STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONS HEALTHCARE CAPITOL CITY	2425 25TH STREET SE W

(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 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Transitions Healthcare Capitol City from October 17, 2016 through October 25, 2016. Survey activities consisted of a review of 40 residents' clinical records during Stage 1; and review of 44 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center	F 000	Transitions Healthcare Capitol City is filing this Plan of Correction in accordance with State and Federal requirements. Submission of this Plan of Correction is not an admission of any of the deficiencies identified are correct. This Plan of Correction is to serve as the facility's credible allegation of compliance with all the requirements of the Medicare/Medicaid Programs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/25/16

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

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F 000	Continued From page 1 HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	**483.13 Develop/Implement Abuse/Neglect, etc. Policies** 1. An incident report was completed upon discovery that one had not been written. The attending physician, Department of Health and Ombudsman had previously been notified 2. A review of all incidents was conducted by the Director of Nurses to evaluate if any other residents were involved in allegations of abuse. None were found. 3. Facility staff was inserviced regarding prompt notification, incident reporting, and investigation of all allegations of abuse. The Nursing Quality Improvement Team will monitor the medical records and incident reports to ensure prompt response and reporting requirements are followed. The results of this monitoring will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/19/16 6/15/16 11/29/16 11/29/16

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This REQUIREMENT is not met as evidenced by:

Based on resident interview, staff interview and record review for one (1) of 44 Stage 2 sampled residents, it was determined that facility staff failed to (a) thoroughly investigate and address an allegation of an alleged sexual abuse of one (1) resident. Resident #12 and Resident #336 reported the allegation to the State Agency.

The findings include:

In response to a Stage 1 question: "Have you ever seen anyone being sexually abused the resident responded " yes." The resident identified the resident of the alleged abuse as his/her roommate. The resident then stated that a male resident had lifted his/her roommate's covers and placed his/her hands between the resident's legs. The incident occurred while they were in the hall. He/she could not identify the male but knows that he is a resident of the facility. He/she told CNA [Employee #33] of the incident. The resident added, " The manager came, took me to his/her office and asked me about the incident and I told him/her what I saw. I don ' t know what happened after that. "

A face-to-face interview was then attempted with Resident #12 on October 18, 2016 at approximately 11:30 AM. However, the Resident is nonverbal and was unable to respond to queries.

A face-to-face interview was conducted with Employee #6 at approximately 11:00AM on

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October 18, 2016. He/she was queried whether the facility was aware of Resident #336 ' s allegation of sexual abuse. The employee responded, " Yes " and added, " According to [Resident ' s name] the incident took place during the extermination of the resident ' s room and all of the residents were out of their rooms. When (Name of the Pesticide Company exterminates the facility. All residents are required to be out of their rooms while the extermination takes place.) We investigated the allegation but the resident ' s information could not be corroborated. We looked at the video camera but we did not see anything. " The employee was then asked whether the investigation was documented. He/she responded, " Yes. " A copy of the investigation was requested. The employee was also queried whether an Incident Report had been sent to the State Agency. The employee stated he/she did not know as he/she was not on duty at the time of the allegation.

The requested report was received at approximately 2:00 PM on October 18, 2016. The report was in the form of a nurse ' s note dated June 19, 2016 15:08. The nurse documented the following, " It was report to me at 11:25 am on 6/19/16 by RP [Responsible Party] [parent] of [named resident] that [his/her] roommate informed [him/her] while [he/she] was visiting yesterday at about 8:00pm that a [male/female] resident on [his/her] wheel chair was rolling [his/her] hand under the resident ' s blanket while they were in the hallway ... on Wednesday 6/15/16. Resident assessed. No bruises or symptoms of pain observed. MD [medical doctor] notified. DOH [Department of Health] and Ombudsman notified via message left .... "

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" [The informant] (named) was asked what happened? She said a male resident on his wheel chair was rolling his hand under [named resident ' s] blanket while they were in the hallway ... on Wednesday 6/15/16. When asked if he/she could identify the person involved [named resident] said [he/she] might not be able to identify the said individual on the wheel chair. Resident is being monitor throughout the shift. Report given to incoming shift to continue monitoring. "

A telephone interview was conducted with Employee #32 (Nurse who documented receiving the report from the resident ' s parent) at approximately 10:45 AM on October 24, 2016. Employee #32 acknowledged being responsible for the aforementioned documentation. When queried whether an Incident Report had been completed the employee stated, " No. "

Employee #33 whom the resident stated was informed of the incident was not available for questioning.

According to Section V. Investigation of the facility ' s policy titled " Abuse Prohibition-Abuse, Neglect, and Misappropriation of Resident ' s Property " Item A states: " The Administrator or the designated person will report alleged incident immediately to the local Department of Human Services and Licensing and Regulation " and Item B states;
" A thorough investigation will be initiated immediately for all alleged incidents of abuse involving staff members, residents, family and/or visitors who have potential knowledge of the incident or its circumstances. "

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F 226	Continued From page 5 A face-to-face interview was also conducted with Employee #2 at approximately 4:00PM on October 19, 2016. The employee was queried whether a full report had been completed and an Incident Report forwarded to the State Agency. In addition, Employee #2 acknowledged the findings. The facility failed to (a) thoroughly investigate and address an allegation of an alleged sexual abuse of Resident #12. The record was reviewed on October 19, 2016.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: A. Based on resident interview, staff interview and record review for two (2) of 44 Stage 2 sampled residents, it was determined that facility staff failed to accommodate two (2) residents ' needs and preference by failing to provide them with showers. Residents #336 and 457. The findings include: 1. During a face-to-face Stage 1 interview conducted on October 17, 2016 at approximately	F 246	**483.15(e)(1) Reasonable Accommodation of Needs/Preferences** **1. Resident #336** 1. Upon discovery, the resident was offered and received a shower. 10/20/16 2. Residents preference for a shower or bath was collected and entered on to the CNA Care Card in an effort to ensure that their preference was known and recorded for monitoring. 11/22/16 3. The nursing staff was inserviced on the accommodation of residents' bathing preferences. The Nursing Quality Improvement Team will audit on a monthly basis for compliance and will forward the results of these audits to the Director of Nurses. 11/22/16 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16	

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F 246	Continued From page 6 4:49 PM, Resident #336 stated that he/she has not had any showers for several weeks. Resident #336 further stated, " I cannot remember how long ago but I know it is a long time. The reason I do not get any showers is that the water is too cold. They (staff) usually heat the water in the microwave to wash me up in the mornings. " When asked how he/she felt about that the resident responded, " They [staff] do a good job when they wash me up but it would be nice to have a shower sometimes. " A review of the "Shower Sheets" (A form on which the staff documents when the resident receives baths/showers) was provided by the facility for September and October 2016 and revealed that the resident has had bed baths but no showers. A face-to face interview conducted with manager Employee #6 on October 19, 2016 at approximately 4:30PM. He/she reviewed the shower sheets and acknowledged the finding. 2. During a face-to-face Stage 1 interview conducted on October 18, 2016 at approximately 4:24 PM, Resident #457 was asked whether he/she chose the number of times a week he/she took a bath/shower. The resident responded, " I have not had a shower since I was admitted to the facility on the 26th of September [2016]. " The resident added, " They wash me up real good in the bed but I like showers. " A review of the resident ' s " Shower Sheets " (A form on which the staff documents when the resident receives baths/showers) revealed that Resident #457 received no showers between the	F 246	**483.15(e)(1) Reasonable Accommodation of Needs/Preferences** (continued) **2 A. Resident #457** 1. Upon discovery, this resident was offered and received a shower. 10/20/16 2. Residents preference for a shower or bath was collected and entered on to the CNA Care Card in an effort to ensure their preference was known and recorded for monitoring. 11/22/16 3. The nursing staff was inserviced on the accommodation of residents' bathing preferences. The Nursing Quality Improvement Team will audit on a monthly basis for compliance and will forward the results of these audits to the Director of Nurses. 11/22/16 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16	

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F 246	Continued From page 7 resident ' s date of admission to the facility (9/26/16) and the date of review (October 18, 2016). A face-to-face interview was conducted with Employee #6 at approximately 4:30 PM on October 19, 2016. The employee reviewed the shower sheets and acknowledged the finding. B. Based on observations made during the environmental tour of the facility on October 20, 2016 at approximately 2:30 PM and on October 21, 2016 at approximately 10:30 AM, it was determined that the facility failed to ensure that residents receive services with reasonable accommodations of individual needs as evidenced by call bells pull cords that were too short to be accessible in four (4) of 64 resident ' s bathrooms. The findings include: The call bell cords in the bathroom of resident room #359, #332, #250, #219, #129 were too short to be accessible to residents. These observations were made in the presence of Employee #21 who acknowledged the findings.	F 246	**483.15(e)(1) Reasonable Accommodation of Needs/Preferences** (continued) **2. B. Call Cords** 1. Call cords found to be too short were replaced upon discovery. 10/21/16 2. All call cords in the facility were inspected to ensure their proper length. Call cords were replaced whenever necessary. 10/31/16 3. The Maintenance Staff was Inserviced on the proper length of the call cords. The Maintenance Quality Improvement Team will monitor the length of the call cords on a monthly basis and report their findings to the Director of Facilities. 11/29/16 4. The Director of Facilities will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	**483.15(g)(1) Provision of Medically Related Social Service.** 1. The Social Worker involved has been counseled on the need for accuracy when coding Section Q and providing documentation to support referrals to agencies when discharge planning is requested by the resident or legal guardian. 10/31/16 2. An audit was done on other residents assigned to this Social Worker for discharge planning to ensure that interventions to connect the resident with communities supports and follow up of those supports, when requested, was present. 11/29/16	

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F 250	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 44 Stage 2 sampled residents, it was determined that facility staff failed to follow-up on possible discharge resources from the local agencies for Resident #93. The findings include: Resident #93 was readmitted to the facility on March 3, 2015. An annual history and physical dated April 4, 2016 revealed [his/her] diagnoses included: " [Status Post] Bowel Obstruction, Colostomy, Coronary Artery Disease, Hypertension Seizure Disorder and left AKA (Above the Knee Amputation). The resident ' s treatment [and/or] plan of care were: " Physical Therapy, Occupational Therapy, Treat hypertension and coronary artery disease. " The annual Minimum Data Set (MDS) with an ARD (Assessment Reference Date) of November 23, 2015 revealed that the resident was coded as " Cognitively Intact " based on a Brief Interview of Mental Status (BMS) score of 15 in Section C [Cognitive Patterns]. In response to Section Q0600 (Referral), " Has a referral been made to the Local Contact Agency? That section was coded " yes- Referral made. " There was no documentation in the clinical record regarding Local Contact Agencies that could provide information about community living	F 250	**483.15(g)(1) Provision of Medically Related Social Service.** (continued) 3. Inservice was conducted with the Social Work staff to review Section Q for the annual and quarterly MDS to ensure accurate coding and documentation for each resident. The Social Work Quality Improvement Team will audit the medical records on a monthly basis focusing on section Q and the accompanying progress notes. The results of these audits will be forwarded to the Director of Social Work for her review and assessment. 4. The Director of Social Work will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/29/16 11/29/16

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options and available supports and services.

A review of the care plan which was last updated on September 8, 2016 identified a focus that Resident # 93 presents as needing 24 hours of care and supervision secondary to diagnosis/medical condition. The following statement was noted under the heading of Goal: "Resident will have a post discharge plan that meets the resident ' s need at discharge if it is determined that discharge is an appropriate plan for [him/her]. "

The following interventions were listed as the mechanisms for accomplishing the aforementioned goals: " ... Writer will refer the resident to the DCOA/ADRC [District of Columbia Office on Aging/Aging and Disability Resource Center] program in November 2015 for possible discharge resources secondary to [his/her] annual assessment. The Social Worker will consult with the IDT and the resident will be assessed for discharge potential upon admission and quarterly. The Social Worker will communicate the residents ' status with discharge planning to all the appropriate people. Resident endorses wanting to be discharged to live with [his/her] [RP]. Family has not endorsed resident returning home at this time. Referrals to outside agencies will be made as the resident ' s medical condition improves and discharge becomes a reality. "

A review of the electronic progress notes revealed the following:
" December 12, 2015 at 12:33PM- Social Service

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Note: IDT (Interdisciplinary Team) summary note: Resident is oriented [times] three (3) and [his/her] long/short term memory appears to be intact ... Resident ambulates with a manual wheelchair ... Resident was referred to the DCOA/ADRC program in December 2015 for possible discharge resources secondary to [his/her] annual assessment. No concrete discharge plans or date, yet, "

December 14, 2015- 12:31 PM ... IDT conference note: Resident attended the IDT mtg (meeting), but [his/her] RP (responsible party) did not ...

February 29, 2016- 18:36 (6:36 PM) - Social Service Note ... Resident is oriented [times] three ... Resident ambulates with a manual wheelchair... Resident is a long term care resident until further notice and [his/her] RP (Responsible Party) agrees...

February 29, 2016- 18:33 (6:33 PM) ... IDT invite note: Writer invited the resident to [his/her] IDT meeting on 3-10-16 at 11:00 am and [he/she] will represent [himself/herself] ...

May 31, 2016- 15:50 (3:50 PM) Social Service Note ... Resident is oriented [times] three ... [Resident #93] ambulates with a manual wheelchair... Resident is a long term care resident until further notice and [his/her] RP (Responsible Party) agrees ...

May 31, 2016- 15:49 (3:49PM) ... IDT invite note: Writer invited the resident to [his/her] IDT mtg (meeting) on 6-9-16 at 11:15 am and [he/she] will represent [himself/herself] ... "

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F 250	Continued From page 11 August 24, 2016-17:11 (5:11 PM)- Social Service Note ... Resident is oriented [times] three ... [Resident #93] ambulates with a manual wheelchair... Resident is a long term care resident until further notice and [his/her] RP (Responsible Party) agrees ... August 24, 2016- 17:10 (5:10 PM)- IDT invite note: ... Writer invited the resident to [his/her] IDT mtg (meeting) on 9-8-16 at 11:15 am and [he/she] will represent [himself/herself]... " Review of the active clinical record lacked evidence that the social worker implemented interventions to connect the resident with community supports; as there was no evidence of follow-up with the referred local contact agencies. Also, there was no documentation of coordination of care with the resident and [RP] regarding discharge planning. A face-to-face interview was conducted with Employee #16 on October 24, 2016 at approximately 2:00 PM regarding the aforementioned findings. He/she acknowledged the findings. The clinical record was reviewed on October 24, 2016.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made on October 20,	F 253	**483.15(h)(2) Housekeeping & Maintenance Services** **1. Exhaust Vents** 1. Exhaust vents noted soiled at the time of the survey were cleaned upon discovery. 2. All exhaust vents were inspected by the Maintenance and Housekeeping staff for cleanliness. 3. The Maintenance Staff was Inserviced on the cleanliness of the vents. The Maintenance Quality Improvement Team will monitor the cleanliness of the vents on a monthly basis and report their findings to the Director of Facilities. 4. The Director of Facilities will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/20/16 10/20/16 11/29/16 11/29/16

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F 253	Continued From page 12 2016 at approximately 2:30 PM and on October 21, 2016 at approximately 10:30 AM, it was determined that the facility failed to provide essential housekeeping services to maintain a sanitary environment as evidenced by soiled exhaust vents in nine (9) of 64 resident ' s rooms and stained ceiling tiles in five (5) of 64 resident ' s rooms. The findings include; 1. Exhaust vents in the resident's bathroom on the G-Wing and in nine (9) of 64 resident ' s rooms were soiled on the inside with dust including room # 359, #347, #341, #323, #313, #258, #250, #201 and #145. 2. Ceiling tiles were stained in resident ' s rooms #201, #219, #243, #107, #114, five (5) of 64 resident ' s rooms surveyed. These observations were made in the presence of Employee #21 who acknowledged the findings.	F 253	**483.15(h)(2) Housekeeping & Maintenance Services (continued)** **2. Ceiling Tiles** 1. Ceiling tiles noted soiled at the time of the survey were replaced upon discovery. 2. All ceiling tiles were inspected by the Maintenance staff for cleanliness. 3. The Maintenance Staff was Inserviced on the cleanliness of the ceiling tiles. The Maintenance Quality Improvement Team will monitor the ceiling tiles on a monthly basis and report their findings to the Director of Facilities. 4. The Director of Facilities will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. discovery.	10/20/16 10/29/16 11/29/16 11/29/16
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272	**483.20(b)(1) Comprehensive Assessments** **1. Resident #247** 1. The Social Worker involved was counseled on the need for accurate coding of section Q and documentation to support referrals to agencies needed for discharge planning. 2. The charts of all residents followed by this Social Worker were audited to ensure the accurate documentation of section Q and accompanying progress notes addressing referral to community agencies, If needed, were also present.	10/31/16 11/25/16

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F 272	Continued From page 13 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 44 Stage 2 sample residents, it was determined that facility staff failed to code the quarterly Minimum Data Set (MDS) under Section Q (Return to community and Referral) for one (1) resident wanting to leave the community and one (1) resident for referral to a local contact agency. The findings include: 1. The facility staff failed to code the quarterly	F 272	**483.20(b)(1) Comprehensive Assessments** (continued) 3. Social Workers were inserviced to understand the intent of section Q, understand the components of section Q, and to understand how to accurately code section Q. The Social Work Quality Improvement Team will audit section Q and its supporting documentation on a monthly basis and submit the results of their audit to the Director of Social work for her review. 4. The Director of Social Work will present her findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/22/16 11/29/16

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F 272	Continued From page 14 MDS for the Resident #247 ' s return to the community. A review of Resident ' s Quarterly MDS dated July 28, 2016 revealed that Section Q Q0500 Return to community, " Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community " was coded as " 0 " indicating no. Section Q0600 Referral, " Has a referral been made to the local contact agency " was coded as " 0 " indicating no referral was needed. A review of the progress note dated July 28, 2016 stated, " Unit Social Worker and [Name] from DCOA (District of Columbia Office on Aging) are assisting the resident with locating an affordable, wheelchair assessable apartment. " A review of The care plan last initiated July 28, 2016 revealed an intervention, " Writer referred the resident to the DCOA/ADRC [District of Columbia Office on Aging/Aging and Disability Resource Center] program in October 2015 for possible discharge resources secondary to [his /her] annual assessment " . There is no evidence that the facility staff coded the quarterly MDS for the Resident ' s possible return to the community. A face-to-face interview was conducted with Employee #16 October 21, 2016 at 10:42 AM. He/she stated, " the Resident is working with [a representative] from District of Columbia office on Aging. The resident is eligible for Money Follows the Person program. [He/she] will need 24-hour care with some help from a family member or friend and [he/she] wants to return to the	F 272		

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F 272	Continued From page 15 community " . Employee #16 acknowledged the findings. The clinical record was reviewed on October 21, 2016. 2. Facility staff failed to accurately code the annual Minimum Data Sets (MDS) under Section Q for " Participation in Assessment and Goal Setting/Return to Community " for Resident #129. The annual MDS with an Assessment Reference Date (ARD) of December 9, 2015 was coded as " Yes " under Section Q, indicating a referral was made to a local contact agency. A quarterly MDS with an Assessment Reference Date of June 22, 2016 was coded " Yes " under Section Q, indicating a referral was made to a local contact agency. According to a social service note dated March 15, 2016 at 06:58 revealed: " ... He/she remains alert, oriented [times] two (2), verbally responsive and ambulatory. [Resident ' s name] Guardian endorses this placement and [he/she] remains a long-term care placement. [He/she] remains on ... caseload and has not presented any behavioral issues this review ... " There was no documentation in the clinical record of a referral being made to a local contact agency that could provide information about community living options and available supports and services. A face-to-face interview was conducted with Employees #14 and #16 at approximately 1:00 PM on October 20, 2016. The employees were queried regarding the referrals to the local contact	F 272	**483.20(b)(1) Comprehensive Assessments** (continued) **2. Resident #129** 1. The Social Worker involved was counseled on the need for accurate coding of section Q and documentation to support referrals to agencies needed for discharge planning. 10/31/16 2. The charts of all residents followed by this Social Worker were audited to ensure the accurate documentation of section Q and accompanying progress notes addressing referral to community agencies, if needed, were also present. 11/25/16 3. Social Workers were inserviced to understand the intent of section Q, understand the components of section Q, and to understand how to accurately Code section Q. The Social Work Quality Improvement Team will audit section Q and its supporting documentation on a monthly basis and submit the results of their audit to the Director of Social work for her review. 11/22/16 4. The Director of Social Work will present her findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16	

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F 272	Continued From page 16 agency and community discharge. Employee #14 stated that there was no referral made to the local contact agency. Both acknowledged that the MDS coding was incorrect. The clinical record was reviewed on October 20, 2016.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for three (3) of 44 Stage 2 sampled residents, it was determined that staff failed to ensure that each resident received and the facility provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care as evidenced by: Failure to consistently assess one (1) resident's pain level; failed to measure the circumference of the of the upper arm for a resident with a midline catheter and to flush the resident ' s midline catheter in accordance with the physician ' s order; and failed perform a comprehensive assessment of one (1) resident's intravenous site; and failed to obtain a physician ' s order for the medical trapeze [medical resident transfer device located over the head of a hospital bed that assists the patient	F 309	**483.25 Provide Care/Services for Highest Well Being** **1. Resident #25** 1. The resident was assessed for pain upon discovery. The resident was not in pain at that time. 10/23/16 2. A review of the MARs for residents receiving PRN narcotic pain medication was done and there were no other issues. 11/29/16 3. The licensed nursing staff was inserviced on accurate assessment and documentation of pre and post pain levels with the administration of PRN narcotic pain medication. The Nursing Quality Improvement Team will audit medical records on a monthly basis of all residents on PRN pain medication for on-going compliance. Their findings will be forwarded to the Director of Nurses for his review. 11/29/16 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16	

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F 309	Continued From page 17	F 309	**483.25 provide Care/Services for Highest Well Being** (continued)	

with positioning themselves] affixed to the resident's bed. Residents ' #25, #34 and #247.

The findings include:

1. Facility staff failed to consistently assess Resident #25's pain level.

The physician ' s order signed April 3, 2016 directed, " Oxycodone/APAP Tab (Opioid Analgesic) 5-325 mg- Give 2 tablets by mouth every 8 hours as needed for severe pain ... "

A review of the April 2016 MAR (Medication Administration Record) revealed the following:
Resident #25 was administered Oxycodone/APAP tablet 5-325mg- two tablets at 1200 AM [Percocet] on April 2, 2016, the pain was assessed as " pain 4/10; E- effective. "
Resident #25 was administered Oxycodone/APAP tablet-325mg- 2 tablets at 1854 (6:54PM) on June 9, 2016, the pain was assessed as " effective "
June 30, 2016 at 0331 AM- Pain level prior to administering Oxycodone/APAP tablet -325mg- 2 tablets, pain assessed as " 9. "

A review of the "eMAR- electronic Medication Administration Notes " revealed the following:
"April 2, 2016- 12:06 [AM]- pain 4/10
April 2, 2016- 12:08 [AM] - med not given. Pharmacy called. PRN (as needed) Percocet administered pain- 4/10
April 2, 2016- 15:04 (3:04 PPM)- Pain 5/10
April 2, 2016- 15:12 (3:12PM)- PRN administration was: Effective

June 9, 2016- 18:55 (6:55 PM)-

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F 309	Continued From page 18 Oxycodone/APAP, 2 tabs given PRN for pain June 9, 2016- 23:01 (11:01 PM)- PRN Administration was: Effective June 30, 2016- 03:32 (3:32 AM)- Generalized pain scale of 6/10... " There was no evidence facility staff consistently identified that Resident #25 had pain or conducted pain assessments pre and post administration of the pain medication. A face-to-face interview was conducted with Employees ' #4 and #23 on October 21, 2016 at approximately 11:00 AM. Both acknowledged the aforementioned findings. The record was reviewed on October 21, 2016. 2A. Facility staff failed to measure the circumference of Resident #34 ' s with a midline catheter in accordance with the Physician's order. A review of the "Central Line Catheter Protocol" [according to Employee #7 this form served as the protocol form managing the midline catheter and the physician ' s order] form dated October 12, 2016 section "Monitoring" indicated, " measure upper arm circumference .8 inches above insertion site on admission, Q (every) 5 days with dressing change and PRN (as needed) " A review of the Medication Administration Record, Treatment Administration Record and nursing notes did not show evidence that the order was transcribed or that the nursing staff measured the resident's arm circumference as ordered. A face-face interview was conducted on October	F 309	**483.25 Provide Care/Services for Highest Well Being** (continued) **2A. Resident #34** 1. This resident's arm circumference, external catheter length, and intravenous site were assessed and measured upon discovery. 10/25/16 2. A review of two other residents on IV therapy was performed immediately with corrections implemented where necessary. 10/25/16 3. The licensed nursing staff was inserviced on following the facility's vascular access protocols and physician orders. The Nursing Quality Improvement Team will audit medical records on a monthly basis of all residents on IV therapy for on-going compliance. Their findings will be forwarded to the Director of Nurses for his review. 11/29/16 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16	

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F 309	Continued From page 19 20, 2016 at 11:10 AM with Employee # 7. He/she acknowledged the findings. The record was reviewed on October 20, 2016. 2B. Facility staff failed to flush Resident #34 ' s midline catheter in accordance with the physician ' s order. A review of the physician ' s order dated October 16, 2016 [no time indicated] directed, " flush midline on left arm with 5 ml normal saline daily . " A nurses note on October 16, 2016 at 04:55 revealed " Resident finished [his/her] second bag of D5W [intravenous fluid that contains 5% dextrose in water] 50 ml/hr at 1:30 AM via midline on left arm. Midline site on left hand is intact, no bleeding, no swelling noted. " A review of the October 2016 Medication Administration Record revealed that there was an order to flush midline [catheter] on left arm on with 5 ml daily every day shift for open line start date October 18, 2016. Also, there was an initial and a check mark in the designated box on October 18, 2016 which indicated that the Resident first received the flush on that date. According to the nursing progress note Resident #34 ' s hydration therapy ended on October 16, 2016 at 1:30 AM. There was no evidence facility staff flushed the Resident ' s midline catheter starting on October 17, 2016. A face-to-face interview was conducted on October 20, 2016 at 11:10 AM with Employee # 7. He/she acknowledged the findings. The record was reviewed on October 20, 2016.	F 309	**483.25 Provide Care/Services for Highest Well Being** (continued) **2B. Resident #34** 1. This resident's midline catheter was assess and flushed upon discovery. 2. A review of two other residents on IV therapy was performed immediately with corrections implemented where necessary. 3. The licensed nursing staff was inserviced on following the facility's vascular access protocols and physician orders. The Nursing Quality Improvement Team will audit medical records on a monthly basis of all residents on IV therapy for on-going compliance with flushing the IV site. Their findings will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/25/16 10/25/16 11/29/16 11/29/16

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F 309	Continued From page 20 2C. Facility staff failed to perform a comprehensive assessment of Resident #34 ' s intravenous site. An interim order dated October 24, 2016 [no time indicated] directed, " D5W at 50 ml/hr x 2 liters via left arm midline [catheter] x 48 hours ... " A review of the nursing progress note dated October 24, 2016 at 2300 hours, revealed, " Hydration therapy was initiated, but on reassessment midline was patent but signs of infiltration was noted on midline site on left arm. Resident denies pain, no distress, no discomfort noted. No respiratory distress noted, lung sounds clear on auscultation, respiration even and unlabored. V/S (vital signs): 130/86, Pulse 79, Respirations 18, Temp 98.1 Fahrenheit, O2 saturation 97% on room air. [Physician] notified, order given to hold D5W for 2 days, continue to monitor midline site every shift...SIC " A review of the October 2016 Treatment Administration Record revealed: October 11, 2016 at 1500 [3:00 PM] the order was recorded as " Check for infiltration signs and symptoms of infection every shift for right forearm IV (intravenous) site. " However, there was no evidence of a IV site to the resident ' s right forearm from October 12, 2016 through October 20, 2016. In addition, there was no evidence staff checked for signs and symptoms of infiltration on the resident ' s left arm from October 12, 2016 evening shift and stopped on October 20, 2016 day shift. In addition, an order was entered on October 12,	F 309	**483.25 Provide Care/Services for Highest Well Being** (continued) **2C. Resident #34** 1. This resident's intravenous site was assessed upon discovery. 2. A review of two other residents on IV therapy was performed immediately with corrections implemented where necessary. 3. The licensed nursing staff was inserviced on following the facility's vascular access protocols and physician orders. The Nursing Quality Improvement Team will audit medical records on a monthly basis of all residents on IV therapy for on-going compliance of comprehensive assessment of the IV site. . Their findings will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/25/16 10/25/16 11/29/16 11/29/16

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F 309	Continued From page 21 2016 at 1500 which directed, " Observe left arm every shift for midline site check every 2 hours and document in nursing notes. " It was documented that staff observed the left arm every shift from October 12, 2016 evening shift, and stopped on October 20, 2016 day shift. There was no evidence that staff continued to monitor/observe the resident's left arm after October 20, 2016. There was no evidence that nursing staff completed a comprehensive assessment related to the status of the infiltrate such as: recording the circumference of the left arm, inflammation at or near the insertion site, an assessment of pain at the site, was the infusion of the fluids slowed or stopped and was there backflow noted. In addition, there was no documentation in the clinical record to reflect the time the fluids were hung, the amount of fluid recorded when hung, infused and remaining. A face-to-face interview was conducted on October 25, 2016 at approximately 11:00 am with Employee # 7. He/she acknowledged the findings. The record was reviewed on October 25, 2016. 3. Facility staff failed to obtain a physician ' s order for the medical trapeze device that was observed affixed to Resident #247 ' s bed. A face-to-face interview was conducted on October 20, 2016 at 10:30 AM with Resident #247. During the time the resident was observed in bed. The resident was asked, " Do you use your trapeze device? " The Resident responded,	F 309	**483.25 Provide Care/Services for Highest Well Being** (continued) **3. Resident #247** 1. A physician order was obtained for this resident's trapeze immediately upon discovery. Rehab educated the resident on its use. 11/25/16 2. No other residents currently in the facility have a trapeze. 11/25/16 3. The nursing staff will be inserviced on obtaining orders for such assistive devices and ensuring that care plans are updated and the resident is educated about its use. The Nursing Quality Improvement Team will audit medical records on a monthly basis of all residents with such devices for on-going compliance in having a physician order for their use. Their findings will be forwarded to the Director of Nurses for his review. 11/29/16 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16	

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"Yes. I do it all the time. " The Resident then demonstrated by reaching up with his/her right arm, grabbed the end of the trapeze pole and repositioned him/herself. At this time, it was also observed that the metal chain attached to the triangular bar was wrapped around the top back portion of the device, not in position for the resident's use. The Resident stated, "I use the end of the pole. " Also noted on the bar itself were two (2) bags containing personal use items. The Resident was asked, " Why are there bags hanging on the trapeze pole? " The Resident stated, " I keep them close to me so they can be reached. "

A face-to-face interview was conducted with Employee #13 on October 20, 2016 at 11:48 am. He/she stated, " The resident does not use the trapeze bar to move himself/herself, [he/she] is totally dependent for all activities of daily living. In July of this year, when the resident was away from [his/her] room, we removed the trapeze [device]. Upon return to [his/her] room, [he/she] requested the trapeze [device] be brought back. [He/she] called the Ombudsman to obtain assistance in getting the trapeze returned. At that time, we returned the trapeze. Again [he/she] was told not to hang bags from the trapeze [pole]. "

A face-to-face interview was conducted with Employee #7 on October 20, 2016 at 10:47 AM. The Employee was asked, "Why does the resident have bags hanging from the trapeze pole? He/she stated, "The resident has been told many times not to hang bags from the trapeze [device]. We do go into [his/her] room to remove the bags often."

A review of the Resident clinical record lacked

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F 309	Continued From page 23 evidence of a physician ' s order for placement or use the trapeze device. The last rehabilitation evaluation for bed mobility and transfers was conducted on October 22, 2015. The evaluation revealed that the resident required total assistance for bed mobility and transfer, no skilled physical therapy services needed. There was no evidence documented which indicated that the resident was assessed for the use of the trapeze device. A review of the physician ' s order form printed October 20, 2016 revealed that there was no order found to direct the placement and use of the trapeze device. The care plan was last updated on August 11, 2016 revealed that interventions, Focus Note dated November 16, 201 stated, " Resident have a preference of hoarding items which make [his/her] room clutter. " Employee #7 stated, "Educate resident on the unsafe habit of hanging plastic bag with food on the trapeze. " However, there was no note regarding when the resident was educated or evaluated for safe use of trapeze device. There was no evidence that facility staff obtained a physician ' s order for the use of the trapeze device. The clinical record was reviewed on October 20, 2016.	F 309	**483.25(a)(2)Treatment/Services To Improve/Maintain ADLs** 1. The resident was assessed by Rehab Department upon discovery and was assigned to an appropriately fitted chair. 2. A review of all other residents who ambulate with the assistance of a wheelchair to ensure the proper sizing of each chair. Corrections were made when necessary. 3. The nursing staff was inserviced to ensure they are referring residents to Rehabilitation for the fitting of every chair and/or ambulation device. The Nursing Quality Improvement Team will audit medical records on a monthly basis of all residents with such devices for on-going compliance for fit of each wheelchair.. Their findings will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/17/16 10/31/16 11/29/16 11/29/16
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.	F 311		

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This REQUIREMENT is not met as evidenced by:

Based on observation, record review and staff and resident interview for one (1) of 44 Stage 2 sampled residents, it was determined that facility staff failed to provide a wheel chair that would enhance that resident ' s mobility by allowing the resident to propel him/herself within the facility. Resident #336.

The findings include:
During a face-to-face interview with Resident #336 on October 17, 2016 at approximately 4:10 PM the resident stated, " I sure wish I had a wheel chair that fit me. This wheel chair is too big for me and when I sit in I can ' t go anywhere by myself. I have to wait for somebody to push me. " Pointing to his/her feet the resident said, " See, when I sit in the chair my feet cannot touch the floor. If my feet touched the floor I could push myself along. " The resident was asked whether the chair belonged to him/her or to the facility. He/she responded, " The person who gave me the chair does not work here anymore. When they gave me the chair I was heavier and the chair fit me. Now I am smaller and the chair is too big for me. "

On observation of the chair it was approximately 12 inches larger than the resident ' s body and the resident ' s feet were greater than six (6) inches from the floor.

A review of the Nursing and the Rehabilitation Department ' s documentation there was no information about the resident ' s lack of mobility while seated in the wheel chair.

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F 311	Continued From page 25 A face-to-face interview was conducted with Employee #25 at approximately 1:30 PM on October 20, 2016. The employee was asked assess the resident ' s chair. After assessing the chair he/she acknowledged that the chair was an incorrect fit for the resident. The record was reviewed on October 20, 2016.	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 record review and staff interview for one (1) of 44 Stage 2 sampled residents, it was determined that facility staff failed to consistently assess and monitor the condition of Resident #227 ' s skin to ensure that necessary treatment and services were provided. Subsequently, the resident developed an Unstageable Sacral Pressure Ulcer that was initially identified at an advanced stage. The findings include: Policy:	F 314	**483.25(c) Treatment/Svcs to Prevent/Heal Pressure Sores** 1. This resident no longer resides at our facility. 10/18/16 2. A skin sweep was performed on all residents by the wound team which is headed by a CWON to ensure that all residents were assessed and subsequently monitored to ensure the necessary treatment and services are provided. 11/15/16 3. Licensed and certified nursing staff were retrained on the facility policy and procedure for proper skin/wound assessment and monitoring. The Assistant Directors of Nurses, Clinical Managers and House Supervisors will monitor and audit this process weekly to ensure compliance and report all of their findings to the Director of Nurses for his review. 11/29/16 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16	

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" CLIN-027 Skin Care - Preventive Care; Revision date 3/21/16 [March 21, 2016]
Purpose: To identify residents who are at risk for the development of skin breakdown. To provide nursing interventions to prevent skin breakdown whenever possible.

Policy:
1. Residents will be assessed using the Braden scale (tool used for predicting pressure sore risk). On admission and readmission, quarterly, and whenever an (Minimum Data Set) MDS is completed for change of condition ...
2. Nursing care measures will be instituted based upon the risk assessment score. An individualized care plan will be developed addressing the risk of and actual skin breakdown.
3. Newly admitted residents who are non-ambulatory and/or incontinent of bowel/bladder are considered at risk for skin breakdown and will have preventive measures initiated.
4. Resident ' s skin will be inspected daily by the GNC (G Nursing Assistant) and he/she will report abnormal findings to the nurse.
5. A nurse will assess the resident ' s skin condition weekly and document findings ...

Procedure

1. Residents who are incontinent will be checked at least every 2 hours and PRN [as needed] If soiled, perineal area will be cleansed using perineal cleaner. Pat dry ....
5. Residents who are dependent in bed/chair mobility will be turned and repositioned at least every 2 hours. Positioning devices will be used to avoid pressure on bony prominence and pressure

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F 314	Continued From page 27 over skin-to-skin contact surfaces (e.g., between knees). Procedure: ...10. If identified by the Braden scale as risk, the following will be implemented: a. All general measures listed above in the policy, b. Pressure reduction mattress c. Pressure reduction cushion when OOB (out of bed) d. Dietary recommendations for nutritionally compromised resident e. " Potential for Skin Breakdown " will be identified as a problem on the care plan list f. Develop care plan to address individual needs ... " Resident #227 was admitted to the facility on July 18, 2016 with the following diagnoses: Aortic Aneurysm S/P [Status/Post] EVAR (Endovascular Aneurysm Repair). A review of the History and Physical examination signed by the physician July 20, 2016 revealed that Resident #227's skin was " intact" at the time of admission. A review of the Admission Minimum Data Set [MDS] dated July 25, 2016 revealed under Section G0110 Activities of Daily Living (ADL ' s) that Resident #227 was coded as (3) requiring that the resident needed extensive assistance of two (2) persons for bed mobility, transfer, dressing, toilet use personal hygiene, and bathing. Section G0600-Mobility Devices revealed the resident required a wheelchair for mobility and	F 314		

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under Section H- Bladder and Bowel, Resident #227 was frequently incontinent of urine and always incontinent of bowels. Section M-Skin Conditions revealed the resident was coded in Section M0150 as at risk for developing pressure ulcers; M0210 the resident was coded as having no unhealed pressure ulcers upon admission.

A review of the Physician ' s Orders for July 2016 directed:

" ...Original order date July 18, 2016: (1) Barrier cream to buttocks for protection and miniaturization [moisturize] every shift, (2) Braden scale quarterly and PRN (as needed); (3) Braden scale weekly x 4 every evening shift, every mon [Monday] for 4 weeks], (3) turn and reposition, (4) weekly skin checks, turn and reposition every 2 hours and as needed, every shift;

Order date July 18, 2016, start date July 25, 2016: Weekly skin check by licensed nurse every day shift every mon (document and notify MD/NP for new findings.) "

Order date August 2, 2016: " Air mattress "

Order date August 8, 2016: " Cleanse with Normal Saline, pat dry, apply Santyl followed by Calcium Alginate, cover with dry dressing ... "

Order date August 20, 2016 " transfer resident to ER for sacral eval [evaluation] for possible infection. "

Order date August 21, 2016 " Transfer via Life Star as situation not an emergency ... "

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A review of the Admission Nursing Assessment dated July 19, 2016 00:41 [12:41 AM] indicated that the resident ' s Skin integrity was normal color, temperature was warm and dry, skin turgor was normal and the resident did not have a pressure sore upon admission to the facility. The assessment also showed that the resident required extensive assistance with ADL ' s [Activities of Daily Living].

A Braden Scale assessment [Used for predicting pressure sore risk] dated July 18, 2016 revealed that the resident scored " 13 " which indicated that the resident was at moderate risk for skin breakdown. The Braden Scale also revealed that the resident " responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort; occasionally moist which would require extra linen change ...; Chairfast indicating the residents ' ability to walk was severely limited or non-existent ...; Mobility was very limited indicating the resident makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. "

A review ofse " Progress Notes " dated July 19, 2016 revealed "...Resident skin is warm and dry to touch, skin intact but for the right groin surgical site for the aortic dissection, which measures 1.5cm wide and 3cm long... Resident needs extensive assist with transfer and to be turn and reposition q [every] 2hr [hours] for pressure relief and for comfort..." There was no evidence in the clinical record that Resident #227 was admitted to the facility with a sacral pressure sore. However,

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F 314	Continued From page 30 licensed staff documented the initial assessment of an unstageable sacral wound on August 2, 2016 as follows: A nurse ' s entry dated August 2, 2016 at 20:34 (2:34 AM), " Late entry ...Dr. [named] called and orders given. Cleanse sacral wound with normal saline, pat dry, apply hydrogel and cover with borders ... " A review of the facility ' s " Weekly Wound Report " revealed documentation recorded by the licensed nurse on August 2, 2016, ' unstageable pressure wound of the sacrum ...size, 6x6x0.5 cm (centimeter) with 50% slough, 50% granulation, moderate serous sanguineous drainage ... ' A review of the Activities of Daily Living Flowsheets [ADL tracking recorded by certified nurse assistants] for Resident #227 indicated that from July 18, 2016 through August 2, 2016 the resident was totally dependent on staff for bed mobility which included when the resident was turned and repositioned by staff; the resident did not have any behavior symptoms observed except for July 29, 2016 23:29 [11:39 pm] in which the resident was observed " Yelling/screaming. " Under the Skin Observation section, the resident was first identified with an open area by the CNA on July 30, 2016 at 21:15, July 31, 2016 at 19:49 [7:49 PM] and August 2, 2016 at 10:52 AM. The Bladder and Bowel Continence section revealed the resident was always incontinent, however the resident was provided incontinent care no more than once per shift. There was no evidence that the CNA informed the licensed nurse of the open area that was observed three (3) days prior to the Charge nurse	F 314		

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F 314	Continued From page 31 ' s first assessment of the wound on August 2, 2016. A review of the "Comprehensive CNA [Certified Nursing Assistant] Shower Review " revealed that the resident was offered a bath, shower or bed bath on July 25, 2016, which he/she refused as evidenced by the word refused written on the line for reason and a check mark on the " No " line, no comments were noted in the Charge Nurse Assessment/Intervention section, however the charge did sign the sheet. On July 26, 2016 the resident received a shower as evidenced by a check mark on the line for shower, with the CNA ' s signature, no comments for assessment/intervention was made by the charge nurse although he/she signed the shower sheet. On July 28, 2016 the resident refused a bath, shower or bed bath as evidenced by a check mark on the space for " No " and the word " refused " was written on the line next to reason ...the CNA's signature along with the charge nurse signature was noted on the sheet. However, there were no comments in space designated for the charge nurse assessment/interventions. The resident received a shower on July 30, as evidenced by the CNA ' s signature and check mark in the space for shower. The Charge nurse signed the sheet, however there were no comments in space designated for charge nurse assessment/interventions and there were no descriptions of any skin abnormalities identified on the body chart. On August 3, 2016 there was a check mark in the space for shower, as evidenced by the CNA ' s signature, however there was no description of the skin identifying the skin abnormality of the sacral area. The shower was given one (1) day after the wound	F 314		

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was discovered. There were no comments made by the charge nurse in the " Charge Nurse Assessment/Intervention " section although the charge signed the sheet.

There was no evidence in the clinical record that a pressure reduction mattress was implemented once the resident was assessed with a moderate risk of developing skin breakdown as stipulated in the facility ' s skin care policy. The pressure reduction mattress, according to the Physician ' s Orders was not ordered until August 2, 2016, the day that the unstageable wound was discovered.

A face-to-face interview was conducted on October 24, 2016 with Employee #6 at approximately 11:20 AM. He/she stated that the resident did not have any skin breakdown upon admission, the resident was a very " skinny " [small framed] person and the resident would like to sit up for long periods of time.

A face-to-face interview was conducted on October 24, 2016 with Employee #22 at approximately 3:00 PM. He/she stated that he/she saw the resident on August 16, 2016 the resident was non-compliant, [his/her] condition went down fast. I saw the resident when I was contacted by staff to see the resident.

A face-to-face interview was conducted on October 24, 2016 with Employee #28 at approximately 10:15 AM. He/she stated that he/she " took care of the resident on July 30, 2016 which the resident had [his/her] wound before I did ADL on [him/her.] "

A face-to-face interview was conducted on

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F 314	Continued From page 33 October 24, 2016 with Employee #29 at approximately 10:55 AM. He/she stated " the last I cared for [Resident #227] was on July 22, 2016, there was no wound. The end of July (July 28, 2016) there was a very little skin tear." The clinical record lacked evidence that facility staff consistently assessed and monitored the condition of Resident #227 ' s skin although the resident was identified as a " moderate risk " for skin breakdown. Resident #227 sustained a facility acquired unstageable pressure wound of the sacrum approximately 2 weeks following admission. The record was reviewed October 24, 2016.	F 314		
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: Based on observations made on October 18, 2016 at approximately 10:00 AM and on October 19, 2016 at approximately 2:15 PM and interviews held on October 21 at approximately 11:00 AM, it was determined that facility staff failed to ensure that resident's environment remain free of accident hazard as evidenced by a frayed call bell in one (1) of 64 resident ' s rooms, a damaged entrance door in one (1) of 64	F 323	**483.25(h)Free of Accident Hazards/Supervision/Devices**	

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F 323	Continued From page 34 resident ' s rooms, unsecured oxygen tanks in two (2) of 64 resident ' s rooms ; the use of a single edge razor blade by one (1) resident for personal use and failed to consistently update the assessments/evaluations for one (1) resident who was identified as a smoker. Resident #129 The findings include: 1. A. The call bell in resident room #313 was frayed, one (1) of 64 resident ' s rooms. B. The entrance door to resident room #106 was chipped in several areas and had some sharp edges that constituted an accident hazard in one (1) of 64 resident ' s rooms. C. Oxygen tanks in two (2) of 64 resident ' s rooms were stored on the floor and were not secured on an oxygen cart. (Room #116 and #120). D. On October 18, 2016 at approximately 10:00 AM, Resident #93 was observed using a single-edge razor blade to cut out newspaper articles for personal use. The resident stated that he/she has been using a blade since he/she has lived in the facility and it ' s a hobby he/she enjoys. In a face-to-face interview on October 21 at approximately 11:00 AM, the resident said that the facility staff had never seen [him/her] use the razor blade and was not aware that he/she had one. The resident said that [his/her] [family member] brought [him/her] the razor blades and [he/she] only uses them to cut out the newspaper	F 323	**483.25(h) Free of Accident Hazards/Supervision/Devices** (continued) **1. A. Call Bell** 1. The call bell was replaced upon discovery. 10/25/16 2. All call bells in the facility were reviewed to ensure no other ones were frayed. All call bells were found to be in compliance. 10/25/16 3. The Maintenance Staff was Inserviced on the replacement of call bells. The Maintenance Quality Improvement Team will monitor the call bells on a monthly basis and report their findings to the Director of Facilities. 11/29/16 4. The Director of Facilities will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16 **B. Resident Room Door** 1. The resident room door was fixed Immediately. 10/25/16 2. No other doors required such repair. 10/25/16 3. The Maintenance Staff was Inserviced on the maintenance of the room doors. The Maintenance Quality Improvement Team will monitor the room doors on a monthly basis and report their findings to the Director of Facilities. 11/29/16 4. The Director of Facilities will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16	

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F 323	Continued From page 35 articles. Resident #93 further stated that [he/she] keeps the blade(s) concealed in a drawer in [his/her] cabinet. When asked how he/she disposed of the razor blade when he/she is finished with it, the resident replied that [he/she] covers the blade with paper, puts it in a plastic bag and throws it in the trash. During a face-to-face interview with Employee #7 and Employee #31 on October 21, 2016 at approximately 11:10 AM, both employees said that they were not aware that Resident #93 had a razor blade or used a razor blade to cut out newspaper articles. Observations 1, 2 and 3 were made in the presence of Employee #21 who acknowledged the findings. 2. Based on record review and staff interview for one (1) of 44 Stage 2 sampled residents, it was determined that facility staff failed to consistently update the assessments/evaluations for Resident #129 who was identified as a smoker. The findings include: According to the facility ' s " Smoking Policy and Guidelines for Residents " OPS- (last updated 7/15/16) stipulates: " ... Procedure- 1. A smoking assessment will be performed by designated staff for all residents who request to smoke. The assessment is designed to determine the level of supervision required for each individual, 2. Facility staff will provide supervision if a need is determined by the smoking assessment, 3. A reassessment will be performed quarterly ... "	F 323	**483.25(h) Free of Accident Hazards/Supervision/Devices** (continued) **C. Oxygen Storage** 1. The oxygen tanks were immediately secured to an oxygen cart.	10/25/16
			2. All other oxygen tanks in resident rooms were inspected to ensure all were stored properly. No further corrections were needed.	10/25/16
			3. The Nursing Staff was Inserviced on the proper storage of oxygen tanks. The Nursing Quality Improvement Team will monitor Oxygen storage on a monthly basis and report their findings to the Director of Nurses..	11/29/16
			4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/29/16
			D. Use of a Razor Blade 1. The resident has agreed to allow the nursing staff to store his razor blade in the Nursing medication cart when not in use and to be monitored when he is using the razor blade for his scrapbooking hobby and to be involved when he is ready to dispose of the razor blade.	11/25/16
			2. No other residents are affected.	11/25/16
			3. Nursing staff on the unit have been Inserviced to monitor the resident's storage, use and disposal of his razor blades.	
			4. The Director of Nurses will report on this issue at the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/29/16

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F 323	Continued From page 36 The resident was evaluated and classified as an independent smoker on November 1, 2015. A review of the clinical record revealed that the resident had no review of his/her smoking status from January 2016 through August 2016. On September 1, 2016 the resident was identified as dependent smoker [related to] noncompliance to smoking policy due to impaired cognition. A review of the clinical record for Resident #129 revealed that the facility failed to evaluate the resident ' s smoking ability quarterly as directed by the smoking policy. A face-to-face interview was conducted with Employees # 4 and #15 at approximately 1:00 PM on October 20, 2016. Both reviewed the resident ' s electronic clinical record and acknowledged that smoking reassessments for Resident #129 were not consistently updated. The clinical record was reviewed on October 20, 2016.	F 323	**483.25(h) Free of Accident Hazards/Supervision/Devices** (continued) **2. Resident #129** 1. The involved Social Worker has been counseled regarding the need for accurate and timely smoking assessments. 2. The medical records of all other residents who smoke were reviewed to ensure accurate and timely smoking assessment. Corrections were made when found. 3. Inservice was conducted with the Social Work staff to review the facility policy on timely and accurate documentation specific to Smoking Assessment. The Social Work Quality Improvement Team will audit the medical records on a monthly basis focusing the timely and accurate documentation of smoking assessments. The results of these audits will be forwarded to the Director of Social Work for her review and assessment. 4. The Director of Social Work will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/2/16 11/26/16 11/2/16 11/29/16 11/29/16
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**483.35(i)Food Procure, Store/Prepare/ Serve - Sanitary** 1. Soiled Deep Fryers 1. The soiled fryer was cleaned upon discovery. 2. The second deep fryer was not in need of cleaning. 3. Kitchen staff was inserviced on when and how the deep fat fryers are cleaned. The supervisors will monitor throughout the month and report their findings to the	10/20/16 10/20/16 10/27/16

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F 371	Continued From page 37 This REQUIREMENT is not met as evidenced by: A. Based on observations made on October 20, 2016 at approximately 10:00 AM, it was determined that the facility failed to prepare, and serve food under sanitary conditions as evidenced by one (1) of two soiled (2) deep fryers, two (2) of three (3) expired containers of honey flavored thickened fluid, one (1) of two (2) soiled six-inch deep pan, and three (3) of eight (8) full pans and one (1) of two (2) six-inch deep pans that were dented. The findings include: 1. One (1) of two (2) deep fryers was soiled with burnt food residue. 2. Two (2) of three (3) forty-eight-ounce containers of honey flavored thickened fluid were expired as of September 4, 2016. 3. One (1) of two (2) six-inch deep pans was soiled with leftover food residue. 4. Three (3) of eight (8) full pans and one (1) of two (2) six-inch deep pans were dented. These observations were made in the presence of Employee #27 who acknowledged the findings.	F 371	**483.35(i)Food Procure, Store/Prepare/ Serve – Sanitary** (continue) 3. (continued) Director of Nutritional Services. 4. The Director of Nutritional Services will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. **2. Expired Containers** 1. The product found to be outdated were removed from stock and discarded. 2. The store room stock was reviewed to ensure no other products were outdated. 3. Kitchen staff was inserviced on when and how to rotate products in the stock room. The supervisors will monitor throughout the month and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. **3&4. Soiled or dented Pans** 1. Dented pans were discarded and the soiled pan was rewashed immediately upon discovery. 2. All remaining pots and pans were Inspected with no other issues being found. 3. Kitchen staff was inserviced on when to discard dented pans and how to thoroughly wash them. The supervisors will monitor throughout the month and report their findings to the Director of Nutritional Services.	11/29/16 10/20/16 10/20/16 10/27/16 11/29/16 10/20/16 10/20/16 10/27/16
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	F 431		

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F 431	Continued From page 38 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations made during Medication Storage review on one (1) of three (3) units observed, it was determined that facility staff failed to write the opened dates and times on two (2) of three (3) vials of medications when they were opened.	F 431	**483.35(i)Food Procure, Store/Prepare/ Serve – Sanitary** (continue) 4. The Director of Nutritional Services will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/29/16
			483.60(b),(d),(e)Drug Records, Label/Store Drugs & Biologicals 1. Vials found not to be properly Initialed and timed upon opening were discarded immediately upon discovery.	10/21/16
			2. All insulin vials throughout the facility were appropriately initialed, dated and timed upon opening.	10/21/16
			3. Inservice was conducted with the Licensed nursing staff to review the facility Policy on proper dating and initialing of Insulin vials upon opening. The Nursing Quality Improvement Team will audit the medication carts on a monthly basis focusing on the dating and initialing of opened insulin vials. The results of these audits will be forwarded to the Director of Social Nurses for his review and assessment.	11/2/16 11/29/16
			4. The Director of Nurses will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/29/16

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F 431	Continued From page 39 The findings include: The following observation was made on Unit 2 North on October 21, 2016 at approximately 4:18 PM: Two (2) of three (3) Lantus injection Insulin- 10 ml (millimeters) vials were opened and there were no dates and times recorded as to when the vials were first opened. The observation was made in the presence of Employee #5, who acknowledged the findings.	F 431		
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 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	F 441	**483.65 Infection Control, Prevent Spread, Linens** 1. The staff involved was immediately Instructed on how to serve food in a sanitary manner and on proper hand hygiene. 2. Many staff were observed serving food appropriately and washing their hands using proper techniques. 3. Nursing staff was inserviced regarding CDC guidelines for proper hand hygiene techniques as well as proper procedures for handling food and liquids. The Nursing Quality Improvement Team will audit monthly for compliance. Their findings will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/25/16 10/25/16 11/29/16 11/29/16

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F 441	Continued From page 40 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 and staff interview facility staff failed to maintain proper hand hygiene practice during the dining observation. The findings include: " Evidence supports the belief that improved hand hygiene can reduce health-care-associated infection rates. Failure to perform appropriate hand hygiene is considered the leading cause of health-care-associated infections and spread of multiresistant organisms and has been recognized as a substantial contributor to outbreaks " http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf#page=19 During a dining observation conducted on October 17, 2016 at approximately 12:50 PM.	F 441		

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F 441	Continued From page 41 Employee #24 was observed bending down to the floor and using a tissue to wipe up spilled beverage from the floor. The soiled tissue paper that was used to wipe the floor was then place on the beverage cart, without washing or sanitizing his/her hands. The employee then poured a beverage into a cup and served it to the resident. The Resident was observed receiving the beverage. A face-to-face interview was conducted with Employee #4 and Employee #23 on October 17, 2016 at approximately 1:00 PM in the presence of Employee #24. The Employees acknowledged the findings after discussion with Employee #24. The observation was made on October 17, 2016.	F 441		
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 on October 20, 2016 at approximately 10:00 AM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by low final rinse temperatures from the dishwashing machine, loose door handles from two (2) of four (4) convection ovens and missing handles from two (2) of five (5) steam table well covers. The findings include:	F 456	**483.70(c)(2) Essential Equipment, Safe Operating Condition** 1. Dish Washing Machine 1. Hobart was called immediately to repair/correct the temperature of the final rinse. A small adjustment to the booster heater was made and the dish washing machine's final rinse temperatures were at 180 degrees F or higher. 10/20/16 2. No other equipment was effected. 10/20/16 3. Inservicing was done with the Dietary staff on monitoring of the dish washing machine temperatures. Final rinse temperatures are monitored and recorded daily. The written results are given to the Director of Nutritional Services for his review. 10/31/16 4. The Director of Nutritional Services will present the results of the monitoring and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 11/29/16	

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F 456	Continued From page 42 1. The dishwashing machine final rinse temperature failed to reach 180 degrees Fahrenheit on numerous occasions on October 20, 2016 between 9:30 AM and 10:30 AM. The dishwashing machine was repaired at approximately 4:15 PM and the final rinse temperature was consistently above 180 degrees Fahrenheit during multiple, consecutive rinse cycles. 2. Door handles from two (2) of four (4) convection ovens were loose. 3. Two (2) of five (5) steam table well covers were missing a handle. These observations were made in the presence of Employee #27 who acknowledged the findings.	F 456	**483.70(c)(2) Essential Equipment, Safe Operating Condition** (continued) **2&3. Handles – Convection Ovens and Steamtable wells** 1. Handles requiring repair or replacement were attended to immediately upon discovery. 2. There were no other steam table wells or convection oven handles which needed attention. 3. Inservicing was done with the Dietary staff on monitoring of the handles of the various equipment. The supervisors will monitor the repair of the equipment monthly. The written results will be given to the Director of Nutritional Services for his review. 4. The Director of Nutritional Services will present the results of the monitoring and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/20/16 10/20/16 10/31/16 11/29/16
F 463 SS=D	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: Based on observations made on October 20, 2016 at approximately 2:30 PM and on October 21, 2016 at approximately 10:30 AM, it was determined that the facility failed to maintain resident call bell system in good working condition as evidenced by call bells that did not operate as intended in two (2) of 64 resident ' s	F 463	**483.70(f) Resident Call System-Rooms/Toilet/Bath** 1. The call systems in the 2 resident rooms which did not alarm were repaired immediately and put back in to service. 2. The call system throughout the facility was tested and no other issues found. 3. Maintenance Staff was inserviced on the proper testing and repair of the call system. The Maintenance Quality Improvement Team will monitor the functioning of the call system monthly and report their findings to the Director of Facilities.	10/21/16 10/21/16 11/29/16

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F 463	Continued From page 43 rooms. The findings include: Call bells in resident room #103 (A) and #116 (B) were not functioning and did not initiate an alarm when tested, two (2) of 64 resident ' s rooms. These observations were made in the presence of Employee #21 who acknowledged the findings.	F 463	**483.70(f) Resident Call System-Rooms/Toilet/Bath** (continued) 4. The Director of Facilities will present the results of the monitoring and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/29/16
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that facility staff failed to ensure the glucometer (blood glucose monitoring system used to monitor blood glucose levels) was working properly with the test strips as evidenced by not consistently documenting on the " Quality	F 514	**483.75(l)(1) Res Records-Complete/ Accurate/Accessible** **1. Glucometer Control Log** 1. A new glucometer monitoring sheet was implemented on the nursing unit noted with incomplete documentation on the Glucometer Control Log. 2. All other Glucometer Control logs were reviewed without issues. 3. Licensed nursing staff was inserviced on the appropriate and consistent documentation needed for the Glucometer Control Log. The Nursing Quality The Nursing Quality Improvement Team will audit monthly for compliance. Their findings will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/21/16 10/21/16 11/29/16 11/29/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 44 Control Log " for one (1) of two medication carts. The findings include: Review of the " Quality Control Log " lacked evidence of consistent monitoring. The following days were omitted: Unit 1 South: Team II October 2, 2016 October 14, 2016 September 18, 2016 August 20, 2016 August 23, 2016 August 25, 2016 August 26, 2016 August 28, 2016 August 31, 2016 July 6, 2016 July 10, 2016 July 17, 2016 July 13, 2016 July 18, 2016 July 28, 2016 A face-to-face interview was conducted with Employee #4 on October 21, 2016 at approximately 3:00 PM. After review of the Quality Control Log; he/she acknowledged the above findings. The record was reviewed on October 21, 2016. 2. Based on record review and staff interview for two (2) of 44 Stage 2 sampled residents, it was determined that the facility staff failed to maintain	F 514	**483.75(l)(1) Res Records-Complete/ Accurate/Accessible** (continued) **2. Resident #25 – Timing of Percocet** 1. The licensed staff involved was Immediately inserviced on accurate documentation of controlled substances. 2. The Clinical Managers reviewed the documentation on all other residents receiving similar medications. No other corrections needed to be done. 3. Licensed nursing staff was inserviced on the need for accurate documentation including the time of medication administration. The Nursing Quality Improvement Team and Clinical Managers will audit monthly for compliance. Their findings will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/25/16 10/25/16 11/29/16 11/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	10/25/2016

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TRANSITIONS HEALTHCARE CAPITOL CITY	2425 25TH STREET SE WASHINGTON, DC 20020

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F 514	Continued From page 45 clinical records in accordance with accepted professional standards and practices that are complete and accurately documented as evidenced by: facility staff failed to record the accurate time of administration of Percocet [a Schedule II controlled substance] for one (1) resident; facility staff to document the correct site of the knee immobilizer and failed to document the correct site of the midline catheter in the nurse ' s notes for one (1) resident. Residents ' #25 and #34. The findings include: 1.Facility staff failed to record the accurate time of administration of Percocet [a Schedule II controlled substance] for Resident #25. The physician " Medication Review Report " signed April 3, 2016 directed: " Oxycodone/APAP (Opioid Analgesic) Tab 5-325mg- Give 2 (two) tablet by mouth every 8 hours as needed for severe pain ... " A review of the April 2016 Medication Administration Record revealed that signatures in the assigned spaces indicated that Percocet- 2 tablets were administered to Resident #25 on April 2, 2016 at 0522 (5:22AM) and 12 Noon. A review of the " Controlled Drug Receipt/Record/Disposition Form " revealed two (2) Percocet tablets were signed out to be administered at 5:20 AM to Resident #25 on April 2, 2016. The controlled drug receipt/record form lacked documented evidence that the resident received Percocet - two (2) tablets at 12 Noon.	F 514	**483.75(l)(1) Res Records-Complete/ Accurate/Accessible** (continued)	

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F 514	Continued From page 46 A face-to-face interview was conducted with Employee # 4 on October 21, 2016 at approximately 12 Noon regarding the aforementioned findings. He/she stated acknowledged the findings. Further stated that he/she consulted with the assigned nurse; who stated he/she documented the wrong time. The resident received the Percocet at 12 Noon. The clinical record was reviewed on October 21, 2016. 3A. Facility staff to document the correct site of the knee immobilizer in the nurse ' s notes. According to the Nurse Practitioner ' s Progress Note dated September 28, 2016 at 13:22 revealed, " ...s/p (status post) hospitalization for fracture of distal femur ...RLE (right lower extremity) immobilizer in place ... " On October 18, 2016 at 11:28 am Resident # 34 was observed in bed resident resting with a right knee immobilizer in place. A review of the Nursing progress notes revealed that the nursing staff recorded their assessment of the resident ' s leg immobilizer as follows: 10/18/2016 at 22:09 - " ...left leg immobilizer ... " 10/18/2016 at 15:55 - " ...left leg immobilizer ... " 10/19/2016 at 13:51 - " ...left leg immobilizer ... " 10/19/2016 at 23:11 - " ...left leg immobilizer ... " There was no documented evidence that facility staff consistently recorded the correct placement of the leg immobilizer. The staff recorded the leg immobilizer as being on the left leg instead of the right leg. A face-to-face interview was conducted on	F 514	**483.75(l)(1) Res Records-Complete/ Accurate/Accessible** (continued) **3A.Resident #34 – Knee Immobilizer** 1. The licensed staff involved was immediately inserviced on accurate documentation of the knee immobilizer. 2. The Clinical Managers reviewed the documentation on all other residents receiving similar medications. No other corrections needed to be done. 3. Licensed nursing staff was inserviced on the need for accurate documentation of knee immobilizers. The Nursing Quality Improvement Team and Clinical Managers will audit monthly for compliance. Their findings will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/25/16 10/25/16 11/29/16 11/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	B. WING _____	10/25/2016

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F 514	Continued From page 47 October 20, 2016 at 11:10 am with Employee # 7. He/she acknowledged the findings. The record was reviewed on October 20, 2016. 3B.Facility staff to document the correct site of the midline catheter in the nurse ' s notes. Resident #34. According to the [Company Name] Vascular Access form dated October 12, 2016 the resident had a Midline placement to the left baslic vein [of the left arm]. On October 18, 2016 at 11:28 am Resident # 34 was observed in bed resident resting with a midline catheter placed in the left upper arm. A review of the Nursing progress notes revealed that the nursing staff recorded their assessment of the resident ' s midline catheter as follows: 10/14/2016 at 05:42 - " ...midline site on left hand is intact ... " 10/16/2016 at 04:55- " ...midline site on left hand is intact ... " 10/16/2016 at 20:52- " ...midline site on left hand is intact ... " 10/18/2016 at 07:04 - " ...midline site on left hand is intact ... " There was no documented evidence that facility staff consistently recorded the correct placement of the midline catheter placement. A face-to-face interview was conducted on October 20, 2016 at 11:10 am with Employee #7. He/she acknowledged the findings. The record was reviewed on October 20, 2016.	F 514	**483.75(l)(1) Res Records-Complete/ Accurate/Accessible** (continued) **3B. Resident #34 – Midline Catheter** 1. The licensed staff involved was immediately inserviced on accurate documentation of the correct site of the midline catheter. 2. The Clinical Managers reviewed the documentation on all other residents with midline catheters. No other corrections needed to be done. 3. Licensed nursing staff was inserviced on the need for accurate documentation of the site of midline catheters. The Nursing Quality Improvement Team and Clinical Managers will audit monthly for compliance. Their findings will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will present the results of these audits and any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	10/25/16 10/25/16 11/29/16 11/29/16