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 _____	02/02/2011

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

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F 000	INITIAL COMMENTS An annual recertification survey was conducted on January 24 through February 2, 2011. The following deficiencies were based on observation, record review, staff and resident interviews. The sample included 27 residents based on a census of 169 residents on the first day of survey and 12 supplemental 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	F157 1. Resident # 19 Nurse Manager of unit where resident resides conducted a one to one education with nurse caring for resident, that nurse is to notify the responsible party immediately following any changes in resident #19 plan of care. Following notification made to responsible party of resident #19 an entry will be made in the nursing progress note. 2. Nurse Managers will audit 10% of the resident medical records on their respective units of any residents that have experienced any change in condition, medication order change or any other situations where family notification is warranted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/8/11

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 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 27 sampled residents and two (2)of 12 supplemental residents, it was determined that facility staff failed to notify the resident's responsible party of changes to the residents mode of transportation of allowing the staff to wheel the resident backwards, to notify resident ' s responsible party that one (1) resident attempted to elope, to notify the responsible party that one (1) resident developed a pressure sore and to notify the physician/nurse practitioner of one (1) resident ' s significant weight loss . Resident #19, #26, #M1, P1 The findings include: 1. Facility staff failed to notify the responsible party of the modifications with the residents ' mode of transportation. Resident # 19 A review of the medical record revealed an " Interim Order Form " dated January 25, 2011 at 9:30AM directing the following: 1. Okay to move patient in merry walker backwards when he/she is not actively walking him/herself -see progress note, 2. Check CMP (complete metabolic panel) ..., 3. Start lasix 40 mg po (by mouth) daily for fluid overload, 4. Start ambien 5 mg po daily at hs (bed time) for insomnia, ... " A review of the " Nurses Notes " dated January 25, 2011 at 2:40 PM revealed an entry indicating " patient relative gave permission for ambien 5mg	F 157	Audits will be submitted to the Quality Improvement Nurse. Nurse Managers and supervisors of all facility units will hold unit education session with charge nurses by April 8, 2011 to remind nurses whenever any changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. During the education session, the discussion will include, that following notification to a responsible party of a resident regarding change(s) to the residents' plan of care, the notification is to be documented in the nursing progress note. 3. Nurse managers are to review their unit 24 hour reports daily for changes to the resident plan of care. If the 24 hour report shows changes in the resident plan of care, the nurse manager will go to the medical record of the resident to review if documentation of notification of the responsible party is reflected in the medical record. Variances will be corrected by immediate notification of the responsible party. Nurse Managers and supervisors of all facility units will hold unit education sessions with charge nurses by April 8, 2011 to remind nurses whenever changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident.	

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F 157	Continued From page 2 po at hs for insomnia, also updated him/her on other orders diet, lasix, blood work " The entry failed to indicate that the relative/responsible party was informed about the modifications to allow staff to wheel his/her relative backwards. A face-to-face interview was conducted on January 26, at 11:30 AM with Employee #32 a query was made if the relative was informed about the order to allow the staff to wheel the resident backwards. Employee #32 indicated that he/she " did include the order to allow staff to wheel the resident backwards in the update. " Facility staff failed to document that the relative was informed about the order to allow the staff to wheel his/her relative backwards. The record was reviewed on January 25, 2011 2. Facility staff failed to notify the resident's responsible party of the resident attempt to elope. Resident #26 A review of Resident #26's clinical record revealed that a nurse's note dated November 28, 2010 at 3:00 PM documented, "Resident condition stable. Hospice care in progress. Adjusting to new environment well. Resident tried to elope during morning time. Nurse Practitioner notified. Order to apply wander guard to resident ankle, for safety and check wander guard every week day for function. House supervisor notified. Monitor continues." The record lacked documentation that facility staff notified the resident's responsible party of the resident attempt to elope. A face-to-face interview was conducted with Employee#3 on February 1, 2011 at 9:30 AM.	F 157	4. Making use of the unit 24 hour report to identify changes in residents plan of care as a guide, the QI nurse will conduct weekly chart audits to ensure that notification to responsible parties of changes to residents plan of care, have been documented in residents nursing progress note. 5. Compliance Date 1. On 11/28/2010, when resident #26 left the building, the resident was alert and deemed able to make her own decisions. The resident was her own responsible party and left the building accompanied by a friend. Resident 26 stated she would return to facility at a specific time. Staff documented the occurrence as an elopement when the resident did not return to the facility by the time the resident specified. The resident nor the friend did not make any attempt to contact the facility when the specified time the resident was to return had passed. The staff proceeded to document the occurrence as an elopement. As stated, the resident was her own responsible party, therefore it was not necessary to notify a responsible party of the resident's not returning to the facility. 2. Nurse Managers will audit 10% of the resident medical records on their respective units of any residents that have experienced any change in condition, medication order change or any other situations where family notification is	4/8/2011

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F 157	Continued From page 3 He/she acknowledged that the responsible party was not notified of the change of condition of the resident. The record was reviewed February 1, 2011. 3. Facility staff failed to notify the resident's responsible party that the resident developed a pressure sore. Resident M1 A review of Resident #M1's clinical record revealed that a nurse's note dated October 27, 2010 at 3:00 PM documented, " Resident is alert and verbally responsive was observed today with reopen left buttocks wound measure 1cm x 0.5cm, with scant drainage noted. Nurse Practitioner made aware, new order for Santyl daily and reassess after 14 days." A review of resident Treatment Administrative Record (TAR) revealed for December, 2010 revealed that a wound care order initiated October 26, 2010 and reads, " cleanse left buttocks open area with soap and water, apply Santyl cover with 2x2 and secure with tegaderm daily " , was resolved. A review of Resident #M1's clinical record revealed that a nurse's note dated January 19, 2011 at 3:00 PM documented, " Resident remain stable, reported by nursing assistant, resident had a opening to left buttocks, measure 0.5cm x 0.1cm, reopen with scant amount of clear drainage. Evercare Nurse Practitioner made aware, new order in place until heal". The record lacked documentation that facility staff notified the resident's responsible party between October 27, 2010 and January 19, 2011 that resident developed a pressure sore.	F 157	warranted. The audits will be forwarded to the Quality Improvement Nurse. Nurse Managers and supervisors of all facility units will hold unit education session with charge nurses by April 8, 2011 to remind nurses whenever any changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. During the education session, the discussion will include, that following notification to a responsible party of a resident regarding change(s) to the residents' plan of care, the notification is to be documented in the nursing progress note. 3. Nurse managers are to review their unit 24 hour reports daily for changes to the resident plan of care. If the 24 hour report shows changes in the resident plan of care, the nurse manager will go to the medical record of the resident to review if documentation of notification of the responsible party is reflected in the medical record. Variances will be corrected by immediate notification of the responsible party. Nurse Managers and supervisors of all facility units will hold unit education session with charge nurses by April 8, 2011 to remind nurses whenever any changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. During the education session, the discussion will include, that following notification to a responsible party of a resident regarding change(s) to the residents' plan of care, the notification is to be documented in the nursing progress note.	

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F 157	Continued From page 4 A face-to-face interview was conducted with Employee#3 on January 31, 2011 at 9:30 AM. He/she acknowledged that the record showed that the responsible party was not notified that the resident developed a pressure ulcer. The record was reviewed January 31, 2011. 4.Facility staff failed to inform the physician/nurse practitioner of Resident P1 ' s significant weight loss. A review of the dietary note in the resident ' s clinical record revealed a note dated October 18, 2010 which stated, " Nutritional note wt [weight] declined 138 lb or 8.6% is significant but he/she is above IBW [Ideal Body Weight. " Another note dated December 16, 2011 stated, " Current wt [weight] 135.2# [pounds] or 9.8% lost in 180 days significant. " A review of the documentation of the monthly weights in the resident ' s clinical record revealed that the resident ' s weight declined from 160 pounds in April 2010 to 138 pounds in October which was reflective of a significant weight loss of 13% in six [6] months or 180 days. A review of the significant change Minimum Data Set [MDS] which was completed on December 4, 2010 revealed that the MDS was coded for the significant weight loss. A review of the nursing and dietary documentation failed to reveal any evidence that the physician/NP was informed of the resident ' s significant weight loss. A face-to-face interview was conducted with Employee # 6 at approximately 10:00AM on February 2, 2011. He/she acknowledged that the	F 157	4.Making use of the unit 24 hour report to identify changes in residents plan of care as a guide, the QI nurse will conduct weekly chart audits to ensure that notification to responsible parties of changes to residents plan of care, have been documented in residents nursing progress note. 5. Compliance Date 1. Resident # M1 Nurse Manager of unit where resident resides conducted a one to one education with nurse caring for resident, that nurse is to notify the responsible party immediately following any changes in resident #M1 plan of care. Following notification made to responsible party of resident #M1 an entry will be made in the nursing progress note. 2. Nurse Managers will audit 10% of the resident medical records on their respective units of all residents that have experienced any change in condition, medication order change or any other situations where family notification is warranted. The Audits will be forwarded to the Quality Improvement Nurse. Nurse Managers and supervisors of all facility units will hold unit education session with charge nurses by April 8, 2011 to remind nurses whenever any changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. During the education session, the discussion will include, that following notification to a responsible party of a resident regarding change(s) to the	4/8/2011

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F 157	Continued From page 5 physician/NP was not notified of the resident ' s significant weight loss. Another face-to-face interview was conducted with Employee #26 at approximately 10:30AM on February 2, 2011. He/she stated, " He/she was initially above his/her IBW and his/her Albumin level is good [3.5]. I have been working with him/her to make sure he/she gets the foods he/she likes. The record was reviewed on January 28, 2011.	F 157	residents' plan of care, the notification is to be documented in the nursing progress note. 3. Nurse managers are to review their unit 24 Hour reports for changes to the resident plan of care. If the 24 hour report shows changes in the resident plan of care, the nurse manager will go to the medical record of the	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES 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. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview it was determined that facility staff failed to ensure that grievances were resolved in a prompt manner for two (2) of 27 sampled residents. Residents #24 and F2. The findings include: 1. The spouse for Resident #24 filed a grievance on 2/28/2010 regarding delay of care. Review of this grievance and the facility's response indicated that the grievance was resolved on 6/29/10. The facility ' s " Family Resident Communication Tool Log " revealed, " June 28, 2010 ...delay of care concern ... Follow-up: Unit Manager found no evidence to substantiate allegations made in the concern and met with [spouse of Resident #24]. Grievance was resolved." A review of the " Resident/Family Concern Form " dated June 28, 2010 revealed, " Describe	F 166	resident to review if documentation of notifi cation of the responsible party is reflected in the medical record. Variances will be corrected by immediate notification of the responsible party and documentation of the notification in the medical record. Nurse managers and supervisors of all units will hold unit education sessions with charge nurses by April 8, 2011 to remind nurses whenever any changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. During the education session, the discussion will include, that following notification to the responsible party, regarding changes, documentation of the notification is made in the nursing progress note. 4.Making use of the unit 24 hour report to identify changes in residents plan of care as a guide, the QI nurse will conduct weekly chart audits to ensure that notification to responsible parties of changes to residents plan of care, have been documented in residents nursing progress note 5. Compliance Date	4/8/2011

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F 166	Continued From page 6 action taken to address concern: At this time my finding is [Resident #24] is keeping the staff preoccupied with him. The needs of all residents have to be met. I have requested the nurse call bell report for the record and will forward. All of [spouse of Resident #24] concern forms have been answered by me since my arrival.. this is the fourth one, 5/27/10, 6/7/10, 6/21/10 and today 6/28/10. " Facility staff failed to resolve a grievance in a timely manner voiced by Resident #24 on February 28, 2010. A face-to-face interview was conducted with Employees #1, Employee #2 and Employee #3 on February 1, 2011. Employee #3 indicated that a request was made to IT [Informational Technology] for the call bell log. However, it was not followed through, because no one knew how to obtain the log. " Employee #1 indicated they now " have a systematic approach to work on grievances. " 2. Facility staff failed to completely resolve Resident #F2 ' s grievances for food preferences. The Diet Communication Form dated and signed by the dietitian on December 15, 2010 revealed, " New Admit; WW (whole wheat) Bread (circled); Additional information no pork or pork products. The " Resident/Family Communication Tool Log " -Concern from Resident #F2 dated December 26, 2010 revealed, " I informed the dietitian that I did not eat pork, white bread and I did not drink coffee. It took a while before the kitchen, dietitian and myself were on the same page. Time and time again I receive coffee and I still am receiving pork." The Food Services Manager addressed the menu problem and counseled staff	F 166	1. The physician of resident P1 was given notification of the recorded weight loss of the resident. 2.The nutritionist upon identification of any resident with a weight loss or weight gain of 5 lbs or more will do the following: a. Ask the Weight Team to re-weigh the resident for verification of a change. b. If a change is verified, the nutritionist will notify the physician/nurse practitioner of the change and whether it is expected or unexpected. c. The nutritionist will in turn offer recommendations to the physician/nurse practitioner and the interdisciplinary care team as to how (if appropriate) the variance can be corrected. d.The nutritionist will document in the medical record the notification of the physician/ nurse practitioner, the interdisciplinary care team and the recommendations made. e. In order to identify other residents for nutritional risk, the nutritionist will audit 10% of the resident charts on each unit. If nutritional variances are found, the nutritionist will follow the guidelines in A thru D as noted above. Audit findings will be presented at the next scheduled QI meeting. 3. Beginning April 8, 2011, the QI Nurse will conduct a monthly Nutritional Risk audit using the Weight Loss Report and review charts of residents with a weight variance to determine if physician/nurse practitioner notification, along with all weight variance processes, took place	

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F 166	Continued From page 7 member and Resolved the concern on December 29, 2010. A review of the Census List, which lists current diets likes and dislikes for all residents in the facility, dated January 31, 2011 list Resident #F2 ' s Diet Note as " No Pork Products" . There was no evidence that the white bread and coffee was included on the "Census List" as a dislike. A review of the Nutritional Screening and Assessment form dated December 14, 2010 and the progress notes last updated January 25, 2011 lacked evidence that whole wheat bread was included as a food preference for Resident #F2. A face-to-face interview was conducted with Resident #F2 on January 31, 2011 at 9:40 AM. He/she stated, " They [the facility] are still putting pork on my plate and white bread. " A face-to-face interview was conducted with the dietitian on January 31, 2011 at 11:15 AM. After discussion with the dietitian about the resident ' s concern, he/she acknowledged that the white bread and coffee was not added to the "Census List" as a dislike and whole wheat bread was not added to the "Census List" as a food preference. A face-to-face interview was conducted on February 1, 2011 with Resident #F2. He/she stated, " I received white toast on my breakfast tray this morning. " There was no evidence the facility staff completely resolved Resident #F2 ' s grievances for food preferences.	F 166	and was documented. The DON or designee will review and discuss with the nutritionists the process listed for all residents to followup with the education session and will discuss nutritionally at risk residents, weekly. 4.Negative trends and corrections will be Reviewed during the facility QI monthly Meeting. 5. Compliance Date F166 1. Identified grievances involving Resident #24 and Resident F2 have been resolved. Call bells are answered within the parameters for Resident #24. Resident F2 received whole wheat toast as stated as a food preference. 2. All concerns/grievance documented on the Communication Tool from residents, family members or visitors will be responded to and a resolution attempt will be completed in a timely manner. Call bell reports are reviewed on a weekly basis for all units and all resident diet orders are confirmed with the dietician and/or nursing staff. 3. The Communication Tool policy and procedure will be re-distributed to the Home staff to re-educate steps to timely resolve a concern/ grievance. All concerns/grievances on the Communication Tool are forwarded to Nursing Home Administration, logged in an electronic database and reviewed for response and resolution. 4. The Communication Tool log will be monitored monthly by Nursing	4/08/11 2/2/2011 3/31/2011 4/8/2011 4/8/2011

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F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview for three (3) of 27 records reviewed, it was determined that the facility failed to ensure the safe practice of self-administered medications. Residents #1, 18 and F1. The findings include: 1. Facility failed to ensure the safe practice of self-administered medications for Residents #1. Upon review of the clinical record for Resident #1, it was determined that multiple " natural " medications were stored at the bedside and self-administered by the resident. There was no evidence that the interdisciplinary team determined that self administration was a safe practice for Resident #1. A review of the admission Minimum Data Set (MDS) dated October 13, 2010 revealed that Resident #1 was coded as cognitively intact, non-ambulatory with impairment of lower extremities, no impairment of the upper extremities and required extensive assistance for activities of daily living. A review of the clinical record lacked evidence that the interdisciplinary team (IDT) made a	F 176	Home Administration and our Quality Improvement Manager for timely response, outstanding resolution and trends. 5. Compliance Date F176 1. Residents #1, 18 and FI received an assessment to ensure they were safe to administer medications. Facility purchased and gave resident a lock box with a pad lock and key (nurse also given a second key for box) in order that the resident can safely secure the medications they self-administer. 2. The Nurse Managers conducted a sweep of all other residents on their unit to ascertain if there were other residents self administering their medications in order to offer any other residents a lock box: no other residents were found to self administer their medications. The Self-Administration of Medication policy has been amended to include a safety assessment of each resident desiring to administer their medications. The assessment will be done for an initial review, quarterly at the time of review of the interdisciplinary care plan and when a significant change occurs to the resident.	4/8/2011

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F 176	Continued From page 9 determination that it was safe for the resident to self-administer drugs. The care plan lacked evidence of the determination regarding the storage and documentation of the administration of drugs. A face-to-face interview was conducted with Employee #3 on January 25, 2011 at approximately 4:00 PM who acknowledged the findings. The record was reviewed on January 25, 2011. 2. Facility staff failed to assess Resident #18 for the ability to self administer eye ointment. According to Resident #18 ' s January 2011 Physician ' s Order Sheet signed by the physician on January 11, 2011 directed, " Ciloxan Ophthalmic 0.3% Ointment... apply to right eye twice daily for chronic conjunctivitis (indefinitely). A review of the Medication Administration Record for January 2011 reveals initials indicating " Ciloxan Ophthalmic 0.3% ointment ... apply to right eye twice daily for chronic conjunctivitis " was administered daily at 10:00 AM and 6:00 PM. A review of the clinical record lacked evidence that the interdisciplinary team (IDT) made a determination that it was safe for the resident to self-administer drugs. The care plan lacked evidence of the determination regarding the storage and documentation of the administration of drugs. A face-to-face interview was conducted on January 24, 2011 at approximately 12:00 Noon with Resident #18. He/she stated, " Yes, I put my own ointment in my right eye. They showed me how to do it, and they watched me do it. I wash my hands before and after putting it in my	F 176	3. Upon admission to the facility the resident will be queried to determine if they want to self-administer their medications. If an affirmative answer is given, the Self-Administration of Medications policy will be implemented. The Nurse Manager and Nursing Supervisors will conduct an education session with all clinical nurses regarding the Self-Administration of Mediation policy and the amendment made to the policy. 4. A quarterly audit of the implementation of the Self-Administration policy will be conducted by Nurse Managers. Identified trends and their corrections will be reported to QI and Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011

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F 176	Continued From page 10	F 176		

eye. The ointment is for my conjunctivitis. "
A face-to-face was conducted on January 24, 2011 at approximately 11:30 AM with Employees #6 and Employee #15. Both stated, " [Resident#18] self administers his/her eye ointment twice a day. The record was reviewed January 24, 2011.

3. Facility staff failed to have the IDT (interdisciplinary team) team evaluate Resident #F1 for self administration of medications.

On January 26, 2011 at 3:00 PM a tour of Resident #F1 ' s room was conducted. A can of Cetacaine spray was observed on the night stand (on left side of the bed). At that time Employee #16 was present and acknowledged that the medication was on the resident night stand. Employee #16 stated, " [He/she] self administers the spray to his/her throat. "

Additionally, Resident #F1 wrote the following on his/her communication board, " I spray it in my mouth. "

The Physician Order Form dated January 2011 and signed by the physician on January 10, 2011 directed, " Cetacaine Spray 2 sprays every 3 hours as needed for pain-may keep at bedside to use as needed. "

A review of IDT notes, the physician progress notes and nursing notes lacked evidence that an assessment was conducted to determined that this practice is safe for Resident # F1 to self administer Cetacaine.

A face-to-face interview was conducted on

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F 176	Continued From page 11 February 1, 2011 at 11:30 AM with Employee #6. He/she acknowledged that the medication was at the bedside and that there was no evidence that the IDT team had determined it was safe for Resident #F1 to self administer the Cetacaine. The record was reviewed on February 1, 2011.	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 27 sampled residents, it was determined that the facility staff failed to ensure that residents were free from physical restraints. Residents #4 The findings include: A review of the clinical record for Resident #4 revealed facility staff failed to identify a merry walker as a restraint and follow a systematic process of evaluation and care planning by the interdisciplinary team for the least restrictive device. According to facility's Policy and Procedure "The Use of Manual/Chemical Restraints" Policy No: TX-00026/97" revealed "Re-evaluation of need for continued use of restraint device at each quarterly care conference." According to a Social Work care conference and	F 221	F221 1. Resident #4 MDS was updated to accurately code the merry walker as a restraint. Resident #4 has documented assessment that the merry walker is appropriate for their use. Beginning with the next interdisciplinary quarterly care plan and MDS update, a documented assessment will be conducted to determine if the merry walker continues to be appropriate for use by this resident. Education conducted with interdisciplinary team as to accurate MDS coding of a merry walker as a restraint. 2. Nurse Managers conducted a site review and medical record review of all residents using Merry Walkers and other restraints. Any resident identified as needing a restraint will receive an initial assessment to determine if restraint to be used is the least restrictive. Continued need for the restraint will be reviewed quarterly at the time of review of the MDS and inter-disciplinary care plan and/or with a significant change that occurs to a resident.	

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F 221	Continued From page 12 quarterly progress note dated December 10, 2010 revealed, " Team met with the resident ' s [daughter]. Care plans and medications were reviewed with no changes made. Resident is in her meri-walker daily in the dining area." A physician ' s order dated and signed January 7, 2011 directed, " Patient to ambulate in merry walker on unit as tolerated. " ..... " Restraints... Vigilon monitor while in bed and merry walker. " There was no evidence that an assessment was conducted to determine if the merry walker was the least restrictive and/or most effective device to use. A face-to-face interview was conducted with Employee #6 on January 25, 2011, who acknowledged that there was no assessment to determine if the merry walker was the least restrict and or most effective device to use. The record was reviewed January 25, 2011.	F 221	3. By April 8, 2011, a Resident Restraint Policy will be initiated and the inter-disciplinary team educated regarding assessment for use of the least restrictive restraint when appropriate for resident usage. 4. During the time of review of the MDS, the MDS Nurse will ensure accurate coding of the merry walker as a restraint. QI will report restraint usage to the Quality Improvement Committee quarterly. 5. Compliance Date F226 1. Human Resources changed its back-ground screen vendor. ADP is now our background check provider as well as our overall HRIS system provider. By having one sole vendor, the recruitment and hiring process is streamlined. The HR Director also conducted a department meeting stressing the importance of adhering to the Selection and Hiring of Personnel policy. More specifically, it was stressed that in order for a new employee to begin employment, he/she must have met all of the pre-employment requirements, including a complete background screening. 2. In the event that a newly hired employee's background screening (or any other pre-requisite) is not complete before their scheduled start date, he/she will be notified by Human Resources that their start date will be delayed. The hiring manager will also be notified.	4/8/2011
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that facility staff failed to ensure that newly hired staff background checks and references checks were final/completely investigated prior to the employees working in the facility as per the facility policy in one (1) of five (5) newly hired employees. The findings include:	F 226		

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F 226	Continued From page 13 The facility's policy entitled: "Abuse and Neglect " Policy No: TX-00001.97, 1/11 stipulated: Resident Abuse and Neglect policy and procedures 7 step approach: 1. Screening- screen potential employees for history of abuse, neglect and mistreatment. Criminal background checks ...references from previous employers. " A review of Employee # 31 ' s file was conducted on January 26, 2011. The employee's file revealed the following: Date of hire December 13, 2010. A review of the employee application revealed that he/she attended school and/or resided in the states of Colorado and California. The criminal background check was initially sent on November 15, 2010. On December 31, 2010, January 16, and 26, 2011 the status of the background check was " in progress " and all jurisdictions were not checked for the criminal search. Additionally, Education History and Reference Verification status was " pending " . Employee #31 ' s record lacked evidence that a complete screening of background information was completed prior to the employee working 21 days in the facility. A face-to-face interview was conducted with Employee # 10 on January 26,, 2011 at approximately 3:45 PM. Employee #10 acknowledged that the criminal background check was not completed prior to Employee #31 working in the facility.	F 226	3. In order to assure that the deficient practice does not occur again, the following measures have been implemented: a. Terminated the contract with the former background check provider and implemented a new vendor on 2/14/2011; b. Educated the HR staff on the Selection and Hiring of Personnel policy; c. Background checks are submitted according to the states lived and worked during the past seven years, verify all necessary education/ schools that are applicable, etc.; d. In the event that a background check is pending and not complete by the scheduled start date, HR will notify the pending new hire and delay their start date until the background check is complete and in good standing; e. HR will keep the hiring manager informed of the pending new hire's status. 4. Background checks are being completed within 3-5 days from submission. In the event that the vendor could not complete the background screen in its entirety, within the five day window, HR is notified via an alert. At that point, it is Human Resources responsibility to complete the check (i.e. references, verify education by obtaining a copy of the license/degree and verifying the education via the source). Identified trends and their corrections will be reported to QI and Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241		

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F 241 SS=D	Continued From page 14 INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview for three (3) residents observed, it was determined that facility staff failed to promote resident dignity as evidenced by one resident who was exposed during medication pass, one (1) resident who sat idle as others dined in his/her presence and failure to provide sufficient mealtime supervision for one (1) resident , . Residents #10, # K1 and K2. The findings include: 1. During a medication pass on January 24, 2011, it was determined that facility staff failed to ensure Resident #10' s dignity by failing to provide sufficient covering to chest. The findings include: During a medication pass on January 24, 2011 at approximately 9:30 AM, Resident #10 was observed sitting in the bed after consuming his/her breakfast. In response to the query, " can we come in? " the resident verbalized discontent with his/her chest being exposed. He/she stated that [he/she] wasted coffee and he/she likes to " show respect ...I am from the old school. I like to be presentable. " A face-to-face interview was conducted with Employee #6 on January 24, 2011 at approximately 10:30 AM. He/she stated that Employee #15 should have acknowledged Resident ' s #10 ' s comments and asked if	F 241	F241 1. Resident #10 - One on one education done with staff member to acknowledge resident before entering room by knocking on door and waiting for an answer from resident giving the staff member permission to enter the room. 2. Re-education of nursing staff (by April 8, 2011) by the Education Department regarding preserving resident dignity: knocking before entering resident room, wait for permission to enter before actually entering resident room. Staff will be observed randomly to ascertain if they are maintaining resident dignity, as daily unit rounds are made by Nurse Managers and House Supervisors beginning April 8 through April22, 2011. On-the-spot education will be conducted as needed if staff is not observed maintaining resident dignity. 3. An annual mandatory staff education class, topic: Maintaining Resident Dignity and Respect will be offered to all facility staff by the Education Department. 4. Nursing management team will make daily rounds on nursing unit. On-the-spot education for individuals found in violation of maintaining resident dignity will be given (disciplinary action will be given where needed and if appropriate. 5. Compliance Date 1. Resident #K1- One on one education done with staff member reminding them when serving meals to resident K1, ensure resident K1 meal is placed on the table at the same time the other table mates receive their meals.	4/8/2011

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F 241	Continued From page 15 he/she needed assistance with providing cover for his/her bare chest. 2. During a dining observation of the breakfast meal on January 25, 2011, it was determined that facility staff failed to promote Resident K1 ' s dignity by allowing the resident to sit idle while others dined. Resident K1 sat idly at the dining table in the main dining room on the unit while other resident ' s dined in his/her presence. When Resident K1 received assistance to consume his/her breakfast, the other residents who accompanied him/her at the table had completed their meals. Approximately 25 minutes elapsed between the time the others were served and the time Resident K1 was offered feeding assistance. The findings were reviewed with Employee #3 on January 31, 2011 at approximately 2:00 PM 3. During a dining observation of the breakfast meal on January 25, 2011, it was determined that facility staff failed to promote Resident K2 ' s dignity by failing to provide sufficient mealtime supervision. Resident K2 ' s breakfast tray was set up by facility staff at the table in the main dining area on the unit. The resident exhibited limited dexterity of the hands and appeared to have difficulty managing the fork that was provided [no spoon was observed]. The resident was observed eating cereal covered with yogurt with his/her fingers. According to an occupational therapy progress note dated January 14, 2011, Resident #K2 had decreased motor control for wrist flexion and extension with limited range of motion. His/her	F 241	2. Re-education of nursing staff (by April 8, 2011) by the Education Department regarding preserving resident dignity: meal service to residents. Random meal observations were conducted by the Nurse Managers April 8 through April 12th: no other residents were affected. 3. Systemic: During orientation of newly hired nursing staff the Education Department will present the topic—Maintaining Resident Dignity & Respect: a portion of the session will include serving a resident meals (ensuring all residents that are table mates will receive their meals on the table at the same time). The same topic is to be presented as a mandatory staff education class annually for all nursing staff. On-going random meal observations will be conducted by Nurse Managers and House Supervisors to observe staff in the practice of maintaining dignity while serving meals (specifically observing that idle diners are not present at dining tables). Variances will be corrected on- the- spot and on-the-spot education given to staff. 4. The Quality Improvement Nurse, Unit Nurse Managers and House Nursing Supervisors will conduct random meal observations to ensure staff education is successful. Negative trends will warrant on-the-spot individual staff counseling. 5. Compliance Date	4/8/2011

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F 241	Continued From page 16 level of function for feeding included set up with minimal assist. Mealtime supervision/assistance was not provided for Resident K2. The resident was assisted with clean-up following the completion of breakfast.	F 241	1. Resident #K2—re-education of staff member regarding maintaining resident dignity during meals: ensuring resident receives the appropriate utensils to complete their meal. 2. Re-education of nursing staff (by April 8, 2011) by the Education Department regarding preserving resident dignity: meal service to residents. Random meal observations were conducted by the Nurse Managers April 8 through April 12th: no other residents were affected. 3. Systemic: During orientation of newly hired nursing staff the Education Department will present the topic—Maintaining Resident Dignity & Respect: a portion of the session will include serving a resident a meal. The same topic is to be presented as a mandatory staff education class annually for all (residents have the appropriate utensils for meal completion) nursing staff. 4. The Quality Improvement Nurse, Unit Nurse Managers and House Nursing Supervisors will conduct random meal observations to ensure staff education is successful. Negative trends will warrant on-the-spot individual staff counseling. 5. Compliance Date	4/8/2011
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview for one (1) of 27 residents reviewed, it was determined that facility staff failed to assist the resident in the fulfillment of exercising choices. Resident #11 The findings include: During the orientation tour of the facility on January 24, 2011 at approximately 9:20 AM, Resident #11 was observed sitting on the side of the bed consuming breakfast. In response to the query, " how are you? " the resident verbalized discontent with the meal and rising schedule. He/she stated that [he/she] had always been an " early riser " and expressed a desire to get started with his/her day at an earlier hour, " this is too late for breakfast. " He/she stated that this had			

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F 242	Continued From page 17 been expressed to staff prior to this dialogue. A review of the clinical record revealed the resident was admitted to the subacute unit of the facility on December 23, 2010 and transferred within the facility to a long term care unit on January 19, 2011. According to the admission Minimum Data Set (MDS) dated January 4, 2011, Resident #11 was coded as cognitively intact, required limited assistance for activities of daily living and consumed meals independently with set up help only. The record lacked evidence that staff proactively assisted the resident in fulfilling choices related to his/her daily arising/dining schedule. A face-to-face interview was conducted with Employee #3 on January 28, 2011 at approximately 9:40 AM. . He/she stated that the facility offered an option of an early breakfast tray for those who chose to eat early, however, acknowledged that the option had not been explored with Resident #11.	F 242	F242 1. Resident #11—was given explanation of early tray option and placed on list to receive an early tray. Discussion documented. 2. At time of admission and quarterly thereafter, residents are to be queried regarding their preference for an early tray option.Nutritionists & licensed nurses will receive (by April 8, 2011) education to remind them to query newly admitted residents for the early tray option. The IDT will receive education to remind them to query resident about this choice during quarterly care plan conferences. 10% of new admission charts were audited and no other residents had concerns regarding request for an early tray. 3. At time of admission a documented explanation of the early tray meal option will be a part of the admission packet. Verbal explanation will be given to resident as part of the nurse assessment interview (where applicable) with second follow up during the admission nutritionist interview. 4. As per facility policy, (or per resident request) during the nutritionist's quarterly resident review, the nutritionist will review resident options of meal choices—including the option of early meal tray. 5. Compliance Date	4/8/2011
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility from January 26 to January 28, 2011, it was determined that the facility failed to provide a safe and clean	F 252		

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F 252	Continued From page 18 environment as evidenced by a torn carpet on one (1) of five (5) unit, a broken tile in one (1) of 48 resident ' s bathrooms, and a urine like smell in two (2) of 48 resident ' s rooms. The findings include: 1. The carpet in front of rooms #255 and 256 was torn and has numerous lumps which present a tripping hazard. 2. There was a broken tile in the bathroom of room #306 that also presented a tripping hazard. 3. A malodorous smell was evident in rooms #346 and 357. These observations were made in the presence of employees # 8 and 37 who acknowledged these findings during the survey	F 252	F252 1. Capital proposal submittal for replacement of worn/damaged carpet in resident units. Frayed edges were re-cut to minimize tripping hazards. 2. All carpeting was observed for frays, buckles, etc. Repairs were scheduled as indicated. 3. The plant operations staff was retrained on observing deteriorating carpet conditions, especially in residential areas. Carpet conditions are observed monthly during life safety rounds conducted by plant operations 4. Carpeting conditions will be monitored daily by plant operations and reported to supervisory staff. 5. Compliance Date	4/8/2011 4/8/2011
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on January 26, 2011through January 28, 2011, it was determined that the facility failed to provide effective maintenance services in residents rooms as evidenced by cluttered storage room on three (3) of five (5) units. The findings include:	F 253	1. The broken tile in the bathroom of room #306 was replaced. 2. Floor tile throughout the facility were observed for conditions of service. No other areas of concern were noticed. 3. The plant operations staff was retrained on observing floor tile and other potential tripping hazards. Safety conditions are observed monthly during life safety rounds conducted by plant operations. 4. Bathroom tile conditions will be monitored daily by plant operations and reported to supervisory staff. 5. Compliance Date F253 1. Rooms #345 and 357 were cleaned by housekeeping staff. Special attention was paid to the trash cans located in the resident rooms.	01/28/11. 4/8/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 19 Storage rooms observed on units 1A, 2A, and 2B, in three (3) of five (5) storage rooms observed. These observations were made in the presence of Employees #8 and 37 who acknowledged these findings during the survey.	F 253	2. All resident rooms were observed for malodorous smells. No other areas of concern were noticed. 3. The housekeeping staff was retrained on observing odors, especially in residential areas. These conditions are observed monthly during environmental rounds conducted by housekeeping. 4. Malodorous smells will be monitored daily by plant operations and reported to supervisory staff. 5. Compliance Date	4/8/2011
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on an isolated record review and staff interview, it was determined that facility staff failed to complete a quarterly Minimum Data Set [MDS] assessment for Resident #1. The findings include: A review of the clinical record for Resident #1 revealed an admission MDS assessment was completed October 13, 2010. There was no evidence of a MDS assessment subsequent to the admission assessment. A face-to-face interview was conducted with Employees #3 and #17 January 31, 2011 at approximately 11:30 AM. It was acknowledged that the quarterly assessment was due on or about January 13, 2011, and confirmed that the quarterly assessment was not completed and that an interdisciplinary meeting had not been	F 276	1. Storage rooms on units 1A, 2A, 2B were cleared of excessive clutter. 2. Unit Secretaries on all nursing units by April 8, 2011 will conduct a unit 'spring cleaning' to de-clutter all unit storage areas 3. Unit Secretaries will conduct weekly de-clutter sweeps of unit storage rooms. 4. All Nursing Unit Managers will conduct monthly unit rounds to inspect all storage areas for clutter. Outcomes will be reported to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011