| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 095005 | A. BUILDING _____ B. WING _____ | 03/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE WASHINGTON HOME | 3720 UPTON STREET NW WASHINGTON, DC 20016 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification Quality Indicator Survey was conducted February 21, through March 6, 2012. The deficiencies are based on observations, record reviews, resident and staff interviews for 50 sampled residents. | F 000 | The Washington Home makes its best effort to operate in substantial compliance with both Federal and State law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following Plan of Correction constitutes the facility's written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law. | |
| F 166 SS=D | 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations, record review, staff and family interview for one (1) of 50 sampled residents, it was determined that facility staff failed to ensure that a prompt effort was made to resolve a grievance concerning Resident #74's missing eyeglasses.<br><br>The findings include:<br><br>During an initial tour conducted on February 21, 2012 at approximately 9:42 AM; Resident #74 was observed sitting in a chair with a breakfast tray in front of him/her. His/her hands were positioned in front of the food on his/her plate; however, he/she was not eating. The resident was queried about why he/she was not eating. He/she responded, " I can ' t see. " Employee #10 proceeded to ask; " where are your glasses? " He/she stated, " I don ' t know. "<br><br>Another observation was made on February 24, | F 166 | F166<br><br>1. Resident #74 completes his meal independently and continues to complete meal unassisted without the use of glasses. Responsible Party of resident #74 educated regarding use of concern log to voice concerns with the expectation they receive a response to their concern within (5)days. Resident #74's responsible party has stated they do not want to have the eyeglasses replaced and do not want an ophthalmology consult for Resident #74. This has been documented in the medical records. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Administrator | 4/23/12 |

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 166 | Continued From page 1<br>2012 at approximately 4:30 PM; the resident was lying flat in bed and was not wearing his/her eyeglasses.<br><br>An interview was conducted with Employee #74 ' s responsible party (RP) on February 22, 2012 at approximately 12:45 PM. He/she stated, " This is the second pair of eyeglasses I have brought for [Resident #74]. I have not seen his/her eyeglasses since Friday [February 17, 2012]. I reported this to [Employee #10]. "<br><br>According to the "Resident's Property List" dated Novevmber 1, 2011, articles retained by resident included glasses and case.<br><br>A review of the facility's policy titled: " Family/Resident Communication Tool " indicated that the family/resident will be contacted within five (5) business days with a response and/or resolution".<br><br>A review of the facility's " Communication Forms " lacked evidence that a grievance/concern form was initiated as a result of the resident ' s responsible party's verbalized concern to facility management staff.<br><br>A face-to-face interview was conducted with Employee #10 on February 24, 2012 at approximately 1:15 PM he/she confirmed the RP's reporting of the resident ' s missing eyeglasses. He/she stated, " I will follow-up with the RP. " The clinical record was reviewed on February 24, 2012. | F 166 | 2. Administration reviewed all open monthly concern logs and ensured that all responses/solutions were received or in process for resolution.<br>3. All verbal concerns brought to the attention of the nursing staff will be documented on The Washington Home Concern (Communication Tool) Report Form, brought forward to the Nurse Manager/designee and reported to Administration for summation on the Log. The Concern Report Log will be incorporated into the weekly nursing department Focus QI Committee meeting. Review of the log will ensure concerns submitted from residents and/or family members receive a timely response. The Clinical Educator or designee will conduct an education session with nursing staff by no later than May 4, 2012. All nursing staff will be made aware to complete written documentation of verbal concerns voiced by residents and/or the responsible party of residents and the formal process for concern log sub-mission and reporting.<br>4. The QI Manager will submit a monthly report to the QI committee of the number of concerns responded to or not responded to within (5) business days of receiving the concern.<br>5. Date of completion: | 5/4/2012. |
| F 224 SS=D | 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIAT | F 224 | | |

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| F 224 | Continued From page 2<br>N<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations and staff interview, during the environmental tour of the facility on February 29, 2012, it was determined facility staff failed to safeguard one (1) of one (1)resident ' s personal property after death. Resident #F1.<br><br>The findings include:<br><br>The policy entitled, " Gifts, Gratuities, & Payment Policy No. Re-00017.97 "<br>Policy: " Employees and volunteers are prohibited from receiving any gift, gratuity or payment for services rendered, making any promises on behalf of the facility or engaging in any activity, practice, or act which conflicts with the interests of the facility or its residents.<br>Procedure: 1. At no time will an employee or volunteer accept money, gifts valued over $10.00, jewelry etc, from a resident/patient and/or family. Human Resources should be consulted to determine value. If the resident/patient or family is insistent, the employee/volunteer will suggest that they make a donation to The Washington Home or Hospice of Washington. If the party is still insistent, the matter should be presented to the Director of | F 224 | **F224**<br>1. Employee #29 received one to one education regarding the organization's policy No. Re-00017.97 entitled Gifts, Gratuities, & Payment. The personal item found was returned to the family of the deceased resident.<br>2. All residents' televisions were safe-guarded and documented as personal property in the medical record.<br>3. The Nurse Manager or their designee of nursing unit 2B shall conduct an education session with all nursing staff on unit 2B in reference to The Washington Home policy No. Re-00017.97 Gifts, Gratuities, & Payment. The Clinical Educator or their designee will conduct education sessions to nursing staff regarding The Washington Home policy No. Re-00017.97. An education session will also be accomplished to review the pro-cedure used to secure resident belongings, where in the responsible party does not assume responsibility for the belongings of the resident discharged from the facility.<br>4. The Clinical Educator or designee will conduct during the time of orientation of new staff and annually, staff education sessions that refer to The Washington Home Policy No. Re-00017.97. | |

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| F 224 | Continued From page 3<br>Social Work who will then contact the patient, resident or family member to reaffirm the Home ' s policy ... "<br><br>During an environmental tour of Unit 2B on February 29, 2012 at approximately 9:45 AM in the presence of Employee #31 a television and its accompanying equipment [cable box, remotes and cords] were atop shelving in the resident multipurpose area. The television, approximately 19 inches desktop style, was stored in a clear plastic bag proximal to Employee #29 ' s personal belongings (purse/tote bag) and the equipment was observed wrapped in newspaper behind the employee ' s personal belongings.<br><br>In response to a query regarding the storage of the items atop the shelving, Employee #31 asked Employee #7 to whom do the items belong too. S/he stated that the items belonged to Employee #29.<br><br>A face-to-face interview was conducted with Employee #15 on February 29, 2012 at 2:00 PM. S/he stated that the television belonged to Resident # F1 who died on yesterday. His/her relative wanted me to have the television and [I] declined to accept it. The relative asked me to put the television away for another relative so that s/he would not have access to the resident ' s other personal property. Employee #29 stated that the TV was placed on the shelf at approximately 7:30 AM on February 29, 2012 and s/he was assisted by Employee #28. Employee #29 confirmed that the TV was stored on the shelf in the multipurpose room proximal to his/her purse. | F 224 | The Clinical Educator or designee will submit a monthly report to the QI Committee on all education sessions presented and the number of attendees.<br>5. Date of compliance: | 5/4/2012 |

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| F 224 | Continued From page 4<br>Employee #29 stated that the customary process that is used to safeguard resident ' s property at the time of death is to lock the resident ' room door and allow the family and/or responsible party to remove the items. Usually the Social Worker coordinates that process. " I used poor judgment. "<br><br>A face-to-face interview was conducted with Employee #28 on February 29, 2012 at 3:00 PM. S/he acknowledged that s/he assisted Employee #29 to remove the TV and accompanying equipment from Resident #F1 ' s room on the morning of February 29, 2012. " [He/she] told me that the TV was given to him/her and I just helped him/her to carry it out of the room and placed the item(s) on the shelf [in the resident multipurpose area].<br><br>In response to a query regarding the customary method that staff follow to safeguard resident ' s personal property in the event of death, Employees #15 and #29 stated that the clinical staff lock the resident ' s room and allow the responsible party and/or next of kin to obtain the property.<br><br>Facility staff improperly apportioned the personal property of Resident # F1 at the time of death. The resident ' s property was removed from the resident ' s room and comingled with Employee #29 ' s personal belongings.<br><br>There was no evidence that Employee # 15 complied with the facility ' s policy on receiving gift(s) from a resident/patient/family. | F 224 | | |
| F 241 SS=E | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY | F 241 | | |

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| F 241 | Continued From page 5<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on resident observations and staff interviews for four (4) of 50 sampled residents, it was determined that facility staff failed to maintain dignity as evidenced by staff standing while assisting resident with meal for one (1) resident; allowing one (1) resident to sit idle as others dinned; one (1) resident asked by staff if he/she wanted an alcoholic beverage and one (1) resident pulled backwards following dinning. Residents #144, #155, #170 and #195.<br><br>The findings include:<br><br>1. Facility staff failed to promote dignity post dining by pulling Resident #144 backwards from the dining area to social area.<br><br>On February 20, 2012 at approximately 12:40 PM, Employee #22 was observed pulling Resident #144 backwards from the dining area to the social area.<br><br>A face-to-face interview was conducted with Employee #4 on February 20, 2012 at approximately 12:41 PM. He/she brought the concern to the attention of Employee #22 and corrected the deficient behavior. The | F 241 | **F241 – 1,2,3,4**<br><br>1. Residents identified #144, #155, #170 and #195 will have their dignity maintained at all times. Resident #144 did not sustain any injury from the transfer. Employee # 19 was given an education session as to how to maintain resident dignity when assisting with a resident meal: their body must be seated in order to be at the same level of the resident. Employee #38 received an education session regarding use of appropriate and non-appropriate statements to use when carrying on a verbal conversation with residents. All nursing unit 1A staff received education regarding prevention of idle dining of residents during meal service.<br>2. All other residents were evaluated, observed and processed to ensure that their dignity is maintained while being transported, eating and interacting with staff.<br>3. The Clinical Educator or a designee will conduct education sessions on maintaining the dignity of residents, with a focus on transportation of residents, body posture when assisting residents to eat, prevention of idle dining during meal service to residents, and appropriateness of language used when conversing with residents. | |

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| F 241 | Continued From page 6<br>observation was made on February 20, 2012.<br><br>2. Facility staff failed to ensure Resident #155 ' s dignity was maintained in two (2) of two (2) dining observations as evidenced by Employee #19 standing while assisting with lunch meal.<br>During dining observations conducted on February 21, 2012 at approximately 12:40 PM and March 1, 2012 at approximately 12:45 PM in Resident #155 ' s room on Unit #3A, Employee # 19 was observed assisting Resident #155 with meal consumption. Employee #19 stood proximal to the resident ' s bed and offered spoonfuls of food for the resident to consume.<br>A face-to-face interview was conducted with Employee #10; who observed Employee #19 standing while assisting resident with meal, on March 1, 2012 at approximately 12:45 PM. He/she acknowledged at the time of observation that the employee should have sat down while assisting the resident with lunch meal.<br>3. Facility staff failed to maintain the resident ' s dignity by asking the resident did he/she wanted an alcoholic beverage.<br><br>On February 21, 2012 at 12:32 PM during a lunch meal dining observation, Resident #170 stated, "This is water I want juice." Employee #38 who was assisting residents with their meal replied, " [Resident #170] do you want Gin? " The resident did not respond and Employee #38 stated again, " [Resident #170] do you want Gin?"<br>On February 21, 2012 at approximately 12:45 PM Employee #7 was made aware. Employee #7 then ask Employee #39 (who was providing the resident with the juice at the time of this | F 241 | A standardized method of meal service will be adopted by all nursing units and meals to all residents served accordingly. Education sessions will be provided to nursing staff to review the standardized meal service.<br>4. The Clinical Educator or a designee will conduct during orientation of new staff and annual education sessions about maintaining resident dignity inclusive of : transportation of residents, meal service, appropriate conversation when speaking with residents. The Clinical Educator or their designee will submit a monthly report of education sessions and the number of attendees to the QI Committee.<br>5. Date of Completion: | 5/4/2012. |

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| F 241 | Continued From page 7<br>incident) did this happen. Employee #39 replied, " Yes. "<br>There was no evidence that facility staff spoke to the resident with respect and dignity.<br><br>4. Facility staff failed to promote dignity during dining by allowing Resident #195 to sit idle on two (2) different occasions as others dined.<br><br>During a dining observation that was conducted on February 20, 2012 at approximately 12:30 PM the following was observed of Resident #195.<br><br>The lunch trays arrived to Unit 1A at approximately 12:37 PM, seven (7) residents were seated for dinning, two (2) residents were served trays and ate independently. At approximately 12:55 PM Resident #195 had not been served, at approximately 1:02 PM, Resident #195 resident had not been served. The resident was served at approximately 1:07 PM. A CNA (Certified Nursing Assistant) assisted the resident to open his/her tray. Employee #4 uttered "[he/she] can feed herself". The resident sat for approximately 30 minutes until he/she began to eat his/her meal at approximately 1:09 PM.<br><br>A second dining observation was conducted on March 1, 2012 at approximately 12:45 PM six (6) residents were seated for dining. All residents were again served and Resident #195 sat for approximately 22 minutes until served.<br><br>A face-to-face interview was conducted with Employee #4 on March 1, 2012 at approximately | F 241 | | |

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| F 241 | Continued From page 8<br>2:00 PM, after review of the events he/she acknowledged the findings. A query was made what was the unit process for distributing trays. Employee #4 indicated that there is no formal process, but those seated in the common dining area are served first, then the residents in the rooms and then the CNA's assist with feeding in the rooms and in the common dining area as needed.<br><br>Facility staff failed to promote dignity during dining by allowing Resident #195 to sit idle on two (2) different occasions as others dined. The observation was made on February 20, 2012 and March 1, 2012. | F 241 | **F253 – Soiled items**<br>#1<br>1. Carpet identified as soiled was cleaned.<br>2. All carpeting was inspected; no additional soiled areas were identified.<br>3. Maintenance staff will be re-inserviced to perform carpet inspections during Weekly Maintenance Rounds. The Director of Plant Operations or designee will review the Weekly Maintenance Rounds reports and implement corrective action for identified variances. Carpets will be replaced with an upgraded surface throughout the facility.<br>4. The Director of Plant Operations will prepare a summary of the Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly. The carpet replacement schedule and carpets replaced will also be reported to the Quality improvement Committee quarterly.<br>5. Date of completion: | 5/4/2012 |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations during the environmental tours on February 21, 2012 at various times, February 24, 2012 between 9:30 AM and 1:30 PM, and February 29, 2012 from 9:15 AM to12:30 PM, it was determined the facility failed to maintain a sanitary and orderly and comfortable environment as evidence by soiled: carpet in two (2) of 15 hallways observed, carpet in one (1) of one (1) sitting area on Unit 3A; merry walkers in six (6) of six (6) observed; baseboard surfaces in three (3) of 12 observations; Interior and exterior louver surfaces of exhaust vents were soiled in three (3) | F 253 | #2<br>1. The 6 merry walkers identified as soiled were cleaned.<br>2. All merry walkers were inspected; all were clean.<br>3. Staff cleaning merry walkers will be re-in-serviced on cleaning the joints on merry walkers. The Assistant Director of Plant Operations or designee will inspect merry walkers for clean joints a minimum of once-monthly and submit a report of findings to the Director of Plant Operations. | |

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| F 253 | Continued From page 9<br>of 10 observed; surfaces in electrical closets on five (5) of five (5) units; ceiling tile surfaces were soiled in one (1) of two (2) observed. Marred/scarred: surfaces in the pantry in one (1) of five (5) observed; counter top edges at the nursing stations in five (5) of five (5) nursing units observed and entrance doors, door jamb and closet door surfaces were marred and scarred on the frontal surfaces in eight (8) of 20 observed. Damaged: tile in one (1) of three (3) shower rooms observed on Unit 3A; wallpaper was peeled/separated in four (4) of 15 hallways observed; a hole in the wall in the sitting area on one (1) of one (1) observed, a splintered countertop on Unit 1 in one (1) of one (1) countertop observed; a torn white sofa and soiled covering on sofa in one (1) of one (1) white sofa observed; window screens were observed to be damaged and separated from frames in one (1) of four (4) observed and the baseboard was missing in one (1) of one (1) observed. Clutter was observed in two (2) of 30 resident rooms; book shelves were observed with items improperly stored on them in two (2) of two (2) observed and nails were observed sticking out of the wall and the baseboard was detached from the wall in one (1) of 30 resident rooms observed.<br><br>The findings include:<br><br>Soiled:<br>1. Soiled carpet was observed on hallway #1 on Unit 2B, and on hallway #3B in two (2) of 15 hallways observed; Soiled carpet was observed on Unit 3A in the sitting area (near the elevators) in one (1) of one (1) observed. | F 253 | 4. The Director of Plant Operations will prepare a summary of the merry walker inspections to the Quality Improvement Committee quarterly.<br>5. Date of completion: 5/4/2012<br><br>#3<br>1. Hallway baseboard surfaces identified as soiled were cleaned.<br>2. All hallway baseboard surfaces were inspected; all were clean.<br>3. Floor care staff will be re-inserviced on hallway baseboard surface cleaning. Hallway baseboard surfaces will be inspected during Weekly Maintenance Rounds. The Assistant Director of Plant Operations or designee will review Weekly Maintenance Rounds reports for completion and spot-check hall baseboard surfaces a minimum of monthly.<br>4. The Director of Plant Operations will prepare a summary of the Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: 5/4/2012<br><br>#4<br><br>1. The interior and exterior louver surfaces of exhaust vents identified with accumulated dust in soiled linen closets were cleaned.<br>2. All interior and exterior louver surfaces of exhaust vents in soiled linen closets were inspected and cleaned. Soiled linen closet vents will be added to the | |

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| | 095005 | A. BUILDING _____ B. WING _____ | 03/06/2012 |

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| F 253 | Continued From page 10<br>2. Six (6) of six (6) merry walkers were observed soiled on Unit 2A.<br><br>3. Baseboard surfaces in the hallways were soiled on Units: 1A, 2A, 2B and 3B in four (4) of 12 observations;<br><br>4. The interior and exterior louver surfaces of exhaust vents were soiled with accumulated dust in soiled linen closets on Units 1A, 1B, and 3B in three (3) of 10 observed.<br><br>5. Electrical Closets on five (5) of five (5) units were observed to have soiled floors, walls and door jams.<br><br>6. Ceiling tile surfaces were soiled with accumulated dust over washers in the main laundry room in one (1) of two (2) observed.<br><br>Marred/scarred:<br><br>1. In two (2) of five (5) pantries the following was observed: 2A walls in and around the pantry area are marred, counter edges are marred; swing door to the pantry was damaged.<br><br>2. Marred/scarred counter top edges at the nursing stations on Units 1, 2A, 2B, 3A and 3B in five (5) of five (5).<br><br>3. Marred /scarred wall (by the window) in room #354A.<br><br>4. Entrance doors, door jamb and closet door surfaces were marred and scarred on the frontal surfaces in rooms #218 and #253; closet door | F 253 | Weekly Maintenance Rounds inspection list and maintenance staff will be in-serviced on revised form.<br>3. The Assistant Director of Plant Operations or designee will review the Weekly Maintenance Rounds for completion and spot-check soiled linen closet exhaust vents a minimum of monthly.<br>4. The Director of Plant Operations will prepare a summary of the Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion:<br><br>#5<br>1. The unit electrical closets identified as soiled were cleaned.<br>2. There are no other unit electrical closets in the facility.<br>3. Inspection of unit electrical closets will be added to the Weekly Maintenance Rounds form. Maintenance staff will be in-serviced to inspect unit electrical closets and clean the closets if soiled. The Assistant Director of Plant Operations or designee will review the Weekly Maintenance Rounds reports for completion and spot-check unit electrical closets a minimum of monthly.<br>4. The Director of Plant Operations will prepare a summary of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: | 5/4/2012<br><br>5/4/2012 |

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| F 253 | Continued From page 11<br>surfaces in room #253, the Medical Supply room on 2A, #314 and #355, closet door room #368 and the cafeteria entrance door in eight (8) of 20 doors observations.<br><br>Damaged:<br>1. The shower room near room #313 on Unit 3A was observed with damaged tile in one (1) of three (3) shower rooms observed.<br><br>2. Wall paper was peeled/separated in the following areas: Unit 1 Hallway #1, Unit 2B Hallway # 1. On Unit 2A the wall paper near the activity office was damaged; and on Unit 2A the blue hallway the wall paper was damaged near the end of the hallway in four (4) of 15 hallways observed.<br><br>3. The sitting area on Unit 1 was observed to have a hole in the wall/damaged in one (1) of one (1) wall observed.<br><br>4. The counter top in the dining area on Unit 1 was observed to be splintered in one (1) of one (1) counter tops observed in the dining area on Unit 1.<br><br>5. A torn white sofa with a soiled covering was observed on Unit 2A in one (1) of one (1) white sofa observed.<br><br>6. Window screens were observed to be damaged and separated from frames in the hallway near room #329 in one (1) of four (4) window screens observed.<br><br>7. Unit 2A near room #227 the baseboard was | F 253 | #6<br>1. The main laundry room ceiling tile surfaces over 1 washer identified as dusty was replaced.<br>2. Ceiling tile surfaces over the all washers were inspected and found clean.<br>3. Maintenance staff will be in-serviced to inspect ceiling tiles over washers during weekly vent cleaning. The Assistant Dir. of Plant Operations or designee will spot-check the vents a minimum of monthly.<br>4. The Director of Plant Operations will prepare a summary of the Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion:<br>**Marred/scarred**<br>#1, #2, #3, #4<br>1. The marred walls in proximity to or within the 2-A pantry area will be repaired and repainted. Marred 2-A pantry counter edges will be repaired. The 2-A pantry swing door will be repaired. Marred/ scarred counter top edges at all nurses' stations will be repaired. The marred/ scarred wall near window in room 354-A was repaired. Marred/scarred frontal surfaces on entrance doors, door jamb, and closet door in rooms 218 and 253 was repaired/repainted. Closet door surfaces in room 253, the Medical Supply Room on 2-A, and rooms 314, | 5/4/2012 |

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| F 253 | Continued From page 12<br>missing in one (1) of one (1) observed.<br><br>Other concerns:<br>1. Resident room ' s #108A and #323A were observed to have cluttered items at beside and on floor in two (2) of 30 resident rooms observed.<br><br>2. Bookshelf: water bottles and newspaper items were store on top of the bookshelf in one (1) of one (1) observed on Unit 2A and a pink color hand bag (an employee ' s personal belongings) stored in a clear plastic bag, a 19 " /21 " television was stored in a clear plastic bag and cable/adaptive wires were stored under news paper (items that belonged to a resident that expired) were observed on the bookshelf in one (1) of one (1) bookshelf observed on Unit 2B.<br><br>3. On February 22, 2012 at 11:15 am in room #215B nails were observed sticking out of the wall proximal to bed in one (1) of four (4) walls observed in the resident ' s room; and the baseboard strip wad observed detached from the wall. This was observed in the presence of Employee # 7 who acknowledged the findings at the time of the observation.<br><br>These observations were made in the presence of Employee #30 or Employee # 31 and they acknowledged the findings at the time of the observations. | F 253 | 355, and 368 will be repaired. The café-teria entrance doors will be re-finished. Painted surfaces will be repaired first; stained wood surfaces will be done second.<br>2. Doors and counters were inspected and found in good condition. Doors and counters are included in Weekly Maintenance Rounds.<br>3. Replacing worn counter edges is a facility-wide project. 3 to 5 days are planned for repairing counter edges on each of the 5 Units. Maintenance staff will be re-inserviced on inspection of counters and door surfaces during Weekly Maintenance Rounds. The Director of Plant Operations or designee will spot-check walls, counters, and doors a minimum of monthly and review Weekly Maintenance Rounds reports.<br>4. The Director of Plant Operations will prepare a summary of the Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: 5/4/2012<br><br>**Damaged**<br>#1<br>1. The wall tile in shower room near room 313 on Unit 3-A will be repaired.<br>2. Wall tiles in other showers were inspected; tiles were intact.<br>3. Maintenance staff will be re-inserviced to inspect shower room tiles during | |
| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically | F 272 | | |

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| F 272 | Continued From page 13<br>a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>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:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced | F 272 | Weekly Maintenance Rounds. The Dir. of Plant Operations or designee will review the Weekly Maintenance Rounds reports.<br>4. The Director of Plant Operations will prepare a summary of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: 5/4/2012<br><br>#2<br>1. Damaged wall paper on Units 1-A, 2-A, and 2-B will be removed and walls repaired and painted.<br>2. Wall paper was inspected facility-wide and found to be intact. A full time painter was hired to repair and maintain wall surfaces throughout the facility.<br>3. Maintenance staff will be re-inserviced on inspection and prompt reporting of damaged wall surfaces, as part of Weekly Maintenance Rounds. The Dir. of Plant Operations or designee will spot-check the condition of walls a minimum of monthly.<br>4. The Director of Plant Operations will review the Weekly Maintenance Rounds report and prepare a summary for the Quality Improvement Committee quarterly.<br>5. Date of completion: 5/4/2012<br><br>#3<br>1. The hole in wall of sitting area on Unit 1-A was repaired.<br>2. An inspection of other sitting area walls found walls undamaged. | |

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| F 272 | Continued From page 14<br>by:<br>Based on record review resident and staff interview for one (1) of 50 sampled residents, it was determined that facility staff failed to accurately code the annual and quarterly Minimum Data Set (MDS) for Glaucoma and Blindness for Resident #175.<br><br>The findings include:<br><br>A during a face-to-face interview with Resident #175 he/she stated, " Staff sometimes place my tray down [on the over-the-bed table] and doesn ' t open the items. I can ' t see to open my tray because I am blind in my left eye. "<br><br>A review of the follow up Ophthalmology Consult dated June 29, 2011 revealed, "Findings: Glaucoma OS (left eye), Blind OS ...Recommendations: See pt (patient) in 6 months. Stop drops."<br><br>A review of the annual Minimum Data Set (MDS) completed on August 30, 2011 Resident #175 was coded in Section B1000 [Vision] as his/her vision being moderately impaired. Under Section B1200 [Corrective Lens] the resident was coded as not using corrective lenses. In Section I [Active Diagnoses] the resident was not coded as having visual impairment.<br><br>The quarterly MDS completed on November 15, 2011 Resident #175 was coded in Section B1000 [Vision] as his/her vision being highly impaired. | F 272 | 3. Maintenance staff will be re-inserviced to inspect sitting areas for wall damage during Weekly Maintenance Rounds. The Director of Plant Operations or designee will review Weekly Maintenance Rounds reports<br>4. The Director of Plant Operations will prepare a summary of Weekly Maintenance Report findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: 5/4/2012<br>#4<br>1. The countertops identified as splintered will be replaced.<br>2. All Unit 1 countertops were inspected; countertops will be replaced during scheduled repair of nurses' station.<br>3. Maintenance staff will be re-inserviced to inspect countertops during Weekly Maintenance Rounds. The Director of Plant Operations or designee will review Weekly Maintenance Rounds reports. The Director of Plant Operations or designee will spot-check countertops monthly.<br>4. The Director of Plant Operations will prepare a summary of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: 5/4/2012 | |

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| F 272 | Continued From page 15<br>Under Section B1200 [Corrective Lens] the resident was coded as not using corrective lenses. In Section I [Active Diagnoses] the resident was not coded as having visual impairment.<br><br>There was no evidence that facility staff accurately coded Resident #175 for the diagnoses of Glaucoma and Blindness to the Left eye on the aforementioned annual and quarterly MDS.<br><br>A face-to-face interview was conducted with Employee #10 on February 28, 2012 at 3:40 PM. He/she acknowledged that the MDS was not coded to reflect the Residents diagnoses of Glaucoma and Left Eye Blindness. The record was reviewed on February 28, 2012. | F 272 | #5<br>1. The torn/soiled sofa will be replaced as soon as the new one ordered is delivered.<br>2. Upholstered furniture was inspected and found clean. New furniture ordered will be impervious to fluid.<br>3. Maintenance staff will be re-inserviced on completion of Weekly Maintenance Rounds form. Assistant Director of Plant Operations or designee will review weekly findings and address soiled furniture as identified.<br>4. The Director of Plant Operations or designee will review Weekly Maintenance Rounds reports and prepare a summary of findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: | 5/4/2012 |
| F 279 SS=E | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>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.<br><br>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 | F 279 | #6<br>1. The window screen identified as damaged will be replaced.<br>2. Window screens throughout the facility will be inspected; replacement screens will be ordered as needed.<br>3. Maintenance staff will be re-inserviced to inspect window screens on Weekly Maintenance Rounds. The Director of Plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check window screens a minimum of monthly.<br>4. The Director of Plant Operations or designee will prepare a summary of Weekly Maintenance Rounds | |

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| F 279 | Continued From page 16<br>§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).<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations, record review and interviews for six (6) of 50 sampled residents, it was determined that facility staff failed to initiate care plans with goals and objectives to address: one (1) resident with a positive Level Two Screen; approaches required to ensure safe oral intake of pleasure meals for one (1) resident with dysphagia; for refusal of medications and activities for one (1) resident; for one (1) resident with contractures; one (1) resident with urinary incontinence; and for one (1) resident with allergies. Residents #2, #107, #175, #178, #287 and #337.<br><br>The findings include:<br><br>1. Facility staff failed to develop a care plan with measureable goals and objectives for Resident #2 who has a positive screen for Mental Retardation. A review of the medical record for Resident #2 identifies that the resident was admitted to the facility in March 25, 1968.<br><br>Review of the PASSAR [Pre-Admissions Screen/Resident Review for Mental Illness and/or Mental Retardation] Screen dated January 20, 2008, identified the resident as positive for Mental Retardation. | F 279 | findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: 5/4/2012<br>#7<br>1. The baseboard near room 227 was replaced.<br>2. Baseboards were inspected; no other baseboards identified as missed when the new carpeting was installed.<br>3. Maintenance staff will be in-serviced to include baseboards in Weekly Maintenance Rounds inspection report. The Director of Plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check baseboards a minimum of monthly.<br>4. The Director of Plant Operations or designee will prepare a summary of the Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: 5/4/2012<br>**Other Concerns**<br>#3<br>1. The protruding nails and detached base board strip identified in room 215 were repaired.<br>2. An inspection of other resident rooms found no repeat occurrences.<br>3. Maintenance staff will be in-serviced to inspect resident rooms for protruding nails and/or detached baseboards during Weekly Maintenance Rounds. | |

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| F 279 | Continued From page 17<br>Review of the quarterly Minimum Data Set with an ARD [Assessment Reference Date] of November 16, 2011 identifies:<br><br>Section I : Diagnosis reveals the following diagnoses: Anemia, Heart Failure, HTN [Hypertension], Hyperlipidemia, Asthma, Sensory Hearing Loss Bilateral, Unspecified Osteoporosis, Dysphagia Oropharyngeal Phase, Vitamin D Deficiency, OBST [Obstructed] Chronic Bronchitis..., Slow transit constipation, other drug allergy, Unspecified Infantile Cerebral Palsy, Mild Intellectual Disabilities [Mental Retardation].<br><br>Review of the Social Service's Notes reviewed that the resident's care conference was conducted on December 1, 2011. Relative attended via telephone.<br><br>Review of the care plans last updated December 1, 2011 lacked evidence of a care plan with appropriate goals and approach to address and resident with a positive screen for Mental Retardation.<br><br>A face-to-face interview was conducted with the Employee #4 on February 24, 2012 at 5:10 PM. After a review of the care plans, he/she acknowledged the findings. The record was reviewed on February 24, 2012.<br><br>2. A review of the clinical record for Resident #107 lacked evidence of problem identification, goals and approaches required to ensure safe oral intake of pleasure meals for the resident whose diagnoses includes dysphagia. Additionally, the record lacked evidence of | F 279 | The Director of Plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check resident rooms a minimum of monthly.<br>4. The Director of Plant Operations will prepare a summary of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: | 5/4/2012 |

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| F 279 | Continued From page 18<br>caregiver education for safe oral intake strategies.<br><br>According to physician ' s progress notes dated January 20, 2012, Resident #107 ' s diagnoses included dysphagia. According to the quarterly Minimum Data Set [MDS] dated November 29, 2011, the resident received 51% or more of daily calories and 501cc or more of fluid intake per tube feeding.<br><br>Physician ' s orders dated January 27, 2012 directed, " Patient to receive puree food, nectar-thick liquids, Tuesday and Thursdays, Pleasure evening meal only. "<br><br>A review of the speech therapy progress notes dated February 22, 2012 read: " the patient is safely tolerating pleasure feeds of nectar-thick liquids and puree consistency solids. SLP [speech/language pathologist] wrote an order and arranged for patient to receive pleasure feedings with the patient to improve quality of life. Patient consumes less than 25% at each pleasure feed meal ...provided ongoing diet texture evaluation and established effective swallowing compensatory strategies for the patient. Educated the family on safe swallowing compensatory strategies ...[training] ongoing with family/POA [power of attorney] who is the one requesting pleasure feeds and will be the one to give pleasure feeds ... "<br><br>The record lacked documented evidence of the development interventions and approaches in the comprehensive care plan to address the swallowing requirements for Resident #107. There was no evidence that training was | F 279 | **F272**<br><br>1. The MDS coding for resident #175 in Section B1200 and B1200 was corrected during the survey process. A care plan with measurable goals and objectives for Mental Retardation was added to the medical record of Resident #2.<br>2. All residents with a diagnosis of Glaucoma and Blindness were reviewed for accuracy on the MDS.<br>3. The MDS Team will conduct a monthly audit of the MDS 3.0 to ensure it matches the resident's interdisciplinary plan of care. The MDS Coordinator will develop an audit tool for the MDS3.0 that will address incorporation of the interdisciplinary plan of care with the MDS3.0. The MDS Coordinator will conduct an education session with the MDS team as to how the audit tool will be utilized.<br>4. The MDS Coordinator or designee will submit a monthly report to the QI Committee reflecting any variances in MDS coding addressed by the MDS 3.0 audit tool.<br>5. Date of completion: | 5/4/2012 |

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| F 279 | Continued From page 19<br>provided to the caregiver staff as it relates to safe swallow strategies.<br><br>A face-to-face interview was conducted on March 5, 2012 at approximately 3:30 PM with Employee #40 regarding the lack of a care plan and training of staff regarding the resident ' s oral intake requirements. S/he reviewed the record and acknowledged the findings. The record was reviewed March 1, 2012.<br><br>3. Facility staff failed to initiate a care plan for Resident #175 ' s refusal of medication and activities.<br><br>The resident was observed in room in bed watching television per his/her choice on February 21, 22, 28, and 29, 2012.<br><br>The psychiatric follow-up note dated February 9, 2012 revealed, " Resident #175 has been refusing to go along with the recommended IV (Intravenous) antibiotic treatment for his/her probably osteomyelitis in his/her toes. He/she has also been losing weight slowly and reluctant to eat regularly...<br><br>Recommendations: 1. A slight increase in his/her sertraline (150 mg to 250 mg) may be marginal benefit, although the majority of his/her denial and resistance to therapy appears related to his/her sense of loneliness and loss of control. 2. Given the difficulty with weight control, would recommend that we loosen the dietary restrictions as much as possible to allow him/her to eat what he/she might enjoy more. Ideas | F 279 | **F279**<br>1. A care plan was developed with measurable goals and objectives for Resident #2, who has a positive screen for Mental Retardation.<br>2. All residents with a positive screen for Mental Retardation were reviewed to ensure a care plan was developed with measurable goals.<br>3. Residents with a positive screen for MIMR will have their care plans reviewed for measurable goals on admission, and quarterly by the Social Worker or designee. The care plans will be updated appropriately if deficiencies are found.<br>4. Social Work or designee will report non-compliance or variances to the Quality Improvement Committee at the quarterly meeting.<br>5. Date of Compliance | |

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| F 279 | Continued From page 20<br>discussed included meals brought on visits by [name] team as well as " take out " lunches ordered through his/her petty cash account by TWH staff ... 3. Most importantly, organized and regular visits with volunteers and friends would give him/her more personal contact and help with his/her loneliness. "<br><br>According to the activity notes: dated November 15, 2011 and February 14, 2012 the resident is encouraged to come out of his/her room to activities. One-to-one visits are provided.<br><br>A telephone interview was conducted with Employee #32 on February 28, 2012 at 1:20 pm. He/she stated, " Yes, every day I offer him /her opportunity to participate in activities. He/she refuses to come out of his/her room. Yes, I go in his/her room and speak with him/her. I stress that our volunteers come and talk to him/her as well. "<br><br>A face-to-face interview was conducted with Employee # 26 on February 28, 2012 at 1:15 pm. He/she stated, "We put him/her in the chair. He/she comes out of the room on his/her own. He/she is in an electric chair. We offer him/her to come out but he/she doesn ' t."<br><br>A face-to-face interview was conducted with Employee # 10 on February 28, 2012 at 3:40 PM. He/she stated that the resident has refused his/her medication therapy several times. | F 279 | 1. The care plan of Resident #107 was adjusted during the survey process to include the following: pleasure feedings of puree food and nectar thick liquids Tuesday and Thursday for the evening meal, and with interventions & approaches to be used by the resident's POA when they assist the resident with the resident's meal. During the survey process the care plan of Resident #175 was corrected to include their refusal of medications and their refusal to participate in activities outside of their room: this includes meals. During the survey process the care plan of Resident # 178 was corrected to address the resident's contracture of their right hand and arm. During the survey process it was explained that during the waking hours of Resident #287, a toileting schedule where the resident is transferred to the commode is maintained. In order to provide quality hours of sleep for the resident, a standard every 2 hour incontinence care schedule is used: the resident's care plan has been corrected to reflect the toileting schedule during waking hours and the every 2 hour incontinence care when the resident is asleep. Resident #337 has been discharged from the facility. | |

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| F 279 | Continued From page 21<br><br>There was no evidence that the care plan was initiated with goals and approaches to address the residents refusal of medication therapy, reluctance to eat and to come out of his/her room to participate in activities.<br><br>A face-to-face interview was conducted with Employee # 10 on February 28, 2012 at 3:40 PM. He/she acknowledged that there was not care plan initiated to address the resident ' s refusal of medication therapy, reluctance to eat and to come out of his/her room. The record was reviewed on February 28, 2012.<br><br>4. Facility staff failed to initiate a care plan with goals and objectives to address the resident's contracture of his/her right hand/arm. Resident # 178.<br><br>A review of the admission data base revealed that the resident was admitted to the facility with diagnoses which included Cerebrovascular Accident (CVA) and Hemiplegia on December 28, 2009.<br><br>A review of the resident ' s last annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of October 19, 2011 revealed that the resident ' s active diagnoses included: Cerebrovascular Accident (CVA) and Hemiplegia.<br><br>Upon observation the resident was observed seated in a wheel chair with his/her right arm | F 279 | 2. The Nurse Manger or designee will audit 10% of the resident charts monthly. At least two of the charts audited will be one of a resident where an incident has occurred and one will be a resident that has received a recent consult and/or has had a change in their plan of care: includes newly diagnosed problems and/or allergies.<br>3. The Speech Pathologist will conduct an education with the POA of Resident #2 as to the interventions and approaches that may be used as compensatory strategies when the POA assists the resident with meals. The DON or designee will conduct an education session with the Nurse Managers as to how to incorporate the new reviews (residents receiving a recent consult and residents that have had a change in their plan of care) into their chart audit process.<br>4. The chart audits completed by the Nurse Managers will be submitted to the QI Manager. The QI Manager or their designee will submit a monthly report of the chart audits to the QI Committee.<br>5. Date of Completion: | 5/4/2012 |

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| F 279 | Continued From page 22 | F 279 | | |

resting on the arm of the wheel chair and fingers clasped to the palm.

Review of the care plans in the resident ' s active clinical record failed to reveal a care plan to address the resident's contracture.

Employee #22 confirmed that the resident had a contracture of the right arm during a face-to-face interview at 10:56 AM on February 23, 2012.

After a review of the care plans in the resident ' s clinical record there was no evidence that a care plan was initiated with goals and approaches to address the resident ' s contracture.

A face-to-face interview was conducted with Employee # 4 at approximately 10:33 AM on February 29, 2012. During the interview the employee was queried whether the resident had a care plan that addressed his contractured arm and leg. The employee looked at the record and responded, " No. I don ' t see one. " The record was reviewed on February 29, 2012.

The facility staff failed to initiate a care plan with goals and objectives to address the resident's contracture of his/her right hand/arm.

5. Facility staff failed to initiate a care plan with goals and objectives to address Resident # 287 ' s incontinence.

A face-to-face interview was conducted with Resident # 287 on March 1, 2012 at approximately 12:00 PM. He/she informed this investigator that he/she has problems with " dribbling " and wears " pull-ups. "

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| F 279 | Continued From page 23<br><br>A review of the admission data base revealed that the resident was admitted to the facility on October 7, 2011. A review of the admission MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of October 14, 2011 revealed that the resident was coded with a one (1) which indicated that the resident was occasionally incontinence under Section H 300 [Urinary Continence]. The coding was the same for the 30 day [11/3/11] and the 60 day [12/6/11] assessments. However, the quarterly assessment dated December 20, 2011 revealed that the resident was coded with a three (3) indicating that the resident was always incontinent.<br><br>The record lacked evidence that a care plan was initiated with goals and approaches to address the resident' s incontinence<br><br>A face-to-face interview was also conducted with Employee # 10 at approximately 12:15 PM on March 1, 2012. During the interview the employee acknowledged that the resident was incontinent and that the record lacked evidence of a care plan to address the resident ' s incontinence. The record was reviewed on March 1, 2012.<br><br>6. Facility staff failed to initiate a care plan with goals and approaches to address Resident #337's allergies (ASA, Codeine and Sulfa).<br>A review of January 11, 2012 Physician ' s Order Sheet and Plan of Care, signed by the physician on January 11, 2012 revealed, " | F 279 | | |

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| F 279 | Continued From page 24<br>Allergy History: ASA [Aspirin], Codeine [and] Sulfa " According to the " Nursing Admission Assessment " form dated January 11. 2012 revealed: " Food/Drug Allergies: ASA, Codeine, Sulfa. "<br>The resident ' s care plan initiated January 12, 2012, lacked evidence that a care plan with goals and approaches was developed to address the resident ' s allergies.<br>A face-to-face interview was conducted on February 27, 2012 at approximately 3:00 PM with Employee #6. He/she acknowledged that there was no care plan for allergies for Resident #337. The record was reviewed February 27, 2012. | F 279 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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 changes in care and treatment.<br><br>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. | F 280 | | |

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| F 280 | Continued From page 25<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for two (2) of 50 sampled residents, it was determined that facility staff failed to amend the nutrition care plan for one (1) resident to address the resident ' s current nutritional status and to update one (1) resident ' s care plan to include a diagnosis of blindness. Residents # 107 and #175.<br><br>The findings include:<br>1. A review of the comprehensive care plan for Resident #107 updated December 6, 2011 revealed facility staff failed to update the nutrition care plan to include the resident ' s current nutritional status.<br><br>A review of the physician ' s progress notes dated January 20, 2012 revealed the resident ' s diagnoses included dysphagia, intracerebral hemorrhage, percutaneous placement of Gastrostomy tube, stroke syndrome, epilepsy and recurrent seizures.<br><br>Physician ' s orders dated January 27, 2012 directed, " Patient to receive puree food, nectar-thick liquids, Tuesdays and Thursdays, Pleasure evening meal only. "<br><br>The care plan included the following: " problem: alteration in nutrition - needs tube feeding to meet daily needs. "<br><br>The care plan lacked evidence of an update to | F 280 | **F280**<br>1. The care plan of Resident #107 has been corrected to include their current nutritional status: receiving pleasure feedings for the evening meal on Tuesdays and Thursdays. The care plan of Resident #175 has been corrected to include a diagnosis of blindness to the left eye & Glaucoma.<br>2. The Nurse Manger or designee will audit 10% of the resident charts monthly. At least two of the charts audited will be one of a resident where an incident has occurred and one will be a resident that has received a recent consult and/or has had a change in their plan of care: includes newly diagnosed problems and/or allergies.<br>3. The DON or designee will conduct an education session with the Nurse Managers as to how to incorporate the new reviews (residents receiving a recent consult and residents that have had a change in their plan of care) into their chart audit process.<br>4. The chart audits completed by the Nurse Managers will be submitted to the QI Manager. The QI Manager or their designee will submit a monthly report of the chart audits to the QI Committee.<br>5. Date of Completion: | 5/4/2012 |

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| F 280 | Continued From page 26 | F 280 | | |

include the pleasure feeding implemented as of January 25, 2012. The record was reviewed March 1, 2012.

2. Facility staff failed to update the vision care plan to include Resident #175 diagnoses of blindness to the left eye and Glaucoma.

A during a face-to-face interview with Resident #175 he/she stated, " Staff sometimes place my tray down [on the over-the-bed table] and doesn ' t open the items. I can ' t see to open my tray because I am blind in my left eye. "

A review of the follow up Ophthalmology Consult dated June 29, 2011 revealed, " Findings Glaucoma OS (left eye), Blind OS ...Recommendations: See pt (patient) in 6 months. Stop drops. "

A review of the annual Minimum Data Set (MDS) completed on August 30, 2011 Resident #175 was coded in Section B1000 Vision as his/her vision being moderately impaired.

The quarterly MDS completed on November 15, 2011 Resident #175 was coded in Section B1000 [Vision] as his/her vision being highly impaired.

The Visual Function care plan last reviewed November 22, 2011 list, " Problem: Visual deficits related to cataracts. There was no evidence that the care plan for vision was

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| F 280 | Continued From page 27<br>updated to include the Resident #175 ' s diagnoses of blindness to the left eye and Glaucoma.<br><br>At the time of this review there was no evidence in the active clinical record that Resident #175 seen in by the ophthalmologist since June 29, 2011 as recommended. Additionally, there was no documented follow up with the Ophthalmologist after the noted change in vision from the August 30, 2011 to November 15, 2011 MDS.<br><br>A face-to-face interview was conducted with Employee #10 on February 18, 2012 at 3:40 PM. He/she acknowledged that the care plan was not updated to include the resident ' s diagnoses of blindness and Glaucoma. The record was reviewed on February 18, 2012. | F 280 | | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and interview for one (1) of 50 sampled residents, it was determined that facility staff failed to follow physician ' s orders and provide care and services with | F 309 | | |

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| F 309 | Continued From page 28<br>timeliness, for the management of one resident with respiratory difficulty and edema. Resident #353.<br><br>The findings include:<br><br>Facility staff failed to follow physician ' s orders and implement care and services with timeliness for the management of respiratory difficulty and fluid retention exhibited by Resident #353 who was subsequently hospitalized approximately one week post admission, with an acute exacerbation of congestive heart failure.<br><br>A review of the clinical record for Resident #353 revealed the 92 year old was admitted on February 10, 2012 for physical rehabilitation with diagnoses that included urosepsis, Alzheimer ' s dementia and a past history of hypercholesterolemia, pacemaker, BPH (benign prostatic hypertrophy) and aortic stenosis. The resident was admitted with an indwelling urinary catheter to manage a history of urinary retention and a peripherally inserted central catheter [PICC] of the right upper arm. The resident ' s medication regimen included intravenous antibiotic therapy administered every six (6) hours for urosepsis.<br><br>Interdisciplinary notes documented by the medical team included, but was not limited to the following: February 10, 2012 [no time indicated]- admission physical examination; " Extremities: 3+ edema; lungs clear with bilateral congestion and good air flow. " | F 309 | **F309**<br><br>1. The resident is discharged from the facility. During the survey process, one to one education was conducted for the licensed nurse that failed to act on the prescribed interventions and/or to act on them with timeliness (for Resident #353).<br>2. The respiratory therapist will be in-serviced to document in the medical record all discussion of respiratory recommendations with the physician. The respiratory therapist will also be in-serviced to document physician and charge nurse notification related to respiratory therapist recommendations. Using the 24 Hour Chart Check protocol, licensed nurses will conduct a daily audit of any chart with newly transcribed orders. Using the Open Chart protocol, licensed nurses will document a nursing progress note each shift for any resident experiencing a change in status or condition: according to protocol the resident will remain on "Open Charting" until the change is resolved. | |

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| F 309 | Continued From page 29<br><br>February 14, 2012 at 10:00 AM; " Patient ' s [responsible party named] concerned that patient is more lethargic and short of breath than usual " ...Assessment - hypoxic, recent urosepsis, dementia ...Plan - Lasix (diuretic) 40 mg po (by mouth) for one dose, oxygen at 2 liters via nasal cannula with pulse oximetry (P02) assessments every shift, " maintain P02 at 94%. "<br><br>February 15, 2012 [no time indicated]-chief complaint: " nurse reports patient with edema generalized ... " examination - bilateral lower extremity " taut " edema 2+, right upper extremity edema 1+, " mild " dyspnea (shortness of breath) and tachypnea (rapid breathing); Treatment plan - " start low dose Lasix 10 mg po daily ...CXR [chest x-ray], respiratory consult for pulmonary toileting, bilateral lower extremity compression stockings .... "<br><br>February 17, 2012 at 9:00 AM " caregiver feels breathing is about the same, [he/she] has occasional congested cough ...Chest x-ray 2/16/12 - bilateral pleural effusion, likely increased; Assessment - Dyspnea, likely increasing pleural effusion, Na (sodium) overload from urosepsis?...on Lasix 10 mg daily and KCL 10 mg daily, will increase Lasix to 20 mg bid and K- Dur to 20 mg bid ... "<br><br>February 17, 2012 at 5:00 PM, " [responsible party named] complaining that patient is swollen ...nursing states there is no change in behavior since admission ...P02 97% room air, chest clear ; extremity +3 edema legs; Assessment/Plan - | F 309 | 3. All respiratory therapists assigned to the facility will be re-inserviced as stated above. The in-services will also address completion of initial respiratory assessments and timeliness requirements.<br>At the end of each shift licensed nurses will document information to be communicated to the House Supervisor. The House supervisor will compile this information into a "24 Hour Report". All residents with a change in condition and/or status will remain on the "24 Hour Report" until the change is resolved. The Clinical Educator will conduct education sessions for licensed nurses and House Supervisors addressing physician notification, the 24 Hour Chart Check protocol, the Open Charting protocol and the revised method of using the 24 Hour Report.<br><br>4. The District Manager for Respiratory Services or designee will audit monthly the timeliness of respiratory treatments and completion of documentation. Audit findings will be reported to the Quality Improvement Committee quarterly. | |

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| F 309 | Continued From page 30<br>volume overload, Lasix increased to 20mg bid, renal function normal, started on pulmonary toilet with nebulizer. "<br><br>A review of Physician ' s orders included, but was not limited to the following:<br>February 14, 2012 at 9:30 AM: " Lasix 40 mg po x 1 dose now for CHF (congestive heart failure) "<br><br>February 14, 2012 at 4:30 PM: "Oxygen at 2 liters/minute via nasal cannula with pulse oximetry (P02) assessments every shift, " maintain P02 at 94%. "<br><br>February 15, 2012 at 3:40 PM: "Lasix 10 mg po daily for dyspnea and edema, hold if systolic blood pressure is less than 110; chest x-ray to evaluate dyspnea; respiratory consult for pulmonary toileting."<br><br>February 17, 2012 at 9:20 AM: " increase Lasix to 20 mg po [by mouth] bid [twice daily] for CHF (congestive heart failure), hold for systolic BP less than 100; K-Dur 20 mg po bid for CHF."<br><br>February 17, 2012 at 10:30 AM: " Duo Neb [aerosolized nebulization treatment] every 4 hours for pulmonary toileting; Incentive spirometer for deep breathing/cough. "<br><br>A review of the Medication Administration Record for February 2012 included, but was not limited to the following:<br>February 14, 2012: [transcribed order] " Lasix 40 mg po x 1 dose now for CHF 10:00 AM. " | F 309 | The Nurse Manager or designee will incorporate an audit of the 24 Hour Chart Check protocol and the Open Charting protocol into the monthly audits conducted on 10% of the resident charts on their units. The QI Manager will submit a monthly report to the QI Committee of the 10% chart audits completed by the Nurse Managers or their designee. The Nurse Manager or their designee will receive an education session to address using the Chart Audit tool to incorporate the 24 Chart Check protocol and the Open Charting Protocol.<br>5. Date of Completion: | 5/4/2012 |

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| F 309 | Continued From page 31<br>The MAR lacked evidence of the administration of the one-time dose of Lasix. The space allotted for documenting the administration of Lasix was blank.<br><br>February 15, 2012: [transcribed order] " Lasix 10mg by mouth daily for dyspnea and edema, hold for SBP (systolic blood pressure) less than 110, 9AM "<br><br>The MAR revealed the initial dosage of Lasix 10 mg was administered at 9:00 AM on February 16, 2012, more than 17 hours after it was prescribed. There was no documented evidence that the Lasix was held and/or omitted due to the resident ' s inability to meet the parameters of administration (e.g. low blood pressure).<br><br>February 17, 2012: [transcribed order] " increase Lasix to 20 mg po bid for CHF - hold for SBP less than 100, 9AM, 5PM "<br><br>The MAR revealed the increased Lasix dosage was initiated at 5:00 PM, approximately eight (8) hours after it was prescribed.<br><br>February 17, 2012: [transcribed order] " DuoNeb every 4 hours for pulmonary toileting, CHF, bilateral pleural effusion; 1AM, 5AM, 9AM, 1PM, 5PM, 9PM "<br><br>The MAR revealed the Duo Neb treatment was initiated at 9:00 PM, greater than ten (10) hours after it was prescribed.<br><br>Review of Respiratory Therapy Notes:<br>A review of Respiratory Therapy (RT) notes | F 309 | | |

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| F 309 | Continued From page 32<br>revealed the initial respiratory therapy consult was performed February 17, 2012 at 10:38 AM, two (2) days after the physician ' s request for services.<br><br>The Consultation request form for respiratory services dated February 15, 2012 was blank. The RT Recommendations and Order Request form dated February 17, 2012 at 10:38 AM read: " patient cannot tolerate any pulmonary toileting at this time. Incentive spirometer recommendation for 10 days as tolerated ... "<br><br>Review of nurse ' s progress notes as it relates to the resident ' s respiratory status and fluid retention included but was not limited to:<br><br>February 14, 2012 6:00 AM, " ...lung sounds clear but slightly diminished on the left upper lobe. "<br><br>February 14, 2012 11:00 PM, " O2 at 2 liters running, no SOB [shortness of breath] however, nasal congestion present. "<br><br>February 15, 2012 6:00 AM, " ...no respiratory distress noted.. "<br><br>February 15, 2012 4:00 PM, " [Medical staff named] made aware about edema on lower extremities and shortness of breath, new orders given. "<br><br>February 16, 2012 7:00 AM, " ...bilateral lower extremity edema, non-pitting, Lasix therapy ongoing ... "<br><br>February 16, 2012 8:00 PM, " ...Pulse oximetry | F 309 | | |

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| F 309 | Continued From page 33<br>93% respiratory therapy aware of request for pulmonary toileting ...on lasix and potassium ... "<br><br>February 17, 2012 6:45 AM, " ...no respiratory distress, bilateral lower extremity edema noted ... "<br><br>February 17, 2012 6:30 PM, " patient seen by medical team and respiratory for (upward arrow - increased) CHF [congestive heart failure] and bilateral pleural effusion, new orders received ... "<br><br>February 18, 2012 1:50 AM, " resident noted with dyspnea, tachycardia, SOB, shallow respiration, duo neb treatment administered, pulse oximetry still between 88-89%... MD on call notified with new order to send resident to ER [emergency room] for further evaluation ... "<br><br>February 18, 2012 5:30 AM, " spoke with nurse at [hospital named] who stated that patient was admitted for exacerbation of CHF. "<br><br>Summary:<br>According to medical team progress notes, the resident ' s respiratory difficulty and fluid retention progressed and interventions were prescribed. However, licensed nursing staff failed to act on the prescribed interventions and/or act on them with timeliness as follows:<br>The clinical record revealed licensed nursing staff failed to administer diuretic therapy [Lasix 40mg] ordered by the physician on February 14, 2012 for the management of CHF. Licensed nursing staff failed to act with timeliness in the implementation of pharmacologic interventions prescribed; several hours (specified above) | F 309 | | |

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| F 309 | Continued From page 34 | F 309 | | |

lapsed prior to administering prescribed diuretic medication and aerosolized nebulization therapy. There was no documented evidence that the prescribed diuretic medication (Lasix) was held and/or omitted due to the resident ' s inability to meet parameters of administration (e.g. low blood pressure). There was no evidence that staff consulted with the medical team to explore alternative measures when and/or if it was determined that prescribed interventions could not be implemented with timeliness [e.g. medication pending delivery etc.].

Nursing assessments of the resident ' s respiratory status were inconsistent. Entries such as " [Medical staff named] made aware about shortness of breath " (February 15, 2012 at 4:00 PM); there was no evidence of a correlating note related to an assessed state of " shortness of breath. "

On February 17, 2012, during the evening (3 - 11:30 PM) shift, the MAR/TAR revealed the resident ' s P02 level was 98%, however a nurse ' s entry at 1:50 AM on February 18, 2012 read: " ...pulse oximetry still between 88-89%... " There was no evidence of a correlating note and/or assessment that identified a prior P02 level that ranged between 88-89% as implied by " still. "

The medical team prescribed, on more than one occasion, the intervention of pulmonary toileting as a component in the management of the resident ' s respiratory status. It was initially prescribed on February 15, 2012 and again on February 17, 2012. However, the respiratory therapy staff failed to implement the treatment.

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| F 309 | Continued From page 35<br>Respiratory therapy staff failed to act with timeliness on a physician ' s request for consultation; a period of 2 days lapsed before the consult was performed. The respiratory therapy consultation lacked documented evidence of a complete assessment of the resident ' s respiratory status. A chest x-ray done February 16, 2012 revealed the resident had pulmonary congestion and bilateral pleural effusions; there was no evidence of an assessment of the resident ' s respiratory status consistent with the radiologic result. The physician ' s request for pulmonary toileting was not followed through. The order for pulmonary toileting was not discontinued even though the therapist recommended " patient cannot tolerate any pulmonary toileting at this time. " Physician ' s notes (February 17, 2012 at 5:00 PM) and orders (February 17, 2012 10:30 AM) referred to pulmonary toileting as a component of the resident ' s plan of care.<br><br>A face-to-face interview was conducted with Employee #36 on March 2, 2012 at approximately 4:00 PM. She/he stated that the resident was not appropriate for pulmonary toileting and that the recommendation was verbally communicated to the medical staff prior to February 17, 2012. However, s/he acknowledged that there was no documented evidence of a recommendation against pulmonary toileting prior to March 17th and the record revealed the medical team continued to include pulmonary toileting in the resident's plan of care. The employee stated that respiratory therapy services were available 7 days per week and requests for respiratory services were usually acted on the same day "if it ' s during the | F 309 | | |

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| F 309 | Continued From page 36<br>hours that a therapist is on duty."<br><br>In response to a query regarding the delay in initiating the nebulization treatment, Employee #36 stated that the medication had to be ordered and nursing staff administer the treatments in the absence of respiratory staff. In response to a query as to whether or not the medical team was not consulted for an alternative treatment in the interim, s/he stated "no, because there is no alternative to Duo-neb [atrovent and albuteral]. "<br><br>In response to a query regarding the lack of a full respiratory assessment, Employee #36 stated that the therapist documented [his/her] findings as s/he assessed.<br><br>Facility staff failed to follow physician ' s orders and act with timeliness to manage the needs of Resident #353 ' s respiratory difficulty and fluid retention. The resident was subsequently hospitalized with an acute exacerbation of congestive heart failure. The record was reviewed March 2, 2012. | F 309 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interviews for one (1) of 50 sampled residents, it was determined that | F 312 | | |

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| F 312 | Continued From page 37<br>facility staff failed to ensure incontinence care was provided consistent with one (1) resident ' s needs. Resident #107.<br><br>The findings include:<br><br>On February 28, 2012 at approximately 3:40 PM a face-to-face interview was conducted with the responsible party for Resident #107. The responsible party conveyed that s/he had informed the staff that the resident was in need of incontinence care but hours passed and incontinent care had not been provided to the resident.<br><br>In response to concerns regarding the provision of care verbalized by Resident #107 ' s responsible party (RP), an observation was conducted. On February 28, 2012 at approximately 3:50 PM, moments after the RP verbalized the concerns to the survey team, facility staff were observed transporting the resident from a common area on the unit to his/her room via wheelchair. Staff transferred the resident via mechanical lift and proceeded to provide incontinent care. The staff removed the resident ' s incontinent brief and it was observed to be " soggy " and thoroughly saturated with urine.<br><br>An interview was conducted with the staff who performed the incontinence care at the time of the observation. In response to a query regarding the last time the resident received incontinence care, they responded that they were unaware because they recently arrived to duty for the | F 312 | **F312**<br>1. Resident #107 received incontinence care during survey process. Resident #107 did not sustain any skin impairment.<br>2. All residents with incontinence care will be monitored daily by the Nurse Manager or designee to ensure consistent continence care is provided in a timely manner.<br>3. Nursing Assistants and Charge Nurses will utilize a Shift Duties Worksheet to assist them in organizing and prioritizing the care of residents. All residents will be provided consistent incontinent care. Nursing Assistants and Charge Nurses will receive an education session addressing organizing and prioritizing resident care to better serve the needs of all residents. Nurse Managers or their designee will conduct random unit rounds at least twice during a shift with added focus on residents requiring toileting assistance.<br>A Shift Duties Worksheet will be created to assist Nursing Assistant and Charge Nurses to better organize and prioritize the delivery of resident care. The Clinical Educator or their designee shall conduct education sessions on utilization of the Shift Duties Worksheet. | |

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| F 312 | Continued From page 38<br>evening shift.<br><br>Facility staff failed to provide incontinence care consistent with the resident ' s needs as evidenced by the removal of a " soggy " and thoroughly saturated incontinent brief. The observation was made on February 28, 2012. | F 312 | 4. During the weekly Focus QI meeting the QI Manager will receive a summation from the Nurse Manager or designee of the random nursing unit rounds.<br>5. Date of Completion: | 5/4/2012 |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff interview for one (1) of 50 sampled residents, it was determined that facility staff failed to ensure that one (1) resident received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Resident #45<br><br>The findings include:<br><br>1. Facility staff failed to ensure that Resident #45 received necessary treatment and services, promoted healing, prevented infection and | F 314 | | |

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| F 314 | Continued From page 39<br>prevented new sores from developing.<br><br>The quarterly Minimum Data Set (MDS) completed November 15, 2011; under Section I [Active Diagnoses] included the following diagnoses: Hypertension, Neurogenic Bladder, Diabetes Mellitus, Hyperlipidemia, Paraplegia, Cervical Spinal Stenosis, and Arthropathy.<br><br>The Braden Scale (for predicting pressure sore risk) completed November 8, 2011equaled a score of 18 (low risk).<br><br>The Laboratory Report dated January 11, 2012 revealed that the resident ' s Red Blood Count was 3.31-low (range, 4.30-5.70); Hemoglobin was 10.6-low (range, 11.6-15.6); Hematocrit was 30.4-low (range, 34.0-46.0)<br><br>Physician ' s Orders:<br><br>The Physician ' s Order dated " November 2, 2011 at 11:00 AM directed, 1) Cleanse sacral skin tear with NSS (normal saline solution), pat dry, apply thin layer of Bacitracin to would daily x (times) 14 days, cover with dry dressing. "<br><br>The Physician ' s Order dated " November 17, 2011 at 1:20 PM directed, Cleanse sacral skin tear with normal saline, pat dry, apply thin layer of Bacitracin to area daily x 14 days, cover with dry dressing. "<br><br>The Physician ' s Order dated " December 3, | F 314 | **F314**<br>1. Resident #45 received treatments for the wound without sustaining deterioration to the wound.<br>2. All residents will receive the necessary treatment and services to promote healing, prevent infection or development of new wounds. The Clinical Educator or their designee will conduct a Wound Care Competency check (including identification of wounds, assessments, and measurements) for all newly hired licensed nurses. The Clinical Educator or designee will conduct a Wound Care Competency Check with licensed nurses that work on the nursing unit where Resident #45 resides.<br>3. The Clinical Educator or their designee will conduct a Wound Care Competency check (to include identification of wounds, assessments, and measurements) during the orientation of newly hired nurses and annually with all other licensed nurses<br>4. The Clinical Educator or designee will submit a monthly report of education sessions, number of attendees. The report will also include audit of wounds and wound measurements. Any variances will be reported to the QI Committee.<br>5. Date of Completion: | 5/4/2012 |

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| F 314 | Continued From page 40<br>2011 at 11:00 AM directed, Cleanse sacral skin tear with normal saline, pat dry, apply thin layer of Bacitracin Ointment to wound daily x 14 days, cover with dry dressing. "<br><br>The Physician ' s Order dated " December 8, 2011 at 1:00 PM directed, 1) D/C [discontinue] previous wound (sacral) order; 2) Cleanse sacral and R (right) buttock Stage II PU (pressure ulcer) with NSS, pat dry, apply Collagen dressing every shift x 4 weeks ... "<br><br>The Physician ' s Order dated " January 3, 2012 at 2:00 PM directed, Cleanse pressure ulcer to coccyx with normal saline, pat dry, apply Santyl to wound base cover with dry dressing twice daily for 14 days and reassess. "<br><br>The Physician ' s Order dated " January 18, 2012 at 11:00 AM directed, Cleanse pressure ulcer to coccyx with normal saline, pat dry, apply Santyl to wound base, cover with dry dressing twice daily for 30 days and reassess. Cleanse left buttock pressure ulcer with normal saline, pat dry, apply Santyl to wound base, cover with dry dressing twice daily for 30 days and reassess. "<br><br>The Physician ' s Order dated " January 20, 2012 at 12:00 noon directed, discontinue all wound orders. Cleanse pressure ulcer to coccyx with normal saline, pat dry, apply Santyl and Polysporin powder to wound, twice daily until healed. "<br><br>The Physician ' s Order dated " January 20, 2012 at 12:00 noon directed, Cleanse left buttock pressure ulcer with normal saline, pat dry, apply | F 314 | | |

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| F 314 | Continued From page 41<br>Santyl and Polysporin powder to wound, twice daily until healed. "<br><br>Medication Administration Record<br><br>On November 2, 2011 the Medication Administration Record (MAR) revealed, Cleanse sacral skin tear with NSS, pat dry, apply thin layer of Bacitracin to would daily x (times) 14 days, cover with dry dressing. "<br><br>Nurse ' s initials were placed in the designated box on November 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14 indicating adherence to the aforementioned entry.<br><br>On November 17, 2011 the MAR revealed, Cleanse sacral skin tear with NSS, pat dry, apply thin layer of Bacitracin to would daily x (times) 14 days, cover with dry dressing. Nurse ' s initials were placed in the designated box on November 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30 indicating adherence to the aforementioned entry.<br><br>The November 2011 MAR reflects that the resident received treatment to the sacral skin tear on November 1, 2011 however according to the clinical record the physician ' s order was not initiated until November 2, 2011. Additionally there was no physician ' s order to provide treatment to Resident # 45 and there were no nurse ' s initials in the designated box for November 16, 2011 indicating the resident did not received treatment on November 16, 2011. | F 314 | | |

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| F 314 | Continued From page 42 | F 314 | | |

On December 3, 2011 the MAR revealed, Cleanse sacral skin tear with NSS, pat dry, apply thin layer of Bacitracin. Nurse ' s initials were placed in the designated box on December 3, 4, 5, 6, 7 and 8 indicating adherence to the aforementioned entry.

On December 8, 2011 the MAR revealed, Cleanse sacral and right buttock stage II pressure ulcer with normal saline, pat dry, apply Collagen dressing every shift x 4 weeks. Nurse ' s initials were placed in the designated box on December 8, 9, 10, 11, 12,13,14,15,16,17, 18,19, 20, 21,22, 23, 24, 25, 26, 27, 28, 29, 30 and 31 indicating adherence to the aforementioned entry.

After reviewing the December 2011 physician ' s orders and the December 2011 MARs there was no evidence of an order directing staff to treat Resident #45 ' s open area on the sacral area and there was no order on the MAR with nurse ' s initials indicating that treatment was done to the sacral area on December 1 and 2, 2011. Additionally, the wound changed from a sacral skin tear on December 3, 2011 to a sacral and right buttock stage II pressure ulcer on December 8, 2011.

On January 18, 2012 the MAR revealed, Cleanse pressure ulcer to coccyx with normal saline, pat dry, apply Santyl to wound base, cover with dry dressing twice daily for 30 days and reassess. Cleanse left buttock pressure ulcer with normal

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saline, pat dry, apply Santyl to wound base, cover with dry dressing twice daily for 30 days and reassess. According to the nurse ' s initials that were placed in the designated box, the treatment as directed began on January 20, 2012 two days after the order originated.

The Nutrition Care Progress Notes dated November 15, 2011- " Quarterly Note: Wt (weight) 130.6 stable this past Q (quarter) ...PO (by mouth) good 75-100%, labs ok, skin intact, no edema ... " December 13, 2011 " Skin Note: Open area Stage II sacral per nursing will add foods, increase protein on tray ... "

There was no evidence that the dietitian included Resident # 45 ' s skin tear which was first observed on November 2, 2011 in the November 15, 2011 quarterly note. The dietitian documented that Resident #45 ' s skin was intact.

Nursing Notes revealed:
November 2, 2011 at 11:35 AM, " Resident noted with skin tear on the coccyx. NP (nurse practitioner) notified, new order given ... "

There was no evidence that measurements to the skin tear on the coccyx was noted/documented.

The Monthly Note by CRNP dated November 23, 2012 revealed, " ...11/2/11 resident noted with skin tear on sacrum, treated with Bacitracin x 14 days, 11/17/11 reordered Bacitracin x14 more days. Resident appears stable ... "

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| F 314 | Continued From page 44<br><br>The Weekly Skin Sheet Rounds revealed: November 17, 2011, Date of Onset-left blank; Risk - left blank; Braden Scale-left blank; Pressure Ulcer-IH (In House); Site-Sacrum; Stage-2; Length-0.3 cm; Width-0.2 cm; Depth-none; Drainage-scanty; Current order-Bacitracin; ...Dietary supplements-N/A; Support Surfaces-air low mattress; ...Last Albumin-N/A; Last pre-albumin-N/A; Weekly Documentation-yes ... "<br><br>December 15, 2011, Date of Onset-left blank; Risk - left blank; Braden Scale-left blank; Pressure Ulcer-IH Pressure Ulcer; Site-Lt (left) Buttocks; Stage-2; Length-2.0cm; Width-1.0cm; Depth-none; Drainage-none; Current Order-Collagen Dressing; ...Dietary supplements-N/A; Support Surfaces-air low mattress; ...Last Albumin-N/A; Last pre-albumin-N/A; Weekly Documentation-yes ... "<br><br>February 2, 2012, Date of Onset-left blank; Risk - left blank; Braden Scale-left blank; Pressure Ulcer-IH/Stasis, Ulcer; Site-Lower Lt (left) Buttocks; Stage-2; Length-2.0cm; Width-1.5cm; Depth-0.2cm; Drainage-scanty; Current Order-Polysporin and Santyl, cover with Allevyn; ...Dietary supplements-N/A; Support Surfaces-air low mattress; ...Last Albumin-N/A; Last pre-albumin-N/A; Weekly Documentation-yes ... "<br><br>The Skin Condition Report revealed: December 4, 2011, " Skin and wound update to site 651 ...Sacrum is a skin tear/laceration. The | F 314 | | |

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| F 314 | Continued From page 45<br>following findings were documented, Skin is not blanchable, no odor is apparent, drainage consistency is thin, moderate drainage is present, color is yellow ...This wound was not present on admission, pressure reducing or relieving device(s) are in place ... "<br>December 8, 2011, " Skin and wound update ...Present on the Sacrum is a skin tear/laceration. The following findings were documented, skin site is healed. "<br>December 8, 2011, " (New 2nd recording) for site-651 ...Present on the sacrum is a pressure ulcer ...Stage 2 length in cm=6, width in cm=3, skin is not blanchable, drainage consistency is thick, moderate drainage is present, color is yellow ... This wound was not present on admission ...Wound base is visible, pink wound =50%, red wound base=50%, granulation tissue=85%, eschar tissue type=15%... "<br>January 5, 2012, " New (1st recording) for site-348. Present on the right lower buttocks is a Pressure Ulcer. The following findings were documented, Staging, Stage 2, length in cm=2, width in cm=0.8, skin is not blanchable, no odor is apparent, drainage consistency is thick, moderate drainage is present, color is yellow ... This wound was not present on admission ... Wound base is visible, pink wound =50%, red wound base=50%... "<br>January 5, 2012, " Skin and wound update to site-651. Present on the Sacrum is a Pressure Ulcer. The following findings were documented, Staging, Stage 2, length in cm=4, width in cm=4.7, skin is not blanchable, no odor is apparent, drainage consistency is thick, moderate drainage is present, color is yellow ... This wound was not present on admission ... Wound base is visible, pink wound =50%, red | F 314 | | |

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| F 314 | Continued From page 46<br>wound base=50%... "<br><br>The Skin Impairment care plan was dated November 2, 2011 revealed, " Skin Impairment- Stage II pressure ulcer to sacrum. The care plan update of December 8, 2011 documented that the resident had a Stage II pressure to right buttock. The care plan updated January 18, 2012 documented that both sites continue as Stage II Ulcers, slight decrease in sized noted. Cont (continue) POC (plan of care).<br><br>After reviewing the Nursing Notes, the Weekly Skin Sheets Round, and the Skin Condition Report there was no evidence that facility staff consistently assessed and measured the open area to the sacrum/coccyx and the lower left buttocks at least weekly as evidenced by:<br><br>The Nursing Notes revealed that the coccyx was first observed on November 2, 2011 and identified as a skin tear, no assessment/measurements documented.<br><br>According to the Weekly Skin Sheet Rounds on November 17, 2011(15 days later) the coccyx is now identified as a stage 2 pressure ulcer to the sacrum measuring 0.3cm x 0.2 cm (no depth documented). However the November 17 physician ' s order directs care for a sacral skin tear.<br><br>On November 23, 2011 the Nurse Practitioner documented that the resident had a skin tear, however no assessment/measurements were documented.<br>According to the December 4, 2011 Skin | F 314 | | |

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| F 314 | Continued From page 47<br>Condition Report (11 days later) the coccyx/sacrum area is documented as a sacrum skin tear/laceration and no measurements are documented.<br><br>On December 8, 2011 the Skin Condition Report revealed that the sacrum was documented as healed. However, there is a new Stage 2 pressure area on the sacrum measuring, length in cm=6, width in cm=3 (no depth documented). The skin was not blanchable, drainage consistency was thick, moderate drainage was present, color is yellow ... This wound was not present on admission ...Wound base is visible, pink wound =50%, red wound base=50%, granulation tissue=85%, eschar tissue type=15%... While the facility staff identified the new area to the sacrum , the facility also describes the area as having eschar. According to the Long-Term Care Facility Resident Assessment Instrument User ' s Manual August 2010, page M-46, " Necrotic tissue (Eschar)-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin " and is considered unstagable.<br><br>The next entry that referenced the sacrum was on January 5, 2012 (28 days later) the area was now documented as a Stage 2, measuring length in cm=4, width in cm=4.7 (no depth documented) and there is a new Stage 2 pressure area on the right lower buttock measuring length in cm=2, width in cm=0.8 (no depth documented).<br><br>The Lower Left Buttocks was first identified on | F 314 | | |

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| F 314 | Continued From page 48<br>December 15, 2011 as in house Stage 2 pressure ulcer measuring, Length-2.0cm; Width-1.0cm; Depth-none; Drainage-none and the treatment is Collagen Dressing. The next entry regarding this area was February 2, 2012 (49 days later) the lower Lt (left) Buttocks was documented as a Stage-2 measuring Length-2.0cm; Width-1.5cm; Depth-0.2cm; Drainage-scanty and the treatment is Polysporin and Santyl, cover with Allevyn.<br><br>There was no evidence that the " Skin Impairment " care plan was updated to reflect all of the resident ' s pressure ulcers.<br><br>There was no evidence in the clinical record that a physician ' s order was in place to direct care and services to the resident ' s sacral, right and left buttocks on November 16, December 1 and 2, 2011; and no evidence that facility staff provided treatment to the resident ' s coccyx and left buttocks on January 18 and 19, 2012.<br><br>A face-to-face interview was conducted with Employees #10 and #33 on February 28, 2011 at 4:00 PM. Employee #33 stated, "We were suppose to measure [the sacrum area] on the 8th of December [2011] when the wound got bigger. " After Employees #10 and #33 reviewed the record, they acknowledged that the record lacked consistent assessments/measurements and treatment to the open areas and the care plan was not updated to reflect the resident ' s entire pressure ulcer status. The record was reviewed on February 28, 2012. | F 314 | | |
| F 315 | 483.25(d) NO CATHETER, PREVENT UTI, | F 315 | | |

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| F 315 SS=D | Continued From page 49<br>RESTORE BLADDER<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review, resident and staff interview for one (1) of 50 sampled residents, it was determined that facility staff failed to provide services to improve/prevent a decline in bladder function for Resident #287.<br><br>The findings include:<br><br>A face-to-face interview was conducted with Resident #287 at 12 noon on March 1, 2012. Resident informed this investigator that he/she has problems with what he/she described as "dribbling" and wears what he/she called "pull-ups." In response to a query whether he/she participates in any form of bladder training, he/she responded " no. "<br><br>A review of the clinical record revealed that the resident was admitted to the facility on October 7, 2011. A review of the admission MDS (Minimum Data Set) with an Assessment | F 315 | **F315**<br><br>1. The MDS coding for Resident #287 for section H0300 has been corrected. During the survey process it was explained for waking hours of Resident #287, a toileting schedule where the resident is transferred to the commode is maintained. In order to provide quality hours of sleep for the resident, a standard every 2 hour incontinence care schedule is used: the resident's care plan has been corrected to reflect the toileting schedule during waking hours and the every 2 hour incontinence care when the resident is asleep. Resident #287 is not on a bladder retraining program however they are on a scheduled toileting program that maintains bladder function.<br>2. The Interdisciplinary Care Team (including the Primary Physician) will review the appropriateness of a bladder retraining and/or scheduled toileting plan of residents on admission, quarterly or whenever a change in any resident's urinary status occurs with the recommendations and/or physician orders coded into the MDS 3.0 and incorporated into the residents' plan of care. | |

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| F 315 | Continued From page 50<br>Reference Date (ARD) of October 14, 2011 revealed that the resident was coded with a one (1) which indicated that the resident was occasionally incontinent under Section H 0300 [Urinary Continence]. However, the quarterly assessment dated December 20, 2011 revealed that the resident was coded with a three (3) indicating that the resident was always incontinent in H0300.<br><br>Resident #287 had not been evaluated for and/or involved in a bladder training program as evidenced by the coding of the admission and quarterly MDS ' dated October 14, 2011 and December 20, 2011 respectively. A " no " response was coded in Section H-0200, [Urinary Continence], indicative that a toileting plan had not been attempted.<br><br>There was no evidence that facility staff provided appropriate treatment and services to improve and/or prevent a decline in bladder function for Resident #287.<br><br>A face-to-face interview was conducted with Employee #10 on March 1, 2012 at approximately 12:15 PM. In response to a query whether the resident receives bladder training, he/she stated " no. " The record was reviewed on March 1, 2012. | F 315 | 3. The MDS Nurse or their designee as a part of the Interdisciplinary Care Team will provide the appropriate coding for the MDS3.0 and incorporate the recommendations and/or physician orders addressing the need of any resident for a bladder training program or a scheduled toileting program into the residents' plan of care: this will occur on admission, quarterly and/or if the residents' urinary status changes.<br>4. The MDS Coordinator or designee will report weekly to the Nursing Department Focus QI Committee the status and number of residents participating in bladder training or scheduled toileting programs. The QI Manager will submit a monthly report to the QI Committee of residents on bladder training or toileting programs.<br>5. Date of Completion: | 5/4/2012 |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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 | F 323 | | |

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| F 323 | Continued From page 51<br>prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>A. Based on record review and staff interview for three (3) of 50 sampled residents, it was determined that facility staff failed to ensure application and functionality of a posey senor alarm for one (1) resident; failed to properly supervise one (1) resident during transfer from the wheel chair to the bed resulting in an injury, and failed to properly assess the use of a posey sensor monitor for one (1) resident. Residents #107, #137, and #237.<br><br>The findings include:<br><br>1. Facility staff failed to ensure the application and functionality of a posey sensor pad alarm [bed alarm] to Resident #107 ' s bed.<br><br>Physician ' s orders dated February 8, 2012 directed: " provide posey sensor pad alarm to bed at all times "<br><br>An observation of Resident #107 on February 28, 2012 at 4:00 PM revealed the resident was lying in bed after being assisted to bed by facility staff. A cord was observed dangling from the bed onto the floor. Electrical appearing wires of various colors were protruding from the distal end of the cord. The staff assisting the resident stated that the cord was a part of the resident ' s " bed | F 323 | **F 323 1,2,3**<br>1. The sensor pad alarm for Resident #107 was replaced. Resident #107 did not sustain any injury.<br>The resident sensor pad for resident #137 was in place at the time of the fall of the resident. The licensed nurse had initialed on the TAR that they had checked the alarm to see if it was functioning. The nursing assistant responded promptly to the observation made by the environmental service staff member that resident #137 had fallen. Resident #137 did not sustain an injury following the fall.<br>The nursing assistant that failed to transport Resident #161 received one to one education addressing safe transfer of resident.<br>2. All residents utilizing Posey sensor alarms (including Residents #107, #137, and #237) were checked for proper application and functionality.<br>3. All nursing staff will receive an education session addressing how to safely transfer residents. Fall sensor alarms are checked for functionality by licensed nurses each shift. The licensed nurse initials the TAR after completing the functionality check of the alarm. Each nursing assistant physically checks the functionality of fall sensor alarms before and after the transport of residents: functionality is denoted by a green light on the battery of the alarm. | |

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| F 323 | Continued From page 52<br>alarm, " in response to my query regarding the purpose and origin of the wires. They concluded that the cord was not functioning as intended and that an adaptor piece was detached.<br><br>A review of the treatment administration record [TAR] for February 2012 revealed that staff initialed in the box for the day shift on February 28, 2012 indicating that the bed alarm was in place.<br><br>A face -to-face interview was conducted with Employee #10 on February 28, 2012 at 4:45 PM. S/he acknowledged the findings.<br><br>2. Facility staff failed to properly assess the posey sensor monitor for Resident #137 who was discovered on the fall mat inside of his/her room.<br><br>A review of the unusual incident report dated February 22, 2012 revealed that Resident #137 sustained a fall without injury on February 22, 2012 at 7:45 AM. The report read: " Resident was observed lying on [his/her] floor mat bedside bed. "<br><br>Through face-to-face interview with Employee #20 on February 22, 2012, it was determined that the resident was identified on the floor at his/her bedside by environmental staff who alerted licensed nursing staff. A viglon monitor (sensor pad) was in place on the bed, however failed to activate. The resident sustained no apparent injury.<br><br>A physician's order dated February 6, 2012 | F 323 | A yellow light indicates battery decline and for the Vigilon brand of alarm a continuous beeping occurs denoting battery decline: declining batteries will be replaced with a fresh battery and/or new alarm to maintain functionality of the alarm.<br>4. The Nurse Manager or their designee utilizing a fall sensor alarm audit tool, will conduct a twice weekly fall sensor alarm functionality test. The Clinical Educator or their designee will conduct an education session for the Nurse Managers addressing the fall sensor alarm audit tool and how the audit should be completed.<br>5. The Nurse Manager or designee will report audit findings weekly to the Focus QI Committee. The QI Manager will report a summary of the audits to the QI Committee monthly.<br>6. Date of Completion: | 5/4/2012 |

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| F 323 | Continued From page 53<br>directed " sensor pad to bed for safety. "<br><br>A face-to-face interview was conducted with Employee #21 on February 28, 2012 at approximately 12:30 PM, he/she indicated that random checks were made to test the batteries and the pads of the sensor pads.<br><br>A face-to-face interview was conducted with Employee #21 on February 28, 2012 at approximately 12:30 PM, a query was made if there was a policy for the use of the bed sensor pads (Vigilon monitors) and the posey sensors. Confirmation was made by Employee #2 that the facility does not have a written policy, however they are checked weekly by the Charge Nurse and documented in the TAR [Treatment Assessment Record] as being checked.<br><br>Review of the TAR reflects the sensor pad to bed for safety was checked for the 3-11 shift with no indication that there was a problem with the sensor.<br><br>The facility staff failed to properly assess the functionality of the sensor pad for Resident #137. The record was reviewed on February 22, 2012.<br><br>3. Facility staff failed to properly supervise a resident to prevent an injury/accident during transfer from the wheel chair to the residents bed. Resident #237<br><br>Resident had an admissions date of February 20, | F 323 | **323B**<br>#1<br>1. The non-slip skids inside the shower room near room 313 were replaced.<br>2. Inspection of the skids in all shower rooms were found in good repair.<br>3. The Maintenance staff will be in-serviced to inspect shower room skids during Weekly Maintenance Rounds. The Dir. of Plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check shower room skids a minimum of monthly.<br>4. The Director of Plant Operations or designee will prepare a summary of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: | 5/4/2012 |

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| F 323 | Continued From page 54<br>2009. Last physical exam was performed on February 23, 2012<br><br>The resident's Quarterly MDS [Minimum Data Set] with an ARD [Assessment Reference Date of February 9, 2012 Section G Physical Function indicated that the resident is a two (2) person transfer, totally dependent with ADL's. Section I Active Diagnoses indicated that the resident had anemia, Hyperlipidemia, Aphasia, Dementia, Hemiplegia, Seizure Disorder, Anxiety Disorder, Attention to Gastrostomy, Essential Hypertension, Benign, Vascular Dementia Uncomplicated, dysphagia Oropharygeal Phase, Unspecified Osteoporosis, Other Drug Allergy, Other Cataract, Hyopotassemia, Muscle Weakness (Generalized).<br><br>A review of the facility's incident report dated February 23, 2012 revealed ..."CNA [Certified Nursing Assistant]observed and reported during transfer from wheelchair to bed, resident's foot got caught on her wheelchair and went forward and bumped her left l[side] of the face on the right bedside rail...8:20 PM...3cmx4.5cm with slightly bluish skin discoloration at the center aspect 1.3cm x 2.5cm noted on [his/her] left above eyebrow has [slight] swelling area of 1.8cmx1.3cm with slightly reddish skin discoloration at the center aspect 1.9cm x2cm and also noted slightly greenish skin discoloration to his/her inner lower eyelid of 3cmx0.9cm skin remains intact, no skin breakdown, no facial grimaces noted and no signs of discomfort to touch, neuro check initiated..." | F 323 | #2<br>1. Carpet identified as buckled in hallway #1 on Unit 3-A will be kicked back in place.<br>2. An inspection of facility-wide carpets identified all securely attached to the floor.<br>3. Maintenance staff will be in-serviced to inspect carpets for buckling during Weekly Maintenance Rounds. The Dir. of Plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check carpets a minimum of monthly.<br>4. The Director of Plant Operations or designee will prepare a summary of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion:<br>#3<br>1. The carpet identified as torn in hallway #2 on Unit 3-B will be repaired.<br>2. An inspection of facility-wide carpet identified no other torn areas.<br>3. Maintenance staff will be in-serviced to inspect carpets for tears during Weekly Maintenance Rounds. The Director of Plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check carpets a minimum of monthly.<br>4. The Director of Plant Operations or designee will prepare a summary report | 5/4/2012 |

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| F 323 | Continued From page 55<br><br>Review of the Nurses Notes revealed on February 23, 2012 11:00 PM indicated "CNA [was] taking care of the resident called [writer] to come to the room immediately. CNA informed [writer] that while [he/she] was putting the patient in bed [he/she] hit the side of [his/her] face on the left cheek area- The patient did this. The patient was in the bed when I arrived I [was] assigned to [his/her] and noticed [his/her] face on the left cheek was beginning to swell...No pain noted, the [resident ] is usually alert and oriented times 2-3 and is dysphagic most of the time. Left swollen cheek bone with skin discoloration at the center 1.3x2.5 cm, skin intact, swollen left area above left eyebrow 1.8x1.3cm with reddish color at the center 1.9 on length 2 cm width skin is intact. Left below eyelid bruise is 3 cm x 0.9 cm skin intact...Cold compresses to left cheek, neuro-checks done per protocol."<br><br>A face-to-face interview was conducted with Employee # 7 at approximately 10:15 AM on March 2, 2012. A query was made of the incident, and what interventions if any were implemented? {if opthalmology or orbital x-rays} were performed, he/she indicated that the physician performed the exam, no further studeies were indicated.<br><br>A face-to-face interview was conducted with Employee #17 on March 1, 2012 at approximately 11:20 AM. He/she demonstrated how the resident was transferred. The resident was assisted to a standing position, held under left arm, and back of pants. As Employee #17 assisted the resident to his/her feet to pivot the resident, the resident fell forward, and sustained | F 323 | of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: May 4, 2012<br><br>#4<br>1. The threshold/metal carpet strip identified as unsecured at the entrance to hallway by rooms 104 to 116 was repaired.<br>2. An inspection of threshold/metal carpet strips in other areas identified that strips were secured.<br>3. Maintenance Staff will be in-serviced to inspect threshold/carpet strips during Weekly Maintenance Rounds. The Dir. of Plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check threshold/metal carpet strips a minimum of monthly.<br>4. The Director of Plant Operations will prepare a summary report of Weekly Maintenance Rounds findings for the Quality Improvement Committee quarterly.<br>5. Date of completion: | 5/4/2012 |

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| F 323 | Continued From page 56 | F 323 | | |

an injury to the left side of the face. Employee #17 saw that the residents right leg was caught behind the leg rest on the right side of the wheelchair which caused the resident to fall forward. Employee #17 acknowledged that the resident was more drowsy than normal.

Another face-to-face interview was conducted with Employee #7 on March 2, 2012 at 11:45 AM, a query made if the staff member was sent for reeducation/ training of assisting a resident during transfer. Employee #7 indicated that Employee #17 was not sent for re-education, and the resident was not sent to PT [Physical Therapy] because the resident is not cognitively able to follow instruction.

A face-to-face interview was conducted with Employee #9 on March 2, 2012 at 1:30 PM, he/she identified that Employee #17 attended an in-service on February 24, 2012 "Transfers, Lifting, Mechanical Lift, falls Management, Body Mechanics.

Facility staff failed to properly supervise a resident to prevent an injury/accident. The record was reviewed on February 23, 2012

B. Based on observation and staff interview, it was determined that facility staff failed to ensure that the environment was free of accident hazards as evidenced by: skids lifting inside the shower in one (1) of three (3) observed; carpet was observed buckled in one (1) of three (3) hallways observed, the carpet was torn in one (1) of three (3) hallways observed, and the threshold/metal carpet strip was observed

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| F 323 | Continued From page 57<br>unsecured in one (1) of one (1) observed.<br><br>The findings include:<br><br>During a tour of the enviroment on February 29, 2012 from 9:15 AM to12:30PM the following was observed:<br>1. The shower room near room #313 was observed with skids lifting inside the shower in one (1) of three (3) shower rooms observed on Unit 3A.<br><br>2. Carpet was observed buckled on Unit 3A Hallway #1 in one (1) of three (3) hallways observed.<br><br>3. The carpet was torn on Hallway #2 on Unit 3B in one (1) of three (3) hallways observed.<br><br>4. The threshold/metal carpet strip at the entrance to the hallway was observe unsecured (hallway 104-116) in one (1) of three (3) hallways observed. These observations were made in the presence of Employee #31 and he/she acknowledged the findings at the time of the observation. | F 323 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care; | F 328 | | |

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| F 328 | Continued From page 58<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 50 sampled residents, it was determined that facility staff failed to comprehensively assess and act on physician ' s orders with timeliness to meet the respiratory needs of Resident #353.<br><br>The findings include:<br><br>The respiratory therapist failed to comprehensively assess the respiratory status of Resident #353 who exhibited respiratory difficulty and fluid retention, was subsequently diagnosed with congestive heart failure (CHF) and hospitalized approximately one (1) week post admission with an exacerbation of CHF.<br><br>A review of the clinical record for Resident #353 revealed the 92 year old was admitted on February 10, 2012 for physical rehabilitation with diagnoses that included Urosepsis, Alzheimer ' s dementia and a past history of Hypercholesterolemia, Pacemaker, BPH (Benign Prostatic Hypertrophy) and Aortic Stenosis. The physician ordered a chest x-ray on February 15, 2012. The study was performed and results provided on February 16, 2012. The findings of the Chest x-ray " cardiomegaly (enlarged heart) with pulmonary vascular congestion and bilateral pleural effusions. " | F 328 | **F328**<br><br>1. The resident is discharged from the facility.The charge nurse was counseled regarding deficient documentation.<br>2. The respiratory therapist will be in-serviced on completing and documenting a respiratory assessment. In-service will include timeliness of the assessment and documenting physician and nurse communication related to respiratory therapist recommendations. Wound rounds are conducted by the Clinical Educator and ADON and focuses on the correct identification of wounds along with corresponding physicians' orders.<br>3. All respiratory therapists assigned to the facility will be re-inserviced as stated above. The Clinical Educator and ADON will send a weekly report of the status and treatment of wounds in the facility to the DON. Any resident with a new wound is placed on 'open chart' until the wound heals.<br>4. The District Manager for Respiratory Services or designee will audit monthly the timeliness and documentation of respiratory assessments, including documentation of physician and nurse notification of respiratory therapist recommendations. The QI Manager will use the Wound Rounds audit findings to report the total percent of wounds to the Quality Improvement Committee on a monthly basis.<br>5. Date of completion: | 5/4/2012 |

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| F 328 | Continued From page 59<br><br>The physician wrote an order for a respiratory consultation on February 15, 2012 at 3:40 PM to address dyspnea. The order read as follows: " respiratory consult pulmonary toileting."<br><br>A physician ' s order for aerosolized nebulization [neb] treatment [Duo-Neb every 4 hours for pulmonary toileting] was written by the physician on February 17, 2012 at 10:30 AM. Approximately 10 hours lapsed before the initial neb treatment was administered at 9:00 PM on February 17, 2012. EMS (emergency medical services) was activated and the resident was transported to the hospital approximately 5 hours later at 1:50 AM on February 18, 2012.<br><br>The request for the respiratory consult was acted on after 2 days, on February 17, 2012 at 10:38 AM. The consultation form remained blank and the therapist completed a Respiratory Therapy Recommendations and Order Request form that read: " patient cannot tolerate any pulmonary toileting at this time. Incentive spirometer recommendation for 10 days as tolerated by patient. Duo-Neb treatment every 4 hours ordered as well ...to start treatment as soon as medication is available. "<br><br>A Respiratory Treatment Note, February 17, 2012 10:55 AM read: IS (incentive spirometer) therapy for pulmonary toileting; lung sounds pre-treatment " decreased " and post-treatment " slight improvement. " SPO2 88-95%. " Patient instructed and encouraged with use of IS at this time. . Patient was unable to follow instructions well, but with the assistance from patient ' s [next | F 328 | | |

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of kin] patient attempted a maximum effort of 500ml x2.

The response to the physician ' s request for a respiratory consult lacked evidence that the respiratory therapist performed a complete assessment of the resident ' s respiratory status. There was no evidence of a respiratory assessment inclusive of inspection, palpation, percussion and auscultation. There was no evidence of an assessment of breath sounds, lung regions, work of breathing or skin color that would correlate with the findings of the chest x-ray report [pleural effusion & pulmonary congestion].

The physician ' s request for pulmonary toileting was not followed through. The order for pulmonary toileting was not discontinued even though the therapist recommended " patient cannot tolerate any pulmonary toileting at this time. " Physician ' s notes (February 17, 2012 at 5:00 PM) and orders (February 17, 2012 10:30 AM) referred to pulmonary toileting as a component of the resident ' s plan of care.

Respiratory Therapy staff failed to act with timeliness on a physician ' s request for consultation; a period of 2 days lapsed before the consult was performed.

A face-to-face interview was conducted with Employee #36 on March 2, 2012 at approximately 4:00 PM. She/he stated that the resident was not appropriate for pulmonary toileting and that the recommendation was verbally communicated to the medical staff prior to February 17, 2012. However, s/he

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| F 328 | Continued From page 61<br>acknowledged that there was no documented evidence of a recommendation against pulmonary toileting prior to March 17th and the record revealed the medical team continued to include pulmonary toileting in the resident's plan of care. The employee stated that respiratory therapy services were available 7 days per week and requests for respiratory services are usually acted on the same day if it ' s during the hours that a therapist is on duty.<br><br>In response to a query regarding the delay in initiating the nebulization treatment, Employee #36 stated that the medication had to be ordered and nursing staff administer the treatments in the absence of respiratory staff. In response to a query as to whether or not the medical team was not consulted for an alternative treatment in the interim, s/he stated "no, because there is no alternative to Duo-neb [atrovent and albuteral]. "<br><br>In response to a query regarding the lack of a full respiratory assessment, s/he stated that the therapist documented [his/her] findings as s/he assessed.<br><br>The record was reviewed March 2, 2012. | F 328 | | |
| F 371 SS=D | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | **F371**<br><br>#1<br>1. The 5 burgundy damaged pellet plates were discarded.<br>2. All 25 pellet plates were inspected; none are damaged.<br>3. Pellet plate will be inspected by the Food Services Manager or designee monthly. Damaged pellet plates will be removed from service and discarded.<br>4. Inspection of pellet plates will be added to the monthly Safety and Sanitation Audit. Audit findings will be reported to the Quality Improvement Committee monthly.<br>5. Date of completion: | 5/4/2012 |

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| F 371 | Continued From page 62<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on a tour of the kitchen on February 24, 2012 at approximately 5:00 PM, it was determined that staff failed to store, prepare and/or distribute foods under sanitary conditions as evidenced by five (5) of 18 damaged pellet plates and one (1) of three (3) hand washing sinks was non-operational.<br><br>The findings include:<br><br>1. Five (5) of 18 burgundy pellet plates were damaged.<br><br>2. One (1) of three (3) hand washing sinks was non-operational.<br><br>These findings were made in the presence of Employee #34 at the time of the observation. | F 371 | #2<br>1. The non-operational hand washing sink was repaired.<br>2. The other 3 hand washing sinks were inspected and are operational. Inspection of all hand washing sinks in the kitchen will be added to the Opening & Closing Checklist.<br>3. The Food Services Manager or designee will check operation of the 3 kitchen hand washing sinks as part of the checklist, at opening and closing of the kitchen daily.<br>4. The Food Services Manager or designee will report any variances identified by the Opening & Closing Checklist to the Quality Improvement Committee monthly.<br>5. Date of completion: May 4, 2012 | |
| F 386 SS=D | 483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS<br><br>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 | F 386 | | |

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| F 386 | Continued From page 63<br>contraindications.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 50 sampled residents, it was determined that the physician failed to review the total program of care for one (1) resident as evidenced by the lack of a plan of care and/or directives to address the need for transmission based precautions for a diagnosis of Clostridium Difficile (C. Diff). Resident #310.<br><br>The findings include:<br><br>A review of Resident #310 ' s admission orders dated January 24, 2012 revealed diagnoses that included, C.Diff [Clostridium Difficile]; Diabetes Mellitus, Hypertension and Decreased Mobility.<br>A " Physician ' s Order Sheet and Plan of Care " dated January 24, 2012 directed: Vancomycin 125 mg by mouth every [six] hours for [two weeks] until February 6, 2012 [for] C. Diff. "<br>A Nurse ' s note dated January 25, 2012 at 12 PM revealed, " Contact isolation for C. Diff maintained. "<br>A review of the MAR [Medication Administration Record] revealed the resident was administered Vancomycin 125 mg by mouth at 6 AM, 12 Noon, 6 PM, and 12 AM from January 25, 2012 thru February 6, 2012.<br>A review of the physician's orders and assessments lacked documented evidence that the physician addressed the resident ' s contact isolation needs in his/her total plan of care.<br>A face-to-face interview was conducted with Employee #6 on March 1, 2012 at approximately | F 386 | **F386**<br><br>1. A physician's order was obtained for Resident #310 to be on Contact Isolation. Contact Isolation was maintained in accordance with the physician's order.<br>2. Upon audit and review, no other resident was affected by this practice. All residents were reviewed and noted to include physicians' orders.<br>3. The Nurse Manage or designee will utilize an Admission Chart Checklist audit tool to identify completeness and reconciliation of the medical record of newly admitted residents. The Nurse Manager or designee will review the audit tool twice weekly during the interdisciplinary Clinical Managers meeting and variances will be corrected. The Clinical Educator or designee will revise the Admission Chart Checklist audit tool to meet the current needs of residents admitted to The Washington Home. The Clinical Educator or their designee will conduct an education session addressing the revisions of the Admission Chart Checklist audit tool and how to utilize the Admission Chart Checklist audit tool.<br>4. The QI Manager will submit a quarterly summation of the Admission Chart Checklist to the nursing department Focus QI Committee and will report audit findings to the QI Committee quarterly.<br>5. Date of Completion: | 5/4/2012 |

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| F 386 | Continued From page 64<br>11:51 PM, he/she stated that the resident had been on contact isolation for C. Diff since admission. He/she acknowledged that the physician did not include an order for contact isolation. The chart was reviewed March 1, 2012. | F 386 | | |
| F 406 SS=D | 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES<br><br>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review, staff interview and observations for one (1) of 50 sampled residents, it was determined that facility staff failed to obtain a Level II Screen for Mental Retardation to determine if specialized rehabilitative services were required for Resident #2.<br><br>The findings include:<br><br>A review of the medical record for Resident #2 revealed a PASRR [Pre-admission Screen and Resident Review for Mental Illness and/or Mental Retardation] was performed on January 20, | F 406 | **F406**<br>1. A Level II screen was obtained for Mental Retardation for Resident #2.<br>2. All residents requiring specialized rehabilitative services were reviewed to have a Level II screen.<br>3. Social Work or designee will audit the medical record of residents quarterly to ensure a Level II screen has been obtained for residents that require it.<br>4. Social Work or designee will report to Quality Improvement Committee at the quarterly meeting.<br>5. Compliance Date | 5/4/2012 |

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| F 406 | Continued From page 65<br>2008. The screen identified the resident was positive for Mental Retardation (MR), and required a Level II Screen as coded in Section D of the form.<br><br>Further review of the medical record lacked evidence that a Level II Screen was performed.<br><br>A face-to-face interview was conducted with Employee #1 on February 24, 2012 at approximately 4:30 PM. He/she confirmed that the resident was positive for Mental Retardation, however, was unable to identify a Level II Screen for Resident #2.<br><br>Facility staff failed to obtain a Level II Screen for Mental Retardation for Resident #2 to determine if specialized rehabilitative services were required. The record was reviewed on February 24, 2012. | F 406 | | |
| F 412 SS=D | 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS<br><br>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.<br><br>This REQUIREMENT is not met as evidenced by: | F 412 | **F412**<br><br>1. Resident #225 did not sustain any harm. The resident was able to complete meals and did not suffer weight loss. A dental progress note was faxed to facility during survey process.<br><br>2. The medical records of all other residents, who received a dental consult, for this time period, were audited. No variances found. | |

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| F 412 | Continued From page 66<br>Based on observation, record and staff interview for one (1) of 50 sampled residents, it was determined that facility staff failed ensure a dental consultation was performed when it was determined the resident's denture(s) was lost. Resident #225.<br><br>The findings include:<br><br>According to a nurses note dated February 17, 2012; (no time indicated), "Resident lower partial dentures missing. Staff searching for denture since yesterday [February 16, 2012]. MD [Medical Doctor] informed of missing denture. Dental consult to evaluate for denture. "<br><br>A physician ' s interim order dated February 17, 2012 at 10:30 PM directed, " Dental consult to evaluate for denture. "<br><br>A review of the clinical record on March 6, 2012 lacked evidence of a consultation by the dentist for the evaluation of Resident #225's lost lower denture[s].<br><br>An interview was conducted with Employee # 10 on March 6, 2012 at approximately 2:00 PM. He/she acknowledged that the resident " has not been seen by the dentist. " The clinical record was reviewed on March 6, 2012. | F 412 | 3. The Nurse Manger or designee will audit 10% of the resident charts monthly. At least two of the charts audited will be one of a resident where an incident has occurred and one will be a resident that has received a recent dental consult and/or has had a change in their plan of care.<br>4. The chart audits completed by the Nurse Managers will be submitted to the QI Manager. The QI Manager or their designee will submit a monthly report of the chart audits to the QI Committee.<br>5. Date of Completion: | 5/4/2012 |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and | F 441 | | |

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| F 441 | Continued From page 67<br>to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on a review of the Infection Control Program and staff interview, it was determined | F 441 | **F441**<br><br>1. During the survey process, the February 2012 Infection Control Line listing was completed using the data available. Resident #175 did not sustain injury or pain following the wound care technique. Resident #244 did not sustain food borne illness after they were served the toast. The residents served at the Activity event did not sustain food-borne illness. Employee #27 received one to one Wound Care Competency check: including aspetic technique. Employees # 15 and #4 received one to one education addressing safe food handling techniques. The Infection Control Program has been amended to provide a safe, sanitary and comfortable environment.<br>2. The Clinical Educator/Infection Control Nurse revised the Infection Control Line listing to capture the variances noted during the survey process. The clinical Educator/Infection Control Nurse or designee will conduct an education session for all employees addressing safe food handling.<br>The Clinical Educator/Infection Control Nurse or designee will conduct a Wound Care Competency (including aseptic technique) for licensed nurses. | |

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| F 441 | Continued From page 68<br>that facility staff failed to consistently include the admission date, organism type and date resolved on the "Infection Control Log" line listing report and failed to implement an Infection Control Program that provided a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility staff failed to wash hands and sanitize hands during dressing change;and facility staff used gloved index finger to apply santyl ointment to resident's open wound for one (1) resident; and the facility staff failed to practice infection control techniques as evidenced by staff using bare hands to butter one (1) resident 's toast for two (2) of 50 sampled residents and used bare hands to distrubute cookies. Resident's # 175 and #244.<br><br>The findings include:<br>1. Facility staff failed to consistently include the admission date, organism type and date resolved on the "Infection Control Log" line listing report and failed to implement an Infection Control Program that provided a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br>The policy " Investigating Infectious Disease Outbreaks, Epidemics and Problems " , Policy No. IC-00021.97 stipulated the following:<br>Purpose: To provide guidelines for the investigation of infectious disease outbreaks, epidemics and problems.<br>Policy: The Infection Control Professional (IP) will gather information on infectious disease outbreaks, epidemics and problems using appropriate surveillance techniques. Referrals by physicians, nurses, and allied health | F 441 | 3. The Clinical Educator/Infection Control Nurse will utilize the revised Infection Control Line listing daily to capture the variances noted during the survey process. The Clinical Educator/Infection Control Nurse or designee will conduct safe food handling education sessions during the general orientation and annually for Washington Home staff. The Clinical Educator/Infection Control Nurse or designee will conduct a Wound Care Competency check during orientation and annually with licensed nurses.<br>4. The QI Manager will submit a monthly report of all education sessions and the number of attendees to the QI Committee.<br>5. Date of Completion: | 5/4/2012 |

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| F 441 | Continued From page 69 | F 441 | | |

professionals are also a source of information in identifying infectious outbreaks and issues. Any suspected or potential problems are discussed by the Infection Control Practitioner with the members of the Infection Control Committee and respective TWH Department heads. The goal of an investigation is to interrupt further transmission of the disease-causing agent and to develop/implement control measures to prevent its reoccurrence.

A review of the facility's monthly " Infection Control Log" revealed the following:
August 2011 - 29 residents were identified as having an infection; six (6) of the 29 residents listed did not have an admission date documented in the designated column for "Admit Date ".

September 2011 - 18 residents were identified as having an infection; 15 of 18 residents listed did not have a date documented in the designated column for " Admit Date"; and for 17 of 18 residents the " Date Resolve" column was left blank.

October 2011 - 57 residents were identified as having an infection; 20 of 57 residents listed did not have a date documented in the designated column for " Admit Date " ; 13 of 57 residents did not have an organism listed for " Organism Type" or indicated that no organism was obtained; and for 25 of 57 residents the " Date Resolve " column was left blank.

November 2011 -27 residents were identified as having an infection; 16 residents did not have a date documented in the designated column for

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| F 441 | Continued From page 70<br>"Admit Date"; three (3) of 27 residents did not have an organism listed for "Organism Type" or indicated that no organism was obtained; and seven (7) of 27 residents the "Date Resolve" column was left blank. Additionally, one (1) of the 27 residents listed on the " Infection Control Log " had an onset date of November 16, 2011, Site Infection UTI (Urinary Tract Infection), no organism listed, the resident received an antibiotic, and the comment " Not Yet " was documented in the " Date Resolved " column.<br><br>December 2011-32 residents were identified as having an infection; 22 of 32 residents listed did not have a date documented in the designated column for " Admit Date " ; for eight (8) of 32 residents listed had no " Onset Date " listed; 19 of 32 residents did not have an organism listed for " Organism Type" or indicated that no organism was obtained; and 25 of 32 residents the " Date Resolve " column was left blank.<br><br>January 2012- 31 residents were identified as having an infection; 31 of 31 residents listed did not have a documented " Admit Date " listed in the designated column; five (5) of 31 residents listed had no " Onset Date " listed; eight (8) of 31 residents had no " Site of Infection " listed; 27 of 31 residents did not have an organism listed for " Organism Type" or indicated that no organism was obtained; and 28 of 31 residents the " Date Resolve " column was left blank.<br><br>After a review of the " Infection Control Log " from August 2011 to January 2012, there was no evidence that the facility staff consistently documented the residents admission date, the | F 441 | | |

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| F 441 | Continued From page 71<br>onset date of the infection(s), the site of infection, the organism type and the date resolved.<br><br>Additionally, there was no evidence that surveillance and investigations of infections were completed as evidenced by incomplete Infection Control Log sheets. There was no evidence, based on the results of the infection control log surveillance that steps were taken to ensure an accurate account of community vs. facility-acquired infections. There was no evidence that the facility had processes and practices, by the way of an Infection Control Program, to consistently promote infection control and assist in the prevention of the spread of infectious diseases.<br><br>A face-to-face interview was conducted with Employees # 3 and #9 on March 5, 2011 at 1:00 PM. They acknowledged that the Infection Control Log had several areas that were left blank and acknowledged that there was no evidence, based on the inconsistencies identified in the infection control logs, that the facility consistently implemented an Infection Control Program to help prevent, investigate and control infections in the facility.<br><br>2. Facility staff failed to wash hands and sanitize hands during dressing change;and facility staff used gloved index finger to apply santyl ointment to resident's open wound for Resident #175.<br><br>The policy " Hand Washing " , Policy No. | F 441 | | |

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| F 441 | Continued From page 72<br>IC-00019.97 stipulated the following:<br>Purpose: To prevent/control the spread of nosocomial infections to residents/patients, staff, volunteers, and visitors.<br>Policy: Hand washing is the single most effective means of preventing the spread of infections. Personnel will follow established guidelines for hand washing in order to prevent the spread of infection and disease to patients/residents, staff, volunteers and visitors.<br>Procedure: 1. Hand washing will be performed under the following conditions: c. after removal of gloves.<br><br>At approximately 11:30 AM on February 28, 2012, Employee #27 was observed performing a dressing change on Resident #175.<br><br>During the procedure Employee #27 conducted a dressing change to Resident # 175 ' right top of the foot. He/she washed hands applied gloves and removed the old dressing, changed his/her gloves, cleaned the area with normal saline solution and applied skin prep to the area. The employee changed gloves and cleaned the right heel ulcer. He/she changed gloves and then applied skin prep to the eschar in the center of the wound. With the same pair of gloves the employee then applied Santyl Ointment with his/her right gloved index finger to the open areas on the right heel. The employee then applied the dressing as per ordered, changed his/her gloves and repositioned the resident.<br><br>There was no evidence that Employee #27 washed or sanitized his/her hands between change of gloves and used a gloved index finger instead of an applicator to apply the prescribed | F 441 | | |

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| F 441 | Continued From page 73<br>Santyl Ointment to the open areas of the wound.<br><br>A face-to-face interview was conducted with Employee #27 at 11:55 PM on February 28, 2012. The employee acknowledged he/she did not sanitize or wash hands after removing gloves and applying new gloves. The employee also acknowledged that he/she applied the Santyl Ointment with his/her gloved index finger.<br><br>3. Facility staff failed to practice infection control techniques as evidenced by staff using bare hands to butter Resident #244 ' s toast during breakfast.<br><br>During a dining observation on March 5, 2012 at approximately 8:40 AM; Employee #15 was observed buttering Resident #244 ' s toast with bare hands.<br><br>A face-to-face was conducted with Employees # 4 and #15 on March 5, 2010 at approximately 2:00 PM. In response to a query regarding the facility ' s protocol for handling food for residents that required feeding assistance, Employee #4 stated; " We do not have serving gloves on the unit. " Employee #15 stated; " I do that[butter residents toast], I washed my hands. "<br><br>Facility staff failed to ensure the proper handling of food while assisting a resident.<br><br>4. A Random observation conducted during the survey period revealed an employee failed to utilize proper hand hygiene practices in the distribution of food products. | F 441 | | |

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| F 441 | Continued From page 74<br><br>Residents were observed participating in a structured activity program on the nursing unit. At the conclusion of the program, Employee #41 offered the participants a cookie. The employee used his/her bare hands to distribute the cookies to those residents that expressed a desire for a cookie.<br><br>An interview was conducted with Employee #41 at the time of the observation and s/he acknowledged the findings. S/he stated that tongs were usually used to distribute the cookies. | F 441 | **F456**<br>#1<br>1. The kitchen hand washing sink identified as non-operational was repaired.<br>2. The 2 other kitchen hand washing sinks were inspected and found operational.<br>3. The functionality of kitchen hand washing sinks will be added to the daily Environmental inspection list. The Director of Dietary Services or designee will inspect the 3 hand washing sinks daily and report malfunctions promptly.<br>4. The Director of Dietary Services will report a summary of daily inspection findings to the Quality Improvement Committee monthly.<br>5. Date of completion: May 4, 2012<br><br>#2<br>1. The bottom panel on Unit 2-A pantry refrigerator was re-secured. The panel missing from the Unit 3-A pantry refrigerator is no longer manufactured or available. A replacement refrigerator will be ordered.<br>2. An inspection of refrigerator panels in other unit pantries identified all were securely in place.<br>3. Maintenance staff will be in-serviced to inspect unit pantry refrigerator panels during Weekly Maintenance Rounds. | |
| F 456 SS=D | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION<br><br>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations during a tour of the kitchen on February 24, 2012 at approximately 5:00 PM and a tour of the enviroment on February 29, 2012 from 9:15 am to12:30 pm, it was determined staff failed to maintain essential equipment as evidenced by: one (1) of three (3) hand washing sinks was non-operational; the bottom panel of one (1) refrigerator was unsecure and another refrigerator's bottom panel was missing in two (2) of five (5) refrigerators observed.<br><br>The findings include: | F 456 | | |

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| F 456 | Continued From page 75<br><br>1. During a tour of the main kitchen on February 24, 2012 at approximately 5:00 PM one (1) of three (3) hand washing sinks was non-operational in the main kitchen.<br><br>This finding was made in the presence of Employee # 34 at the time of the observation.<br><br>2. During a tour of the enviroment on February 29, 2012 from 9:15 am to12:30 pm, it was observed that the bottom panel to one (1) refrigerator in the pantry on Unit 2A was unsecure and the refrigerator in the pantry on Unit 3A was missing a bottom panel in two (2) of 5 refergerators observed.<br>These observations were made in the presence of Employee# 31 and he/she acknowledged the findings at the time of the observations. | F 456 | The Director of Plant Operations or designee will review Weekly Maintenance Rounds reports and spot-check unit pantry refrigerator panels a minimum of monthly.<br>4. The Director of Plant Operations will prepare a summary of Weekly Maintenance Rounds findings to the Quality Improvement Committee quarterly.<br>5. Date o completion: May 4, 2012<br><br>**F463**<br><br>1. The identified call-bell cords were untied and placed properly in the bathroom wall socket.<br>2. All residents' bathrooms were inspected to ensure call-bell cords were not tied improperly. | |
| F 463 SS=D | 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br><br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and staff interview for one (1) of 40 resident rooms/bathrooms observed, it was determined that facility staff failed to ensure that the call system in one (1) resident room was functioning to allow communication from the resident to the nurse ' s station. | F 463 | 3. The Interdisciplinary team during rounds on the nursing units will observe bathroom call systems are not tied to the grab bars in the bathrooms. If observed the variance will be reported to appropriate staff and corrected.<br>4. The Clinical Educator or designee will conduct an education session for all general staff to observe the call bell system in resident bathrooms—that they are not tied to the grab bar in the bathroom. If the variance is found, it will be reported and corrected. | |

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| F 463 | Continued From page 76<br>The findings include:<br><br>On February 22, 2012 at approximately 10:15 AM during a tour of room #215, the bathroom call system was observed tied to the grab bar. This was observed in the presence of Employee # 7.<br><br>There was no evidence, if the need arose, that the resident would be able to activate the call system with the pull cord tied to the grab bar. | F 463 | Bathroom call bell system variances will be reported to Focus QI weekly and monthly by the QI Manager to the QI Committee.<br>5. Date of Completion: | 5/4/2012. |
| F 514 SS=D | 483.75(l)(1) RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>A. Based on observations, record review and interview for two (2) of 50 sampled residents, it was determined that the dentist failed to document a complete assessment for dental services provided for one (1) resident and staff failed to document an accurate account of an alteration in skin integrity for two (2) residents. | F 514 | | |

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| F 514 | Continued From page 77<br>Residents #4, #329 and #356.<br><br>The findings include:<br><br>1. A review of the clinical record for Resident #4 that the dentist failed to document a complete assessment for dental services provided.<br><br>Medical team progress notes revealed that the dentist visited the resident on October 7, 2011 as evidenced by a dental note that read " x-rays taken - bone loss appears - 4+mm pockets. "<br><br>The record lacked evidence that the dentist documented a reason for the visit, a summary of the examination and a plan of care and/or proposed follow up.<br><br>The findings were confirmed during a face-to-face interview with Employee #7 on February 23, 2012 at approximately 3:30 PM.<br><br>2. A review of the clinical record for Resident #329 revealed facility staff failed to document an accurate account of the status of the resident ' s alteration in skin integrity.<br><br>According to Section M, Skin Conditions of the admission MDS [Minimum Data Set] dated December 20, 2011, Resident #329 was admitted with one Stage 1 pressure ulcer.<br><br>A nurse ' s progress note dated January 12, 2012 included: " present on the left middle calf is a venous ulcer ... " | F 514 | **F514 1,2**<br>1. Resident #4 was not adversely affected by the incomplete dental assessment. The dentist completed the dental assessment for Resident #4 Resident #329 was not adversely affected by the inaccurate documentation of their wound. The documentation was corrected. Resident #356 was not adversely affected by the inaccurate documentation.<br>2. The Nurse Manger or designee will audit 10% of the resident charts monthly. At least two of the charts audited will be one of a resident where an incident has occurred and one will be a resident that has received a recent consult and/or has had a change in their plan of care: includes newly diagnosed problems and/or allergies. The DON or designee will conduct an education session with the Nurse Managers as to how to incorporate the new reviews (residents receiving a recent consult and residents that have had a change in their plan of care) into their chart audit process. The Clinical Educator or their designee will conduct a Wound Care Competency check (including identification of wounds, assessments and measurements) for all newly hired licensed nurses. The Clinical Educator or designee will conduct a Wound Care Competency Check with licensed nurses. | |

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| F 514 | Continued From page 78<br>Hospice progress notes dated January 12, 2012 included, " left leg lateral mid shin dry necrotic area with loose edge, peri-wound erythema size 5cm x 6.5cm x 0cm, minimal edema, no evidence of pain. "<br><br>The care plan updated January 11, 2012 included, " open area on left lower extremity stage II pressure ulcer, will heal by 30-days. "<br><br>The assessment of the altered skin integrity for Resident #329 ' s left lower extremity was variable. The documented assessments included variable sites, calf vs. shin and a variation in wound type, venous vs. pressure.<br><br>Facility staff failed to document an accurate account of the resident ' s alterated in skin integrity of the left lower extremity. The record was reviewed February 29, 2012.<br><br>3. A review of the clinical record for Resident #356 revealed facility staff failed to document an accurate account of the status of the resident ' s alteration in skin integrity.<br><br>An admission nursing assessment dated February 15, 2012 revealed the resident ' s skin was intact at the time of admission.<br><br>A nurse ' s entry dated February 29, 2012 read: " new (1st recording) for site -137 present on the left elbow is a skin tear/laceration ....this wound was present on admission. "<br><br>A face-to-face interview was conducted with Employee #6 on February 29, 2012 at 4:00 PM. | F 514 | 3. The Clinical Educator or their designee will conduct a Wound Care Competency check (to include identification of wounds, assessments, and measurements) during the orientation of newly hired nurses and annually with all other licensed nurses to achieve consistency of wound care documentation. The Nurse Manger or designee will audit 10% of the resident charts monthly. At least two of the charts audited will be one of a resident where an incident has occurred and one will be a resident that has received a recent consult.<br>4. The QI Manager will submit monthly to the QI Committee a summation of the Nurse Manager Chart Audits. The QI Manager will submit a monthly report to the QI Committee of all education sessions and the number of attendees.<br>5. Date of Completion: | 5/4/2012. |

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| F 514 | Continued From page 79<br>S/he acknowledged that the February 29th nurse ' s entry was inaccurate (the skin tear was not present on admission) and would be corrected. The record was reviewed February 29, 2012.<br><br>B. Based on observations, record review and staff interview it was determined that facility staff failed to consistently document the temperatures on the refrigerator temperature log on two (2) of five (5) units.<br><br>The findings include:<br><br>Facility staff failed to consistently document refrigerator temperatures on the designated temperature log on one (1) of five (5) units.<br>A review of the "Refrigerator Temperature Log " was conducted on February 21, 2012 at approximately 12:30 PM on unit 3A. It was determined that there were no temperatures documented for a period of seven days, during the period of December 20 - 27, 2011. The spaces allotted for that time period were blank. The observation was made in the presence of Employee #10.<br>A second review of the refrigerator temperature log records was conducted on March 2, 2012 at approximately 3:30 PM. The log sheets included temperatures documented in the spaces for the period of December 20 - 27, 2011, however; the initial observation revealed the log sheets were blank.<br>A face-to-face interview was conducted with Employee #10 at the time of the initial observation on February 21, 2012. After a review of the log records, he/she acknowledged the | F 514 | | |

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| F 514 | Continued From page 80<br>absence of temperatures for the period of December 20 - 27, 2011.<br>Facility staff failed to consistently document refrigerator temperatures on the designated log record. Additionally, a secondary observation of the log sheets revealed that the blank spaces were subsequently annotated with numerical data. Employee #10 was unable to determine the source of the newly entered data.<br>The observations were made on February 21, 2012 and March 2, 2012. | F 514 | | |
| F 520 SS=D | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. | F 520 | | |

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| F 520 | Continued From page 81<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on staff interview, it was determined that the Quality Assessment and Assurance Committee failed to correct quality deficiencies identified for five (5) months as it relates to the Infection Control Program.<br><br>The findings include:<br><br>The facility failed to ensure that there was an Infection Control Program in place that collects and analyzes data regarding infections acquired in the facility. There was no evidence of an established methodology to consistently identify where infections are acquired and/or to determine when to implement and terminate transmission based precaution procedures.<br><br>A review of facility documents revealed facility staff documented a form entitled " Infection Control Log " that served to track and trend infections in the facility. A review of the documents revealed inconsistencies in capturing the source, location and resolution or lack thereof of infections in the facility. There was a lack of determination regarding the need for terminating transmission based precautions.<br><br>A face-to-face interview was conducted with Employee # 37on March 6, 2012 at approximately 11:30 AM. He/she acknowledged that the program was not consistently maintained | F 520 | **F 520**<br><br>1. A system/plan has been implemented to correct concerns with the Infection Control program. The Quality Improvement committee will audit the Infection Control program.<br>2. The Clinical Educator/Infection Control Nurse or designee has reviewed the inconsistencies of the Infection Control program and has established a methodology to consistently identify where infections are acquired and/or to determine when to implement and terminate transmission base precaution procedures. The new line listing will be submitted to the Quality Improvement committee.<br>3. The Clinical Educator/Infection Control Nurse will utilize the revised Infection Control Line listing daily to capture the variances noted during the survey process. Inconsistencies or omissions will be brought forward to Nursing.<br>4. The Clinical Educator/Infection Control Nurse or designee will submit the Infection Control Log to the Quality Improvement committee monthly for review and oversight<br>5. Date of Compliance | 5/4/2012 |

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| F 520 | Continued From page 82<br>as it relates to a complete and accurate account of community and in- house acquired infections and based on the outcomes, surveillance and there was no evidence that control and prevention efforts were implemented. Employee #37 stated that the facility recently hired an Infection Control Practitioner (hired approximately two (2) weeks prior to this interview) as a corrective measure to the identified concerns.<br><br>However, from September 2011 through January 2012 there was no evidence that a system/plan was implemented to correct the identified concerns with the Infection Control Program. | F 520 | | |