of care. During an isolated interview with Resident #290 ' s responsibility party on February 21, 2014 at approximately 12:45 PM. He/she expressed concerns regarding resident not being repositioned every two (2) hours. According to the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of January 17, 2014 revealed that Resident #209 was coded in Section M (Skin Conditions) as	L 051		

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L 051	Continued From page 20 having no venous and arterial ulcers and no foot problems; however, he/she was coded as being at risk of developing pressure ulcer(s). A review of the " Braden Scale for Predicting Pressure Ulcer Risk " dated December 3, 2013; the resident ' s score was 14 indicating he/she was at moderate risk for developing a pressure ulcer. A review of the comprehensive care plan most recently updated, December 17, 2013 revealed , " Problem: The resident is potential for pressure ulcer development related to immobility ; Interventions: The resident needs assistance to turn/reposition at least every 2 (two) hours, more often as needed or requested. " Observations of the resident during the survey period revealed the following: February 25, 2014 at approximately 12:10 PM- Observed resident lying in bed on his/her back. February 25, 2014- at approximately 1:25 PM- Observed resident lying in bed on his/her back. February 25, 2014- 3:00 PM- Observed resident lying in bed on back. February 25, 2014 4:10 PM- Observed resident lying in bed on back. There was no evidence that facility staff turned and repositioned Resident #209 in accordance with the care plan as evidenced by observations and family interview. A face-to-face interview was conducted with Employee #7 on February 25, 2014 at approximately 3:00 PM regarding the aforementioned findings. After consulting with	L 051		

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L 051	Continued From page 21 the assigned staff (CNA assigned to resident), Employee #7 stated, " The resident refuses to be turned and repositioned sometimes. " Employee #7 acknowledged the findings. The clinical record review and observations were conducted on February 25, 2014. 3. The charge nurse failed to consistently assess, monitor and manage Resident #316's PICC [peripherally inserted central catheter] line. The nurse ' s Admission note dated January 3, 2014 at 19:11 [7:11 PM], Resident #316 was re-admitted to the facility on January 3, 2014 with a Right Upper Arm PICC line. The facility ' s Central Line Catheter Protocol form initiated on January 4, 2014 but signed by the physician on January 6, 2014 revealed," Device Type: PICC, non-valved; Type of Infusion: unknown, this section of the form was blank; Number of Lumens: unknown, this area was blank; On Admission the PICC gauge , total catheter length and external catheter length sections were blank. Unused lumens/minimum flush interval: PICC non-valved q [every] 12 hours each lumen 5 ml [milliliters] ns [normal saline], 5 ml 10 units/ml heparin flush. " According to the Central Line Catheter Protocol/Fluid/Medication Orders dated and signed by the physician January 6, 2014 at 10:00 AM, directed: Ertapenem 1 gm [gram] IV q 24 hours x [times] 10 days for UTI [Urinary Tract Infection]. According to the resident ' s Infusion Medication Record and the MAR [Medication Administration Record], the resident received the antibiotic from	L 051		

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L 051	Continued From page 22 January 4 through January 10, 2014 [seven days]. There was no documented evidence in the clinical record that after the resident completed the antibiotics on January 10, 2014 that facility staff maintained the resident ' s PICC line according to the Central Line Catheter Protocol. Further review of the Central-Line Catheter record revealed that the record lacked consistency in observing the site at least q 2 hours and PRN [as needed]. The 8:00 PM and 10:00 PM observations for the month (month not legible but likely January since the resident ' s PICC line was in place from January 3 through February 7, 2014]) for dates of the 4th and 5th were left blank; 12M [midnight], 2:00 AM, 4:00 AM, 6:00 AM for the 5th, 6th and 7th and the 9th through the end of the month were left blank; 4:00PM, 6:00 PM 8:00 PM and 10:00 PM were left blank for the 11th, 12th; the 13th was not assessed at no time; 12M, 2:00 AM, 4:00 AM and 6:00 AM were left blank for the 14th and 15th; 12M to 4:00 PM was left blank for the 16th; 12M to 6:00 AM and 6:00 PM to 10:00 PM were left blank; 18th was not assessed at no time; 22nd, 23rd was not assessed at no time; 27th through the rest of the month [likely January 31st] was not assessed. The PICC line remained in place from January 11, 2014 through February 7 2014 without evidence of nursing management/intervention [e.g. site assessment, dressing change and/or flushing to ensure patency].According to a nurse ' s note dated February 7, 2014 at 07:53, the Resident#316 was sent to the hospital due to an elevated temperature of 104.7 and three (3)	L 051		

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L 051	Continued From page 23 loose stools. According to the Hospital Course February 7 through February 18, 2014, the resident was found to have positive blood cultures for " Coag [coagulation] Negative Staph [staphylococcus] " of[his/her] PICC line. A face-to-face interview was conducted with Employee #8 on February 25, 2014 at approximately 11:30 AM. He/she acknowledged the lack of consistent management of the resident ' s central catheter. Facility staff failed to consistently assess, monitor and manage Resident #316 ' s centrally inserted catheter [PICC line] and the resident consequentially sustained Central - Line Associated Bloodstream Infection [CLABSI]. The record was reviewed March 6, 2014. 4. The charge nurse failed to consistently assess the pre and post respiratory status of Resident #80 who received respiratory treatments. A review of the physician orders for February 2014 directed, " DuoNeb (Ipratropium-Albuterol) 0.5-2.5 (3) MG/3ML Inhalation-Every six hours every day for shortness of breath; Wheezing " A review of the February 2014 Medication Administration Records (MAR) revealed that DuoNeb was administered to the resident on the following dates and times: February 21, 2014 at 1300, and 2100 February 22, 2014 at 1300, 1700, 2100 February 23, 2014 at 1300, 1700, 2100 February 24, 2014 at 1300, 1700, 2100 February 25, 2014 at 1700, 2100 There was no evidence in the clinical record that	L 051		

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L 051	Continued From page 24 facility staff assessed the resident for shortness of breath or wheezing, obtained the pulse, respirations, oxygen saturation, and/or lung sounds of the resident pre and post the administration of the DuoNeb treatments. A face-to-face interview was conducted with Employee #11 on February 25, 2014 at approximately 4:06 PM. He/she stated respiratory therapists and licensed nurses both administer respiratory treatments and that assessments should be done prior to administering. He /she acknowledged aforementioned the findings. The clinical record was reviewed on February 25, 2014. B. Based on observation, record review and staff interview for six (6) of 51 sampled residents, it was determined that the charge nurse failed to initiate a care plan with appropriate goals and approaches for one (1) resident use of bilateral resting hand splint, assessment and follow up care of dialysis access site pr and post dialysis and dependent feeding, one (1) resident for assessment with follow up care of dialysis access site pre and post dialysis and nine (9) or more medications to address the potential for adverse drug interactions and one (1) resident for restorative nursing program; and failed to develop a care plan for management of a Right Upper Arm PICC [Peripherally Inserted Central] Line for one (1) resident. Based on record review and staff interview for one (1) of 43 sampled residents, it was determined that facility staff failed to develop a care plan with goals and approaches to address: The use of CPM (Continuous Passive Motion) machine to treat one (1) resident as ordered by the physician.	L 051		

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L 051	Continued From page 25 Residents' #50, #121 and #222, 265, 316 and 401. The findings include: 1A. The charge nurse failed to initiate a care plan with appropriate goals and approaches for one resident use of bilateral resting hand splint. Resident #50 A review of resident #50 ' s History of Present Illness for March, 2014 revealed diagnosis of End Stage Renal Disease, Diabetic without complication type 2/ Unspecified not stated uncontrolled, Unspecified Quadriplegia, Acute but ill-defined Cerebrovascular Disease, Unspecified infantile Cerebral Palsy, Unspecified Essential Hypertension, Paraplegia, Unspecified Glaucoma, Esophageal Reflux, Unspecified Anemia, Insomnia unspecified, Renal Dialysis Status, Unspecified Backache and Spinal Stenosis, Lumbar region without Nuerogenic Claudication. Physician ' s orders Sheet for March, 2014 revealed that the "Restorative Nursing Order dated December 30, 2013 directed, " Apply b/l resting hand splints daily to be worn every 6 hours on , 2 hours off during each shift as tolerated without redness or skin breakdown, except during ADL ' s ongoing - Complex. " There was no evidence in Resident # 50 ' s chart that a care plan was initiated with goals and approaches for the use of bilateral hand resting	L 051		

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L 051	Continued From page 26 splint. A face-to-face interview was conducted on February 27, 2014 with Employee # 8 at approximately 11:55AM. He/she acknowledged the findings. The record was reviewed on February 27, 2014. 1B. The charge nurse failed to initiate a care plan with appropriate goals and approaches for assessment and follow up care of dialysis access site pre and post dialysis. Resident #50 A review of resident #50 ' s history of present illness for March, 2014 revealed diagnosis of End Stage Renal Disease, Diabetic without complication type 2/ Unspecified not stated uncontrolled, Unspecified Quadriplegia, Acute but ill-defined Cerebrovascular Disease, Unspecified infantile Cerebral Palsy, Unspecified Essential Hypertension, Paraplegia, Unspecified Glaucoma, Esophageal Reflux, Unspecified Anemia, Insomnia unspecified, Renal Dialysis Status, Unspecified Backache and Spinal Stenosis, Lumbar region without Nuerogenic Claudication A review of the physician order on " the Consolidated Orders (Chart) Report " for February 2014 revealed a order that directs, " Dialysis: Mondays, Wednesdays, Fridays - once daily Specific days of week: Mon Wed Fri [Monday Wednesday Friday] " There was no evidence that a care plan was initiated with goals and approaches for assessment and follow ups care of dialysis access site pre and post dialysis found in Resident # 50 ' s chart.	L 051		

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L 051	Continued From page 27 A face-to-face interview was conducted on February 25, 2014 with Employee # 8 at approximately 9:30AM. He/she acknowledged the findings. The record was reviewed on February 25, 2014. 1C. The charge nurse failed to initiate a care plan with appropriate goals and approaches for one resident dependent feeding. Resident #50 A review of resident #50 ' s history of present illness for March, 2014 revealed diagnosis of End Stage Renal Disease, Diabetic without complication type 2/ Unspecified not stated uncontrolled, Unspecified Quadriplegia, Acute but ill-defined Cerebrovascular Disease, Unspecified infantile Cerebral Palsy, Unspecified Essential Hypertension, Paraplegia, Unspecified Glaucoma, Esophageal Reflux, Unspecified Anemia, Insomnia unspecified, Renal Dialysis Status, Unspecified Backache and Spinal Stenosis, Lumbar region without Nuerogenic Claudication A review of dietary quarterly notes dated October 8, 2013 revealed a note that reads, " ... Renal diet and nepro supplement tolerated 75 - 100% as staff assist with feeding ... " On February 28, 2014 resident# 50 was observed in his/her assigned room seated in a geri-chair. His/her post dialysis snack was on the table. Resident asked this surveyor " if you do not mind can you give me the drink on the table and leave the sandwich for later. " Employee#8 called staff to assist resident. There was no evidence a careplan was initiated with goals and approaches for resident #50 ' s	L 051		

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L 051	Continued From page 28 dependent feeding. A face-to-face interview was conducted on February 28, 2014 at approximately 11:55AM with Employee # 8. He/she acknowledged the findings. The record was reviewed on February 28, 2014. 2A. The charge nurse failed to initiate a care plan with appropriate goals and approaches for assessment with follow up care of dialysis access site pre and post dialysis. Resident #121 A review of resident #121 ' s History of Present Illness dated November 29, 2013 revealed diagnosis of End Stage Renal Disease on dialysis, Diabetes, Hypertension, Coronary artery disease status post by pass graft, Anemia, hyperlipidemia and delusional depressive disorder. A review of the physician order on " the Consolidated Orders (Chart) Report " for February 2014 revealed a order that directs, " Dialysis: Tuesdays, Thursdays, Saturdays - once daily Specific days of week " There was no evidence that a care plan was initiated with goals and approaches in Resident # 121 ' s chart for assessment with follow up care of dialysis access site pre and post dialysis. A face-to-face interview was conducted on February 25, 2014 at approximately 10:50AM with Employee #8. He/she acknowledged the findings. The record was reviewed on February 25, 2014. 2B. The charge nurse failed to initiate a care plan	L 051		

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L 051	Continued From page 29 with appropriate goals and approaches for nine (9) or more medications to address the potential for adverse drug interactions for Resident #121. A review of the resident ' s Physician Order Form dated and signed by the physician on February 3, 201 revealed that the resident is on the following medications: Claritin, Mucinex, Diabetic Robitussin, Diphenhydramine, Risperidone, Trental, Humalog (Insulin Lispro (Human), Tylenol, Docusate Sodium, Zithromax, Aspirn, Cozaar, Lipitor, Omeprazole, Remeron, Ambien, Calcium carbonate-vitamin-D, Coreg, Albuterol, Tylenol #3. There was no evidence that a care plan was initiated with goals and approaches to address the potential for adverse drug interactions associated with the use of nine (9) or medications found in resident # 121 ' s chart. A face-to-face interview was conducted on February 25, 2014 at approximately 10:50AM with Employee # 8. He/she acknowledged the findings. The record was reviewed on February 25, 2014. 3. The charge nurse failed to initiate a care plan with goals and approaches for restorative care for Resident #222. A review of the medical record revealed that Resident #222 was admitted to the facility on September 20, 2013 with diagnoses of CHF, peripheral vascular disease, Heart Failure, Hypertension, Anemia, Hyperkalemia, Rhabdomylosis, Chronic Kidney, Pressure Ulcer	L 051		

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L 051	Continued From page 30 and History of hip fracture. Physician ' s orders dated November 4, 2013 at 2:30 PM directed as follow: " Pt [patient] D/C [discharged] from skilled OT [occupational therapy] services to RNP [Restorative program] for BUE [bilateral upper extremity] AROM [Active Range of motion] ex. for all j ' ts [joints] in all plains 20 reps x2 sets: L/E [lower extremities] Dressing with SBA to pull his pants to his waist to maintain current functional level. " Pt [Physical Therapy] order to start restorative nursing program for - (1) AROM of b/l [bilateral] LE hip/knee flex /ext [extension], hip abduction/adduction & [and] ankle plantar dorsiflex 15reps x 3 sets, all shifts 7 days a week during am/pm care & (2) Ambulation program with fww for 100feet with CGA or with min assist as needed for active participation in activities of choice/hobbies & for walk to dine % walk to activities program. Resident to transfer from bed to w/c with SBA & encouraged to maintain sitting position for at least 4 - 5 hrs daily " A review of the " Therapy to Nursing Rehab Program Communication Form revealed a note signed by therapist and dated November 5, 2013that reads, " under the section Problems/Needs: Resident requires Nursing rehab program to maintain current bilateral upper extremity range of motion and to maintain decreased assistance for ADLS [activity of daily livings] for lower body dressing/bathing and functional mobility. Also to reduce the risk for falls and injury "	L 051		

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L 051	Continued From page 31 A review of the "Restorative Program Plan and Summary revealed that on November 8, 2013 resident #222 started " Restorative Program: Active Range of Motion (BUE). Goals: To maintain and enhance current level of function and to reduce risks of falls. Intervention: Resident to start on the program for active range of motion to the bilateral upper extremities at the shoulders, elbows, wrists and fingers with 2 sets of 20 repetitions. Range of motion should be incorporated in am care " . There was no evidence that a care plan was initiated with goals and approaches for Restorative Care in Resident #222 ' s chart. A face-to-face interview was conducted on February 24, 2014 at approximately 11:00AM with Employee # 8. He/she acknowledged the findings. The record was reviewed on February 24, 2014. 4. The charge nurse failed to implement a care plan to address Resident #265 ' s refusal to use a nicotine patch. A review of the Physician ' s order dated January 14, 2014 directed, " Nicotine patch 21 mg/hr [per hour] [topical] once daily every day " . A review of the February 2014 Medication Administration Record revealed that on the following days the resident refused the nicotine patch: February 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25.	L 051		

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L 051	Continued From page 32 A review of the care plan section of the active clinical record revealed that there was no care plan initiated to address the resident ' s refusal to use the nicotine patch. A face-to-face interview was conducted on February 25, 2014 at approximately 4:20 PM with Employee #11. He/she acknowledged the findings. The record was reviewed on February 25, 2014. 5. The charge nurse failed to develop a care plan with goals and interventions to manage Resident #316's PICC Line. According to the " Admissions Progress Notes " dated January 3, 2014 19:11 [7:11 AM] " [Resident #316] was readmitted to the facility...Resident was sent for stent removal [Follow/up] F/up and was admitted for monitoring after stent removal ...On assessment [he/she] is alert, verbally responsive and oriented x [time] 3 [three], skin warm to touch, Right upper arm with single lumen PICC ... " Review of the " Physician ' s Order " signed January 6, 2014 revealed Ertapenem [Antibiotic] 1g [gram] via [by] PICC line every 24 hours x 10 days for UTI [Urinary Tract Infection]. ", and review of the MAR [Medication Administration Record] revealed that the medication was received on January 4, 2013 through January 10th, 2014.	L 051		

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L 051	Continued From page 33 A review of the resident ' s care plan last updated October 11, 2013 lacked evidence of a focus area with goals and approaches to manage a resident with a PICC line. A face-to-face interview was conducted with Employee #8. After review of the care plans he/she acknowledged the findings. 6. The charge nurse failed to initiate a care plan with goals and approaches to address the use of a CPM machine to treat Resident #401 who had a right total knee replacement. Resident #401 was admitted on February 12, 2014 with a continuous order to receive CPM treatments for five (5) hours per day on his/her right lower extremity. A written order dated February 18, 2014 read " PT clarification order for pt to start on CPM daily for 3-5 hrs for knee ROM 0-60 (degrees) as per physician ' s orders, within pain limits ... " A review of the care plans for Resident #401 lacked evidence that a care plan to address the daily use of a CPM machine was initiated. A face to face interview was conducted on March 7, 2014 at approximately 2:00 PM with Employee #25. He/she acknowledged the findings. The record was reviewed on February 21, 2014. C. Based on record review and staff interview for two (2) of 51 sampled residents, it was determined that the charge nurse failed to review and revise one (1) residents care plan to include specific interventions for a right arm splint and refusal of dental treatment and one (1) resident 's care plan to reflect their current status of continent voiding. Residents #290 and #348	L 051		

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L 051	Continued From page 34 The findings include: 1. The charge nurse failed to amend Resident #290 ' s care plan to include specific interventions for a right arm splint and refusal of dental treatment. A. During the course of the survey, Resident #290 was observed on February 20, 21, 27 and 28, 2014 during the hours of 10:00 AM to 4:00 PM with a splint applied to his/her right upper arm. According to an interim physician order dated January 22, 2014 at 5:30 PM directed; " OT [Occupational Therapy] Discharge Order: [Patient] discharged from skilled OT intervention to rehab nursing program for [right] elbow extension splint application daily [times] 7 (seven) days per week. [Right] elbow extension splint to be applied to [right] elbow after PROM (Passive range of motion) to RUE (right upper extremity) shoulder, elbow, wrist [and] hand. Application of [right] elbow extension splint times: on 10 am- 4PM; off 4PM-6PM; on 6Pm-12AM; off 12AM-2AM; on 2AM-8AM. " The comprehensive care plan most recently updated, December 17, 2013 lacked evidence of a revision to include the specific interventions to manage Resident #290 ' s right arm splint. Facility staff failed to amend Resident #290 ' s care plan to include specific interventions for his/her right arm splint. A face-to-face interview was conducted with Employees #3, #7 and #25 on March 5, 2014 at approximately 10:30AM. After reviewing the care plan, all aforementioned employees acknowledged the findings. The clinical record was reviewed on March 5, 2014.	L 051		

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L 051	Continued From page 35 B. The charge nurse failed to amend care plan to include Resident #290 ' s refusal of treatment. A review of the clinical record for Resident #290 revealed the resident repeatedly refused dental treatment as follows: " April 22, 2013- " FMD- #28 OL Comp #29 to be determined April 30, 2013- Patient refused treatment September 11, 2013- Annual exam- Patient refused exam. " The comprehensive care plan most recently updated, December 17, 2013 lacked evidence of a revision to include the specific interventions to manage Resident #290 ' s right arm splint. Facility staff failed to amend care plan to include Resident #290 ' s refusal of treatment. A face-to-face interview was conducted with Employee #7 on March 5, 2014 at approximately 10:30AM. After reviewing the care plan, he/she acknowledged the findings. The clinical record was reviewed on March 5, 2014. 2. The charge nurse failed to review and revise Resident #348 ' s care plan to reflect the resident ' s current continent voiding status. According to the resident ' s quarterly bladder and bowel assessment dated December 12, 2013 the resident is continent of bowel and bladder. The resident has no change in continence status. Review of the residents care plan last updated September 18, 2013 revealed that the resident has an ADL [Activities of Daily Living] Self Care	L 051		

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L 051	Continued From page 36 Performance Deficit r/t [related/to] Stroke, Limited Mobility with interventions to include: Toilet use: resident is totally dependent on staff for toileting... A face-to-face interview was conducted with Resident #348 on February 25, 2014 at approximately 10:00 AM. A query was made if [he/she] was able to void when needed. The resident stated " When I first came here I was incontinent, but now I can use bathroom on my own, I am continent of both bladder and bowel. " A face-to-face interview was conducted with Employee #9 at approximately 10:30 AM. He/she stated " the resident was incontinent upon admissions [September 18, 2013], and according to my recollection the resident has been continent of urine since November. " The charge nurse failed to review and revise the residents care plan to reflect the resident ' s current status of continent voiding.	L 051	L052 1. Resident#399, #401, #10 and #150 are no longer residents at this facility. Resident #347 has been assessed by our Wound Care Certified Nurse Practitioner and Dietitian to address his healing and nutritional needs in addition to his non-compliance with recommendations that would aid in his wound healing. Nutritional interventions, education and care-plan updates have been added. Resident #303 Parameters for use of Hydralazine were reviewed with the Physician and clarified with record. 2. All residents have the potential to be affected by the failure to ensure the residents have received necessary care and services to attain or maintain the highest practicable well being. Charts will be reviewed to address all concerns identified and education to be provided as applicable. Skin sweeps were conducted on all residents to identify any current or potential areas of skin integrity impairment, documentation needs, and Care Plan Development for interventions to prevent breakdown and promote wound healing when applicable. Nursing Management will review all residents' records for care plan initiation, which have an order for a CPM machine and proper documentation to include the daily use and management of the CPM machine.	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of	L 052		

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L 052	Continued From page 37 ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by:	L 052	3. A. Residents who are currently receiving medications that require monitoring parameters will be reviewed to ensure parameters are in place and being followed. Nurses have been in-serviced on parameters for medications by Nursing Management/Staff Development Coordinator. Compliance will be monitored by Unit Managers on a weekly basis. B. Acute Changes in Condition- Policies and protocols for assessing and reporting changes in condition were reviewed by Nursing Management. All Nurses will be in-serviced on protocols to assess residents for changes in condition, how to complete a SBAR, and how to report changes in condition appropriately. C. Policies and Protocols for weight monitoring were reviewed by the Dietitian and Nursing Management. Resident records were reviewed to ensure facility protocols for weight monitoring have been followed. Nurses and C.N.A.'s were in-serviced on facility protocols for weight monitoring. The Dietitian's will review weight documentation weekly to ensure compliance. D. A new Certified Wound Care Nurse Practitioner has started at the facility to provide oversight of the Wound Care Program and to assist with education to the staff. The Wound Care Protocols and Policies, treatment protocols and documentation requirements were reviewed by the Wound Care Team and Nursing Management and updated as	

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L 052	Continued From page 38 A. Based on observation, record review and interviews for three (3) of 51 sampled residents, it was determined that sufficient nursing time was not provided as evidenced by failure to: administer antihypertensive medication in accordance with physician ' s orders for one (1) resident; assess weights in accordance with physician ' s orders for one (1) resident and administer controlled passive range of motion as prescribed for one (1) resident. Residents' # 303, 399, 401 The findings include: 1. Sufficient nursing time was not provided to administer blood pressure medication according to physician ' s orders for Resident #303. According to a physician ' s history and physical dated May 2, 2013, Resident #303 ' s diagnoses included: Hypertension, Chronic Pancreatitis and COPD (Chronic Obstructive Pulmonary Disease). According to a physician ' s order dated October 4, 2013 directed; " Hydralazine HCL [Hydrochloride] (antihypertensive medication) 100mg oral- three (3) times daily everyday: 1 tab [by mouth] tid (three times a day) for HTN (Hypertension. Hold for SBP (Systolic Blood Pressure) less than 110 and HR (Heart Rate) less than 55. " A review of the October 2013 MAR (Medication Administration Record) revealed on October 18, 2013 at 2100 (9:00 PM), the resident received Hydralazine 100mg and the resident ' s blood pressure was recorded as 106/76 [systolic blood pressure less than 110].	L 052	necessary. Nurses have been educated by the Staff Development Coordinator and Wound Care Consultant regarding the requirements for consistent and accurate skin sweeps to be completed at a minimum weekly, Wound Care Policies and Protocols, Treatment Protocols, and Wound Care Prevention. C.N.A.'s were educated on skin breakdown prevention and the documentation and notification requirements when an area of the resident's skin appears red, open, or compromised by the Staff Development Coordinator. The Director of Nursing/Assistant Director of Nursing will review the weekly skin documentation completed by the Wound Care Team for completion, timeliness, and accuracy. Unit Managers will audit the skin sweeps weekly to ensure they have been completed and conduct random audits themselves to identify any possible omissions in the documentation process. New incidents of compromised skin integrity will be reviewed during daily clinical review to ensure an incident report, investigation, treatment orders and care-plan updates have been completed. Care Plan for CPM machine was initiated which addressed daily used and management of the CPM machine. Education was given to Nursing Staff by the Therapy Department on the daily use and management of the CPM machine. Continued education will be given to Licensed Nursing Staff prior to any prospective admission to the facility with an order of the application and use of a CPM machine. Audits will be performed weekly by Nursing Management when there is an order for the use and application of a CMP	

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L 052	Continued From page 39 Facility staff failed to ' hold ' the Hydralazine medication as stipulated in the prescribed parameters, the resident ' s systolic blood pressure was assessed less than 110.The clinical record lacked evidence that Resident #303 received his/her medication in accordance to physician ' s orders. A face-to-face interview was conducted on March 5, 2014 at approximately 10:30 AM with Employee #7 regarding the aforementioned findings. He/she acknowledged the findings. The clinical record was reviewed on March 5, 2014. 2. Sufficient nursing time was not provided to weigh Resident #399 in accordance to physician ' s orders. A review of the Resident #399 ' s clinical record revealed that the resident was admitted to the facility on February 14, 2014 with diagnoses which included: Seizure Disorder, Chronic Pancreatitis, Debility and Hypertension. A review of the physician's orders dated February 14, 2014 directed, " ... Weight on admission, 2nd (second) day weight to be done on [7AM-3PM shift], weekly weight [times] 4 weeks to be done by [7AM-3PM] shift. Monthly weight to be done on [7AM-3PM] shift. " According to the electronic medical record " weight summary and dietary progress notes " the following was revealed: February 14, 2014- 218.8 pounds (admission) February 15, 2014- 218.8 pounds (2nd day weight) February 27, 2014- 226.2 pounds	L 052	machine to ensure compliance. 4. The QA Nurse will review all new incidents of skin impairment to ensure the incident report, investigation, MD/NP documentation and Care-planning are in place. The Wound Care Team will report to the QAPI team their tracking and trending of all wounds, documentation, and care-planning during the monthly QAPI meeting the Wound Care Nurse Practitioner and Wound Care Team will trend the occurrence of in-house acquired wounds to look for patterns and identify root causes to further reduce the incidence of in-house acquired wounds. Results of this performance improvement plan will be reviewed in QAPI to identify areas of further education or monitoring needed. Compliance with follow through will be monitored monthly through the QAPI process. Further education and/or counseling will be provided when identified by the compliance audits.	5/13/14

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L 052	Continued From page 40 The clinical record lacked evidence that the resident ' s weight was obtained weekly for 4 weeks as indicated in the physician ' s order. A face-to-face interview was conducted with Employee #18 on February 28, at approximately 11:15 AM. He/she acknowledged the clinical findings after reviewing the clinical record. 3. Sufficient nursing time was not provided to ensure that controlled range of motion via a CPM device [Continuous Passive Motion - a mechanical device used for rehabilitation that provides controlled range of motion <http://en.wikipedia.org/wiki/Range_of_motion> to a joint e.g. knee] was provided for Resident #401as prescribed. The resident was admitted from the hospital on February 12, 2014 following total knee replacement procedure. Physician ' s orders dated February 6, 2014 directed: " ORDER: CONTINUOUS PASSIVE MOTION " The CPM treatment was to be administered to the right lower extremity five (5) hours per day. On February 18, 2014 the order was modified by a Physical Therapist (PT) to read " PT [physical therapy] clarification order for patient to start on CPM daily for 3-5 hrs for knee ROM [range of motion] 0-60 (degrees) as per physician ' s orders, within pain limit, check for skin redness/breakdown before + after use. " A face to face interview with Resident #401 was conducted on February 19, 2014 at approximately 1:00 PM. He/she stated that the CPM machine was used twice on February 19,	L 052		

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L 052	Continued From page 41 2014. He/she said that he/she could not tolerate using the CPM machine for five (5) straight hours due to pain in his/her knee and he/she could only use it for a few minutes at a time. He/she said that he/she was given medication for pain. A review of the Treatment Administration Record (TAR) on February 20, 2014 revealed the following under the heading ' Schedule for February 2014 ' : " PT clarification order for pt to start on CPM daily for 3-5 hrs for knee ROM 0-60 (degrees) as per physician ' s orders, within pain limit, check for skin redness/breakdown before + after use. Order date: 2/18/2014 2x/day twice daily " . " And under the heading ' Hours ' it read: 0900 1400 ON OFF A review of the TAR [treatment administration record] for February and March 2014 revealed the following: " 2-19-14 and 2-20-14 CPM treatment initialed at 0900 and at 1400 2-21-14: CPM treatment initialed at 0900 only and written notes on the back of TAR sheet: 'cmp machine not on because incision site was bleeding + therapy did not put it'... Also in nurses notes late entry on 2-24-14 2-22-14: Previous order discontinued. New order on TAR to reflect change from " 2x/day twice daily " to " 1x/day once daily " and " ON " at 10:00 AM and " OFF " at 12 PM.	L 052		

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L 052	Continued From page 42 2-23-14: " ON " at 11:00 AM, No entry for " OFF " time. 2-24-14: Nurse ' s notes indicate: ' resident bleeding noted on left knee " surgery site pressure dressing applied. " TAR initialed to indicate initiation of CPM treatment but no " ON " or " OFF " time indicated. 2-25-14: Nurse ' s notes indicate: " Resident refused CPM to left knee " and back of TAR: 'refused CPM not applied 2-26-14: TAR initialed to indicate CPM treatment , " OFF " time at 12:20 PM 2-27-14: TAR [reverse side]: " res out on appt CPM not applied. "[resident out on appointment CPM not applied] 2-28-14: No entries related to CPM treatment indicated on TAR or nurses notes. 3-1-14 and 3-2-14: Time is documented to indicate that CPM treatment initiated, however no end time is recorded. 3-3-14 = TAR initialed to indicate CPM treatment was initiated. No hour recorded. 3-4-14: From nurse's notes: 'resident refused CPM TX [CPM treatment]. " 3-5-14 = Observed resident receiving CPM at 11:30 AM. A review of the Treatment Administration	L 052		

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L 052	Continued From page 43 Records lacked evidence that the CPM device was applied with consistency and in accordance with physician ' s orders. The findings were acknowledged during a face-to-face interview with Employees #26 and 8 on February 21, 2014 at 4:30 PM. The clinical record was reviewed on February 21, 2014. B. Based on observation, record review and staff interview for three (3) of 51 sampled residents, it was determined that sufficient nursing time was not provided to promote healing, and prevent new pressure ulcers from developing for two (2) residents who were initially assessed with pressure ulcers at an advanced stage [unstageble]; failed to ensure that one (1) resident's condition and wound did not become worse and failed to prevent new wounds from developing. Residents' #10, #150 and #347. The findings include: 1. Sufficient nursing time was not provided to comprehensively assess Resident #10 ' s skin with consistency and timeliness. The resident was subsequently identified with four (4) Pressure Ulcers that were initially assessed as unstageble. A review of Resident " 10 ' s clinical record revealed that the resident was readmitted to the facility after treatment at an area hospital on May 22, 2013. The resident ' s diagnoses on readmission included: " Pressure Ulcer Buttock, Unspecified Anemia, Thyroid toxicity without Goiter, Reflux Esophagitis, Chronic Duodenal Ulcer, Other and Unspecified Lipidemia, Unspecified Essential Hypertension, Intermittent	L 052		

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L 052	Continued From page 44 Explosive Disorder, Nondependent Alcohol Abuse, Unspecified Paralysis, Hemiplegia, and Cerebral Vascular Disease. A review of the facility ' s Skin and Wound Management Policy revealed the following under Procedure: " Residents are evaluated on admission, quarterly, annually and with a significant change of status for their risk for the development of Pressure Ulcers using the Braden Scale. " [No date noted]. Resident #10 was admitted to the facility with a diagnosis of Anemia for which he/she was treated with Aranesp and weekly Hemoglobin and Hematocrit (H&H) evaluation/testing according to physician ' s orders dated December 19, 2013 and January 2, 2014. In addition ther resident was also noted to be receiving Ferrous Sulfate 325mg po daily, Thiamine 100mg daily and Folic Acid 1mg daily. A review of physician ' s orders for December 13, 2013 revealed the following orders: Therapeutic MVI 1 [one] PO [by mouth Qd [daily]; Zinc 220mg PO Qd x [for] 30 days and Vitamin C 500mg PO Qd for wound healing. Review of dietary notes dated December 12, 2013 revealed that the resident often skipped breakfast due to a preference to sleep late according to caregiver. A review of preferences included a snack between breakfast and lunch. The resident receives " Enlive with meals [high calorie nutritional supplement], and Arginaid 1 pkt [packet - protein supplement] po [by mouth] twice daily. " A dietary note dated January 14, 2014 read: "	L 052		

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L 052	Continued From page 45 RDN [registered dietitian] to request orders for Prostat 30ml po three times a day and a health shake with meals. " Resident #10 was admitted to the facility with one (1) pressure ulcer. Resident was later observed with four (4) unstageble pressure ulcers. A review of a Skin Integrity Assessment form revealed that upon readmission the resident was noted with " Multiple old scars ... no open or current wound noted. " The unstageble ulcers are outlined below. A. Sacral ulcer identified as unstageble on October 28, 2013. Review of the Pressure Ulcer Evaluation sheet with an Effective Date of November 27, 2013 revealed the following: Under Site of Pressure Ulcer - Sacral Under Current Stage of Pressure Ulcer - Unstageble Under Documentation of measurement in centimeters Current length of Pressure Ulcer = 5.8cm Current Width of Pressure Ulcer = 7cm Current depth of Pressure Ulcer = 1.5cm Under date Pressure Ulcer first observed - October 28, 2013 Under Stage of Pressure Ulcer when first identified - Unstageble and Under exudates - Moderate amount, [Drainage on old dressing is the same size as the wound bed] serous: Clear or light yellow; thin watery drainage.	L 052		

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L 052	Continued From page 46 Review of the same Pressure Ulcer Evaluation with an " Effective Date " of December 4, 2013 revealed the following: Origin of Wound - Facility acquired Site of Pressure Ulcer - Sacral Current Stage of Pressure Ulcer - Unstageble Documentation of measurement in centimeters Current length of Pressure Ulcer = 7 cm Current Width of Pressure Ulcer = 6cm Current depth of Pressure Ulcer = 0.9cm Date Pressure Ulcer first observed - October 28, 2013 Stage of Pressure Ulcer when first identified - Unstageble Exudates - Moderate amount, [Drainage on old dressing is the same size as the wound bed] serous: Clear or light yellow; thin watery drainage. B. R lateral leg ulcer identified as unstageble on January 1, 2014. Review of the Pressure Ulcer Evaluation sheet with an " Effective Date " of January 1, 2014 revealed the following: Under Origin of Wound - Facility acquired Site of Pressure Ulcer - Rt. [Right] lateral leg Current Stage of Pressure Ulcer - Unstageble Documentation of measurement in centimeters Current length of Pressure Ulcer = 7 cm Current Width of Pressure Ulcer = 2.5cm Current depth of Pressure Ulcer = 0cm Date Pressure Ulcer first observed - January 1, 2014 Stage of Pressure Ulcer when first identified - Unstageble and	L 052		

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L 052	Continued From page 47 exudates - none. Review of the same Pressure Ulcer Evaluation sheet with an " Effective Date " of January 15, 2014 revealed the following: Origin of Wound - Facility acquired Site of Pressure Ulcer - Rt. [Right] lateral leg Current Stage of Pressure Ulcer - Unstageble Documentation of measurement in centimeters Current length of Pressure Ulcer = 14cm Current Width of Pressure Ulcer = 2.4cm Current depth of Pressure Ulcer = 0cm date Pressure Ulcer first observed - January 1, 2014 Stage of Pressure Ulcer when first identified - Unstageble and Exudates - none. No further evaluations were available for this ulcer. The resident was transferred to an area hospital on January 23, 2014. Review of the same Pressure Ulcer Evaluation sheet with an " Effective Date " of January 22, 2014 revealed the following: Origin of Wound - Facility acquired Site of Pressure Ulcer - Rt. [Right] lateral leg Current Stage of Pressure Ulcer - Unstageble Documentation of measurement in centimeters Current length of Pressure Ulcer = 14cm Current Width of Pressure Ulcer = 2.3cm Current depth of Pressure Ulcer = 0cm Date Pressure Ulcer first observed - January 1, 2014 Stage of Pressure Ulcer when first identified - Unstageble and Exudates - none.	L 052		

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L 052	Continued From page 48 The resident was transferred to an area hospital on January 23, 2014. C. Rt. [Right] knee Pressure Ulcer identified as unstageble on January 8, 2014. Review of a Pressure Ulcer Evaluation sheet with an " Effective Date " of January 22, 2014 revealed the following: Origin of Wound - Facility acquired Site of Pressure Ulcer - Rt. [Right] knee Current Stage of Pressure Ulcer - Unstageble Documentation of measurement in centimeters Current length of Pressure Ulcer = 2.5cm Current Width of Pressure Ulcer = 2.5cm Current depth of Pressure Ulcer = 0 cm Date Pressure Ulcer first observed - January 8, 2014 Stage of Pressure Ulcer when first identified - Unstageble Exudates - none. No other documentation was available for this ulcer. D. According to the Pressure Ulcer Evaluation documentation with an Effective Date of January 9, 2014 the ulcer was described as: Origin of Wound - Facility acquired Site of Pressure Ulcer - Rt. [Right] hip Current Stage of Pressure Ulcer - Unstageble Documentation of measurement in centimeters Current length of Pressure Ulcer = 2.5cm Current Width of Pressure Ulcer = 2.5cm Current depth of Pressure Ulcer = 0.1cm Date Pressure Ulcer first observed - January 9,	L 052		

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L 052	Continued From page 49 2014 Stage of Pressure Ulcer when first identified - Stage 2 Exudates - none. However, the same wound was described as being unstageble when first observed on January 9 in Pressure Ulcer Evaluations with effective dates of January 15, 2014 and January 22, 2014. A face-to-face interview was conducted with Employee #39 at approximately 2:00PM on March 4, 2014. However, the employee was new to the facility and not able to explain the discrepancy in the documentation [regarding the staging of the right hip Pressure Ulcer.] He/she acknowledged that documentation in the clinical record reflects the pressure ulcers were initially identified as unstageble. A review of " Skin Sweep " sheets which were a part of Resident #10 ' s clinical record revealed that the resident ' s skin was being evaluated since June 2013. In reviewing the sheets for October, 2013; documentation was noted for October 3, 7, 10, 17, 21, 24, 28 and 31, 2014. The Skin Sweep Sheets were also reviewed for December and January, 2013. No new skin impairments were identified for December except on December 16, 2013. Per the Skin Sweep documentation for December, 2013 a new skin impairment was identified on the resident ' s right heel in the form of a blister. However, there was no documentation of any skin impairments for December on the Pressure Ulcer Evaluation Sheets for December. Documentation was done on the Skin Sweep Sheets for December 5, 12, 16, 19 and 26, 2013.	L 052		

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L 052	Continued From page 50 A review of the Skin Sweep Sheets for the month of January 2014 revealed documentation of the resident ' s skin condition for January 16, 20, 22 and 23, 2013. Ruptured blister was written in on the document with a diagram of the resident ' s left leg for January 23, 2014. However, there was no check (>) to indicate whether there was an old ulcer, a new ulcer or no ulcer. The documentation for October 28, 2013 identified open blister on the sacrum and right buttock. This documentation conflicted with the Pressure Ulcer Evaluation for the same date [October 28, 2014] which identified the sacral impairment as an Unstageble Pressure Ulcer. Facility staff failed to consistently monitor the status of Resident #10 ' s skin and consistently provide preventive measures to prevent new sores from developing for Resident #10 who was subsequently identified with four (4) unstageble pressure ulcers on initial assessment. The record was reviewed on March 5, 2014. 2. Sufficient nursing time was not provided to assess Resident #150 ' s skin comprehensively and in a timely manner. The resident was subsequently identified with an unstageble Sacral Pressure Ulcer. According to the Admission documentation Resident #150 was admitted to the facility on August 30, 2013 from an area hospital. Admitting diagnoses listed on the clinical record were DM [Diabetes Mellitus], Gastrointestinal bleeding, Hepatic Encephalopathy,	L 052		

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L 052	Continued From page 51 Hepatocellular Carcinoma and Portal Vein Thrombosis. The lower extremities were described as being weak with legs that could not bear weight and the right foot had " +1 [plus one] pitting edema]. " The resident ' s skin was described as, " Skin between folds of buttocks and abdomen showing signs of skin breakdown. Healed ulcer on both elbows, multiple bruised areas on rt [right] and lt [left] arm from blood works. " A review of the facility ' s Skin and Wound Management Policy [No date noted] revealed the following under Procedure: " Residents are evaluated on admission, quarterly, annually and with a significant change of status for their risk for the development of Pressure Ulcers using the Braden Scale. " A review of the resident ' s Skin Assessment Sheets revealed documentation of what was classified as a " Non-Pressure Ulcer Skin Condition. " The type of skin condition was documented as a " Blister. " The site was documented as the " Left medial ankle. " The measurements were documented as " Length 6.0 centimeters, Width 4.0 centimeters and depth 0.0 centimeter. " The date of onset was listed as August 30, 2013. No other skin impairment was identified at that time. A review of additional skin sheets for the resident revealed documentation on " Pressure Ulcer Evaluation " form. On the first form (1) a Sacral Ulcer was described as Community acquired, first observed on September 14, 2013, Stage 2, measuring 0.8x0.6x0.1 centimeters with " Serous: clear or light yellow in color; thin watery;	L 052		

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L 052	Continued From page 52 scant drainage, no odor and intact Peri-wound. " Another Pressure Ulcer Evaluation form (2) dated September 23, 2014 described a facility acquired Unstageble Pressure Ulcer which (according to the documentation) was initially assessed as " unstageble " on September 14, 2013. This ulcer measured 4x7x0 centimeters with " Serosanguinous: light red to pink; thin, watery; Minimal/small [amount]: drainage smaller than size of the wound bed " and no odor. The resident was discharged to an area hospital on September on September 28, 2013 and no other documentation on the wounds was available. The facility has in place a weekly a policy that weekly skin assessments are to be conducted on the residents by the charge nurse. However, no skin assessment/evaluation sheets were available for Resident #150. A face-to-face interview was conducted with Employee #39 at approximately 2:30PM on March 5, 2014. However, the employee was new to the facility and therefore unable to respond to the query regarding the accuracy of the documentation of the pressure ulcer. The facility staff failed to consistently assess the condition of the Resident #150 ' s skin in order to identify impairment in the resident ' s skin integrity prior to an advanced and/or " unstageble " status. The record was reviewed on March 04, 2014. 3. Sufficient nursing time was not provided to consistently assess, monitor and provide	L 052		

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L 052	Continued From page 53 preventive measures to promote healing and ensure that Resident #347 ' s pressure ulcers did not become worse and failed to implement measures to prevent new wounds from developing. A review of the clinical record revealed that the resident was admitted to the facility on September 12, 2013. According to the History and Physical dated September 13, 2013 the resident was admitted with the following diagnoses: " Spina Bifida Cerebral Palsy, Right leg Osteomyelitis, Rt[Right] lower extremity gangrene s/p [Status/Post] BKA [Below Knee Amputation], Sepsis secondary to Rt. LE [lower Extremity] gangrene, Rt. BKA wound and according to the Central-Line Catheter Protocol dated September 12, 2013 the resident was admitted with a PICC Line [Peripheral Inserted Central Catheter] ... " There was no evidence that the physician included Left Ischium wound in the History and Physical. Further review of the clinical record Quality Assurance: Skin Integrity Assessment dated September 13 revealed that the resident was admitted with ... " left Ishium unstageble wound measured 3x2.5x0 50% red, 50% black, no exudates. Wound bed moist. No foul odor present, treatment Hydrocolloid every 2 days and PRN [as needed]. " According to the Pressure Wound Evaluation conducted by the wound team on September 13, 2013, the resident was admitted with a	L 052		

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L 052	Continued From page 54 community acquired; Site: left ischium; Current Stage of Pressure Ulcer: Unstageble; measurements: 3x2.5x0; No exudates ... The following measurements were recorded on the Pressure Ulcer evaluation forms for the period of September 25, 2013 through November 1, 2013: September 20, 2013 Unstageble 3x2.5x0 Exudate: Sanguineous: bloody, red, thin, watery September 27, 2013 Unstageble 3x2.5x.1 Exudate: Sero-sanguineous: light red to pink; thin, watery October 4, 2013 Unstageble 3.5x4x.1 Exudate: Sero-sanguineous: light red to pink; thin, watery October 11, 2013 Unstageble 3.5x4x.1 Exudate: Sero-sanguineous: light red to pink; thin, watery October 18, 2013 Unstageble 5.5x3x0 Exudate: Sero-sanguineous: light red to pink; thin, watery October 25, 2013 Unstageble 4x4x0 Exudate: Cloudy, yellow to tan; thin, watery ... November 4, 2013 Unstageble 4x4x0 Exudate: Purulent: yellow, tan or green, thick, opaque; foul smelling and /or viscous, contain pus. Physicians Orders dated November 4, 2013 at 1:45 PM read: " (1) send resident out to [hospital name] ER [Emergency Room] for eval	L 052		

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L 052	Continued From page 55 [evaluation] secondary fever, hypotension, and sacral wound debridement ... " Review of the Nurses Notes revealed the following: November 1, 2013 at 23:21 [11:21 PM] " Writer noted a new skin impairment developed at the left upper buttocks area measuring approximately 4cm [centimeters] x 2cm. Both Supervisor and MD [medical doctor] notified. November 2, 2013 at 07:13 " ...sacral area done on shift, resident able to make needs known, denies any pain and discomfort at this time ... November 2, 2013 14:42 " Resident is alert and verbally responsive. IV Normal Saline in progress at 125mls/hr via PICC line, Rocephin 1 gm via picc line for wound infection no adverse reaction noted. Temp [temperature] to be monitored q [every] 2 hrs. [hours] At 9:30am, T 99.1. T101.7 at 3pm. Cold compress applied to cool [him/her] down. November 3, 2013 01:40 " Called unit to assess resident with a temp. of 104.9 and who was perspiring quite a bit and very warm to touch. It was determined between myself and charge nurse that the resident need to be sent out for evaluation. DON [Director of Nursing] was informed about sending the resident out due to [his/her] deteriorating condition but the resident flatly refused to go out and in this case the PMD [Private Medical Doctor] was not called at this time. Resident was bathed and dressing	L 052		

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L 052	Continued From page 56 changed and made as comfortable as possible. V.S. [vital signs] 104.9 -122-22-78/50 O2 sats 97. " November 3, 2013 03:33 " ...Wound tx done, wound had moderate drainage brown in color, with slough covering the entire wound bed, and had foul odor. Vs=95/54, 112, 22, 99.1 with oxygen saturation 97% on room air. " There was no evidence in the clinical record that the physician was notified of the change in the residents ' condition on November 3, 2013. According to the Skin Integrity Assessment dated November 4, 2013, " [facility staff] reported that resident has an open blister on the left upper buttock. Upon assessment noted unstageble wound measured 8x5.3x0 cluster, 90% black, 10% skin, no exudates noted. Wound bed moist, peri-wound intact. Wound edges defined. Tx [treatment] Santyl and Xeroform TID [three times a day] Left sacrum wound was also noted. Measured 3x2x0 100% black, no exudates noted. Foul odor present. Treatment Santyl and Xeroform TID. According to the November 4, 2013 Pressure Ulcer Evaluation the resident developed a " facility acquired; site: left sacrum; Unstageble; measuring 3x2x0 ...wound bed 100% black ... " Review of the Skin Sweeps for November 1, 2013 through November 8, 2013 lacked evidence of any skin impairment noted for November 4, 2013.	L 052		

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L 052	Continued From page 57 November 4, 2013 14:22 " ...Resident has persistence temperature, low blood pressure with an increase heart rate. At 0900 temp was 99.9 and administered 2 Tylenol and decreased to 98.6 at 0930 and spike again at 12:30pm to 101.5 administered 2 Tylenol again and evaluate at 1330pm [1:33] pm and was 99.5. Call was made at 1400 pm [2:00 PM] for [ambulance] transfer resident to [hospital name] and will pick up in 2 hrs .... " November 4, 2013 22:08 [10:08 AM] writer call [hospital name] resident admitted. According to the hospital discharge summary signed November 9, 2013 " this resident came in with severely infected sacral Decubitus ulcer with hypotension and sepsis, who was resuscitated in step-down ICU [Intensive Care Unit]. At the time of admission, [his/her] white blood count was 12.4 and as an outpatient it was 21. He had anemia and received units of blood transfusion prior to surgery. Surgery showed extensive sacral Decubitus ulcer that required extensive surgery... " According to the Nurses Notes dated November 8, 2013 the resident was readmitted to the facility ... " On assessment skin warm to touch lungs are clear on auscultation, abdomen is soft to touch and non-tender ... " The above nurse ' s note lacked description of the wound upon re-admission on November 8, 2013. The clinical record lacked evidence that the resident received care and services in a timely	L 052		

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L 052	Continued From page 58	L 052		

manner to ensure that the residents ' condition and wound did not become worse and prevent new wounds from developing. The resident was subsequently sent to the emergency room for evaluation secondary to fever, hypotension, and sacral wound debridement.

A face-to-face interview was conducted with Employee #10. A query was made regarding the timeliness of the residents treatment to ensure that his/her condition did not worsen. Employee #10 acknowledged findings and that the care could have been delivered differently.

Review of the Pressure Ulcer Evaluation dated February 5, 2014 revealed: " facility acquired rt [right] Ischium " current stage: Stage 2; measuring: 1x1.6x0.1; peri-wound intact, wound bed 100% granulation ...during wound rounds, resident was noted with new wound on the right ischium, 100% gran [granulation], no exudates, wound bed moist, peri-wound intact, wound edges defined. Tx [treatment] Aqcel ag daily and PRN [as needed]. "

Review of the Skin Sweep sheets for February 5, 2013 lacked evidence of a wound recognition for that day.

A-face-face interview was conducted on January with Employee #21 on March 6, 2013 at approximately 11:00 AM. A query was made regarding the skin sweep assessment on February 5, 2013. He/she indicated that when he/she went into the room to check the skin there was already a bandage on it, so he/she did not look at it.

A face-to-face interview was conducted with

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L 052	Continued From page 59 Employee #22 on March 6, 2013 at approximately 11:30 AM. A query was made regarding the condition of skin on February 5, 2014 and what is the process for notifying the nurse. Employee #22 stated " the wound team discovered the wound, I documented in the electronic notes, I do not remember who I told about it. " Review of the TAR [treatment administration record] revealed that the resident was to have an " air loss mattress to prevent skin breakdown " order date February 19, 2014 one (1) after developing two (2) unstageble wounds. The clinical record lacked evidence that the facility staff ensured that the residents ' condition and wound did not become worse and failed to prevent new wounds from developing. The resident was subsequently sent to the emergency room for evaluation secondary to fever, hypotension, and sacral wound debridement, returned and developed another facility acquired wound one (1) month later.	L 052	L056 1.Retrospectively all residents had the potential to be affected by this deficient practice as there was not sufficient staff to meet the needs of residents. The Administrator developed a plan with corporate approval to ensure the integration, coordination, and monitoring of the facilities practices related to resident care and safety to ensure that each resident attains or maintains the highest practicable physical, mental and psychosocial well-being. The DON, Administrator and HR met to immediately determine a plan for staffing. We discussed having an open house for staff; hiring as soon as possible; staff agencies; and more orientations. 2. Until we have all appropriate staff in place to meet the required PPD. All residents have the potential to be affected by the deficient practice. For each deficient practice identified in the POC a total audit (100%) was completed for all other residents to ensure no other residents were affected by the deficient practice.	
L 056	3211.5 Nursing Facilities Nursing personnel, licensed practical nurses, nurse aides, orderlies, and ward clerks shall be assigned duties consistent with their education and experience and based on the characteristics of the patient load. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that facility staff failed to meet 0.6 [six tenths] hours for Registered Nurses/APRN [Advanced Practice	L 056		

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L 056	Continued From page 60 Registered Nurse] hours on 19 of the 19 days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on March 6, 2014 at approximately 1:30 PM. According the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. Of the 19 days reviewed, 18 of the days failed to meet the 0.6 [six tenths] hours of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] as follows: February 15, 2014 : 0.25 February 16, 2014 : 0.25 February 17, 2014 : 0.51 February 18, 2014 : 0.58 February 19, 2014 : 0.55 February 20, 2014 : 0.58 February 21, 2014 : 0.50	L 056	3. . Staffing requirements were reviewed with Staffing Coordinator and requirements needed for each shift to meet the needs of the residents. Human Resources and Director of Nursing met to identify open positions and strategies. Interviews were conducted, and on 2/28/14. During The week of March 3-6 additional interview were conducted and offers extended to additional staff for orientation on 3/11/14. On 4/15/14 we had another orientation class . We are planning to have another orientation class on 5/12/2014. The DON has been conducting interviews and having oversight to hire competent and qualified staff to fill staffing needs identified. Nursing is reviewing staffing levels daily at clinical morning meeting to ensure staffing is scheduled as required to meet federal/district guidelines and to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. We began offering $100 gift cards to CNAs, LPNs and RNs to take on additional shifts. On 3/21/2014 we signed contracts with two staffing agencies for RNs and LPNs with Align Staffing and Healthcare Staffing. 4. Staffing reports will be brought through the monthly QAPI process to ensure compliance and identify areas for improvement. HR Department will also report monthly on staff vacancies.	5/13/14

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L 056	Continued From page 61 February 22, 2014 : 0.22 February 23, 2014 : 0.19 February 24, 2014 : 0.61 February 25, 2014 : 0.56 February 26, 2014 : 0.50 February 27, 2014 : 0.44 February 28, 2014 : 0.44 March 1, 2014 : 0.22 March 2, 2014 : 0.25 March 3, 2014 : 0.51 March 4, 2014 : 0.55 March 5, 2014 :0.55 Of the 19 days reviewed, 19 of the days failed to meet minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day as follows: February 15, 2014 : 2.84 February 16, 2014 : 3.0 February 17, 2014 : 3.5 February 18, 2014 : 3.47 February 19, 2014 : 3.71 February 20, 2014 : 3.65 February 21, 2014 : 3.62 February 22, 2014 : 3.07 February 23, 2014 : 3.31 February 24, 2014 : 3.61 February 25, 2014 : 3.87 February 26, 2014 : 3.81 February 27, 2014 : 3.81 February 28, 2014 : 3.81 March 1, 2014 : 2.96 March 2, 2014 : 2.93 March 3, 2014 : 3.62 March 4, 2014 : 3.87 March 5, 2014 : 4.0	L 056		

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L 056	Continued From page 62 The review was made in the presence of the Employee #45 who acknowledged the findings.	L 056	L069	
L 069	3214.3 Nursing Facilities Each area of in-service training shall be conducted by a registered nurse, qualified and experienced in the area of instruction. This Statute is not met as evidenced by: Based on staff interview and a review of records, it was determined that the facility failed to ensure that in-service training for nursing personnel was conducted by a registered nurse, qualified and experienced in the area of instruction. The findings include: A review of in-service education records and orientation documents for nursing personnel for the period of January through March 2014, it was determined that Employee #50 conducted orientation, in-service education and/or competency verification for nurses. A review of the personnel file for Employee #50 revealed the employee ' s job title was " Staff Development (In-Service Education). " The job description included, " assist licensed nursing personnel (i.e., RNs, LPNs, and CNAs/GNAs) [registered nurses, licensed practical nurses, certified nurse aide and geriatric nurse aide] in obtaining in-service training to keep their license current in accordance with state law. Provide in-service training, as necessary or required. Further review of the personnel file for Employee #50 revealed the employee was licensed as a LPN, licensed practical nurse.	L 069	1. A Masters prepared RN was brought on as a Nurse Consultant to assist the Staff Development Department with educational requirements on March 31, 2014. 2.All residents have the potential to be affected by this deficient practice. 3.The facility hired the Consultant Nurse Educator on April 28, 2014 on a full time basis. When the former Staff Development Director returns we will offer her an RN position in some other capacity. The new Staff Development Director will assume the role for ensuring that all RNs in the building are getting an in-service education per regulatory requirements. 4.The Administrator and the DON will ensure that in the event the RN Nurse educator is out or absent that another RN is assigned to take on that duty and any and all incidents will come through the monthly QAPI process.	5/13/14

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L 069	Continued From page 63 A face-to-face interview was conducted with Employee #2 on March 6, 2014 at approximately 3:00 PM. He/she acknowledged that Employee #50 conducted in-service training for new hires and staff nurses. However, stated that this was an interim plan because the director of staff development was on extended leave. Facility staff failed to ensure that in-service for nursing personnel was conducted by a registered nurse. The records were reviewed March 6, 2014.	L 069	L087 1.Resident #50 did not present with Any negative outcome related to the Employee failure to follow established Protocols for hand washing. Employee #37 Was educated by ADON on 3/13/14 on the prevention of infection with proper hygiene technique and the administration of eye drops. 2.All residents have the potential to be affected by the failure to follow CDC guidelines for hand hygiene. Nursing and IC Nurse will review the	
L 087	3217.2 Nursing Facilities The Chairperson of the Infection Control Committee shall be knowledgeable about or have experience in infection control. This Statute is not met as evidenced by: Based on observation, it was determined that facility staff failed to maintain proper hand hygiene practices during the administration of medication for one (1) resident. Resident #50 The findings include: According to the Centers for Disease Control and Prevention [CDC] Guidelines for Hand Hygiene in Health-Care Settings; Hand-hygiene technique includes: " When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet (IB) (90-92, 94,411). Avoid	L 087	infection control guidelines and protocols to ensure compliance with all State and Federal requirements for the prevention of the spread of infection as it relates to hand hygiene and the administration of eye drops to a resident and identify areas of education needed. 3.Nursing and IC Nurse have reviewed infection control policies and protocols and made modifications as necessary to be compliant with State and Federal requirements. Licensed Nurses will be educated by IC Nurse, Staff Development and/or Nurse Manages on proper administration of eye drops. All staff will be educated on the guidelines for hand hygiene. Nurse Management will conduct random eye drop administration observations weekly X4 to identify where further education is needed. Nursing Management/Infection Control Nurse will	

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L 087	Continued From page 64 using hot water, because repeated exposure to hot water may increase the risk of dermatitis (IB) (254,255). " A Medication Pass observation conducted on March 3, 2014 at approximately 9:35AM revealed Employee #37 failed to decrease the potential spread of infection as evidenced by failing to wash and/or sanitize hands prior or donning gloves during the administration of eye drops. The employee#37 ' s hands were in contact with environmental surfaces when retrieving the eye drops from the medication cart. An observation of Employee #37 ' s hand washing technique subsequent to medication administration revealed that the employee washed his/her hands for approximately 8 seconds in contrast to the CDC guidelines stipulated above.	L 087	conduct random hand washing observation on all departments to ensure compliance with proper hand hygiene (20 seconds of hand washing). IC Nurse scheduled quarterly IC in-services for the rest of the year. 4. Results of all audits will be reviewed by the IC Nurse and brought to monthly QAPI to ensure compliance and identify other areas where further education is needed. Audits will be reviewed for a 3 months to ensure compliance is being mandated.	5/13/14
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on February 19, 2014 at approximately 9:15 AM and on February 25, 2014 at approximately 9:45 AM, it was determined that the facility failed to prepare, distribute and serve food under sanitary conditions as evidenced by six (6) of six (6) one-quarter hotel pans that were soiled and dented, six (6) of six (6) one-half pans that were soiled and dented, two (2) of three (3) full pans	L 099	L099 1.The two soiled convection ovens and four soiled steam table wells were cleaned on 2/25/14. All soiled hotel pans were washed and dented hotel pans were discarded on 2/25/2014. 2. All other convection ovens, steam tables were cleaned and inspected. Staff were counseled for not following cleaning schedule created for the ovens and steam table wells. Other residents had the potential to be affected by this deficient practice.	

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L 099	Continued From page 65 that were soiled and dented, two (2) of two (2) soiled convection ovens and four (4) of eight (8) soiled steam table wells. The findings include: 1. Six (6) of six (6) one-quarter hotel pans were soiled and dented and needed to be replaced. 2. Six (6) of six (6) one-half pans were soiled and dented and needed to be replaced. 3. Two (2) of three (3) full pans were soiled and dented and needed to be replaced. 4. Two (2) of two (2) convection ovens were soiled with dry and cooked food residue and needed to be cleaned. 5. Four (4) of eight (8) steam table wells were soiled with various, overheated food particles and needed to be cleaned. These observations were made in the presence of Employee #15 who acknowledged the findings.	L 099	3.All dietary associates were in-serviced on pot and pan cleaning. Checking pots and pans for dents will be a part of weekly kitchen audits. A new audit tool was created. Evening Supervisor was hired in kitchen to assist FNS Director with staff compliance on April 15, 2014. 4. Weekly pot and pan, oven and steam table audits will be captured on new tool for FNS Director to report to QAPI Committee monthly.	5/13/14
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator	L 128	L128 1.Residents #24, #290, and #106 did not have negative outcomes related to the deficient practice of the facility not ensuring the consultant pharmacist generated communication sheets for drug irregularities. All concerns identified were addressed with the specific residents. 2. All resident's have the potential to be affected by the deficient practice of not ensuring the consultant pharmacist generated communication sheets for drug irregularities. A new pharmacy consultant team started on March 1, 2014 and did a complete audit of all resident's medication record. All residents have the potential to be affected by the facility's lack of consistently maintaining records for the receipt and reconciliation of controlled medications.	

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L 128	Continued From page 66 on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: A. Based on record review and staff interview for one (1) of 51 sampled residents it was determined that facility staff failed to ensure pharmacy generated communication sheet (s) for drug irregularities after conducting the monthly drug review regimen for Resident #290. The findings include: Facility staff failed to ensure that pharmacy generated a communication sheet for drug irregularities after conducting the monthly drug review regimen. A review of the physician ' s order revealed that Resident #290 was prescribed the antipsychotic medications Risperadal for psychosis and Remeron for depression. An interim physician order dated December 22, 2013 directed ' " [Discontinue] Risperdal 2mg po (by mouth) [every hour of sleep], [Decrease]	L 128	3. The Pharmacy Consultant Policy and Protocols were reviewed with the new Consultants and modified as needed. The Consultant Pharmacist agrees to render the required service in accordance with Local, State, and Federal Laws, Regulations, and guidelines; nursing care center policies and procedures; community standards of practice; and professional standards of practice. the new consultants have reviewed and followed-up previous pharmacy recommendations with the nursing care center staff. The Consultants will document the completion of the review along with the Consultant Pharmacist's signature and date on the MRR review/pharmacist signature log. They will submit a monthly summary report to the nursing care center outlining specific findings based on the Consultant Pharmacist's Medication Regimen Review following the completion of the review. In-services were provided by the Pharmacy Consultants on the protocols for follow through on pharmacy recommendations and managing the gradual dose reductions with the physician's. All Pharmacy recommendations will be kept in the resident's record. Director of Nursing will monitor the pharmacy recommendations to ensure compliance with follow through. Nursing Management reviewed the policy and protocol for Narcotic accountability and documentation during reconciliation between shifts and updated protocols as needed. A full audit was completed on all reconciliation of controlled substances log. Education was provided to the licensed nurses on the protocols for the reconciliation of controlled substances. The Narcotic Reconciliation sheets will be audited weekly by Nursing Management to identify any areas of non-compliance. Further education and counseling will be provided as necessary.	

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L 128	Continued From page 67 Risperdal 1mg po q HS for psychosis. " A review of the pharmacy " Drug Regimen Review " the following was revealed: July 25, 2013- SPP- Significant Potential Problem- Risperdal [2mg] HS (hour of sleep) August 23, 2013- No Potential Problem September 19, 2013- No Potential Problem October 29, 2013- No Potential Problem November 20, 2013- Significant Potential Problem December 19, 2013- No Potential Problem January 30, 2014- Significant Potential Problem February 20, 2014- No Potential Problem A review of the " Psychiatric Evaluations " revealed the following: August 22, 2013 revealed; " Psychotropic medications: Remeron- Indications-Depression ... Recommendations/Plan: (1) No changes in treatment, (2). Follow up in 1-2 months. November 22, 2013- Psychotropic medications: Remeron- Indications -Depression, Psychiatric Diagnosis: Depression- Psychosis; Recommendations/Plan: ... No changes in treatment. Patient is still symptomatic. Decreasing of medications dosages is not recommended. December22, 2013- Psychotropic Medications: Remeron30mg po QHS- Indications-Depression; Risperdal 2mg- PO QHS; Indications- Depression. Recommendations/Plans: ... Continue Remeron 30mg po QHS for depression. Psychiatric Diagnosis: Vascular Dementia, Major Depressive Disorder with Psychotic features, Schizophrenia, Paranoid Type. " The clinical record lacked evidence that the	L 128	4. Compliance with follow through will be monitored monthly through the QAPI process by the Director of Nursing and quarterly by the pharmacy consultants. Further education and/or counseling will be provided when identified by the compliance audits. Results of the audit will be reviewed monthly through the QAPI process for 3 months to identify any areas of further education or modifications needed. Monthly review and audits will continue until full compliance is reached for 60 days.	5/13/14

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L 128	Continued From page 68 psychiatrist included Risperdal in his/her psychiatric evaluations from July 2013 until December 2013. Resident was started on Risperdal 2mg on June 3, 2013. There were no pharmacy communication sheets in the clinical record to address the significant potential problem after the monthly medication review regimen was conducted. Facility staff failed to ensure that pharmacy generated a communication sheet for drug irregularities after conducting the monthly drug review regimen. A face-to-face interview was conducted with Employees # 1, #2, and #5 on March 7, 2014 at approximately 4:30 PM. All acknowledged the aforementioned problems. Employee #2, stated; " We have been having problems with one of the psychiatrist. That is being corrected. Also, we will work with pharmacist in making sure physician communication sheets are generated to address potential problems. " The clinical record was reviewed on March 5, 2014. 2. Facility failed to ensure that irregularities, indicated in the Drug Regimen Review (DRR) by the consultant pharmacist as a Significant Potential Problem (SPP), are acted upon for Resident #24. A review of the Drug Regimen Review (DRR) for Resident #24 revealed that the pharmacist identified the prescribed antidepressant medication Remeron on December 18, 2013 as a SPP medication. Remeron for Resident #24. There was no documentation to confirm that the	L 128		

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L 128	Continued From page 69 attending physician (s) was notified of these irregularities or that these irregularities were acted upon. A face-to-face interview with Employee #2 on February 28, 2014 at approximately 3:00 PM. He/she revealed that the consultant pharmacist reports any findings or irregularities to the Director of Nursing Services. He/she, in turn, reports or forwards them to the physician (s). 3.Facility failed to ensure that irregularities, indicated in the Drug Regimen Review (DRR) by the consultant pharmacist as a Significant Potential Problem (SPP), are acted upon for Resident #106. A review of the Drug Regimen Review (DRR) for Resident #106 revealed that the pharmacist identified the prescribed antipsychotic medication Seroquel as a SPP medication on the following dates: February 11, 2013, September 22, 2013 and January 28, 2014. Seroquel for Resident #106. A face-to-face interview with Employee #2 on February 28, 2014 at approximately 3:00 PM, he/she revealed that the consultant pharmacist reports any findings or irregularities to the Director of Nursing Services. He/she, in turn, reports or forwards them to the physician (s). There was no documentation to confirm that the attending physician (s) was notified of these irregularities or that these irregularities were acted upon.	L 128		

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L 128	Continued From page 70 B. Based on observations, record review and staff interview, it was determined that facility staff failed to consistently maintain records to account for the receipt and reconciliation of controlled medications on the 4 north and 4 south unit nursing floors. The findings include: Facility staff failed to consistently maintain records to account for the receipt and reconciliation of controlled medications on 4 north and 4 south unit nursing floors. The observation of a controlled medication count was conducted on the 4thth floor on March 6, 2014 at approximately 3:00 PM. At this time it was observed that there were no signatures to verify the reconciliation of controlled substances in the spaces allotted for off-going/on-coming nurses for all shifts (night, day and evening) as follows: February 20, 2014 off going nurse 3PM - 11:30AM 4 North sheet #1 February 2, 2014 off going nurse 3PM -11:30PM 4 North sheet #2 February 13, 2014 off going nurse 11PM - 7:30AM 4 North sheet #2 February 21, 2014 on coming nurse 11PM - 7:30AM 4 North sheet #2 February 22, 2014 off going nurse 11PM - 7:30AM 4 North sheet #2 February 24, 2014 off going nurse 3PM - 11:30PM 4 North sheet #2 February 1, 2014 off going nurse 11PM - 7:30AM 4 South sheet #1 February 1, 2014 off going nurse 3PM - 11:30PM 4 South sheet #1	L 128		

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L 128	Continued From page 71 February 2, 2014 off going nurse 11PM - 7:30AM 4 South sheet #1 February 2, 2014 on coming nurse 7AM - 3:30PM 4 South sheet #1 February 2, 2014 off going nurse 7AM - 3:30PM 4 South sheet #1 February 2, 2014 off going nurse 3PM - 11:30PM 4 South sheet #1 February 2, 2014 on coming nurse 11PM - 7:30AM 4 South sheet #1 February 6, 2014 off going nurse 11PM - 7:30AM 4 South sheet #1 February 10, 2014 off going nurse 7AM - 3:30PM 4 South sheet #1 February13, 2014 off going nurse 3PM - 11:30PM 4 South sheet #1 February 25, 2014 on coming nurse 11PM - 7:30AM 4 South sheet #1 February 1, 2014 on coming nurse 7AM - 3:30PM 4 South sheet #2 February 1, 2014 off going nurse 3PM - 11:30PM 4 South sheet #2 February 3, 2014 off going nurse 7AM - 3:30PM 4 South sheet #2 February 4, 2014 on coming nurse 11PM - 7:30AM 4 South sheet #2 February 5, 2014 off going nurse 7AM - 3:30PM 4 South sheet #2 February 9, 2014 on coming nurse 11PM - 7:30AM 4 South sheet #2 February 10, 2014 off going nurse 7AM - 3:30PM 4 South sheet #2 February 14, 2014 on coming nurse 11PM - 7:30AM 4 South sheet #2 February 15, 2014 on coming nurse 7AM - 3:30PM 4 South sheet #2 February 15, 2014 off going nurse 3PM - 11:30PM 4 South sheet #2 There was no evidence that facility staff	L 128		

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L 128	Continued From page 72 consistently maintain records to account for the receipt and reconciliation of controlled medications on 4 north and 4 south unit nursing floors as evidenced by missing signatures for on-coming and off-going nurses. A face-to-face interview was conducted with Employees #9 on March 7, 2014 at approximately 3:35 PM. After reviewing the signature sheet forms, he/she acknowledged the aforementioned findings. The observation was conducted March 7, 2014. B.Based on observation and staff interview, it was determined that facility staff failed to reconcile controlled substances as per facility's protocol. The findings include: On February 19, 2014 at approximately 3:50 PM on Unit 3 South, observed Employee #43 (on-coming nurse) standing at Medication Cart I counting narcotics. A face-to-face interview was conducted with Employee #7 at the time of the observation. In response to a query regarding how the facility ensures that the controlled substances are reconciled. Employee #7 responded, " The off-going/on-coming licensed nurses ' count narcotics each shift together and both have to sign the narcotic book verifying that the count is correct." Subsequently, Employee #43 (on-coming nurse) and Employee #42 (off-going nurse) counted the	L 128		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 73 narcotics together and signed the narcotic log sheet verifying that the narcotics were reconciled. The findings were acknowledged at the time of the observation by Employees #7 and #42.	L 128	L199 1.None of the residents identified had negative outcomes related to the deficient practice of maintaining clinical records in accordance with accepted professional services. All concerns identified were addressed with residents #50, 121 180, 290, 316, and 347.	
L 199	3231.10 Nursing Facilities Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on staff interviews and record review for six (6) of 43 sampled residents, it was determined that facility staff failed to ensure that the established communication log for coordination of services between the facility and the dialysis center documentation was consistently completed for two (2) resident active chart, to consistently document in the comprehensive intake record and document signatures on the Medication Administration record for one (1) resident, and failed to accurately document behaviors for one (1) resident receiving anti-anxiety medication (Cymbalta); to document according to the physician ' s Central Line-Catheter Protocol for a Right Upper Arm PICC [peripherally inserted central catheter], and to accurately document on the skin sweep sheets. Resident # 50, #121, #80, #290 and #316, #347 The findings include: 1. Facility staff failed to ensure that the established communication log for coordination	L 199	2.All residents have the potential to be affected by the deficient practice of maintaining clinical records in accordance with accepted professional services. The facility will review the current protocols, dialysis communication sheets for all current dialysis residents, update as necessary, and identify areas of education needs. Tube feeding documentation protocols will be reviewed and updated as necessary for all residents receiving hydration and/or feeding via PEG tube. Facility will identify areas of education needed. All MARs will be reviewed to ensure appropriate signage required has been completed and identified areas of education needed. The Central Line Protocol and documentation was reviewed for all residents receiving medication/fluids through this devise to ensure protocols were followed and identify any areas of education needed. Protocols for completing the weekly skin observation sheets were reviewed and updates were made as necessary and we identified areas of educational needs.	

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L 199	Continued From page 74 of services between the facility and the dialysis center was consistently completed. Resident #50 A review of Resident #50's medical record revealed that dialysis treatment days were on Monday, Wednesday and Friday. A review of the dialysis communication book revealed pre dialysis weights, pre and post resident status, Time vital sign taken, Access site location, assessment do you hear bruit, do you feel thrill, did patient eat before dialysis, current diet/supplement, problem noted and/or resident complaint, time resident returned from dialysis, nurse signature and date, medication(s) administered and post dialysis nursing assessments were not consistently documented for the period of February 3, 2014 to February 24, 2014. A face-to-face interview was conducted February 26, 2014 at 10:00 AM with Employee #8. He/she acknowledged that the findings. The record was reviewed February 26, 2014. 2. Facility staff failed to ensure that the established communication log for coordination of services between the facility and the dialysis center was consistently recorded. Resident #121 A review of Resident #121's medical record revealed that dialysis treatment days were on Tuesday, Thursday and Saturday. A review of the dialysis communication book revealed pre dialysis weights, pre and post resident status, Time vital sign taken, Access site location, assessment do you hear bruit, do you	L 199	3.In coordination with the Dialysis Center, Nursing Administration has reviewed and updated the dialysis communication sheet and protocols including monitoring, assessment and documentation of the dialysis access site. Licensed Nurses have been educated on these protocol and they will now complete communication sheet and place in resident's dialysis notebook for each dialysis treatment. Dialysis Center will complete their portion prior to sending resident back to facility. Dialysis books will be audited weekly by Unit Managers to ensure completion and compliance. Protocols to monitor and document tube feeding and hydration were reviewed by Nursing and Dieticians. Updates to the protocol were made to ensure better compliance with documentation. Licensed Nursing staff have been educated on these protocols. Intake records will be reviewed to ensure compliance. Policy and protocols for medication administration record documentation were reviewed with nursing leadership. Licensed Nurses were educated on requirements related to medication administration. MARs are being audited weekly by Nursing Administration to ensure completion and compliance. Central Line Protocol was reviewed by Nursing Administration to identify further areas of education needed for Licensed Nurses.	

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L 199	Continued From page 75 feel thrill, did patient eat before dialysis, current diet/supplement, problem noted and/or resident complaint, time resident returned from dialysis, nurse signature and date, labs drawn, medication(s) administered and post dialysis nursing assessments were not consistently documented for the period of February 3, 2014 to February 24, 2014. A face-to-face interview was conducted February 28, 2014 at 11:00 AM with Employee #8. He/she acknowledged the findings. The record was reviewed February 28, 2014. 3A. Facility staff failed to consistently document the amount of tube feeding, flushes, H20 with medications and water totals the resident received on the comprehensive intake record. A. A review of the clinical record for resident #80 revealed that the comprehensive intake record dated February 19- February 25, 2014 twenty -four (24) hour and shift totals were blank on twenty-nine (29) occasions. 3B. Facility staff failed write name and signature on the Medication Administration Record (MAR) for Resident #80. A review of the clinical record for Resident #80 revealed that the initials are present under dates and times medications were administered the designated areas for full name and signatures are blank. On all reviewed MAR ' s. A face-to-face interview was conducted with Employee #11 on February 25, 2014 at approximately 4:06 PM. He/she acknowledged that Resident #80's comprehensive intake record was incomplete and that the Medication Administration Record did not have the appropriate signage required. The record was reviewed February 25, 2014.	L 199	Licensed Staff were educated on the requirements related to documentation of the use of PICC Lines for medication/fluid admin on initiation of medication/fluid admin during its use, and removal of devise. Education was provided by Nursing Administration and the contracted PICC Line Services. Unit Managers and Supervisors will audit residents PICC Line documentation on initiation of use of the device, weekly, on completion of the medication and/or fluids administered and when the device is removed. 4. Audits will be reviewed weekly by Nursing Administration for three months and reported to monthly QAPI process to identify any further needs for education or modification to protocols.	5/13/14

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L 199	Continued From page 76 4.Facility staff failed to accurately and consistently record Resident #290 ' s tube feeding and water flushes on the comprehensive intake record. According to the physician ' s orders dated November 1, 2013 directed the following: " Nepro at 65 ml [millimeters] per hour [times] 16 hours, up at 1600 (4:00 PM) and down at 0800 (8:00 AM0- once daily everday. Flush G-Tube with 500mls of water every 4 hours for hydration. Flush tube with 5 ml of water in between meds [every] shift. Flush with 30 ml of water before and after med pass- every shift. " A review of the clinical record for Resident #290 revealed that the comprehensive intake record dated November 1- November 30, 2014 twenty -four (24) hour totals were blank for the entire month. The total intakes for all shift totals were not consistently filled in. A face-to-face interview was conducted February 26, 2014 at 10:00 AM with Employees #2 and #5. Both acknowledged the aforementioned findings. The record was reviewed February 26, 2014. 5. According to the Admissions notes dated January 3, 2014 at 19:11 [7:11 AM], Resident #316 was re-admitted to the facility on January 3, 2014 with a Right Upper Arm PICC line. According to the Central Line Catheter Protocol dated January 4, 2014 revealed, for " Unused lumens/minimum flush interval: PICC non-valved q [every] 12 hours each lumen 5 ml	L 199		

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L 199	Continued From page 77 [milliliters] ns [normal saline], 5 ml 10 units/ml heparin flush. " According to the Central Line Catheter protocol/Fluid/Medication Orders dated and signed by the physician January 6, 2014 at 10:00 AM, directed: Ertapenem 1 gm [gram] IV q 24 hours x [times] 10 days for UTI [Urinary Tract Infection]. According to the residents Infusion Medication Record and the MAR [Medication Administration Record], the resident received the antibiotic from January 4 through January 10, 2014. There was no documented evidence in the clinical record that after the resident completed the antibiotics on January 10, 2014 that facility staff maintained the resident ' s PICC line according to the Central Line Catheter Protocol. A face-to-face interview was conducted with Employee #8 on February 25, 2014 at approximately 11:30 AM. After review of the Central Line Catheter management record, Employee #8 acknowledged that the Central Line Catheter Protocol lacked documented evidence of management of the PICC line according to protocol. 6. Facility staff failed to accurately document on the " Skin Sweep " sheets for Resident #347. A review of the clinical record revealed that the resident was admitted to the facility on September 12, 2013. Review of the Pressure Ulcer Evaluation dated	L 199		

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L 199	Continued From page 78 February 5, 2014 revealed: " facility acquired rt [right] Ischium " current stage: Stage 2; measuring: 1x1.6x0.1; peri-wound intact, wound bed 100% granulation ...during wound rounds, resident was noted with new wound on the right ischium, 100% gran [granulation], no exudates, wound bed moist, peri-wound intact, wound edges defined. Tx [treatment] Aqcel ag daily and PRN [as needed]. " Review of the Skin Sweep sheets for February 5, 2013 lacked evidence of a wound recognition for that day. A-face-face interview was conducted on January with Employee #22 March 6, 2013 at approximately 11:00 AM. A query was made regarding the skin sweep assessment on February 5, 2013. He/she indicated that when he/she went into the room to check the skin there was already a bandage on it, so he/she did not look at it. Facility staff failed to accurately document on the " Skin Sweep " sheets for Resident #347.	L 199		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on February 25, 2014 at approximately 11:00 AM it was	L 214	L214 1. Loose oxygen tanks were immediately secured in the appropriate designated stands. 2. Other residents have the potential to be affected by the deficient practice of employee not securing oxygen tanks in the appropriate designated stands. All other clean utility rooms were checked to ensure oxygen tanks were secured appropriately.	

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L 214	Continued From page 79 determined that the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public as evidenced by loose, unsecured oxygen tanks in one (1) of four Clean Utility rooms. The findings include: 1. Two (2) of two (2) oxygen tanks were stored on the floor of the clean utility room on 5 South, unsecured in one (1) of four (4) Clean Utility rooms. These observations were made in the presence of Employee #30 who acknowledged the findings.	L 214	3. Education was provided to all staff on the proper storage of oxygen tanks. Respiratory Therapy and Central Supply will check the oxygen tank storage area daily to ensure they are compliant with recognized safety requirements. 4.Results of a observations will be brought through monthly QAPI to ensure compliance and identify any additional educational requirements needed or further monitoring. L306	5/13/14
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by:	L 306	1.The call bells cited in rooms #202, 205, 207, 220, and 402 were repaired on March 10, 2014. 2. All other call bells were checked in the facility 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 was created and implemented by the Director. Maintenance staff after conducting daily 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 were in-serviced to not wrap call bell cords around bed rails.	

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L 306	Continued From page 80 Based on observations made during an environmental tour of the facility on February 25, 2014 at approximately 11:00 AM it was determined that the facility failed to maintain call bells from residents rooms in proper working condition as evidenced by non-functioning call bells in five (5) of 43 resident's rooms. The findings include: 1. Call bells were not functioning when tested in rooms #202 (Bed A), #205 (Bed A), #207 (Beds A and B), #220 (Bed B) and #402 (Bed D)), five (5) of 43 resident's rooms surveyed. These observations were made in the presence of Employee #32 who acknowledged the findings.	L 306	4. Utilizing the new audit tool the Director will report all deficient practices to the monthly QAPI Committee.	5/13/14
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on February 25, 2014 at approximately 11:00 AM and on February 26, 2014 at approximately 11:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by loose, detached from the hooks privacy curtains in five (5) of 43 resident's rooms surveyed, torn privacy curtains in two (2) of 43 resident's rooms	L 410	L410 1.All privacy curtains found missing, torn, hanging off the hooks, were fixed immediately on February 25, 2014. The dusty blinds were cleaned the same day as well. The litter and debris behind washer was removed and drain pipes behind the washing machine were also cleaned the same day. The bathroom stall in shower room was repaired on 4/7/2014. 2. Rounds were made on every unit to ensure the deficient practice was not on any other units. Administrator will conduct monthly rounds with Housekeeping Director beginning in April. Privacy curtains in stock were also examined to ensure deficient practice would not recur.	

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L 410	Continued From page 81 surveyed, dusty window blinds in two (2) of 43 resident's rooms surveyed, a missing toilet door in one (1) of four (4) Clean Utility rooms and a messy, unclean area in one (1) of one (1) laundry room. 1. Privacy curtains were hanging off the hooks in resident rooms # 202 (Beds C and D), #223 (Bed A), #225 (Bed B), #402 (Beds A and D), and #417 (Beds B and C), five (5) of 43 resident's rooms surveyed. 2. Privacy curtains were torn in two (2) of 43 resident's rooms including rooms #417 (Beds A and D) and room #527(Bed A). 3. Window blinds were dusty in rooms #319, #324, #402, #404, and #417, five (5) of 43 resident's rooms surveyed. 4. The door to the toilet located in the shower room on 5 South was missing. 5. The area located behind the three (3) washing machines in the laundry room was littered with various debris, the drain pipes were covered with lint and the floor was soiled. These observations were made in the presence of Employee #30 who acknowledged the findings.	L 410	All other bathroom stall doors were evaluated by the Director of Maintenance no other stall doors were found with the same deficient practice 3. A carbonized schedule of all rooms was created for staff to clean each facility room. Staff were in-serviced on proper cleaning techniques on 3/20/14. Staff were in-serviced on privacy curtains deficiencies. A new QA tool was developed for housekeeping to utilize monthly and Report to QA. The schedules of the Housekeeping Director and Manger were changed to stagger staff and have more accountability during the day and evening shifts. The Maintenance Director will conduct weekly rounds to ensure all bathroom staff doors are maintained in good repair in all 8 shower rooms. A new QA audit tool was created. Maintenance staff assigned to each unit were In-serviced on putting maintenance Items into the Reqqer system if they are unable to fix issues. 4. All deficient practices will be reported monthly to QAPI committee using new tools.	5/13/14
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	L 442		

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L 442	Continued From page 82 This Statute is not met as evidenced by: Based on observations made during an environmental tour on February 26, 2014 at approximately 11:00 AM, it was determined that the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. 1. One (1) of three (3) washing machines in the laundry room was leaking from a hose mounted accross its access door These observations were made in the presence of Employee #30 who acknowledged the findings.	L 442	L442 1. The washing machine was repaired immediately on 2/26/2014 by HOLT INC . 2. A weekly tour will be done by the Maintenance Director and a daily tour done by the Director of Housekeeping/Designee to ensure that all 3 washing machines will be operating and maintained properly and any deficient areas will be repaired immediately by the Maintenance Director/Designee. 3. A monthly audit tool was initiated and implemented by the Maintenance Director and Director of Housekeeping to ensure all 3 washing machines will be operating and maintained properly. The audit tool will be reviewed by the Director of Maintenance/ Designee. Any required maintenance on washing machines will be repaired immediately or vendor will be called upon the deficient findings. 4. All and any deficient practices will be reported by the Maintenance and Housekeeping Director to the monthly QAPI committee.	5/13/14