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 _____	04/22/2014

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 A Quality Indicator Survey (QIS) recertification survey was conducted at your facility on April 14, 2014 through April 22, 2014. The following deficiencies are based on observations, record reviews, resident and staff interviews for 51 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia D/C discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - emergency medical services (911) g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set	F 000	The Washington Home makes its best effort. To operate in substantial compliance with both Federal and State law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following Plan of Correction constitutes the facility's written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/21/14

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

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F 000	Continued From page 1 Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy P/F- Preservative Free PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- responsible party TAR - Treatment Administration Record	F 000		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 51 sampled records related to residents' personal funds accounts, it was determined that facility staff failed to convey funds within 30 days of the death of two (2)	F 160		

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F 160	Continued From page 2 residents. Residents' #T1 and #T2. The findings include: 1. Facility staff failed to convey funds within 30 days of the death of Resident #T1. A personal funds account review was conducted on April 22, 2014 at approximately 3:00 PM with Employee #29 and the following was identified: The " Resident's Fund Management Service Status Change Form " revealed that the resident expired on November 3, 2013. The " Resident's Fund Management Service: Closed Account Summary form from: November 1, 2013 to April 22, 2014 " revealed that the account was closed on December 13, 2013. The check payable to the [relative ' s name] in the amount of $37.00 was dated February 21, 2014. A face-to-face interview was conducted on April 18, 2014 at approximately 3:00 PM with Employee #29. A query was made regarding the delay in closing and conveying the resident ' s funds to the relative. Employee #29 stated that the delay was due to the fact that " the [deceased] resident ' s [relative] could not be found. We [facility] had to go through another family member. " Facility staff failed to convey funds within 30 days of the resident's death. 2. Facility staff failed to convey funds within 30 days of the death of Resident #T2. A review of the " Resident's Fund Management Service Status Change Form " revealed that the resident expired on January 14, 2014. The "	F 160	F160 1. Checks payable to designated family members of Residents T1 & T2 were issued prior to April 14, 2014 QIS recertification survey. 2. The Reimbursement Director reviewed the Resident's Fund Management Service: Closed Account Summary on April 23, 2014; no other residents were affected by the deficient practice. 3. The Reimbursement Director performed a root cause analysis to identify the reason Reimbursement Department staff failed to close accounts timely for Residents T1 & T2. Staff will notify Reimbursement Director immediately when name and/or address of deceased resident's beneficiary is not available. The Closure of Account-Expired/Discharged Resident Policy & Procedure was re-reviewed with Reimbursement staff. Staff will complete a monthly audit to verify closure of all resident account funds within 30 days of resident death.	

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F 160	Continued From page 3 Resident's Fund Management Service: Closed Account Summary form from: November 1, 2013 to April 22, 2014 " revealed that the account was closed on January 17, 2014. However, the check payable to the [relative ' s name] in the amount of $70.03 was dated February 18, 2014. A face-to-face interview was conducted on April 18, 2014 at approximately 3:00 PM with Employee #29. A query was made regarding the delay in closing and conveying the resident ' s funds to the relative. Employee #29 stated that the delay was due to " a delay in processing of the paper work. " Facility staff failed to convey the resident's funds within 30 days of the death residents death.	F 160	4. The Reimbursement Director will review staff audits monthly to ensure corrective action is achieved and sustained. The Reimbursement Department will submit a report of audit findings to the Quality Assessment-Performance Improvement Committee (QI) monthly. 5. Date of Compliance	5/19/2014
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the	F 164		

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F 164	Continued From page 4 resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations and interview for one (1) of 51 sampled residents, it was determined that facility staff failed to provide privacy during toileting of a resident as evidenced by an observation of one (1) resident who was exposed from his/her head to his/her groin area while using the urinal in his/her room with the door open and in plain view of passersby for Resident #1. The findings include: Facility staff failed to provide privacy to Resident #1 who was observed exposed from [his/her] head to [his/her] groin area while using the urinal in [his/her] room with the door open and in plain view of staff, other residents and visitors who passed by the room. On April 17, 2014 at approximately 10:18 AM, Resident #1 was observed exposed from [his/her] head to [his/her] groin area. He/she had a clear colored urinal in [his/her] left hand at his/her groin	F 164	F164 1. Resident #1 is alert, oriented, and visually impaired. Resident was unaware that bathroom door was open. 2. No other residents were found to be presently affected. Nursing staff will be reeducated to practice proactive observation in protecting privacy of visually impaired residents. 3. All employees working in resident areas will be instructed to proactively protect the privacy of residents, including for residents unable to protect their privacy without staff assistance. Clinical Managers and their designees will monitor resident privacy during daily unit rounds. Environmental Rounds Team will observe residents' privacy during scheduled Rounds. 4. Clinical Managers will monitor compliance by reviewing Manager Unit Rounds reports. Reports are submitted to the Quality Improvement Manager and reported at the Focus Quality Improvement Interdisciplinary Team weekly meetings. A summary report of findings will be presented to the QI Committee monthly. 5. Compliance Date	6/6/2014

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F 164	Continued From page 5 area. The door to the room was open. The surveyor was standing in the hallway when the observation was made. Employee #39 was approximately four feet from the resident ' s room door, acknowledged the finding and closed the door to the room. There was no evidence that facility staff provided privacy to Resident #1 when [he/she] was observed using a urinal in [his/her] room with the door open and in plain view of staff, other residents and visitors. The observation was made on April 17, 2014.	F 164		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 51 sampled residents, it was determined that facility staff failed to resolve a grievance for Resident #174 ' s allegation of physical abuse. The findings include: The " Resident/Family Communication Tool Concern " form initiated on February 24, 2014 at 11:30 PM by the facility staff on behalf of Resident #174 revealed: " Resident Name and	F 166		

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F 166	Continued From page 6 Room Number: [Resident ' s name and room number]; Detailed Information: February 27, 2014- 10:40 PM- [Registered Nurse] was notified by [evening charge nurse named] that the resident reported that " [he/she] was smacked on [his/her] face by [his/her] CNA (Certified Nursing Assistant) 15 minutes ago. " ... It was observed that resident ' s right side of eye sclera was reddish with minimal watery drainage. No swelling noted to external upper/lower eyelids. No visible skin discoloration nor any swelling noted to [his/her] face, mouth and nose. [He/she] denied any pain ... [Named physician] was notified of resident ' s right eye redness, [neurological] checks ordered. Medical team to follow up in AM (morning). [Resident ' s responsible party named] was also notified by phone. " The back of the "Resident/Family Communication Tool Concern" form revealed, "Describe action taken to address concern: Copy provided to Clinical Manager [unit named] to follow-up. Signed :[evening supervisor's signature]; Concern Resolved- space left blank ; Dated Resolved- Blank; Reviewed by (space for Administrator ' s signature): was left blank; Date; was left blank. " According to the Facility ' s Policy and Procedure, " Family/Resident Communication Tool " revised October 2010 stipulates: " [#] 9. The Department Director/Manager or designee receiving the concern will contact the writer of the Family/Resident Communication Tool by telephone, within five (5) business days with a response and/or resolution. 10. It is the responsibility of the Department Director/Manager or designee to document on the Family/Resident	F 166	F166 1. The identified allegation of abuse form – Resident/Family Communication Tool was noted to be resolved, signed and dated. 2. All allegations of abuse and/or grievances will be resolved with in the timeframe of our facility policy. This includes the notification, investigation, action to solution, signature and resolution date. 3. All allegations of abuse and/or grievances will be documented and submitted to Administration for logging into the database. The database will include the pertinent information including the resolution date. 4. The database will be monitored for resolution on a monthly basis and reported to Quality Improvement committee quarterly. 5. Date of Compliance:	6/6/2014

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Communication Tool the date, time and spoken to in regards to the concern, and [#11] The Family/Resident Communication Tool will contain documentation of the response/resolution including the action steps and/or follow-up taken to address the concern and the staff members involved. "

At the time of this review, there was no evidence that facility staff ensured that a prompt effort was made to resolve the grievance for Resident #174 for two (2) months.

A face-to-face interview was conducted with Employee #2 on April 18, 2014 at approximately 11:21 AM. He/she stated that [he/she] talked to the employee regarding the incident. The employee further stated, that human resources intervened in the matter. However, the communication/concern form lacked evidence that an internal investigation was conducted. When queried if [he/she] and the administrator had signed the form to indicate that the concern was resolved. He/she stated, " This is not the original ...let me get the original form. "

A follow-up interview was conducted with Employees #1 and #2 on April 21, 2014 at approximately 11:30 AM. Both employees stated that the concern form did not come down to the administrator, and further stated, " It [the concern form] was found in Employee #25 ' s office. "

Facility staff failed to resolve a grievance for Resident #174 ' s allegation of physical abuse in

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F 166	Continued From page 8 a timely manner. The record was reviewed on April 21, 2014.	F 166		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview for two (2) of 51 sampled residents, it was determined that facility staff failed to ensure that the residents medications were properly stored and the residents were monitored for self administration of medications. Residents ' #136 and #300. The findings include: Review of the facility ' s policy " Self Administration of Medication, " Revised 01/11 stipulates; " Policy: Residents who desire to exercise their right to self-administer their medications are assessed by the interdisciplinary care plan team to be appropriate; An initial assessment is conducted followed by a quarterly reassessment, with a change in condition and more frequently as indicated. Procedure: The attending physician must write an order that the medications may be kept in the resident ' s room, the licensed nurses must monitor the use of medications and maintain documentation in the	F 176		

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F 176	Continued From page 9 medical record, the licensed nurses must instruct the resident of proper use of medications including what the medication is for, how it is used, [and] how often the medication is used. This information will be documented in the resident ' s medical record. " 1. Facility staff failed to ensure medications for Resident #136 could be kept in his/her room and that he/she could self administer his/her own eye drops and shampoo. During a resident interview conducted on April 15, 2014 at approximately 10:15 AM, it was observed that the resident had eye drops and baby shampoo on the over bed table. A query was made to the resident regarding the medication on the table and if [he/she] is allowed to administer [his/her] own eye drops and shampoo. The resident stated " yes, this is my medication, I have to give myself eye drops for eye irritation, I give myself my own eye drops, and I use the shampoo too. " The " Interim Order Form " dated and signed March 24, 2014, it directed, " ...(1) warm compression x [times] 5 minutes; (2) clean eye lash area with 3 [three] drops baby shampoo in 1 oz [ounce] H2O [water], Apply with cotton ball 15 sec [seconds] side-to-side, rinse with water daily. Patient may do by [himself/herself] under supervision. "	F 176	F176 1. Residents #136 and #300 were assessed for ability to self-administer medications by the interdisciplinary team and approved for self-administration. The Self-Medication Administration Assessment Form was completed. A physician's order was obtained for self-administration and approval to keep medications in the residents' rooms. A locked box was provided for medication storage in the residents' rooms. Licensed nurses instructed Residents #136 (eye drops, eye compresses, and shampoo) and #300 (one oral medication and eye drops) on correct administration (dosage, frequency, route, purpose, etc.) and secure storage of the medication. Self-administration of meds was added to the care plan. Residents will be reassessed quarterly for continued ability to self-administer medications. 2. No other residents were found to be presently affected.	

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F 176	Continued From page 10 The Physicians ' Order Sheet signed and dated by the physician on April 7, 2014 directed, " warm compression x [times] 5 minutes to eyes daily. Clean eye lash area with 3 drops baby shampoo in 1 oz [ounce] of H2O [water]. Apply with cotton ball 15 sec [seconds] side-to-side. Rinse with water daily. Patient may do by [himself/herself] under supervision. " There was no evidence in the physicians ' orders that the resident could keep the medications in his/her room and that the resident could administer his/her eye drops and shampoo without supervision. A review of the Medication Administration Records (MAR ' s) for April 2014 revealed that the resident received the above order on April 4, 7, 9, 11, 14, 16, 18, and 21. A face-to-face interview was conducted on April 15, 2014 at approximately 11:00 AM with Employees #5 and #30. A query was made regarding the medications observed on the residents over the bedside table, and if the resident is allowed to administer his/her own medications. Employee #30 stated, "The resident does not have medications in [his/her] room, the medications are in the medication cart. " Employee #30 proceeded to the residents ' room, and acknowledged that the eye drops and baby shampoo were on the resident's table. Employee #5 stated, "The resident is very independent and involved in his/her care. The resident will make [his/her] own doctor's appointment and get [his/her] own prescriptions filled without the staff knowing sometimes. "	F 176	3. All resident's self-administering medication will be assessed to ensure compliance with Self-Medication Policy. Licensed nurses will ensure all required documentation is complete and on the medical record: Self Administration of Medication Assessment Form, physician's order, current Self-Administration of Medications care plan, secure storage, and documentation confirming resident's knowledge of correct self-administration and licensed nurses' required monitoring and documentation. Clinical Managers will conduct a quarterly audit of the medical record for all residents self-administering medications. The current Clinical Manager Audit Tool will be revised to include audit criteria for residents self-administering medications. Clinical Managers and designees will be instructed on correct audit tool use. Licensed nurses will be educated to report to Clinical Manager or designee, medications observed at bedside of residents not currently approved for self-administration. 4. Clinical Manager Audit Tool results, including monitoring of residents approved by the IDT at Focus QI-IDT meeting weekly. Audit findings will be reported to the QI Committee monthly. 5. Compliance Date	6/6/2014

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There was no evidence that the physician or the interdisciplinary team had determined that the resident had the ability to self-administer medication(s) keep the medications at the bedside.

2. Facility staff failed to ensure that Resident #300 ' s medication was properly stored and that the resident was monitored for self administration of medications.

The " Interim Order Form " dated and signed March 12, 2014 directed, " Mosapride 5mg, 1 (one) [tablet] po [by mouth] four (4) times daily as needed for GERD (Gastroesophageal reflux syndrome) - (patient can take [his/her] own Mosapride). "

Resident # 300 ' s Physician ' s Order Sheet signed by the physician on April 8, 2014 directed, " Mosapride 5 mg tablet- one (1) orally four (4) times daily as needed [for] GERD. (Patient can take her own Mosapride); Genteal Severe (Preservative Free) P/F, [Sterile] 0.3% Gel (Gms)- Instill two (2) drops in each eye every 6 hours as needed for dry eyes *Patient May Administer*. "

A review of the MAR for April 2014 lacked evidence that the resident had taken or received the Mosapride 5mg by mouth as needed for

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F 176	Continued From page 12 his/her GERD or the Genteal Severe eye drops in accordance with the physician ' s orders. A face-to-face interview was conducted on April 22, 2014 at approximately 12:00 Noon with Resident #300 in the presence of Employee #7. The eye drop medication was observed in a small basket which was sitting on top of the resident's over-the-bed table. At this time the resident was queried about the eye drops and the GERD medication. He/she stated, " Yes, I take my own medication for my GERD. I also administer my own eye drops/gel for my dry eyes. I have taken my medication for my reflux about three (3) times since being admitted. I use my eye drop medication several times a day. The resident further stated that he/she keeps his/her reflux medication with his/her personal items. There was no evidence that the attending physician wrote an order for the resident to self-medication and to keep the medications at the bedside. Additionally, there was no indication that the licensed nurses monitored the use of the medications and maintained documentation in the medical record. A follow-up face-to-face interview was conducted with Employees #7 and #26 on April 22, 2014 at approximately 12:30 PM. The employees stated, " [Resident #300] self administers [his/her] eye drops and takes [his/her] medication for GERD." When queried about the communication from the resident regarding the frequency [he/she] takes	F 176		

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F 176	Continued From page 13 the medications the employees responded, "[He/she/] usually informs the nurses when [he/she] self administers the medication. " The observation occurred on April 22, 2014. The clinical record was reviewed on April 22, 2014.	F 176		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for eight (8) of 51 sampled residents, it was determined that facility staff failed to ensure residents were free from physical restraints as evidenced by: eight (8) residents who were observed seated in mobility aids "merry walkers" and were unable to self release and exit at will. Residents' #26, 43, 95, 102, 106, 118, 183 and 177. The findings include: According to the Code of Federal Regulations 483.13 (a) Restraints- Definition of Terms stipulates; "An enclosed framed wheeled walker, with or without a posterior seat, would not meet the definition of a restraint if the resident could easily open the front gate and exit the device. If the resident cannot open the front gate (due to cognitive or physical limitations that prevent him or her from exiting the device or because the device has been altered to prevent the resident	F 221		

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F 221	Continued From page 14 from exiting the device), the enclosed framed wheeled walker would meet the definition of a restraint since the device would restrict the resident ' s freedom of movement." The Facility's Policy and Procedure No.TX-00001.11 - Restraints Physical: effective 04/11 and revised 10/11 stipulated the following: " If the IDT (Interdisciplinary Team) determines a physical restraint is needed for a resident an assessment must be completed prior to placement of the resident, quarterly, and with any significant change. Any resident requiring the use of a restraint, as determined by the IDT, must have a restraint reduction assessment completed quarterly and /or with a significant change ... Procedure: Steps for Assessment 1. Consult with the IDT to determine the resident ' s cognitive and physical limitations. 2. Review the resident ' s medical record. 3. Review the definition of restraint: focus on the effect the device will have on the resident, not the type of device. 4. If the device meets the definition of a restraint complete the following as applicable. a. Pre-restraining Assessment (complete as initial assessment only) b. Side Rail Assessment (complete quarterly and/or with significant change) c. Merry walker Ambulation Assessment (complete quarterly and/or with significant change) d. Physical Restraint Elimination (complete quarterly and/or with significant change) 5. If the IDT determines a physical restraint is needed , ensure the following steps: a. Notify the resident and/or responsible party b. Physician must document a medical symptom that supports the use of a restraint c. Obtain a physician order for the type of	F 221	F221 1. Residents # 26, 43, 95, 102, 106, 118, 183, and 177 were reassessed by the IDT to determine the Merry Walker or merry Walker with lap tray restraint is least restrictive to meet resident's current needs. The residents were assessed as clinically appropriate for continued Merry Walker use to support goals for safety and freedom of movement. All required restraint assessments were completed. Physical restraint care plans were updated, including potential for gradual restraint reduction or elimination of restraint if appropriate. Physician orders were obtained to include type of restraint, parameter for use, and medical symptom to support restraint use. Responsible parties were notified of IDT's recommendations for continued use of Merry Walker. 2. A facility-wide review identified no other residents affected by the deficient practice.	

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F 221	Continued From page 15 restraint, the parameter for its use, and medical symptoms that support its use. d. Initiate a care plan that includes a process of gradual restraint reduction and/or elimination as appropriate. e. Assess that the restraint used is the least restrictive, to meet the resident ' s current needs. 6. As part of the IDT care plan the Physical Restraint Elimination Assessment must be completed quarterly and at the time of significant change." 1.Facility staff failed to ensure that Resident #95 was free from physical restraints. Resident #95 was observed seated in a " merry walker " in the dining room area on unit 2A, with a self-release front arm cross bar, covered by a lap tray at approximately 11:30 AM on April 17, 2014. The resident did not respond to a query from the surveyor to remove the lap tray and self-release bar to exit the merry walker. A review of the Physician's Order Form (POS) signed and dated April 1, 2014 directed, "Patient to use merry walker when out of bed for safety. Patient to have lap-tray on merry walker whenever patient is in merry walker." A review of the Quarterly MDS (Minimum Data Set) of Resident #95 dated January 24, 2014 revealed that Section G [Functional Status] coded as total dependent for bed mobility, and extensive assistance for transfer, walking in room, corridor and locomotion on unit. Balance during transitions, and walking was coded as not steady, only able to stabilize with staff assistance, Section I [Active Diagnoses] lists, Non-Alzheimer ' s and Dementia, and Section P [Restraints] was	F 221	3. The Merry Walker Policy and Procedure will be reviewed by the IDT and reeducation conducted to review all physical restraint required assessments, physician orders, documentation, care plans, and notifications for residents using Merry Walkers. Residents with physical restraints will be reassessed quarterly and/or if significant change, to determine clinical indications for continued restraint use. Licensed nurses will be reeducated on management of physical restraints and reeducation repeated quarterly. Clinical Managers or designee will update physical restraint care plans quarterly and/or if significant change, based on Merry Walker Use Assessment and Physical Restraint Elimination Assessment Forms recommendations and notify the responsible party of recommendations. 4. Clinical Managers will monitor physical restraint assessment tools monthly and report findings to the QI Manger for review at Focus QI-IDT meetings. A summary of findings will be reported to the QI Committee a minimum of quarterly. 5. Compliance Date	6/6/2014

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coded as no restraints being used.

A face-to-face interview was conducted with Employee #4 on April 17, 2014 at approximately 11:45AM. He/she was queried regarding Resident # 95 ' s ability to exit the merry walker at will. Employee #4 stated, "No, he/she can ' t release the bar or remove the lap tray, however the merry walker is used to provide dignity and to keep him/her from falling. This was implemented by [the] Rehab (Rehabilitation) Department."

A face-to-face interview was conducted with Employee #10 on April 17, 2014 at approximately 12:00 PM. When queried regarding Resident #95 ' s use of the merry walker. He/she stated, " Resident #95 has been using the merry walker for years, as a safety measure to prevent falls." Upon further query regarding the last time the resident was assessed regarding his/her cognitive ability to remove the bar and lift the lap tray, Employee #10 stated, "The Occupational Therapist recommended and implemented the lap tray. Resident #95 can't be taught how to remove [the] bar to self-release the bar or [the] lap tray." When queried if the resident has been assessed or evaluated for least restrictive device the Employee #10 replied, "No, the merry walker is not a restraint." Employee #10 stated, "merry walkers are recommended for residents with falls as a safety measure to prevent injuries."

A face-to-face interview was conducted with Employee #11 on April 17, 2014 at approximately 2:30 PM. When queried regarding Resident # 95 ' s ability to remove the lap tray, and exit the merry walker at will. Employee #11 stated, "I observed Resident #95 lying with his/her head on his /her arms across the safety bar. Employee #11 further

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stated, "The lap-tray was recommended and implemented to assist with better positioning and comfort." When queried regarding Resident # 95 ' s ability to be taught to remove the safety bar and lap-tray at will, the employee stated, " No " .

The clinical record lacked evidence that the medical team identified a symptom for the use of the merry walker, and there was no evidence that the interdisciplinary team followed a systematic process for evaluation, and care planning prior to and/or after the use of the merry walker.

There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to include a process of gradual restraint reduction and/or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs.

A face-to-face interview was conducted with Employee #4 on April 17, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The record was reviewed on April 17, 2014.
Facility staff failed to ensure that Resident #95 was free from physical restraints.

2. Facility staff failed to ensure that Resident #26 was free from physical restraints.

Resident #26 was observed seated in a merry walker in a dining room on unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014.

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A face-to-face interview was conducted with Employee #4 immediately after the observation on April 21, 2014. A query was made to determine if the resident could self-release his/her front arm cross bar at will. Employee #4 stated, " None of the residents in merry walkers on this unit can self release and exit at will, because of their dementia.

The Physician's Order Form (POS) signed and dated April 1, 2014 directed, "Move patient in Merry Walker backwards when she/he is not "Activity" [Actively] walking [Resident ' s gender] "
A review of the Quarterly MDS (Minimum Data Set) of Resident #26 dated March 7, 2014 revealed that Section G [Functional Status] coded as extensive assistance for bed mobility and transfer, and limited assistance for walking in room, corridor, and locomotion on and off unit. Section I [Active Diagnoses] lists Non-Alzheimer ' s and Dementia, Section P [Restraints] was coded as restraints being used daily.

There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. There was no evidence that the resident was able to voluntarily release the cross bar latch.

There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms, obtained parameters that supports its use, initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is

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F 221	Continued From page 19 the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The Medical Record was reviewed on April 21, 2014. Facility staff failed to ensure that Resident #26 was free from physical restraints. 3. Facility staff failed to ensure that Resident #43 was free from physical restraints. Resident #43 was observed seated in a " merry walker " in an open day room area on unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 2:45 PM. A query was made to determine if the resident could self-release his/her front arm cross bar at will. Employee #4 stated, " No " A review of a physician's order on the Physician Order Form (POS) dated April 1, 2014 directed, "Pt [patient] is to use merry walker for mobility and ambulation within the unit " . A review of the Quarterly MDS (Minimum Data Set) of Resident #43 dated March 7,2014 revealed that Section G [Functional Status] was coded as supervision needed for bed mobility, transfer, walking in room and corridor and locomotion on unit with limited assistance with locomotion off unit. Section I [Active Diagnoses] lists, Non-Alzheimer ' s and Dementia, and	F 221		

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F 221	Continued From page 20 Section P [Restraints] was coded as restraints being used daily. There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. Facility staff failed to ensure that Resident #43 was free from physical restraints. 4. Facility staff failed to ensure that Resident #102 was free from physical restraints. Resident # 102 was observed seated in a " merry walker " in the day room area on the unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014. A review of the Physician Order Form (POS) signed and dated April 1, 2014 directed, "Patient is to use Merry Walker for Mobility "	F 221		

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F 221	Continued From page 21 A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 2:45 PM. A query was made to determine if the resident could self-release his/her front arm cross bar at will. Employee #4 stated, " No " . There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. A review of the Quarterly MDS (Minimum Data Set) of Resident #102 dated January 24, 2014 revealed that Section G [Functional Status] was coded as extensive assistance for, bed mobility and for transfer, and limited assistance for walking in room, corridor, locomotion on unit and extensive assistance with locomotion off unit. Section I [Active Diagnoses] lists, Non-Alzheimer ' s and Dementia. Section P [Restraints] was coded as no restraints being used. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. Facility staff failed to ensure Resident #102 free from physical restraints. The medical record was	F 221		

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reviewed on April 22, 2014.

5. Facility staff failed to ensure that Resident #106 was free from physical restraints.
Resident # 106 was observed seated in a " merry walker " in an open day room area on the unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014.
A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 2:45 PM. A query was made to determine the Resident #106 could self-release his/her front arm cross bar at will. Employee #4 stated, "No" .

A review of the Physician Order Form (POS) signed and dated April 1, 2014 directed, "Patient is to use Merry Walker for ambulation within unit "

A review of the Quarterly MDS (Minimum Data Set) of Resident #106 dated February 10,2014 revealed that Section G [Functional Status] was coded as extensive assistance for bed mobility and transfer, and limited assistance for walking in room, corridor, and locomotion on unit. Section I [Active Diagnoses] lists, Non-Alzheimer ' s and Dementia, and Section P [Restraints] was coded as restraints being used daily.
There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker.

There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to includes a process of

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gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs.

A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings.
Facility staff failed to ensure Resident #106 free from physical restraints. The Medical Record was reviewed on April 21, 2014.

6. Facility staff failed to ensure that Resident #118 was free from physical restraints.
Resident # 118 was observed seated in a " merry walker " in an open day room area on the unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014.

A face- to- face interview was conducted with Employee #4 on April 21, 2014 at approximately 2:45 PM. A query was made to determine if Resident # 118 could self-release his/her front arm cross bar at will. Employee #4 stated, " No "

A review of a physician's order on the Physician Order Form (POS) dated April 1, 2014 directed, "Merry Walker daily for safe ambulation "

A review of the Quarterly MDS (Minimum Data Set) of Resident #118 dated March 27, 2014 revealed that Section G [Functional Status] was coded as extensive assistance for bed mobility, transfer, and limited assistance for walking in room, corridor, and locomotion on unit. Section I [Active Diagnoses] lists Non-Alzheimer ' s and Dementia, Section P [Restraints] was coded as

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F 221	Continued From page 24 restraints being used daily. There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. Facility staff failed to ensure that Resident #118 was free from physical restraints. The Medical Record was reviewed on April 21, 2014. 7. Facility staff failed to ensure that Resident #183 was free from physical restraints. Resident #183 was observed seated in a " merry walker " in the day room area on the unit 2A with a self-release front arm cross bar at approximately 2:30 PM on April 21, 2014. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 2:45 PM. A query was made to determine if Resident # 183 could self-release his/her front	F 221		

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F 221	Continued From page 25 arm cross bar at will Employee #4 stated, " No " . A review of the Physician Order Form (POS) signed and dated April 1, 2014 directed, "Patient is to use Merry Walker for mobility. " A review of the Quarterly MDS (Minimum Data Set) of Resident #183 dated January 18, 2014 revealed, Section G [Functional Status] was coded as extensive assistance for bed mobility, limited assistance for transfer, walking in room, corridor and locomotion on unit. Section I [Active Diagnoses] lists Non-Alzheimer ' s and Dementia, and Section P [Restraints] was coded as restraints being used daily. There was no evidence that the medical team identified a symptom for the use of the merry walker and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. There was no evidence that the facility staff completed quarterly merry walker ambulation assessments, documented medical symptoms or obtained parameters that supports its use, initiated care plans to includes a process of gradual restraint reduction and /or elimination as appropriate, or assessed that the restraint use is the least restrictive, to meet the resident ' s current needs. A face-to-face interview was conducted with Employee #4 on April 21, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings.	F 221		

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	095005	A. BUILDING _____ B. WING _____	04/22/2014

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F 221	Continued From page 26	F 221		

Facility staff failed to ensure that Resident #183 was free from physical restraints. The Medical Record was reviewed on April 21, 2014.

8. Facility staff failed to ensure that Resident #177 was free from physical restraints.

Resident #177 was observed from April 17, 2014 at approximately 10:30 AM and on April 22, 2014 at approximately 9:45 AM on unit 1A in the common area, sitting in merry walker in with a self-release latch front arm cross bar.
A face-to-face interview was conducted with Resident #177 on April 22, 2014 at approximately 9:45 AM. Resident #177 was asked if he/she could remove him/herself from the device [merry walker]. The Resident replied, " I have been trying to get out of this [placing his/her hands on the self-release bar and pulling on it] but I can ' t. "
A face-to-face interview was conducted with Employee #3 on April 22, 2014 at approximately 10:55 AM. A query was made to determine if the resident could self-release and Employee #3 stated, "The resident was not able to self- release from merry walker " .
A review of Section G, Functional Status of the Quarterly MDS (Minimum Data Set) dated January 24, 2014 revealed Resident #177 was coded as total dependent for bed mobility and required extensive assistance for transfers. Section P [Restraints] was coded as no restraints being used

A review of a physician's interim orders and Physician Order Form (POS) dated April 1, 2014 presented no orders for the use of a merry walker.

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F 221	Continued From page 27 There was no evidence that the resident could remove or release him/her self from the merry walker at will. There was no evidence that medical team identified a symptom for the use of the merry walker; and there was no evidence that the interdisciplinary team followed a systematic process for evaluation and care planning prior to and/or after the use of the merry walker. A face-to-face interview was conducted with Employee #4 on April 22, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The medical record was reviewed on April 22, 2014. Facility staff failed to ensure Resident #177 free from physical restraints.	F 221		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident interview and record review for two (2) of 51 sampled residents, it was determined that facility staff failed to report allegations of verbal abuse and misappropriation of property for one (1) resident and an allegation of mistreatment for one (1) resident. Residents #6 and 28. The findings include:	F 226		

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F 226	Continued From page 28 Facility staff failed to report an allegation of staff to resident verbal abuse and possible misappropriation of property [items not specified]. During a resident interview conducted on April 17, 2014 at 2:00 pm with Resident #6, he/she stated " I had two (2) legitimate complaints about two (2) CNA ' s [Certified Nurse ' s Assistant]. A. The first complaint involved a CNA " that had been accused of stealing by other people. I saw [him/her] go into my cabinet when [he/she] thought I was asleep. That employee was suspended and brought back and I agreed to let [him/her] work with me again. " The resident did not specify the date of alleged occurrence. A review of the facility ' s " Disciplinary Action Form " revealed that Employee #23 was suspended on December 4, 2013 and returned to duty, " allegations were not confirmed. " A face-to-face interview was conducted on April 18, 2014 at 11:00 AM with Employees #1, 2 and 12. A query was made regarding the above incident. Employee #1 stated the incident was investigated and not substantiated. B. Resident #6 alleged that a CNA would yell and be moody and snappy at times. Talking with him/her [the CNA] was not effective. The resident did not specify a date of occurrence. A face-to-face interview was conducted on April 18, 2014 at 11:00 AM with Employees #1, 2 and 12. A query was made regarding if the State Agency was notified regarding Resident #6 ' s allegations. Employee #1 stated that the facility ' s	F 226	F226 Resident #6 1. The concerns of residents #6 and 28 were investigated; employees were counseled, suspended, and re-instated after investigation concluded the residents' concerns were unsubstantiated. 2. A review of all Concerns alleging abuse identified no unreported resident abuse allegations. 3. Concern reporting will remain a weekly Focus QI-IDT agenda item. Clinical Managers will continue to report Concerns received to Focus QI-IDT. Abuse reporting requirements will be reviewed with all staff via the May 2014 mandatory annual Elder Justice Act education module. 4. The Administrator will be added to distribution list of Focus QI-IDT meeting summaries, which will continue to be distributed to all Nursing Department Focus QI members. All meeting summary recipients will notify the QI Manager if an open resident abuse allegation is not documented in the Concerns section of Focus QI-IDT meeting summary. The QI Manager will report resident abuse allegation Concerns to QI Committee monthly. 5. Compliance Date	6/6/2014

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F 226	Continued From page 29	F 226		

form, " Resident/Family Communication Tool " was completed, however; he/she had no evidence to support notification to the State Agency.

Facility staff failed to report an allegation of verbal abuse and misappropriation of property for Resident #6.

2. Facility staff failed to report an allegation of mistreatment expressed by Resident #28.

During a resident interview conducted on April 15, 2014 at 2:30 PM the resident responded " no " in reply to a query " does staff treat you with respect and dignity? " He/she stated " I cannot remember the exact date but a CNA put me to bed one time and that ' s when [he/she] acted up ....There was one [gender specified] that was rough. He/she came in here and threw my shoes and clothes everywhere. I don ' t ' know [his/her] name but they call [his/her name mentioned]. [he/she] no longer takes care of me. I reported [him/her] to the supervisor.

A review of the facility documents lacked evidence of any allegations of abuse from Resident #28.

A face-to-face interview was conducted with Employee #30 on April 18, 2014 at 1:00 PM. The employee acknowledged that Resident #28 alleged the throwing of clothes and shoes by a CNA on the unit. " I spoke to the CNA and [he/she] said that the resident ' s clothes were placed on the chair and shoes placed beside the wheelchair. He/she denied reporting the incident to the State Agency, " I did not write it up because I thought it had been resolved "

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F 226	Continued From page 30 However, Employee 35 was made aware. A face-to-face interview was conducted with Employee #5 on April 18, 2014 at 1:15 PM. Tin response to a query regarding the alleged mistreatment by Resident #28, he/she stated " I did not write anything up because I thought it had been resolved. " Facility staff failed to report an allegation of mistreatment expressed by for Resident #28.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews for three (3) of 51 sampled residents, it was determined that facility staff failed to promote dignity as evidenced by posting of signage of resident ' s personal plan of care for (2) residents and one (1) resident whose name was written on the front of his/her jacket. Residents #34, #62 and #115. The findings include: 1. Facility staff failed to promote dignity for Resident #34 as evidenced by the observation of signage of resident ' s confidential clinical and personal information that could be viewed by the public.	F 241	F241 Residents #34 and 62 1. Responsible parties for Residents #34 and 62 were contacted and consent obtained to continue posting critical medical information signage visible on residents' wall for non-nursing department persons (no venipuncture in right arm and/or Aspiration Precautions). Non-critical signage viewed by nursing department staff (no blood pressures right arm, puree diet, position meal tray on right, Code status, dentures, etc.) was relocated to Closet Care Plan posted inside resident's closet door. 2. An inspection of all resident rooms identified a small number of rooms with confidential clinical information posted that was appropriately relocated to Closet Care Plan posted inside resident's closet door. Responsible parties will be notified for consent to continue posting on resident's wall, the remaining information critical for viewing by non-nursing department persons.	

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F 241	Continued From page 31 During a resident observation conducted on April 15, 2014 at approximately 11:40 AM and April 22, 2014 at approximately 1:00 PM; observed signage posted on wall behind the head of Resident #34 ' s bed. The signage revealed; " No B/P (blood pressure) or venipuncture on right arm. Aspiration precautions: Diet: Pure; Position meal tray on right side. " A face-to-face interview was conducted on April 22, 2014 at approximately 1:00PM with Employees #5 and #7. In response to a query regarding the signage observed posted behind Resident #34 ' s bed; both replied that the signage is not to be visibly posted. The observation was made on April 22, 2014. Facility staff failed to promote dignity for Resident #34 as evidenced by the observation of signage of resident ' s confidential clinical and personal information that could be viewed by the public. 2. During tour of Resident #62 ' s room on April 14, 2014 and April 22, 2014 between the hours of 9:00 AM and 4:00 PM, observed signage posted on wall behind the resident ' s head of bed. The signage revealed; " Resident name, Full Code, Bathing: Total Care; Dressing: Total Care; Toilet Transfers-Dependent; Ambulation- Assistive device/at risk for falls/WC (wheelchair); Diet: Diabetic Regular NCS (No Concentrated Sweets); Oral Care: Partials/Dentures; Toileting: Adult briefs (size) M (medium); Activities: Participate Ad-lib (as often as liked); Vigelon monitor on chair ... . " Second signage revealed; " Attention Staff: Swallowing Precautions, No Straws, [Resident named] should be upright at 90 [degrees] when eating in bed.	F 241	3. Clinical Managers or designee will audit the location of clinical care signage during daily Nursing Management Unit Rounds. Restricting signage posted on resident room walls to critical for non-nursing department persons, will be added to existing Nursing Management Unit Rounds form. Employees working in resident rooms will be reeducated on appropriate posting of confidential clinical and personal information. 4. Clinical Managers will submit completed Nursing Management Unit Rounds forms to the QI Manager for reporting to Focus QI-IDT meeting weekly. The QI Manager will report a summary of findings to QI Committee monthly. 5. Compliance Date <u>Resident #115</u> 1. It was the choice of Resident #115's family to write the resident's name with a black marker across the front of the resident's clothing. Staff recommended resident's name be written on inside of garment. 2. No other residents were identified with names on outside of clothing.	6/6/2014

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F 241	Continued From page 32 Thank you! [Discipline named]. " Facility staff failed to promote dignity for Resident #62 as evidenced by the observation of signage of resident ' s confidential clinical and personal information that could be viewed by the public. A face-to-face interview was conducted with Employees #6 on April 22, 2014 at approximately 12N. In response to a query regarding the signage observed posted behind the head of Resident #62 ' s bed, he/she replied that the signage was suppose to be posted inside the resident ' s closet. The signage was immediately removed and posted inside the resident ' s closet door. The observation was made on April 22, 2014. 3. Facility staff failed to promote dignity for Resident #115 whose name was written on the front of his/her jacket. During the breakfast meal, Resident #115 was observed during the breakfast meal on April 15, 2014 at approximately 8:50 AM seated in his/her geri-chair in the dining area on Unit 2 B. He/she was dressed in a blue sweater jacket that had his/her name visibly written in a black colored marker across the left front of the jacket. The observation was made in the presence of Employee #4 who acknowledged the findings, and stated that "The family wrote Resident#115 ' s name on [his/her] jacket and we educated them that the resident name goes in the back on the inside of the clothing. "	F 241	3. Social Services and the Nursing Department will continue to collaborate to explain appropriate labelling of resident clothing to residents and families on admission, and as needed. Resident clothing labeling will be monitored quarterly by Social Services and the Nursing Department during the resident (clothing) Inventory Checklist review. Environmental Rounds Team and employees observing non-recommended clothing-labels will notify the Clinical Manager, who will notify family at appropriate time. 4. Clinical Managers will report identified occurrences of inappropriately labeled resident clothing to Focus QI-IDT meeting. The QI Manager will report summary findings to QI Committee monthly. 5. Compliance Date	6/6/2014

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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 during an environmental tour of the facility on April 18, 2014 at approximately 11:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by seven (7) of seven (7) torn window curtains in two (2) of 27 resident's rooms, loose wallpaper in three (3) of five (5) resident's units, broken window blinds slats in two (2) of 27 resident's rooms and marred walls in four (4) of 27 resident's rooms. The findings include: 1. Five (5) of five (5) sets of window curtains in room #351 were torn in several areas and one (1) of one (1) set of window curtains in room #349 was also torn, two (2) of 27 resident's rooms. 2. The wallpaper was hanging loose, unglued from the wall in three (3) of five (5) resident's units. 3. One (1) of five (5) window blinds had a broken slat in room #254 and two (2) of two (2) window blinds in room #128 had broken slats;	F 253	F253 (Window Curtains & Window Blinds) 1. Damaged window curtains (rooms 351 and 349) and window blinds (room 128) were identified as damaged prior to the annual survey. Funds are budgeted for damaged window treatment replacements (curtains and blinds) in the July 1, 2014-June 30, 2015 fiscal year. 2. All resident room window treatments will be reassessed by the Director of Plant Operations, or designee, to ensure identification of all in need of replacement. Damaged window treatments that are repairable while awaiting replacement (i.e., removal of broken window blind slats, trimming drapes with hanging threads, etc.) will be repaired. 3. Environmental Rounds Team and weekly Maintenance Rounds will continue to identify damaged window treatments. Environmental Rounds Team reports are reviewed by the Administrator and Director of Plant Operations; Maintenance Rounds reports are reviewed by the Director of Plant Operations. Housekeepers will be instructed to report damaged window treatments observed during routine room cleaning to the Housekeeping Team Leader, who will generate the Work Order Request for repair.	

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F 253	Continued From page 34 two (2) of 27 resident's rooms surveyed. 4. The walls were marred in four (4) of 27 resident's rooms (#254, #154, #135, #129). These observations were made in the presence of Employee #9 who acknowledged the findings.	F 253	All Work Order Requests are reviewed a minimum of weekly by the Director of Plant Operations, or designee, to ensure completion of repairs. 4. The Director of Plant Operations or designee will report a summary of damaged window treatment repairs and replacements to QI Committee monthly until damaged window treatments are replaced facility-wide at end of the 2014-2015 fiscal year (06/30/15). 5. Date of Compliance:	5/26/2014
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; 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	F 272	F253 (Wallpaper) 1. Loose wallpaper was either removed or re-glued in the hallways or Common Areas on the 3 resident units. 2. An inspection of all resident units did not identify any other currently torn or hanging wall paper. 3. Wallpaper on all resident units will continue to be inspected during Environmental Rounds and weekly Maintenance Rounds. Repairs will be completed promptly. One resident unit each fiscal year is budgeted for replacement of wallpaper with paint. The Director of Plant Operations or designee will review bi-monthly Environmental Rounds and weekly Maintenance Reports to ensure damaged wall paper repairs are completed in a timely manner.	

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F 272	Continued From page 35 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: A. Based on record review and staff interview for five (5) of 51 sampled residents, it was determined that the facility staff failed to accurately code the Minimum Data set (MDS) for one (1) resident's total care, urinary continent and diagnosis of blindness, for one (1) resident's difficulty swallowing , for one (1) resident's being edentulous on the significant change MDS, one (1) resident for diagnosis of HTN [hypertension], one (1) resident for A-fib [Atrial Fibrillation], CHF [Congestive Heart Failure] and HLD [Hyperlipidemia] and one (1) resident with a diagnosis of CAD [Coronary Artery Disease]. Residents #1, #34, #62 ,#116, #252 and #291 The findings include: 1a. Facility staff failed to accurately code Resident #1's Minimum Data Sets (MDS) for total care, urinary continent and blindness. A review of the clinical record for Resident #1 revealed facility staff failed to accurately code Section G, Functional Status - G0110 Activity of	F 272	4. The Director of Plant Operations or designee will inspect the wallpaper in hallways and Common Areas of resident units during rounds to validate prompt identification and repair of newly damaged areas. 5. Compliance Date F253 (Marred Walls) 1. The marred walls in rooms 254, 154, 135, and 129 were repaired. 2. A facility-wide resident room inspection will be completed to identify and repair any additional marred walls. 3. Environmental Rounds Team and weekly Maintenance Rounds will continue to inspect walls for damage. Housekeepers will be instructed to report damaged walls observed during routine room cleaning to the Housekeeping Team Leader, who will generate a Work Order Request for repair. All Work Order Requests are reviewed a minimum of weekly by the Director of Plant Operations, or designee, to ensure completion of repairs. 4. The Director of Plant Operations, or designee, will report a summary of marred wall repairs to the QI Committee monthly. 5. Date of Compliance	5/26/2014 5/26/2014

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F 272	Continued From page 36 Daily Living Assistance of the quarterly MDS dated November 5, 2013 and annual MDS dated February 5, 2014. The check box allotted next to Section G0110 - Activity of Daily Living Assistance was coded as " 4 " indicating that the resident was total dependence (full staff performance every time during entire 7-day period). On April 17, 2014 at approximately 10:18 AM, Resident #1 was observed exposed from his/her head to his/her groin area with a clear colored urinal in his/her left hand. He/she was observed independently using [his/her] urinal. The observation of Resident #1 independently using the urinal on April 17, 2014 at approximately 10:18 AM provided evidence that facility staff miscoded MDS Section G0110 - Activity of Daily Living Assistance. A face-to-face interview was conducted with Employee # 27 on April 17, 2014 at approximately 10:22 AM. He/she reviewed the clinical record and acknowledged the findings. The record was reviewed April 17, 2014. 1b. A review of the clinical record for Resident #1 revealed facility staff failed to accurately code Section G, Functional Status - H0300 Urinary Continence of the quarterly MDS dated November 5, 2013 and annual MDS dated February 5, 2014. The check box allotted next to Section H0300A - Urinary Continence was coded as " 3 " indicating that the resident was always incontinent (no episodes of continent voiding).	F 272	F272 (Resident #1) 1. The coding of Minimum Data Set (MDS), Section G. for Resident #1 was corrected. 2. An MDS audit identified no other Section G. Coding errors. 3. The MDS Coordinator or designee will monitor coding accuracy for residents with a diagnosis of vision impairment and/or urinary incontinence by auditing the quarterly and annual MDS assessments. The MDS Coordinator or designee will reeducate staff coding Section G. and schedule an annual education session on MDS coding for all IDT members. 4. The MDS Coordinator or designee will audit 10% of all MDS assessments for coding accuracy on each nursing unit on a rotating schedule monthly and report findings to the QI Manager. The QI Manager will present audit findings to Focus QI-IDT meeting and QI Committee monthly. 5. Compliance Date	6/6/2014

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F 272	Continued From page 37 On April 17, 2014 at approximately 10:18 AM, Resident #1 was observed exposed from his/her head to his/her groin area with a clear colored urinal in his/her left hand. He/she was observed to be independently using the urinal. There was no evidence that facility staff accurately coded Resident #1's urinary continence on the quarterly MDS. A face-to-face interview was conducted with Employee # 27 on April 17, 2014 at approximately 10:22 AM. After reviewing the clinical record; he/she acknowledged the findings. The record was reviewed April 17, 2014. 1c. A review of the clinical record for Resident #1 revealed facility staff failed to accurately code Section I, Active Diagnosis under I8000 D Additional Active Diagnosis for Blindness both eyes: impaired level N of the quarterly MDS dated November 5, 2013 and annual MDS dated February 5, 2014. A review of the comprehensive care plan initiated on February 8, 2014 revealed; "Problem [Resident's name] has a visual impairment. " The care plan of Resident #1 provided evidence that facility staff miscoded MDS Section I8000D - Additional Active Diagnosis coded for Blindness in both eyes: impaired level N.	F 272	F272 (Resident #34) 1. Resident #34's record is closed; blank MDS Section K. cannot be corrected. 2. An MDS audit identified no other blank Section K. coding. 3. The MDS Coordinator or designee will audit Section K. coding in all quarterly and annual MDS assessments. The MDS Coordinator will reeducate staff responsible for coding Section K. and conduct an annual MDS coding education session with all IDT members. 4. The MDS Coordinator or designee will audit 10% of all Section K. MDS assessments on each nursing unit on a rotating schedule monthly and report findings to the QI Manager. The QI Manager will present audit findings to the Focus QI-IDT weekly meeting and summary to the QI Committee monthly. 5. Compliance Date	6/6/2014

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F 272	Continued From page 38 A face-to-face interview was conducted with Employee # 27 on April 17, 2014 at approximately 10:22 AM. He/she reviewed the clinical record and acknowledged the findings. The record was reviewed April 17, 2014. 2. Facility staff failed to accurately code Section K(Swallowing/Nutritional Status) on the admission Minimum Data Set [MDS] dated April 1, 2014 for Resident #34. An admission history and physical dated March 26, 2014 included diagnoses: Old CVA (Cerebral Vascular Accident) with left hemi paresis with left leg neuropathy and Thrush. He/she has had thrush of [the] mouth for some time. Treated with magic mouth wash and Nystastin. [He/she\] has trouble eating solid food. " According to a nutrition care progress note dated March 26, 2014 revealed: " Weight is 84 [pounds] ... does not want mechanical soft or puree diet has thrush so bad cannot swallow at all. Have list of foods to send ..." The admission MDS dated April 1, 2014 lacked evidence that facility staff coded [the section was blank] Section K, Swallowing/Nutritional Status [K0100-C] to include complaints of difficulty or pain with swallowing. Facility staff failed to code Resident #34 for a swallowing disorder on the admission MDS.	F 272	F272 (Resident #62) 1. Resident #62's record is closed; MDS coding cannot be corrected. 2. A MDS audit identified no other resident assessments with Section I. hypertension coding errors. 3. The MDS Coordinator or designee will audit quarterly and annual MDS Section I. coding accuracy for residents with diagnosis of hypertension. The MDS Coordinator will reeducated staff responsible for coding Section I. and conduct an annual coding education session for all IDT members. 4. The MDS Coordinator or designee will audit 10% of all Section I. MDS assessments on each nursing unit on a rotating schedule monthly and report findings to the QI Manager. The QI Manager will present audit findings to the Focus QI-IDT weekly meeting and a summary to QI Committee monthly. 5. Compliance Date	6/6/2014

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F 272	Continued From page 39 A face-to-face interview was conducted with Employee #14 on April 22, 2014 at approximately 10:30 AM. After review of the MDS, he/she acknowledged the aforementioned findings. The record was reviewed on April 22, 2014. 3. Facility staff failed to accurately code Section L (Oral/Dental/Status) of the significant change MDS for no natural teeth (edentulous) for Resident #62. According to a dental consultation dated June 6, 2013 revealed: " Upon clinical exam patient presents totally edentulous. No soft or hard tissue pathology noted. No facial asymmetry. Patient seems to be OK. Patient wearing dentures upper/lower. " During an isolated observation of Resident #62 in the presence of Employee #28 on April 21, 2014 at approximately 10:00 AM, the resident mouth was observed with no teeth. The assigned CNA was completing the resident ' s am care. He/she was in the process of cleaning the resident ' s dentures. Observed upper and lower dentures in the denture cup. The significant MDS dated August 27, 2013 and September 12, 2013 lacked evidence that facility staff coded [the section was blank] Section L, Oral/ Dental Status [L0200-B] to include the resident being edentulous on the dentist assessment. Facility staff failed to code Resident #62 for no	F 272	F272 (Resident #116) 1. Resident #116's record is closed; MDS coding cannot be corrected. 2. An MDS audit identified no other residents with diagnosis of hypertension Section I. coding errors. 3. The MDS Coordinator or designee will audit all quarterly and annual MDS Section I. assessments for coding accuracy. The MDS Coordinator will reeducate staff responsible for coding Section I. and conduct an annual coding review for all IDT members. The Unit Clerk will audit closed records for MDS Section I. coding accuracy, as part of the closed record review, within 72 hours of medical record closure. The Unit Clerk will submit Closed Record Review reports to the Clinical Manager for review and follow-up, if indicated. The Director of Medical Records will continue the monthly Closed Record Review. 4. The MDS Coordinator or designee will audit 10% of Section I. MDS assessments on each nursing unit on a rotating schedule monthly. The MDS Coordinator and Unit Clerk will submit audit reports to the QI Manager monthly. The QI Manager will report findings to the Focus QI-IDT weekly meeting and QI Committee monthly. The Director of Medical Records will continue to submit Closed Record Review Reports to the QI Committee monthly. 5. Compliance Date	6/6/2014

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F 272	Continued From page 40 natural teeth (edentulous) on the significant change MDS. A face-to-face interview was conducted with Employee #27 on April 22, 2014 at approximately 11:00AM. After reviewing the clinical record, he/she acknowledged the aforementioned findings. The record was reviewed on April 22, 2014. 4. Facility staff failed to accurately code Resident #116's admission Minimum Data Sets (MDS) for a diagnosis of HTN [hypertension]. This was a closed record review. A review of the Admissions MDS with an ARD [Assessment Reference Date] of February 11, 2014 revealed facility staff failed to accurately code Section I, Active Diagnoses - I0700 Hypertension, A review of the admissions " Physician Order Sheet And Plan Of Care " dated and signed February 6, 2014 revealed under diagnoses included: Cardiac Thrombosis, CAD [Coronary Artery Disease], HTN [hypertension], Ischemic Cardiomyopathy, Nephrolithiasis, Acute Renal Failure, Acute Tubular Necrosis. " The check box allotted next to Section I0700 - Hypertension was left " blank " indicating that the resident was not coded for the diagnosis of Hypertension.	F 272	F272 (Resident #291) 1. Resident #291's record is closed; MDS coding cannot be corrected. 2. A MDS audit identified no other residents with Section I coding errors for Coronary Artery Disease diagnosis. 3. As stated for Resident #116 4. As stated for resident #116 5. Compliance Date: F272 (Residents #1 and 62) 1. The MDS CAA information for the sections mentioned for Residents #1 and #62 was corrected. 2. A MDS audit of Sections G., H., and V. identified no other residents with coding errors. 3. The MDS Coordinator or designee will audit 10% of Sections G., H., and V. on the nursing units on a rotating monthly schedule for coding accuracy. The MDS Coordinator will reeducate staff responsible for completing Sections G., H., and V. and conduct an annual MDS coding education session (including identification of location and date of CAA information) with IDT members. 4. The MDS Coordinator will submit audit reports to the QI Manager for presentation of findings to the Focus QI-IDT weekly meeting. The QI Manager will report a summary to QI Committee monthly. 5. Compliance Date:	6/6/2014 6/6/2014

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F 272	Continued From page 41 A face-to-face interview was conducted with Employee #27 on April 17, 2014 at approximately 2:30 PM. After review of the admissions MDS He/she acknowledged the findings. The record was reviewed April 17, 2014. 5 . Facility staff failed to accurately code Resident #252's admission Minimum Data Set (MDS) for diagnoses of A-fib [Atrial Fibrillation], CHF [Congestive Heart Failure] and HLD [hyperlipedemia]. This was a closed record review. A review of the Admissions MDS with an ARD [Assessment Reference Date] of February 12, 2014 revealed that facility staff failed to accurately code Section I, Active Diagnoses - I0300 Atrial Fibrillation, I0600 CHF [Congestive Heart Failure] and I3300 Hyperlipedemia. The check box allotted next to the Sections were left " blank " indicating that the resident was not coded for the above diagnoses. A review of the admission ' s "Physician Order Sheet And Plan Of Care" signed and dated February 5, 2014 revealed the diagnoses included: A-Fib, COPD [Chronic Obstructive Pulmonary Disease] CHF [congestive heart failure], HLD [Hyperlipedemia]. " A face-to-face interview was conducted with Employee #27 on April 17, 2014 at approximately	F 272		

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F 272	Continued From page 42 2:30 PM. After review of the admissions MDS, he/she acknowledged the findings. The record was reviewed April 17, 2014. 6. Facility staff failed to accurately code Resident #291's admission Minimum Data Set (MDS) for a diagnosis of CAD. Resident #291. A review of the admissions MDS with an ARD date of March 6, 2014 revealed that facility staff failed to accurately code Section I, Active Diagnoses - I0400 Coronary Artery Disease. A review of the admissions " Physician Order Sheet And Plan Of Care " signed and dated February 6, 2014 revealed under diagnoses: Left heel wound and cellulites, Anemia, Aortic Stenosis, BPH, CAD s/p [status/post] CABG [Coronary Artery Bypass Graft], Gout, Pulmonary Hypertension, PVD [Peripheral Vascular Disease]. " The check box allotted next to Section I0400 - Coronary Artery Disease was left " blank " indicating that the resident was not coded for the diagnosis of Coronary Artery Disease. A face-to-face interview was conducted with Employee # 27 on April 17, 2014 at approximately 2:30 PM. After review of the admissions MDS, he/she acknowledged the findings. The record was reviewed April 17, 2014.	F 272		

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F 272	Continued From page 43	F 272		

B. Based on record review and staff interview for two (2) of 51 sampled residents, it was determined facility staff failed to identify the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section G [G0110] and H [H0300] for one (1) resident, Section V [V0200A] for one (1) resident and Residents #1, and # 62.

The findings include:

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

1.Facility staff failed to indicate in the location and date of CAA documentation column for Resident #1 where information related to the CAA could be found on the Annual MDS dated February 5, 2014.

A review of Resident #1' s annual Minimum Data Set dated February 5, 2014 revealed that in the Care Areas Assessment (CAA) Results section revealed the following: Care Plan triggered areas for #3 Visual Function, #5 ADL [Activities of Daily Living] Functional/ Rehabilitation Potential and #6 Urinary Incontinence and Indwelling Catheter slots allotted for location, date of CAA documentation were left blank.

The clinical record lacked evidence of

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F 272	Continued From page 44 documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employees #27 on April 22, 2014 at 10:30 AM. He/she acknowledged that the date and locations where information related to the CAA can be found was not documented on the CAA Summary. 2. Facility staff failed to identify the location and date of Care Area Assessment (CAA) information under Section V [V0200A], " Care Area Assessment Summary " of the significant Minimum Data Set [MDS] for Resident #62. A review of Resident #62 ' s annual Minimum Data Set dated September 12, 2013 revealed that Care Areas Assessment and ' addressed ' in Care Plan triggered for #1 Delirium, #2 Visual Function, #4 Communication, #6 Urinary Incontinence and Indwelling Catheter, #7 Psychological Well-Being, ##9 Behavioral Symptoms, #11 Falls, #12 Nutritional Status, #13 Feeding Tube, #16 Pressure Ulcer, and #17 Psychotropic Drug Use. " The record revealed that the location and date of CAA information [for care areas #1, 2, 4, 6, 7, 9, 11, #12, #13, 16, and #17] were recorded as " CAA Analysis, Disease Process ..., and 1:1 interactions ... "	F 272		

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F 272	Continued From page 45 There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. There were no " CAA worksheets " available for review. The clinical record lacked evidence of documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employees #27 on April 22, 2014 at 10:30 AM. He/she acknowledged that the date and location where information related to the CAA can be found was not documented on the CAA Summary.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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	F 279		

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F 279	Continued From page 46 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 three (3) of 51 sampled residents, it was determined that facility staff failed to develop care plans with goals and approaches for the management of a Nephrostomy tube for one (1) resident, one (1) resident receiving hospice services and for the use of compression stockings for one (1) resident with edema. Residents # 207, #211 and #252 The findings include 1. Facility staff failed to develop a care plan with goals and approaches to address resident#207 ' s use of a Nephrostomy tube. This was a closed record review. A review of the physician " history and physical " signed and dated December 14, 2013 revealed, " ... Nephrostomy tube placement secondary to acute renal failure. " A review of Physician ' s order sheet and plan of care dated and signed December 18, 2013 directed: Change Nephrostomy bag every week and as needed. Change dressing to Nephrostomy tube every three days and as needed. ... Flush Nephrostomy tube every 8hrs [hours] with 30ml [milliliters] water. Measure output every shift. "	F 279	F279 (Resident #207) 1. Resident record is closed. Care plans cannot be added. 2. No other residents were found to be presently affected. 3. Within 72 hours of any admission to a nursing unit, the Clinical Manager will complete the Admission Chart Audit Tool which includes an audit of appropriate care plans for the needs of a resident. The Clinical Manager will monthly audit 10% of all resident(s) medical records utilizing the Chart Audit Tool: audit includes review of care plans. The monthly Chart Audit tools are submitted to the Director of Nursing for review and following review are forwarded to the QI Manager. 4. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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F 279	Continued From page 47 A review of the care plan section lacked evidence that a care plan with goals and approaches were developed to address Resident #207 ' s Nephrostomy tube management. A face-to-face interview was conducted on April 15, 2014 at approximately 11:20 AM with Employee #7. He/she acknowledged the findings after reviewing the record. The record was reviewed April 15, 2014. 2. Facility staff failed to develop a jointly coordinated care plan with goals and approaches between the facility and the hospice services for Resident #211. A review of the " Physician Order Sheet and Plan of Care " revealed that the resident was admitted to the facility on February 21, 2014 with the following diagnosis: Adenocarcinoma of the Esophagus, Hx [history] [of] Upper Gastrointestinal bleed secondary to Adenocarcinoma of [the] esophagus. According to the Interdisciplinary Progress Note dated February 24, 2014, no time indicated, " 81 year old woman with Esophageal Adenocarcinoma admitted to [facility name] 2/21/14 [February 21, 2014] DNR/DNI [Do Not Resuscitate/Do Not Intubate] in Hospice. " Review of the " Progress Notes by Resident " progress notes identified that hospice care had been conducted February 22, 2014 through March 12, 2014.	F 279	F279 (Resident #211) 1. Resident record is closed. Care plans cannot be added. 2. No other residents were found to be presently affected. 3. Within 72 hours of admission of a resident to Hospice Services, the Clinical Manager will audit the resident's medical record to ensure an integrated Long Term Care/Hospice Care plan is a part of the medical record and collaborate with Hospice Services if integrated care plan is not available. Within 72 hours of any admission to a nursing unit, the Clinical Manager will complete the Admission Chart Audit Tool which includes an audit of appropriate care plans for the needs of a resident. The Clinical Manager will monthly audit 10% of all resident(s) medical records utilizing the Chart Audit Tool: audit includes review of care plans. The monthly Chart Audit tools are submitted to the Director of Nursing for review and following review are forwarded to the QI Manager. 4. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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F 279	Continued From page 48 Review of the resident ' s care plans lacked evidence of a jointly coordinated care between the hospice services and the facility. A face-to-face interview was conducted with Employee #32, after review of the medical record he/she acknowledged that the resident's record lacked evidence of a jointly coordinated care plan between the hospice service and the facility. Facility staff failed to initiate an integrated care plan with goals and approaches to reflect the resident ' s current status. 3. Facility Staff Failed to develop a care plan with goals and approaches to address resident#252 ' s use of compression stockings for edema. This was a closed record review. A review of the physician " history and physical " signed and dated February 5, 2014 revealed, " ... (4) CHF [Congested Heart Failure]: compensated, EF [Ejection Fraction] 58; continue Metoprolol [antihypertensive]; off Lasix [diuretics] due to dehydration. Start compression stockings. " A review of Physician ' s order sheet and plan of care dated and signed February 5, 2014 directed: " Bilateral knee, apply skin prep every shift. Compression stocking B/L [bilateral] lower legs on 8AM [morning] off 8PM [night]. " A review of the care plan section lacked evidence	F 279	F279 (Resident #252) 1. Correction has been made: care plan for compression stockings added to medical record. 2. No other residents were found to be presently affected. 3. The Clinical Manager using the Chart Audit Tool will conduct an audit of 10% of all resident medical records: audit includes review of care plans to meet the resident(s) needs. The Clinical Manager will monthly audit 10% of all resident charts. Chart Audit Tools are submitted to the Director of Nursing for review and following review are forwarded to the QI Manager. 4. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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F 279	Continued From page 49 that a care plan with goals and approaches were develop to address Resident #252 ' s use of Compression stockings. A face-to-face interview was conducted on April 15, 2014 at approximately 11:20 AM with Employee #7. After the review of the care plan, he/she acknowledged the findings. The record was reviewed April 15, 2014.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview for three(3) of 51 sampled residents, it was	F 280		

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F 280	Continued From page 50 determined that facility staff failed to review and revise a care plan with goals and approaches to reflect the resident ' s current status for one (1) resident with a change in delivery of ADL (Activities of Daily Living) care; one (1) who refused care, one (1) resident abnormal INR [international Normalized Ratio] levels. Residents #6, #122 and #154 The findings Include: 1. Facility staff failed to review and revise a care plan for Resident #6 who had a change in delivery of ADL care. A resident interview was conducted on April 17, 2014 at approximately 2:00 PM with Resident #6. The resident stated that on all three (3) shifts that his/her care has been expanded to include two (2) CNA ' s [Certified Nursing Assistants], and that he/she could understand a second person during the night shift for turning and repositioning because of the wedge pillow that is put in place, but not on all three (3) shifts. Resident #6 further indicated that there is also a timer placed in his/her room to let the CNA ' s know when 45 minutes are up, that is the time limit to provide care to me. A face-to-face interview was conducted on April 18, 2014 with Employees #1, #2, and #12 at approximately 2:00 PM. A query was made regarding the above statement voiced by the resident.	F 280	F280 (Resident #6) 1. The care plan indicating the need for the resident to have two (2) nursing staff care for them within a 45 minute time frame has been in place since 2010 and was thinned from the current medical record. A more current revised care plan was place in the resident's medical record during the Survey. 2. No other residents were found to be presently affected. 3. The Clinical Manager using the Chart Audit Tool will conduct an audit of 10% of all resident medical records: audit includes review of care plans to meet the residents(s) needs. The Clinical Manager will monthly audit 10% of all resident charts. Chart Audit Tools are submitted to the Director of Nursing for review and following review are forwarded to the QI Manager. 4. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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F 280	Continued From page 51 Employee #2 stated " there are two (2) persons per shift to perform direct care, if water needed or if trash is to removed, there is only a need for one (1) person. The 45 minute timer is still in use. " A review of the resident care plan lacked evidence of revision to include the two (2) CNA ' s that are required for direct care during all three (3) shifts and a time to identify 45 minutes of time allowed to provide care by the CNA. A face-to-face interview was conducted with Employee #6 on April 21, 2014 at approximately 1:00 PM. After review of the care plan he/she acknowledged the findings and stated that the previous unit manager is not here, when I took over, these issues were already addressed. Facility staff failed to review and revise a care plan with goals and approaches to reflect the resident ' s current status. 2. Facility staff failed to review and revise Resident #122 ' s care plan to include refusal of care. During an initial tour conducted on April 14, 2014 at approximately 9:15 AM, observed Resident #122 lying in bed on his/her back. Resident was covered with a white sheet and blanket. Observed resident hair with multiple braids held together with a single rubber band. His/her hair	F 280	F280 (Resident #122) 1. The need of the resident to have their care plan include refusal of care has been corrected. 2. No other residents were found to be presently affected. 3. The Clinical Manager using the Chart Audit Tool will conduct an audit of 10% of all resident medical records: audit includes review of care plans to meet the residents(s) needs. The Clinical Manager will monthly audit 10% of all resident charts. Chart Audit Tools are submitted to the Director of Nursing for review and following review are forwarded to the QI Manager. 4. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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F 280	Continued From page 52 was untidy and matted in the back. A second observation occurred on April 22, 2014 at approximately 3:00 PM. Resident #122 was lying in his/her bed; observed resident ' s hair with white flakes throughout his/her hair. The back of his /her head; the hair was braided and held together with a single rubber band. The hair was matted and untidy. A face-to-face interview was conducted with Employee #36 on April 22, 2014 at approximately 3:05 PM. When queried regarding care of resident ' s hair; he/she replied; " He/she refused to get his/her hair cut and combed. He/she gets a shower and his/her hair is washed. However, he/she does not want anyone to comb it. " A face-to-face interview was conducted with Employee #35 on April 22, 2014 at approximately 3:20 PM. He/she stated; " [Resident named] POA (Power of Attorney) wanted him/her to go down to the barber ...but when I ask him if he/she is ready to go down to the barber; he always states, " Not today. " The comprehensive care plan most recently updated, February 16, 2014 lacked evidence of a revision to include goals and approaches to manage repeated refusal of hair grooming. Facility staff failed to review and revise Resident #122 ' s care plan to include refusal of care. A follow-up face-to-face interview was conducted with Employee #6 on April 22, 2014 at approximately 3:30 PM. He/she acknowledged the aforementioned findings. The observation and clinical record review was conducted on April 22, 2014.	F 280	F280 (Resident #154) 1. The care plan of resident #154 was revised and updated to include abnormal INR levels. 2. No other residents were found to be presently affected. 3. The Clinical Manager using the Chart Audit Tool, will conduct an audit of 10% of all resident medical records: audit includes review of care plans to meet the residents(s) needs. The Clinical Manager will, on a monthly basis, audit 10% of all resident charts. Chart Audit Tools are submitted to the Director of Nursing for review and following review are forwarded to the QI Manager. 4. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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F 280	Continued From page 53	F 280		

3. Facility staff failed to review and revise Resident #154's care plans with approaches and interventions to reflect the residents abnormal INR levels.

A review of the clinical record revealed lab work with PT/INR levels that follows:

January 2, 2014 PT/INR was 1.90 low ranges (2.00 - 3.00)
February 3, 2014 PT/INR was 1.60 low ranges (2.00 - 3.00)
March 13, 2014 PT/INR was 3.69 high ranges (2.00 - 3.00)
March 20, 2014 PT/INR was 2.23 WNL (2.00 - 3.00)

A review of the physician orders on the active clinical record revealed the following orders:

January 2, 2014 directed " PT/INR in one month, no change to Coumadin dose at this time. "
February 3, 2014 directed, D/C Coumadin 2mg, Coumadin 2.5mg by mouth daily for A-fib.
February 25, 2014 directed check PT/INR Dx A-fib
March 13, 2014 directed D/C Coumadin 2.5mg, Coumadin 2mg by mouth daily for A-fib, check PT/INR in one week 3/20/14

A review of the careplan on the active clinical record for Resident #154 revealed that the facility staff failed to update the care plans with approaches and interventions to reflect the abnormal INR levels.

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F 280	Continued From page 54 The careplan lacked evidence that the facility staff updated the careplan with approaches and interventions to reflect the abnormal INR lab values as it relates to the resident. A face-to-face interview was conducted on April 14, 2014 with Employee #3 at approximately 3:05PM. He /she acknowledge the findings. The record was reviewed April 15, 2014.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview for two (2) of 51 sampled resident, it was determined that facility staff failed to ensure proper techniques were followed according to accepted standards of clinical practice prior to administration of medications. Residents #78 and #182. The findings include: Facility staff failed to ensure proper techniques were followed according to accepted standards of clinical practice prior to administer medications via the gastrostomy tube for Residents #78 and #182. Employee #34 was observed on April 14, 2014 during two (2) medication pass at approximately 12:30 PM and 1:10 PM. The employee was observed preparing Resident #78 and #182 ' s medications. Prior to administering the	F 281		

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F 281	Continued From page 55 medications via gastrostomy tube, he/she informed the residents the indications for each medication. After checking for residual, Employee #34 proceeded to administer each medication separately through a 60 ml (millimeter) syringe attached to the gastrostomy tube and allowed each to infuse by gravity. He/she did not check for correct placement of the gastrostomy tube prior to the administration of the medications. The facility ' s policy entitled; " Medication Administration, " Policy No: TC-00003.12, page 5 of 6 stipulates: " Prior to infusion of a feeding and/or before administering medications via a feeding tube, the feeding tube must be checked for placement each time. To accomplish this task do the following: Remove the plug from the end of the tube, Attach a 50-60 ml. syringe to the end of the tube, Place a stethoscope over the abdomen approximately 3cm below the sternum. Unclamp tube and inject 10 ml of air into the stomach: listen for a gurgling sound- gurgling equals probable proper placement of tube, As a second check, draw back on the syringe and aspirate stomach contents: ....." According to " The Lippincott Manual of Nursing Practice " , Seventh edition, page 664 stipulates; " Procedure- Nursing Action-Preparatory Phase- #7. Use the catheter-tipped syringe, inject 20 cc-30cc of air while listening with a stethoscope positioned at the epigastric area. Rationale: Auscultation of a " whooshing " or bubbling sound assists in confirmation of proper tube placement. " Facility staff failed to ensure proper techniques were followed according to accepted standards of clinical practice prior to administering medications	F 281	F281(Resident #78 and 82) 1. License Nurse that failed to check placement of the gastrostomy tube for residents 78 and 82 received counseling and education regarding medication administration of medications through a gastrostomy tube and for all medications. 2. No other residents were found to be presently affected. 3. An education session to review the facility Medication Administration Policy (includes administration of medications through a gastrostomy tube) will be conducted for all licensed nurses. All licensed nurses will take and must successfully pass an annual Medication Administration Competency: skill and written exam. All licensed nurses to ensure continued competency in medication administration will receive a Medication Administration Observation conducted at least once monthly by the Clinical Manager or designee on all three shifts. 4. The findings of the Medication Administration Observations will be discussed weekly at the Focus QI Meeting with recommendations offered for nurse counseling and/or education and will be reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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F 281	Continued From page 56 via the gastrostomy tube for Residents #78 and #182. A face-to-face interview was conducted with Employee #34 on April 14, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The observation was conducted on April 14, 2014.	F 281		
F 309 SS=E	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 observations, record review and staff interview for ten (10) of 51 sampled residents, it was determined that facility staff failed to ensure that each resident received 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 as evidenced by a failure to: administer medications in accordance with physician's orders for three (3) residents; assess oxygen saturation levels for one (1) resident as prescribed; consistently conduct monitoring and assessments for one (1) resident with a respiratory disorder; provide end of life services and implement end of life policies for three (3) residents identified as receiving	F 309		

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F 309	Continued From page 57 palliative care; assess oxygen saturation levels as prescribed for one (1) resident; obtain physician's orders for one (1) resident who received hospice services and assess the level of pain for one (1) resident prescribed more than one (1) analgesic for pain. Residents #78, #95, #98, #106, #153, #182, #211, 213, #291, #305. The findings include: The facility ' s policy entitled; " Medication Administration, " Policy No: TC-00003.12, page 5 of 6 stipulates: " Prior to infusion of a feeding and/or before administering medications via a feeding tube, the feeding tube must be checked for placement each time. To accomplish this task do the following: Remove the plug from the end of the tube, Attach a 50-60 ml. syringe to the end of the tube, Place a stethoscope over the abdomen approximately 3cm below the sternum. Unclamp tube and inject 10 ml of air into the stomach: listen for a gurgling sound- gurgling equals probable proper placement of tube, As a second check, draw back on the syringe and aspirate stomach contents: ... ..." The American Academy of Hospice and Palliative Medicine (AAHPM) www.aahpm.org <http://www.aahpm.org> Clinical Practice Guidelines for Quality Palliative Care Statement: The goal of palliative care is to prevent and relieve suffering, and to support the best possible quality of life for patients and their families, regardless of their stage of disease or the need for other therapies, in accordance with their values and preferences. Palliative care is both a philosophy of care and an organized, highly structured system for delivering care....	F 309	F309 Resident 95 1. Resident #95 is discharged. 2. A review of physician orders for residents nearing end-of-life, identified the same or similar Comfort Care orders. The Medical Director will implement corrective actions. 3. The Medical Director will develop a plan to replace the terminology of Comfort Care orders with a breakdown of specific orders to provide individualized Palliative Care for residents at the end of life. The resident-specific orders will reflect the resident's choice, with a plan of care to support the resident's personal preferences for care and treatment. The Medical Staff will determine the process and the Medical Director or designee will educate facility staff. The Medical Director will obtain Medical Staff consensus for peer review audit criteria for use by QI Manager to pre-screen for effectiveness of the changes. 4. The QI Manager will pre-screen the current monthly Mortality Review Report using criteria provided by the Medical Director, who will follow with physician peer review. The Medical Director will report physician peer review findings to the Medical Staff and QI Committee monthly. 5. Date of Compliance:	6/6/2014

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F 309	Continued From page 58 According to the "Lippincott Manual of Nursing Practice Seventh Edition " Palliative Care P162 " Palliative care is the active total care of patients with advanced illness. The focus is no longer on curative treatment, but on quality of life and integrating the physical, psychological, spiritual, and social aspects of care. Principles of Palliative Care P163: 1. Palliative care is an interdisciplinary team approach, including experts from medicine, nursing, social work, the clergy and nutrition. This team is approach is needed to make necessary assessments and to institute appropriate interventions. 2. The essential components of Palliative care are relief of relief of symptom distress, improved quality of life, opening of communication on a regular basis with patients to provide appropriate care on their terms, and psycho social support for patients and families. 3. The goal is to provide comfort and maintain the highest possible quality of life for a long as possible. 4. The traditional focus of palliative care is not on death but on a compassionate understanding of patient suffering and focuses on providing effective pain and symptom management to seriously ill patients, while improving quality of life. 1. Facility staff failed to administer medications in accordance with physician's orders, via [by] Gastrostomy tube, for Resident #78.	F 309	Resident #78 1. License Nurse that failed to check placement of the gastrostomy tube for residents 78 and 82 received counseling and education regarding medication administration of medications through a gastrostomy tube and for all medications. 2. No other residents were found to be presently affected. 3. An education session to review the facility Medication Administration Policy (includes administration of medications through a gastrostomy tube) will be conducted for all licensed nurses. All licensed nurses will take and must successfully pass an annual Medication Administration Competency: skill and written exam. All licensed nurses to ensure continued competency in medication administration will receive a Medication Administration Observation conducted at least once monthly by the Clinical Manager or designee on all three shifts. 4. The findings of the Medication Administration Observations will be discussed weekly at the Focus QI Meeting with recommendations offered for nurse counselling and/or education and will be reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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F 309	Continued From page 59 Employee #34 was observed on April 14, 2014 during a medication pass at approximately 12:30 PM. The employee was observed preparing Resident #78 ' s medications for administration via Gastrostomy. After checking for residual, Employee #34 proceeded to administer each medication separately through a 60 ml syringe attached to the Gastrostomy tube and allowed each to infuse by gravity. He/she did not check for correct placement of the Gastrostomy tube prior to the administration of the medications. According to the physician ' s order form dated April 4, 2014 directed: "Flush G-Tube (Gastrostomy Tube) with 300 ml of water every shift. Check residual before feeding ..., Check tube for proper placement prior to each feeding, flush or medication administration every shift. " Facility staff failed to check for proper placement of Gastrostomy tube prior to administration of medications. A face-to-face interview was conducted with Employee # 34 on April 14, 2014 at approximately 3:00 PM. He/she acknowledged he/she did not listen with his/her stethoscope for proper placement of the Gastrostomy tube prior to administering the medication. The observation was made on April 14, 2014. 2. Facility staff failed to develop and implement measures to provide comfort care services for Resident #95 who was identified as receiving " comfort care. " A review of the QIS [Quality Indicator Survey] entrance conference worksheet submitted upon	F 309	Resident #153 1. Too much time had elapsed to complete a late entry into nursing progress note of resident # 153. 2. No other residents were found to be presently affected. 3. The licensed nurse will consistently document for three days the status of all residents admitted to the facility: to include vital signs. The process will be added to the Open Charting Policy. All licensed nurse will receive a Back to Basics education session: to include systems assessment, review of the Open Charting Policy and review of documentation of alterations in resident skin integrity. Using the Open Charting Policy all residents experiencing an acute change in status will be documented on in the EMR until the acute change in status is resolved. The Clinical Manager as part of their monthly chart audit will review when appropriate for the resident(s) if the Open Charting Policy was implemented.	

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F 309	Continued From page 60 request to the survey team, Resident #95 was identified as requiring " Comfort Care/End of Life Care. " A review of the clinical record revealed that there were no physician orders, treatment or care plan directing staff in caring for and meeting Residents #95 ' s comfort care needs. " A fact- to- face interview was conducted with Employee# 2 on April 21, 2014 at approximately 3:00 PM, when queried requesting a copy of the facilities palliative care policy, he/she stated "there is no policy related to palliative/comfort care. " A face-to-face interview was conducted with the Employee #4 on April 21 at approximately 3:30 PM, when queried regarding how staff knew what comfort care orders and treatment to implement he/she stated the, Physician Orders for Life Sustaining Treatment (POLST) is used as comfort care orders on the unit. Employee #4 stated he/she was not aware of a specific comfort care policy. When queried regarding POLST form last signed and dated April 4, 2008 he/she stated " I was not aware of that. " A face to face interview was conducted with Employee #20 on April 21, 2014 at approximately 4:00 PM, when queried about a comfort care treatment plan he/she replied " The medical team does not write comfort care orders, they discuss care with families and document in the medical record progress notes which the nurses always can use as a guideline " Employee #20 further stated " I don ' t see a need for writing specific comfort care orders. "	F 309	4. Findings from the monthly chart audit to ascertain implementation of the Open Charting policy will be discussed when appropriate at the Weekly Focus QI meeting and will reported quarterly (as part of monthly Chart Audit Tool findings) by the QI Manager to the QI Committee. * Implementation of Open Charting Policy will be added to the Chart Audit Tool used by the Clinical Manager to audit 10% of the medical records on their nursing units each month. 5. Compliance Date: <u>Resident #182</u> 1. License Nurse that failed to check placement of the gastrostomy tube for resident # 182 received counseling and education regarding medication administration of medications through a gastrostomy tube and for all medications. 2. No other residents were found to be presently affected.	6/6/2014

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F 309	Continued From page 61 A face to face interview was conducted with Employee #1 on April 20, 2014 at approximately 5:00 PM when questioned about the facility ' s Palliative/Comfort care program and policies he/she stated " there is no program or policies. " A face to face interview was conducted with Employee #1 on April 21 at approximately 9:15 AM when queried if there was a policy or guidelines for use of Physician Orders for life sustaining treatment form(POLST) His/her response was "no." There was no evidence that the facility was providing palliative care to Resident #95. A face to face interview was conducted with Employee #2 on April 21, 2014 he/she acknowledged the aforementioned findings. The medical record was reviewed on April 21, 2014. 3. Facility staff failed to develop and implement measures to provide comfort care services for Resident #98. A review of the QIS entrance conference worksheet submitted upon request to the survey team, identified Resident #98 as requiring " Comfort Care/End of Life Care. " A review of the clinical record revealed that there were no orders, treatment or care plan directing staff in caring for and meeting Residents #98's comfort care needs. " A fact to face interview was conducted with Employee# 2 on April 21, 2014 at approximately 3:00 PM, when queried requesting a copy of the facilities palliative care policy, he/she stated	F 309	3. An education session to review the facility Medication Administration Policy (includes administration of medications through a gastrostomy tube) will be conducted for all licensed nurses. All licensed nurses will take and must successfully pass an annual Medication Administration Competency: skill and written exam. All licensed nurses to ensure continued competency in medication administration will receive a Medication Administration Observation conducted at least once monthly by the Clinical Manager or designee on all three shifts. 4. The findings of the Medication Administration Observations will be discussed weekly at the Focus QI Meeting with recommendations offered for nurse counseling and/or education and will be reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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F 309	Continued From page 62 "there is no policy related to palliative/comfort care " A face-to-face interview was conducted with the Employee #4 on April 21 at approximately 3:30 PM, when queried regarding how staff knew what comfort care orders and treatment to implement he/she stated the, Physician Orders for Life Sustaining Treatment (POLST) is used as comfort care orders on the unit. Employee #4 stated he/she was not aware of a specific comfort care policy. When queried regarding POLST form last signed and dated April 4, 2008 he/she stated " I was not aware of that. " A face to face interview was conducted with Employee #20 on April 21, 2014 at approximately 4:00 PM when queried about a comfort care treatment plan he/she replied " The medical team does not write comfort care orders, they discuss care with families and document in the medical record progress notes which the nurses always can use as a guideline " Employee #20 further stated " I don ' t see a need for writing specific comfort care orders, the residents care is individualized. " A face to face interview was conducted with Employee #1 on April 21, 2014 at approximately 5:00 PM when questioned about the facility ' s Palliative/Comfort care program and policies he/she stated " there is no program or policies. " A face to face interview was conducted with Employee #1 on April 21 at approximately 9:15 AM when queried if there was a policy or guidelines for use of Physician Orders for life sustaining treatment form(POLST) His/her response was " no. "	F 309	Resident #213 1. License Nurse that failed to administer nasal spray according to physician orders received counseling and education regarding medication administration of all medications. 2. No other residents were found to be presently affected. 3. An education session to review the facility Medication Administration Policy will be conducted for all licensed nurses. All licensed nurses will take and must successfully pass an annual Medication Administration Competency: skill and written exam. All licensed nurses to ensure continued competency in medication administration will receive a Medication Administration Observation conducted at least once monthly by the Clinical Manager or designee on all three shifts. 4. The findings of the Medication Administration Observations will be discussed weekly at the Focus QI Meeting with recommendations offered for nurse counseling and/or education and will be reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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F 309	Continued From page 63 There was no evidence that facility was providing palliative care to Resident #98. A face to face interview was conducted with Employee #2 on April 21, 2014 he/she acknowledged the aforementioned findings. The medical record was reviewed on April 21, 2014. 4. Facility staff failed to develop and implement measures to provide comfort care services for Resident #106 who was identified as receiving " comfort care. " A review of the QIS entrance conference worksheet submitted upon request to the survey team, identified Resident #106 as requiring " Comfort Care/End of Life Care " . A review of the clinical record revealed that there were no orders, treatment or care plan directing staff in caring for and meeting Residents #106's comfort care needs. " A fact to face interview was conducted with Employee #2 on April 21, 2014 at approximately 3:00 PM, when queried requesting a copy of the facilities palliative care policy, he/she stated "there is no policy related to palliative/comfort care. " A face-to-face interview was conducted with the Employee #4 on April 21 at approximately 3:30 PM, when queried regarding how staff knew what comfort care orders and treatment to implement he/she stated the, Physician Orders for Life Sustaining Treatment (POLST) is used as comfort care orders on the unit. Employee #4 stated he/she was not aware of a specific comfort	F 309	Resident # 291 1. Medical record could not be corrected. Licensed nurses failing to obtain oxygen saturation level as per physician order have received counseling. 2. No other residents were found to be presently affected. 3. The Clinical Manager will, on a daily basis, audit the resident MAR and TAR of any resident that has received a new medication and/or treatment order to ensure the order has been implemented. Any resident receiving a new medication and/or treatment order will have the Open Charting Policy implemented. Using the Open Charting Policy all residents experiencing an acute change in status will be documented on in the EMR until the acute change in status is resolved. The Clinical Manager as part of their monthly chart audit will review when appropriate for the resident(s) if the Open Charting Policy was implemented. 4. Findings from the monthly chart audit to ascertain implementation of the Open Charting policy will be discussed when appropriate at the Weekly Focus QI meeting and will reported quarterly (as part of monthly Chart Audit Tool findings) by the QI Manager to the QI Committee.	

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F 309	Continued From page 64 care policy. When queried regarding POLST form last signed and dated March 13, 2009 he/she stated " I was not aware of that. " A face to face interview was conducted with Employee #20 on April 21, 2014 at approximately 4:00 PM when queried about a comfort care treatment plan he/she replied " The medical team does not write comfort care orders, they discuss care with families and document in the medical record progress notes which the nurses always can use as a guideline " Employee #20 further stated " I don ' t see a need for writing specific comfort care orders , the residents comfort care is individualized " . A face to face interview was conducted with Employee #1 on April 20, 2014 at approximately 5:00 PM when questioned about the facility ' s Palliative/Comfort care program and policies he/she stated " there is no program or policies. " A face to face interview was conducted with Employee #1 on April 21 at approximately 9:15 AM when queried if there was a policy or guidelines for use of Physician Orders for life sustaining treatment form(POLST) His/her response was " no. " There was no evidence that facility was providing palliative care to Residents #106 A face to face interview was conducted with Employee #2 on April 21, 2014 he/she acknowledged the aforementioned findings. The medical record was reviewed on April 21, 2014. 5. Facility staff failed to complete an admission	F 309	Implementation of Open Charting Policy will be added to the Chart Audit Tool used by the Clinical Manager to audit 10% of the medical records on their nursing units each month. 5. Compliance Date:	6/6/2014

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F 309	Continued From page 65 assessment for Resident #153 in a timely manner. Additionally, facility staff failed to consistently assess and monitor the status of Resident #153 ' s condition. The resident was assessed as having an unwitnessed fall, complaints of shortness of breath and an alteration in skin integrity. A. According to the facility ' s policy " Charting-Documentation " Policy No: IM-00015.86, Revised 11/13, stipulates: " Nursing- 5. A comprehensive note detailing the patient/resident ' s condition is written on admission is entered into the electronic medical record. " A review of the electronic " Progress Notes By Resident " dated March 4, 2014 at 04:34 PM revealed Resident #153 was re-admitted from [hospital named] .... With [diagnoses] of Atrial Fibrillation, CAD (Coronary Artery Disease), COPD (Chronic Obstructive Pulmonary Disease) and Dementia ... On [oxygen]... on 2 liter via nasal cannula. A further review of the " Cardiovascular and Respiratory " sections of the nurses ' observation form revealed that the blood pressure and pulse rate was recorded as being completed on April 18, 2014. The comments section of the form revealed the following note, " 03/04/2014 PM, [nurse named]: Resident Re-admitted note. " The " Attestation " section of the form was signed by a License Practical Nurse and the date recorded as being completed was April 20, 214 at 4:13 AM. There was no documented evidence that	F 309	Resident #305 1. Licensed nurse counseled and received education regarding pain assessment and documenting resident's level of pain prior to administration of pain medication. 2. No other residents were found to be presently affected. 3. All licensed nurses will receive education regarding pain assessment and documentation of the resident's level pain level prior to administration of pain medication. All licensed nurses will receive education about Pain Management as part of their orientation and Pain Management will be an annual mandatory education offering. Pain Management. 4. Assessment and documentation of resident level of pain will be added as an item to the Clinical Manager monthly Chart Audit Tool. During the monthly chart audit completed by the Clinical Manager, at least two of the medical records audited must be a resident receiving Pain Management. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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Resident #153 ' s vital signs were assessed and recorded in a timely manner. There was a time lapse of 45 days from when the admission observation form was started on March 4, 2014 to actual completion date of April 20, 2014.

A face-to-face interview was conducted with Employee #3 on April 20, 2014 at approximately 11:00 AM regarding the aforementioned findings. He/she acknowledged that the admission assessment was not completed in a timely manner. The clinical record was reviewed on April 20, 2014.

B. Facility staff failed to consistently assess and monitor the status of Resident #153 ' s condition. The resident was assessed as having an unwitnessed fall, complaints of shortness of breath and an alteration in skin integrity.

Resident #153 was transferred to another assigned room within the same unit on December 2, 2013 at 03:04 PM.

According to a quarterly Minimum Data Set (MDS) with a Assessment Reference Date (ARD) of October 15, 2013 revealed in Section I (Active Diagnoses) diagnoses included, CHF (Congestive Heart Failure), COPD (Chronic Obstructive Pulmonary Disease), and Dementia.

Physician ' s Orders:

The physician ' s order form dated and signed January 6, 2014; with a start date of January 1, 2014 directed, " [Oxygen] at 2 liters via nasal cannula for shortness of breath, Change O2

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humidifier bottle and nasal cannula weekly and as needed ... Check O2 [saturation] as needed and monitor # [number] of times [resident] is taking off [his/her] nasal cannula. Skin checks by licensed nurse every week. Vigilon monitor."

Interim order dated January 30, 2014 at 4:22 AM directed, " [Physical Therapy/Occupational Therapy] Screen post fall. "

Nursing Notes:

A review of the clinical record revealed the following nursing notes:

" December 9, 2013- 10:21 PM- Comments: Resident complains [of shortness of breath] on assessment, HR [Heart rate- 91-], B/P [Blood Pressure] - O2 sat [saturation] checked 95% with 2L/minute Oxygen via nasal cannula continues. Breathing treatment provided as ordered.

December 11, 2013- 10:37 PM- Resident alert and responsive. Medication provided as ordered. No acute distress or [shortness of breath] noted at this time.

December 12, 2013- 4:21 AM- Resident transferred from [room assigned] on unit [unit named] to room [room and unit named] at 3PM this afternoon. [He/she] remains alert and on continuous oxygen at 2L/minute. [He/she] remains alert and [quiet]. [He/she] refused to go in bed and was still sitting [in] dining area watching television. [He/she] denied pain and discomfort. VS [Vital signs] - B/P- 118/64,

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F 309	Continued From page 68 Respirations-20, Temperature- 97.3 and O2 [saturation] 96% at 2l/min. December 12, 2013 -4:51 AM- Monthly Summary for November 2013- Resident had fall [times] 1 without injury on November 2, 2013 during the 7AM-3PM shift when staff responded to an alarm and upon entering [room named], observed resident in sitting position leaning against the bed. Neuro check protocol initiated and within resident ' s limits .... Continues to receive oxygen via nasal cannula for shortness of breath. No increase [shortness of breath] noted. December 30, 2014- 4:52 AM- ... Respiratory: Shortness of breath or trouble breathing with exertion, Oxygen delivered via Nasal cannula in l/min=2, [Status post] unwitnessed fall from bed. December 31, 2013 12:02 PM- No acute distress noted, no [shortness of breath] noted ... continue on oxygen on 2 liter via [nasal cannula] with no discomfort noted. January 30, 2014- 4:52 AM- Audible bed sensor alarm. Entered resident ' s room. Observed resident on floor. Resident returned to bed via [a] hoya lift. [Range of motion] to upper and lower extremities without statement of discomfort, [Medical doctor] and family notified. Neuro checks in progress. February 2, 2014 11:40 AM- ...sitting in wheelchair with oxygen, no evidence of any	F 309		

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F 309	Continued From page 69 respiratory distress noted at around 8 AM. Assigned CNA (Certified Nursing Assistant) reported that patient has a [bruise] to [his/her] left upper arm measuring 8 [cm] by 9.3 cm ... denies pain when touch. [Medical doctor] on call was notified ... Vital signs are Temp-97, respirations-20, Pulse-89, Blood Pressure- 123/68, O2 saturation 97%. Continue to monitor patient. February 9, 2014 12:01 PM- While performing ADL (Activities of Daily Living) care, CNA observed resident with skin discoloration, upon assessment, resident was noted with skin discoloration located at left lateral thigh measured 3 cm x1.5cm, non tender upon palpation, surrounding tissue normal ... Will continue to monitor. February 27, 2014 5:14 AM- Resident observed with shortness of breath with [oxygen] via [nasal cannula]. Pulse oximetry- 61%, heart rate-108, [blood pressure] 96/53, Temperature- 95, Respirations-46 and shallow. [Medical doctor] notified. Order obtained to transfer [to hospital] 911. Family notified of transfer to [hospital named]. " A review of the record lacked documented evidence of consistent respiratory assessment(s) for the resident between December 9, 2013 and the time that the resident was transferred out via 911 to an acute hospital on February 27, 2014. The progress notes documented by the nurse on December 9, 2013 revealed that Resident # 153 complained of [shortness of breath] on assessment; utilizing O2 at 2l/min via nasal cannula for shortness of breath.	F 309		

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F 309	Continued From page 70 There were inconsistencies in assessing the resident ' s respiratory status and a lack of follow up assessment to indicate that interventions were effective and episodes of shortness of breath were resolved. The clinical record lacked documented evidence that Resident #153 was consistently monitored after an unwitnessed fall on January 30, 2014. The clinical record lacked documented evidence that skin assessments were consistently conducted on Resident #153 after an alteration in skin integrity was identified by the Certified Nursing Assistant on February 9, 2014. Facility staff failed to consistently assess and monitor the status of Resident #153 ' s condition. A face-to-face interview was conducted with Employee #3 on April 18, 2014 at approximately 10:00 AM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on April 18, 2014. 6. Facility staff failed to administer medications in accordance with physician's orders, via [by] Gastrostomy tube, for Residents #182. Employee #34 was observed on April 14, 2014 during a medication pass at approximately 12:30	F 309		

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PM. The employee was observed preparing Resident #182 ' s medications for administration via Gastrostomy. After checking for residual, Employee #34 proceeded to administer each medication separately through a 60 ml syringe attached to the Gastrostomy tube and allowed each to infuse by gravity. He/she did not check for correct placement of the Gastrostomy tube prior to the administration of the medications.

According to physician order form dated April 4, 2014 directed: " Flush G-Tube (Gastrostomy Tube) with 300 ml of water every shift. Check residual before feeding ... Check tube for proper placement prior to each feeding, flush or medication administration every shift. "

Facility staff failed to check for proper placement of Resident #182 ' s Gastrostomy tube prior to administration of medications.

A face-to-face interview was conducted with Employee #34 on April 14, 2014 at approximately 3:00 PM. He/she acknowledged that he/she did not check for proper placement with her stethoscope prior to administering the medication. The observation was made on April 14, 2014.

7. Facility staff failed to obtain physician's orders for hospice services for Resident #211.

A review of the " Physician Order Sheet and Plan of Care " revealed that the resident was admitted to the facility on February 21, 2014 with the following diagnosis: Adenocarcinoma of the Esophagus, Hx [history] [of] Upper Gastrointestinal bleed secondary to

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THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

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F 309	Continued From page 72 Adenocarcinoma of [the] esophagus. According to the Interdisciplinary Progress Note dated February 24, 2014, no time indicated, " 81 year old with Esophogeal Adenocarcinoma admitted to [facility name] 2/21/14 [February 21, 2014] DNR/DNI [Do Not Resuscitate/Do Not Intubate] in Hospice. " Review of the " Progress Notes By Resident " revealed that hospice care had been conducted February 22, 2014 through March 12, 2014. Further review of the medical record lacked evidence of physician orders to initiate hospice services for Resident #211. A face-to-face interview was conducted on April 21, 2014 with Employee #1 at approximately 10:00 AM. A query was made regarding the facility ' s process when admitting a resident to hospice service. Employee #1 stated that "if the resident is an " in patient " resident, the medical director would be the admitting physician that is already on staff. If the resident is not a resident of this long term care facility, the hospital will speak with the liaison here at this facility and then admit through the regular process and the admitting nurse would call and confirm the admissions orders. Employee #1 acknowledged that there were no admitting orders for hospice services for the Resident #211.	F 309		

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A face-to-face interview was conducted on April 21, 2014 with Employee #20 at approximately 10:00 AM. A query was made regarding the lack of physician ' s orders for admitting the resident to hospice services. After review of the medical record, Employee #20 acknowledged the lack of an order for hospice services. However, stated that the resident did receive the services as intended.

8. Facility staff failed to ensure Resident #213 was administered a nasal spray in accordance with the physician ' s orders.

A medication observation was conducted on April 15, 2014 at approximately 10:00 AM. During the observation Employee #16 administered two (2) sprays of " Deep Sea 0.65% Spray " in each nostril of the resident.

A review of the April 2014 " Physician ' s Order Form " last signed and dated April 7, 2014 directed, Deep Sea 0.65% Spray - 1 spray each nostril every four hours as needed for dryness. " Facility staff failed to ensure that a nasal spray was administered to resident in accordance with the physician ' s orders [one (1) spray per nostril as opposed to 2 sprays].

A face-to-face interview was conducted with Employee #16 on April 15, 2014 at approximately 10:15 AM. He/she acknowledged that the resident was administered two (2) sprays in each nostril at the time of the administration. The observation occurred on April 15, 2014.

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F 309	Continued From page 74	F 309		

9. Facility staff failed to assess Resident #291 ' s oxygen saturation level as directed by the physician.

A review of the Physician ' s order sheet and plan of care signed and dated on February 27, 2014 directed, Oxygen at 2 liters per minute via nasal cannula continuous, check pulse ox [oxygen saturation] every shift. "

A review of the Medication and Treatment Administration record revealed that the 11P-7A shift left the slot allotted for check pulse ox every shift scheduled for April 22, 2014 was " blank " indicating that the treatment was not done.

The Medication and Treatment Administration record " lacked evidence that resident #291 ' s pulse oximetry was checked on February 22, 2014 11PM - 7AM shift.

A face-to-face interview was conducted on April 22, 2014 at approximately 3:05PM with Employee #7. After reviewing the medication and treatment administration record, he /she acknowledge the findings. The record was reviewed April 22, 2014.

10. Facility staff failed to assess Resident #305 ' s pain prior to administration of pain medication.

A. According to the facility ' s policy " Pain Management " , Policy No: PE-00008.01, revised date 11/13 stipulates, " II- 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

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F 309	Continued From page 75 quantitative scale. The quantitative scale is 0-10: 1 being the less severe level of pain and 10 being the most severe level of pain .... " A medication observation was conducted on April 14, 2014 at approximately 10:30 AM. During the observation Employee #16 made an attempt to reposition Resident #305. At this time, the resident grimaced. Employee #15 asked the question, " Are you in pain. " Resident #305 replied, " Yes. " Employee #16 stated, " I will give you something for pain. " The employee returned to the medication cart, obtained two (2) tablets of acetaminophen along with the other scheduled medications from the medication cart. He/she returned to the resident ' s room and administered the pain medication. " The physician ' s order dated April 12, 2014 and signed by the physician on April 13, 2014, directed " Acetaminophen 325mg 2 [two] [tablets] p.o. [by mouth] q [every] 6 h [hours] prn (as needed) for pain. " According to an interim order form dated April 11, 2014 at 4:00 PM directed, " MSO4 (Morphine Sulfate) (20 mg/ml) oral concentrate. Take 0.25ml (5mg) by mouth or under the tongue every 4 [hours] prn [as needed] [for] moderate to severe pain or shortness of breath. " The April 2014 MAR (Medication Administration Record) revealed: " Morphine Sulfate 20mg/ml 0.25ml (5mg by mouth or under the tongue every 4 (four) hours as needed [for] moderate to severe pain or shortness of breath. " A review of the back of the MAR revealed that Employee #16 recorded that acetaminophen	F 309	F323 (Power Strips & Three Outlet Connector) 1. The power strips on floor of rooms 356-A and 323 were mounted on the wall. The three-outlet electrical connector in room 305 was inspected and approved for use by Maintenance. 2. A facility-wide resident room inspection will be completed to identify power strips on the floor of resident rooms and electrical outlet connectors not inspected and approved for use by Maintenance. 3. The information provided on admission pertaining to resident-owned electrical equipment in resident rooms will be reviewed by Director of Plant Operations and revised, if indicated. Resident and Family Councils will be reminded that all resident-owned electrical equipment must be inspected and approved by Maintenance prior to use. Environmental Rounds Team and Maintenance Rounds will inspect for power strips and outlet connectors. Housekeepers will report power strips on the floor and outlet connectors observed during routine room cleaning, to the Team Leader who will initiate appropriate corrective action. 4. The Director of Plant Operations, or designee, will review Work Order Requests a minimum of weekly to identify reports of resident/family noncompliant electrical equipment.	

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F 309	Continued From page 76 325mg - two (2) [tablets] were administered for pain at 10:30 AM and recorded that the acetaminophen was effective at 12:00 PM. There was no evidence that facility staff assessed the resident ' s level of pain prior to the administration of acetaminophen to determine the appropriate medication to administer based on the parameters. A face-to-face interview was conducted with Employee #18 on April 14, 2014 at approximately 10:30 AM. He/she acknowledged the aforementioned findings. The observation and clinical record was conducted on April 14, 2014.	F 309	A summary of findings will be reported to the QI Committee monthly. 5. Date of Compliance:	5/26/2014
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on April 18, 2014 at approximately 11:00 AM, it was determined that facility staff failed to maintain the facility free of accident hazards as evidenced by: four (4) of four (4) power strips and two (2) of two (2) extension cords that were observed on the floor in three (3) of 27 resident's rooms, unsecured oxygen tanks	F 323	F323 (Extension Cords) 1. Extension cords were removed from room 323. 2. All resident rooms will be inspected and extensions cords removed. 3. Environmental Rounds Team, Maintenance, and Housekeepers will check for extension cords during routine inspection/cleaning of resident rooms. Extension cords present will be immediately removed. All departments working in resident rooms will be instructed to notify Maintenance immediately for removal of any extension cords observed. Resident and Family Councils will be reminded that extension cords are unsafe and use is prohibited. 4. The Director of Plant Operations, or designee, will report to QI Committee monthly if extension cords are found in resident rooms. 5. Date of Compliance	5/26/2014

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F 323	Continued From page 77 in two (2) of five (5) storage rooms and in one (1) of 27 resident's rooms and one (1) of one (1) mirror that was stored on top of a dresser unsecured in one (1) of 27 resident's rooms. The findings include: 1. Three (3) of three (3) power strips were in use and stored on the floor of room # 356A, one (1) of one (1) power strip was in use and stored on the floor of room #323, two (2) extension cords were in use and on the floor of room #323, and a three-outlet, electrical connector was in use in room #305, three (3) of 27 resident's rooms. 2. Oxygen tanks were observed unsecured on numerous occasions including: One (1) of eight (8) E-cylinder type tank in the Oxygen storage room on Unit 3A (#A345A) in one (1) of five (5) Oxygen storage rooms and two (2) of 14 E-cylinder type tanks in the Oxygen storage room on Unit 1, two (2) of five (5) Oxygen storage rooms. One (1) of one (1) E-cylinder type tank in resident room #129, one (1) of 27 resident's rooms. 3. One (1) of one (1) mirror was observed on top of a dresser, loose and unmounted in room #135, one (1) of 27 resident's rooms. These observations were made in the presence of Employee #9 who acknowledged the findings.	F 323	F323 (#2 Oxygen tanks) 1. All identified oxygen tanks have been secured. 2. Rounds were completed in the facility and all oxygen tanks were checked to be secure. 3. Environmental Rounds Team and weekly Maintenance Rounds will inspect oxygen storage rooms and resident rooms to ensure all oxygen tanks are secure. Tanks that are not secure will be secured immediately. All employees working in resident rooms and on the units near the oxygen storage will be instructed to observe and report unsecure oxygen tanks immediately. 4. The Environmental Rounds Team will report to the QI Committee monthly any repeat occurrences of this unsafe practice. 5. Compliance Date:	6/6/2014
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

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F 332	Continued From page 78 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for two (2) medication pass observations conducted, it was determined that facility staff failed to instill eye drops according to physician orders for one (1) resident and failed to administer nasal spray for one (1) resident. Residents' #213 and #217. The findings include: 1.Facility staff failed to ensure Resident #213 was administered a nasal spray in accordance to the physician's orders. A medication observation was conducted on April 15, 2014 at approximately 10:00 AM. During the observation Employee #16 administered two (2) sprays of "Deep Sea 0.65% Spray" in each nostril of the resident. A review of the April 2014"Physician's Order Form" last signed and dated April 7, 2014 directed, Deep Sea 0.65% Spray - 1 spray each nostril every four hours as needed for dryness." Facility staff failed to ensure that a nasal spray was administered to resident in accordance with the physician's orders. A face-to-face interview was conducted with	F 332	F323 (Mirror) 1. The mirror was removed from the dresser in room 135. 2. A facility-wide check of resident room mirrors identified no other occurrences of this deficient practice. 3. Environmental Rounds Team and weekly Maintenance Rounds will inspect security of mirrors in resident rooms. All mirrors are to be securely wall mounted. Housekeepers will be instructed to report unsafe mirror placement observed during routine cleaning to the Team Leader, who will correct the unsafe practice. All employees working in resident rooms will be instructed to observe and report unsafe mirror placement immediately. 4. The Director of Plant Operations will report to the QI Committee monthly any repeat occurrences of this unsafe practice. 5. Date of Compliance	5/26/2014

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F 332	Continued From page 79 Employee #16 on April 15, 2014 at approximately 10:15 AM. He/she acknowledged that the resident was administered two (2) sprays in each nostril at the time of the administration. The observation occurred on April 15, 2014. 2. Facility staff failed to ensure Resident #217 was administered the correct amount of eye drops in accordance with physician orders. According to the physician's orders signed and dated April 7, 2014,"Dorzolamide-Timolol 2%-0.5% drops (COSOPT Ocumeter PLUS): instill 1 [one] drop to right eye twice daily at 9AM-9PM. " According to the Medication Administration Record (MAR) for April 2014, it directed " Dorzolamide - Timolo 2% [percent]-0.5% original order date March 18, 2014 ...Drops; COSOPT Ocumeter PLUS: Instill 1 drop to right eye twice daily, for glaucoma ... " During a medication pass observation with Employee #40 on April 14, 2014, at approximately 10:49 AM the following was observed: After Employee #40 followed necessary measures to ensure sanitization of hands, identification of the resident and ensuring the right medication by reading the label on the medication bottle and the physician's order preprinted on the Medication Administration Record (MAR). Employee #40 used his/her left hand to open the lower lid and the right had to	F 332	F332 Resident # 213 1. License Nurse that failed to administer nasal spray according to physician orders received counseling and education regarding medication administration of all medications. 2. No other residents were found to be presently affected. 3. An education session to review the facility Medication Administration Policy will be conducted for all licensed nurses. All licensed nurses will take and must successfully pass an annual Medication Administration Competency: skill and written exam. All licensed nurses to ensure continued competency in medication administration will receive a Medication Administration Observation conducted at least once monthly by the Clinical Manager or designee on all three shifts. 4. The findings of the Medication Administration Observations will be discussed weekly at the Focus QI Meeting with recommendations offered for nurse counseling and/or education and will be reported quarterly by the QI Manager to the QI Committee. Compliance Date: June 6, 2014	

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F 332	Continued From page 80 hold the eye drops, the resident assisted by opening his/her eye also. Employee #40 instilled one (1) and then immediately another drop equating to two (2) drops of medication given in the right eye. A face-to-face interview was conducted at that time following the administration of the eye drops. A query was made how many eye drops did the physician ' s order call for? Employee #40 reviewed the MAR and stated one (1); and how many eye drops did you give? Employee #40 stated "two (2) and that the one (1) had fell out" However, if that was the case, the employee failed to allow the eye drop to contact the eye for a sufficient period of time before the next eye drop was instilled. Facility staff failed to administer eye drops according to physician orders.	F 332	Resident #217 1. License Nurse that failed to administer eye drops according to physician orders received counseling and education regarding medication administration of eye drops and all medications. 2. No other residents were found to be presently affected. 3. An education session to review the facility Medication Administration Policy will be conducted for all licensed nurses. All licensed nurses will take and must successfully pass an annual Medication Administration Competency: skill and written exam. All licensed nurses to ensure continued competency in medication administration will receive a Medication Administration Observation conducted at least once monthly by the Clinical Manager or designee on all three shifts. 4. The findings of the Medication Administration Observations will be discussed weekly at the Focus QI Meeting with recommendations offered for nurse counseling and/or education and will be reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014
F 371 SS=D	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	F 371		

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F 371	Continued From page 81 by: A. Based on observations made on April 17, 2014 at approximately 9:00 AM, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by expired foods in one (1) of three (3) refrigerators, one (1) of one (1) soiled flat top grill and two (2) of two (2) soiled convection ovens and two (2) of three (3) soiled air curtains fron one (1) of one (1) dishwashing machine. The findings include: 1. A one-third pan of guacamole stored in refrigerator #3 was expired as of April 12, 2014 and a partially filled salad bar container with shredded yellow cheese stored in refrigerator #3 was expired as of April 13, 2014. 2. One (1) of one (1) flat top grill and two (2) of two (2) convection ovens were soiled. 3. Two (2) of three (3) air curtains from the dishwashing machine were soiled. These observations were made in the presence of Employee #8 who acknowledged the findings. B. Based on observation and staff interview, for one (1) of 51 sampled residents, it was determined that facility staff failed to prepare residents food in a sanitary manner as evidenced by the following:	F 371	F371 (1) 1. The out dated items were immediately discarded. 2. A check of all refrigerated foods identified no other foods past the expiration date. 3. Dietary Services shift supervisors will monitor expiration dates on refrigerated foods on a daily basis, as part of Open-Closing Checklist. 4. Dietary Services Director or designee will monitor Open-Close Checklist findings on a weekly basis to ensure corrective actions are effective and sustained. The Dietary Director will report findings to the QI Committee monthly. 5. Date of Compliance F371 (2) 1. Ovens and Flat Top were cleaned on April 18, 2014. 2. All ovens were inspected and found to be clean. 3. Dietary Services shift supervisors will monitor cleanliness of ovens and flat top grill daily, as part of Open-Close Checklist. The Master Cleaning List will be revised to increase frequency of oven cleanings to weekly. Flat top grill cleaning will be added to the closing cook's daily cleaning assignment. 4. Dietary Services Director or designee will monitor Open-Close Checklist findings weekly to ensure corrective actions are effective and sustained. The Dietary Services Director will report findings to QI Committee monthly. 5. Date of Compliance	5/23/2014 5/23/2014

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F 371	Continued From page 82 The findings include: During a dining observation conducted on April 18, 2014 at approximately 1:00 PM. Employee #33 was observed touching a resident ' s food with his/her bare hands. A face-to-face interview was conducted with Employee #4 on April 22, 2014 at approximately 2:00 PM. After review of the above, he/she acknowledged the findings and stated that " we have gloves on the unit that is not acceptable. "	F 371	F371 (3) 1. New dishwashing machine air curtains have been ordered to replace current curtains. 2. The remaining air curtain was inspected and found clean. 3. Dietary Services shift supervisors will monitor air curtain cleanliness on a weekly basis, as part of the Weekly Checklist. Inspection of dish machine air curtains will be added to the Monthly Sanitation Audit. 4. Weekly Checklists and Monthly Sanitation Audits will be reviewed by Dietary Director or designee to ensure corrective actions are effective and sustained. Findings will be reported to the QI Committee monthly. 5. Date of Compliance Employee #33 1. Employee #33 counseled and received education regarding sanitary food service: includes wearing of food grade gloves to handle resident food items. 2. No other residents were found to be presently affected. 3. All nursing staff will receive education regarding sanitary food service: to include food grade gloves must be worn to handle resident food. Sanitary Food Service will be added as an annual mandatory education requirement for all nursing staff and to the new staff orientation program.	5/23/2014
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 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.	F 431		

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F 431	Continued From page 83 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 observations made on one(1) of four nursing units it was determined that the facility failed to ensure that one (1) of one (1) of vial of Influenza Virus Vaccine was stored beyond the expiration date. The findings include: At approximately 10:30 AM, on April 15, 2014, in the medication storage refrigerator, one (1) vial of Influenza Virus Vaccine was observed with an open date of 2/2/14. Expiration date on the vial was March, 2014. The observation was made in the presence of Employee # 5. He/she acknowledged the findings.	F 431	4. The Clinical Educator will submit a quarterly report to the QI Manager of any Sanitary Food Service Education sessions offered during the reported quarter. The QI Manager will submit the quarterly report from the Clinical Educator to the QI Committee 5. Compliance Date: 6/6/2014 <u>F431</u> 1. The one vial was removed from the nursing unit medication refrigerator and was destroyed according to standard drug destruction policy and procedure. 2. There were no other vials of Influenza Vaccine found expired. 3. The Clinical Manager will conduct daily nursing unit rounds to include a check of the medication administration refrigerator for expired medications. The Clinical Manager will use the Nursing Unit Rounds Tool to document the medication refrigerator check for expired medications. 4. The clinical Manager will submit the Nursing Unit Rounds Tool weekly to the Director of Nursing. The Director of Nursing after review of Nursing Unit Rounds Tool will forward to the QI Manager. Findings will be discussed weekly at Focus QI Meeting facilitated by the QI Manager or designee. 5. Compliance Date: 6/6/2014	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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	095005	A. BUILDING _____ B. WING _____	04/22/2014

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F 441	Continued From page 84 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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	Residents #1, #78, # 182 1. Licensed nurses that failed to practice infection control practices for residents #1, #78, and #182 were counseled and received education regarding infection control during clean technique during treatments and infection control practices when administering medications. 2. No other residents were found to be presently affected. 3. All licensed nurses will receive education regarding Infection Control Practices when performing clean technique and when administering medications. Clean and sterile technique and Infection Control Practices while administering medications will be added as an annual mandatory education offering for all licensed nurses and to new licensed nurse orientation. 4. Infection Control Practices when administering medications is an item listed on the Medication Administration Observation Tool used by Clinical Managers or a designee when monthly Medication Administration Observations are conducted. Medication Administration Observations for all licensed nurses will be conducted randomly by the Clinical Manager or a designee.	

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F 441	Continued From page 85 Based on observations, staff interview and record review for three (3) of 51 sampled residents, it was determined that the facility failed to follow infection control practices to prevent potential cross contamination and spread of infection as evidenced by: failure to clean the over bed table after removing a urine filled catherization tray for one (1) resident, and failure to wash/sanitize hands prior to administration of medications for two (2) residents. Residents' #1, #78 , #182. The findings include: 1. Facility staff failed to clean Resident #1's over-bed table after removing a urine filled catherization tray. On April 21, 2014 at approximately 12:30 PM Employee #38 was observed performing an in and out catherization. After measuring the urine, he/she picked up the catherization tray from the over bed table and emptied the urine into the commode. Employee #38 proceeded to dispose of the tray in the trash can. After washing his/her hands, he/she readjusted the resident, washed his/her hands and left the resident's room. After the nurse returned to the medication cart, he/she was asked had she finished caring for the resident,. he/she replied, "Yes." At that time she was told that she failed to clean the overbed table. He/she acknowledged theaforementioned finding in the presence of Employee #3. The observation was conducted on April 21, 2014. Facility staff failed to clean Resident #1's over	F 441	Findings from the Medication Administration Observations will be discussed weekly at Focus QI Meeting and reported to the QI Committee quarterly by the QI Manager. 5. Compliance Date:	6/6/2014

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F 441	Continued From page 86 bed table after removing a urine filled catherization tray. 2. Facility failed to follow accepted standards of hand hygienepractices during medication administration for Resident #78. During a medication pass observation on April 14, 2014 at approximately 12:30 PM. Prior to administering Resident #78's medication. Employee #34 washed his/her hands and donned gloves. He/she repositioned the resident's wheelchair and locked its brakes. Using the same gloved hands, he/she proceeded to administer the medication through Resident #78's gastrostomy tube. Facility failed to follow infection control practices to prevent potential cross contamination and spread of infection during medication administration. A face-to-face interview was conducted with Employee #34 on April 14, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The observation occurred on April 14, 2014. 3. Facility failed to follow infection control practices to prevent potential cross contamination and spread of infection during medication administration for Resident #182. During a medication pass observation on April 14, 2014 at approximately 1:00 PM. Prior to administering Resident #182's medication, Employee #34 washed his/her hands and donned the gloves. He/she removed the fall matt from the	F 441	F456 (#1,2 Inoperable equipment) 1. The identified inoperable reach in refrigerators and freezer have been scheduled to be fixed or if they are not operable will be removed from the area. 2. All equipment in the kitchen was checked and is operating to the standard for the equipment. 3. The Dietary manager or designee will complete weekly equipment rounds to inspect all equipment for operations. Inoperable equipment will be reported to have maintenance. Any inoperable equipment that cannot be fixed will be removed. 4. The outcome of the audit will be reported to the monthly Quality Improvement Committee. 5. Compliance Date:	6/6/2014

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F 441	Continued From page 87 floor. Using the same gloved hands, proceeded to administer medication through Resident #182's gastrostomy tube. Facility failed to follow infection control practices to prevent potential cross contamination and spread of infection during medication administration. A face-to-face interview was conducted with Employee #34 on April 14, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The observation occurred on April 14, 2014.	F 441	F456 1. All kitchen fire extinguishers were inspected. 2. All fire extinguishers were checked facility-wide; all had documentation of monthly checks. 3. Failure to correctly inspect kitchen fire extinguishers was addressed with the employee assigned responsibility for the inspections. The Maintenance Rounds kitchen checklist will be revised to list inspection of ABC and K-type fire extinguishers. New maintenance staff will be trained to identify and inspect both extinguisher types. The Director will review the competency of Maintenance staff to inspect kitchen fire extinguishers a minimum of annually. 4. The Director of Plant Operations, or designee, will review kitchen Maintenance Rounds reports a minimum of weekly and verify inspection of ABC and K-type extinguishers. A summary of findings will be reported to the QI Committee monthly. 5. Compliance Date	5/26/2014
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on April 17, 2014 at approximately 9:00 AM, it was determined that the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by two (2) of five (5) Reach-in refrigerators and one (1) of two (2) freezers that have been out of order for more than a year, five (5) of five (5) type E fire extinguishers and two (2) of two (2) type K fire extinguishers that have not been inspected monthly. The findings include:	F 456		

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F 456	Continued From page 88 1. Two (2) of five (5) Reach-in refrigerators located in the kitchen have been out of order for about a year. 2. One (1) of two (2) freezers was inoperable. 3. Fire extinguishers located in the kitchen are not inspected monthly as required. These observations were made in the presence of Employee #8 who acknowledged the findings.	F 456		
F 463 SS=E	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 during an environmental tour of the facility on April 18, 2014 at approximately 11:00 AM, it was determined that facility staff failed to maintain call bells in good working condition as evidenced by call bells that fail to function as intended in three (3) of 27 resident's rooms, frayed call bell cords in two (2) of 27 resident's rooms and a call bell that was secured with transparent tape in one (1) of 27 resident's rooms. The findings include: 1. Call bells in rooms #249B, #237A and #116 did not consistently initiate an alarm when tested, in three (3) of 27 resident's rooms.	F 463		

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F 463	Continued From page 89 2. Call bell cords were torn and frayed in two (2) of 27 resident's rooms #154 and #114 and the call bell in room #128 was secured with transparent tape in one (1) of 27 resident's rooms (#128). These observations were made in the presence of Employee #9 who acknowledged the findings.	F 463	F463 1. Call bells in rooms 249-B, 237-A, and 116 were immediately assessed, unplugged, and re-plugged in correctly. Call bell cords in rooms 154, 114, and 128 were immediately replaced. The call bells were triggered and the call bell system was fully functional.	
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: A. Based on record review and staff interview for four (4) of 7 sampled residents reviewed for transfer/discharge rights; it was determined that facility staff failed to provide transfer/discharge and appeal rights notices in accordance with state law. D.C. Law 6-108. Residents 37, 59, 237 and 299. The findings included: Pursuant to D.C. Code §44-1001.01.1; Law 6-108 " ...Whenever a resident is to be discharged, transferred or relocated, a facility representative shall give that resident and his or her representative both oral and written notice of the reasons for, procedures for contesting and	F 492	2. Maintenance will check all call bells for correct placement in wall and call bell cords for wear-and-tear. 3. The Director of Plant Operations will schedule a train-the-trainer session on correct call bell placement in wall and recognition of damaged call bell cords for department managers and directors working in resident rooms. All staff working in resident rooms will be educated or reeducated. New employees will be educated during new employee orientation on plugging call bell into wall correctly and recognizing damaged call bell cords. Environmental Rounds Team and Maintenance will inspect call bells and call bell cords during ongoing Rounds. 4. The Director of Plant Operations, or designee, will inspect call bell placement and call bell cords during Rounds. Call bell placement and call bell cord damage will be reported to the QI Committee monthly. 5. Compliance Date	5/26/2014

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F 492	Continued From page 90 proposed effective date of the discharge, transfer or relocation ... " During a review of clinical records on April 21, 2014 at approximately 5:00 PM, the following residents were transferred out of the facility and there was a lack of documented evidence that transfer/discharge and/or appeal rights notices were provided to the residents and/or their representative. Resident #237- Transferred to hospital on April 2, 2014. Had not returned to facility. Resident #59- Transferred to hospital on March 28, 2014; returned to facility on April 7, 2014 Resident #37- Transferred to hospital on March 4, 2014; returned to facility. Resident #299- Transferred to hospital on April 3, 2014; had not returned. Facility staff failed to provide transfer/discharge notices and appeal rights as required by state law. A face-to-face interview was conducted with Employee#12 on April 21 2014 at approximately 5:00 PM. He/she stated they have been having problems with the submission of the forms. When they are not done electronically, it is done manually. He/she further stated that one of the social worker positions was vacant and the other social workers were covering. The clinical record was reviewed on April 21, 2014. B. Based on record review and staff interview during a review of staffing [direct care per	F 492	F492 1. The completed PL6-108 form and appeal rights notice will be delivered to those patients/residents affected by the deficient practice and a copy placed in their chart. 2. All patients/residents who will be transferred/relocated/discharged will receive a PL6-108 notice and an appeal rights notice completed by the unit or covering social worker. They will be identified by review of the daily census, attendance at daily PPS meetings, and/or the nursing 24-hour report. 3. Per protocol, all PL6-108 forms will be completed and submitted electronically. In the event the form cannot be completed and/or transmitted electronically, the form will be hand-written, delivered to the resident and/or responsible party, and copies faxed to DOH and the Ombudsman's office. A copy of the form will be placed in the resident's chart and a copy maintained in a file kept by the unit social worker and/or Director of Social Services. 4. The Director of Social Services will maintain and update a list of all patients/residents receiving PL6-108 forms and appeal rights notices on a monthly basis. The information will be reported to the QI Committee quarterly. Chart audits will be conducted to ensure that PL6-108 forms were completed timely and accurately. 5. Date of compliance:	5/27/2014

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F 492	Continued From page 91 resident day hours], it was determined that facility staff failed to meet minimum nurse staffing requirements in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on April 21, 2014 at approximately 1:30 PM. According the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. Of the five (5) days reviewed, one (1) of the days failed to meet the 0.6 [six tenths] hours of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] as follows: April 20, 2014 - 0.51 hours of direct nursing (RN) care per resident day. Of the five (5) days reviewed, two (2) of the days failed to meet minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day as follows: April 19, 2014 - 3.3 hours of direct nursing care per resident day	F 492	4.1 hours of direct nursing care per resident 1. Failure to meet standard was acknowledged by facility. 2. Director of Nursing or designee will meet daily with Staffing Coordinator to ensure staffing needs have been filled and meet daily PPD for staffing requirements 3. Director of Nursing and Staffing Coordinator will meet weekly with the Human Resources Department to review staff recruitment and retention offerings 4. Human Resources Department will submit a quarterly report of recruitment and retention efforts: report includes retention percentages of licensed and unlicensed staff, to the QI Manager. QI Manager submits report quarterly to the QI Committee 5. Compliance Date:	Ongoing

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F 492	Continued From page 92 April 20, 2014 - 3.66 hours of direct nursing care per resident day The review was made in the presence of Employee #37 who acknowledged the findings.	F 492		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 51 sampled residents, it was determined that facility staff failed to initiate transfer orders for one (1) resident transferred to the emergency room, record the correct date on a STAT (administer immediately) potassium chloride order for one (1) resident, document a physician ' s order for hospice services and ensure that the medical record was inclusive of the hospice documents for one (1) the resident. Residents #23, #207, #211	F 514		

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F 514	Continued From page 93 The findings include: 1. Facility staff failed to initiate 6-108 for Resident #23 ' s transfer to the emergency room [ER]. Resident #23 was transferred to acute hospital ER for evaluation. No 6-108 was generated. A face to face interview was conducted with Employee #12 on April 21, 2014 at approximately 5:00 PM. He/she acknowledge the aforementioned findings. 2. Facility staff failed to document the correct date for Resident #207 ' s potassium chloride (KCl) order. This was a closed record review. A review of a physician order signed and dated December 24, 2013 at 2:00PM directed "KCL 20 meq [millieqivalents] po [by mouth] BID [twice daily] 1st dose now x [times] 2 days then KCL meq (20) 1 po daily for hypokalemia. " A review of the Medication Administration Record (MAR) revealed that the order Potassium 20meq by mouth twice daily x 2 days for hypokalemia first dose was administered on December 20, 2013 at 3PM, then administered on December 21, 2013 at 9AM and 5PM and on December 22, 2013 at 9AM and 5PM. The Potassium chloride was then continued to be administered on December 23, 2013 at 9AM to be given daily per physician order. A review of the Interim order form revealed that the KCL order signed and dated December 24,	F 514	F514 (6-108) 1. Resident #23 has been discharged from the facility and all paperwork completed. 2. All residents transferred to the hospital will have a 6-108 initiated within the applicable timeframe. 3. Per protocol, all PL6-108 forms will be completed and submitted electronically. In the event the form cannot be completed and/or transmitted electronically, the form will be hand-written, delivered to the resident and/or responsible party, and copies faxed to DOH and the Ombudsman's office. A copy of the form will be placed in the resident's chart and a copy maintained in a file kept by the unit social worker and/or Director of Social Services. 4. The Director of Social Services will maintain and update a list of all patients/residents receiving PL6-108 forms and appeal rights notices on a monthly basis. The information will be reported to the QI Committee quarterly. Chart audits will be conducted to ensure that PL6-108 forms were completed timely and accurately. 5. Date of compliance:	5/27/2014

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F 514	Continued From page 94 2013 was documented on December 20, 2013 at 2:25PM as evidence by the verification date December 20, 2013 at 6:00PM written across the page of the medication order. Facility staff was queried concerning the difference in the documented physician date compared to the date of medication administration. Employee #2 stated that the physician wrote the wrong date when he/she was prescribing Resident #207 ' s order. A face-to-face interview was conducted on April 22, 2014 at approximately 3:05PM with Employee #2. He /she acknowledge the findings. Facility staff failed to document the correct date for Resident #207 ' s potassium chloride (KCL) order. This was a closed record review. The record was reviewed April 22, 2014. 3a. Facility staff failed to write hospice orders for a Resident #211 who received receiving hospice services. A review of the " Physician Order Sheet and Plan of Care" revealed that the resident was admitted to the facility on February 21, 2014 with the following diagnoses: Adenocarcinoma of the Esophagus, Hx [history] [of] Upper Gastrointestinal bleed secondary to Adenocarcinoma of [the] esophagus. According to the Interdisciplinary Progress Note dated February 24, 2014, [no time indicated], " [Resident #211] with Esophageal Adenocarcinoma admitted to [facility name]	F 514	F514 (#2 Resident #207) 1. Resident identified #207 is a closed record and the date can not be amended. 2. All medication physician orders for residents will have the correct date documented. Physician orders were verified in the facility. 3. The Clinical Manager using the Chart Audit Tool, will conduct an audit of 10% of all resident medical records: audit includes review of documented physician date. The Clinical Manager will, on a monthly basis, audit 10% of all resident charts. Chart Audit Tools are submitted to the Director of Nursing for review and following review are forwarded to the QI Manager. 4. The findings of the monthly Chart Audit Tools completed by the Clinical Manager are reported quarterly by the QI Manager to the QI Committee. 5. Compliance Date:	6/6/2014

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 _____	04/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 95 2/21/14 [February 21, 2014] DNR/DNI [Do Not Resuscitate/Do Not Intubate] in Hospice. " Review of the " Progress Notes By Resident " documented that hospice care had been delivered February 21, 2014 through March 12, 2014. The medical record lacked evidence of written physician orders to provide hospice services for Resident #211. A face-to-face interview was conducted on April 21, 2014 with Employee #1 at approximately 10:00 AM. A query was made regarding the facility ' s process when admitting a resident to hospice service. Employee #1 stated that "if the resident is an " in patient " resident, the medical director would be the admitting physician that is already on staff. If the resident is not a resident of this long term care facility, the hospital will speak with the liaison [located] here at this facility and then admit through the regular process and the admitting nurse would call and confirm the admissions orders." Employee #1 acknowledged that there were no admitting orders for hospice services for the Resident #211. 3b. Facility staff failed to ensure that the medical record was inclusive of the hospice documents	F 514	F514 (Resident #211) 1. Resident #211 is discharged. 2. An audit of all in-house residents receiving hospice services on long term care units identified no other residents without current physician hospice service orders. 3. The Medical Director will remind the hospice IDT to maintain three (3) months of hospice records available in the charts of hospice patients on long term care units. 4. The Medical Director or designee will monitor compliance by monthly auditing records of residents receiving hospice services on long term care units monthly. The Medical Director will report audit findings to the hospice IDT, QI Manager, Medical Staff, and QI Committee monthly. 5. Compliance Date	6/6/2014

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 _____	04/22/2014

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 514	Continued From page 96 for Resident #211. A review of the " Physician Order Sheet and Plan of Care" revealed that the resident was admitted to the facility on February 21, 2014 with the following diagnosis: Adenocarcinoma of the Esophagus, Hx [history] [of] Upper Gastrointestinal bleed secondary to Adenocarcinoma of [the] esophagus. According to the Interdisciplinary Progress Note dated February 24, 2014, no time indicated, " 81 year old woman with Esophageal Adenocarcinoma admitted to [facility name] 2/21/14 [February 21, 2014] DNR/DNI [Do Not Resuscitate/Do Not Intubate] in Hospice. " Review of the " Progress Notes By Resident " progress notes identified that hospice care had been conducted February 22, 2014 through March 12, 2014. According to the hospice sign in sheets the resident was seen by the RN [Registered Nurse] on February 22, 2014 and February 23, 2014; the Case Manager on February 26, 2014; the Social Worker on March 4, 2014and the RN Case Manager on March 5 and March 10, 2014. The medical record lacked evidenced of the initial nurses assessment, the twenty-four hour nurse follow up, the initial case manager documents and the coordinated care plan between the facility and hospice services.	F 514		

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 _____	04/22/2014

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F 514	Continued From page 97 A face-to-face interview was conducted on April 22, 2014 at approximately 10:19 AM with Employee #32. A query was made regarding the process when a resident is admitted to hospice services through their organization. Employee #32 stated " Once at the facility I would talk to the nurses and CNA ' s. I would complete an assessment and hand write notes that are placed in the chart [medical record]. Each time I come I would sign in on the sign in sheet. There should have been documents from the admitting nurse, the nurse that conducts the 24 hour follow-up visit and the case manager ' s documents. I would then meet every two (2) weeks with the team to review and discuss the patients care and formulate a care plan. I speak to the charge nurse, the nurse ' s aides and document in my notes which are kept in the medical record. " There was no evidence of any of the above mentioned documents in the medical record. A face-to-face interview was conducted on April 22, 2014 with Employee #1 at approximately 10:30 AM. A query was made regarding if the system that the hospice services use to electronically document interface with the facility ' s electronic documentation system. Employee #1 indicated that the electronic systems for documentation are separate and do not interface. Facility staff failed to ensure that the medical record was inclusive of the hospice documents.	F 514		