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

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 ______	02/26/2016

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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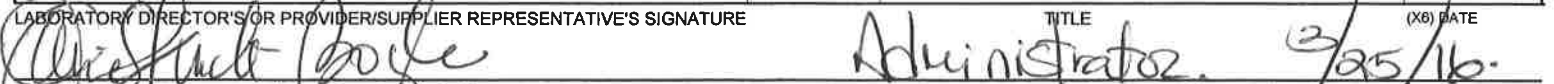
F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at The Washington Home from February 22, 2016 through February 26, 2016. Survey activities consisted of a review of 40 resident clinical records during Stage 1; and review of 17 sampled residents during Stage 2. There were 43 supplemental records reviewed during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. On September 15, 2015 the Skilled Nursing facility announced that it will be closing. The anticipated closure date is December 2016. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status G-tube- Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - emergency medical services (911) EMAR- electronic medication administration record HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA- Certified Nurse Aide	F 000	Please begin typing your responses here:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE



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

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F 000	Continued From page 1 cc - cubic centimeter DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L - Liter Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury POS - physician ' s order sheet Prn - As needed Pt- Patient TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - Interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- Discontinue Rp, R/P- Responsible Party PO- By Mouth S/he She/he SIC thus was it written	F 000	The Washington Home makes its best effort to operate in substantial compliance with both the Federal and State law. Submission of the 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 facilities written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State Law.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable	F 246	F246 1.Room 155-Call light cord replaced 2.Evaluated all other resident rooms with no identified concerns of shortened call light cords 3.Resident rooms will be inspected During weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern related to length of call light cord 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trends to the QAPI committee Monthly 5.Compliance Date	4/9/16

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F 246	Continued From page 2 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations made on February 22, 2016 between 11:30 am and 3:00 pm, it was determined the facility failed to accommodate one resident ' s needs as evidenced by a call bell cord in one (1) of 38 resident rooms that was too short to be easily accessible. The findings include: The call bell cord in the bathroom of room #155 was too short to be easily accessible for the Resident in one (1) of 38 resident rooms surveyed. These observations were made in the presence of Employees' #22 and #23 who acknowledged the findings.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made on February 22, 2016 between 11:30 AM and 3:00 PM, it was	F 253	F253 1.Loose wallpaper removed from walls between room 203/204 and 207/208 2.BR vents cleaned in rooms 123,207,212 3. Rooms 207,212,255 inspected by maintenance and marred walls repaired 4. Cover base in room 208 repaired 2.Maintence evaluated all other rooms to identify areas needing repair (loose wallpaper, soiled BR vents, Marred walls, loose cove base) areas of concerns repaired 3.Resident rooms will be inspected During weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern of loose wallpaper, soiled BR vents, marred walls, loose cove base. 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trends to the QAPI committee Monthly 5.Compliance Date	4/9/16

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F 253	Continued From page 3 determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior as evidenced by loose wallpaper on one (1) of five (5) resident care units, soiled bathroom vents in three (3) of 38 resident rooms, a loose cove base in one (1) of 38 resident rooms and marred walls in three (3) of 38 resident rooms. The findings include: 1. The wall paper was loose, unglued from the walls in unit 2b across from rooms #203 and #204; and between rooms #207 and #208. 2. Bathroom vents were soiled on the inside and outside in three (3) of 38 resident rooms. (#123, #207 and #212). 3. The cove base close to the bathroom was hanging loose and needed to be secured in one (1) of 38 resident rooms (#208). 4.Walls were marred in three (3) of 38 resident rooms (#207, #212, #255). These observations were made in the presence of Employee #22 and Employee #23 who acknowledged the findings.	F 253	F272 1.Resident #24 coded incorrectly. This remarkable event cannot be changed. MD evaluated to determine resident status related to hospice. 2.Audit MDS section J1400 of all current residents to identify any concerns- no other concerns identified 3.MDS co-coordinator or designee to audit section J monthly to identify any areas of inappropriate coding. 4.MDS co-coordinator will submit monthly reports to the QI department and identified trends will be reported to th e QAPI committee monthly. Compliance Date:	4/9/16
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 272		

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F 272	Continued From page 4 functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview for one (1) of 17 sampled residents, it was	F 272		

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F 272	Continued From page 5 determined that facility staff failed to accurately code Section J, ' Special Treatments and Programs ' of the Significant Change Minimum Data Set (MDS) for Resident #24. The findings include: A review of Resident #24 ' s clinical record revealed his/her diagnoses included Metastatic Colon Cancer, Hypertension, Glaucoma, and Chronic Kidney Disease. A ' Hospice Recertification ' form signed by the physician on November 4, 2015 included a statement that read, " Based on the patient ' s diagnosis and current condition, I expect this patient has a limited life expectancy of six (6) months or less ... " A review of the Significant Change MDS completed November 17, 2015, with an assessment reference date (ARD) of November 10 - 17, 2015 revealed that Section J, J1400, Prognosis was coded " no, " indicative that the medical record does not contain physician documentation that the resident is terminally ill. On February 25, 2016 at approximately 2:50 PM a face-to-face interview was conducted with Employee #9, the MDS Coordinator, regarding the coding of section J1400, Prognosis the significant change MDS dated November 17, 2015. Upon secondary review, Employee #9 acknowledged the aforementioned findings.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 6 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for nine (9) of 17 Stage 2 sampled residents and three (3) supplemental residents, it was determined that facility staff failed to develop comprehensive care plans with measurable goals, timetables and specific interventions to manage the discharge needs of residents. Residents' #20, 24, 37, 56, 62, 69, 84, 88, and 112. The findings include: The provider ' s ' Notice of Closure ' A review of the facility ' s documents revealed the facility provided a "Notice of Closure" letter signed	F 279	F279 1.Resident # 20,24,37,56,62,69,84,88 and 112- Discharge care plans initiated. 2.Current resident records audited to identify needs for discharge care plan- identified concerns corrected 3.Re-educate Social service department related to the need for discharge care plans and timely documentation of resident and family meetings related to discharge process. 4.Director of Social services or designee to audit upcoming discharge charts weekly x 4 then monthly x 3. Any identified trends will be reported to the QAPI committee monthly. Compliance Date	4/9/16

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by the Chief Executive Officer and dated November 3, 2015 (initial notification was September 15, 2015) addressed to all residents [and/or responsible parties] residing in the facility that read: "This letter serves each of you as your official notice of closure and the need to transfer or discharge to another location. Final closure will be December 15, 2016...We will assure the continuity of services by providing the receiving facility with assessment and care plan, and for discharge, by arranging for those services required by the post discharge plan..."

Pursuant to The District of Columbia ' s Transfer/Discharge statute - D.C. Law 6-108, the Nursing Home and Community Residence Facilities Protections Act, DC Code 44-1003.01 " ...Residents residing at the facility will undergo involuntary discharge as follows: Chapter 10. Nursing Homes and Community Residence Facilities Protections. Subchapter III. Discharge, Transfer, and relocation of residents. § 44-1003.01. Grounds for involuntary discharge, transfer, or relocation by facility. (a) Unless a resident and his or her representative consent otherwise, a facility may discharge the resident, transfer the resident to another facility, or relocate the resident from one part or room of the facility to another only:...(5) If the facility is closing or officially reducing its licensed capacity ... "

1. Facility staff failed to develop a discharge plan of care for Resident #20.

A review of Resident #20's clinical record revealed a social service progress note dated September 18, 2015 at 3:21 PM that read , "

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Spoke with [family member] about the closing of [facility]. S/he is interested in working with [family member] to find a place for [him/her] to live ....SE [southeast], NE [northeast] are a possibility. Also [local facility] is an option. Will continue to work with them to explore a safe discharge plan. "

A social service progress note dated November 9, 2015 at 4:37 PM read, "The formal letter to resident notifying [gender] of closure of [name of facility] in December 2016, has been placed in the chart. This letter has also been mailed to the resident's responsible representative."

The interdisciplinary team last updated Resident #20 ' s comprehensive care plan on January 22, 2016. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge.

A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016.

2. Facility staff failed to develop a discharge plan of care for Resident #24.

A review of social work progress notes revealed the following:

January 7, 2016 at 2:38 PM " Have been speaking with [family members named]. They have begun to look into facilities. The requested a referral to go to [facility named]. Called that facility

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and had Medical records send them a packet. The family is to visit other facilities ...but does not want referrals sent to them as yet ... "

January 14, 2016 at 4:09 PM " [family members named] are now actively working on placement. They visited [facility named] and felt that this was an acceptable place to transfer the resident ...spoke with admission coordinator and they don ' t have any LTC [long term care] beds. As asked, will check back ... "

The interdisciplinary team last updated Resident #24 ' s comprehensive care plan on November 17, 2015. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge.

A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016.

3. Facility staff failed to develop a discharge plan of care for Resident #37.

A review of Resident #37 's clinical record revealed the following Social Service progress note dated and timed 12:42 PM February 24, 2016; " On January 1/14/2016, [attendees named including responsible party(s)] met for the individualized discharge planning meeting. The resident had been denied by [Facility name] for admittance, so family had many questions about

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the reason. Per [responsible party] it was because of " aggressive behavior " so [attendee named] reviewed the resident ' s chart and spoke with the psychiatrist about behaviors. SW [social worker] explained the process of finding, applying, and being transferred to another facility. It was decided, after reviewing the facility ' s lists, that resident ' s [responsible party] was going to explore some out of state facilities. "

The interdisciplinary team last updated Resident #37 ' s comprehensive care plan on February 20, 2016. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge.

A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016.

4. Facility staff failed to develop a discharge plan of care for Resident #56.

A review of Resident #56 ' s clinical record revealed the following Social Services progress notes:

" October 26, 2015 11:26 AM: Care conference / discharge planning on10/14/15: The interdisciplinary team met with the resident and [his/her] RP [Responsible Party]. Care plans and medications were reviewed....RP is pleased with [his/her] family members care ...RP has visited nursing homes but has not made a decision

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where to apply. "

" December 17, 2015 15:32[3:32PM] Length of Stay discharge planning comment= Residents RP, has had many conversations with the social worker regarding [his/her] family member. RP feels that as long as [resident] is receiving good care, [he/she] will remain at [Name of facility]. SW [Social Worker] gave RP the list of DC [District of Columbia] nursing homes, which [she/he] used when [he/she] visited them ... RP told SW that [he/she] was not impressed with any of the homes. RP stated that [he/she] was instead working on getting extension until 6/2017 [June 2017]. "

" December 30, 2015 16:21 [4:21PM] Length of Stay discharge planning comments= On 12/30/15[at] 3:00 PM, the SW [social worker], SW Director, RP [responsible party] and [family member] met for a discharge assessment meeting. RP was given the Maryland and DC lists of nursing homes and a source book ..."

The interdisciplinary team last updated Resident #56 ' s comprehensive care plan on January 31, 2016. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge.

A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016.

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5. Facility staff failed to develop a discharge plan of care for Resident #62.

A review of Resident #62 ' s clinical record revealed the following Social Services progress notes:

" November 9, 2015 16:54 [4:54PM] General Social Services Comments = The formal letter to the resident notifying [him/her] of the closure of [Facility Name] in December 2016, has been placed in the chart. The letter has also been mailed to the resident's responsible representative. "

" December 18, 2015 14:38 [2:38PM] General Social Services Comments = Speak regularly to [family member]. [His/her] first choice had been for [facility name] for transfer ...Discussed with the [family member]. Explained that other options needed to be explored ...Will continue to follow and assist with planning ... "

February 26, 2016 at 14:35 [2:35 PM] " Formal discharge planning meeting was held on 2/4/16 ...[attendees listed, including family member] ...[family member] made it clear that [he/she felt that the only comparable transfer location for [Resident] would be [facility named] ...SW [social worker] offered to continue to have follow up informal and formal meetings ....[family member] said [he/she] would like to continue to meet .... "

The interdisciplinary team last updated Resident #62 ' s comprehensive care plan on December 15, 2015. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s

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F 279	Continued From page 13 impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 6. Facility staff failed to develop a discharge plan of care for Resident #69. A review of social worker progress notes dated February 3, 2016 revealed a care conference was conducted on February 3, 2016 to address the resident's continuing care needs and discharge planning. The resident and family member was in attendance. The interdisciplinary team last updated Resident #69 ' s comprehensive care plan on November 29, 2015. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 7. Facility staff failed to develop a discharge plan of care for Resident #84. A review of Resident #84 ' s clinical record	F 279		

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revealed the following Social Services progress notes:

November 12, 2015 at 17:31 [5:31PM]; " The RP [responsible party] has submitted [his/her] preferences. Medical records has sent records to [facility names] ...Will continue to follow for discharge plans. "

November 13, 2015 at 17:31 [5:31PM]; " The formal letter to the resident notifying [gender] of closure of [name of facility] in December 2016, was given and read to the resident. A copy has been placed in the chart. This letter has also been mailed to the resident ' s responsible representative. "

December 1, 2015 at 13:33 [1:33PM]; " RP has released medical records to [names of facilities] No bed matches yet ...SW to continue to follow for discharge planning ... "

The interdisciplinary team last updated Resident #84 ' s comprehensive care plan on February 1, 2016. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge.

A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016.

8. Facility staff failed to develop a discharge plan

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F 279	Continued From page 15 of care for Resident #88. A review of Resident #88 ' s clinical record revealed the following Social Services progress notes: November 9, 2015 at 16:50 [5:50PM]; " The formal letter to resident notifying [gender] of closure of [name of facility] in December 2016, has been placed in the chart. This letter has also been mailed to the resident's responsible representative. " November 20, 2015 at 16:07 [4:07PM]; " Left message for RP [responsible party] on this date, to discuss discharge planning. Await call back. " January 18, 2016 at 15:37 [3:37 PM]; " Placed follow up call to [RP name] ...Awaiting call back to discuss transition planning. " The interdisciplinary team last updated Resident #88 ' s comprehensive care plan on December 5, 2015. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016. 9. Facility staff failed to develop a discharge plan of care for Resident #112.	F 279		

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F 279	Continued From page 16 A review of Resident #112 ' s clinical record revealed the following Social Services progress note dated and timed November 11, 2015 at 12:49; " On November 6, 2015, the social worker hand delivered and read to the resident the official letter of closure of [name of facility]. " The interdisciplinary team last updated Resident #112 ' s comprehensive care plan on November 17, 2015. However, there was no evidence of a care plan that reflected problem identification, goals and approaches to address the resident ' s impending involuntary discharge. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged there was no discharge plan. The record was reviewed February 26, 2016.	F 279		
F 284 SS=E	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for seven (7) of seven (7) discharged sampled residents, it was determined that facility staff failed to develop a post-discharge plan of care to ensure the individual ' s needs will be met after	F 284	F284 1.Resident #12,40,96,100,101,107 and 118-previusly discharged 2. Audited current resident records to identify the need for Discharge Plan of Care-identified concerns corrected 3.New Interdisciplinary Discharge plan of Care form implemented. Educate IDT on completion of Discharge Plan of Care 4.Director of Social services or designee to audit upcoming discharge charts weekly x 4 then monthly x 3. Any identified trends will be reported to the QAPI committee monthly. Compliance Date	4/9/16

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discharge from the facility into the community. Residents ' #12, #40, #96, #100, #101, #107, and #118

The findings include:

A letter sent to the residents from the Chief Executive Officer and Administrator of the facility dated November 3, 2015, regarding the facility ' s closure stipulated; " This letter is to establish the next steps as required by the District of Columbia Model Resident Transfer and Discharge Plan for Nursing homes .... When you and your representative are ready to move, we will provide you with the following information: A written statement of the medical assessment and evaluation, and post-discharge plan of care ... "

A review of the District of Columbia official Code 2001 Edition, Division VIII. General Laws
Title 44. Charitable and Curative Institutions.
Subtitle I. Health Related institutions.
Chapter 10. Nursing Homes and Community Residence Facilities Protections.
Subchapter III. Discharge, Transfer and Relocation of Residents. §44-1003.04 Discussion and Counseling "Before a resident is voluntarily or involuntarily discharged, transferred to another facility or reacted within a facility, a facility representative shall discuss the reasons for the move with the resident and his or her representative and shall answer any questions they must have about the move or the written notice they received pursuant to §44-1003.02 (a). The contents of the discussion shall be summarized in writing, include the names of the individuals involved in the discussion and be made a part of the resident ' s clinical record. In addition, the facility representative shall strongly

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recommend and offer to provide counseling services to the resident and his or her representative before the move. If the resident has requested a hearing pursuant to §44-1003.03 (a), facility staff shall attempt to prepare the resident for the possibility of having to move on 3-day (for an intra-facility relocation) or 5-day (for a discharge or transfer to another facility) notice should the hearing decision not be in his or her favor."

1. Facility staff failed to develop a post discharge plan of care for Resident #12.

A review of Resident #12 ' s closed record revealed that the resident was admitted to the facility on April 2, 2013 and was discharged to another facility on December 22, 2015.

There was no evidence that facility staff developed a post discharge plan to assess Resident #12 ' s continued care needs and developed a plan of care designed to ensure the individual ' s needs would be met after discharge from the facility.

A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 1:00 PM regarding the aforementioned findings. He/she acknowledged there was no post discharge plan. The record was reviewed February 26, 2016.

2. Facility staff failed to develop a post discharge plan of care for Resident #40.

A review of Resident #40 ' s closed record revealed that the resident was admitted to the

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F 284	Continued From page 19 facility on January 14, 2015 and was discharged to another facility on November 23, 2015. There was no evidence that facility staff developed a post discharge plan to assess Resident #40 ' s continued care needs and developed a plan of care designed to ensure the individual ' s needs would be met after discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 1:00 PM regarding the aforementioned findings. He/she acknowledged there was no post discharge plan. The record was reviewed February 26, 2016. 3. Facility staff failed to develop a post discharge plan of care for Resident #96. A review of Resident #96 ' s closed record revealed that the resident was admitted to the facility on February 5, 2014 and was discharged to another facility on February 5, 2016. There was no evidence that facility staff developed a post discharge plan to assess Resident #96 ' s continued care needs and developed a plan of care designed to ensure the individual ' s needs would be met after discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 1:00 PM regarding the aforementioned findings. He/she acknowledged there was no post discharge plan. The record was reviewed February 26, 2016.	F 284		

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F 284	Continued From page 20 4. Facility staff failed to develop a post discharge plan of care for Resident #100. A review of Resident #100 ' s closed record revealed that the resident was admitted to the facility on December 3, 2013 and was discharged to another facility on December 11, 2015. There was no evidence that facility staff developed a post discharge plan to assess Resident #100 ' s continued care needs and developed a plan of care designed to ensure the individual ' s needs would be met after discharge from the facility. 5. Facility staff failed to develop a post discharge plan of care for Resident #101. A review of Resident #101' s closed record revealed that the resident was admitted to the facility on December 27, 2013 and was discharged to another facility on February 26, 2016. There was no evidence that facility staff developed a post discharge plan to assess Resident #101 ' s continued care needs and developed a plan of care designed to ensure the individual ' s needs would be met after discharge from the facility. 6. Facility staff failed to develop a post discharge plan for Resident #107. A review of Resident #107 ' s closed record revealed that the resident was admitted to the facility on July 22, 2014 and was discharged to another facility on October 12, 2015.	F 284		

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The resident ' s discharge date was prior to the facility ' s closure letter sent to the residents. However, there was no evidence that facility staff developed a post discharge plan to assess Resident #96 ' s continued care needs and developed a plan designed to ensure the individual ' s needs would be met after discharge from the facility.

A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 1:00 PM. He/she acknowledged that there was no post discharge plan. The record was reviewed February 26, 2016.

7. Facility staff failed to develop a post discharge plan for Resident #118.

A review of Resident #118' s closed record revealed that the resident was admitted to the facility on June 19, 2015 and was discharged to another facility on December 6, 2015.

The resident ' s discharge date was prior to the facility ' s closure letter sent to the residents. However, there was no evidence that facility staff developed a post discharge plan to assess Resident #118's continued care needs and developed a plan designed to ensure the individual ' s needs would be met after discharge from the facility.

A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 1:00 PM. He/she acknowledged that there was no post discharge plan. The record was reviewed February 26, 2016.

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 17 stage 2 sampled residents, it was determined that facility staff failed to provide the necessary care and services to ensure residents attain or maintain the highest practicable state of well-being as evidenced by failure to perform pain assessments and re-assessments prior to and after the administration of " as needed " [prn] pain medication and failed to clarify physician ' s orders for the prescribed indication for use of Morphine [analgesic medication] for one (1) resident; and failed to administer a pneumococcal vaccine and follow through with timeliness on a physician ' s order for a speech evaluation for one (1) resident. Resident ' s #24, and #92. The findings include: 1. Facility staff failed to perform pain assessments prior to and following the administration of " as needed " [prn] pain medication [Morphine - an Opioid analgesic medication.] and failed to clarify physician ' s	F 309	1.Resident # 24-order for morphine clarified 2/25/16 to be for dyspnea/pain. 2. Audit conducted 3/10/16 of prn medications to identify appropriate indication- no other concerns identified Audit completed 3/3/16 to identify any residents requesting pneumonia vaccine-identified concerns corrected 3. Re-educate Licensed nursing staff on medication indications and pain assessment 4. Unit Manager or designee to audit prn medication administration and pre and post pain assessment weekly x4 then monthly x 3 and report any identified trends to the QAPI committee monthly 5.Compliance Date 2. Resident # 92 seen by ST on 2/26/16. To be followed to determine appropriateness of diet upgrade. 2. Audit conducted of current orders for ST-no other concerns noted 3.Re-educate Licensed Nursing staff on24 hour chart check policy and procedure 4. 11-7 Supervisor to audit new written orders nightly to identify appropriate follow through. Audits to be forwarded to the Unit Managers for review. Any identified trends will be reported to the QAPI committee monthly 5. Compliance date	4/9/16 4/9/16

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orders for the prescribed 'indication for use' of Morphine.

A.. Facility staff failed to conduct pain assessments prior to and following the administration of " prn " Morphine.

A review of the facility policy titled, " Pain Management " Revised July, 2015 states under the section titled ' Purpose, ' " To relieve or decrease the level of the resident ' s/patient ' s pain. 1). Pain assessment ...3) pain evaluation ... " In section ' II ' titled ' Pain Assessment - Administration of Pain Medications. ' a. Prior to administration of PRN [as needed] medications for pain, the licensed nurse must assess the resident ' s/patient level of pain using a quantitative scale ...A Progress Note with the quantitative pain measurement documented in the note, must be entered in the EMR [electronic medical record] under the category of Pain management. One hour (or earlier if the resident/patient voices concern) following the administration of the PRN pain medication the licensed nurse must re-assess the resident ' s/patient ' s level of pain using the quantitative scale ... "

A review of the clinical record revealed that Resident #24 ' s diagnoses included Metastatic Colon Cancer.

A Physician's progress note dated January 27, 2016 revealed, " ...Pain 2/2 [secondary to] Cancer: well controlled w/ [with] methadone [narcotic pain medication] and PRN [as needed] morphine [narcotic pain medication]. "

The " Physician's Order Sheet " dated February

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1, 2016 directed the administration of Morphine Sulfate solution, " give 60mg (milligrams) under the tongue as needed, every hour for dyspnea " [shortness of breath].

On February 24, 2016 at approximately 2:10PM, a face-to-face interview was conducted with Employee #11, the nurse for Resident #24. When asked why Resident #24 was receiving Morphine, Employee #11 stated, "The resident receives Morphine for pain. Morphine was typically given prior to wound care." The employee was asked how pain was assessed for Resident #24. Employee #11 stated, "When the resident is in pain, I see it on [his/her] face. " When asked where the effectiveness of the medication is documented, Employee #11 stated, " We do not always document the effectiveness. "

A review of the " Electronic Medication Administration Record (EMAR) " for February 2016 revealed the following:

Morphine was administered on February 14, 2016 at 11:00AM for pain. The result was documented as " Effective. "

Morphine was administered on February 23, 2016 at 11:42 AM for pain. The result is documented as " effective. "

Morphine was administered on February 24, 2016 at 10:42 AM, however the reason documented was "Given as ordered." The result was documented as "effective no pain"

A review of the nursing notes and the pain management notes lacked documented evidence that pain assessments were performed prior to,

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and after the administration of PRN (as needed) pain medication.

On February 25, 2016 at approximately 4:45 PM, a face-to-face interview was conducted with Employee #4. He/she acknowledged the aforementioned findings. The record was reviewed on February 24, 2016.

B. Facility staff failed to clarify the prescribed ' indication for use ' of Morphine an Opioid analgesic medication.

A review a physician ' s progress note signed and dated November 24, 2015, in the section titled HPI (history and physical information) revealed, " ...prn [as needed] morphine sulfate for dyspnea, for pain uses [approximately] 4 [times] a month usually [with] dressing [changes] ... "

A Physicians progress note dated January 27, 2016 revealed, " ...Pain 2/2 [secondary to] Cancer: well controlled w/ [with] methadone and PRN [as needed] morphine [narcotic pain medication]. "

The " Physician Order Sheet " dated February 1, 2016 directed that the resident was prescribed Morphine Sulfate solution, " give 60mg (milligrams) under the tongue as needed, every hour for dyspnea. " The order was initially ordered July 8, 2015.

On February 24, 2016 at approximately 2:10PM, a face-to-face interview was conducted with Employee #11, the nurse for Resident #24. When asked why Resident #24 was receiving Morphine, Employee #11 stated that the resident

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received Morphine for pain.

The physician ' s order lacked evidence that the Morphine was to be administered as needed for pain.
Facility staff failed to clarify the prescribed indication for use for ' as needed ' Morphine.

On February 25, 2016 at approximately 4:45 PM, a face-to-face interview was conducted with Employee #4. He/she acknowledged the aforementioned findings. The record was reviewed on February 24, 2016.

2. Facility staff failed to administer Resident #92's pneumococcal vaccine in accordance with physician's orders and failed to follow through with timeliness on a physician 's order for a speech evaluation.

A. Facility staff failed to administer Resident #92's pneumococcal vaccine in accordance with physician's orders.

A " Physician ' s Order Sheet " dated February 5, 2016 directed, " Pneumovax 23 (Pneumococcal 23-Valps Vaccine), Injectable, 25mcg (micrograms) /05ml (milliliters): Inject 0.5 ml Intramuscular as needed for immunization.

A review of the Medication Administration Record (MAR) for February 1-26, 2016 revealed the Pneumovax was not administered.

It was further determined through review of the electronic clinical record and the immunization history form that Resident #92 was not administered the pneumococcal vaccine.

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THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

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There was no evidence that facility staff offered and/or administered the Pneumovax to Resident #92 in accordance with physician's orders.

A face-to-face interview was conducted with Employee #4 and Employee #8 on February 24, 2016 at approximately 11:00 AM. Both acknowledged the aforementioned finding. The clinical record was reviewed on February 24, 2016.

B. Facility staff failed to follow through with timeliness on a physician's order for a speech evaluation for Resident #92.

An " Interim Order Form " dated January 8, 2016 at 11:30AM directed, " Speech screen for upgrade in diet consistency, especially the meat items per resident ' s request. "

A review of the speech section of the clinical record revealed the most recent speech screen/evaluation was October 1, 2015.

The clinical record lacked evidence of a speech evaluation subsequent to October 1, 2015.
A face-to-face interview was conducted with Employee#4 on February 25, 2016 at 3:00 PM. He/she acknowledged that the speech therapist had not seen the resident.

A follow-up interview was conducted with Employee #19 on February 24, 2016 at approximately 3:30 PM regarding the aforementioned order. He/she acknowledged the finding and further stated, " I never received the consult for an evaluation. However, I will follow-up. "

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F 309	Continued From page 28 Facility staff failed to follow through with timeliness on a speech evaluation, until brought to their attention during the survey process. A period of 30 days lapsed before the evaluation occurred. There was no evidence that the resident exhibited any nutritional status deficits secondary to the delay. The clinical record was reviewed on February 24, 2016.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on observations, record review and staff interview for one (1) of 17 sampled residents, it was determined that facility staff failed to ensure that the resident environment remained as free from accident hazards as is possible and that adequate supervision was provided in order to enhance safety and reduce the risk of an accident as evidenced by one (1) resident who sustained a fall with injury. Resident #54 The findings include: On February 26, 2016 at approximately 9:00 AM, Employee #2 informed the survey team that Resident #54 sustained a fall with injury " this	F 323	F323 1. Resident #54 returned from hospital, assessed and monitored x 72 hours with no negative outcomes 2.Reviewed all residents with fall with injury in the last 30 days to identify concerns related to hazards in the environment-no identified concerns, areas noted to be free of safety hazards 3.All resident rooms will be inspected During weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern related to safety hazards -loose carpet, exposed electrical wiring, surge protectors unmounted 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trends to the QAPI committee Monthly 5.Compliance Date	4/9/16

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F 323	Continued From page 29 morning " and was sent to a local hospital for emergency treatment via ambulance. A review of the facility ' s incident report titled, " Incident Details, " documented by nursing staff, dated February 26, 2016 at 4:48 AM read as follows: " Around 2:48 AM there was a sound from resident ' s room, writer and the assigned CNA [certified nursing assistant] rushed to the room where resident was found on the floor in sitting position leaned on [his/her] right side noted with blood all over [his/her] face. Resident alert and oriented x3 [person, place, time], resident stated to writer [he/she] fell from chair and hit [his/her] head on the floor. Supervisor made aware and came to the unit. Resident noted with laceration on [his/her] forehead ...and laceration on left eyebrow ....pressure dressing applied to the sites. Resident denied back and neck pain at this time, pupils react to light equal. Active and passive ROM [range of motion] with normal limit to all extremities. Dr [named] notified and new order received to transfer resident to hospital ER [emergency room ' for further evaluation and treatment. 911 [emergency medical services] called and resident was transferred to hospital [named] ER at around 3:25 AM ... " {SIC} On February 26, 2016 at approximately 9:30 AM, an observation was conducted of Resident #54 ' s room. The room was observed cluttered. Multiple items were noted scattered along the floor surface and the bed was covered with personal belongings. For example the observations included but was not limited to the following: A dining tray was noted lying upside down on the floor proximal to the room entrance, blocks of wood, long rolls of paper, plastic containers, cans, a towel and a blow dryer were observed on	F 323	F323 2. Surge protectors in rooms 208 and 323 re- mounted 3. Carpet in hall of blue pod-tightened 4.Call light replaced in room 104 2.Evaluated other resident rooms with no identified concerns of exposed electrical wiring/surge protectors not mounted and loose carpeting 3.All resident rooms will be inspected During weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern related to safety hazards-loose carpet, exposed electrical wiring, surge protectors unmounted 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trends to the QAPI committee Monthly 5.Compliance Date	4/9/16

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the floor surface posing a potential trip hazard and an unsafe environment. The room had three (3) free-standing garment racks, three (3) stationary chairs, one (1) wheelchair and a rolling cart similar to a shopping cart filled with items. Resting atop the rolling cart was a carpenter-style hand saw approximately 15 - 18 inches in length readily accessible to anyone entering the room. The private bathroom was filled with clutter including large plastic bags and plastic containers. The toilet and sink were not accessible because the entryway and space was blocked with items.

On February 26, 2016 at approximately 10:15 AM, during the observation of Resident #54 ' s room, the resident appeared in the doorway lying on a stretcher accompanied with private ambulance transporters. A gauze bandage was observed on his/her forehead and alongside the left eyebrow. He/she stated " what ' s going on ...why are you in my room, get out of my room. " When greeted, Resident #54 responded in the affirmative to his/her name and stated " fine " in response to the query, " How are you? " The resident was advised regarding the survey process and the purpose for observing his/her room. The resident further verbalized " take me to my room, my room is fine. "

A review of the quarterly Minimum Data Set [MDS] dated November 26, 2015 [assessment reference date (ARD) 11/19 - 26/2015] under Section I, Active Diagnoses revealed Resident #54 ' s diagnoses included Hypertension, Peripheral Vascular Disease, Cerebrovascular Accident, Neuralgia and Depression. Section G, Functional Status was coded as the resident utilized a wheelchair for mobility, required limited

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F 323	Continued From page 31 assistance for transfer between bed and chair, supervision for locomotion and limited assistance for toilet use; G0400, Functional Limitation in Range of Motion was coded as " B1, " indicative of impairment on one side of the lower extremity. Section C, Cognitive Patterns revealed the resident was moderately cognitively impaired with a score of " 9 " in the Brief Interview for Mental Status. Section E, Behavior was coded as Delusions, verbal behavioral symptoms directed toward others occurred 4 to 6 days out of seven days and rejection of care occurred daily. A review of the most recent psychiatric consultation dated December 22, 2015 revealed Resident #54 ' s mental health diagnoses included Major Depression and severe Obsessive Compulsive Disorder with significant Hoarding. The psychiatric follow up note dated December 22, 2015 included: " [Resident named] has a long history of depression and obsessive compulsive disorder. There has been a history of agitation with both verbal and physical aggressiveness, particularly when [Resident] is confronted about [his/her] hoarding or any of [his/her] habits. Staff has spent a great deal of time developing a treatment plan for [Resident] trying to accommodate [his/her] whishes while also making sure that [his/her] room was safe ...of note is that while [his/her] room is quite cluttered with unnecessary paraphernalia, the room in passable and safe for easy entry and exit (a difference from the past) ... " A review of the comprehensive care plan for Resident #54 revealed the interdisciplinary team [IDT] updated the plan on November 17, 2015 and updated the problem area related to " Falls " on February 26, 2016. The following problem	F 323		

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F 323	Continued From page 32 areas [including but not limited to] were identified by the IDT: " Problem: Falls - potential for falls related to history of falls. Goals: resident will have no injury related to falls in the next 90 days. Approaches: give resident verbal reminders to ask or call for assistance when [he/she] needs it ...have staff clear bed each evening of all belongings, if [he/she] will permit it to allow resident choice of sleeping in bed or chair. This may prevent [him/her] from falling from chair when [he/she] is sleeping .... " Under the evaluation section dated 9/14/15 " had a fall from wheelchair; abrasion noted on LUA [left upper arm]. Bacitracin ordered till healed. Probably fell asleep in chair, where [he/she] sleeps most of the time. Clutters bed so that [he/she] can ' t go to bed and sleep. This is [his/her] normal routine sitting up in chair and sleeping. Refuses to go to his bed even when offered to remove clutter from bed ... " " Problem: Behavior problem - Resident displays inappropriate behavior when [he/she] is asked to make [his/her] room more tidy, to remove excess items from room and when [he/she] is denied access to things [he/she] wants to do; resident exhibits inappropriate behavior toward staff as evidenced by verbal and physical abuse when asked to tidy up room or does not get [his/her] way; pillaging and hoarding. Goals: resident will decrease episode of inappropriate behavior ...will not display verbal and/or physical abuse towards staff ...pillaging and hoarding will not negatively impact self or others through next review. Approaches: allow resident to be aware of the harmful items that will be removed ...check for harmful items weekly and remove from room, report the resident informed refusal of having the	F 323		

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harmful items removed to the family members. Evaluation: continues to have verbally abusive outbursts ...refuses psyche meds [psychotherapeutic medications] as well as other meds at times, still gets upset and agitated at times especially when it comes to referencing room cleaning ...Still gets very angry and agitated at times when staff tell [him/her] [he/she] can ' t do certain things ... "

" Problem: Noncompliance to calling for assistance with transfers and ADLs [activities of daily living]. Goal: resident will adhere to calling for assistance when needed with transfers and ADLs. Approaches: praise resident for demonstrating desired behavior, discuss with resident implications of not complying with therapeutic regime Evaluation: remains non-adherent to calling for assistance with transfers and ADLs. Attempts to do things for [him/herself] but not able to, so when staff see [him/her] struggling, they assist ... "

" Problem: Mood State, resident continues to hoard and store too much in room, causing safety issues. Goal: room will be tidy and less congested. Approaches: monitor room for tidiness ...solicit friends or family to help [him/her] pare down [his/her] belongings. Evaluation: limits have been placed on [him/her] to remove the trash and clean up the room. [He/she] straightens it up a little and before many hours have passes the room looks horrible ... "

A review of the behavior monitoring records for the period of January 1, 2016 to February 26, 2016 revealed that nursing staff documented three times daily regarding the occasions that Resident #54 exhibited combativeness and/or

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medication non-compliance. The records revealed " no problem behaviors noted " for the review period with the exception of January 16, 2016 at 6:43 AM when the resident exhibited an episode of screaming when he/she wanted a drink from the refrigerator.

A review of nursing notes for February 25 and 26, 2016 (the day prior to and of the fall incident) read as follows:

February 25, 2015 at 7:53 AM " resident remain alert and verbally responsive, no complain of pain or any discomfort, status post [S/P] ABT [antibiotic medication] ...no adverse reaction noted. Will continue with plan of care. "

February 25, 2016 at 18:07 [6:07 PM] " S/P ABT for [diagnosis recorded]. No adverse reactions noted PO [oral] fluids encouraged. Resident refused both breast to be assessed, MA [physician] aware. Denied any pain/discomfort. No concern verbalized. " {SIC}.

February 25, 2016 at 19:29 [7:29 PM] " Patient had quiet evening. ADLs [activities of daily living] provided. Patient tolerated due medication and feeding well. No acute distress noted. Post ABT therapy. "

February 26, 2016 at 00:38 [12:38 AM] " Resident remain alert and stable, status post ABT ...no adverse reaction noted. "

February 26, 2016 at 03:37 [3:37 AM] " Transfer to emergency department 2/26/16 03:35 [3:25 AM]. Fall related minor injury ... "

A review of the facility ' s document detailing "

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F 323	Continued From page 35 Resident Rights " included in the admission packet, included but was not limited to the following: " Your rights as a resident ...you have the right to exercise you rights as a resident of this facility and as a citizen or resident of the United States ...you have the right to retain and use personal possessions including some furnishings, and appropriate clothing as space permits, unless to do so would infringe upon the rights or health and safety of other residents. A face-to-face interview was conducted with Employee # 25 on February 26, 2016 at approximately 10:45 AM. He/she stated that Resident #54 had a long history of hoarding behaviors and that it was challenging to get him/her to be compliant. He/she was seen by the psychiatrist recently. The family, facility administration and the Long Term Care [LTC] Ombudsman have participated in meetings involving concerns with this resident and related behaviors. A face-to-face interview was conducted with Employee #26 on February 26, 2016 at approximately 11:00 AM. He/she stated that Resident #54 most often sleeps in the chair. That is his/her preference. He/she does not like people to change his/her room and prefers his/her bed cluttered. He/she verbalized that Resident #54 had a long history of challenging behaviors and that the facility administration was directly involved with managing his needs. A face-to-face interview was conducted with Employee #1 on February 26, 2016 at approximately 1:00 PM. He/she was aware of the hoarding behaviors of Resident #54 and that the facility was trying to balance the rights of the	F 323		

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resident and safety of the resident and others. He/she stated that dangerous items such as an electric drill and lumbar have been removed from the resident ' s possession. He/she was unaware that Resident #54 had a hand saw in his/her room.

Resident #54 had a documented history of behavioral challenges and hoarding practices that the interdisciplinary team identified and recommended approaches for managing. The IDT identified an approach to " have staff clear bed each evening of all belongings, if [he/she] will permit it to allow resident choice of sleeping in bed or chair. This may prevent [him/her] from falling from chair when [he/she] is sleeping " There was no evidence that staff implemented measures to clear the resident ' s bed so that he/she may sleep in it on February 26, 2016. The resident reportedly fell from sleeping in a chair and sustained lacerations to the head and face. There was no evidence in the behavior monitoring records and/or nursing notes that Resident #54 exhibited noncompliance and/or refusals on or about February 26, 2016, the day of the fall with injury. There was no evidence that the resident ' s bed was cleared so that he/she could sleep in it. Additionally, observations of the resident ' s room during the period that he/she was out of the facility obtaining medical treatment at a local emergency department on February 26, 2016, revealed that the resident ' s bed surface was filled with clutter, the room floor had items scattered across the surface posing a trip hazard and a hand saw was readily accessible to whomever entered which posed a potential accident hazard.

Facility staff failed to ensure that Resident #54 ' s

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room was free from accident hazards and that the resident, who was assessed as moderately cognitively impaired, was adequately supervised as to prevent accidents.

The record was reviewed February 26, 2016.

B. Based on observations made on February 22, 2016 between 11:30 AM and 3:00 PM, it was determined that the facility failed to provide an environment that is free from accident hazards as evidenced by surge protectors that were not mounted in two (2) of 38 resident rooms, a loose carpet on one (1) of three (3) pods on the third floor and a cluttered resident room was observed with a hand saw.

The findings include:

1. The surge protector was not properly mounted and was observed on the floor in two (2) of 38 resident rooms. (#208 and #323).
2. The carpet in the hallway of unit 3A (blue pod) was loose and presented a tripping hazard.
3. Resident room #323 was cluttered with numerous items such as nails, screws, pieces of wood and metal that were scattered throughout and presented an accident hazard to the resident, staff and visitors, one (1) of 38 rooms surveyed.
4. The call bell in one (1) of 38 resident rooms surveyed was torn (#104) exposing the electrical wiring.

These observations were made in the presence of Employee #22 and Employee #23 who acknowledged the findings.

An isolated observation conducted on February 26, 2016 at approximately 10:00 AM revealed that

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F 323	Continued From page 38 a carpenter-style hand saw approximately 15 - 18 inches in length was observed in one (1) resident room, resting atop a push cart readily accessible to anyone entering the room which posed a potential accident hazard. The findings were acknowledged by Employee #26 at approximately 10:05 AM on February 26, 2016.	F 323	F329	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329	1.Resident # 24 behavior monitoring added to TAR, MD addressed usage of medication 2. Audited current residents utilizing psychotropic medications to identify need for behavior monitoring.-identified concerns corrected 3.Unit managers to audit behavior monitoring for psychotropic medications weekly x4 and when ever a psychotropic medication change occurs. Any identified trends will be reported to the QAPI committee monthly, Compliance Date:	4/9/16

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Based on record review and staff interview for one (1) of 17 stage 2 sampled residents, it was determined that facility staff failed to ensure that one (1) resident was free of unnecessary medications as evidenced by a failure to consistently monitor psychopharmacological medications for Resident #24.

The findings include:

A review of the clinical record revealed that Resident #24 ' s diagnoses included Metastatic Colon Cancer, Anxiety, and Depression.

The " Physician's Order Sheet " dated February 1, 2016 revealed Resident #24 ' s medication regimen included the following:

1. Ativan [anxiolytic] 0.25mls [milliliters] sublingual [under the tongue] every 12 hours for anxiety/seizure.

2. Celexa [antidepressant] 20mg [milligram], 1 tablet by mouth, 1 time a day for depression

A review of the Electronic Medication Administration Record (EMAR) for February 2016 revealed that Ativan was given every day at 9:00AM and 9:00PM between February 1, 2016 and February 24, 2016. Celexa was given every day at 9:00AM between February 1, 2016 and February 24, 2016.

A review of the clinical record lacked documented evidence of behavior monitoring in the section of the Electronic Medical Record (EMR) dedicated to documenting behaviors, or in the nursing progress notes.

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F 329	Continued From page 40 On February 24, 2016 at approximately 2:10PM, a face-to-face interview was conducted with Employee #11. When asked what behaviors were exhibited by Resident #24, he/she stated that the resident is agitated at times, [uses profanity] and calls the staff names. When asked where that information is documented Employee #11 stated that they don ' t always document those behaviors. On February 24, 2016 at approximately 2:25 PM a face-to-face interview was conducted with Employee #4 regarding the aforementioned findings. He/she acknowledged the findings. There was no evidence that facility staff monitored Resident #24 ' s target symptoms; therapeutic effectiveness and/or potential adverse consequences of the resident ' s anxiolytic and antidepressant medications. . The record was reviewed on February 24, 2016.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 334	F334 1. All current residents that had previously declined or unsure of vaccination were reoffered the vaccine 2. Audit completed 3/3/16 to determine all current resident immunization status 3. All immunization status is current 4.All immunization status is current, due to closing of facility will not require readdressing 5.Compliance Date:	4/9/16

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(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive

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the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview for 15 of 17 Stage 2 sampled residents and 35 supplemental residents, it was determined that facility staff failed to ensure that the immunization program included a method to track the status of pneumococcal immunization for eligible residents and determine those residents who might benefit from pneumococcal revaccination. Residents' #7, 20, 24, 26, 39, 54, 69, 72, 74, 75, 84, 86, 92, 101 and 112. Supplemental residents' # 1, 5, 16, 18, 23, 27, 28, 30, 31, 42, 43, 44, 45, 48, 49, 50, 51, 52, 55, 56, 58, 59, 62, 63, 64, 68, 71, 81, 87, 91, 97, 106, 113, 115 and 117.

The findings include:

A review of the facility ' s Immunization Protocol [Effective date July 2002 and last reviewed July 2012] revealed:

"Policy: The Washington Home will provide education to residents and family regarding the importance of the pneumococcal...vaccines as well as administration and documentation of

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vaccines. Procedure: 4) ...If the consent box is not checked then the admitting nurse of Clinical Manager contacts the responsible party to determine why the resident is not to receive the immunizations. The Clinical Manager or admitting nurse will discuss the importance of the vaccination program to the health of the resident, of other residents, and the staff in the building. If the answer is still no, the admitting nurse or Clinical Manager contacts the medical staff so that the further discussions with the resident/responsible party take place. 5) When the resident receives the vaccinations this information is entered into the resident immunization record. 6) Resident immunization status will be reviewed every 60 days. Their status will be placed on the physicians round sheet ...8) Weekly monitoring of the immunization status as updated on the HCFA 672 Form ... "

A review of the facility ' s immunization program lacked evidence that resident ' s pneumococcal vaccination status was monitored on an ongoing basis. Additionally, there was no evidence that a monitoring mechanism was in place to determine whether or not residents were eligible for and should be offered an opportunity for revaccination.

A face-to-face interview was conducted with Employee #3 on February 26, 2016 at approximately 9:20 AM. In response to a query regarding the vaccination status of residents in the facility, he/she requested additional time to obtain the information. At approximately 1:30 PM, Employee #3 produced a line listing of some residents that had received the pneumococcal from data that was available via the facility ' s electronic medical record system. However; s/he

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F 334	Continued From page 44 stated that he/she would need to manually review archived records to obtain data on all eligible residents. Employee #3 acknowledged that there was no mechanism currently in place to monitor and/or track pneumococcal immunization status of residents. The immunization records for the 15 Stage 2 sampled residents and 35 supplemental residents reviewed; indicated that they were eligible for the pneumonia vaccination and/or revaccination, however; there was no evidence that the facility developed a mechanism for consistently tracking his/her pneumonia vaccination status. The records were reviewed February 26, 2016.	F 334	F371 1.No residents directly affected 1.Food items undated were discarded 2. Steam table steam wells have been corrected and properly cleaned. 3. Fryers properly cleaned 4. Water inlet valve to juice machine properly reported to Maintenance, machine has since been taken out of service as it is no longer needed for service. 5. Tilt Skilled lid handle properly reported to Maintenance, equipment taken out of service until properly repaired 6. Plastic cover to sugar storage bin	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations that were made during a tour of the dietary services on February 22, 2016 at approximately 9:45 AM, it was determined that the facility failed to store, prepare and serve food under sanitary conditions as evidenced by nine (9) of nine (9) plates of chicken salad, one (1) of one (1) tray of macaroni salad, a quarter pan of	F 371	replaced. 3/3/16 7. On/off control valve of tilt skilled properly reported to Maintenance, equipment taken out of service until properly repaired. 8. Storage scoops properly cleaned for sugar and flour bins 9. Convection Ovens cleaned of food debris	

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cooked broccoli and one whole pan of cooked chicken breast that were not dated , eight (8) of eight (8) steam wells and two (2) of two (2) grease fryers that were soiled, a leaking inlet valve to one (1) of one (1) juice machine, a leaking control valve to one (1) of one (1) tilt skillet, a missing handle to one (1) of one (1) tilt skillet and a broken plastic cover to one (1) of one (1) sugar storage bin.

The findings include:

1. Nine (9) of nine (9) plates of chicken salad with tomatoes and crackers, stored in refrigerator box #7 were not dated.

2. One (1) of one (1) tray of macaroni salad, a quarter pan of cooked broccoli and one whole pan of cooked chicken breast stored in the walk-in refrigerator were not dated.

3. Eight (8) of eight (8) steam wells from two (2) of two (2) steam tables were soiled with food residue.

4. Two (2) of two (2) grease fryers were soiled with leftover fried food residue.

5. The water inlet valve to one (1) of one (1) juice machine was leaking.

6. The on/off control valve to one (1) of one (1) tilt skillet was leaking.

7. The handle from the lid cover to one (1) of one (1) tilt skillet was missing.

8. One (1) of two (2) plastic covers to one (1) of one (1) sugar storage bin was broken and a piece

F 371

F371 cont
3. Opening and closing checklist to be completed daily and forwards to the Dining Services Director for review. On the spot corrections to be completed as appropriate.
1.Addressed proper labeling and dating procedures with all team associates by conducting the following: Completed 2/23/16
- All staff mandatory in-service on "Labeling & Dating Procedures" on 2/23/16.
- Instituted department Opening and Closing checklists with emphasis on inspecting all food products with proper label & date.
- Implemented closing check out procedures for each team member. All staff will be properly checked out by a Manager or Supervisor in their respective area to ensure that all products is properly labeled and dated before end of shift.

2.The following procedures have been implemented addressing this area: Steam table cleaning 2/29/16
- Daily clean-up of steam wells after each meal service updated in position job flow.
- Supervisor and Management inspection taking place after each meal period and end of shift.

3.Manager reviewed proper procedures for cleaning fryers with staff for cleaning and maintaining. Completed 3/1/16

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F 371	Continued From page 46 of that cover was missing. 9. Two (2) of two (2) scoop storage containers were soiled at the bottom with excess sugar and flour. 10. Two (2) of two (2) convection ovens were soiled with burnt food deposits. These observations were made in the presence of Employee #20 and Employee #21 who acknowledged the findings.	F 371	F 371 cont 4. Water inlet valve to juice machine properly reported to Maintenance, machine has since been taken out of service as it is no longer needed for service. 5. Tilt Skilled lid handle properly reported to Maintenance, equipment taken out of service until properly repaired 6. Plastic cover to sugar storage bin replaced. 3/3/16 7. On/off control valve of tilt skilled properly reported to Maintenance, equipment taken out of service until properly repaired. 8. Storage scoops placed on weekly cleaning rotation in sanitation schedule. Completed 3/1/16 9.Convection Ovens placed on weekly and monthly cleaning & sanitation schedules. Completed 3/1/16 4.Dining Services Director will review Daily Checklist inspections weekly and report any identified trends to the QAPI committee monthly 5. Compliance Date	4/9/2016
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for one (1) of 17 stage 2 sampled residents, it was determined the physician failed to review the total program of care for Resident #69 as evidenced by a failure to act on a consulting specialists ' recommendation to initiate rehabilitation services. The findings include:	F 386		

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F 386	Continued From page 47 Random observations of Resident #69 during the survey period, February 22 through 26, 2016 revealed the resident stayed mostly in his/her room in the bed. The resident was interviewed during the Stage I phase of the survey process and verbalized he/she was able to make his/her needs known. During the interview, he/she stated that staff would assist him/her to get out of bed when he/she wanted; however had no desire to get out of bed at the time of the interview on February 23, 2016 at approximately 1:00 PM. According to the physician ' s progress note dated November 24, 2105, Resident #69 ' s diagnoses included Schizophrenia, Depression, Cerebrovascular Disease, status post Cerebrovascular accident with right sided weakness. A psychiatric follow up note dated February 9, 2016 included the following: " [Resident named] ...has noted recently that [he/she] has spent more time in [his/her] room than usual. While [he/she] will say that [he/she] goes out " once a day " the staff reports that [he/she] is resistant to get dressed and go outside of [his/her] room despite many invitations and encouragements. [Resident] denies being depressed ...[he/she] is pleasant most of the time but that [he/she] does not like to change [his/her] routine ....recommendations ...if available, would restart the physical therapy with [Resident] as [he/she] will otherwise develop muscle weakness ... " A review of physician progress notes and physician orders lacked evidence that the physician/medical team acted on the psychiatrists ' recommendation to initiate rehabilitation [rehab] services for Resident #69. There was no	F 386	F386 1.Resident #69-Therapy attempted screen of 2/26- resident refused therapy intervention 2.Audit current psych evaluations to identify needed recommendations- no concerns identified 3. Designated clipboard placed on Units for MD to review consults prior to filing within the chart to ensure recommendations are seen. 4.Unit manager or designee to audit psych consults weekly x 3 then monthly x 3 to evaluate recommendations. Any identified trends will be reported to the QAPI committee monthly Compliance Date	4/9/16

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F 386	Continued From page 48 documentation by the physician/medical to indicate that he/she was aware of the recommendation or that he/she disagreed with the recommendation. A face-to-face interview was conducted with Employee #19 on February 25, 2016 at approximately 3:00 PM. In response to a query regarding rehabilitative services for Resident #69, he/she stated that physical, occupational and speech therapy services are available but that he/she had not received a request or referral for rehab services for the resident. A face-to-face interview was conducted with Employee #4 on February 25, 2016 at approximately 12:30 PM. The employee stated that he/she was unaware of a request for rehab services for Resident #69 but advised that he/she would inquire with the physician regarding rehab. The record was reviewed February 25, 2016.	F 386		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	F431 1.No resident affected –expired medication disposed of 2/26/16 2.Medication refrigerators on all Units checked for expired medication- no concerns noted 3. Unit Managers to audit expiration dates in the medication refrigerators weekly 4.Any identified trends to be reported to the QAPI committee monthly Compliance Date	4/9/16

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F 431	Continued From page 49 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility failed to ensure that medications were not stored beyond the manufacturer's expiration date in one (1) of three (3) Medication Rooms observed. The findings include: On February 25, 2016 at approximately 11:00 AM, during an inspection of Unit 1A (the locked medication refrigerator), three (3) of three (3) boxes of Pneumovac- Pneumococcal Vaccine Polyvalent-10 single- dose- 0.5ml (millimeters) vials were observed with an expiration date of January 13, 2016 on each of the vials. The observation was made in the presence of	F 431		

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F 431	Continued From page 50 Employee #18 on February 24, 2016 at approximately 4:10 PM. He/she acknowledged the findings and removed the vials from the refrigerator.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	1.No actual harm to the resident # 24 2. No resident directly affected 2.Re-educate license nurses on wound management and dressing change technique 2.Re-educate Unit Managers on infection control monitoring 3.Unit Managers to perform (1 or 10% of current wounds)random dressing change audit weekly to identify trends. Any identified trends will be reported to the QAPI committee monthly Unit Managers to complete infection control surveillance sheets weekly and forward to the QAPI department. 4.QA/ED to audit ABT/infection usage weekly and report any identified trends to QAPI committee monthly Compliance Date	4/9/16

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Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview for one (1) of 17 sampled residents it was determined that facility staff failed to manage wound treatment supplies in a manner equipment as to reduce and/or prevent the potential for cross contamination during a wound treatment; and facility staff failed to ensure that the Infection Control Program included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. Resident #24

The findings include:

1. Facility staff failed to manage wound treatment supplies in a manner as to reduce and /or prevent the potential for cross contamination during wound care for Resident #24.

On February 26, 2016 at approximately 10:15AM, a wound care observation was conducted. During this time Employee #12 removed clean uncovered/unwrapped cotton tipped applicators from a package and placed them uncovered into a cardboard box containing "Non-Woven Sponges." The clean tips of the applicators were touching the inside surface of the box. When Employee #12 started to perform the dressing change to the resident ' s right hip, he/she removed the cotton tip applicators from the box and placed them on an open, clean gauze pad

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F 441	Continued From page 52 wrapper. The employee then applied Skin integrity Hydrogel dressing (a gel that is used to maintain a moist wound environment) to the wound on the resident's right hip. He/she then used the cotton tip applicator to spread the gel around the wound. On February 26, 2016 at approximately 11:00AM a face-to-face interview was conducted with Employee #12 regarding clean technique and the potential for cross contamination. He/she acknowledged the findings and stated that the cotton tipped applicators should have been placed on the clean gauze when removed from the package. Facility staff failed to manage wound treatment supplies in a manner as to reduce and/or prevent the potential for cross contamination during wound care. 2. Facility staff failed to ensure the implementation of an infection control program that included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. A review of the November 2015 surveillance forms lacked evidence of consistent tracking and trending such as: The "Most recent Admit or Readmit Date " was not recorded for nine (9) of nine (9) residents listed; The "Infection Site" was not recorded for one (1) of nine (9) residents listed;	F 441		

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	095005	A. BUILDING ______ B. WING ______	02/26/2016

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F 441	Continued From page 53 The onset date of the infection was not recorded for nine (9) of nine (9) residents listed; The infection was " in-house acquired " was not recorded for two (2) of nine (9) residents listed " Present on Admission " was not recorded for two (2) of nine (9) residents listed " Antibiotic " the strength of the antibiotic and duration of use was not record for two (2) of nine (9) residents listed. The date the antibiotic was initiated and completed was not recorded for four (4) of nine (9) residents listed A review of the December 2015 surveillance forms lacked evidence of consistent tracking and treading such as: The " Most recent Admit or Readmit Date " was not recorded for nine (9) of 10 residents listed; The onset date of the infection was not recorded for five (5) of 10 residents listed; The infection was " in-house acquired " was not recorded for two (2) of 10 residents listed " Present on Admission " was not recorded for four (4) of 10 residents listed " Antibiotic " the strength of the antibiotic and duration of use was not recorded for one (1) of 10 residents listed. The date the antibiotic was initiated and completed was not recorded for nine (9) of 10 residents listed	F 441		

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F 441

Continued From page 54

F 441

A review of the January 2015 surveillance forms lacked evidence of consistent tracking and treading such as:

The " Most recent Admit or Readmit Date " was not recorded for five (5) of 10 residents listed;

The " Infection Site " was not recorded for one (1) of 10 residents listed;

The onset date of the infection was not recorded for six (6) of 10 residents listed;

The infection was " in-house acquired " was not recorded for three (3) of 10 residents listed

The " infection site " was not recorded for four (4) of 10 residents listed

" Present on Admission " was not record for two (2) of 10 residents listed

" Antibiotic " the strength of the antibiotic and duration of use was not recorded for two (2) of 10 residents listed.

The date the antibiotic was initiated and completed was not recorded for seven (7) of 10 residents listed

There was no evidence that the facility ' s Infection Control Program included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. In addition, at the time of this review the facility had no residents on transmission based precautions and no evidence of outbreaks of communicable disease.

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F 441	Continued From page 55 A face-to-face interview was conducted with Employee # 3 on February 23, 2016 at 3:16 PM. He/she acknowledged the findings and stated, " I have implemented a new surveillance sheet."	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made on February 22, 2016 between 11:30 AM and 3:00 PM, it was determined that the facility failed to maintain resident call systems as evidenced by inoperative call bells in two (2) of 13 resident rooms. The findings include: Call bells did not function as intended in two (2) of 38 resident rooms (#115 and #127). These observations were made in the presence of Employee #22 and Employee #23 who acknowledged the findings.	F 463	F463 1.Call lights in 115 and 127 replaced 2. Audited all call lights- no identified concerns noted 3.Resident rooms will be inspected During weekly Maintenance Rounds to identify any concerns. Maintenance technicians re-educated on identifying areas of concern 4. Plant operations Director or designee will review weekly Maintenance rounds checklists and report any identified trend to the QAPI committee Monthly 5.Compliance Date	4/9/16
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514		

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

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F 514	Continued From page 56 systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for three (3) of 17 sampled residents and three (3) supplemental residents, it was determined that facility staff failed to ensure that a hospice discharge note was readily available in the active clinical record for Resident #24 and that the clinical record included documented evidence of discharge planning activities for two (2) residents. Additionally, facility staff failed to ensure that eight (8) of eight (8) glucometers [a medical device for measuring blood glucose] were set with the current date(s) and time. Resident's #20, 24 and 88. The findings include: 1. Facility staff failed to document evidence of measures related to facilitating Resident #20 ' s involuntary discharge from the facility. A review of the facility ' s documents revealed the facility provided a "Notice of Closure" letter signed by the Chief Executive Officer and dated November 3, 2015 (original notification was dated September 15, 2015) addressed to all residents	F 514	F514 1. Resident # 88,and # 20-Social services progress notes updated in regards to discharge planning 2.Audited current residents Social Services progress notes to identify needed documentation related to discharge planning-identified areas corrected 3.Re-educate Social Services department related to the need for ongoing and timely documentation related to discharge planning. 4. Director of Social Services or designee to audit Social Services progress notes weekly x 4 then monthly x 3. Any identified trends to be reported the QAPI committee monthly. Compliance Date 2.NP reviewed resident chart and completed a late entry related to hospice discharge 2.No other hospice clients at this time 3. UM to audit any residents on hospice caseload for appropriate documentation relating to admission and or discharge from services 4. Any identified trend will be reported to the monthly QAPI committee meeting. 5. Compliance Date	4/9/16 4/9/16

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F 514	Continued From page 57 [and/or responsible parties] residing in the facility that read: "This letter serves each of you as your official notice of closure and the need to transfer or discharge to another location. Final closure will be December 15, 2016...We will assure the continuity of services by providing the receiving facility with assessment and care plan, and for discharge, by arranging for those services required by the post discharge plan..." A social service progress note dated September 18, 2015 at 3:21 PM read, " Spoke with [family member] about the closing of [Facility named]. S/he is interested in working with [family member] to find a place for [him/her] to live ....SE [southeast], NE [northeast] are a possibility. Also [local facility] is an option. Will continue to work with them to explore a safe discharge plan. " A social service progress note dated November 9, 2015 at 4:37 PM read, " The formal letter to resident notifying [gender] of closure of [name of facility] in December 2016, has been placed in the chart. This letter has also been mailed to the resident's responsible representative. " The clinical record lacked documented evidence of measures implemented by the social work staff subsequent to September 2015, as it relates to facilitating Resident #20 ' s involuntary discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM who acknowledged the findings. The record was reviewed February 26, 2016.	F 514	F514 cont. 3. No resident adversely affected 2. Glucometer reset to correct time and date 3. 3-11 Supervisors to audit glucometers weekly to check for appropriate date and time. 4. Any identified trend will be reported to the monthly QAPI committee meeting. 5. Compliance Date	4/9/16

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F 514	Continued From page 58	F 514		

2. Facility staff failed to ensure that a hospice discharge note was readily available in Resident #24 ' s active clinical record.

A review of a physician order dated October 29, 2015 directed, "discharge from hospice on 11/3/15 ..."

A review of a Community Hospices note dated November 3, 2015 read: " ...Swer [social worker] discussed with pt [patient] discharge from hospice ..."

A review of the clinical record lacked documented evidence of a hospice discharge note.
On February 25, 2016 at approximately 9:45 AM a face-to-face interview was conducted with Employee #14 regarding the process of discharging a resident from hospice. He/she stated that the hospice staff will review the care plan to see if it has been adjusted, and a discharge note is placed in the chart. When asked where the discharge summary from hospice is found in the chart, Employee #14 stated that [vendor named] is the electronic medical record system that is used by hospice and that the information is typically placed in the hospice section of the active clinical record.

Employee #14 acknowledged that the hospice discharge summary was not in Resident #24 ' s clinical record. The record was reviewed February 24, 2016.

3. Facility staff failed to document evidence of

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F 514	Continued From page 59 measures related to facilitating Resident #88 ' s involuntary discharge from the facility. A review of the facility ' s documents revealed the facility provided a "Notice of Closure" letter signed by the Chief Executive Officer and dated November 3, 2015 (initial notification was September 15, 2015) addressed to all residents [and/or responsible parties] residing in the facility that read: "This letter serves each of you as your official notice of closure and the need to transfer or discharge to another location. Final closure will be December 15, 2016...We will assure the continuity of services by providing the receiving facility with assessment and care plan, and for discharge, by arranging for those services required by the post discharge plan..." A review of Resident #88 ' s clinical record revealed the following Social Services progress notes: November 9, 2015 at 16:50 [5:50PM]; " The formal letter to resident notifying [gender] of closure of [name of facility] in December 2016, has been placed in the chart. This letter has also been mailed to the resident's responsible representative. " November 20, 2015 at 16:07 [4:07PM]; " Left message for RP [responsible party] on this date, to discuss discharge planning. Await call back. " January 18, 2016 at 15:37 [3:37 PM]; " Placed follow up call to [RP name] ...Awaiting call back to discuss transition planning. " A review of the facility ' s social work discharge planning tracking document(s) revealed that	F 514		

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F 514	Continued From page 60 Resident #88 ' s primary representative [family] was contacted via teleconference on February 9, 2016. A discussion was held regarding " discharge options. " There was no evidence of documentation related to the February 9, 2016 teleconference regarding " discharge options. " A review of social service progress notes lacked documented evidence of measures implemented to facilitate Resident #88's involuntary discharge from the facility. A face-to-face interview was conducted with Employee #10 on February 26, 2016 at approximately 3:30 PM regarding the aforementioned findings. He/she acknowledged the social service notes were not current. The record was reviewed February 26, 2016. 4. Facility staff failed to ensure that eight (8) of eight (8) glucometers were set with the current date(s) and time. An observation of eight (8) of eight (8) glucometers (on Unit 1A, 2A, 2B, 3A) revealed that the current date and time was not set on the devices/machines; and the dates and times of the blood glucose results registered in the device did not reconcile with the dates and times recorded in the electronic medical record for the respective resident(s). A face-to-face interview was conducted on February 22, 2016 at approximately11:25AM with Employees #4, #5, #6 and #7. They verified that the glucometers were not calibrated yearly for accuracy, they are used until they are unable to	F 514		

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F 514	Continued From page 61 be turned on then they would be discarded and be replaced with new ones. There was no evidence that the glucometers machines were being checked by the facility to make sure the correct dates and times were set. A face-to-face interview was conducted with the Employee #24 on February 22, 2016 at approximately 12:05PM. He/she acknowledged findings. This record was reviewed February 22, 2016.	F 514		