FOREST HILLS OF DC

INCLUSIVE SENIOR LIVING

August 6, 2015

Sharon Williams Lewis, DHA, RN-BC, CPM
Program Manager, Health Facilities Division
Department of Health
899 North Capitol Street, NE
Washington, DC 20002

Dear Dr. Lewis:

Enclosed please find executed Statement of Deficiencies and Plan of Correction (CMS-2567) for Forest Hills of DC.

This plan of correction is submitted for purposes of regulatory compliance and as part of Forest Hills of DC's ongoing efforts to continuously maintain the high quality of care and services provided. As such it does not constitute an admission of the facts or conclusions cited in the survey report for any purpose whatsoever.

If you have any questions, please contact me directly at 202-777-3320. Thank you.

Sincerely,

Mary Savoy

Mary Savoy, RN, MS, LNHA
Administrator

Enclosure (CMS-2567)

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

PRINTED: 07/27/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095038		06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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F 000	INITIAL COMMENTS A Quality Indicator Survey (QIS) recertification survey was conducted June 8 through 12, 2015. The following deficiencies are based on observation, record review and resident and staff interview for 30 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center 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	F 000	THIS PLAN OF CORRECTION IS SUBMITTED FOR PURPOSES OF REGULATORY COMPLIANCE AND AS PART OF FOREST HILLS OF DC'S ONGOING EFFORTS TO CONTINUOUSLY MAINTAIN THE HIGH QUALITY OF CARE AND SERVICES PROVIDED. AS SUCH IT DOES NOT CONSTITUTE AN ADMISSION OF THE FACTS OR CONCLUSIONS CITED IN THE SURVEY REPORT FOR ANY PURPOSE WHATSOEVER.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Savoy, RN, NHA	ADMINISTRATOR	8/7/15

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 MDS - Minimum Data Set Meq Milliequivalent 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	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment	F 157		

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F 157	Continued From page 3 Significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to notify the physician when Resident #45 received more than twice the prescribed dosage of medication. The findings include: During a medication administration observation on June 10, 2015 at approximately 10:20AM, it was determined the charge nurse administered greater than twice the prescribed dosage of an ' as needed ' expectorant medication (Siltussin) to Resident #45. The medication that was administered (Siltussin) was not the intended medication. There was no documented evidence	F 157	**F157 Failure to notify physician.** 1. **Corrective Action for Affected Resident:** Attending physician notified 06/10/15. No new orders obtained. Employee making error counseled on facility's policy and procedure, for Medication Administration and Physician Notification for changes in residents condition. Resident experienced no negative outcome. 2. **Identification of Other Residents Potentially Affected by Same Practice:** All residents can be potentially affected by this practice. No other resident affected by this practice. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staffs were in-serviced on facility's policy and procedure for comprehensive assessment and documentation of unusual incidents/accidents. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** The Staff Development Nurse will monitor medical records for all residents experiencing unusual incidents or accidents. Threshold for compliance 00%. Results will be reported to QA Committee quarterly x2 quarters.	6/10/15 6/10/10 6/15/15 7/23/15

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F 157	Continued From page 4 Potassium Chloride 30 ml (40 MEq) by mouth every day for supplement. Siltussin AF/SF [alcohol free/sugar free] liquid (aka: Diabetic tussin) 100mg/5 [give] 10ml by mouth 3 times a day as needed for cough. Employee #20 was observed to pour 30 ml of Siltussin instead of the intended 30cc of Potassium. The dosage of Siltussin that was administered to Resident #45 was greater than twice the prescribed (10 ml) dosage. There was no evidence that Resident #45 sustained any untoward effect from the medication error. A review of the clinical record for Resident #45 lacked evidence of physician notification regarding the medication error. A face-to-face interview was conducted with Employee #2 who acknowledged the record lacked evidence of physician notification.	F 157	**F241 Failure to promote residents' dignity.** 1. **Corrective Action for Affected Residents:** Tongue blades were immediately replaced on 06/10/15 with an appropriate feeding utensil. Employee #20 & #7 were counseled on the importance of maintaining the dignity of residents during all aspects of care. Education was provided on the appropriate feeding utensils and adaptive equipment to aide in administration of medications to residents who require medications to be crushed and/or to be placed in pudding or applesauce.	6/10/15
F 241 SS=B	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on random observations during the survey period, it was determined that facility staff failed to promote resident dignity, as evidenced by the utilization of tongue blades for the administration of oral medication in lieu of a spoon or an	F 241	2. **Identification of Other Residents Potentially Affected by Same Practice:** All residents experienced this practice. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** Medical Supplies coordinator has been instructed to only purchase plastic spoons, packaged in plastic wrap, for use during med pass. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Use of appropriate utensils will be randomly monitored during med passes. Compliance will be reported to the QA committee x 2 quarters.	6/10/15 6/15/15 7/23/15

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review it was determined that the facility staff failed to ensure residents' rights to make choices consistent with wishes for two (2) of 30 sampled residents. Residents # 6 and # 26. The findings include: Resident #6 was admitted to the facility September 29, 2011 with diagnoses which included Peripheral Neuropathy, Lumbar Disk Degenerative Disease, Anemia, Hypertension, and Hyperlipidemia. During resident interview on June 9, 2015 at approximately 12:48 PM Resident #6 stated that s/he does not choose when to get up or when to shower. According to the Annual Minimum Data Set (MDS) dated September 24, 2014, Section F, relative to Preferences, item F-400 was coded indicating it is very important for Resident #6 to chose clothes, choose type of hygiene, choose bedtime, and use the phone in private; and important for Resident #6 to take care of belongings, have snacks between meals, and have involvement in care decisions. Item F-700	F 242	**F242 Facility staff failed to ensure residents' rights to make choices consistent with wishes for Residents #6 and #26.** 1. **Corrective Action for Affected Resident:** Residents #6 and #26 were interviewed immediately to determine their preferred time & method for bath/shower 2. **Identification of Other Residents Potentially Affected by Same Practice:** Other residents were also interviewed and stated bath shower preferences were met. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** Update shower policy to include flexibility in shower/bath schedule per resident's preference. In-service staff on Resident Rights and Preferences. Review/update care plan quarterly to reflect any changes in resident preferences. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Care plan audits will be conducted Quarterly to determine compliance with resident preferences. Results of monitoring will be presented to QA committee.	6/12/5 6/15/15 6/30/15 6/15/15 6/30/15 7/23/15

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F 242	Continued From page 7 was coded for no staff assessment of preferences. Resident #6 ' s care plan for Activities of Daily Living (ADLs), initiated November 14, 2014 included the following approaches: assume unhurried manner, allow ample time for tasks; assist with bathing/dressing; maintain limited assistance in dressing/grooming and allow as much as possible for self participation; and honor resident ' s preference for shower schedule. The care plan did not address preferences for bedtime or awakening. According to the Resident Bathing Chart for May 13, 2015 through June 12, 2015 Resident #6 received showers on five (5) occasions and received bed bath on 39 occasions. According to the current Weekly Skin Check Sheets for May and June 2015, Resident #6 ' s shower days are Wednesday and Saturday; and skin inspections were performed on May 2, 6, 16, 20, 27 and 30; 2015 and June 3, 6, ands 10, 2015. Facility staff failed to ensure Resident #6 ' s right to choose a bathing schedule according to preferences. On June 12, 2015 at approximately 11:45 AM a face to face interview was conducted with the Employee #6 When queried about the shower schedules, and plan for getting up in the morning, he/she expressed Resident #6 had not verbalized concerns regarding what time to get up or with the current shower schedule. The nurse reinforced that skin inspections are performed in conjunction with the shower. When queried as to how staff determines resident preferences, s/he responded " during the care plan meeting every	F 242		

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F 242	Continued From page 8 three (3) months residents are asked about concerns they have about anything. " Employee #6 restated being unaware of the resident ' s concerns. 2. Patient #26 was admitted to the facility May 2, 2014 with diagnoses which included Parkinson ' s Disease, Dementia, Anemia and Hypertension. During resident interview on June 8, 2015 at approximately 11:40 AM Resident #26 stated that s/he does not choose when to shower or the type of bath [e.g. shower, bed bath, tub bath]. According to the Annual Minimum Data Set (MDS) dated September 24, 2014, Section F, relative to Preferences, item F-400 was coded as very important for Resident #6 to chose clothes, choose type of hygiene, choose bedtime, and use the phone in private; and important for Resident #6 to take care of belongings, have snacks between meals, and have involvement in care decisions. Item F-700 was coded for no staff assessment of preferences. Resident #26 ' s care plan for Activities of Daily Living (ADLs), initiated March 20, 2015 included the following approaches: assume unhurried manner, allow ample time for tasks; assist with bathing/dressing; maintain extensive and limited assistance in dressing/grooming and allow as much as possible for self participation; and honor resident ' s (or POA ' s [power of Attorney ' s]) preference for shower/bath schedule as requested. According to the Resident Bathing Chart for May 11, 2015 through June 10, 2015 Resident #26 received shower on three (3) occasions and received bed bath on 31 occasions. According to	F 242		

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F 242	Continued From page 9 the current Weekly Skin Check Sheets for June 2015, Resident #26 ' s shower days are Tuesday and Friday and skin inspections were performed on June 2, 5, and 8, 2015. On June 10, 2015 at approximately 4:15 Resident #26 was observed at medicine cart with. Within course of conversation Resident #26 requested " shower tonight. " Resident was reminded " ... had one (1) last night. " Resident was noted to agree and left area, appeared to interpret as negative response to request. Facility staff failed to ensure Resident #6 ' s right to choose bathing schedule according to preferences. On June 10, 2015 at approximately 4:15 PM a face to face interview was conducted with the Employee #8. When queried about the shower schedules, and bath type, she/he explained that all residents are bathed daily, and showered twice weekly. She/he recounted Resident #26 ' s current bathing schedule and explained that skin inspections are performed in conjunction with the shower. Employee #8 further confirmed the facility does not perform tub baths. When queried as to how staff determines resident preferences, s/he responded " during the care plan meeting every three (3) months residents are asked about concerns they have about anything. " Employee #8 stated s/he was unaware of the resident ' s concerns. She/he stated whenever the resident has concerns, they are taken to the family, and the family works with facility staff to resolve the issues quickly. A face to face interview was conducted with Employee #16 on June 10, 2015 at 4:35 PM. The	F 242		

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F 242	Continued From page 10 employee confirmed Resident #26 ' s shower schedule and that skin assessments are performed in conjunction with the shower. When queried relative to residents requesting showers, the employee replied " residents can request & receive shower at any time. We never deny shower."	F 242	**F 253- Wall Clocks with Incorrect Times** **1. Corrective Action for Affected Residents:** Upon discovery of the inoperable clocks the staff immediately replaced batteries In the clocks that were displaying the wrong times **2. Identification of Other Residents Potentially Affected by Same Practice:** A complete healthcare wall clocks inspection was conducted to ensure accurate times were being displayed **3.Systemic Changes to Ensure Deficient Practice Does Not Recur:** Maintenance staff will inspect healthcare rooms every two weeks to ensure correct times are being displayed **4. Performance Monitoring to Make Sure Solutions Are Sustained** Maintenance supervisor will conduct monthly room inspections and review logs Findings will be reported to the QA Committee X2 quarters	06/08/15 06/8/15 06/08/15 06/08/18
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on June 8, 2015 at approximately 11:30 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by wall clocks in five (5) of 21 resident ' s rooms that were not functioning and detached privacy curtains in two (2) of 21 resident ' s rooms. The findings include: 1. Wall clocks in five (5) of 21 resident rooms surveyed did not display correct time including rooms #159, #246 on the ' A ' side, #247 on the ' A ' and ' B ' side, #252 on the ' B ' side and #253 on the ' A ' side . 2. Privacy curtains in two (2) of 21 resident rooms were completely detached from its hooks, including rooms #159 and #261.	F 253	**F 253 – Privacy Curtains Detached from Hooks** **1. Corrective Action for Affected Residents:** Upon discovery the detached privacy curtains were immediately re-attached on the tracks **2. Identification of Other Residents Potentially Affected by Same Practice:** A complete inspection of healthcare privacy curtains was conducted to ensure all curtains are hanging properly No additional deficient practice was identified **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a Housekeeping staff were trained to inspect Healthcare rooms daily to ensure that privacy curtains are properly hung b Maintenance checklist has been revised to include Inspection of curtain tracks and replacing curtain hooks as needed **4. Performance Monitoring to Make Sure Solutions Are Sustained** Housekeeping supervisor will conduct bi-weekly room inspections to ensure that curtains are attached on tracks Results will be reported to the QA Committee quarterly	06/08/15 6/9/15 6/11/15 7/23/15

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F 253	Continued From page 11 These observations were made in the presence of Employee # 4 who confirmed the findings.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and interview for two (2) of 30 sampled residents,	F 278		

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F 278	Continued From page 12 it was determined the facility staff failed to accurately code the Minimum Data Set (MDS) Under Section M, Skin Conditions for one (1) resident and Section L, Oral/Dental status for one (1) resident. Residents #55 and 67. The findings include: 1. Facility staff failed to accurately code Section L Item L0200- " D. Obvious or likely cavity or broken natural teeth " for Assessment Reference Date October 2, 2014 for Resident #55. During an interview with Resident #55 on June 9, 2015 at approximately 11:55 AM, Resident #55 was observed to have several missing and broken teeth. When queried about the missing and broken teeth, Resident #55 ' s Power of Attorney interjected and stated s/he has been complaining of tooth pain but does not want any dental work at this time. Resident #55 nodded his/her head in agreement. Medical record review conducted on June 10, 2015 at approximately 9:00 AM revealed the nursing staff documented an oral assessment on the Admission Nursing Assessment dated September 23, 2014. The oral cavity exam revealed Resident #55 had " few broken teeth " and partial upper and lower dentures that fit. The Minimum Data Set Admission Assessment with Assessment Reference Date of October 10, 2014 revealed the clinical staff failed to document the presence of the broken teeth noted during the admission oral assessment documented on September 23, 2014. The clinical staff failed to accurately code the Minimum Data Set Section L	F 278	**F 278- #1 Facility staff failed to accurately code Section L, Oral/Dental Status** 1. **Corrective Action for Affected Resident:** MDS Section L for the resident was modified on and submitted to CMS. 2. **Identification of Other Residents Potentially Affected by Same Practice:** Section L was found to be accurate for all other MDSs included with the batch in question. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** MDS coordinator will review dental progress notes after each visit to ensure accuracy and coding of MDS section L 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** MDS coordinator will conduct audits for residents seen by the dentist monthly for accuracy and coding of section L of MDS. Compliance threshold is 100%. Results will be presented to QA committee quarterly.	06/15/15 6/15/15 7/20/15. 7/23/15

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F 278	Continued From page 13 Item L0200- " D. Obvious or likely cavity or broken natural teeth " for Assessment Reference Date October 2, 2014. Resident #55's medical record contained Dental Care Notes dating as far back as June 15, 2010 prior to the current admission. On October 14, 2014, an annual dental exam and debridement was completed. The exam revealed Resident #55 had poor oral hygiene and stated s/he had adjusted to the discomfort. "Patient has root tips and mobile teeth. Will refer to O.S. [oral surgery] if necessary". On January 20, 2015 a follow-up dental exam was completed and at that time a full mouth x-ray was taken and revealed the following issues: teeth #03, 07 and 08 were mobile, #06 was missing, #22, 23, and 24 showed some mobility. Resident #55 was referred to oral surgeon for possible extraction and then possible fabrication of new dentures. The dental visit note dated February 24, 2015 stated "Per social worker family wants no Tx. [treatment] at this time. " On June 5, 2015, a consult with oral surgeon was conducted for "non-restorable teeth". The oral surgeon recommended full Maxillary extraction. The resident was informed of recommendations and requested no treatment to be completed at this time. Further review of the Significant Change in Status Assessment with Assessment Reference Date of February 27, 2015 and a Quarterly Assessment with Assessment Reference Date of May 27, 2015 revealed the clinical staff failed to document the following findings relative to " Oral/Dental Status in Section L0200- Dental E. Inflamed or bleeding gums or loose natural teeth " . In	F 278		

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F 278	Continued From page 14 addition, review of Section K Swallowing/Nutritional Status on the Minimum Data Set dated May 27, 2015 revealed the clinical staff entered a zero (0) for Resident #55 ' s weight in Item K0200B- Weight. The medical record lacked documented evidence the clinical staff accurately and consistently completed the Minimum Data Set relative to oral/dental status and weights. The clinical staff failed to accurately complete the Minimum Data Set Section L. A face to face interview was conducted with Employee #5 on June 10, 2015 at approximately 4:20 PM. According to Employee #5, the dietician is responsible for the completion of Section K. When queried about the accuracy of Section L Oral/Dental Status relative to the broken teeth noted on Admission and confirm by the dental consult and mobile/loose teeth, s/he stated that " how would I know? " A copy of the dental notes and Admission Nursing Assessment were reviewed with Employee #5 that documented the presence of broken and mobile teeth. S/he stated that s/he could not agree with the findings. A face to face interview was conducted with the Employee #3 on June 10, 2015 at approximately 4:30 PM. The employee stated that it was an error and confirmed that s/he had failed to accurately code the Minimum Data Set on May 27, 2015. At the completion of the survey, the clinical staff provided the surveyor a copy of the corrected Minimum Data Sets for the February 27, 2015 and May 27, 2015 to reflect an accurate assessment of Resident #55 oral/dental statuses.	F 278		

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F 278	Continued From page 15 2. Facility staff failed to accurately code Section M-Skin Conditions for Resident #67. Medical record review conducted on June 10, 2015 revealed that on the Admission Nursing Assessment dated March 31, 2015 revealed the nursing staff documented the presence of multiple present on admission alterations in skin integrity to include the description of the bilateral heels pressure ulcers in the " Skin Condition " section as follows: left heel " redden area " measuring 3x2 centimeters; and right heel " deep purple area, no pain on palpation " measuring 2.5x3.5 centimeters. The Braden Scale - For Predicting Pressure Sore Risk dated March 31, 2015 revealed the nurse assessed Resident #67 as high risk for pressure ulcer as indicated by a total score of 12. Comprehensive Minimum Data Set with Assessment Reference Date of April 7, 2015 revealed the nursing staff documented in Section M-Skin Conditions the following data: M0100 Determination of Pressure Ulcer Risk- B. Formal assessment instrument/tool and C. Clinical Assessment " as indicated by the presence of an " X " in the box beside each item. The following options were left blank: " A. Resident has a stage 1 or greater and Z. None of the above " ; M0210 Unhealed Pressure Ulcer(s) - Does this resident have one or more unhealed pressure(s) Stage 1 or higher? " The code enter was " 1 " indicating Yes; M0300 Current Number of Unhealed Pressure Ulcers at Each Stage- A. Number of Stage 1 pressure ulcer- the code enter was " 2 " indicating the presence of two Stage 1 pressure ulcers. Stage 1 pressure ulcers are defined as "	F 278	**F278 - # 2 Facility staff failed to accurately code Section M- Skin Conditions for Resident #67.** 1. **Corrective Action for Affected Resident:** Care plan was revised during the survey 2. **Identification of Other Residents Potentially Affected by Same Practice:** No other residents were Affected by this coding error. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** MDS coordinator will review residents' skin care records with charge nurse and nurse supervisor. MDS coordinator will also attend weekly wound rounds and update care plan for skin conditions accordingly. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** MDS coordinator will conduct audits for residents with impaired skin integrity for accuracy and coding monthly. Compliance threshold is 100%. Results will be presented to QA committee quarterly.	06/12/15 06/10/15 7/20/15 7/23/15

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F 278	Continued From page 16 Intact skin with non-blanchable redness of localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues " . The medical record lacked documented evidence the nursing staff accurately completed the Minimum Data Set on April 7, 2015 relative to the presence of Stage 1 pressure ulcer for the determination of Pressure Ulcer Risk. In addition, based on the description of the right heel pressure ulcer description provided in the Nursing Admission Assessment as " deep purple " is consistent with the National Pressure Ulcer Advisory Panel definition of a suspected deep tissue injury; " purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear " . A interview was conducted with Employee #2 regarding the assessment of Resident #67 skin upon admission. According to him/her, Resident #67 was admitted with the presence of pressure areas on bilateral heel. A discussion was held concerning him/hers description of the right heel as " deep purple " . S/he stated that s/he could not recall the specifics of the skin at the time of the admission; however, s/he agrees with the documentation completed at the time of the assessment. When queried about the staging of the bilateral heel areas as documented on the Pressure Ulcer Record and the Minimum Data Set, s/he was unable to provide further details as they were completed by other employees.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 17 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and medical record review, it was determined the nursing staff failed to ensure a comprehensive care plan was developed with measureable outcomes and interventions relative to pain and oral/dental care in one (1) of 30 records reviewed Resident #55. The findings include: The facility staff failed to develop an individualized plan of care relative to pain and oral/dental care for Resident #55 A review of the medical record was conducted on	F 279	**F 279 - The facility staff failed to develop an individualized plan of care relative to pain and oral/dental care for Resident #55** 1. **Corrective Action for Affected Resident:** Individualized care plan relative to pain and oral/dental care for Resident #55 was developed immediately during survey. 2. **Identification of Other Residents Potentially Affected by Same Practice:** Dental records for all residents were reviewed. No other residents were affected. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** Mobile dentist's progress note after each visit will be reviewed and care plan developed based on residents' need. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Monthly care plan audits will be conducted for all residents seen by dentist. Compliance threshold is 100%. Results will be presented to QA committee quarterly.	6/10/15 6/15/15 7/23/15 7/23/15

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F 279	Continued From page 18 June 10, 2015 at approximately 9:00 AM. The Admission Nursing Assessment dated September 23, 2014 revealed the nursing staff documented an oral assessment. The oral cavity exam revealed Resident #55 had " few broken teeth " and partial upper and lower dentures that fit. The Minimum Data Set Admission Assessment with Assessment Reference Date of October 10, 2014 revealed the clinical staff failed to document the presence of the broken teeth noted during the admission oral assessment documented on September 23, 2014. The clinical staff failed to accurately code the Minimum Data Set Section L Item L0200- " D. Obvious or likely cavity or broken natural teeth " for Assessment Reference Date October 2, 2014. The medical record revealed a Significant Change in Status Assessment with Assessment Reference Date of February 27, 2015. The Care Area Assessment (CAA) Summary identified the " Dental Care " Care Areas was triggered with location and date of CAA documentation noted as " Dental consult note 01/20/2015 " . The " Pain " Care Area was not triggered. Resident #55's medical record contained Dental Care Notes from June 15, 2010 prior to the current admission. On October 14, 2014, an annual dental exam and debridement was completed. The exam revealed Resident #55 had poor oral hygiene and stated s/he had adjusted to the discomfort. "Patient has root tips and mobile teeth. On January 20, 2015 a follow-up dental exam was completed and at that time a full mouth x-ray was taken and revealed the following issues: teeth #03, 07 and 08 were mobile, #06 was missing, #22, 23, and 24 showed some	F 279		

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F 279	Continued From page 19 mobility. Resident #55 was referred to oral surgeon for possible extraction and then possible fabrication of new dentures. The dental visit note dated February 24, 2015 stated "Per social worker, family wants no Tx. [treatment] at this time. " On June 5, 2015, a consult with oral surgeon was conducted for "non-restorable teeth". The oral surgeon recommended full Maxillary extraction. The resident was informed of recommendations and requested no treatment to be completed at this time. Review of Resident #55 ' s care plans revealed the clinical staff initiated care plan for oral care, nutrition and pain. The " Oral care " care plan revealed the " Problem: Start Date: 10/2/14 [typed in] and 2/27/15 [handwritten in] Needs routine oral/dental care by assistance R/T Dx Dementia, generalized weakness " ; and " Resident is wearing partial upper/lower denture. The " Oral care " care plan lacked documented evidence of the oral/dental problems of discomfort, broken, and loose teeth as identified on the Dental Notes from October 14, 2014 and January 20, 2015. The " Goal " was documented as " Resident will be free from oral/dental problems. " The approaches for oral care do not reflect intermediate steps for each goal as the resident was admitted with ongoing oral/dental problems. The clinical staff failed to develop an accurate care plan to address the oral/dental care problem identified for Resident #55 upon assessment. According to the Dental Note dated October 14, 2015, Resident #55 " stated s/he has adjusted him/herself to discomfort. " The medical record	F 279		

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F 279	Continued From page 20 lacked documented evidence the clinical staff care planned for refuse of care relative to dental discomfort. The " Pain " care plan contained in the medical record identified the " Problem: Pain Prevention " . The " Goal " was documented as " Minimal to no discomfort through next review " . The care plan failed to identify the area of pain concern. The clinical staff failed to develop a care plan to address Resident #55 reported adjustment to dental discomfort and/or resident refusal of treatment for discomfort. A face to face interview was conducted with Employee #8 on June 10, 2015 at approximately 3:45 PM. When queried about the status of Resident #55 ' s oral/dental status, s/he stated that Resident #55 does not complain of pain or discomfort because of declining cognitive status related to Dementia. According to Employee #8, Resident #55 has been observed not eating a lot of meal especially meats; however, s/he enjoys soft texture food such as ice cream and yogurt. On June 9, 2015, speech therapy evaluated resident for texture tolerance, and new order was received for ground meats to assist with chewing and meal consumption. The facility staff failed to ensure the development an individualized care plan and establish measureable goals to manage Resident #55's identified problem(s).	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280		

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F 280	Continued From page 21 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for two (2) of 30 sampled residents, it was determined that facility staff failed to review and revise care plans to reflect goals and approaches to ensure one (1) resident's nutritional needs were met and to include measureable effect interventions relative to falls for one (1) resident. Residents # 7 and 24, The findings include: 1 . Facility staff failed to revise a care plan to address Resident #7 ' s refusal to eat his/her meals when served. During a dining observation on June 8, 2015 at approximately 1:30 pm Resident #7 was observed sitting at a table with two residents who were served their lunch meals , and Resident was	F 280	**Facility staff failed to revise a care plan to address resident refusal to eat his/her meal.** 1. **Corrective Action for Affected Resident:** • Prescribed diet was offered to resident during survey; she refused diet. • Individualized care plan relative to Resident #7's refusal to eat his/her meals when served was developed during survey. 6/9/15 2. **Identification of Other Residents Potentially Affected by Same Deficient Practice:** Review of all diet orders revealed no other residents were affected. 6/15/15 3. **Systemic change to Ensure Deficient Practice Does not Recur:** New policy developed to require care plans to be compared to prescribed diet orders quarterly and updated, as needed, to reflect resident's dietary preferences. 6/26/15 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Findings will be reported to the QA committee quarterly. Compliance threshold is 100%. 7/23/15	

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F 280	Continued From page 22 served a can of a supplemental nutritional to drink and no meal. On June 9, 2015 at approximately 9:00AM Resident #7 was noted sitting in dining room without a meal drinking a supplemental nutritional drink. On June 10, 2015 at approximately 9:30 AM during breakfast, Resident #7 was observed dining without a meal drinking a supplemental nutritional drink. Resident#7 was not offered any food during the observation. A review of the clinical record revealed: Physicians Order Form dated June 2015; Diet Mechanical soft texture, regular diet with thin liquids. Dietary supplements Ensure Plus 8oz by mouth three times a day, provide ice cream with lunch and dinner provide 8 oz. (ounce) 2%milk with breakfast lunch and dinner. A review of the Quarterly Nutrition review dated March 18, 2015 revealed; " Current weight stable with minimal changes x 6 months appetite for meals poor but takes 100% of ensure supplement, ice cream and milk ...f/u [follow-up] as needed " . A review of Resident #7's Intake and Output records revealed a zero (0) intake for breakfast and lunch for seven (7) out of seven (7) days reviewed. There was no evidence Resident # 7"s care plan was updated with goals and approaches to address the resident ' s refusal to accept meals. A face-to-face interview with Employee #7 on	F 280		

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F 280	Continued From page 23 June 10, 2015 at 10:00 AM at when queried why Resident #7 was not being given meals he/she stated, " Resident #7 pushes the food away so they stop giving it to him/ her and since he/she likes the ensure that ' s what we serve." A face to face interview was conducted with Employee's # 2 and# 11 on June 11, 2015 at approximately 3:00 PM. Both were informed of the aforementioned findings. Employee ' s # 2 and # 11stated they were not aware Resident # 7 was not being served his/ her scheduled diet. Employees #2 and #11 acknowledged the findings. The clinical record was reviewed on June 11, 2015. 2. Resident #24 was admitted September 9, 2013 with diagnoses which included Anemia, Non-Alzheimer ' s Dementia and Depression. During staff interview on June 9, 2015 at 11:39 AM, the staff member noted Resident #24 sustained a Hematoma status post fall on May 28, 2015 on the 3:00 PM to 11:00 PM shift. Further record review revealed Resident #24 sustained a fall without documented injury March 4, 2015 on the 3:00 PM to 11:00 PM shift. According to the Minimum Data Set Comprehensive Assessment dated September 19, 2014 for Resident #24 Item 11 ' Falls ' care area was triggered, and care planning decision was checked, and Section E of the MDS relative to Behavior, was coded as no for rejection of care. Resident #24's written care plan initiated March	F 280	**F280 # 2 – Failure to update the care plan with measurable interventions relative to the prevention of falls and resident safety** 1. **Corrective Action for Affected Resident:** Resident's care plan reviewed and updated to include measurable individualized approaches to fall prevention during survey 2. **Identification of Other Residents Potentially Affected by Same Practice:** Care plans of all residents with fall risk assessments scores of 10 or greater were reviewed and updated to reflect residents' individual needs and safety. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** Review and update facility policies on falls and care plan reviews, if needed. In-service staff on policy changes if any. Monitor implementation of policies through random chart audits of residents who experience falls. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** MDS coordinator will review and update falls care plans randomly. Compliance threshold 100%. Findings will be reported to QA quarterly.	6/9/15. 7/23/15 7/23/15 7/23/15

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F 280	Continued From page 24 12, 2015 included the following general approaches: use walker to ambulate under supervision and resident to be assisted to the bathroom at all times. Measurable approaches included " as needed fall risk assessment and physical therapy for gait and strength. " Resident #24's Quarterly Fall Risk Assessments for September 2014 through March 2015 reflected a total score of 11, interpreted as high risk for falls. Handwritten entries noted that Resident #24 had a fall on March 4, 2015 with subsequent care plan interventions of evaluation by rehabilitation therapy and reminders to the resident to ask for help. Subsequent entry on the written care plan dated May 20, 2015 reflected " as needed evaluation by rehabilitation therapy and reminders to ask for help. " The care plan was again updated May 29, 2015, directing " continue to remind resident to ask for assistance, cold compress to head per orders ... " The aforementioned interventions did not detail the frequency of evaluations, monitoring and reminders, and were not measurable. Resident #24 was evaluated by Rehabilitation Services (Physical Therapy) on June 2, 2015 and determined low risk for falls as evidenced by a score of three (3) of ten (10) on the rehabilitation fall screen. Previously, on March 13, 2015 Resident #24 scored five (5) of ten (10) indicative of moderate risk or falls, however the therapist noted evaluation not indicated because " Patient has no complaint of pain and is able to ambulate with rolling walker. " The facility staff failed to update the care plan with measurable interventions relative to the prevention of falls and resident safety.	F 280		

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F 280	Continued From page 25 A face to face interview was conducted with Employee #14 on June 9, 2015 at approximately 10:45 AM . When quried Employee #14 stated " Resident # 24 is impulsive, and wants to do as [s/he] pleases when [s/he] pleases. The resident refused care after the fall initially, and would only take ice packs for the hematoma. " The employee acknowledged Resident #24 ' s care plan was not revised with goals and approaches to address the residents fall status. A face to face interview was conducted with Employee # 15 who reiterated Resident #24 is impulsive. The employee explained interdisciplinary team meetings occur weekly, and resident s who have fallen are discussed and care plans updated as required. Employee #15 was unable to explain how information from the meeting is incorporated into the resident ' s record or how discrepancies in assessments are reconciled between nursing and rehabilitation therapy. The employee acknowledged the care plan for Resident #24 was not updated with all information and interventions, measurable or not, relative to Resident #24 ' s fall status and/or care plan.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview of two (2) of 30 sampled residents, it	F 281		

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	095038		06/15/2015

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F 281	Continued From page 26 was determined the facility staff failed to assess one (1) resident ' s Apical pulse in a manner consistent with accepted standards of practice and ensure a comprehensive assessment was performed in accordance with professional standards of practice relative to a change in condition for one (1) resident. Residents #27 and 67. The findings include: 1. Facility staff failed to obtain Resident #27 ' s Apical pulse in accordance with accepted standards of practice. On June 10, 2015 at approximately 11:15 AM, Employee #20 was observed obtaining Resident #27 ' s blood pressure and pulse with an automatic electronic vital sign apparatus. The employee recorded the resident ' s pulse (59 beats per minute) on the Medication Administration Record in the section allotted for " Apical Pulse daily. " In response to a query regarding the technique used to assess the resident ' s " Apical " pulse, Employee #20 stated he/she did not have a watch or stethoscope to obtain it otherwise. According to the Lippincott Manual of Nursing Practice, 7th Edition, an Apical pulse is obtained via auscultation utilizing a stethoscope placed at the apex of the heart and counted for 60 seconds. Facility staff failed to obtain Resident #27 ' s Apical pulse consistent with accepted standards of practice.	F 281	**F 281- #1 Failure to assess resident's apical pulse in a manner consistent with accepted standards of practice.** 1. **Corrective Action for Affected Resident:** Nurse was counseled on rationale and appropriate method for obtaining apical pulse prior to administration of Coreg (and drugs in this class). No negative resident outcome was identified 2. **Identification of Other Residents Potentially Affected by Same Practice:** Records of all other residents with orders for medications from the same class were reviewed. Findings indicated that only radial pulse was documented for five of six residents. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff were in-serviced on rationale and proper method for assessing apical pulse. Medication administration policy was updated to include this information. Competency testing for licensed staff will include apical pulse measurements. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** MARs will be monitored monthly for documentation of apical pulse readings for Coreg and similar drugs. Outcomes will be reported to QA committee quarterly.	6/10/15. 6/15/15 6/15/15 7/23/15 7/23/15

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F 281	Continued From page 27 Cross reference CFR 483.25 2. The facility staff failed to ensure a comprehensive assessment was performed when changes in wound condition was noted in accordance with professional standards of quality. Resident #67 admitted facility on March 31, 2015 with diagnoses to include status post Open Reduction Internal Fixation of Right Hip for skilled nursing services with plans to return to an assisted living facility upon discharge. Medical record review conducted on June 10, 2015 revealed that on the Admission Nursing Assessment and admission Physician Orders dated March 31, 2015 the nursing staff documented the presence of present on admission Stage I pressure ulcers to bilateral heels with orders The Admission Nursing Assessment dated March 31, 2015 revealed the nursing staff documented the presence of multiple present on admission alterations in skin integrity to include the description of the bilateral heels pressure ulcers in the " Skin Condition " section as follows: left heel " redden area " measuring 3x2 centimeters; and right heel " deep purple area, no pain on palpation " measuring 2.5x3.5 centimeters. The Braden Scale - For Predicting Pressure Sore Risk dated March 31, 2015 revealed the nurse assessed Resident #67 as high risk for pressure ulcer as indicated by a total score of 12. The Pressure Ulcer Record revealed weekly skin assessments for the right heel as follows: March	F 281	**F281 Failure to ensure a comprehensive assessment was performed when changes in wound condition was noted in accordance with professional standards of quality.** 1. **Corrective Action for Affected Residents:** • Licensed staff were immediately in-serviced on the rationale for comprehensive assessments when deterioration in wounds is observed. • RN assessed wound and instructed charge nurse to notify MD of wound status; new orders received. • Comprehensive assessment completed by RN. 2. **Identification of Other Residents Potentially Affected by Same Practice:** Wound rounds were conducted and skin sheets reviewed. No other residents were affected by this practice. No deterioration detected. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** • RN to conduct wound rounds weekly. (Ongoing) • All licensed personnel in-serviced on the facility policy for wound identification and documentation. This in-service will also be provided as part of new employee orientation and annually. • Licensed staff in-serviced by AMT wound care nurse on wound identification and staging. 4. **Performance Monitoring to Make Sure Solutions are Sustained:** TARs and skin sheets will be audited on a monthly basis to ensure compliance. Results will be reported to QA Committee quarterly x2.	6/8/15 6/9/15 6/9/15 6/13/15 7/15/15 7/23/15

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F 281	Continued From page 28 31, 2105 Stage I, 2.5x2 centimeters no depth, drainage and/or odor; April 7, 2015- Stage I 2.5x2 centimeters no depth, drainage and/or odor, grayish color; April 13, 2015- " DTI [Deep Tissue Injury] " 4x2.5 centimeter no depth, drainage, and/or odor, " dark red " color; April 21 and 28, 2015- " DTI [Deep Tissue Injury] " 4x2.5 centimeters, " dark black " color; May 5, 2015 " DTI [Deep Tissue Injury] " 4x2.5 centimeters , no depth, drainage and/or odor, black in color; May 12, 2015- " DTI [Deep Tissue Injury] " 2.5x3.8 centimeters , no depth, drainage and/or odor, black in color; May 19, 2015- " DTI [Deep Tissue Injury] " 2.5x3.5 centimeters , no depth, drainage and/or odor, black in color; May 26, 2015 - " DTI [Deep Tissue Injury] " 4x2.5 centimeters , no depth, drainage and/or odor, black in color; May 27, 2015- " Stage II " 3x2 centimeter, no depth, drainage, and/or odor, red color; June 3, 2015- Stage II 3x4 centimeters no depth, drainage and /or odor, pink color; and June 9, 2015- " Stage II " 4x3 centimeters no depth, drainage, odor, yellow slough color. The assessments relative to the right heel pressure ulcer document on the Pressure Ulcer Record revealed that on April 7, 2015, April 21, 2015, April 28, 2015, May 5, 2015 and June 9, 2015 were performed by the Licensed Practical Nurse. The documentation on the Pressure Ulcer Record and medical record lacked documented evidence that a Registered Nurse performed a comprehensive assessment and/or co-signed the assessment to support evaluation of the resident ' s intrinsic risks and other factors to include causal factors for delayed wound healing. A subsequent review of the medical record	F 281		

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F 281	Continued From page 29 revealed the medical record lacked documented evidence of depth after the debridement performed on May 27, 2015 and June 3, 2015. The nursing staff failed to document the amount depth after debridement down to the subcutaneous tissue of right heel pressure ulcer. The assessments relative to the right heel pressure ulcer documented on the Pressure Ulcer Record revealed that on April 7, 2015, April 21, 2015, April 28, 2015, May 5, 2015 and June 9, 2015 were the assessments were performed by the Licensed Practical Nurse. The medical record lacked documented evidence that a Registered Nurse performed a comprehensive assessment to evaluate the resident ' s needs related to deteriorating wound. On June 9, 2015 at 3:50 PM, the surveyor observed the Licensed Practical Nurse return to nurse ' s station and placed a call to the physician to report changes in wound condition. Upon completion of the call, the Licensed Practical Nurse requested the wound/skin for Resident #67 from the surveyor reviewing documentation. The pressure ulcer assessment documented on June 9, 2015 indicated " Response to Treatment: Deteriorated " . The medical record lacked documented evidence the Registered Nurse assessed Resident #67 ' s right heel ulcer when the Licensed Practical Nurse identified a change in the wound condition. According to D.C Municipal Regulations for Registered Nurses 5414.1(a) Scope of Practice, it stipulates The practice of registered nursing means the performance of acts requiring substantial specialized knowledge, judgment, and	F 281		

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F 281	Continued From page 30 skill based upon the principles of the biological, physical, behavioral, and social sciences in the following: (a) The observation, comprehensive assessment, evaluation and recording of physiological and behavioral signs and symptoms of health, disease, and injury, including the performance of examinations and testing and their evaluation for the purpose of identifying the needs of the client and family. (b) The development of a comprehensive nursing plan that establishes nursing diagnoses, sets goals to meet identified health care needs, and prescribes and implements nursing interventions of a therapeutic, preventive, and restorative nature in response to an assessment of the client ' s requirements. " The Licensed Practical Nurse performed a focused pressure ulcer assessment; however, the facility failed to establish a mechanism to ensure a registered nurse performed a comprehensive assessment in accordance with applicable professional standards of practice. Subsequent review of nursing notes following the identification of wound " deterioration " revealed the nursing staff failed to document any further information relative to the right heel wound from June 9- 11, 2015. Resident #67 was seen by Plastic Surgeon in follow-up to the changes to the right heel wound condition on June 11, 2015. Cross reference CFR 483.25	F 281		
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	F 309		

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F 309	Continued From page 31 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 observations, record review and interview for three (3) of 30 sampled residents, it was determined that facility staff failed to ensure that care was delivered in a manner for residents to attain the highest practicable level of physical and/or psychosocial well-being as evidenced by failure to administer medications as prescribed by the physician for one (1) resident; administer medications with timeliness for two (2) residents and properly assess an apical pulse prior to medication administration for one (1) resident. Residents #27, 44 and 45 The findings include: 1. During a medication administration observation on June 10, 2015 at approximately 10:20AM, it was determined the charge nurse administered greater than twice the prescribed dosage of an ' as needed ' expectorant medication (Siltussin) to Resident #45. The medication that was administered (Siltussin) was not the intended medication. There was no documented evidence that the healthcare team of the oncoming shift(s) were notified about the medication error and subsequent review of the medical record lacked evidence that Resident #45 was comprehensively assessed and/or closely monitored following the incident.	F 309	**F309 Failure to provide care/services for highest well being** 1. **Corrective Action for Affected Resident:** Employee involved was counseled regarding facility's policy and procedure for safe medication administration. No negative outcome identified by this practice. 2. **Identification of Other Residents Potentially Affected by Same Practice:** There were no clinical indications that other residents were affected by this deficient practice. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff in-service on facility's policy for safe medication administration. Random med pass observations will be conducted monthly until all licensed staff has been observed. (On-going) 4. **Performance Monitoring to Make Sure Solution Are Sustained:** These findings will be reported with any corrective actions to QA committee quarterly.	6/10/15 6/10/15 6/15/15 7/23/15

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F 309	Continued From page 32 A. Employee #20 administered the wrong medication to Resident #45. Employee #20 was observed administering medications for Resident #45 on June 10, 2015 at approximately 10:20 AM. During the observation, a record of each of the medications prepared by the nurse was recorded, as required for the survey process. The nurse [Employee #20] retrieved a multidose bottle of " Siltussin " [an oral syrup - expectorant; used to treat coughs and congestion] from the medication cart and poured 30 cc into a medication cup. He/she gathered the remainder of the medications that had been prepared and entered Resident #45 ' s room. Employee #20 handed Resident #45 the medication cup and as the resident drank the syrup, Employee #20 said " that is your potassium. " Employee #20 returned to the medication cart and was queried regarding the comment made to the resident regarding " potassium. " He/she stated that potassium was given to the resident. In contrast, the employee was informed that he/she was observed to retrieve a bottle of " Siltussin " and poured the syrup into the medication cup; the documentation detailing the sequence of observations that was recorded was shared with Employee #20. It was requested that the nurse pour a sample of each of the medications for the purpose of observation, he/she complied and it was determined that the medications are similar in appearance [both were red colored syrup]. The samples were discarded after the observation. A review of physician ' s orders signed May 14, 2015 included the following:	F 309		

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F 309	Continued From page 33 Potassium Chloride 30 ml (40 MEq) by mouth every day for supplement. Siltussin AF/SF [alcohol free/sugar free] liquid (aka: Diabetic tussin) 100mg/5 [give] 10ml by mouth 3 times a day as needed for cough. Employee #20 was observed to pour 30 ml of Siltussin instead of the intended 30cc of Potassium. The dosage of Siltussin that was administered to Resident #45 was greater than twice the prescribed (10 ml) dosage. There was no evidence that Resident #45 sustained any untoward effect from the medication error. Employee #20 acknowledged the findings. B. Facility staff failed to conduct a comprehensive assessment of Resident #45 after he/she received greater than twice the prescribed dosage of an expectorant medication that was administered in error. Additionally, there was no evidence that Resident #45 was closely monitored following the incident. A review of Resident #45 ' s clinical record on July 12, 2015 at 9:00 AM, two (2) days after the medication error, lacked evidence that licensed staff conducted a comprehensive assessment and/or close monitoring of Resident #45 on June 10, 2015 after the aforementioned medication error. The most recent progress note recorded by nursing staff was dated June 3, 2015 [days prior to the incident]. According to the Nursing Spectrum Drug Handbook 2012, adverse effects of Siltussin include: headache, dizziness, nausea, vomiting, diarrhea, stomach pain, rash and urticaria.	F 309	**F309-B Failure to conduct comprehensive assessment after receiving greater than twice the prescribed dosage.** 1. **Corrective Action for Affected Resident:** No negative resident outcome occurred as a result of this deficiency. Employee involved was counseled during survey re: importance of assessment/monitoring following unusual occurrences. Med error repot completed and MD was notified by DON. 2. **Identification of Other Residents Potentially Affected by Same Practice.** No other residents were affected by this deficiency. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff were in-serviced on facility's policy and procedure for comprehensive assessment and documentation of unusual incidents/accidents. In-service will be repeated annually. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Medical records for all residents experiencing unusual incidents/accidents will be reviewed monthly for compliance with the policy. Threshold for compliance is 100%. Results will be reported to QA Committee quarterly.	6/10/15 6/10/15 6/15/15 7/23/15

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F 309	Continued From page 34 A face-to-face interview was conducted with Employee #2 on July 12, 2015 at approximately 9:30 AM. In response to a query regarding the lack of evidence of assessment and monitoring of Resident 45 following the medication error, he/she reviewed the record and acknowledged the lack of documentation, however, asked to follow up after researching the events. Employee #2 followed up and stated that the doctor was notified but the nurse did not document it. There was no evidence that licensed staff conducted a comprehensive nursing assessment following the medication error. Additionally, there was no evidence that Resident #45 was closely monitored for potential adverse effects after receiving more than twice the prescribed dosage of Siltussin. There were no nursing progress notes recorded after June 3, 2015. C. Facility staff failed to communicate to oncoming shifts that Resident #45 required follow-up and/or monitoring after he/she was administered medication greater than twice the prescribed dosage and that the medication that was administered was unintended. A review of facility ' s 24-hour report for the period of June 10 thru 11, 2015, under the heading, " Residents requiring follow up over next twenty-four hours " lacked evidence of documentation related to the medication error sustained by Resident #45. Resident #45 was not included as a resident requiring follow-up for the evening or night shift on June 10, 2015. Resident #45 was not included on the 24-hour report for June 10th or June 11th 2015.	F 309	**F309-C Facility staff failed to communicate resident's need for follow up to oncoming shifts** 1. **Corrective Action for Affected Resident:** No negative outcome occurred as a result of this practice. 2. **Identification of Other Residents Potentially Affected by Same Practice.** No other residents were affected by this deficiency. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff were re-educated on facility policy and procedure for completing twenty-four hour report to communicate all unusual occurrences and/or changes in residents' condition. This in-service will be included as part of new employee orientation. 4. **Performance Monitoring to Make Sure Solution Are Sustained:** The Twenty-four hour report will be monitored on a random basis, not less than once each week to ensure proper communication and follow up. Results will be documented and reported to the QA Committee quarterly.	 6/10/15 6/10/15 6/20/15 7/23/15

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F 309	Continued From page 35 According to the facility ' s policy entitled " Twenty-Four Hour Report " stipulates, " It is the policy of the Methodist Home to maintain a nursing 24-hour report. This report communicates changes in resident status over a 24-hour period. It also documents actions taken or clinical/administrative actions needed ... " A face-to-face interview was conducted with Employee #2 on June 12, 2015 at approximately 9:30 AM. He/she reviewed the 24-hour report for June 10 - 11, 2015 and acknowledged the findings. There was no documented evidence that facility staff communicated to the oncoming healthcare team regarding the medication error that Resident #45 sustained on June 10, 2015. There was no documentation noted in the nursing progress notes and the resident was not included on the 24-hour report. The records were reviewed June 12, 2015. 2. During a medication administration observation on June 10, 2015 at approximately 11:45AM, it was determined that Employee #20 administered an antihypertensive medication outside of the prescribed parameters for Resident #27 and failed to properly assess the resident ' s Apical pulse. Additionally, there was no evidence that the resident was comprehensively assessed and/or closely monitored following the administration of the antihypertensive medication. A. Facility staff failed to follow the physician ' s parameters of administration by failing to withhold an antihypertensive medication when the resident ' s blood pressure and pulse was less than the	F 309	**F309-2A Failure to follow the physicians parameters of administration by failing to withhold anti-hypertensive medication.** 1. **Corrective Action for Affected Resident:** Attending physician notified 06/10/15. No new orders obtained. Employee making error was counseled on facility's policy and procedure for anti-hypertensive medication administration and notification of physician for changes in residents condition. Resident did not experience negative outcome. 2. **Identification of Other Residents Potentially Affected by Same Practice:** MAR"s for all residents receiving anti-hypertensive medications were reviewed for compliance with facility policy for administration of anti-hypertensive medications. All were in compliance. 3. **Systematic Changes to Ensure Deficient Practice Does not Recur:** Licensed staff were in-serviced on safe medication administration practices and the eight rights of medication administration. (Nursing 2012 Drug Handbook Lippincott Williams and Wilkins Philadelphia PA.). 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** MAR's will be monitored monthly for compliance. Findings will be reported to QA Committee quarterly.	6/10/15 6/15/10 6/15/15 7/23/15

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F 309	Continued From page 36 range for administration. A review of physician ' s orders signed May 7, 2015 revealed Resident #27 ' s medication regimen included the following: Coreg 6.25 mg 1 tablet by mouth twice daily before meals breakfast and supper for Atrial Fibrillation. " Monitor B/P [blood pressure] daily prior to administration of antihypertensive medication. Notify MD [doctor] if SBP [systolic blood pressure] <100 mm HG [millimeters mercury] and or DBP [diastolic blood pressure] <60 mm Hg x2 [twice] consecutive readings " " Apical pulse daily " A review of the Medication Administration Record [MAR] for June 2015 revealed that Coreg was scheduled for administration at 9:00 AM and 10:00 PM daily and the Apical pulse was scheduled at 9:00 AM daily. Employee #20 was observed administering medications to Resident #27 on June 10, 2015 at 11:45 AM. The employee assessed the resident ' s vital signs with the automatic electronic vital sign apparatus. Employee #20 recorded the resident ' s blood pressure as 90/52 and pulse 59 and proceeded to administer the medications [including Coreg]. In response to a query regarding whether or not parameters of administration were prescribed for Resident #27, Employee #20 reviewed the MAR and identified the prescriber ' s parameters [delineated above]. Thereafter, Employee #20	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095038		06/15/2015

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F 309	Continued From page 37 used the automatic electronic apparatus to reassess the resident ' s blood pressure and pulse. He/she recorded the repeat blood pressure as 100/60 and pulse 61 (after the medication was administered). In response to a query regarding the technique used to assess the resident ' s " Apical " pulse, Employee #20 stated he/she did not have a watch or stethoscope to obtain it otherwise. According to the Nursing Spectrum Drug Handbook 2012, Coreg is a ' Beta blocker ' antihypertensive medication indicated for use in Hypertension and Heart Failure. Under the section labeled Administration ... " Give with food to slow absorption and minimize orthostatic hypotension [low blood pressure]; check apical pulse before administering, if it ' s below 60 beats per minute withhold dosage and contact prescriber ... " Employee #20 administered Coreg even though the physician ' s parameters of administration directed that the medication be ' held ' if the SBP was less than 100 and the DBP was less than 60 on two (2) consecutive readings. The resident ' s blood pressure was assessed at 90/52 and pulse 59 [less than manufacturer ' s recommendation for administration - " hold if pulse less than 60]. The employee did not reassess the resident ' s blood pressure and pulse until after the medication was administered. Additionally, the resident ' s Apical pulse was not assessed in accordance with acceptable standards of practice. A face-to-face interview was conducted with Employee #20 at the time of the observations.	F 309		

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F 309	Continued From page 38 She/he stated that the resident ' s blood pressure was within administration range upon reassessment. B. Facility staff failed to comprehensively assess and closely monitor Resident #27 after the nurse administered an antihypertensive medication (Coreg) outside of the prescribed parameters for administration (listed above). A review of Resident #27 ' s clinical record on June 12, 2015, two (2) days after the medication observation [detailed above], lacked evidence that licensed staff conducted a comprehensive assessment and/or close monitoring of Resident #27 following the morning administration of Coreg on June 10, 2015. The record revealed a nursing entry dated June 11, 2015 at 5PM that read, " Residents monthly POS [physician order sheet] reviewed/signed to by Nurse Practitioner. " The nursing entry preceding the June 11th note (above) was dated June 2, 2015. The clinical record lacked evidence that Resident #27 was comprehensively assessed and/or closely monitored after the administration of the morning Coreg. The resident was not included on the 24-hour report and there was no evidence that the oncoming shift was informed. A face-to-face interview was conducted with Employee #2 on June 12, 2015 at approximately 9:30 AM who acknowledged the findings. 3. Facility staff failed to administer medications with timeliness for Residents #27 and 44. During	F 309	**F309 –2B Staff failed to comprehensively assess and closely monitor resident after the nurse administered an antihypertensive medication outside of the prescribed parameters for administration.** 1. **Corrective Action for Affected Resident:** No negative resident outcome occurred as a result of this deficiency. Employee involved was counseled during survey re: importance of assessment/monitoring following unusual occurrences. Med error repot completed and MD was notified by DON. 2. **Identification of Other Residents Potentially Affected by Same Practice.** No other residents were affected by this deficiency. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff were in-serviced on facility's policy and procedure for comprehensive assessment and documentation of unusual incidents/accidents. In-service will be repeated annually. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Medical records for all residents experiencing unusual incidents/accidents will be reviewed monthly for compliance with the policy. Threshold for compliance is 100%. Results will be reported to QA Committee quarterly.	6/10/15 6/10/15 6/15/15 7/23/15

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F 309	Continued From page 39 a random medication observation on June 10, 2015, Employee #20 was observed administering medications prescribed more frequently than once daily, greater than one (1) hour after the scheduled administration time. According to "The Institute for Safe Medication Practices," guidelines for timely medication administration for Non-Time Critical scheduled medications are as follows: " Daily, weekly or monthly medications - [administer] within 2 hours, before or after the scheduled time ....for medications prescribed more frequently than daily but no more frequently than every 4 hours - [administer] within 1 hour, before or after the scheduled time." A. Employee #20 was observed administering medications scheduled for 9:00 AM at 11:45 AM for Resident #27. A review of the June 2015 Medication Administration Record [MAR] revealed five (5) of the 8 medications administered were prescribed for twice daily or more. One (1) of those five (5) medications (Coreg) was to be administered before breakfast. However, the resident had already consumed his/her breakfast prior to its administration. Employee #20 failed to administer medications for Resident #27 with timeliness. Medications prescribed for administration more frequently than ' once ' daily were administered greater than two (2) hours beyond the scheduled time and one (1) medication that was to be administered before breakfast was not. B. Employee #20 was observed administering medications scheduled for 10:00 AM at 11:30 AM	F 309	**F309 (A) Facility staff failed to administer medications with timeliness.** 1. **Corrective Action for Affected Resident:** Employee was immediately counseled re: facility's established med-pass times. No negative resident outcomes resulted from this deficient practice . 2. **Identification of Other Residents Potentially Affected by Same Practice:** All residents had the potential to be affected by this practice on the date the practice was identified. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff were re-educated on facility's policy for medication administration times. Random med pass observations will be conducted monthly until all licensed staff has been observed. (Ongoing) Pharmacy consultant will conduct med pass observations twice annually. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Results of med pass observations will be reported with any corrective action taken to QA Committee quarterly 7/23/15.	6/10/15 6/10/15 6/15/15 7/23/15 7/23/15

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F 309	Continued From page 40 for Resident #44. A review of the June 2015 Medication Administration Record [MAR] revealed one (1) of the 2 medications administered to Resident #44 were prescribed for twice daily or more (Methylphenidate - a Central Nervous System stimulant prescribed for depression medication). Employee #20 failed to administer medications to Resident #44 with timeliness. The Medication prescribed for administration more frequently than ' once ' daily was administered greater than one (1) hour beyond the scheduled time. A face-to-face interview was conducted with Employee #20 at the time of the medication observations. In response to a query regarding the lack of timeliness of medication administration, he/she acknowledged and stated " I don ' t know what happened today, why I am so late. "	F 309		
F 314	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:	F 314		

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F 314	Continued From page 41 Based on medical record review, and staff interview for one (1) of 30 sampled residents, it was determined the nursing staff failed to accurately assess a resident's skin to prevent the worsening of a presence on admission alternation in skin integrity in one (1) of 30 medical record reviewed (Resident #67). The findings include: 1. Facility staff failed to accurately conduct an assessment of Resident #67 skin integrity. Resident #67 admitted to Forest Hill of DC on March 31, 2015 with diagnoses to include Status post Open Reduction Internal Fixation of Right Hip for skilled nursing services with plans to return to an assisted living facility upon discharge. Medical record review conducted on June 10, 2015 revealed that on the Admission Nursing Assessment and admission Physician Orders dated March 31, 2015 the nursing staff documented the presence of present on admission Stage I pressure ulcers to bilateral heels with orders as follows: Right heel- " cleanse Stage I pressure site on Rt. [right] heel with NSS [normal saline solution] pat dry and apply skin prep TID [three times a day] leave to dry until resolved " ; and Left heel- " cleanse Stage I pressure site on Lt. [left] heel with NSS [normal saline solution] pat dry apply skin prep TID [three times daily] leave to dry till resolved " . The Admission Nursing Assessment dated March 31, 2015 revealed the nursing staff documented the presence of multiple present on admission alterations in skin integrity to include the	F 314	**F314-1 Facility staff failed to accurately conduct an assessment of Resident #67"s skin integrity.** 1. **Corrective Action for Affected Resident:** Care plan revision was done immediately. 2. **Identification of Other Residents Potentially Affected by Same Practice:** Wound rounds were conducted and skin sheets reviewed. No other residents were affected by this identified practice. 3. **Systemic Changes to Ensure Deficient Practice Does not Recur.** Licensed personnel in-serviced on the facility policy for wound identification and documentation. RN will conduct wound rounds weekly. This in-service will be provided as part of new employee orientation and annually 3. **Performance Monitoring to Make Sure Solutions are Sustained:** TAR's and skin sheets will be audited monthly to ensure compliance. Results will be reported to QA Committee quarterly.	6/10/15 6/10/15 7/17/15 7/23/15

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F 314	Continued From page 42 description of the bilateral heels pressure ulcers in the " Skin Condition " section as follows: left heel " redden area " measuring 3x2 centimeters; and right heel " deep purple area, no pain on palpation " measuring 2.5x3.5 centimeters. The Braden Scale - For Predicting Pressure Sore Risk dated March 31, 2015 revealed the nurse assessed Resident #67 as high risk for pressure ulcer as indicated by a total score of 12. According to the National Pressure Ulcer Advisory Panel, it has redefined the definition of a pressure ulcer and the stages of pressure ulcers in 2007 that stipulates " Suspected Deep Tissue Injury - depth unknown is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment; and Stage I: Non-blanchable erythema is intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate " at risk " persons. The Pressure Ulcer Record revealed weekly skin	F 314		

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F 314	Continued From page 43 assessments for the right heel as follows: March 31, 2105 Stage I, 2.5x2 centimeters no depth, drainage and/or odor; April 7, 2015- Stage I 2.5x2 centimeters no depth, drainage and/or odor, grayish color; April 13, 2015- " DTI [Deep Tissue Injury] " 4x2.5 centimeters, no depth, drainage, and/or odor, " dark red " color; April 21 and 28, 2015- " DTI [Deep Tissue Injury] " 4x2.5 centimeters, " dark black " color; May 5, 2015 " DTI [Deep Tissue Injury] " 4x2.5 centimeters , no depth, drainage and/or odor, black in color; May 12, 2015- " DTI [Deep Tissue Injury] " 2.5x3.8 centimeters , no depth, drainage and/or odor, black in color; May 19, 2015- " DTI [Deep Tissue Injury] " 2.5x3.5 centimeters , no depth, drainage and/or odor, black in color; May 26, 2015 - " DTI [Deep Tissue Injury] " 4x2.5 centimeters , no depth, drainage and/or odor, black in color; May 27, 2015- " Stage II " 3x2 centimeter, no depth, drainage, and/or odor, red color; June 3, 2015- Stage II 3x4 centimeters no depth, drainage and /or odor, pink color; and June 9, 2015- " Stage II " 4x3 centimeters no depth, drainage, odor, yellow slough color. A subsequent review of the medical record revealed the medical record lacked documented evidence of depth after the debridement performed on May 27, 2015 and June 3, 2015. The nursing staff failed to document the amount depth after debridement down to the subcutaneous tissue of right heel pressure ulcer. The facility staff failed to assess Resident #67 ' s skin accurately in accordance with prevailing standards of practice. 2. The facility staff failed to ensure a comprehensive nursing assessment was	F 314		

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F 314	Continued From page 44 performed when a change in the skin integrity was identified. Continued review of the medical record on June 10, 2015 revealed the following: On May 27, 2015, Resident #67 was seen by Plastics for " ulcer of right heel " . The consult relative to visit with Plastics revealed " wound soaked with Vashe solution, surgical debridement performed down to subcutaneous tissue with #15 blade, forceps, and scissors. All necrotic tissue removed. Dressing applied. " Recommendation upon return from Plastics appointment was as follows: dressing changes every day, apply Silvadene, gauze, Kerlix, and Coban. In addition resident was instructed to wear bunny boot and put minimal pressure on site, and must float foot during sleep and follow-up in seven (7) to ten (10) days. Resident #67 returned to the Plastic surgeon ' s office on June 3, 2015 for follow-up relative to ulcer of right heel. A surgical debridement was performed and dressing applied. The recommendations were to continue with Silvadene, gauze, Kerlix, and Coban; continue to float during sleep; and may have Percocet as needed for pain. The assessments relative to the right heel pressure ulcer document on the Pressure Ulcer Record revealed that on April 7, 2015, April 21, 2015, April 28, 2015, May 5, 2015 and June 9, 2015 were performed by the Licensed Practical Nurse. The documentation on the Pressure Ulcer Record and medical record lacked documented evidence that a Registered Nurse performed a	F 314	**F314-2 The facility staff failed to ensure comprehensive nursing assessment was performed when a change in skin integrity was identified.** 1. **Corrective Action for Affected Residents:** • Licensed staff were immediately in-serviced on the rationale for comprehensive assessments when deterioration in wounds is observed. • RN assessed wound and instructed charge nurse to notify MD of wound status; new orders received. • Comprehensive assessment completed by RN. 2. **Identification of Other Residents Potentially Affected by Same Practice:** Wound rounds were conducted and skin sheets reviewed. No other residents were affected by this practice. No deterioration detected. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** • RN to conduct wound rounds weekly. (Ongoing) • All licensed personnel in-serviced on the facility policy for wound identification and documentation. This in-service will also be provided as part of new employee orientation and annually. • Licensed staff in-serviced by AMT wound care nurse on wound identification and staging. 4. **Performance Monitoring to Make Sure Solutions are Sustained:** TARs and skin sheets will be audited on a monthly basis to ensure compliance. Results will be reported to QA Committee quarterly x2.	6/8/15 6/9/15 6/9/15 6/13/15 7/15/15 7/23/15

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F 314	Continued From page 45 comprehensive assessment and/or co-signed the assessment to support evaluation of the resident ' s intrinsic risks and other factors to include causal factors for delayed healing. On June 9, 2015 during a unit observation, the licensed practical nurse was observed placing a call to the medical staff to report the deterioration of the right heel wound. The pressure ulcer assessment documented on June 9, 2015 indicated " Response to Treatment: Deteriorated " . The medical record lacked documented evidence the Registered Nurse assessed Resident #67 ' s right heel ulcer after the Licensed Practical Nurse identified a change in the wound condition. The facility failed to ensure qualified professional personnel performed wound assessments when a change in condition was identified by the licensed practical nurse. 3. The facility staff failed to develop an individualized care plan with specific interventions and measureable goals relative to the right heel ulcer for Resident #67. Pressure Ulcer Care Plan initiated on April 1, 2015 revealed documentation of " Goal " as " Resident will remain free of skin breakdown through next review (stage I redness to both heels will be resolved) " ; and " Approach " includes " Provide floating bilateral heels on pillow to relieve pressure and wound round q [every] week to monitor the effective of treatment, consult to md [Medical Doctor] as needed. On April 13, 2015 the Pressure Ulcer Record identifies the right heel skin alteration as a Deep	F 314	**F 314 - 3 Failure to develop an individualized care plan with specific interventions and measureable goals relative to the right heel ulcer for Resident #67.** **1. Corrective Action for Affected Resident:** Resident no longer resides in facility. No corrective action can be implemented. **2. Identification of Other Residents Potentially Affected by Same Practice:** Care plans and skin sheets for residents with wounds were audited. No other residents were affected by this practice. **3. Systemic Changes to Ensure Deficient Practice Does not Recur.** Licensed personnel in-serviced on the facility policy for wound identification and documentation. This in-service will be provided as part of new employee orientation and twice annually. **4. Performance Monitoring to Make Sure Solutions are Sustained:** Care plans will be audited on a monthly basis to ensure compliance. Results will be reported to QA Committee quarterly.	6/9/15 6/15/15 7/15/15 7/23/15

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F 314	Continued From page 46 Tissue Injury, and a corresponding physician order was obtained to change the treatment order. The Pressure Ulcer care plan lacked documented evidence that the goals were amended to reflect the change in condition relative to the goals. Subsequently on May 19, 2015, changes in the wound were documented as follows: DTI [Deep Tissue Injury] 2.5 by 3.5 centimeters with no depth, drainage or odor and black in color. " Response to Treatment " - " New Tx. [treatment] order soak/ Santyl " were documented. In addition, check marks were documented in the columns for " Date Notified- Dietary and Physician " . The medical record lacked documented evidence the facility staff revised the care plan goals and/or interventions to reduce the risk for deterioration of existing right heel wound. On May 28, 2015, the Pressure Ulcer care plan was discontinued and a new care plan for " Surgical Wound Care " was initiated after surgical debridement of right heel on May 27, 2015. The " Goal " for the " Surgical Wound Care " care plan was documented as follows: " Surgical site to right heel will be free from s/s of infection through nest review and Resident will remain free of skin breakdown through next review. " The area on the right heel is still considered a pressure ulcer following the debridement and is not a surgical wound. The " Approach " for the identified area was documented as " Provide right heel on Prevalon boot while in bed and off when out of bed to relieve pressure. " The care plan lacked documented evidence of nursing interventions address the deterioration of the right heel pressure ulcer.	F 314		
F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325		

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F 325 SS=D	Continued From page 47 UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review for one (1) of 30 sampled residents it was determined that facility staff failed to ensure one (1) resident received a therapeutic diet as ordered by the physician. Resident # 7 The findings include: During a dining resident observation on June 8, 2015 at approximately 1:30 PM, Resident #7 was observed sitting at a table without a meal with two residents who were actively eating their meals , after further observation Resident #7 was served a can of a supplemental nutritional to drink . On June 9, 2015 at approximately 9:00AM Resident #7 was observed sitting in dining room alone without a meal drinking a supplemental nutritional drink. On June 10, 2015 at approximately 9:30 AM during breakfast Resident #7 was observed	F 325	**F325 Facility staff failed to ensure one resident received a therapeutic diet as ordered by the physician.** 1. **Corrective Action for Affected Resident:** Prescribed diet was offered to resident during survey; she refused. 2. **Identification of Other Residents Potentially Affected by Same Practice:** Diet orders were reviewed for all residents. All residents received prescribed diets. 3. **Systemic changes to Ensure Deficient Practice Does Not Recur:** New policy developed to require care plans to be compared to prescribed diet orders quarterly and updated, as needed. 4. **Performance Monitoring to Make Sure solutions are sustained:** Findings will be reported to the QA committee quarterly. Compliance threshold is 100%.	6/8/15 6/11/15 6/18/15 7/23/15

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F 325	Continued From page 48 during dining without a meal drinking a supplemental nutritional drink. There was no observation of Resident#7 being offered or served his/her prescribed diet during the above noted observations. A review of the clinical record revealed: Physicians Order Form dated June 2015; Diet Mechanical soft texture, regular diet with thin liquids. Dietary supplements Ensure Plus 8oz by mouth three times a day, provide ice cream with lunch and dinner provide 8 oz. (ounce) 2%milk with breakfast lunch and dinner. A review of the Quarterly Nutrition review dated March 18, 2015 revealed; Current weight stable with minimal changes x 6 months appetite for meals poor but takes 100% of ensure supplement, ice cream and milk ...f/u as needed. A review of residents Intake and output revealed a zero (0) intake for breakfast and lunch seven out of seven days reviewed. There was no evidence Resident # 7 was receiving his/her diet as ordered. A face to face interview with Employee #7 on June 10, 2015 at 10:00 AM at when queried why Resident #7 was not being given meals he/she stated, " Resident #7 pushes the food away so we stop giving them and since he/she likes the ensure that ' s what we serve " . A Face to face interview was conducted with Employee's # 2 and 11 on June 11, 2015 at approximately 3:00 PM. Both were informed of the aforementioned findings. Employee ' s #2 and	F 325		

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F 325	Continued From page 49 11 both stated they were not aware Resident #7 was not receiving his/her meals as ordered. Employee #11 stated " the supplemental nutrition is in addition to his her prescribed therapeutic diet not in place of it " . Facility staff failed to administer Resident # 7 ' s diet as prescribed. Employee # 2 acknowledged the above findings. The clinical record was reviewed on June 11, 2015	F 325	**F328 Failure to provide comprehensive assessment relative to change in respiratory status.** 1. **Corrective Action for Affected Residents:** Licensed staff were Immediately in-serviced during survey on the rationale for conducting a comprehensive assessment prior to initiating respiratory medications, and on pre and post assessments during administration of the medication.	6/8/15
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and interview it was determined that the licensed nursing staff failed to provide comprehensive assessment relative to change in respiratory status for one (1) of 30 sampled residents. Resident #34. The findings include:	F 328	2. **Identification of Other Residents Potentially Affected by the Same Practice:** The MAR and medical record for two (2) residents receiving nebulizer treatments were reviewed on 06/12/15. Comprehensive assessment were not included. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** All licensed personnel were in-serviced on the facility policy for pre and post assessments, administration, and documentation of nebulizer treatments. This in-service will be provided as part of new employee orientation and annually. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Medical records for all residents with nebulizer treatments will be audited monthly to ensure compliance. Results will be reported to QA Committee quarterly x4. Threshold for compliance 100%.	6/12/15 6/15/15 7/23/15

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F 328	Continued From page 50 Mosby ' s Nursing Drug Reference, 24th Edition references nursing considerations with administration of Albuterol and stipulates " ....Assess respiratory function: vital capacity, forced expiratory volume, lung sounds, heart rate and rhythm ... Evaluate therapeutic response: absence of Dyspnea, wheezing after 1 hour, improved airway exchange ... " Mosby ' s Nursing Drug Reference, 24th Edition references nursing considerations with administration of Ipratropium Bromide and stipulates " ....Respiratory status: rate, rhythm, auscultate breath sounds prior to and after administration ... " Resident #34 was admitted to the facility March 1, 2012 with diagnoses which included Dementia, Psychotic Disorder, Prostate Cancer, and Gastroesophageal Reflux Disorder. During the noon meal dining observation conducted on June 8, 215 at approximately 1:00 PM, Resident #34 was observed experiencing excessive coughing and minimal to mild respiratory distress while at the dining table. According to Resident #34 ' s Comprehensive Minimum Data Set dated February 25, 2015 and the Quarterly Minimum Data Set dated May 22, 2015, Resident #34 had no history of chronic respiratory disease processes. No care plans were required for acute onset respiratory dysfunction. According to the nursing notes, on June 1, 2015 the resident was " ...noted with congestion during auscultation. Physician updated, new order for	F 328		

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F 328	Continued From page 51 Duoneb one (1) vial three (3) times daily for seven (7) days ... " Duoneb is a combination bronchodilator (Albuterol and Ipratropium) respiratory medication used in the treatment of shortness of breath and wheezing associated with acute and/or chronic lung disease. The medical record lacked documented evidence that Resident #34 was assessed according to standards of care relative to the use of respiratory medication to include assessment of vital capacity, forced expiratory volume, and/or respiratory status prior to and at the completion of respiratory medication administration. Resident #4 received respiratory treatments according to physician orders three (3) times daily at 6:00 AM, 2:00 PM, and 8:00 PM on June 2, 3, 4, 5, 6, and 7, 2015 and at 6:00 AM and 2:00 PM on June 8, 2015. The facility staff failed to perform pre and post nebulizer treatment assessments in all instances. A face to face interview was conducted with Employee # 8 at 11:45 AM on June 10, 2015. The employee confirmed the absence of clinical staff notes specifying assessment of lungs to include location, amount of congestion, presence of wheezing and/or decreased breath sounds prior to initiation of and with continued use of respiratory medication. Further, the employee confirmed the nursing notes lacked details of the communication with medical staff relative to justifying the use of Duoneb or addition of an antibiotic on June 4, 2015. Employee #8 stated pre and post respiratory treatment assessments are not required, that the nursing shift notes are the evidence of the overall	F 328		

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F 328	Continued From page 52 assessment of the resident, and the notation of vital signs is evidence of the post treatment assessment. The employee confirmed the staff should note details of assessment and treatment effectiveness and/or ineffectiveness, as well as details of the medical staff consult in the progress notes. On June 10, 2015 at approximately 3:25 PM a face to face interview was conducted with Employee # 6. When queried about the requirement of pre and post nebulizer treatment assessment required she/he responded yes, the staff is required to perform and document pre and post nebulizer treatment assessments. On June 12, 2015 at approximately 12:40 a face to face interview was conducted with Employee # 2 when queried about the requirement of pre & post nebulizer treatment assessment s/he responded the expectation is that the nursing staff would perform and document detailed assessments and details relative to communication with the medical staff for treatment modalities.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

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F 329	Continued From page 53 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30sampled residents, it was determined that facility staff failed to ensure that residents were free of unnecessary medications as evidenced by failure to consistently monitor one (1) resident receiving antianxiety medication for signs of worsening anxiety. Residents #48. The findings include: 1. Facility staff failed to monitor Resident #48 for signs of worsening of anxiety behavior while he/she was receiving antianxiety medication; Xanax. A review of the resident ' s clinical record revealed that he/she was admitted to the facility on February 17, 2014 with diagnoses which included Anxiety with behavioral disturbances. According to physician's orders Resident #48 was	F 329	**F329 – 1 Facility staff failed to monitor Resident#48 for signs of worsening of anxiety behaviors while he/she was receiving antianxiety medication: Xanax** 1. **Corrective Action for Affected Resident:** Psychiatrist reviewed and documented that medications were administered appropriately for the prescribed symptoms. 2. **Identification of Other Residents Potentially Affected by Same Practice:** Progress note by psychiatrist and social worker for residents receiving antianxiety medications were reviewed to determine if behaviors requiring the administration of antianxiety medication were documented. Documentation was present. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** Behavior policy reviewed and updated to include an interdisciplinary approach to behavior tracking to better monitoring residents' behavior. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Random chart audit of residents on psycho active medications will be performed monthly by social worker and results will be reported to QA committee quarterly.	6/18/15 6/15/15 7/20/15 7/23/15

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F 329	Continued From page 54 started on Xanax 25mg PO [by mouth] every 8 hours as needed for severe anxiety on April 18, 2015. The Medication Administration Record (MAR) indicated resident was receiving the prescribed medication . A face-to-face interview was conducted with Employee #7 on June 20 2014 at 10:45AM. He/she stated that the facility does not record Resident behaviors on a "Behavior Monitoring Flow Sheet" and that certified nursing assistants document the resident ' s behaviors in the " care Tracker. " Further review of the resident's clinical record [Nurses' notes] and or Treatment Records failed to reveal any evidence that the resident was being monitored for signs of worsening anxiety and/or behavioral disturbances. A face-to-face interview was conducted with Employee #2 at approximately 2:30 PM on June 12, 2015. The employee was queried regarding the lack of documentation related to the behavioral monitoring he/she stated it is responsibility of all clinical staff to document resident ' s behaviors. Employee # 2 acknowledged aforementioned findings The record was reviewed on June 12, 2015.	F 329		
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	F 371		

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F 371	Continued From page 55 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based an observation and staff interview for one (1) of 30 sampled residents, it was determined that the facility failed to prepare and serve food under sanitary conditions, as evidenced by: soiled equipment such as one (1) of one (1) convection oven, four (4) of four (4) scoops to the cereal dispenser and one (1) of one (1) tilt skillet, a dirty kitchen floor, two (2) of two (2) dusty fire sprinklers, an uncovered pan of rolls, five (5) of five (5) torn steam table lids, five (5) of five (5) stained storage racks; and an employee who was storing clean dishes with his/her bare hands. Resident #33. The findings include: Facility failed to prepare and serve food under sanitary conditions. A. One (1) of one (1) convection oven was soiled with accumulated burnt food deposits on the racks and throughout the interior. B. Four (4) of four (4) scoops to the cereal dispenser were soiled. C. One of one tilt skillet, one (1) of one (1) fryer, and one (1) of one (1) stove were soiled with cooked food deposits and/or grease.	F 371	A. One (1) of one (1) convection oven was soiled with accumulated burnt food deposits on the racks and throughout the interior. 1. **Corrective Action for Affected Resident/Equipment:** Oven was Cleaned on June 9, 2015 2. **Identification of other Residents/Equipment Potentially Affected by same practice:** All other ovens were inspected and found clean on August 6, 2015 3. **Systemic changes to ensure deficient practice does not recur:** A member of the Dining Services Management Team will inspect the ovens daily, as part of the managers opening and closing checklist. The Master cleaning schedule has been updated to include signature for the associate that is assigned the cleaning task. August 6, 2015 4. **Performance Monitoring to ensure solutions are sustained:** Dining Services Management will monitor the opening and closing checklist findings weekly to ensure corrective actions are effective and sustained. Dining Services will report findings to QA quarterly. August 6, 2015 B. Four (4) of four (4) scoops to the cereal dispenser were soiled. 1. **Corrective Action for Affected Resident/Equipment:** Scoops were washed and sanitized during Survey June 8, 2015 2. **Identification of other Residents/Equipment Potentially Affected by same practice:** All other scoops were inspected and found clean. August 6, 2015 3. **Systemic changes to ensure deficient practice does not recur:** A member of the Dining Services Management Team will inspect the scoops daily, as part of the opening and closing checklist. Daily assignments for Dining Services staff have been updated to included washing and sanitizing all scoops. All associates will be in-serviced in the change in task by August 6, 2015	06/09/15 08/06/15 08/06/15 08/06/15 06/08/15 08/06/15 08/06/15

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F 371	Continued From page 56 D. The kitchen floor was unclean throughout with wasted food residue and debris. E. Two (2) of two (2) fire sprinklers in the walk-in refrigerator were covered with dust. F. A pan of uncooked rolls was stored uncovered, on top of the convection oven. G. Five (5) of five (5) steam table lids were bent and torn and needed to be replaced. H. The shelves from five (5) of five (5) storage racks used to store clean dishes and clean utensils were marred. I. An employee in dietary services was observed storing clean dishes with his/her bare hands. These observations were made in the presence of Employee #3 who acknowledged the findings during the survey.	F 371	4. **Performance Monitoring to ensure solutions are sustained:** Dining Services Management will monitor the opening and closing checklist findings weekly to ensure corrective actions are effective and sustained. Dining Services will report finding to QA quarterly. August 6, 2015 C. One of one tilt skillet, one (1) of one (1) fryer and one (1) of one (1) stove were soiled with cooked food deposits and/or grease. 1. **Corrective Action for Affected Resident/Equipment:** Tilt skillet, fryer, and stove were cleaned on June 9, 2015 2. **Identification of other Residents/Equipment Potentially Affected by same practice:** All other equipment was inspected and found clean. June 9, 2015 3. **Systemic changes to ensure deficient practice does not recur:** A member of the Dining Services Management Team will inspect the production equipment daily, as part of the opening and closing checklist. The Master cleaning schedule has been updated and the frequency of the equipment has increased to once a week. The production staff will be in-serviced on the changes by August 6, 2015	08/06/15 06/09/15 06/09/15 08/06/15
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:	F 386		

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		F371	4. **Performance Monitoring to ensure solutions are sustained:** A member of Dining Services Management will monitor the opening and closing checklist findings weekly and report findings to QA quarterly. August 6, 2015	08/06/15
			D. The kitchen floor was unclean throughout with wasted food residue and debris. 1. **Corrective Action for Affected Resident/Equipment:** Floor was swept and mopped during Survey June 8, 2015	06/08/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** No resident or Equipment was affected by practice.	
			3. **Systemic changes to ensure deficient practice does not recur:** Dining Services Management Team will inspect the Floor after each meal. The Dining service daily assignment has been revised to include sweeping and mopping after each meal or as needed. The director of dining services will schedule power washing of the kitchen floor monthly. This will be added to the safety and sanitation audit. All associates will be in-serviced and the first power washing will be completed by August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** The Director of Dining Services will monitor the findings from the Safety and Sanitation audit to ensure corrective actions are effective and sustained. Dining Services will report finding to QA quarterly. August 6, 2015	08/06/15
			E. Two (2) of two (2) fire sprinklers in the walk-in refrigerator were covered with dust. 1. **Corrective Action for Affected Resident/Equipment:** Sprinkler in walk-in were cleaned during survey on June 8, 2015	06/08/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** All other sprinklers in the kitchen were inspected and found clean. June 8, 2015	06/08/15

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		F371	3. **Systemic changes to ensure deficient practice does not recur:** Maintenance supervisor will randomly inspect all kitchen sprinklers every 2 weeks to ensure they are free of dust. A weekly inspection will be conducted by maintenance staff and recorded on the Maintenance Inspection Logs. August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** Logs will be reviewed by the Maintenance Director weekly for completion. Findings will be reported to QA quarterly. August 6, 2015	08/06/15
			F. A pan of uncooked rolls was stored, uncovered, on top of the convection oven. 1. **Corrective Action for Affected Resident/Equipment:** The rolls were covered immediately during Survey June 8, 2015	06/08/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** No resident was affected by practice. June 8, 2015	
			3. **Systemic changes to ensure deficient practice does not recur:** Dining Services Management Team will in-service the production staff on proper storage of food. The team will hold any associate accountable if the policy is not followed. August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** Dining Services Management will continue to monitor and educate the staff to ensure corrective actions are effective and sustained. Dining Services will report progress to QA quarterly. August 6, 2015	08/06/15
			G. Five (5) of five (5) steam table lids were bent and torn and needed to be replaced. 1. **Corrective Action for Affected Resident/Equipment:** The lids were discarded immediately during survey June 8, 2015.	06/08/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** No resident was affected by practice. New lids were purchased and are in place. June 8, 2015	06/08/15

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		F371	3. **Systemic changes to ensure deficient practice does not recur:** Dining Services Management Team will inspect the lids monthly by using our safety and sanitation audit. August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** Dining Services Management will monitor the findings to ensure corrective actions are effective and sustained. Dining Services will report finding to QA quarterly. August 6, 2015	08/06/15
			H. The shelves from five (5) of five (5) storage racks used to store clean dishes and clean utensils were marred.	
			1. **Corrective Action for Affected Resident/Equipment:** No corrective action could be taken as the racks could not be repaired. August 6, 2015	08/06/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** No resident or equipment was affected by practice. August 6, 2015	08/06/15
			3. **Systemic changes to ensure deficient practice does not recur:** Replacements for the marred shelving have been purchased and will be placed as soon as they arrive. Dining Services Management Team will add all kitchen shelving/racks to the Safety and Sanitation audit for inspecting monthly. August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** The Director of Dining Service will monitor the inspection reports to ensure the storage racks remain in good condition. Dining Services will report findings to QA quarterly. August 6, 2015.	08/06/15

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		F371	I. An employee in dietary services was observed storing clean dishes with his/her bare hands. 1. **Corrective Action for Affected Resident/Equipment:** Dishes were rewashed and sanitized June 8, 2015	06/08/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** No resident or equipment was affected by practice. June 8, 2015	06/08/15
			3. **Systemic changes to ensure deficient practice does not recur:** Dining Services Management Team has conducted in-services on proper handling of clean dishes and single use gloves. Dining services staff will also continue 100% participation in infection control in-services offered at Forest Hills of DC. August 6, 2016	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** Dining Services Management will continue to monitor and educate the staff to ensure corrective actions are effective and sustained. Dining Services will report progress to QA quarterly. August 6, 2015	08/06/15

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	095038		06/15/2015

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F 386	Continued From page 57 Based on medical record review ad confirmed on staff interview it was determined that the medical staff failed to conduct comprehensive assessments for two (2) residents with acute change in status. Residents #24 and # 34. The findings include: 1.Resident #24 was admitted to the facility on September 9, 2013 with diagnoses which included Anemia, Non-Alzheimer ' s Dementia and Depression. According to the Minimum Data Set Comprehensive Assessment dated September 19, 2014 for Resident #24 Item 11 ' Falls ' care area was triggered, and care planning decision was checked; and Section E, relative to Behavior, was coded as " no " for rejection of care. Resident #24's written Care Plan initiated March 12, 2015 included the following general approaches: use walker to ambulate under supervision; and resident to be assisted to the bathroom at all times. Resident #24's Quarterly Fall Risk Assessments for September 2014 through March 2015 reflected a total score of 11, interpreted as high risk for falls. On May 28, 2015 the nursing staff noted Resident #24 was " ...found on floor beside bed, supine, walker next to [him/her] .... " The care plan was updated May 29, 2015, directing " continue to remind resident to ask for assistance, cold compress to head per orders..." Per physician ' s telephone order on May 28, 2015, Resident #24 received an analgesic, Tylenol, for a complaint of back pain after fall,	F 386	**F 386 - Medical staff failed to conduct comprehensive assessments for two (2) residents with acute change in status.** 1. **Corrective Action for Affected Resident:** Physician failed to assess residents who experienced acute change in condition. There was no negative outcome for these residents. 2. **Identification of Other Residents Potentially Affected by Same Practice:** All other charts reviewed for timeliness of physician assessment and documentation. No other residents were affected by this practice. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** Medical director and Nurse Practioner were provided information regarding timeliness of assessment and documentation per regulation. Policy will be initiated to address required documentation by medical staff following incidents/accidents. Documentation re: physician assessments following incidents or accidents will be routinely audited weekly. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Results of documentation reviews will be reported to QA committee quarterly Threshold for compliance 100%	6/10/15 7/20/15 6/19/15 7/20/15 7/23/15

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F 386	Continued From page 58 and an ice pack was applied to the hematoma sustained as a result of the fall, and neurological assessments (neuro checks) were documented as follows: May 28, 2015 at 7:30 PM; 11:00 PM; May 29, 2015 at 7:12 AM; 3:26 PM; and 11:20 PM; and May 30, 2015 at 4:46 PM. All assessments were documented as " within normal limits " . On May 29, 2015 at 3:20 PM the nursing staff documented " ...hematoma on the head resolved " . Neurological assessments were discontinued on May 31, 2015 at 6:30 AM and fall precautions were continued. The medical record lacked documented evidence that the medical staff performed a comprehensive assessment post fall. A face to face interview was conducted with Employee #14 on June 9, 2015 at approximately 10:45 AM during staff interview. The employee stated " the resident is impulsive, and wants to do as [she/he] pleases when [she/he] pleases. The resident refused care after the fall initially, and would only take ice packs for the hematoma. " When queried as to whether the medical staff assessed Resident #24 after the fall, she/he could not recall. A face to face interview was conducted with Employee #2 on June 12, 2015 at approximately 12:40 PM. Employee acknowledged and confirmed the findings, and stated the expectation is that the medical staff would perform an assessment after an injury. 2. Resident #34 was admitted to the facility March 1, 2012 with diagnoses which included Dementia, Psychotic Disorder, Prostate Cancer, and Gastroesophageal Reflux Disorder.	F 386		

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F 386	Continued From page 59 During the noon meal dining observation conducted on June 8, 215 at approximately 1:00 PM, Resident #34 was observed experiencing excessive coughing and minimal respiratory distress while at the dining table. According to Resident #34 ' s Comprehensive Minimum Data Set dated February 25, 2015 and the Quarterly Minimum Data Set dated May 22, 2015, Resident #34 had no history of chronic respiratory disease processes. No care plans were required for acute onset respiratory dysfunction. According to the nursing notes, on June 1, 2015 the resident was " ...noted with congestion during auscultation. Physician updated, new order for Duoneb one (1) vial three (3) times daily for seven (7) days ... " On June 5, 2015 at 6:30 PM a verbal order was transcribed to begin treatment with " Avelox " (an antibiotic) for seven (7) days for Bronchitis. The medical record lacked documented evidence of a detailed focused assessment performed by the nursing and/or medical staff relative to the initiation of treatment with Duoneb and/or Avelox to include ruling out Pneumonia, Airway Obstruction, and/or Aspiration. A face to face interview was conducted with Employee #8 at 11:45 AM on June 10, 2015. The employee confirmed the absence of clinical staff notes specifying assessment of lungs, treatment plans or medication management. Further, the employee confirmed the nursing notes lacked details of communication with medical staff relative to use of Duoneb or Avelox.	F 386		

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F 386	Continued From page 60	F 386		
	On June 12, 2015 at approximately 12:40 a face to face interview was conducted with Employee #2 who acknowledged and confirmed the findings, and stated the expectation is that the medical staff would perform an assessment of acute onset illness and confirm/justify use of the prescribed treatment modalities.			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	**F 425 - Failure to acquire a vaccine/medication that was prescribed for Resident #48.**	
	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.		1. **Corrective Action for Affected** Pharmacy notified in writing on regarding medication for resident.	6/15/15
	A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.		2. **Identification of Other Residents Potentially Affected by Same Practice:** No other residents were affected by this practice.	6/12/15
	The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.		3. **Systematic Changes to Ensure Deficient Practice Does not Recur:** Facility policy regarding the pharmacy services was developed whereby pharmacy will notify facility in writing within 72 hours if unable to obtain a medication. Physician will be notified of unavailability, and substitute requested if appropriate. Physician order will be updated to reflect order status.	7/20/15
	This REQUIREMENT is not met as evidenced by:		4. **Systematic Changes to Ensure Deficient Practice Does not Recur:** Policy compliance will be monitored Monthly and results will monitor and report to QA committee quarterly.	7/23/15
	Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that the facility failed to acquire a			

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F 425	Continued From page 61 vaccine/medication that was prescribed for Resident #48. The findings include: A review of the clinical record History and Physical revealed: Resident # 48 was admitted to the facility February 12, 2015 with a diagnoses of Osteoporosis, Pulmonary Hypertension and Increased Lipids. A review of the physician ' s order dated May 14, 2015 revealed "Zostavax " [a vaccine indicated for the prevention of Herpes Zoster - Shingles] was ordered for immunization." A review of the Nurses Notes May 14, 2015 read: "MD ordered Zostavax for resident ... order faxed and transcribed...9:50 PM " . A nurse ' s note dated May 21, 2015 6:00 PM revealed; " Writer called several times to [name] Pharmacy about vaccination Zostavax ... [referring to 5/14/15 nurses note] ... Finally information that Allied pharmacy does not carry the vaccine ... unable to send ...message communicated to resident ' s [next of kin] who will verify from either Walgreens or CVS if vaccination is available ... there after they obtain prescription from [physician's name] to purchase pending response from [next of kin]. " SIC A nurses note dated June 6, 2015 at 9:15 PM revealed ; " Writer called residents [next of kin] following up on Zostavax immunization for [resident] ... was to follow up with local pharmacy like Walgreens, CVS etc.. for [resident] ...Family presently out of country on Vacation ... " .	F 425		

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F 425	Continued From page 62 There was no evidence the pharmacy attempted to acquire the prescribed medication. The medication was not in facility as of June 12, 2015. Face to face interview with Employee #2 was done on June 12, 2015 at approximately 9:00 AM when queried regarding Zostavax he/she was aware of the medication not being available due to it being a very sensitive medication and the vaccine was not delivered because the pharmacy does not have a viable mechanism in place for delivery. Employee #2 acknowledged aforementioned findings. The clinical record was reviewed on June 12, 2015	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be 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	F 431		

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F 431	Continued From page 63 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 observation, record review, and staff interviews for six (6) of 30 sampled residents, it was determined that facility staff failed to: accurately reconcile controlled substances for one (1) resident, as evidenced by an inaccurate narcotic count; failed to label medications in accordance with accepted professional principles for five (5) residents, as evidenced by unlabeled vials in the medication cart; and failed to consistently monitor the refrigerator temperatures on one (1) of two (2) residential units. Residents ' #14, 19, 21, 45, 48, and 52. The findings include: 1. Facility staff failed to accurately reconcile controlled substances for Resident #14. On June 8, 2015 at approximately 11:30 AM, a	F 431	**F 431 Failure to accurately reconcile controlled substances for Resident #14** #1 1. **Corrective Action for Affected Resident:** Controlled substances for resident reconciled during survey. There were no negative outcomes to resident as a result of this practice. 2. **Identification of Other Residents Potentially Affected by Same Practice:** All other narcotic records were reviewed, no other discrepancies noted 3. **Systemic change to Ensure Deficient Practice Does not Recur:** Educational training conducted for licensed nurses regarding the importance of accurate narcotic reconciliation 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Narcotic records will be monitored monthly and reported to QA Committee quarterly.	6/8/15 6/8/15. 6/8/15. 7/23/15

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F 431	Continued From page 64 medication storage observation was conducted on Healthcare Center 2 with Employee #6. The narcotic count conducted with Employee #8 revealed 28 oxycodone [narcotic analgesic] tablets were in the package for Resident #14. The last entry documented on June 7, 2015 at 10:00 PM revealed 29 tablets of oxycodone were left in the package. A review of the physician ' s interim order form dated June 3, 2015 and timed at 6:00 PM, revealed an order for Percocet [oxycodone -narcotic analgesic] one tablet by mouth every eight hours for severe pain for the resident. A review of the Prn [As Necessary] Medication Administration Record (MAR) revealed Percocet was initialed as given at 06:00 AM on June 8, 2015. The ' Controlled Drug Shift Count Sheet ' was signed by the ' off- going ' staff member (Employee #13) and ' on-coming ' staff member (Employee #8) on June 8, 2015 for the 11:00 PM-7:00 AM shift. However, there was no documented evidence that the narcotic count was accurately reconciled. On June 8, 2015 at approximately 11:35 AM, Employee #8 was asked to explain the discrepancy in the narcotic count. Employee #8 stated, " I counted the narcotics and I thought I saw 29 tablets. " He/she reviewed the Prn MAR and stated, " Oh, the night nurse gave the resident a Percocet at 6:00 AM and did not document it on the narcotic sheet. 28 is the correct count for the narcotics, not 29. " Employee #8 could not explain why the ' Controlled Drug Shift Count Sheet ' was signed	F 431		

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F 431	Continued From page 65 to indicate a correct count, when the count was incorrect. The records were reviewed on June 8, 2015. 2. Facility staff failed to label medications in accordance with accepted professional principles. On June 8, 2015 at approximately 11:00 AM, a medication storage observation was conducted on Healthcare Center 1 with Employee #7. A review of the medication cart revealed the following: Two open bottles of Fluticasone (corticosteroid) nasal spray that were unlabeled with a name or date on the bottle. The bottles were stored in boxes labeled with Resident #19 ' s name. An open bottle of Morphine (narcotic analgesic) liquid that was observed unlabeled with a name or date opened on the bottle. The bottle was stored in a box labeled with Resident #21 ' s name. One open bottle of Fluticasone nasal spray that was unlabeled with a name or date opened and was stored in a box labeled with Resident #48 ' s name. There was no documented evidence that the open bottles of medications were labeled with the residents ' names and dates that they were opened. On June 8, 2015 at approximately 11:15 AM, a face-to- face interview was conducted with Employee #7 regarding the aforementioned findings. He/she acknowledged and confirmed	F 431	**F 431 Failure to label medications in accordance with accepted professional principles #2** 1. **Corrective Action for Affected Resident:** There were no negative outcomes Identified by this deficient practice. All open containers not dated/initials during survey were discarded upon discovery. 2. **Identification of Other Residents Potentially Affected by Same Practice:** Pharmacy was notified that all narcotics and other medications with an inner/outer containers must have label on both inner and outer containers. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** Educational training was done for licensed nurses regarding the importance of dating vials when opened. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** All medications with an outer container and opened vials will be monitored for proper labeling, initials of licensed staff opening the vials and date opened monthly; findings will be reported to QA committee quarterly X 2.	6/8/15 6/8/15 6/9/15 7/23/15

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F 431	Continued From page 66 the findings. He/she further stated, " Pharmacy should have labeled the bottles of medications, like they did the others. " 3. On June 8, 2015 at approximately 11:30 AM, a medication storage observation was conducted on Healthcare Center 2 with Employee #6. A review of the medication refrigerator revealed the following: Two open bottles of Lantus Insulin that were unlabeled with a name or date and were stored in separate boxes that were labeled with Resident #45 ' s and Resident #52 ' s names. One open bottle of Influenza Vaccine, Lot #UI189AB, that was not labled to reflect the date it was opened. One open bottle of Tuberculin, Lot# 762017, that was not labled to reflect the date it was opened. There was no documented evidence that the open bottles of medications were labeled with the residents ' names and/or dates that they were opened. On June 8, 2015 at approximately 11:45 AM, a face-to- face interview was conducted with Employee #6 regarding the aforementioned findings. He/she acknowledged and confirmed the findings. 4. Facility staff failed to consistently monitor medication refrigerator temperatures. On June 8, 2015 at approximately 11:30 AM, a medication storage observation was conducted	F 431	**F 431 #3 - Failure to ensure that open bottles of medications were labeled with the residents ' names and/or dates that they were opened.** 1. **Corrective Action for Affected Resident:** Open bottles not dated, labeled, or initialed were discarded during survey. 2. **Identification of Other Residents Potentially Affected by Same Practice:** Pharmacy was notified that all medications with inner/outer containers must be labelled on both containers. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** Policy was reviewed with licensed nurses regarding proper labeling and dating vials when opened. Open vials will be randomly checked monthly to ensure compliance with policy. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Findings will be reported to QA quarterly X 2.	6/8/15 6/8/15 6/9/15 7/20/15 7/23/15

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F 431	Continued From page 67 on Healthcare Center 2 with Employee #6. A review of the refrigerator temperature log revealed that the spaces allotted for temperature readings and staff signatures were left blank on the following days and shifts: May 20, 2015 11:00 PM-7:00 AM and 7:00 AM - 3:00 PM May 21, 2015 3:00 PM-11:00 PM May 22, 2015 7:00 AM- 3:00 PM May 24, 2015 7:00 AM- 3:00 PM May 28, 2015 3:00 PM-11:00 PM There was no documented evidence that facility staff consistently monitored the temperature of the medication refrigerator. On June 8, 2015 at approximately 11:55 AM, a face-to- face interview was conducted with Employee #6 regarding the aforementioned findings. He/she acknowledged and confirmed the findings.	F 431	**F 431 - #4 Facility staff failed to consistently monitor medication refrigerator temperatures.** 1. **Corrective Action for Affected Resident:** No residents were affected by this deficient practice. 2. **Identification of Other Residents Potentially Affected by Same Practice:** None identified. **Systemic change to Ensure Deficient Practice Does not Recur:** Staff in-serviced on policy for monitoring refrigerator temperatures. Temperature logs will be reviewed daily to ensure accuracy and timeliness of recordings. **Performance Monitoring to Make Sure Solutions Are Sustained:** Results from monitoring will be reported to QA committee X 2 quarters.	6/8/15 6/8/15 6/8/15 7/23/15