STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING ______ B. WING ______	08/18/2014

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F 000	INITIAL COMMENTS	F 000		

A recertification Quality Indicator Survey was conducted on August 11 through August 18, 2014. The deficiencies are based on observation, record review, resident and staff interviews for 51 sampled residents.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
D/C discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - emergency medical services (911)
g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning
FU/FL Full Upper /Full Lower
ID - Intellectual disability
IDT - interdisciplinary team
INR - International Normalised Ratio
L - Liter
Lbs - pounds (unit of mass)
MAR - Medication Administration Record

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 10-6-14

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 MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MRR- Medication Regimen Review Neuro - Neurological NP - Nurse Practitioner OBRA - Omnibus Budget Reconciliation Act 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 RAI- Resident Assessment Instrument ROM- Range of Motion TAR - Treatment Administration Record CAA- Care Assessment Area QAA- Quality Assessment and Assurance	F 000	F241 #1 1. Employee # 39 is no longer employed by Ingleside at Rock Creek. 2. The Administrator and Department Heads rounded and noother employees were noted to be speaking harshly and in a loud tone. 3. Staff have been inserviced on professional conduct and maintaining dignity and respect for residents. 4. Department Heads will conduct random observations on resident units for loud harsh speaking. Results will be forwarded to QA committee for further review and action.	8/15/14 8/15/14 9/5/14
F 241 SS=E	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	F 241		

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F 241	Continued From page 2 by: Based on an isolated observation on August 15, 2014, it was determined that facility staff failed to promote care for residents in a manner and in an environment that enhanced dignity as evidenced by the observation of an employee speaking in an elevated tone and harsh manner on the residential unit in one (1) of one observation. Additionally, facility staff failed to wait to receive permission to enter the room of one (1) of 51 sampled residents. Resident #12. The findings include: 1. Facility staff failed to promote and maintain an environment that enhanced residents' dignity as evidenced by the observation of an employee speaking in an elevated tone and harsh manner on the residential unit. The following observation was made on August 15, 2014 at approximately 1:30 PM: Employee #39 entered the Lower Level Residential Unit common area, approximately 25 feet from the nurses' station, Employee #39 said to Employee 6, "Don't ask me to make any more copies I am going to lunch." The statement was made in an elevated tone and conveyed in a harsh, matter-of-fact manner within hearing distance of residents who were seated in the common area television/activity room. Facility staff failed to promote an environment that enhanced dignity as evidenced by speaking	F 241	**F241 #2** 1. Employee # 11 was re-educated on maintaining resident's dignity and the importance of waiting for a response to enter resident's room after knocking. 2. An audit was conducted by the Director of Nursing (DON) and staff were noted to be waiting for response prior to entering resident's rooms. 3. The Staff Development Coordinator has re-educated all other staff on maintaining dignity and respect for residents and waiting for a response before entering resident's rooms. 4. Audits will be done by DON or designee weekly x 4, then monthly x 3 to ensure that staff are knocking and waiting for a response to allow entry into resident's rooms. Report will be forwarded to QA committee for review and action.	8/18/14 9/5/14

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F 241	Continued From page 3 in an elevated tone and harsh manner in the presence of residents and visitors. The observation was made on August 15, 2014 in the presence of Employee #6. 2. Facility staff failed to wait to receive permission to enter Resident #12's room. On August 12, 2014 at approximately 10:41AM during an interview with Resident #12, Employee #11 knocked on the door to the resident's room and entered the resident's room without waiting for permission to enter. Resident #12 commented, "Sometimes, they knock and just come in just like [he/she] did." A face-to-face interview was conducted with Employee #11 on August 12, 2014 at approximately 10:55 AM. He/she acknowledged the aforementioned findings. The observation was made on August 12, 2014.	F 241	**F246** 1. The call bell in the bathroom of room #196 was unwrapped from the grab bar and made accessible for use. The call light was unknotted from the call bell housing unit and is accessible for residents. 2. The Director of Nursing (DON) conducted an audit and all call bells are accessible for all residents to use. 3. Staff was re-inserviced on keeping call bells unwrapped to be accessible at all times to all residents. 4. Compliance will be monitored by the Interdisciplinary Team during rounding to ensure that call bells are unwrapped, unknotted, and within reach for residents. Audits will be done weekly x 4, then monthly. Trends will be reported to QA Committee for review and action.	8/18/14 8/22/14 9/5/14
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations made on August 13, 2014 between 9:20 AM and 12:30 PM, it was	F 246		

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F 246	Continued From page 4 determined that the facility failed to maintain call bells in resident ' s rooms readily accessible at all times as evidenced by a call bell that was wrapped around the grab bar in the bathroom of one (1) of 23 resident rooms surveyed and a call bell that was tied into a knot in one (1) of 23 resident rooms surveyed. The findings include: 1. The call bell in the bathroom of room #196 was wrapped around the grab bar, could not be activated and was not readily accessible in one (1) of 23 resident rooms. 2. The call bell in one (1) of 23 resident rooms (#199) was tied into a knot at the call bell housing and was not readily accessible. These observations were made in the presence of Employee #30 and Employee #39 who acknowledged the findings.	F 246	**F253 #1** 1. Fall mats and trash bags were removed from the "Weight Room". The floor was cleaned and the wall was cleaned and painted. 2. All storage areas were checked and found to be clean and free of clutter. 3. Facility staff was re-educated on cleanliness and proper storage of equipment. 4. Facilities Director or designee will check storage rooms weekly x 4 then monthly x 3 and then quarterly on an ongoing basis to ensure cleanliness. Reports will be forwarded to QA for further review and action.	8/13/14 8/13/14 8/19/14
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 on August 13, 2014 at approximately 3:00 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by a soiled and	F 253		

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F 253	Continued From page 5 marred room on the upper level unit and one (1) of 23 resident rooms observed with clutter and missing dresser and nightstand knobs. The findings include: 1. A room on the upper level unit identified as " weighing room " as noted by a piece of paper posted on the door, was cluttered with two (2) fall mats and a trash bag stored on the floor. The floor was soiled and the walls were marred. 2. One (1) of 23 resident rooms (room #177) was cluttered with approximately 10 to 12 cardboard boxes that were stored on the floor and numerous pages of newspapers that were scattered over the boxes. Eleven (11) of 14 knobs were observed missing from the dresser and nightstand. These observations were made in the presence of Employee #30 and Employee #39 who acknowledged the findings.	F 253	**F253 #2-3** 1. Resident # 177 room was de-cluttered by Maintenance and Housekeeping staff. Dresser was replaced. 2. All other rooms were checked and no other resident rooms were found to be cluttered or with furniture knobs missing. 3. Housekeeping will check residents' room daily to clean and remove clutter. 4. Unit Manager or designee will monitor resident rooms weekly x 4 to ensure that resident's room is clean and organized. Reports will be forwarded to QA committee for review and action.	8/13/14 8/13/14
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272		

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F 272	Continued From page 6 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A] of Minimum Data Sets (MDS) for five (5) residents. Residents' #20, 128, 130, 133, and 143. The findings include:	F 272	**F272 #1-5** 1. Residents #20 and #130 MDS records will be modified to reflect location and date CAA. Residents #128, #133, and #143 have been discharged from the facility. 2. All current MDS were reviewed for location and date of CAA documented in the MDS and were found to be in compliance. 3. MDS Coordinator was re-inserviced on complete documentation of MDS to include location and date of CAA. 4. The Director of Nursing (DON) or designee will conduct audits on all completed MDS prior to transmittal weekly x 4, then monthly x3 to ensure location and date of CAA is on MDS.	10/15/14 9/15/14 9/15/14

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F 272	Continued From page 7	F 272		

According to Chapter 4 of the MDS 3.0 Users ' Manual, " for each triggered care area, indicate the date and location of the CAA documentation...CAA documentation should include information on the complicating factors, risks and any referrals for the resident for this care area ... "

1. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #20.

A review of Resident #20's Admission Minimum Data Set dated October 1, 2013 revealed the Care Areas and the Care Planning Areas triggered for #2 Cognitive Loss/Dementia, #4 Communication, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #16 Pressure Ulcers and #17 Psychotropic Drug Use.

The record revealed that the location and date of CAA information for care areas [#2, 4, 6, 11, 16 and 17] was omitted.

There was no evidence that facility staff documented the date and location where in the clinical record the information related to the triggered areas could be found.

A face-to-face interview was conducted with Employee #15 on August 14, 2014 at 2:09 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 14, 2014.

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F 272	Continued From page 8	F 272		

2. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #128.

A review of Resident #128's Admission Minimum Data Set dated August 1, 2014 revealed the Care Areas and the Care Planning Areas triggered for #2 Cognitive Loss/Dementia, #4 Communication, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #16 Pressure Ulcers, #17 Psychotropic Drug Use, #19 Pain, and #20 Return to Community Referral.

The record revealed that the location and date of CAA information for care areas [#2, 4, 6, 11, 12, 16, 17, 19, and 20] was left blank.

There was no evidence that the facility staff documented the location and date in the clinical record regarding information related to the CAA's.

A face-to-face interview was conducted with Employee #15 on August 14, 2014 at 2:09 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 14, 2014.

3. Facility staff failed to identify the location and date of the Care Area Assessment (CAA) information on the admission Minimum Data Set

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F 272	Continued From page 9	F 272		

(MDS) under Section V0200A for Resident #130.

A review of Resident #130 's admission MDS with an Assessment Reference Date (ARD) of August 1, 2014 revealed that "Care Area Triggered [and] the Care Planning Decision Area" was selected for #2 Cognitive Loss/Dementia, #5 ADL Functional/Rehabilitation Potential, #6 Urinary Incontinence / Indwelling Catheter, #11 Falls, #12 Nutritional Status, #15 Dental Care and #16 Pressure Ulcers.

The record revealed that the location and date of CAA information for care areas [#2, 5, 6, 11, 12, 15, and 16] was left blank.

There was no evidence that facility staff documented the date and location where in the clinical record the information related to the triggered areas could be found.

A face-to-face interview was conducted with Employee #15 on August 14, 2014 at approximately 10:20 AM. He/she acknowledged that the date and location where information related to the triggered care areas could be found was not recorded. The record was reviewed August 14, 2014.

4. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #133.

A review of Resident #133's Admission Minimum Data Set dated August 5, 2014 revealed the Care Areas and the Care Planning Areas

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F 272	Continued From page 10 triggered for #5 ADL Functional/Rehabilitation Potential, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #16 Pressure Ulcers, #17 Psychotropic Drug Use, #19 Pain, and #20 Return to Community Referral. The record revealed that the location and date of CAA information for care areas [#5, 6, 11, 12, 16, 17, 19, and 20] was left blank. There was no evidence that the facility staff documented the location and date in the clinical record regarding information related to the CAA's. A face-to-face interview was conducted with Employee #15 on August 14, 2014 at 2:09 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 14, 2014. 5. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the Minimum Data Set [MDS] for Resident #143. A review of Resident #143's Admission Minimum Data Set dated August 4, 2014 revealed the Care Areas and the Care Planning Areas triggered for #5 ADL Functional/Rehabilitation Potential, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #16 Pressure Ulcer, and #20 Return to Community	F 272		

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Referral.

The record revealed that the location and date of CAA information for care areas [#5, 6, 11, 12, 16, and 20] was left blank.

There was no evidence that the facility staff documented the location and date in the clinical record regarding information related to the CAA's.

A face-to-face interview was conducted with Employee #15 on August 14, 2014 at 2:09 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 14, 2014.

Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on the Minimum Data Sets (MDS) under Section V [V0200A] for five (5) residents reviewed.

F 278 SS=D — 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED — F 278

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

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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 observations, record review and interview for two (2) of 51 sample residents, it was determined that the facility staff failed to accurately code Minimum Data Sets (MDS) for one (1) resident receiving hospice services and one (1) resident for skin condition under Section M. Residents #10 and 52.

The findings include:

1. Facility staff failed to accurately code the MDS for Resident #10 who was receiving hospice services.

A review of the Resident #10 ' s clinical record revealed a Physician's order dated September 25, 2013 that directed, " [name] Hospice please evaluate resident secondary to debility." Hospice services were initiated in September 2013 and

F 278 — Provider's Plan of Correction

F278 #1-2

1. Residents #10 and #52 are discharged from the facility. We cannot retrospectively correct. — 9/15/14

2. Audits of MDS for all residents on hospice and with skin alteration were done. All were coded correctly. — 9/15/14

3. MDS Coordinator was re-educated on accurate coding of hospice and skin alterations on MDS.

4. The Director of Nursing (DON) or designee will audit MDS for accurate coding for residents on hospice care with skin alteration monthly x 4. Residents will be forwarded to QA committee for review and action.

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F 278	Continued From page 13	F 278		

continued to the present.

The Physician ' s order dated September 26, 2013 directed, " Pt (patient) admitted to [provider named] Hospice on 9/25/13 under the care of ...Dx [diagnosis] Debility. "
A review of the Physician's Recertification form , revealed Resident #10 was certified to receive Hospice services on September 25, 2013 and was recertified to receive Hospice services on December 23, 2013, March 23, 2014 and May 20, 2014 (effective for 90-day periods).

A review of the annual MDS dated July 18, 2014 revealed that the resident was not coded as receiving Hospice Care in Section O [Special Treatments, Procedures, and Programs].

The " Comfort Care/Hospice" care plan last updated on July 22, 2014 revealed, " Evaluation ... 7/22/14- remains on hospice care. Comfortable and no pain noted. "

There was no evidence that facility staff coded the resident for receiving hospice services on the annual MDS.

A face-to-face interview was conducted on August 15, 2014 at approximately 1:50 PM with Employee # 4. He/she acknowledged the findings. The record was reviewed on August 15, 2014.

2. Facility staff failed to accurately code the admission Minimum Data Set [MDS] under Section M, Skin Conditions for Resident #52.

An Admission nursing Assessment dated March

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F 278	Continued From page 14 20, 2014 revealed, " Stage 2 wound on right buttock- 1 [cm] x 0.5 cm, [right] and left heels redness. " According to the facility ' s wound forms dated March 20, 2014, Resident #52 ' s skin was assessed as follows: " right heel- Stage I, left heel- Stage I, Right buttock- Stage II, and Left buttock Stage 2. " A review of the admission MDS assessment with an Assessment Reference Date (ARD) of dated March 27, 2014 revealed that Section M, Skin Conditions was coded as having one (1) Stage 2 pressure ulcer and one (1) Stage 1 pressure ulcer. There was no evidence that the admission MDS was coded to reflect the resident's two (2) stage II " buttocks " pressure ulcers and the two (2) Stage I " heels " pressure ulcers. A face-to-face interview was conducted with Employee #15 on August 14, 2014 at approximately 10:15 AM. He/she acknowledged that the MDS was not coded to reflect the resident ' s unhealed pressure ulcers at each stage. Facility staff failed to accurately code the admission MDS for pressure ulcers. The record was reviewed on August 14, 2014.	F 278		
F 286 SS=F	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.	F 286		

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F 286	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for 40 of 40 residents with MDS assessments in a sample of 51 residents; it was determined that facility staff failed to ensure the MDS (Minimum Data Sets) assessments were readily and easily accessible to all professional staff members (including consultants; this information must also be made readily and easily accessible for review by the State Survey agency and CMS.) who need to review the information in order to provide care to residents. The findings include: According to Chapter 2.3 of the MDS 3.0 RAI Manual " In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record. Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident." During a review of clinical records on the residential care unit on August 14, 2014 at	F 286	**F286** 1. MDS records for all identified residents were placed on residents records. 2. MDS for current residents in facility are now easily accessible and are part of the active clinical record. 3. MDS Coordinator has been inserviced on maintaining 15 months of MDS records on resident's clinical records. 4. The Director of Nursing (DON) or designee will audit resident's clinical records to ensure that 15 months of MDS are easily accessible on resident's clinical records. Audits will be done monthly x 4. Results will be forwarded to QA committee for further review and action.	10/6/14 10/6/14 10/3/14

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F 286	Continued From page 16 approximately 10:00 AM, Employee #6 was asked regarding the location to review residents ' MDS assessments, as they were not observed in the active clinical record. Employee #6 stated that the MDS assessments were maintained electronically and required a special access code that was maintained by the MDS Coordinator. He/she stated that he/she did not have access to the assessments and proceeded to contact the MDS Coordinator to obtain the MDS assessments. A face-to-face interview was conducted with Employee #15 on August 14, 2014 at 2:09 PM regarding the accessibility and availability of MDS assessments. He/she acknowledged that MDS ' were not accessible to clinical staff in the residential care areas. He/she stated that he/she is the MDS Coordinator and is normally the person who accesses and prints the MDS records when requested for review. There was no evidence that facility staff maintained MDS assessments on the active clinical records or in a manner where they were accessible and easily retrievable for professional review. Facility staff failed to ensure the MDS was easily retrievable, readily accessible, and on the resident's active clinical records.	F 286		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		

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F 309	Continued From page 17 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for three (3) of 51 sampled residents, it was determined that facility staff failed to: complete an oral assessment for one (1) resident; administer a nutritional supplement (Med Pass 2.0) in accordance with physician ' s orders for one (1) resident and failed to consistently assess the status of skin alteration (bruises) and lower extremity edema for one (1) resident. Residents #127, 137 and 144. The findings include: 1. Facility staff failed to complete Resident #127's oral assessment on admission. This was a closed record review. A review of the facility ' s " Resident-Data Collection " form dated July 18, 2014 revealed, " Oral Assessment: Own teeth, Dentures: Upper: Complete. " The sections of the form to denote if dentures fit and the condition of the resident ' s teeth remained blank. The facility ' s form entitled " Initial Nutrition Risk Assessment for Short-Term Stay " under the section, " Oral/Dental Condition/Swallowing Disorder " , read " Complete upper denture. " A face -to- face interview was conducted with Employees #2 and #15 on August 15, 2014 at	F 309	**F309 # 1** 1. Resident #127 has been discharged from the facility. We cannot retrospectively correct. 2. An audit was completed of all data collection forms by Unit Managers and Supervisors and the collection forms were noted to have the oral/dental section completed. 3. The Staff Development Coordinator will inservice staff on assessment of oral dental status and the importance of documentation on the resident data collection form. 4. Audits will be conducted by Unit Managers and Supervisors weekly x 4, then monthly to verify that oral assessments are completed and documented on data collection forms. Results will be forwarded to QA committee for further review and action.	8/19/14 10/7/14

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F 309	Continued From page 18 approximately 2:00 PM regarding the lack of completion of the " Resident - Data Collection " form. Both acknowledged the sections of the form that remained blank. The clinical record was reviewed on 8/15/14. Facility staff failed to complete the oral assessment section of Resident #127's Resident Data Collection form. 2. A review of the clinical record for Resident #137 revealed that facility staff failed to administer a nutritional supplement (Med Pass 2.0) in accordance with the physician ' s order. The physician ' s order dated July 29, 2014 at 4:45 PM directed, " Med Pass 2.0 [two] 2 ounces po (by mouth) BID [twice daily] 10:00 AM, 2:00 PM - document % consumed " A review of the July 2014 Medication Administration Record revealed that Med Pass was administered on July 30 and 31, 2014. A review of the August 2014 MAR revealed that Med Pass 2.0 was not administered to the resident from August 1 - 15, 2014 as prescribed. A face-to-face interview was conducted on August 15, 2014 at approximately 12:30 PM with Employee #4 who acknowledged the findings. The record was reviewed on August 15, 2014. 3. Facility staff failed to consistently assess Resident #144 ' s lower extremities for edema and assess the status of skin alteration (bruises) initially identified at the time of admission. A. Facility staff failed to consistently assess	F 309	**F309 #2** 1. Resident # 137's Med Pass 2.0 was restarted and documented as given starting 8/16/2014. Resident suffered no ill effects from not having received the Med Pass 2.0. 2. All residents with orders for Med Pass 2.0 are receiving supplements as ordered and documented as given. 3. The Staff Development Coordinator has inserviced staff on accurate transcription of all physician orders for supplements. 4. The Director of Nursing (DON) or designee will audit Medication Administration Records to ensure that physician orders for supplements are accurately carried over to the next month's Medication Administration Record. Audits will be done monthly. Results will be reported to QA committee for further review and action.	8/16/14 8/20/14 9/5/14

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Resident #144 ' s lower legs for edema.

A review of the 'Resident - Data Collection' Admission assessment dated August 7, 2014, revealed the nurse identified, assessed and documented the presence of 2[+] plus edema for Resident #144's right lower leg and 1[+] plus edema for the left lower leg.

Further review of the clinical record revealed " Skilled Daily Nurses Notes" dated August 7, 2014 through August 14, 2014 lacked documented evidence that Resident # 144 was assessed regarding the status of lower leg edema.

A face-to-face interview was conducted with Employee # 4 on August 15, 2014 at approximately 3:20 PM. He/she acknowledged the findings. The clinical record was reviewed on August 15, 2014.

Facility staff failed to consistently assess Resident #144' s lower legs for edema.

B. Facility staff failed to consistently assess Resident #144's alteration in skin condition related to the multiple 'Bruises' identified on admission.

A review of the 'Resident - Data Collection' Admission assessment dated August 7, 2014, revealed the nurse identified, assessed and documented the presence of multiple bruises which were reportedly acquired, prior to admission to the facility.

The nurse identified the following locations of the various bruises on the anatomical diagram of the

F 309

F309 #3A

1. Assessment and documentation in skilled nurses notes were done to check and reflect the status of edema of resident #144. Resident has since been discharged from the facility. — 8/15/14

2. All residents identified with edema in lower extremities were checked and documentation is in place in skilled nursing notes. — 8/16/14

3. Staff Development Coordinator will conducted retraining of licensed staff on assessment and documentation of residents with edema. — 9/5/14

4. Audits will be done by the Director of Nursing (DON) or designee to verify appropriate assessments and documentations are in place in skilled nurses notes for residents with edema. Audits will be done weekly x 3, then monthly x 3, and then quarterly thereafter to ensure compliance. Results will be forwarded to QA committee for further review and action.

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F 309	Continued From page 20 'Resident - Data Collection' Admission assessment: Site # 1- Right Foot/ Toes Site # 2- Right Knee Site # 3- Left knee Site # 4- Left hand, anterior upper thumb Site # 5- Left antecubital The clinical record including the Skilled Daily Nurses Notes dated August 7, 2014 through August 14, 2014 did not include subsequent documentation related to the multiple bruises identified on the anatomical Diagram of the 'Resident - Data Collection' Admission assessment. Additional review of the clinical record lacked documented evidence that Resident # 144 was consistently assessed for alteration in skin related to multiple 'Bruises' identified on admission August 7, 2014. The clinical record lacked documented evidence of a Skin Sheet for Resident # 144. A face-to-face interview was conducted with Employee # 4 on August 15, 2014 at approximately 3:20 PM. He/she acknowledged the findings. The clinical record was reviewed on August 15, 2014. Facility staff failed to consistently assess Resident #144's alteration in skin condition related to the multiple 'Bruises' identified on admission.	F 309	**F309 #3B** 1. Resident #144's skin was reassessed for bruising and skin sheets were implemented to monitor the bruises that he came to the facility with. 2. A 100% skin audit was completed to identify residents with bruises, all residents identified had skin sheets in place. 3. Nurses were inserviced regarding appropriate documentation of bruises on skin sheets. 4. The Director of Nursing (DON) or designee will audit for documentation of bruises on skin sheets weekly x 4, then monthly. Report will be forwarded to QA committee for review and action.	8/15/14 8/20/14 9/5/14
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 21 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for two (2) of 51 sampled residents, it was determined that the facility staff failed to ensure that residents with pressure sores were accurately assessed to include the appropriate staging as evidenced by failing to accurately stage wounds for one (1) resident with redness on bilateral heels identified as unstageble and one (1) resident's foot wound with 100% sough identified as a Stage 3-4. Residents #39 and 68. The findings include: According to the Resident Assessment Instrument User ' s Manual Version 3.0 [MDS- Minimum Data Set], pressure ulcer stages and characteristics are noted as follows: " Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence ... Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or	F 314	**F314 #1-2** 1. Residents #39 and #68 skin sheets were corrected to reflect the accurate stages of the wounds. 2. The Director of Nursing (DON) has audited all skin sheets to ensure that there is consistent and accurate staging of wounds on skin sheets. 3. Licensed Nurses were re-inserviced by Staff Development Coordinator on identification, staging and documentation guidelines for residents with wounds. 4. The DON or designee will audit skin sheets for accurate staging and consistent documentation of wounds weekly x 4, then monthly. All findings will be forwarded to QA committee for further review and action.	8/15/14 8/20/14 10/7/14

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F 314	Continued From page 22 pink wound bed, without slough. May also present as an intact or open/ruptured blister Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling Unstageble: Non removable dressing. known but not stageable due to no-removable dressing/device Unstageble: Slough and /or eschar: known but not stageable due to coverage of wound bed by slough and /or eschar Unstageble: Deep tissue: Suspected deep tissue injury in evolution" 1.Facility staff failed to accurately assess the pressure ulcer wound for Resident #39 ' s left inner foot that was covered with 100% slough tissue. On August 15, 2014 at approximately 10:30 AM, a wound observation was made as Employee #11 performed a dressing change to the left inner	F 314		

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foot of Resident #39.

A review of the facility ' s Wound Sheet "used weekly to document the progression of the wound" dated August 14, 2014 described the resident ' s inner foot wound as follows:

Deepest Stage - III-IV
Appearance- 100% Slough
Drainage Type - serosanguinous
Drainage Amount - scant
Wound Edges- Slightly reddened
Odor - No
Length (cm) - 1.2 cms
Width (cm) - .7 cms
Depth (cm) - .3 cm
Undermining -no
Tunneling - no

There was no evidence that the facility staff accurately differentiated between a Stage 3, 4 or Unstageble to determine the appropriate staging for Resident #39's wound.

On August 15, 2015 at approximately 11:30 AM, a face-to-face interview was conducted with Employee #6. He/she acknowledged the wound on the left inner foot of the resident was Unstageble, although the documentation revealed otherwise [Stage III or IV].

Facility staff failed to ensure that residents having pressure sores were accurately assessed to include the appropriate staging.

2. Facility staff failed to consistently and accurately document the staging of Resident #68's pressure ulcers.

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The facility ' s policy entitled: " Prevention of Pressure Ulcers " dated June 5, 2014, stipulated: " 6. the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported ... "

Resident #68 was observed on August 18, 2014 at approximately 9:30 AM prior to AM care. Left heel dry, no open area. Scab present. Right heel- dry, no open area. Sacrum- no redness, no open area.

According to a " History and Physical " dated June 20, 2014 revealed, " ..... [male/female] with multiple [medical] problems which include ear, nose, throat cancer, cognitive impairment. Admitted for debility. [Right] Knee Pain. Past history: Chronic [left] toe ulcer, Gout, [Chronic Kidney Disease, Peripheral Arterial Disease], Anemia, Hypertension. "

An admission " Resident-Data Collection " form dated June 19, 2014 revealed: " Skin Condition- Comments: Bilateral heels soft and slightly reddened. "

According to the care plan initiated June 19, 2014, revealed; " Goals- Resident will remain free from alterations in skin integrity [times] 90 days- Bilateral heel ulcers-discoloration. Evaluation: Resident admitted this evening ... Has reddish discoloration left heel which is soft and boggy. "

There was no evidence that facility staff documented the skin condition of the right heel

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F 314	Continued From page 25 on the care plan. The facility ' s form, " Weekly Wound Documentation Form " designated for the left and right heel revealed the following: " 6/19/14- Site: Left Heel- Stage II- Wound Edges: soft, boggy- Length- entire heel- Undermining/tunneling- 0 6/25/14- Site: Left Heel- U (Unstageble) - Wound Edges- softy, boggy, Length/width-entire heel- 7/9/14- Site: Left heel- Unstageble-Wound Edges- Hard- Length/width- entire heel 7/30/14- Site: Left heel- Observed Stage: No stage identified, Wound edges- Hard [calloused], Length/Width- entire heel 8/7/14- Site: Left heel- Observed Stage- No stage identified, Wound edges- Hard [calloused], Length/Width- Entire heel. 6/19/14- Site: Right heel- U- [Unstageble] - Wound Edges- Hard- Length- 5cm; Width-5cm- Depth- ? 6/25/14- Site- Right heel- U- Unstageble- Wound edges- Hard calloused- Length-5cm; Width-5cm-Depth-? 7/9/14- Site: Right heel- U- Unstageble- Wound edges- Hard; Length/width- 5cm; 5cm- ? Depth- 7/30/14- Site: Right heel- U- Unstageble- Wound	F 314		

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F 314	Continued From page 26 edges- C [calloused]; Length/width- 5 cm/5cm-? Depth 8/7/14- Site: right heel-Unstageble; Wound edges-Hard; Length/Width- 5cm/5cm- ? Depth. " Care plan updated 7/1/14 revealed; " Bilateral heel soft reddened, discolored. Evaluation [Physician Order Sheet] for [treatment] orders. " There was no documented evidence on the wound form to indicate the stage of the left heel for July 30, 2014 and August 7, 2014. There was no documented evidence that there was consistency of the staging of the right and left heel pressure ulcers. A face-to-face interview was conducted with Employee #15 at approximately 11:00 AM. He/she stated when the resident was admitted " both heels were reddened and there was no open area. So, it was a Stage I. " A face-to-face interview was conducted with Employee 6 at approximately 11:30 AM on August 18, 2014. The employee acknowledged that facility staff failed to consistently and accurately document the condition of the resident ' s skin. The clinical record was reviewed on August 18, 2014. Facility staff failed to consistently and accurately document the staging of Resident #68's pressure ulcer wounds.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 27	F 315		
	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.		**F315** 1. Resident #144's urinary catheter bag was correctly positioned to prevent a backflow of urine.	8/12/14
	This REQUIREMENT is not met as evidenced by:		2. There were no other residents in the facility with Foley catheter. 3. All nursing staff were re-educated by the Staff Development Coordinator on appropriate technique and placement of Foley catheter tubing to prevent backflow of urine.	8/15/14
	Based on observations, record review and staff interview, it was determined that facility staff failed to provide appropriate treatment and services as evidenced by failure to ensure the urinary catheter drainage bag was correctly positioned to prevent backflow of urine. Resident #144 The findings include: Facility staff failed to provide appropriate treatment and services as evidenced by failure to ensure Resident #144 ' s urinary catheter drainage bag was correctly positioned to prevent backflow of urine. On August 12, 2014 at approximately 11:30 AM, the surveyor observed Resident #144 lying in bed with a readily visible bulge on the right inner leg of his/her trousers. A face-to-face interview was conducted with the resident at the time of the observation. When		4. Audits will be done by Unit Managers on all residents with Foley catheters to ensure that there is proper placement of tubing. Audits will be done weekly x 4, then monthly x 3, if there are residents in the facility who are using a Foley catheter. Results will be forwarded to QA committee for further review and action.	

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F 315	Continued From page 28	F 315		

queried about the bulging area inside his/her trousers; He/she responded, " The bulging is my leg urine drainage bag. "

On further observation and investigation, the surveyor noted that the urine drainage bag was two-thirds full of slightly cloudy urine.

A second observation was conducted on August 15, 2014 at approximately 9:30 AM. The surveyor observed Resident #144 lying in bed on his/her back. The urine collection bag was secured to the right inner thigh which was secured with rubber straps and contained approximately 30 milliliters of slightly cloudy urine and revealed some urine in the clear tubing between the collection bag and the connection to the catheter.

A review of the resident ' s ADL (Activities of Daily Living) Plan of Care on August 15, 2014 at approximately 12:10 PM revealed special needs documented for the resident with an indwelling Foley catheter included " ... Continence bladder: usually continent ... "

A face-to-face interview was conducted with Employee #22 on August 15, 2014 at approximately 10:07 AM regarding the positioning of Resident #144 ' s urinary drainage bag while in bed. He/she stated that he/she usually empties the urine collection bag at least twice a day; approximately mid-day and afternoon before going off duty at 3:30 PM. He/she further stated that upon arrival on duty the following day, the resident is usually wearing bedside bags with longer tubing which hangs on the rail of the bed. The clinical record was

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F 315	Continued From page 29 reviewed on August 15, 2014. Facility staff failed to provide appropriate treatment and services as evidenced by failure to ensure Resident #144 ' s urinary catheter drainage bag was correctly positioned to prevent backflow of urine.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations made on August 13, 2014 at approximately 3:00 PM, it was determined that facility staff failed to maintain resident environment free from accident hazards as evidenced by one (1) of nine (9) improperly secured oxygen tanks on the upper level unit and a damaged call bell in one (1) of 22 resident rooms. The findings include: 1. One (1) of nine (9) oxygen tanks stored in the oxygen room on the upper level unit was stored on the floor and was not properly secured in an oxygen tank holder. 2. The call bell in one (1) of 22 resident ' s room	F 323	**F323 #1** 1. The oxygen tank was immediately secured in an oxygen tank holder. 2. Oxygen tanks on both units were checked and all other tanks were found to be secured in oxygen tank holders. 3. Inservice was conducted by the Staff Development Coordinator for the licensed nursing staff on proper storage of oxygen tanks. 4. Maintenance Director and Unit Manager will check oxygen room to verify that oxygen tanks are secured in oxygen holders. Audits will be done weekly x 4, then monthly x 3. Oxygen tanks will then be monitored on a quarterly basis. Results will be forwarded to QA committee for further review and action.	8/13/14 8/13/14 8/20/14

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F 323	Continued From page 30 (#198) was held together by clear tape and presented an accident hazard. These observations were made in the presence of Employee #30 and Employee #39 who acknowledged the findings.	F 323	**F323 #2** 1. The call bell held together with tape was replaced. 2. All call bells have been checked and found to be intact and functional by the Maintenance Director.	8/13/14
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on August 13, 2014 between 9:20 AM and 12:30 PM, it was determined that the facility failed to prepare food under sanitary conditions as evidenced by two (2) of two (2) soiled air curtains from the dishwashing machine in the main kitchen, One (1) of one (1) soiled grill in the main kitchen, one (1) of two (2) leaky soup vats in the main kitchen, one (1) of two (2) soiled convection units in the main kitchen , a non-functional pilot light from one (1) of one (1) gas stove in the main kitchen, one (1) of one (1) soiled convection oven unit in the Suites kitchen, foods such as four (4) of four (4) containers of salad dressing and one (1) of one (1) container of cream sauce that were expired, soiled floor surfaces in the Suites	F 371	3. All nursing, housekeeping, maintenance and rehab staff have been inserviced on reporting and replacing damaged call bells and having them replaced promptly. 4. The Maintenance Director will round weekly to verify that all call bells are intact and functional. Audits will be done weekly x 4 then monthly x 3 and quarterly thereafter. Report will be forwarded to QA committee to review and action.	8/13/14 9/5/14

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F 371	Continued From page 31	F 371	**F371**	

kitchen, 10 of 10 one-third hotel pans and 14 of 14 one-sixth pans that were stored wet and one (1) of two (2) one-half hotel pans and three (3) of 14 one-sixth hotel pans that were soiled.

The findings include:

1. Two (2) of two (2) air curtains from the dishwashing machine in the main kitchen were soiled.

2. The grill in the main kitchen was soiled with burnt food residue in several areas.

3. One (1) of two (2) soup vats in the main kitchen was leaking at the on/off valve.

4. Both convection ovens from (1) of two (2) double convection ovens unit was soiled with burnt food residue.

5. The pilot light on the gas stove was broken.

6. Both convection ovens from one (1) of one (1) double convection oven units located in the Suites kitchen were soiled.

7. Foods such as four (4) of four (4) containers of salad dressing and one (1) of one (1) container of cream sauce were stored beyond their expiration date of August 12, 2014.

8. The floor surfaces in the Suites kitchen were soiled with debris .

9. Ten of ten one-third hotel pans and 14 of 14 one-sixth hotel pans were stored wet and ready for reuse.

F371 — Provider's Plan of Correction

1. No residents were affected by this deficiency.

2. Immediate corrective action was taken to resolve all identified issues respectively. (Completion date: 8/13/14)
   - Throughout the production process, all food items will remain covered with parchment paper, foil, film wrap, or speed rack covers.
   - All identified wet food storage containers were re-washed and set to dry completely before being stacked. Utility in-service was conducted.
   - Utilities staff follow a weekly, daily, and monthly master cleaning schedule to ensure all kitchen equipment is free from soil.
   - Maintenance was made aware of the leaking valve on the Soup vat and broken pilot light.
     - Contractor came in and fixed both equipment concerns

3. Staff re-educated on proper food handling, hand hygiene, and equipment handling. (Completion date: 8/20/14)

4. Food service managers conduct daily rounds to monitor food safety and cleanliness of all kitchens/dining areas. Managers offer frequent education and reminders to staff during daily stand up meetings. A thorough Food Safety & Sanitation Audit is also conducted monthly. All trends are tracked for quality assurance and will be reported to QA committee for further review and action.

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F 371	Continued From page 32 10. One (1) of two (2) one-half hotel pan and three (3) of 14 one-sixth hotel pans were soiled with leftover food residue. These observations were made in the presence of Employee #18 and/or Employee #13 who acknowledged the findings.	F 371	**F456** 1. No residents were affected by this deficiency. 2. Immediate corrective action was taken to resolve all identified issues respectively. • High temp dish machine was placed out of order until contractor was able to replace parts to assist machine in reaching proper temperature ○ Procedure was followed and all meal were service on emergency paper supplies until dish machine was running properly. ○ All pots and pans went through the three compartment sink and allowed to air dry before being stored away. ○ Contractor confirmed dish machine was reaching proper temperature. • Low temp dish machine was placed out of service until contractor was able to verify proper sanitizer level and Department of Health employee was able to verify proper chemical levels. ○ Procedure was followed and all meal were service on emergency paper supplies until dish machine was running properly. 3. Utilities staff were inserviced on the low temperature dish machine and how to properly check the chlorine sanitizer solution. 4. Management will continue to monitor to ensure temperatures and sanitizer are reaching correct levels and are being read and recorded properly. Management will monitor daily x 1 month, weekly x 4, then monthly x 3. Reports will be forwarded to QA committee for further review and action.	8/25/14 8/14/14
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on August 13, 2014 between 9:20 AM and 12:30 PM, it was determined that the facility failed to maintain essential equipment in good operating condition as evidenced by one (1) of one (1) dishwashing machine in the main kitchen and one (1) of one (1) dishwashing machine in the ' Suites ' kitchen that failed to operate as intended. The findings include: 1. The high temperature dishwashing machine located in the main kitchen failed to reach a final rinse temperature of a minimum of 180 degrees Fahrenheit on three (3) consecutive complete cycles. 2. The ' Suites ' kitchen low temperature dishwashing machine log was improperly recorded as a high temperature dishwashing	F 456		

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F 456	Continued From page 33 machine from August 1, 2014 through August 12, 2014. The rinse temperature was consistently documented at 180 degrees Fahrenheit during breakfast, lunch and dinner and dietary staff failed to test the final rinse solution for proper bleach chemical concentration of 50 parts per million (PPM). These observations were made in the presence of Employee #18 who acknowledged the findings.	F 456		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview for three (3) of 51 sampled residents, it was determined that the facility staff failed to maintain complete, accurate, and organized clinical records as evidenced by: one (1) resident's name documented three different ways in the active clinical record; failure to accurately	F 514		

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document pain and edema assessments on the skilled daily nurses note for one (1) resident and failed to document the completion date (s) of comprehensive assessments for one (1) resident. Residents' # 10, 20, 132

The findings include:

1. Facility staff failed to document the date the comprehensive assessment was completed for Resident #10.

A review of the Hospice " Interdisciplinary Plan of Care Revision/Physician Orders " for Resident # 10 revealed that the day of the month was not recorded for May 2014. In addition there were five (5) other assessments that lacked a documented date to indicate when the assessment was updated.

A face-to-face interview was conducted on August 15, 2014 at approximately 12:30 PM with Employee # 4. He/she acknowledged the findings. The record was reviewed on August 15, 2014.

There was no evidence that the hospice representatives documented the date the assessments where completed.

Facility staff failed to document the date the comprehensive assessment was completed for Resident #10.

2. Facility staff failed to maintain complete, accurate, and organized clinical records as evidenced by Resident #20's name was documented three different ways in the clinical

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F 514	Continued From page 35 record. On August 11, 2014 at approximately 4:29 PM a face-to-face interview was conducted with Resident #20 and his/her responsible party (RP). When asked how the resident would like to be addressed, the RP stated, "[The Sir name and hypenated last name]." On August 12, 2014 at approximately 12:15 PM, a review of Resident #20 's 'Profile Face Sheet' revealed his/her name documented as " [Last name (Married name), First name, Middle initial, Sir name] upon admission September 13, 2013. A review of the resident's admission Physician's 'History and Physical' dated September 19, 2013 revealed the resident's name documented as " [Hyphenated name (married and maiden) and First name]." The Physician's Order Form, nursing Medication Administration Record [MAR] and Treatment Administration Record [TAR] dated August 2014 revealed the resident's name as "[Last name (Maiden name) and Last name]." There was no evidence that the facility staff maintained complete, accurate, and organized clinical records for Resident #20. A face-to-face interview was conducted with Employee #6 on August 12, 2014 at approximately 12:20 PM. He/she acknowledged the aforementioned findings. He/she further stated, " I know this is confusing" and provided no explanation to address the use of three different names for the resident in the clinical	F 514	**F514 #1** 1. Resident #10's "Interdisciplinary Plan of Care Revision/Physician Orders" notes are now dated. 2. Review of "Interdisciplinary Plan of Care Revision/Physician Orders" for all residents under hospice care and all were appropriately dated. 3. Member of hospice team were re-educated on thorough documentation including dating of all comprehensive assessments and entries into resident's records. 4. The Director of Nursing (DON) or designee will audit resident's records under hospice to verify that all documentation is appropriately dated. Audits will be done weekly x 4 then monthly x 3. Results will be analyzed by QA committee.	8/20/14 9/5/14 10/3/14

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F 514	Continued From page 36 record. Facility staff failed to maintain complete, accurate, and organized clinical records. The clinical record was reviewed on August 12, 2014. 3. Facility staff failed to consistently document and record Resident #132's edema and pain assessment on the daily skilled nurses' notes A review of the Physician ' s Progress Notes dated August 12, 2014 revealed, " ...B [bilateral] trace leg edema " . A review of the directions for the " Skilled Daily Nurses Note " form stipulated, " Check all applicable boxes per shift. Circle appropriate item(s) separated by " / " . Document any specifics on reserve side ... " A review of the Skill Daily Nurses Note (s) revealed the following: On August 6, 2014 the section of the note entitled " Pain " was checked as " No c/o ' s (complaints) of pain for day, evening and night shifts; and the section of the note entitled " Cardiovascular-Edema " was left blank for days evenings and night shifts. A review of the Comments section of the form revealed that on August 6, 2014 at 7:00 AM the nurse documented, " bilateral lower legs edematous pitting +3, will continue to monitor. At 6:30 AM c/o l [left] hip pain scale 10/10 ...at 7:30 AM scale 3/10..abdominal pain 8/10 medicated ... "	F 514	**F514 #2** 1. Resident #20's clinical record was corrected to reflect resident's legal name. 2. Clinical records of all residents were audited to ensure that their legal names were being used on all documents. 3. Medical records clerk, Admission staff and members of the Interdisciplinary team were educated on using resident's legal name on all documents in the clinical records. 4. Medical records clerk will audit clinical records weekly x 4, then monthly x 3 to ensure residents legal names are documented on all records. Results will be sent to QA committee for action.	8/15/14 8/20/14 9/5/14

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INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 37 There was no evidence that facility staff accurately checked and documented information on the skills note related to the resident ' s pain and edema. On August 7, 2014 the section of the note entitled " Pain " was checked as " No c/o ' s of pain for the evening and night shifts, day shift was left blank. The section of the note entitled " Cardiovascular-Edema " was check for the resident having dependent +3 edema, for day and night shifts; the evening shift was left blank. A review of the comments section of the form revealed that on August 7, 2014 at 6:00 AM the nurse documented, " At 6:30 AM [complain of] incision pain -4/10- Oxycontin IR 5 mg given ... On August 7, 2014 at 2:00 PM ...medicated with Oxycontin at 11:15 AM for pain scale 6/10 effective as pain decreased to 2/10 ... " There was no evidence that facility staff accurately checked and documented information on the skills note related to the resident ' s pain and edema. A face-to-face interview was conducted on August 15, 2014 at approximately 12:10 PM with Employee # 4. He/she acknowledged the findings. The record was reviewed on August 15, 2014. Facility staff failed to consistently document and record Resident #132's edema and pain assessment on the daily skilled nurses' notes	F 514	**F514 #3** 1. Resident #132 has been discharged from the facility. We cannot retrospectively correct. 2. All residents with pain and edema were assessed and documentation is in place on skilled nurses notes. 3. The Staff Development Coordinator will conduct inservices on documenting assessment of pain and edema in daily skilled nurses notes. 4. Unit Managers and Supervisors will audit skilled nurses notes weekly x 4, then monthly for documentation of pain and edema in skilled nurses notes. Results will be forwarded to QA committee for further review and action.	9/5/14 10/7/14