STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	03/07/2014

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F 309	Continued From page 72 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 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. Facility staff 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	F 309		

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F 309	Continued From page 73 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 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	F 309		

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F 309	Continued From page 74 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) 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.	F 309		

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F 309	Continued From page 75 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. Facility staff 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 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	F 309		

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F 309	Continued From page 76 assessments should be done prior to administering. He /she acknowledged aforementioned the findings. The clinical record was reviewed on February 25, 2014. 5. Facility staff failed 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]. 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.	F 309		

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F 309	Continued From page 77 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. 6. Facility staff failed 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 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	F 309		

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F 309	Continued From page 78 findings after reviewing the clinical record. 7. Facility staff failed 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, 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	F 309		

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F 309	Continued From page 79 (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. 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	F 309		

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F 309	Continued From page 80 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 Records lacked evidence that the CPM device was applied with consistency and in accordance with physician ' s orders. The findings were acknowledged during a	F 309		

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F 309	Continued From page 81 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. Based on record review and staff interview of one (1) of 43 sampled resident it was determined that facility staff failed to notify the physician that one (1) resident was not seen by the cardiologist. Resident #121 A review of the clinical record revealed that resident was admitted December 3, 2013 with diagnosis of End Stage Renal Disease on dialysis, Diabetes, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, Coronary artery disease status post by pass graft, Anemia, Hyperlipidemia and Delusional, Depressive disorder. A review of Physician Order dated December 3, 2013 directed, " Cardiology consult for follow up CHF [Congested Heart Failure] " . An inquiry was made regarding resident #121 visits to the cardiologist consult for follow up CHF. Employee #8 explained that the appointment was made by facility staff for February 20, 2014 for the cardiovascular doctor. The resident went to the appointment and that is where it was discovered that the appointment	F 309		

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F 309	Continued From page 82 was to be made to see the cardiologist. A review of the Nurses ' Note dated February 20, 2014 at 3:59 read, " Resident alert and verbally responsive. Resident left the unit at 8:30AM to see DR [name]. Resident returned from appt [appointment] at 12:15PM resident was not see [seen]. Resident suppose [suppose] to see DR [name] Cardiology ... " The Nurses Notes lacked evidence that the facility staff notified the physician that resident #121 was not seen by the cardiologist. A face-to-face interview was conducted on February 26, 2014 at approximately 9:39 AM with Employees #8. He/she acknowledged the findings. The record was reviewed on February 26, 2014.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 51 sampled residents, it was determined that facility staff failed to ensure that Resident #62 was given treatment and services to maintain or improve his/her abilities related to ADLs [Activities of Daily Living]. Resident #62. The findings include:	F 311	F-311 1.Resident #62 was approached by Social Services regarding his non-compliance with hygiene and showers and discussed with him his rights to choose hygiene times and the importance of adhering to showers to promote good health and hygiene. Social Services will work with nursing to develop a customized plan of approach in relation to #62 non-compliance. Psychiatric services were also notified to assist in developing a plan for resident #62 hygiene choices.	

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F 311	Continued From page 83 Resident #62 was observed for several days during the survey period, on and off the unit not groomed, malodorous and clothing not cleaned. During a face-to-face interview with Resident #316 [Resident #62 ' s former roommate] conducted on February 24, 2014 at approximately 10:00 AM, he/she expressed a desire to switch rooms due to the malodor of Resident #62. According to the quarterly MDS (Minimum Data Set) dated January 30, 2014, Resident #62 required limited assistance of one person for dressing and personal hygiene and partial physical help for bathing. A review of the Resident #62 ' s care plan revealed a focus of resistive to care with goals approaches initiated May 5, 2012. A face-to-face interview was conducted on February 24, 2014 at approximately 1:00 PM with the Employee #46. A query was made regarding the Resident #62 ' s ADL care. He/she stated " the resident ' s shower days were Tuesday/Friday, the last shower was given on this past Saturday and the resident would refuse at times. " Facility staff failed to ensure that Resident #62 was given treatment and services to maintain and/or improve his/her ability to maintain Activities of Daily Living. The resident was observed during the survey period with unclean clothing and ungroomed; he/she was assessed with requiring limited assistance for ADL	F 311	2. Residents who are resistant to traditional hygiene protocols have the ability to be affected by a lack of planning by facility to support residents freedom of choice and still maintain safe hygiene practices to maintain his/her abilities with ADLs. A facility audit will be completed to identify those residents who are noncompliant with personal hygiene schedules. 3.An audit was completed on all residents to identify those who are non-compliant and resistive to traditional hygiene practices and schedules. Care plans will be developed to allow residents the right to set hygiene times, set specific approach interventions, and have the CNAs inform the Charge Nurse of refusal so they may assist and intervene. Psychosocial support will be ordered as needed. Nursing will audit compliance weekly and inform Social Workers of the need for more Interventions when appropriate. 4. Social Services Director will monitor for compliance and the need for additional psychosocial support when needed on a monthly basis and will be reported through QAPI.	5/13/14

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F 311	Continued From page 84 activities.	F 311		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for three (3) of 51 sampled residents, it was determined that facility staff failed to provide necessary treatment and services 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. Facility staff failed 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	F 314	F-314 1.Resident #10, and #150 are no longer at this facility. Resident #347 has been assessed by Certified Wound NP and Dietician 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. 2.All residents have the potential to be affected by this deficient practice. 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 to promote wound healing when applicable.	

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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) COMPLETION DATE
F 314	Continued From page 85 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 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	F 314	3.A contract was signed with a Certified Wound Care Nurse Practitioner that began providing services in March and also provides oversight of the Wound Care Program and assists with staff education as well. The wound care policies, treatment protocols and documentation requirements were all reviewed by the Wound Care Team and Nurse Management and updated as necessary. Nurses have been educated regarding requirements for consistent and accurate skin sweeps to be done at a minimum of weekly. Wound Care policies, treatment protocols and wound care prevention. CNAs were educated on skin breakdown prevention and the documentation and notification requirements when an areas of the Resident's skin appears red, open, or compromised. The DON/ADON will review the weekly skin documentation completed by the Wound Care Team for completion, timeliness, and accuracy. Unit Managers will audit the skin sweep weekly to ensure they have been completed and conduct random audits to identify any possible omissions in the documentation. All 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 are completed.	

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F 314	Continued From page 86 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: " 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	F 314	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. Wound Care Team will report to QAPI team their tracking and trending of all wounds, documentation, and care planning during the monthly QAPI meeting. Wound Care NP and facility Wound Care Team will trend the occurrences 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.	5/13/14

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F 314	Continued From page 87 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. 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:	F 314		

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F 314	Continued From page 88 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 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:	F 314		

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F 314	Continued From page 89 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. 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.	F 314		

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F 314	Continued From page 90 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, 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	F 314		

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F 314	Continued From page 91 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. 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	F 314		

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F 314	Continued From page 92 was reviewed on March 5, 2014.	F 314		

2. Facility staff failed 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, 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

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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; 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.

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F 314	Continued From page 94 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. Facility staff failed to consistently assess, monitor and provide 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	F 314		

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F 314	Continued From page 95 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 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;	F 314		

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F 314	Continued From page 96 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 [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	F 314		

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F 314	Continued From page 97 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 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	F 314		

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F 314	Continued From page 98 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. 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	F 314		

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F 314	Continued From page 99 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 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	F 314		

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F 314	Continued From page 100 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 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	F 314		

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F 314	Continued From page 101 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.	F 314	F-323	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on 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 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: 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.	F 323	1.Resident #64 and #233 experienced no ill affects from the employee spraying the surface disinfectant deodorant in the air near them. Resident #403 and #404 experienced no ill effects from the facility lack of maintaining a safe and secure environment by spraying stain remover on ceiling tiles in their presence. Employees were immediately educated on the appropriate time and use for spaying these chemicals. 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 and dispensing chemicals in the presence of residents or in a manner not indicated for its use. All oxygen tanks were checked to ensure they were secured appropriately and housekeeping and maintenance staff were educated on the proper use of chemical products.	

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F 323	Continued From page 102 These observations were made in the presence of Employee #30 who acknowledged the findings. B. Based on observation and staff interview for four (4) of 51 sampled residents, it was determined that facility staff failed to ensure that two (2) residents were free on hazardous chemicals; and to ensure that two (2) residents were in a safe and comfortable environment as evidenced by: maintenance staff spraying stain remover on the ceiling of two (2) residents ' room while the residents were in the room. Residents' #64, 233, 403, and 404. The findings include: 1. An observation was made on February 19, 2014 at approximately 10:00 AM. Employee #20 was observed spraying a can of "Hospiseptic, surface disinfectant deodorant" in the air as an air freshener (common area/television area) secondary to odor on the unit. Residents #64 and #233 were also observed sitting in the common at the time of the observation. At that same time Employee #19 had arrived on the unit, a query was made if Employee #20 was allowed to spray in the common areas around residents. Employee #19 retrieved the can of spray and read the label and stated "this spray is not to be used as an air spray" and removed the can from the cart and off of the unit.	F 323	3.An audit was conducted of all clean utility rooms and emergency carts to ensure that oxygen tanks were secured in the designated stands. Education was provided to housekeeping staff. 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 these audits and observations will be brought through monthly QAPI to ensure compliance and identify any additional educational requirements needed or further monitoring.	5/13/14

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F 323	Continued From page 103 Residents' #64 and #233 were queried if the spray had any effect on them. They both stated that "[he/she] was ok". Facility staff failed to ensure that residents were free on hazardous chemicals. The observation was made on February 19, 2014 2. Facility staff failed to ensure that Resident #403 and #404 were maintained in a safe and comfortable environment as evidenced by: maintenance staff spraying stain remover on the ceiling of two (2) residents ' room while the residents were in the room. Residents #403 and 404. On February 19 around 9:30 AM this surveyor was conducting an environmental tour in Room 222. While conducting an interview with the resident in Bed A, a hissing sound was heard emanating from Bed B. Just as the surveyor was preparing to enquire of the origin of the noise Resident #403 queried, " What is that? It smells awful. " At the time of the occurrence Resident #403 was seated in a wheel chair by the side of the bed. Resident #404 was lying in bed and receiving Oxygen via nasal cannula at the time of the incident. The resident was newly admitted to the facility and the Minimum Data Set (MDS) was not completed. The resident was alert and verbally responsive but did not respond when queried regarding whether he/she was bothered	F 323		

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F 323	Continued From page 104 by the spraying of the tiles. This surveyor queried of the maintenance employee what he/she was doing. The employee responded, " I am spraying the tiles to remove the stains. " The employee was advised to stop and informed that he/she could not continue the procedure while the residents were present in the room. The employee ceased what he/she was doing and exited the room. Facility staff failed to maintain a safe and comfortable environment for residents as evidenced by maintenance staff spraying stain remover on the ceiling of two residents ' room while the residents were in the room.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329	F-329 1.Residents #10, 78, 265, and 290 behavior monitoring sheets were added as needed and staff were educated on the need and importance of filling out the form. Resident #265 pain med orders were clarified with the physician and fixed in the physician's order sheet. A pain monitoring flow sheet was added to the record and staff were educated on the need and importance of filling out the form.	

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F 329	Continued From page 105 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 43 sampled residents, it was determined that facility staff failed to consistently monitor the behavior of one (1) resident and failed to monitor the behavior for one (1) resident for the use of psychotropic medications; and to determine parameters under which condition/s each pain medication was to be administered for one (1) resident. Residents' #10 and 78, #265 and #290. The findings include: 1. A review of Resident #10 ' s clinical record revealed that the resident was readmitted to the facility on May 22, 2013 with diagnoses which included Intermittent Explosive Disorder and Nondependent Alcohol Abuse. The resident was initially placed on Remeron 15mg PO [by mouth] q [every] HS [hour of sleep/bed time] for depression on admission (May 22, 2013). On January 24, 2014 the Remeron was increased to 30mg PO q HS. A review of the Medication Administration Revealed that the medication was administered	F 329	2.All residents have the potential to be affected by this deficient practice of the lack of adequate monitoring and indications for use of their medication regime. An audit will be completed on all residents to identify any lack of behavior monitoring forms completion, pain flow sheet monitoring, and/or adequate indications for use of their medications. 3.Nursing Management and Pharmacy Consultants reviewed the protocols for monitoring the use of psychotropic medication and made modifications as needed. Medication regimen reviews will be completed for each skilled resident by the consultant pharmacist at least monthly, or more frequently as needed, to ensure each resident's drug regime is free of unnecessary drugs. Nursing staff will be educated by the Pharmacy Consultants and Staff Development on behavior monitoring forms, pain flow sheet monitoring, and the need for adequate indications for use of all medications. The Unit Manager will review the behavior monitoring sheets and pain management flow sheets weekly to ensure compliance. Physician orders will be reviewed nightly by the 11-7 licensed staff for compliance with indication of use and monthly by the Unit Managers.	

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F 329	Continued From page 106 to the resident in accordance with the physician ' s orders. However, a review of the Behavior Monitoring Sheets for October, November, December and January revealed inconsistent monitoring as outlined below. There was no documentation for the evening shift for October 3, 5, 7, 12, 17, 18, 21 and 31 and no documentation for the day shift on October 4 and the night shift on October 16, 2013. There was no documentation for the evening shift on November 4, 9 and 23 and no documentation for the evening shift on December 8, 12, 16, 19, 20, 27, 28, 29, 30 and 31, 2013 and no documentation for the month of January 2014. A face-to-face interview was conducted with Employee #?? at approximately 3:00PM on March 5, 2014. During the interview the employee reviewed the MARs and acknowledged that the resident ' s behavior was not consistently documented on the Behavior Monitoring Sheets. The record was reviewed on March 5, 2014. 2. A review of Resident #78's clinical record revealed that the resident ' s diagnoses included Schizophrenia, Paranoid Type, Unspecified and Depression. The medications included Remeron 30mg q (every) HS (Hour of Sleep) for depression and Haldol 2 (two) mg q 12 hours for agitation. Review of the Medication Administration Record revealed that the medication was administered but lacked evidence to demonstrate that the resident ' s behavior was being monitored while	F 329	4. Compliance with follow through will be monitored monthly through the QAPI process by the DON and quarterly by Pharmacy Consultants. Any further education and/or counseling will be provided when identified by the compliance audits.	5/13/14

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F 329	Continued From page 107 he/she was receiving Haldol and Remeron. A face-to-face interview was conducted with Employee # (Watson) at approximately 3:50PM on March 4, 2014. The employee reviewed the record and acknowledged that the resident was receiving Psychotherapeutic medications (Haldol and Remeron) and that the record lacked evidence of behavior monitoring. The record was reviewed on March 4, 2014. 3A. Facility staff failed to fail to consistently and accurately monitor the residents ' behaviors on occasions when documented behavioral changes were observed. Resident # 265. A review of the clinical record revealed the following: February 6, 2014 Nurses Progress Note " Resident had an altercation with one of the CNA ' s. This occurred at 7:20 pm. Writer was not there when it happened but was informed by the CNA that [he/she] heard resident shouting and angry when [he/she] was attending to another resident. CNA said [he/she] cane to resident to ask [him/her] what [he/she] could her with but the resident being angry and upset tried to run her over with the wheel chair ... " February 18, 2014 Social Services Progress Note: " Resident threatened a male resident [another resident] in the Lobby, stating she would go and get her cain and hit him. He/She was upset because the other resident didn ' t move his w/c quick enough for her to pass by. He/She appeared to become very annoyed while cursing and threatening [another resident]..."	F 329		

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F 329	Continued From page 108 The February 7, and 18 2014 Behavior Monthly Flow Sheet indicated no adverse behaviors were noted was blank. There was no evidence that facility staff consistently and accurately monitored Resident #265' s behavior. There was no evidence the staff assessed and documented the residents behavioral changes in on the Behavior Monthly flow Sheet. A face-to-face interview was conducted with Employee #11 at approximately 4:40 PM on February 25 21, 2014. During the interview the Resident's Behavior Monthly Flow sheet and corresponding days progress notes were reviewed with the Employee#11 and he/she acknowledged that resident's behaviors were not accurately documented. The record was reviewed on February 25, 2014. 3B. Facility staff failed to determine parameters under which condition/s each pain medication was to be administered to Resident #265. A review of a Physician ' s Orders signed February 1, 2014 revealed two orders for pain medications under the heading of " PRN (As needed) medications. The first order was "Percocet (Oxycodone w/Acetaminophen)5-325 MG Oral - PRN PRN: Give Percocet 2 Tabs po Q 6 hrs. PRN Pain. " The second order was "Tramadol HCL 50 MG Oral (By mouth) - PRN PRN: 1 tab PO EVERY 6 HRS PRN pain " A review of the Medication Administration	F 329		

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F 329	Continued From page 109 Record (MAR) for February 2014 revealed that the Percocet was administered 22 times between February 1 and February 25, 2014; And The Tramadol was administered 8 times between February 2, 2014 and February 25, 2014. There was no evidence the facility staff documented the rationale for administering one medication vs the other. A face-to-face interview was conducted with Employee #11 at approximately 4:40PM on February 25, 2014. The employee was queried regarding the two orders of pain medications prescribed for the resident and the fact that both medications had been administered. The employee stated that the " We should have notified the physician and asked him/her for parameters. Facility staff failed to determine under which condition/s each pain medication was to be administered and to document the level of the pain prior to administering pain medication and the level of effectiveness after the resident was medicated. The record was reviewed on February 25, 2014. 4. Facility staff failed to consistently monitor Resident #290 ' s behaviors while receiving psychotropic medications. According to the physician ' s order dated December 31, 2014 directed Remeron 30mg- 1 tablet by PEG tube at bedtime for depression, Risperdal 1mg every evening at bedtime via G-Tube q HS (hour of sleep) for psychosis.	F 329		

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F 329	Continued From page 110 A review of the December 2014 Medication Administration Record (MAR) revealed the medication Remeron and Risperdal was being administered as directed by the physician. However, further review of the MAR revealed that the resident ' s behavior was not being consistently monitored while he/she was receiving the psychotropic medications. A face-to-face interview was conducted with Employee #4 on March 5, 2014 at approximately 10:30am. After reviewing the behavioral monitoring sheets, he/she acknowledged the aforementioned findings. The clinical record was reviewed on March 5, 2014.	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353	F-353 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.	

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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) COMPLETION DATE
F 353	Continued From page 111 duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, it was determined that sufficient nursing staff was not available to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The findings Include: During the survey, the following areas of concerns were indentified: Failure to provide necessary care and services (Failure to assess and monitor a resident with compromised respiratory status who subsequently expired within 12 hours of admission; Failure to assess and monitor skin for a resident who was diagnosed with dry gangrene of the toe; failed to appropriately manage a PICC line for a resident who consequentially sustained an infection of the bloodstream; failure to follow physicians orders and notify physician of status changes; failure to provide rehabilitative therapy (CPM)); Activities of Daily Living (failed to provide and or assist in daily personal grooming and daily hygiene); Pressure Ulcers and wounds (staging and documentation); failed to ensure that specialty consultations were obtained; Infection Control (observed breaches in practice); Care Planning (lack of care plans and/or amended care plans to meet resident	F 353	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 .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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F 353	Continued From page 112 needs); Pharmacy Services (failed to communicate drug irregularities); Minimum Data Set (incorrect coding and/or incorrect information); and inadequate staffing per the state regulations. There was no evidence that sufficient nursing staff was available to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observations, record review and staff and resident interviews, it was determined that sufficient nursing staff was not available to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The findings include: During the survey, the following areas of concerns were indentified: Failure to provide necessary care and services (Failure to assess and monitor a resident with compromised respiratory status who subsequently expired within 12 hours of admission; Failure to assess and monitor skin for a resident who was diagnosed with dry gangrene of the toe; failed to appropriately manage a PICC line for a resident who consequentially sustained an infection of the bloodstream; failure to follow physicians orders and notify physician of status	F 353		

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F 353	Continued From page 113 changes; failure to provide rehabilitative therapy (CPM)); Activities of Daily Living (failed to provide and or assist in daily personal grooming and daily hygiene); Pressure Ulcers and wounds (staging and documentation); failed to ensure that specialty consultations were obtained; Infection Control (observed breaches in practice); Care Planning (lack of care plans and/or amended care plans to meet resident needs); Pharmacy Services (failed to communicate drug irregularities); Minimum Data Set (incorrect coding and/or incorrect information); and inadequate staffing per the state regulations. There was no evidence that sufficient nursing staff was available to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 353	F-371 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. 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.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on February 19, 2014 at approximately 9:15 AM and on February	F 371		

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F 371	Continued From page 114 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 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.	F 371	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

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F 371	Continued From page 115 B. Based on an observation, and staff interview for one (1) of 43 sampled residents, it was observed that a staff member used bare hands to prepare (tare) the residents bread and served it to him. Resident #195 The findings include: During a dining observation conducted on February 19, 2014 at approximately 1:25 PM, it was observed that Employee #36 had used his/her bare hands to prepare (tare) a piece of bread and serve it to the resident. A face-to-face interview was conducted on February 19, 2014 with Employee #4 and Employee #36 at approximately 3:00 PM. After review of the above occurrence both acknowledged that the food was not prepared or served under sanitary conditions.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced	F 386	F-386 1.Resident #290 was seen by the Nephrologist on 3/12/2014. Recommendations for follow up were received and shared with the physician. Medical Director met with Physician to review resident's chart and to identify areas for better communication between Physicians, Nurse Practitioners and facility regarding follow-up.	

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F 386	Continued From page 116 by: Based on record review and staff interview for two (2) of 51 sampled residents, it was determined that the physician failed to review one (1) resident ' s nephrology follow-up status in his/her total plan of care. Residents ' #290 The findings include: A review of Resident #290 ' s clinical record revealed the resident was readmitted to the facility on June 5, 2013 and diagnoses included [Biliary] Non obstruction Renal Calculi. According to an interim physician ' s order dated August 29, 2013 directed; " Follow-up with nephrology [named doctor] ASAP (As soon as possible) for renal insufficiency. " A review of the doctor ' s progress notes revealed the following: August 17, 2013- Problem List (New) - Dehydration ..., BUN-75, Crt-1.8. Plan/Recommendations: [Increase] flushes, Repeat BMP. Signed: Attending Physician. 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-	F 386	2. Nursing Management will conduct a full audit of all Physicians' orders to ensure all consult recommendations have been addressed. Areas for improved communication and education will be identified for follow up. 3. Licensed Nurses and Unit Secretaries will be educated by Nursing Management and Medical Records Coordinator on a revised/ updated process for scheduling resident's consults and appointments. Review of appointment log will be conducted by Nursing Management and Medical Records Coordinator. Nurse Practitioners will involve the primary Physician with initiating consults to ensure the recommendations are followed up on and/or addressed. 4. Appointment log will be reviewed and audited by the ADON's and Medical Records Coordinator weekly for 3 months. Compliance with follow through will be monitored monthly through the QAPI process by the QA department/Nurse. Further education and/or counseling will be provided when identified by compliance.	5/13/14

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F 386	Continued From page 117 Continue flushes and IV (Intravenous Fluid) fluids; Assessment: Dehydration, P- Continue IV fluid [increase] rate- Continue water flushes. Signed: Attending Physician. 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 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 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. " A review of the physician ' s monthly orders from September 2013 to January 2014 revealed: " Reschedule resident for nephrology [appointment] with [named doctor] due to elevated BUN and Creatinine- Order Date: August 29, 2013. "	F 386		

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F 386	Continued From page 118 There was no evidence in the clinical record that the physician followed up to review the status of the nephrology consult prescribed for the resident. A telephonic interview was conducted with Employee #41 on February 28, 2014 at approximately 4:20 PM. When queried regarding the aforementioned findings, he/she stated that he/she did not realize that the resident did not follow-up with the nephrologist. He/she was not informed. Further stated; " I felt that the resident ' s dehydration was from not getting enough fluids. How can a resident get so dehydrated; especially if you are on a tube feeding, and getting 500 cc of fluid through the GT (Gastrostomy Tube)? " A follow-up face-to-face interview was conducted with Employee #7 on February 28, 2014 at approximately 4:30 PM regarding the aforementioned findings. He/she acknowledged the findings. The clinical record was reviewed on February 28, 2014.	F 386		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F-428 1.Resident #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 residents have the potential to be affected by this deficient practice of not ensuring the Consultant Pharmacist generate communication sheets for drug irregularities. A new Pharmacy Consultant Team started on March 1, 2014 and they conducted a complete audit of all residents medication records.	

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F 428	Continued From page 119 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 51 sampled residents it was determined that facility staff failed to 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] 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 "	F 428	3. The Pharmacy Consultant policy and protocols were reviewed with the new consultants and modified as needed. The consultants agreed to render the required service in accordance with local, State, and Federal Laws, regulations, and guidelines; Nursing Care Center polices and procedures; community standards of practice; and professional standards of practice. The new consultants have reviewed and followed-up with previous pharmacy recommendations with the nursing care staff. The consultants will document the completion of the review along with the consultant pharmacists signature and date on the MRR review/ pharmacist signature log. The consultants will submit a monthly summary report to the DON and Administrator outlining specific findings based on their medication regimen review following completion of the review. In-services were provided by the Consultant Pharmacists on the protocols for follow through on pharmacy recommendations and managing the gradual dose reductions with the physicians all pharmacy recommendations will be kept in the resident's record. DON will monitor pharmacy recommendations to ensure compliance with follow through.	

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F 428	Continued From page 120 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 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.	F 428	4.Compliance with follow through will be monitored monthly through the QAPI process by the DON and quarterly by the Pharmacy Consultants. Further education and/or counseling will be provided when identified by the compliance audits.	5/13/14

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F 428	Continued From page 121 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 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).	F 428		

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F 428	Continued From page 122 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.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	F-431 1.Retrospectively nothing could be done about this deficient practice. No residents were identified within this deficiency. 2. All residents have the potential to be affected by the facilities lack of consistency in maintaining records for the receipt and reconciliation of controlled medications.	

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F 431	Continued From page 123 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 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	F 431	3. 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 by Staff Development and outside consultant resources. The Narcotic reconciliation sheets will be audited weekly by Nurse Management to identify any areas of non-compliance. Further education and counseling will be provided as necessary. 4. 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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F 431	Continued From page 124 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 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 -	F 431		

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F 431	Continued From page 125 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 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.	F 431		

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F 431	Continued From page 126 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 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.	F 431	F-441 1.Resident #50 did not present with 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.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 127 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that	F 441	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 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 conduct random hand washing observation on all departments to ensure compliance with proper hand hygiene. IC Nurse scheduled quarterly IC in-services for the rest of the year.	

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F 441	Continued From page 128 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 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	F 441	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 minimum of 3 months to ensure compliance is being mandated.	5/13/14

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F 441	Continued From page 129 stipulated above.	F 441	F-456 1. The washing machine was repaired immediately on 2/26/2014 by HOLT INC .	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT 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. The findings include: 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.	F 456	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 and or 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
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 463	F-463 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.	

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F 463	Continued From page 130 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 51 resident's rooms. The findings include: 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.	F 463	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 was in-serviced to not wrap call bell cords around bed rails. 4. Utilizing the new audit tool the Director will report all deficient practices to the monthly QAPI Committee.	5/13/14
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined that administration 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	F 490	F-490 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 . 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.	

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F 490	Continued From page 131 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 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. The findings include: The facility administration 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	F 490	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. 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 Advanced Practical Nurse (NP) to assist with education and training on the units with all licensed nurses. We hired a new NP Certified Wound Care Nurse to assist Wound Team. A policy and protocol was written for all clinicians to do survey preparedness/chart audits per unit. A new RN Staff Development Director was also hired. 4. The QA Nurse will work with all department heads to ensure monthly tools are handed in and if thresholds are obtained other areas to improve will be addressed for monitoring and tracking. All items departments will begin reporting monthly to QAPI.	5/13/14
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in	F 492	F-492 1.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.	

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F 492	Continued From page 132 compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT 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 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.	F 492	2. Until we have all appropriate staff in place to meet the required PPD. All residents have the potential to be affected by this deficient practice. 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, and 5RNs were newly hired. During The week of March 3-6 additional interview were conducted and offers extended to additional staff for orientation on 3/11/14. From that orientation class we had 8RNs. On April 15, 2014 we had another orientation class and 5RNs were hired for that class. The DON has been conducting interviews and having oversight to hire competent and qualified staff to fill staffing needs identified. Nursing reviewing staffing levels daily at Clinical Morning Meetings 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 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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F 492	Continued From page 133 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 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	F 492		

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F 492	Continued From page 134 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 The review was made in the presence of the Employee #45 who acknowledged the findings.	F 492	F-493 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.	
F 493 SS=D	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined that the Governing Body failed to integrate, coordinate and monitor	F 493		

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

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F 493	Continued From page 135 the facility ' s practices related to the residents care and safety as evidenced by a failure to: provide supervision from accident hazards; 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 prevent the development and transmission of disease and infection; and provide a program for quality assessments and assurance that implements plans of action to correct identified quality deficiencies. The findings include: The 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	F 493	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. 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 Advanced Practical Nurse (NP) to assist with education and training on the units with all licensed nurses. We hired a new NP Certified Wound Care Nurse to assist Wound Team. A policy and protocol was written for all clinicians to do survey preparedness/chart audits per unit. A new RN Staff Development Director was hired. 4. The QA Nurse will work with all department heads to ensure monthly tools are handed in and if thresholds are obtained in other areas to improve will be addressed to monitoring and tracking. All items departments will begin reporting monthly to QAPI.	5/13/14
F 514	483.75(l)(1) RES	F 514	F-514 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.	

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F 514 SS=E	Continued From page 136 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: 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	F 514	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 educational 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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F 514	Continued From page 137 The findings include: 1. Facility staff failed to ensure that the established communication log for coordination 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	F 514	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 to 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	

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F 514	Continued From page 138 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 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 #3. 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	F 514	Line catheter protocol was reviewed by nursing administration to identify further areas of education needed for licensed staff. 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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F 514	Continued From page 139 Employee #11 on February 25, 2014 at approximately 4:06 PM. He/she acknowledged that Resident #3'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. 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	F 514		

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F 514	Continued From page 140 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 [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.	F 514		

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F 514	Continued From page 141 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 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.	F 514	F-520 1.No specific residents were identified for the concern regarding the requirements that the quality assurance committee developed corrective measures to address the concerns identified during the survey process. 2.All residents have the potential to be affected by this deficient practice. Interdisciplinary Management Team will audit resident's records to identify potential deficient practices as outlined in other tags. Data from these audits will be analyzed using root cause analysis to identify and correct the root causes of events that precipitated the system failure.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		

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F 520	Continued From page 142 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, resident and staff interviews, it was determined that the facility's Quality Assessment and Assurance (QAA) committee failed to develop, implement, and/or revise appropriate corrective actions for identified deficient practices as necessary.	F 520	3.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 problems, but to also identify other opportunities for improvement, and then 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; 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. 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 that will result in improvement or reduce the chance of the event recurring. The goal will be to make changes that will result in lasting improvements. This will be achieved through the new monthly QAPI process.	5/13/14

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F 520	Continued From page 143 The findings include: During the survey, the following areas of concern were indentified: Highest Practicable (failure to monitor resident assessed with compromised respiratory status; lack of management of central catheter; inadequate skin assessment; failure to follow physicians orders and obtain specialty consults) Pressure Ulcers and wounds (failure to consistently assess skin status; initial identification wounds at advanced stages); Infection Control Program (observed breaches in practice); Pharmacy Reviews (failure to communicate irregularities and failure for the physician/nurse practitioner to act upon pharmacy reviews); Minimum Data Set (incorrect coding and/or incorrect information; Staffing (inadequate) On March 7, 2014 at 10:30 AM, the Quality Assessment Coordinator and the Nursing Home Administrator were interviewed regarding their QAA Committee Meetings and identification of the concerns listed above. It was stated that many of the areas of concern had been previously identified corrective action plans were under development and new staff was in the process of being hired. There was no evidence that the Quality Assurance Committee developed corrective measures to address the concerns identified during the survey process.	F 520		