TRANSITIONS HEALTHCARE
Capitol City

January 17, 2015

Sharon Williams Lewis, DHA, RN-BC, CPM
Program Manager
Department of Health
Health Regulation & Licensing Administration
899 North Capitol Street, N.E.
2nd Floor
Washington, D.C. 20002

Dear Dr. Lewis:
Transitions Healthcare Capitol City urges the Health Regulation Administration to reconsider its findings and to remove the following sections from the deficiency report dated 12/9/14 for Federal Health tags and 12/1/14 for Life Safety tags:
F157 and F319: In the Summary Statement of each deficiency, there is a reference to the Psychiatric Times May 2008 specific to Pica. The resident in review has been evaluated by the psychiatrist here and has documented that the resident does not meet the criteria for Pica. I would ask that the references to Pica be removed from the deficiency report.
K018 Latching of the Entrance Doors and Bathroom Doors: This deficiency was sited in 2013 and the facility placed it in IDR at that time. After consideration, the deficiency was removed from our survey report. It should not be cited again.

This following section of the letter is respectfully submitted pursuant to 42 CFR Section 488.331 to request an Informal Dispute Resolution (IDR) on the Notice of Deficiencies sent to Ms. Gail Jernigan, Administrator, by a letter dated January 5, 2015.

1. Specifically, the facility is cited under 483.75(l)(1) Resident Records – Complete/Accurate/Accessible because on the Wednesday of the survey, December 3, 2014, it was determined that five of the closed medical records requested for review were being stored off site in the Cherry Hill, NJ area and were not immediately accessible.

The intent of F514 is, "To assure that the facility maintains accurate, complete, and organized clinical information about each resident that is accessible for resident care." To that point, the five medical records in question were for discharged residents who had not been in the facility (at the latest) since August 31, 2014. No resident care was being rendered to these residents. The ownership of this facility changed on 9/1/14. It was at that time that the former owners of Washington Nursing Facility (now called Transitions Healthcare Capitol City) mandated that all closed records as of 8/31/14 be sent to them for storage in a facility which they oversee. If the facility needed the records for any reason at all, a representative of Seniors Management North, Inc. (the managers of Washington Nursing Facility) would retrieve the needed records from their storage facility and send them to us at Transitions Healthcare Capitol City.

Additionally, when referring to a closed medical record, CMS does not speak to where they are stored but only that they are maintained for a period of time required by State law. The interpretive guidelines and the regulation itself are moot on the issue of where they are stored or how long it takes for a closed medical record to be accessed.

In this case, on the morning of Wednesday, December 3, 2014, after discussion with the team leader, Tamara Freeman and Dr. Sharon Lewis, the Administrator drove to New Jersey, retrieved the records and had them back at the facility on the same day, however after the surveyors had left. The five medical records were waiting for the surveyors upon their return in the morning, they were reviewed and no deficiencies from the records were cited.
It is therefore requested that this section of the deficiency cited under F514 be removed.

2. Citation L052 Nursing Facilities alleges that insufficient nursing time be given to each resident to ensure the resident receives care and services. The citation identifies seven residents and states that this statute is not met as evidenced by:

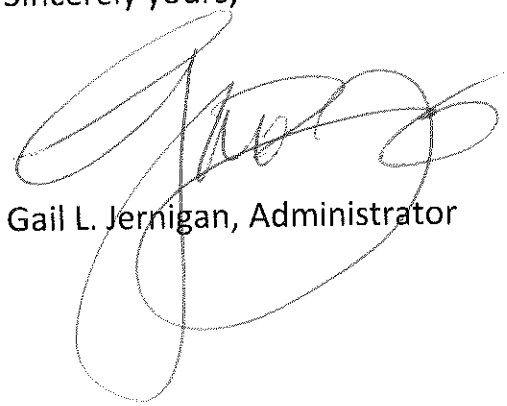
1. Not clarifying physician orders for the use of multiple pain medications;
2. Not implementing measures to prevent fecal impaction for a resident with that history;
3. Failed to ensure a resident, who was being fed by a CNA, was positioned properly;
4. Failed to ensure that appropriate treatment and services were provided for a resident who had a potential for ingestion of non-food items;
5. Failed to obtain a Psychiatry consult per physician orders for a resident diagnosed with weight loss;
6. Failed to administer one dose of Procrit in accordance with physician orders;
7. Failed to obtain a Psychiatry consult per physician orders for a resident diagnosed with advanced dementia

For each of the issues cited above, staff was available but clinical follow-up did not occur as it should have. In the certification survey, the facility was not cited under 483.30 Nursing Services where the stated intent of the regulation is, "To assure that sufficient qualified nursing staff are available on a daily basis to meet residents' needs for nursing care in a manner and in an environment which promotes each resident's physical, mental, and psychosocial well-being, thus enhancing their quality of life." In the licensure survey, the facility met the 4.1 PPD and .6RN/PPD for each day of the survey. This is one of the highest staffing requirements in the country. A cursory review of both the certification and the licensure surveys are replete with surveyor-to-staff interviews, none of which reflected that there was not enough time to perform any of these tasks related to resident care. There were no comments in the survey report or at the exit conference where any resident complain about insufficient staff.

Since there is nothing that quantifiably substantiates insufficient nursing time, the facility requests that the citation relating to insufficient nursing time be removed from the survey report.

Thank you for your time and consideration to my requests. As always, your team's dedication to ensuring quality resident care and their quality of life is always evident. I am always impressed with their sincerity and integrity as professionals doing a very difficult job.

Sincerely yours,



Gail L. Jernigan, Administrator

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	12/09/2014

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F 000	INITIAL COMMENTS A Quality Indicator Survey (QIS) recertification survey was conducted at your facility on December 1, 2014 through December 9, 2014. The following deficiencies are based on observations, record reviews, resident and staff interviews for 53 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status g-tube- Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - emergency medical services (911) HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA- Certified Nurse Aide DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L - Liter Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass)	F 000	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. The Plan of Correction is filed as evidence of the facility's desire to comply with the regulatory requirement of responding to these citations.	

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

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

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F 000	Continued From page 1 mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury POS - physician ' s order sheet Prn - As needed Pt- Patient TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - Interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- Discontinue Rp, R/P- Responsible Party PO- By Mouth	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156	**483.10(b)(5)-(10),483.10(b)(1) Notice of Rights, Rules, Services, Charges** 1. This resident was discharged from the facility without his/her complete admission packet being signed. 11/21/14 2. All new residents' admissions packets have been reviewed to ensure that all admission paperwork was completed and that each resident/Responsible Party was informed of their rights, all rules and regulations governing resident conduct and responsibilities; their rights and benefits for Medicare and Medicaid services in writing (such as, equal access to waiving rights, written assurance of residents eligibility, and costs for services and changes in cost for services). 12/29/14 3. Inservice education was completed with 12/16/14 the Admissions Staff to ensure their competency and understanding of the requirements for notification of their rights,	

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F 156	Continued From page 2 items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification	F 156	483.10(b)(5)-(10),483.10(b)(1) Notice of Rights, Rules, Services, Charges (cont.) all rules and regulations governing resident conduct and responsibilities; their rights and benefits for Medicare and Medicaid services in writing (such as, equal access to waiving rights, written assurance of residents eligibility, and costs for services and changes in cost for services). To ensure on-going compliance, the Admissions Quality Improvement Team will complete a monthly audit of the admission paperwork for new residents and report their findings to the Director of Admissions and Marketing. 4. The Director of Admissions and Marketing will present the finding of the Admissions Quality Improvement Team along with any action plans for improvement to the Quality Assurance/Performance Improve-Ment Committee which meets monthly and Is chaired by the Administrator.	12/29/14 1/12/15

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F 156	Continued From page 3 agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 53 sampled residents, it was determined that facility staff failed to inform one (1) resident at the time of admissions of their rights, all rules and regulations governing resident conduct and responsibilities; their rights and benefits for Medicare and Medicaid services in writing (such as, equal access to waiving rights, written assurance of residents eligibility, costs for services and changes in cost for services), as evidenced by failure to have a resident/responsible party sign the applicable admission forms. Resident #102.	F 156		

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F 156	Continued From page 4 The findings include: A face -to-face interview was conducted with Employee #53 on December 8, 2014, at approximately 10:00 AM. When queried about the admission process he/she stated, "I usually give the resident a day or two to get accommodated. Someone from admissions and the business office meet with the resident and/or the responsible party to ensure all aspects of the admission processes are discussed and signed." A face-to-face interview was conducted with Employee #14 on December 8, 2014 at approximately 10:45 AM. When queried about the admission's process for Resident #102; he/she stated, " There is a process in place when the resident is here. The financial part is completed with admissions. I was notified of this " after the fact. " A review of the facility ' s admission ' s packet included information to notify [the resident/responsible party] of their rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility; and their rights and benefits for Medicare and Medicaid services in writing, such as, equal access to waiving rights, written assurance of residents eligibility, costs for services and changes in cost for services.	F 156		

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F 156	Continued From page 5 A review of the clinical record for Resident #102 lacked evidence that all forms related to the admission ' s process were signed, indicating that the resident was informed of his/her rights, and benefits for Medicare and Medicaid services. A face-to-face interview was conducted with Employee #13 on December 8, 2014 at approximately 11:30 AM. Employee #13 was queried regarding why the admissions contract was not signed. He/she stated that all contracts are to be signed by the resident or responsible party when the resident is admitted into the facility. There was no evidence that facility staff ensured that Resident #102 and/or resident ' s responsible party was informed of his/her rights, all rules and regulations governing resident conduct and responsibilities; and rights and benefits for Medicare and Medicaid services. Employees #13 and #14 acknowledged the findings on December 8, 2014. The clinical record was reviewed on December 8, 2014.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician	F 157	**483.10(b)(11) Notify of Changes(Injury/ Decline/Room, etc.)** 1. Resident #160 was readmitted to the facility and his care plan was updated to address his advanced dementia He was evaluated by the facility's psychiatrist who wrote that the "Pt does not meet the criteria for Pica. It appears that he has a hyper oral fixation related to his dementia. Behavioral interventions implemented at N.H. has been effective."	12/15/14 1/16/15

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F 157	Continued From page 6 intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 53 sampled residents, it was determined that facility staff failed notify the physician, consulting psychiatrist and medical team of Resident #160 ' s assessed behaviors of potential " intake of foreign objects. " The findings include: According to the Psychiatric Times May 2008; " Pica is the pathological craving for and eating of a	F 157	**483.10(b)(11) Notify of Changes(Injury/ Decline/Room, etc. cont.)** 2. All residents with Advanced Dementia were screened to ensure accurate information about the care and services needed by these residents is known to his/her caretakers. 3. A new Behavioral Health contract was initiated at the facility which will afford increased access to Psychiatry and Psychology services. An inservice was done with the clinical staff regarding the referral of residents for evaluation by Psychiatry to ensure the prompt implementation of Physician orders for these services and the clarification of terms such as "close monitoring" and "1:1." Additionally, the inservice address the need for the accurate notification of caretakers of the care and needs for these specific residents. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis to ensure proper communication of the residents needs, care and services as well as the prompt access of Behavioral Health evaluations. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator	1/12/15 1/5/15 1/12/15 1/12/15

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F 157	Continued From page 7 nonnutritive item " " Often, the control of pica in mentally handicapped adults with complicated histories presents a clinical problem that must be approached through individualized design and the presence of aversive but not harmful consequences. " <http://www.psychiatrictimes.com/eating-disorders/update-pica-prevalence-contributing-causes-and-treatment/page/0/1> According to the History and Physical completed on September 22, 2014 Resident #160 ' s diagnoses included: End Stage Renal Disease- Dialysis Dependent, Dementia and Hypertension. Under the section labeled " mental status, " the physician recorded " confused. " According to the Minimum Data Set completed November 12, 2014. Under Section C1000 (Cognitive Skills for Daily Decision Making), the Resident was coded as severely impaired [never/rarely made decisions]. Under Section E 0200 (Behavior), the resident was coded as physical behavioral symptoms directed towards others (e.g. hitting, kicking, pushing, scratching, grabbing ...), Section G (Functional Status), the resident was coded as requiring extensive assistance in bed mobility, and transfers; and required total assistance in toileting, dressing, eating, and personal hygiene. Section G 0400 (Functional Limitation in Range of Motion), the resident was coded as having no impairment to upper or lower extremities. Under Section K (Swallowing/Nutritional Status), the resident was coded as being on a mechanical altered diet. A review of Resident #160 ' s care plan revealed the interdisciplinary team assessed the following	F 157		

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F 157	Continued From page 8	F 157		

problem: " Problematic Manner in which resident acts characterized by inappropriate behavior " last updated September 9, 2014 revealed: "Goal-resident will eliminate intake of foreign objects [times] 90 days. To ensure resident safety [times] 90 days. Interventions: Place resident close to nursing station for safety and close monitoring. Remove harmful substances from room. Remove non-edible but frequently ingested objects from resident's room."

A review of the " Resident Care Card " [no date] revealed that under the heading "Precautions," the line was left blank. However, under the heading " Nutrition, " the resident was listed as a feeder, on aspiration precautions, required assisted to be fed meals. Under the heading "Ambulation/Mobility," the resident required a wheelchair with seatbelt, and 1:1 hourly rotation, monitoring for fall prevention. Under the heading " Safety, " the resident required a seatbelt when up [in] wheelchair. Under " Physical Needs," the staff escorted the resident to dialysis on Monday, Wednesday and Friday. Under "Activities of Daily Living," the resident's was provided total care by staff.

A review of the Physician's Order Sheet signed and dated October 24, 2014 directed, "Exelon [indicated for the treatment of Dementia] Patch 9.5 mg per 24 hours, apply one patch topically daily for Dementia; Paxil [used to treat Major Depressive Disorder] 10 mg take one tablet by mouth daily for Depression"

The interim physician's order dated September 5, 2014 directed, "One-on-one hourly rotation monitoring for fall prevention q [every] shift."

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F 157	Continued From page 9 A review of the facility's "Behavior Monitoring Sheets "for September, October and November 2014 revealed that Resident #160 was monitored for Paranoia, Resistance to Care, and Scratching. However, during this time period, the resident was coded as "zero," indicating that no behaviors were observed. There was no evidence that staff identified as targeted behavior and/or consistently monitored the assessed behavior of [potential] " intake of foreign objects " [per care plan]. A review of the "Consult for Therapy" dated October 9, 2014 revealed, "Please evaluate Resident [secondary to] pocketing foods." A review of the "Speech Therapy Plan of Care" dated October 31, 2014 revealed that the reason for referral was for "reports of pocketing food." The start of care was October 31, 2014 and the resident was discharged from care on November 14, 2014. A review of the Doctor ' s Progress Notes from July 15, 2014 to November 21, 2014 lacked evidence that the attending physician addressed the resident ' s behavior of mouthing and/or chewing non-food items. There was no evidence that the physician and/or medical team was informed regarding the assessed behaviors. A review of consulting specialists ' notes revealed a Psychiatric Consult was most recently conducted October 24, 2013. There was no evidence that the psychiatrist was aware and/or evaluated Resident #160 for behavior of mouthing/chewing non-food items. A nurse ' s note dated November 21, 2014 at	F 157		

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F 157	Continued From page 10 11:30 PM revealed, " 911 call at 3:35 PM. Arrived at 3:45 PM. Resident was transported at 3:50 PM to [hospital name] [second] to declott of [right] upper AV (Arteriovenous) graft site. Resident is still under evaluation at the end of the shift... " A review of the forms utilized by the facility to communicate to a receiving provider/facility (hospital) entitled " Metropolitan Washington Area Inter-Agency Referral Transfer Form " [no date indicated] and the D.C. Fire & EMS[District of Columbia Fire and Emergency Medical System] lacked evidence that facility staff communicated to the receiving hospital and the transport agency, the resident's behavior of [potential for] ingesting non-food items. Face-to-face interviews were conducted on December 8, 2014 between 10:00 AM and 4:00 PM with Employees assigned to care for Resident #160. Facility staff stated the following: Employee #27 stated, " Resident #160 talks and tries to get out of the wheelchair. At one point Resident#160 was briefly on 1:1 monitoring. He/she participates in the restraint reduction program and wears a seatbelt in the wheelchair. He/she would chew on his/her shirt every chance that he/she got. " Employee #28 was asked what type of care needed to be provided for Resident #160. He/she stated, " The Resident was a 1:1. He/she was chewing up and eating everything so he/she was put on 1:1; he /she chewed on socks and shirts in the drawer. He/she went on to state	F 157		

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F 157	Continued From page 11 that Resident #160 had scheduled times to be in the hallway at the nurses ' station with nothing in his/her way that could be grabbed and eaten. Employees #25 stated, " Resident #160 was not being tracked [not being followed by the Behavior Management Team] Employee #26 stated that [Resident #160] is not being tracked but that all staff has been notified to start behavior management forms when behaviors are observed. " Employee #26 was asked what type of residents are candidates for 1:1 are monitoring. He/she stated, " 1:1 monitoring is for fall risks and residents with intense behaviors that need to be monitored. Intense behaviors include agitation, 1:1 monitoring keeps the resident from acting out. " Employee# 8 was asked why Resident #160 was on 1:1 monitoring. He/she stated, " [Resident #160] is on 1:1 monitoring for safety and putting things in his/her mouth. He/she is at the nursing station every day with supervision. The gloves in his/her room are located far from the bed. He/she also stated that [Resident #160] was sent out to have his/her graft de-clotted, and that he/she was fine when sent out. " Employee # 23 was asked about the care of Resident #160. He/she stated that the resident was on hourly monitoring for elopement. Some of those times he/she is at the nursing station and he/she is also in the restraint reduction program. When asked if Resident#160 was able to grab anything with his/her hands Employee# 23 stated that he/she cannot grab anything and that he/she	F 157		

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F 157	Continued From page 12 is a feeder. Employee #23 stated that Resident #160 can ' t talk and was not alert and oriented x 3, he/she likes to gnaw on his/her towel while feeding. The staff holds his/her drink when taking a sip and a towel is used when feeding to protect his/her clothes. He/she eats all of his meals in the dining room except breakfast, and the staff does not feed him/her with gloves. " Employee #22 was asked about the care for Resident #160. Employee #22 stated that he/she was on 1:1 monitoring for high risk of falling for more than a month. He/she sits close to the nursing station to prevent falls. He/she wears a seatbelt when in the wheelchair and someone would be around if the seatbelt was removed by the resident because there is always a charge nurse at the nursing station. He/she stated that Resident #160 was not being monitored for anything else. Employee #29 was asked about the care for Resident# 160. Employee# 29 stated that he/she takes [Resident #160] to the dining room and that he/she is a feeder. Whenever [Resident# 160] is in his/her room," I make sure that I check on the resident every 5 minutes. I place a plastic/paper bib on [Resident #160] when [he/she] is fed and sometimes he/she puts things in his/her mouth. They place a towel around the bib to keep him/her from putting other things in his/her mouth." Employee #31 was asked about the care of Resident #160. Employee #31 stated that he/she keeps an eye on Resident #160 when he/she is in the room. I feed Resident #160 because he/she is unable to feed him/herself. Sometimes when Resident #160 is being fed he/she tries to put	F 157		

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F 157	Continued From page 13 things in his/her mouth, when he/she does this the staff can usually talk to the resident and he/she will stop. Sometimes he/she likes to chew on his/her shirts. On December 9, 2014 at approximately 10:30 AM a face-to-face interview was conducted with Employees #1, 2, 8, and 25. They stated that 1:1 monitoring means that a certified nurse aide is assigned to the resident for a defined period of time; and acknowledged the findings. There was no evidence how staff implemented the management of Resident #160 ' s behavior of [potential] " intake of foreign objects " [per care plan]. According to the aforementioned staff interviews, there were inconsistencies in the knowledge of and/or interventions related to the resident ' s behavior of [potential] " intake of foreign objects. " There was no evidence that [potential] " intake of foreign objects " was identified, tracked and/or monitored as a targeted behavior. There was no evidence that facility staff communicated to the medical team regarding the resident ' s behavior of mouthing/chewing on non-food items. The " Resident Care Card " for Resident #160 lacked problem identification, goals and specific interventions for the management of mouthing/chewing non-food items. According to the nurse ' s note (noted above) dated November 21, 2014, Resident #160 was transported to an acute care facility secondary to a clotted graft site.	F 157		

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F 157	Continued From page 14 A review of hospital records revealed Resident #160 was admitted to the hospital on November 22, 2014. An Endoscopy [diagnostic procedure to visually examine the upper digestive system] was performed on December 2, 2014 [10 days post hospital admission]. A specimen was obtained during the procedure and labeled " stomach, foreign body removal. " A review of the pathology report read: " a tan black disrupted plastic foreign body measuring 14.5x7x2 cm [centimeters]. A Gastroenterology progress note dated December 3, 2014 8:32 AM read: " ...EGD [Endoscopy] 12/2/14 revealed hardened plastic objects in the stomach which turned out to have the appearance of gloves ... " facility staff failed notify the physician, consulting psychiatrist and medical team of Resident #160 ' s assessed behaviors of potential " intake of foreign objects. " There was no evidence that the medical team was informed about the resident ' s assessed behaviors and the record lacked evidence that the behaviors [potential " ingestion of foreign objects "] were communicated to the receiving hospital. The resident was diagnosed with foreign object(s) in the stomach during an Endoscopy procedure conducted 10-days post hospitalization. A face-to-face interview was done on December 9, 2014 at approximately 3:00 PM with Employees #1 and # 2. The findings were reviewed and acknowledged. The record was reviewed on December 9, 2014.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if	F 176	**483.10(n) Resident Self-Administer Drugs if Deemed Safe** 1. Resident #116 was re-educated and observed administering the medication and was deemed capable of self-administration of his/her medication.	1/9/15

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F 176	Continued From page 15 the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews for one (1) of 53 sampled residents, it was determined that the interdisciplinary team failed to assess one (1) resident's ability to self administer medications in a safe manner. Resident #116. The findings include: During a medication observation conducted on December 1, 2014 at approximately 10:00 AM, Resident #116 was observed administering his/her Flovent inhaler (Inhaled Corticosteroid) and Flonase (Nasal Steroid) nasal spray. The resident shooked his/her container of Flovent inhaler; positioned the inhaler in his/her mouth and administered one (1) puff; waited for three (3) seconds, and administered a second (2) puff, proceeded to administer one (1) spray of Flonase in each nostril. According to Drugs.com; " If more than 1 (one) inhalation is to be used, wait a few minutes and repeat. After inhaling, rinse your mouth with water and spit it out." Facility staff failed to follow the manufacturer's specifications for administration of Flovent accurately.	F 176	**483.10(n) Resident Self-Administer Drugs if Deemed Safe (cont.)** 2. There are no other residents who are self-administering their medication. 3. Inservice education was provided to the IDT members on the facility's policy and practice of Self Administration of Drugs by our residents. Clinical Managers or their designees will routinely monitor their residents who have been deemed capable of the self administration of their medication and report their findings to the Director of Nurses. 4. The Director of Nurses will review the data from these monitoring efforts done by the Clinical Managers and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/9/15 1/9/15 1/12/15

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Review of the facility's policy titled " Self Administration of Non-Narcotic Medication " dated 03/08, Policy #1404450A-00 revealed; (1) Residents are assessed for self-administration of medications upon request and physician order, (4) The interdisciplinary team will determine the final decision on whether or not the resident is competent in self-administration of any or all medication; (6) The MAR (Medication Administration Record) must reflect what medication that the resident is self-administering."

The " Physician's Order" form signed November 29, 2014 directed: " Flovent HFA (Hydrofluoroalkane) Inhaler 110 mcg (micrograms) - inhale [two] (2) puffs twice daily for allergy relief; Flonase Nasal Spray- Administer 1 [one] spray to each nostril twice daily for allergic rhinitis."

A review of the November and December 2014 Medication Administration Records lacked evidence that the resident was self-administering [his/her] medications. The aforementioned medications were administered daily at 10:00 AM.

There was no evidence in the clinical record that the Interdisciplinary Care Team (IDT) determined that it was safe for Resident #116 to self administer medications. Additionally, it was observed that there were no instructions provided to Resident #116 when he/she self administered medications on December 1, 2014 at approximately 11:00 AM.

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F 176	Continued From page 17 A face-to-face interview was conducted with Resident #116 on December 3, 2014 at approximately 11:30 AM regarding the aforementioned observation. He/she stated that [he/she] had been self-administering the Flovent inhaler and Flonase spray since it was first ordered. Further stated, the doctor demonstrated to him/her how to use the inhaler and nasal spray in his/her office and no one has instructed [him/her] since that time. However; sometimes [he/she] " does not feel the inhaler go to his/her lungs." A face-to-face interview was conducted on December 3, 2014 at approximately 12:00 PM with Employees #5 and #55. Both stated, "[Resident #116] self administers his/her Flonase nasal spray and Flovent inhaler. We observe [him/her] take the medications." The interdisciplinary team failed to assess Resident #116's ability to self administer medications in a safe manner. The observation and clinical record was reviewed on December 1, 2014.	F 176		
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.	F 241	**483.15(a) Dignity and Respect of Individuality** 1. The Staff involved has been counseled regarding the need to serve the residents in a prompt and dignified. manner.	1/5/15

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F 241	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews for 7 (seven) of 53 sampled residents, it was determined that the facility staff failed to promote care in a manner that maintained or enhanced dignity and respect as evidenced by residents sitting idle, waiting to be served their meals, for more than 30 minutes after their scheduled meal time; while others were eating their meals. Residents' #44, 62, 73, 76, 163, 244, and 325. The findings include: On December 1, 2014 at approximately 12:50 PM, a dining observation was conducted on unit, 1 North. At approximately 1:15 PM, all residents had been served and were eating, except the above mentioned residents. Residents' #62, 73, 163, and 244 were sitting together at the table, waiting for their meal trays. Residents #44, 76, and 325 were sitting together at another table, waiting for their meal trays. Resident #44 called out, "I don't know why we haven't been fed yet." Resident #62 asked, "Where is the food?" Approximately 1:35 PM, the residents received their meals. A face-to-face interview was conducted with Employee #34 regarding the status of the meals, since he/she was attending the dining area. He/she stated, "They ran out of plates and they are waiting for more plates to come up from the kitchen." He/she also explained this to the residents, after it was brought to his/her attention. On December 3, 2014 at approximately 2:00 PM, a face-to-face interview was conducted with Employee #12, who acknowledged the	F 241	**483.15(a) Dignity and Respect of Individuality (cont.)** 2. All dining rooms are monitored to promote care in a manner that maintains or enhances the residents dignity and respect by meals being served in a timely manner. 1/9/15 3. Inservices have been done to emphasize the need to servie our residents their meals in a timely and dignified way. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 1/9/15 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 1/12/15	

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F 241	Continued From page 19 aforementioned findings. Facility staff failed to maintain or enhance the residents' dignity and respect.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews, and record review for one (1) of 53 sampled residents, it was determined that facility staff failed to provide medically related social services to ensure one (1) resident maintained physical, mental and psychosocial well being as evidenced by failing to implement discharge planning services and assess the resident's individual needs in that the resident departed the facility against medical advice in response to a call received from facility staff that the resident would be responsible for incurring costs associated with his/her continued stay at the facility. The findings include: Resident #102 was admitted to the facility on October 13, 2014 for sub acute rehabilitation status post inpatient admission for " Fatigue, Urinary Retention, and Urinary Tract Infection."	F 250	**483.15(g)(1) Provision of Medically Related Social Service** 1. The Social Worker involved has been counseled regarding prompt and Individualized discharge planning. 2. The medical records of all residents who left the facility against medical advice were reviewed to ensure that the Social Worker provided appropriate and individualized discharge planning including addressing any financial issues the resident and/or Responsible Party may have. 3. Inservicing was done with all of the Social Workers to ensure soon after admission that the resident is interviewed, individualized issues and questions are appropriately addressed and their discharge plans and needs are documented in the medical record. The Social Work Quality Improvement team will routinely audit the medical records to assess the discharge plans of all residents with particular emphasis on any resident who was discharge against medical advice. The findings of these audits will be forwarded to the Director of Social Work for analysis. 4. The Director of Social Work will present the finding of the Social Work Quality Improvement Team along with any action plans for improvement to the Quality Assurance/Performance Improve-Ment Committee which meets monthly and Is chaired by the Administrator.	1/5/15 1/10/15 1/12/15 1/12/15

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F 250	Continued From page 20 Interim physician's orders revealed the following: "October 14, 2014- 12:30 PM- [Occupational Therapy Clarification]: (1) Evaluate patient, (2) Treat (five) 5 [times a] week [for] 12 weeks; POC (Plan of Care)- Therapeutic Exercises, Therapeutic Activity, Neuro (neurological) rehabilitation and Neural Repair, Activities of Daily Living and Modality Application [as needed] and Cognition Training. October 14, 2014-12:45 PM- [Physical Therapy Clarification]- Physical Therapy to see patient for evaluation and treatment for gait training, strengthening, transfer, transfer and standing balance activities." An " Initial Social Service Assessment " dated October 14, 2014 revealed; "Discharge Plan: Resident has a plan to return to the community as soon as possible. Additional Comments: Resident is oriented [times] 3 (three), and [his/her] long/short term memory appears to be moderately intact. .. Resident is here to receive rehab [rehabilitation] services. ... Resident is here on a short term basis." A " Transitions Healthcare Activity Report " revealed; " November 19, 2014; Time 15:21 (3:21 PM); Type-Call; Status: Closed; Note: Called and spoke to the [gender] about completing a Medicaid application. [He/she] said that [he/she] would not qualify for Medicaid ... [He/she] said [he/she] would have to leave from the facility because [he/she] could not pay." Employee #19 was asked if the social worker or anyone was alerted that the responsible party was considering removing the Resident #102 from the facility. He/she stated, " No. "	F 250		

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F 250	Continued From page 21 A review of the clinical record "Team Notes" revealed the following: "November 21, 2014- 1:05 PM- Focus: Discharged Against Medical Advice- Resident's RP (Responsible Party)/ and family decided to discharge resident home (resident's address documented) against medical advice on November 21, 2014 around 12:10 PM. RP and family said they were not notified of insurance lapse in a timely fashion so we are taking him home. SW (Social Worker) tried to persuade RP and resident's [resident's relative] to give us a day at least so the facility can order medications for the resident, but they insisted on taking the resident home on November 21, 2014. November 24, 2014- 1:10 PM- Focus: Discharge Note- Resident's RP and his [resident's relative] read the form used to discharge a resident against medical advice and know that there are risks involved when discharging their loved one against medical advice." A "Leaving Facility Against Medical Advice" form dated November 21, 2014 revealed; "Comments: (explanation of circumstances behind resident leaving facility)- Family was not notified of insurance lapse in a timely fashion and decided to take resident home. " A face-to-face interview was conducted with Employee #54 on December 8, 2014 at approximately 9:53 AM regarding the aforementioned concern. He/she stated; "It was something regarding the business office and the insurance lapsing. I tried to get them to stay, but the [resident's responsible party] was rushing	F 250		

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F 250	Continued From page 22 [him/her] out. I did not know anything about the resident/responsible party planning to take [him/her] out of the facility until the day it occurred." When queried if a comprehensive assessment was conducted with resident/responsible party related to his/her prior living status, including assistive devices for mobility? He/she stated, "No, I coordinate the resident ' s needs with the doctors, physical therapists and occupational therapist before discharge. I make referrals to obtain PCA (Patient Care Assistants) and any medical equipment if needed." A telephone interview was conducted with the [resident's family member] on December 8, 2014 at approximately 12 Noon. He/she stated they (resident/ responsible party) were not informed of what was covered or the cost of anything. Further stated; "No admission packet was signed. We hired a private nurse to help when [he/she] came home. He/she comes in twice a week. We are paying for this out of our pockets." A face-to-face was conducted with Employee #17 on December 9, 2014 at approximately 12:50 PM. When queried about Resident #102's discharge plans; he/she stated that the discharge plan would have been to refer the resident to Occupational and Physical Therapy services at home. Facility staff failed to implement discharge planning services and assess Resident #102's individual needs prior to resident's departure from	F 250		

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	095022	A. BUILDING _____ B. WING _____	12/09/2014

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F 250	Continued From page 23 the facility against medical advice. The clinical record was reviewed on December 9, 2014.	F 250	**483.15(h)(2) Housekeeping & Maintenance Services**	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made on December 1, 2014 at approximately 10:00 AM and on December 5, 2014 at approximately 12:30 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by soiled exhaust vents in three (3) of 68 resident's rooms, soiled fire sprinklers in four (4) of 68 resident's rooms and short call bell cords in four (4) of 68 resident's rooms. The findings include: 1. Exhaust vents were soiled with dust particles in three (3) of 68 resident's rooms including rooms #146, #225 and #344. 2. Fire sprinklers were soiled with dust particles in four (4) of 68 resident's rooms including rooms #323, #339, #344 and #360. 3. Pull cords from resident's call bells located in the bathroom of rooms #210, #241, #259, #328 were too short to be readily accessible.	F 253	1. Exhaust Vents 1. The three exhaust fans found soiled with dust particles at the time of survey were cleaned upon discovery. 2. Exhaust fans throughout the facility were evaluated to ensure all were without dust particles. 3. Housekeeping staff were inserviced on the proper cleaning of exhaust vents. The Environmental Services Quality Improvement Team will monitor the cleanliness of the exhaust vents on a routine basis and forward the results of their auditing to the Director of Facilities for his analysis. 4. The Director of Facilities will present the findings of this auditing along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 2. Fire Sprinklers 1. The four fire sprinklers found soiled with dust particles at the time of survey were cleaned upon discovery. 2. Fire sprinklers throughout the facility were evaluated to ensure all were without dust particles. 3. Housekeeping staff were inserviced on the proper cleaning of fire sprinklers. The Environmental Services Quality Improvement Team will monitor the cleanliness of the fire sprinklers on a routine basis and forward the results of their auditing to the Director of Facilities for his analysis.	12/9/14 12/9/14 1/10/15 1/12/15 12/9/14 12/9/14 1/10/15

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F 253	Continued From page 24 These observations were made in the presence of Employee #19 who acknowledged the findings.	F 253	**483.15(h)(2) Housekeeping & Maintenance Services (cont.)** 4. The Director of Facilities will present the findings of this auditing along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/12/15
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 six (6) of 53 sampled residents, it was determined that facility staff failed to provide care and services to attain the residents' highest practicable physical, mental, and psychosocial well-being as evidenced by failure to: clarify physician's orders for the use of multiple PRN (as needed) pain medications for one (1) resident; ensure that one (1) resident was fed in an upright position; implement measures to prevent fecal impaction for one (1) resident; obtain a psychiatric consultation in accordance with physician's orders for one (1) resident diagnosed with advanced dementia and for one (1) resident diagnosed with weight loss; and administer Procrit [medication used to treat Anemia] in accordance to physician ' s orders. Residents' #42, 92, 157, 170, 183, and 357. The findings include:	F 309	3. Pull Cords 1. The four pull cords found to be too short at the time of survey were replaced immediately upon discovery. 2. Pull cords throughout the facility were evaluated to ensure all were long enough to be accessible to the residents. 3. Maintenance staff were inserviced on the proper length of pull cords. The Environmental Services Quality Improvement Team will monitor the accessibility of pull cords on a routine basis and forward the results of their auditing to the Director of Facilities for his analysis. 4. The Director of Facilities will present the findings of this auditing along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. **483.25 Provide Care/Services for Highest Well Being** 1. Resident #42 1. The Attending Physician for this resident has clarified the orders for the use of multiple PRN pain medications. 2. The Physician order for all residents with multiple PRN pain medications have been reviewed to ensure that it is clear when each is to be used.	12/9/14 12/9/14 1/10/15 1/12/15 1/12/15 1/12/15

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F 309	Continued From page 25 1. Facility staff failed to clarify physician's orders for the use of multiple PRN (as needed) pain medications for Resident #42. A review of the resident's history and physical dated March 4, 2014 revealed the resident's admitting diagnoses included: Diabetes Mellitus with Neuropathy and Headache. A review of the Physician's Order sheet signed and dated November 28, 2014 revealed the following: "Acetaminophen tab 325 mg [milligram], take two (2) tablets (650mg) by mouth every 6 [six] hours as needed for pain/ temp [temperature] greater than 100.0 F [Fahrenheit] (use caution with APAP [acetyl-p-aminophenol, total daily dose greater than 3,000 mg] original order date September 25, 2014; Hydromorphone [analgesic] tab 4mg: take one (1) tablet by mouth every 4 hours as needed for pain, original order dated September 10, 2014; Lidocaine patch 5% [analgesic]: Apply one (1) patch daily, original order date September 9, 2014." A face-to-face interview was conducted on December 9, 2014 with Employee #7 at approximately 1:00 PM. After review of the above	F 309	**483.25 Provide Care/Services for Highest Well Being (cont.)** 3. Inservice education was conducted for the Licensed Nurse Staff regarding the need to clarify Physician orders for the use of multiple PRN pain medications. 1/12/15 The Nursing Quality Improvement Team will monitor this issue on a monthly basis to ensure compliance. The results of this monitoring will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will review the data from these monitoring efforts done by the Nursing Quality Assurance Team and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 1/12/15	

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F 309	Continued From page 26 physician ' s orders, Employee #7 acknowledged that the PRN pain medications, noting that the original orders lacked evidence of parameters for pain [mild, moderate, or severe]. Facility staff failed to clarify physician's orders for the use of multiple PRN pain medications for one (1) resident. 2. Facility staff failed to implement measures to prevent fecal impaction for Resident #92 who had a history of fecal impaction. A review of the clinical record revealed that the resident was readmitted to the facility on September 27, 2014. A hospital discharge summary dated September 24, 2014 revealed; "GI [Gastro Intestinal] performed a colonoscopy today, which was unremarkable other than some stool impaction." Another colonoscopy report dated 9/25/2014 [September 25, 2014] revealed the following: " Hard impacted clay stool found in the rectum. Underlying stercoral ulcer can't be ruled out in rectum. Petechiae mucosa found in the ascending colon. Two biopsies taken. Recommendations: Resume regular diet as tolerated. Begin taking soap water enema and manual disimpaction. Follow-up on the results of the biopsy specimens." Further review of the Team Notes on the clinical record lacked documented evidence of measures to address Resident #92's history of fecal impaction.	F 309	**483.25 Provide Care/Services for Highest Well Being (cont.)** 2. Resident #92 1. A Bowel Protocol was implemented for Resident #92 due to the history of fecal impaction. 2. All resident who have a history of fecal impaction have been evaluated for the need for a bowel protocol. 3. Inservice education was conducted for the Licensed Nurse Staff regarding the need to implement the facility's bowel protocol for any resident with a history of bowel impaction. The Nursing Quality Improvement Team will monitor this issue on a monthly basis to ensure compliance. The results of this monitoring will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will review the data from these monitoring efforts done by the Nursing Quality Assurance Team and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/12/15 1/12/15 1/12/15 1/12/15

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F 309	Continued From page 27 A face-to-face interview was conducted with Employee #2 at approximately 9:30AM on December 9, 2014. He/she acknowledged the aforementioned findings. The record was reviewed on December 7, 2014. Facility staff failed to implement measures to prevent fecal impaction. 3. Facility staff failed to ensure that Resident #157 was fed in an upright position. The Quarterly Minimum Data Set (MDS) dated September 24, 2014 revealed the admitting diagnoses under Section I (Active Diagnoses) included Cerebrovascular Accident, Hemiplegia or Hemiparesis, and Parkinson's disease for Resident #157. Under Section G- Functional Status, it also revealed that the resident was totally dependent with Activities of Daily Living (ADL's). On December 1, 2014 at approximately 12:50 PM, a dining observation was conducted on unit, 1 North. Resident #157 was observed sitting in a reclining position in a geriatric chair, near a dining table. Employee #32 was observed feeding Resident #157, while in a reclining position. On December 1, 2014 at approximately 1:05 PM, a face-to-face interview was conducted with Employee #32 regarding the resident's position, while eating. He/she said, "I should get some help to sit him/her up." He/she requested the assistance of a nearby employee who assisted him/her to reposition the resident in an upright position.	F 309	**483.25 Provide Care/Services for Highest Well Being (cont.)** 3. Resident #157 1. The staff member was inserviced immediately upon discovery of the proper positioning of a resident while feeding. 2. All dining rooms are monitored to promote care in a manner that maintains or enhances the residents dignity and respect by ensuring their proper position while being fed. 3. Inservices have been done to emphasize the need to properly position our residents while they are being fed their meals. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/1/14 12/1/14 1/9/15 1/12/15

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F 309	Continued From page 28 Facility staff failed to maintain or attain the highest practicable physical, mental, and psychosocial well-being of the resident. The clinical record was reviewed on December 1, 2014. 4. Facility staff failed to obtain a Psychiatric consult in accordance with the physician's orders for one (1) resident diagnosed with weight loss. Resident #170. A review of the Nutrition Quarterly notes dated August 29, 2014 - 12 PM revealed, " ...Resident being seen by SLP [speech language pathology] for tx [treatment] for oropharyngeal dysphasia per St [speech therapist] order 8/20/14. Per SLP comments and discussion with writer, resident was refusing Puree solids and diet was changed to mechanical soft on 8/28/14. SLP reported to this writer that resident has exhibited episodes of speaking about various things which seem " paranoia" in nature. Resident with dx [diagnosis] of dementia and may benefit from psych [psychiatric] consult to evaluate resident especially in light of recent weight loss. Recommend (1) psych consult - evaluate resident R/T [related to] h/o [history of] dementia, recent sig. [significant] wt [weight] decrease and lab refusals. " Physician's Interim Orders dated August 29, 2014 at 4:40 PM directed, "Psych consult - evaluate Resident R/T [related to] H/O [history of] dementia, recent significant weight loss." A review of the clinical record lacked evidence that facility staff followed through on physician's orders to obtain the order for the psychiatric	F 309	**483.25 Provide Care/Services for Highest Well Being (cont.)** 4. Resident #170 1. The resident was seen by the Consultant Psychiatrist per Physician orders. 2. All medical records were audited to ensure all Physician orders to obtain a Psychiatric consultation was followed. 3. A new Behavioral Health contract was initiated at the facility which will afford increased access to Psychiatry and Psychology services. An inservice was done with the clinical staff regarding the referral of residents for evaluation by Psychiatry to ensure the prompt implementation of Physician orders for these services. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis to ensure the prompt access of Behavioral Health evolutions. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator	1/12/15 1/12/15 1/5/15 1/12/15 1/12/15

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F 309	Continued From page 29 consult. A face-to-face interview was conducted with Employee #6 on December 9, 2014 at approximately 1:45 PM. He/she stated that the psychiatric consult was obtained as directed by the physician. However, after reviewing the clinical record, he/she acknowledged that there was no evidence of a psychiatric consult. The record was reviewed on December 9, 2014. 5. Facility staff failed to administer Procrit in accordance with physician's orders for Resident #183. A review of the November 2014 Physician's Order, with an original order date of August 5, 2014, directed " Procrit INJ (injection) 40,000 units/M inject 1 ML [milliliter] (40,000 units) SUB Q [subcutaneous] every month on the 8th to keep HB [hemoglobin] between 10 and 11 gm/d [gram/deciliter]." A review of the MAR [Medication Administration Record] for November 8, 2014, timed 10:00 AM, revealed the allotted signature space was blank; which indicated the Procrit was not administered. A face-to-face interview was conducted with Employee #7 on December 1, 2014 at approximately 11:30 AM. After reviewing the clinical record, he/she acknowledged the aforementioned findings.	F 309	**483.25 Provide Care/Services for Highest Well Being (cont.)** 5. Resident #183 1. Procrit order was obtained from the Attending Physician and administered immediately. Subsequent orders for Procrit have been administered per the Attending Physician's orders. 2. the medical records for Residents with a Procrit order were evaluated to ensure the medication was administered according to the Attending Physician's orders. 3. Inservice training was provided to the Nursing Staff regarding the need to following the Attending Physician orders in an effort to provided necessary care/services to our residents. Clinical Managers along with the Nursing Quality Improvement Team will monitor the administration of Procrit on a frequent basis and submit the results of their audit to the Director of Nurses for his analysis. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/1/14 1/12/15 1/9/15 1/9/15 1/12/15

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F 309	Continued From page 30 There was no evidence that facility staff administered Procrit to Resident #183 in accordance with physician's orders. One monthly dosage of Procrit was omitted without explanation. The record lacked evidence that the resident sustained any untoward affect. The record was reviewed on December 1, 2014. 6. Facility staff failed to obtain a Psychiatric consultation in accordance with physician's orders for Resident #357 who was diagnosed with advanced dementia. A review of the clinical record revealed a physician's order dated September 17, 2014 for a psychiatrist consult for inappropriate behavior (urinating in public). A face to face interview with Employee #3 was conducted on December 8, 2014, at approximately 10:00 AM. He/she was queried regarding the written physician's order for a psychiatric consult. He/she responded that the psychiatrist was at the facility once a week and had been busy with residents who required immediate attention. He/she admitted that the psychiatric consult for Resident #357 had not been scheduled. There was no evidence that facility staff followed the physician's order for a psychiatric consultation for Resident #357. The clinical record was reviewed on December 8, 2014.	F 309	**483.25 Provide Care/Services for Highest Well Being (cont.)** 6. Resident #357 1. The resident was seen by the Consultant Psychiatrist per Physician orders. 2. All medical records were audited to ensure all Physician orders to obtain a Psychiatric consultation were followed 3. A new Behavioral Health contract was initiated at the facility which will afford increased access to Psychiatry and Psychology services. An inservice was done with the clinical staff regarding the referral of residents for evaluation by Psychiatry to ensure the prompt implementation of Physician orders for these services. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis to ensure the prompt access of Behavioral Health evolutions. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. .	1/15/15 1/12/15 1/5/15 1/12/15 1/12/15
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		

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F 318 SS=D	Continued From page 31 IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for one (1) of 53 sampled residents, it was determined that facility staff failed to ensure that Resident #276 who was observed with limited range of motion of upper and lower extremities, received appropriate treatment and services to manage and or prevent further decline in range of motion. The findings include: On December 1, 2014 at approximately 9:30 AM, Resident #276was lying in bed, with upper extremities drawn up towards chest and [his/her] legs were bent towards his/her back. Bilateral hand rolls were in place. On December 2, 2014 at approximately 11:36 AM during a staff interview, Employee #5 was asked, "Does the resident have a contracture...?" He/she replied, " Yes. The resident has upper and lower contractures."	F 318	**483.25(e)(2) Increase/Prevent Decrease in Range of Motion** 1. Resident #276 was reevaluated and subsequently screened by Occupational Therapy and found not to be a candidate for splint application, orthotics and would not benefit from Restorative Services. 1/9/15 2. Residents who are observed with limited range of motion of upper and lower extremities were reviewed to ensure that they received appropriate treatment and services to manage and or prevent further decline in range of motion. 1/12/15 3. Inservices done with Nursing Staff on appropriate communication and follow-up with Rehabilitation and Restorative Staffs to ensure that our residents are provided the appropriate level of services in a timely and thorough manner. Monitoring will be done on a monthly basis by the Nursing Quality Improvement Team and the Rehab Staff to insure the residents receive appropriate treatment and services to manage and or prevent further decline in range of motion. The results of these monitoring efforts will be forward to the Director of Nursing for his analysis. 1/8/15 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 1/12/15	

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F 318	Continued From page 32 A review of the History and Physical dated July 29, 2014 revealed, " Extremities: Contracted Extremities." A review of the annual Minimum Data Set [MDS], dated May 20, 2014, revealed that under Section G, Functional Status, G0400, Functional Limitation in Range of Motion, the resident was coded as "2" [indicating impairment on both sides]. An " Interdisciplinary Screen " dated June 27, 2014 revealed; "Type of Screen: Other: Splints; Contractures noted however ...Unable to be fitted for splints due to the severity. OT (Occupational Therapy) to follow- up [with] orthotics for suggestions." There were no evidence facility staff implemented measures to obtain an orthotics evaluation for Resident #276 for splint application. A face-to-face interview was conducted with Employee #16 on December 4, 2014 at approximately 10:00 AM. He/she stated that no communication had been received concerning the above -cited recommendation. The therapist who evaluated the resident was no longer at the facility. Resident #276 re-evaluation for splints was completed on December 5, 2014 after the concern was bought to the attention of the staff by the State Agency.	F 318		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONS HEALTHCARE CAPITOL CITY	2425 25TH STREET SE WASHINGTON, DC 20020

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F 318	Continued From page 33 When queried, what was the process for recommendations? He/she stated; "The therapist evaluates the resident and makes recommendations/suggestion. They proceed to contact the orthotics to evaluate if needed." The interdisciplinary screen dated December 5, 2014 revealed; " Admission /Readmission Date: 6/13/12 [June 13, 2012] -Patient demonstrates severe flexion contractures of [right] elbow/wrist/ MCP #2-5 (Metacarppophalangeal) that are fixed. Pt [Patient] also, presenting with severe flexion contractures of [left] wrist/MCP # 2-5 that are fixed. Severity of contractures will not allow PROM (Passive Range of Motion) or splinting " Facility staff failed to ensure that Resident #276 who was observed with limited range of motion of upper and lower extremities, received appropriate treatment and services to manage and or prevent further decline in range of motion. The clinical record was reviewed on December 5, 2014.	F 318		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.	F 319	**483.25(f)(1) Tx/Svc for Mental/Psychological Difficulties** 1. Resident #160 was readmitted to the facility and his care plan was updated to address his advanced dementia and oral fixation to chew on his shirt. He was evaluated by the facility's psychiatrist who wrote that "Pt does not meet the criteria for Pica. It appears that he has a hyper oral fixation related to his dementia. Behavioral interventions implemented at N.H. have been effective."	1/16/15

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F 319	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 53 sampled residents, it was determined that facility staff failed to ensure that appropriate treatment and services to correct and/or manage Resident #160 ' s assessed problem of [potential] "intake of foreign objects" was implemented. The findings include: According to the Psychiatric Times May 2008; " Pica is the pathological craving for and eating of a nonnutritive item " " Often, the control of pica in mentally handicapped adults with complicated histories presents a clinical problem that must be approached through individualized design and the presence of aversive but not harmful consequences." <http://www.psychiatrictimes.com/eating-disorders/update-pica-prevalence-contributing-causes-and-treatment/page/0/1> According to the History and Physical completed on September 22, 2014 Resident #160 ' s diagnoses included: End Stage Renal Disease- Dialysis Dependent, Dementia and Hypertension. Under the section labeled " mental status, " the physician recorded " confused. " According to the Minimum Data Set completed November 12, 2014. Under Section C1000 (Cognitive Skills for Daily Decision Making), the Resident was coded as severely impaired	F 319	**483.25(f)(1) Tx/Svc for Mental/Psychological Difficulties** 2. All residents with Advanced Dementia were screened to ensure accurate information about the care and services needed by these residents is known to his/her caretakers. 3. A new Behavioral Health contract was initiated at the facility which will afford increased access to Psychiatry and Psychology services. An inservice was done with the clinical staff regarding the referral of residents for evaluation by Psychiatry to ensure the prompt implementation of Physician orders for these services and the clarification of terms such as "close monitoring" and "1:1." Additionally, the inservice address the need for the accurate notification of caretakers of the care and needs for these specific residents. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis to ensure proper communication of the residents needs, care and services as well as the prompt access of Behavioral Health evaluations. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/12/15 1/5/15 1/12/15 1/12/15

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F 319	Continued From page 35 [never/rarely made decisions]. Under Section E 0200 (Behavior), the resident was coded as physical behavioral symptoms directed towards others (e.g. hitting, kicking, pushing, scratching, grabbing ...), Section G (Functional Status), the resident was coded as requiring extensive assistance in bed mobility, and transfers; and required total assistance in toileting, dressing, eating, and personal hygiene. Section G 0400 (Functional Limitation in Range of Motion), the resident was coded as having no impairment to upper or lower extremities. Under Section K (Swallowing/Nutritional Status), the resident was coded as being on a mechanical altered diet. A review of Resident #160 ' s care plan revealed the interdisciplinary team assessed the following problem: " Problematic Manner in which resident acts characterized by inappropriate behavior " last updated September 9, 2014 revealed: "Goal-resident will eliminate intake of foreign objects [times] 90 days. To ensure resident safety [times] 90 days. Interventions: Place resident close to nursing station for safety and close monitoring. Remove harmful substances from room. Remove non-edible but frequently ingested objects from resident's room." A review of the " Resident Care Card " [no date] revealed that under the heading "Precautions," the line was left blank. However, under the heading " Nutrition, " the resident was listed as a feeder, on aspiration precautions, required assisted to be fed meals. Under the heading "Ambulation/Mobility," the resident required a wheelchair with seatbelt, and 1:1 hourly rotation, monitoring for fall prevention. Under the heading " Safety, " the resident required a seatbelt when up [in] wheelchair. Under " Physical Needs," the	F 319		

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F 319	Continued From page 36 staff escorted the resident to dialysis on Monday, Wednesday and Friday. Under "Activities of Daily Living," the resident's was provided total care by staff. A review of the Physician's Order Sheet signed and dated October 24, 2014 directed, "Exelon [indicated for the treatment of Dementia] Patch 9.5 mg per 24 hours, apply one patch topically daily for Dementia; Paxil [used to treat Major Depressive Disorder] 10 mg take one tablet by mouth daily for Depression" The interim physician's order dated September 5, 2014 directed, "One-on-one hourly rotation monitoring for fall prevention q [every] shift." A review of the facility's "Behavior Monitoring Sheets "for September, October and November 2014 revealed that Resident #160 was monitored for Paranoia, Resistance to Care, and Scratching. However, during this time period, the resident was coded as "zero," indicating that no behaviors were observed. There was no evidence that staff identified as targeted behavior and/or consistently monitored the assessed behavior of [potential] " intake of foreign objects " [per care plan]. A review of the "Consult for Therapy" dated October 9, 2014 revealed, "Please evaluate Resident [secondary to] pocketing foods." A review of the "Speech Therapy Plan of Care" dated October 31, 2014 revealed that the reason for referral was for "reports of pocketing food." The start of care was October 31, 2014 and the resident was discharged from care on November 14, 2014.	F 319		

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F 319	Continued From page 37 A review of the Doctor ' s Progress Notes from July 15, 2014 to November 21, 2014 lacked evidence that the attending physician addressed the resident ' s behavior of mouthing and/or chewing non-food items. There was no evidence that the physician and/or medical team was informed regarding the assessed behaviors. A review of consulting specialists ' notes revealed a Psychiatric Consult was most recently conducted October 24, 2013. There was no evidence that the psychiatrist was aware and/or evaluated Resident #160 for behavior of mouthing/chewing non-food items. A nurse ' s note dated November 21, 2014 at 11:30 PM revealed, " 911 call at 3:35 PM. Arrived at 3:45 PM. Resident was transported at 3:50 PM to [hospital name] [second] to declott of [right] upper AV (Arteriovenous) graft site. Resident is still under evaluation at the end of the shift... " A review of the forms utilized by the facility to communicate to a receiving provider/facility (hospital) entitled " Metropolitan Washington Area Inter-Agency Referral Transfer Form " [no date indicated] and the D.C. Fire & EMS[District of Columbia Fire and Emergency Medical System] lacked evidence that facility staff communicated to the receiving hospital and the transport agency, the resident's behavior of [potential for] ingesting non-food items. Face-to-face interviews were conducted on December 8, 2014 between 10:00 AM and 4:00 PM with Employees assigned to care for Resident #160.	F 319		

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F 319	Continued From page 38 Facility staff stated the following: Employee #27 stated, " Resident #160 talks and tries to get out of the wheelchair. At one point Resident#160 was briefly on 1:1 monitoring. He/she participates in the restraint reduction program and wears a seatbelt in the wheelchair. He/she would chew on his/her shirt every chance that he/she got. " Employee #28 was asked what type of care needed to be provided for Resident #160. He/she stated, " The Resident was a 1:1. He/she was chewing up and eating everything so he/she was put on 1:1; he /she chewed on socks and shirts in the drawer. He/she went on to state that Resident #160 had scheduled times to be in the hallway at the nurses ' station with nothing in his/her way that could be grabbed and eaten. Employees #25 stated, " Resident #160 was not being tracked [not being followed by the Behavior Management Team] Employee #26 stated that [Resident #160] is not being tracked but that all staff has been notified to start behavior management forms when behaviors are observed. " Employee #26 was asked what type of residents are candidates for 1:1 are monitoring. He/she stated, " 1:1 monitoring is for fall risks and residents with intense behaviors that need to be monitored. Intense behaviors include agitation, 1:1 monitoring keeps the resident from acting out. " Employee# 8 was asked why Resident #160 was	F 319		

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F 319	Continued From page 39 on 1:1 monitoring. He/she stated, " [Resident #160] is on 1:1 monitoring for safety and putting things in his/her mouth. He/she is at the nursing station every day with supervision. The gloves in his/her room are located far from the bed. He/she also stated that [Resident #160] was sent out to have his/her graft de-clotted, and that he/she was fine when sent out. " Employee # 23 was asked about the care of Resident #160. He/she stated that the resident was on hourly monitoring for elopement. Some of those times he/she is at the nursing station and he/she is also in the restraint reduction program. When asked if Resident#160 was able to grab anything with his/her hands Employee# 23 stated that he/she cannot grab anything and that he/she is a feeder. Employee #23 stated that Resident #160 can ' t talk and was not alert and oriented x 3, he/she likes to gnaw on his/her towel while feeding. The staff holds his/her drink when taking a sip and a towel is used when feeding to protect his/her clothes. He/she eats all of his meals in the dining room except breakfast, and the staff does not feed him/her with gloves. " Employee #22 was asked about the care for Resident #160. Employee #22 stated that he/she was on 1:1 monitoring for high risk of falling for more than a month. He/she sits close to the nursing station to prevent falls. He/she wears a seatbelt when in the wheelchair and someone would be around if the seatbelt was removed by the resident because there is always a charge nurse at the nursing station. He/she stated that Resident #160 was not being monitored for anything else. Employee #29 was asked about the care for	F 319		

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F 319	Continued From page 40 Resident# 160. Employee# 29 stated that he/she takes [Resident #160] to the dining room and that he/she is a feeder. Whenever [Resident# 160] is in his/her room," I make sure that I check on the resident every 5 minutes. I place a plastic/paper bib on [Resident #160] when [he/she] is fed and sometimes he/she puts things in his/her mouth. They place a towel around the bib to keep him/her from putting other things in his/her mouth." Employee #31 was asked about the care of Resident #160. Employee #31 stated that he/she keeps an eye on Resident #160 when he/she is in the room. I feed Resident #160 because he/she is unable to feed him/herself. Sometimes when Resident #160 is being fed he/she tries to put things in his/her mouth, when he/she does this the staff can usually talk to the resident and he/she will stop. Sometimes he/she likes to chew on his/her shirts. On December 9, 2014 at approximately 10:30 AM a face-to-face interview was conducted with Employees #1, 2, 8, and 25. They stated that 1:1 monitoring means that a certified nurse aide is assigned to the resident for a defined period of time; and acknowledged the findings. There was no evidence how staff implemented the management of Resident #160 ' s behavior of [potential] " intake of foreign objects " [per care plan]. According to the aforementioned staff interviews, there were inconsistencies in the knowledge of and/or interventions related to the resident ' s behavior of [potential] " intake of foreign objects. " There was no evidence that [potential] " intake of foreign objects " was	F 319		

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F 319	Continued From page 41 identified, tracked and/or monitored as a targeted behavior. There was no evidence that facility staff communicated to the medical team regarding the resident ' s behavior of mouthing/chewing on non-food items. The " Resident Care Card " for Resident #160 lacked problem identification, goals and specific interventions for the management of mouthing/chewing non-food items. According to the nurse ' s note (noted above) dated November 21, 2014, Resident #160 was transported to an acute care facility secondary to a clotted graft site. A review of hospital records revealed Resident #160 was admitted to the hospital on November 22, 2014. An Endoscopy [diagnostic procedure to visually examine the upper digestive system] was performed on December 2, 2014 [10 days post hospital admission]. A specimen was obtained during the procedure and labeled " stomach, foreign body removal. " A review of the pathology report read: " a tan black disrupted plastic foreign body measuring 14.5x7x2 cm [centimeters]. A Gastroenterology progress note dated December 3, 2014 8:32 AM read: " ...EGD [Endoscopy] 12/2/14 revealed hardened plastic objects in the stomach which turned out to have the appearance of gloves ... " Facility staff failed to implement appropriate treatment and services to correct and/or manage Resident #160 ' s assessed problem of potential ingestion of non-food items. There was no evidence that the medical team was informed about the resident ' s assessed behaviors and the	F 319		

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F 319	Continued From page 42 record lacked evidence that the behaviors [potential " ingestion of foreign objects "] were communicated to the receiving hospital. The resident was diagnosed with foreign object(s) in the stomach during an Endoscopy procedure conducted 10-days post hospitalization. A face-to-face interview was done on December 9, 2014 at approximately 3:00 PM with Employees #1 and # 2. The findings were reviewed and acknowledged. The record was reviewed on December 9, 2014.	F 319		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations made on December 5, 2014 at approximately 12:30 PM, it was determined that the facility staff failed to maintain resident environment free of accident hazards as evidenced by loose surge protectors observed on the floor of two (2) of 68 resident's rooms. The findings include: 1. Surge protectors were observed in use, on the floor of resident's rooms #253 and # 258, two of 68 resident's rooms surveyed.	F 323	**483.25(h) Free of Accident Hazards/Supervision/Devices** 1. Surge protectors 1. The two surge protectors noted on the floor at the time of the survey were immediately secured upon discovery. 12/5/14 2. A review of the facility found no other surge protectors on the floor. 12/5/14 3. Maintenance Staff was inserviced on the proper way to install a surge protector. 12/12/14 The Maintenance Quality Improvement Team will inspect the facility for the proper mounting of surge protectors on a monthly basis. The results of their inspections will be forwarded to the Director of Facilities for his review and analysis. 1/9/15 4. The Director of Facilities will present the findings of this auditing along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 1/12/15	

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F 323	Continued From page 43 These observations were made in the presence of Employee #19 who confirmed the findings.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interview for one (1) of 53 sampled residents, it was determined that facility staff failed to implement a therapeutic dietary modification for an isolated resident who was post-operative gastric bypass surgery. Resident #267. The findings include: According to the Mayo Clinic October 2011 as it relates to Gastric Bypass Surgery "...it is critical that all patients adhere to their physician-recommended dietary restrictions without exception. These specialized diets are designed not only to promote healing of the digestive tract but also to prevent additional injury to organs already traumatized by surgery. "	F 325	**483.25(i) Maintain Nutrition Status Unless Unavoidable** 1. Upon discovery by the Director of Nutritional Services, all parameters of this specialized diet was implemented. 12/2/14 2. There are no other residents who have this type of diet ordered. 12/2/14 3. Dietary and Nursing staffs were inserviced regarding the notification of and the implementation of such a specialized diet. The Admissions staff has been asked to notify the Nutritional Services department pre-admission of any such specialized diets. 1/9/15 The Nutritional Services Quality Improvement Committee and the facility's Dieticians will monitor the facility's compliance with such specialized diet on at least a monthly basis. The results of their audits will be forwarded to the Director of Nutritional Services for his review and analysis. 4. the Director of Nutritional Services will present the findings of his analysis along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 1/12/15	

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F 325	Continued From page 44 <http://www.mayoclinic.org/tests-procedures/bariatric-surgery/in-depth/gastric-bypass-diet/art-20048472> According to the American Society for Metabolic and Bariatric Surgery " The Dietitian ' s role is a vital component of the bariatric surgery process. Nutrition assessment and dietary management in surgical weight loss have been shown to be an important correlate with success [1], [2]. A comprehensive nutrition assessment should be conducted preoperatively by a dietitian, physician, and/or well-informed, qualified multidisciplinary team to identify the patient ' s nutritional and educational needs. It is essential to determine any pre-existing nutritional deficiencies, develop appropriate dietary interventions for correction, and create a plan for postoperative dietary intake that will enhance the likelihood of success. " <http://asmbs.org/resources/integrated-health-nutritional-guidelines> Facility staff failed to implement a therapeutic dietary modification for Resident #267 as evidenced by a failure to implement resident specific post-operative Gastric Bypass Surgery diet. A review of Section I, Disease Diagnosis, of the annual Minimum Data Set (MDS) signed December 4, 2014 revealed Resident #267's diagnoses included; Diabetes Mellitus, Hypertension, Anemia, Gastro esophageal Reflux Disease, Obesity, and Bariatric Surgery. Section K, Swallowing /Nutritional status, revealed Resident #267 is on a physician prescribed weight loss regimen.	F 325		

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F 325	Continued From page 45 A review of the doctor ' s progress note dated October 22, 2014 revealed " Pt [patient] has been approved for bariatric surgery ... send patient to see the dietician and surgeon November 15, 2014 at 10:30 AM...begin liquid diet November 10, 2014 for 2 weeks ...scheduled for surgery November 24, 2014 ... [Name of hospital]- Bariatric Department. " November 17, 2014 at 1:30 PM, the nutrition follow up note revealed, " RD [registered dietician] visited resident who is on decreased calorie diet as per ordered per bariatric surgery dietician ...resident tolerating diet and has no complaints ... " November 19, 2014, the physician ' s follow up note revealed, " [he/she] is adjusting to[his/her] new pre-op low calorie soft diet for 2 weeks prior to her surgery on November 24, 2014. " November 28, 2014, the physician progress note revealed " Pt[patient] went to [name of hospital] on November 24, 2014 and came out November 26, 2014- [gender] went for Bypass and had successful surgery and was sent back to [name of facility]. " November 28, 2014, the Nutritional Readmission assessment revealed, " resident on decreased fat full liquid diet and that resident has no concerns s/p lap gastric bypass surgery. For intentional weight loss. ' A copy of the dietary guidelines, provided by the bariatric center was observed in the clinical record. The following dietary modification for stage one	F 325		

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F 325	Continued From page 46 full liquids meal plan was documented on the form: " 7:00 am 4 T fat-free, low sugar yogurt, 1 chewable multivitamin 8:00 am unflavored protein supplement made with 4oz crystal light 9:00 am unflavored protein supplement made with 4 oz crystal light 10:00 4 oz water 11:00 am 4 oz crystal light 12:00 pm 2 T strained low fat cream based soup 2 T sugar free pudding 600mg chewable calcium citrate 1:00 pm Protein supplement made with 4 oz skim milk 2:00 pm Protein supplement made with 4 oz skim milk 3:00 pm 4oz water or crystal light and 600mg chewable calcium citrate 4:00 pm 4 oz chicken broth 5:00 pm 2 T strained low-fat cream based soup 2 T low fat cottage cheese 600mg chewable calcium citrate 6:00 pm unflavored protein supplement made with 4oz crystal light 7:00 pm unflavored protein supplement made with 4oz crystal light 8:00 pm 4oz crystal light 9:00 pm 4oz water Daily totals: 54 ounces of fluid - 76 gram protein " There was no evidence this nutritional regimen was planned and or implemented for Resident #267 post operatively as stipulated in the overall physician planned weight loss regimen. " A face to face interview with Resident # 267	F 325		

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F 325	Continued From page 47 was done on December 2, 2014 at 11:00 AM. He/she revealed, " I had gastric bypass surgery on November 24th and was discharged back to this facility on November 26th, late in the evening. They have not been able to get my diet right since ... this past weekend was the worse. I was told there were no cream based soups and that a specific diet could not be accommodated for me. I am so frustrated. I don't want this to fail, and following the bariatric weight loss program correctly is essential to my success ...I went to the store yesterday and bought the cream based soup, jello and sugar free puddings because they kept telling me they did not have them. I can show you the receipt. The center gave them copies of everything before I began the program so they would know what I ' m supposed to be eating. This morning I received my breakfast tray at 9:00 AM. Nothing was sent up for 7am or 8 am. " A face to face interviewed was conducted on December 2, 2014 at approximately 11:45 AM with Employee #40 when informed of Resident # 267's concerns. A query was made regarding why this occurred. He/she stated the issues with the post bariatric diet will be resolved effective today and there should not be any more problem. He/she acknowledged there have been problems with the resident receiving the modified diet post procedure and discharge. " A face to face interview with Resident # 267 was done on December 3, 2014 at 9:00 AM. He/she revealed the following, " Things are getting better. I had a delivery at 7:00 and 8:00 AM and my breakfast is here on time. Things look better now, although it took five (5) days for them to get it together. "	F 325		

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F 325	Continued From page 48 A face to face interview was conducted with Employee #29 on December 9, 2014 at 4:00 PM. When queried, he/she stated that the resident returned to facility earlier than expected and the information for the specified diet modification was not submitted to the dietary department. The necessary arrangements to meet nutritional needs of Resident #267 have been have been implemented. Facility staff failed to implement therapeutic dietary modifications for Resident #267 who was post operative Gastric Bypass Surgery. The resident was readmitted post Bariatric Surgery and staff were aware of his/her physician prescribed weight loss regimen and post operative dietary requirements prior to readmission. Employee #29 acknowledged the findings the medical record was reviewed on December 9, 2014.	F 325		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	**483.35(i) Food Procure, Store/Prepare/ Serve – Sanitary** 1. & 2. Cutting Boards and Sheet Pans 1. Cutting Boards and Sheet Pans found soiled at the time of the survey were cleaned immediately upon discovery. 2. All Cutting Boards and Sheet Pans were inspected to insure all were free of stains and carbon build-up. Those which could not be cleaned or destained were discarded. 3. Inservices were given to the Dietary Staff regarding the proper cleaning and maintenance of Cutting Boards and Sheet Pans. The Dietary Supervisors and the Dietary Quality Improvement Team will	12/1/14 12/3/14

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F 371	Continued From page 49 by: Based on observations made in the main kitchen on December 1, 2014 at approximately 10:00 AM and on December 3, 2014 at approximately 2:00 PM, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by four (4) of seven (7) soiled cutting boards, one (1) of three (3) soiled sheet pan, one (1) of five (5) dented cans of applesauce and one (1) of 14 dented cans of red peppers in dry food storage, one (1) of six (6) torn splash curtain from the dishwashing machine, uncovered pans (19) of turkey burgers in the walk-in refrigerator, one (1) of one (1) torn air curtain in the walk-in refrigerator and in the walk-in freezer and a soiled and discolored kitchen floor. The findings include: 1. Four (4) of seven (7) cutting boards were soiled. 2. One (1) of three (3) sheet pans was soiled. 3. One (1) of five (5) large cans of applesauce stored in the dry storage room was dented and one (1) of 14 large cans of red peppers stored in the dry food storage room was also dented. 4. One (1) of six (6) splash curtains from the dishwashing machine was torn. 5. 19 pans of uncooked turkey burgers were stored in the walk-in refrigerator uncovered. 6. One (1) of one (1) air curtain from the walk-in	F 371	**483.35(i) Food Procure, Store/Prepare/ Serve – Sanitary (cont.)** monitor the cleanliness of the cutting boards and sheet pans on a monthly basis and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 3. Dented Cans 1. All dented cans found in the dry storage room were removed immediately upon discovery. 2. All cans were reviewed to ensure any cans with dents were stored appropriately. 3. Inservices were given to the Dietary Staff regarding the proper storage of dented cans. The Dietary Supervisors and the Dietary Quality Improvement Team will monitor the storage of dented cans on a monthly basis and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 4. & 6.Splash Curtain and Air Curtain 1. The torn air curtain and splash curtains have been replaced. 2. All air curtains and splash curtains were inspected to insure there were no further tears.	1/9/15 1/12/15 12/1/14 12/1/14 1/9/15 1/12/15 1/12/15 12/5/14

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F 371	Continued From page 50 refrigerator was torn and one (1) of one (1) air curtain from the walk-in freezer was also torn. 7. The kitchen floor was soiled in numerous areas with discoloration. These observations were made in the presence of Employee #19 who acknowledged the findings.	F 371	**483.35(i) Food Procure, Store/Prepare/ Serve – Sanitary (cont.)** 3. Inservices were given to the Dietary Staff regarding the inspection and care of the splash curtain in the dishwasher and the air curtain in the refrigerator. The Dietary Supervisors and the Dietary Quality Improvement Team will monitor these specialty curtains on a monthly basis and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 5. Turkey Burgers 1. Turkey burgers were immediately covered upon discovery. 2. All other food in the refrigerator was inspected to ensure their proper storage. 3. Inservices were given to the Dietary Staff regarding the proper storage of prepped food. . The Dietary Supervisors and the Dietary Quality Improvement Team will monitor the storage of prepped foods on a monthly basis and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 7. Kitchen Floor 1. The areas of the kitchen floor found to be discolored were attended to upon discovery. 2. All areas of the kitchen floor were evaluated to ensure no further areas of discoloration.	1/9/15 1/12/15 12/1/14 12/1/14 1/9/15 1/12/15 12/1/14 12/1/14
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 53 sampled residents, it was determined that the physician failed to address Resident #92 ' s history of fecal impaction in the resident's total plan of care. The findings include: The resident was readmitted to the facility on September 27, 2014 after being hospitalized in an acute care facility for six (6) days. The resident ' s discharge summary dated September 26, 2014 revealed the following:	F 386		

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F 386	Continued From page 51 A report of a colonoscopy dated September 24, 2014: " Hard impacted clay stool found in the rectum. Petechiae mucosa found in the ascending colon. Recommendations: Resume regular diet as tolerated. Begin taking soap water enema and manual disimpaction. " Another colonoscopy report dated 9/25/2014 [September 25, 2014] revealed the following: " Hard impacted clay stool found in the rectum. Underlying stercoral ulcer can't be ruled out in rectum. Petechiae mucosa found in the ascending colon. Two biopsies taken. Recommendations: Resume regular diet as tolerated. Begin taking soap water enema and manual disimpaction. Follow-up on the results of the biopsy specimens." A review of the physician's readmission orders failed to include measures to manage potential bowel dysfunction in light of the fact that the resident was recently diagnosed with fecal impaction. Further review of the Physician's Progress Notes also failed to reveal any documentation regarding the resident's history of fecal impaction. A face-to-face interview was conducted with Employee #2 at approximately 9:30AM on December 9, 2014. He/she acknowledged the finding. The record was reviewed on December 7, 2014 The physician failed to include measures to address a history of Fecal Impaction in the resident ' s total plan of care.	F 386	**483.35(i) Food Procure, Store/Prepare/ Serve – Sanitary (cont.)** 3. Inservices were given to the Dietary Staff regarding the proper and routine care and upkeep of the kitchen floor. The Dietary Supervisors and the Dietary Quality Improvement Team will monitor the upkeep of the kitchen floor on a monthly basis and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. **483.40(b) Physician Visits – Review Care /Notes/Orders** 1.This resident has an order for docusate sodium BID. The attending physician has added a new order for lactulose QD and PRN. A new bowel protocol was initiated by the facility as well. 2. Clinical Managers reviewed the medical records of any other residents with a history of bowel dysfuntion to ensure measures were in place to manage potential issues. 3. Inservice education was conducted for the Licensed Nurse Staff regarding the need to implement the facility's bowel protocol for any resident with a history of bowel impaction. The Nursing Quality Improvement Team will monitor this issue on a monthly basis to ensure compliance. The results of this monitoring will be forwarded to the Director of Nurses for his review. 4. The Director of Nurses will review the data from these monitoring efforts done by the Nursing Quality Assurance Team and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/9/15 1/12/15 10/1/14 1/12/15 1/12/15 1/12/15
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 52 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. 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 an observation, record review and staff interview, it was determined that facility staff	F 431	**486.60(b),(d),(e) Drug Records, Label/ Store Drugs & Biologicals** 1. Expiration of Procrit 1. Medication with an expiration date of 11/30/14 was destroyed upon discovery. 2. All medications were reviewed to ensure any medication due to expire on 11/30/14 was destroyed. 3. Inservice was given to the licensed nursing staff regarding the timely destruction of expired medication. The Clinical Managers and the Nursing Quality Improvement Team will monitor the destruction of expired medication on a monthly basis and report their findings to the Director of Nursing. 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 2. Temperature of Med Refrigerators 1. Temperatures were adjusted upon discovery. 2. All medication refrigerators were inspected to ensure their proper temperature. 3. Inservice was given to the licensed nursing staff regarding the appropriate temps of med refrigerators. The Clinical Managers and the Nursing Quality Improvement Team will monitor the temperature of medication refrigerators on a monthly basis and report their findings to the Director of Nursing. 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/1/14 12/1/14 1/12/15 1/12/15 12/1/14 12/1/14 1/12/15 1/12/15

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F 431	Continued From page 53 failed to label and store medications in accordance with accepted professional principles as evidenced by: medications stored beyond the expiration date; medications not stored at the appropriate temperature in 1 (one) of two (2) medication refrigerators; failed to reconcile a controlled drug count verification sheet for narcotics on two (2) off going shifts and failed to ensure that one of (1) of one blister packet received from pharmacy had an expiration date. The findings include: According to the monograph for drugs manufacturer specifications, the following medications were identified for requiring storage of refrigerated unopen vials of medications between 36-46 degrees Fahrenheit. <http://www.drugs.com/monograph> 1. Facility staff failed to ensure that medications were not stored beyond the expiration date: one (1) of one (1) vial of (Procrit/ Epoetin 20,000 units 1ml [milliliter] daily) expiration date printed on vial 11/14 [November 2014]. The observation was made December 1, 2014. 2. Facility staff failed to ensure that medications were stored at the appropriate temperature. During the medication storage observation, the following medications were observed stored in	F 431	**486.60(b),(d),(e) Drug Records, Label/ Store Drugs & Biologicals (cont.)** **3. Controlled Drug Count Verification** 1. The medical record of the affected residents revealed no adverse effect sustained because the Controlled Drug Count Verification for Narcotics sheet was signed not signed off per policy. 2. Inservice was given to the licensed nursing staff regarding the controlled drug count at the change of shift. 3. The Clinical Managers and the Nursing Quality Improvement Team will monitor the controlled drug count verification on a monthly basis and report their findings to the Director of Nursing. 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. **4. Label on the Blister Pack** 1. The medication was returned to the pharmacy upon discovery of the absence of an expiration date on the label. 2. All other medications were reviewed to ensure that each label had an expiration date. There were no other occurrences. 3. Inservice was given to the Licensed Nursing Staff to ensure the return of medications without labels with expiration dates on them. Monitoring will be done on a monthly basis by the Clinical Managers and Quality Assurance Nurses. The results of their monitoring will be forwarded to the Director of Nurses for his review and analysis.	12/31/15 1/2/15 1/12/15 1/12/15 12/1/14 12/1/14 1/12/15

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F 431	Continued From page 54 the refrigerator located on the 3 South Unit. The internal temperature was observed between 48 - 50 degrees Fahrenheit. The observation was made in the presence of Employee #7 on December 1, 2014 at approximately11:00 AM. · Five (5) of five (5) unopened vials of Lantus 100 units/ml (Long Acting insulin) · One (1) of two (2) unopened vials of Levemir · Two (2) of two (2) unopened vials of Latanoprost ophthalmic solution · One (1) of one (1) unopened vial of Timolol ophthalmic solution · One (1) of four (4) unopened vials of Novolog injection 110 units/ml · Two (2) of two (2) unopened vials of Pneumovax injection · One (1) of one (1) unopened vial of Systane Ultra ophthalmic solution · One (1) of one (1) unopened vial of Procrit Facility staff failed to ensure that medications were stored at the appropriate temperature. 3. Facility staff failed to ensure that the Controlled Drug Count Verification for Narcotics sheet was signed off by the off going duty nurse. Unit 3 South A review of the Controlled Drug Count Verification for Narcotics conducted on December 1, 2014 at approximately 10:00 AM revealed the following dates were not verified by the off going duty nurse: November 21, 2014 -11:00 PM to7:00 AM shift and November 21, 2014 3:00 PM to 11:00 PM shift.	F 431	**486.60(b),(d),(e) Drug Records, Label/ Store Drugs & Biologicals (cont.)** **4. Label on the Blister Pack** 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/12/15

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F 431	Continued From page 55 Facility staff failed to ensure that the Controlled Drug Count Verification Sheet for Narcotics was signed by the off going duty nurse. 4. Facility staff failed to ensure that one blister packet for Resident #111 had an expiration date printed on the package/label when received from pharmacy. During a medication storage observation conducted on one (1) of two (2) medication carts located on 3 South with Employee #57. The medication package for Resident #111, contained Lorazepam (sedative) 10 tabs [tablets] 1mg [milligram] tablets. There was no evidence of an expiration date on the medication package/label. Employee #7 reviewed the back and front of the package and failed to locate the expiration date of the medication. A face-to-face interview was conducted on December 1, 2014 with Employees #7 at approximately 11:30 AM regarding the aforementioned findings. After review of the above, he/she acknowledged the findings. Facility staff failed to ensure that a medication blister packet , when received from pharmacy, had an expiration date printed on the package/label.	F 431		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONS HEALTHCARE CAPITOL CITY	2425 25TH STREET SE WASHINGTON, DC 20020

(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 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**483.65 Infection Control, Prevent Spread, Linens** **A. TB Screening for Physicians** 1. Physician's files found to be lacking an annual screening for TB have been updated. 1/12/15 2. All Physicians file are complete with annual TB screenings with evidence of a Chest x-ray or an annual PPD. 1/12/15 3. The Medical Records Quality Improvement Team will monitor Physician Credentials for completeness on a monthly basis and report their findings to the Director of Medical Records. 1/12/15 4. The Director of Medical Records will present her findings and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 1/12/15 **B. 1. Sanitary Measures While Feeding** 1. The staff member involved was counseled and inserviced on proper Infection Control techniques while feeding a resident. 12/5/14 2. Monitoring rounds are done in the dining rooms and on the units to ensure that all staff who are feeding residents use proper Infection Control techniques. 1/12/15 3. Nursing staff were inserviced on Infection Control and Feeding to ensure their understanding in this area. Monitoring rounds are being done on a weekly basis by members of the Nursing Quality Improvement Team for on-going compliance. The results of these monitoring efforts are forwarded to the Director of Nursing for his review and analysis. 1/12/15 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 1/12/15	

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F 441	Continued From page 57 This REQUIREMENT is not met as evidenced by: A. Based on record review and staff interview for seven (7) of 17 sampled physician records, it was determined that the facility staff failed to assure that all personnel were free of communicable diseases. Physicians' # 41, 43, 44, 45, 47, 49, and 50. The findings include: Centers for Disease Control and Prevention (CDC), Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (TB) in Health Care Setting, 2005. Morbidity and Mortality Weekly Reports (MMWR) 2005:54(RR17); 1-141 stipulates " TB Screening Procedures for Settings Classified as Low Risk - all HCWs (health care workers) should receive baseline screening upon hire ... additional testing is not necessary unless an exposure to M. tuberculosis occurs ....HCWs (health care workers) with a baseline positive or newly positive test result ...should receive one chest radiograph result to exclude TB disease ... " TB Screening Procedures for Settings Classified as Medium Risk - all HCWs (health care workers) should receive baseline screening upon hire ... HCWs should receive TB screening annually (i.e., symptom screen for all HCWs and testing for infection with M. tuberculosis for HCWs with baseline negative test results ...HCWs with a baseline positive or newly positive ...should receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, HCWs should receive a symptom screen annually. " The facility staff failed to ensure an annual PPD	F 441	**483.65 Infection Control, Prevent Spread, Linens (cont.)** **2. Hand Hygiene** 1. The staff member involved was counseled and inserviced on proper Infection Control techniques/Hand Washing to prevent cross contamination and the spread of infection. 2. Monitoring rounds are done in any isolation situation to ensure the proper use of PPE and infection control techniques to prevent cross contamination and the spread of infection. 3. Nursing staff were inserviced on Infection Control/Hand Washing to prevent Cross Contamination and the Spread of Infection. Monitoring rounds are being done on a weekly basis by the Infection Control Nurse for on-going compliance. The results of these monitoring efforts are forwarded to the Director of Nursing for his review and analysis. 4. The Director of Nursing will present the findings of this monitoring along with any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator	12/8/14 12/8/14 1/12/15

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F 441	Continued From page 58 [Purified Protein Derivative]/TB [Tuberculosis] Screening was performed for Physicians' #41, 43, 44, 45, 47, 49, and 50. A review of Physicians ' #41, 43, 44, 45, 49, and 50 ' s personnel records lacked documented evidence that the physicians was screened annually. A review of Physician #47's personnel record revealed that the tuberculosis skin test was last completed on September 8, 2011. There was no evidence that the physician was screened annually. A face-to-face interview was conducted on December 8, 2014 at approximately 10:30 AM with Employee #20 who acknowledged the aforementioned findings. There was no evidence that the facility staff assured that physicians' #41, 43, 44, 45, 47, 49, and 50 were free of communicable diseases. The records were reviewed on December 8, 2014. B. Based on observation and staff interviews for one (1) of 53 sampled residents, it was determined that the facility staff failed to demonstrate care consistent with current infection control practices to prevent contamination and the spread of infection as evidenced by the staff ' s failure to use sanitary measures while feeding Resident #38; and failed to follow accepted standards of hand hygiene practices to help prevent the spread of infection. Resident #38. The findings include: 1. Facility staff failed to use sanitary measures while feeding Resident #38.	F 441		

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F 441	Continued From page 59 The Annual Minimum Data Set (MDS) dated, August 25, 2014 revealed the admitting diagnoses included Cerebrovascular Accident, Hemiplegia or Hemiparesis, Hypertension, and Seizure disorder for Resident #38. Under Section G- Functional Status, it also revealed that the resident was totally dependent with Activities of Daily Living (ADL's). On December 1, 2014 at approximately 12:55 PM, a dining observation was conducted on unit, 1 North. Resident #38 was observed being fed by Employee #39. The employee was observed rubbing his/her stomach with both hands, then continuing to feed the resident without sanitizing. Additionally, he/she put both hands in his/her pocket, while the resident was chewing food. Then he/she resumed feeding the resident, without sanitizing. On December 1, 2014 at approximately 1:10PM, a face-to-face interview was conducted with Employee #39 regarding the aforementioned findings. He/she acknowledged the findings. Facility staff failed to demonstrate care consistent with current infection control practices to prevent contamination and the spread of infection. The clinical record was reviewed on December 1, 2014. 2. Facility failed to follow accepted standards of hand hygiene practices to help prevent the spread of infection. A tour of 3 South was conducted on December 1, 2014 at approximately 9:45 AM. During this time	F 441		

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F 441	Continued From page 60 it was noted that Resident #314 was on isolation for C. Diff [Clostridium Difficile is a bacterial infection that affects the digestive system]. On December 8, 2014 at approximately 9:30 AM, Employee #37 was observed walking into Resident #314's assigned room with a mask on his/her face and no other PPE (personal protective equipment) donned and carrying clean linen. [PPE is equipment worn to minimize exposure to serious workplace illnesses]. Once in the room, Employee #37 placed the clean linen in a chair, removed the mask from his/her face, placed it in the trash receptacle located underneath the hand washing sink, and left the room without first washing his/her hands. Employee #37 acknowledged the finding at the time of the observation. There was no evidence that facility staff followed acceptable standards of hand hygiene practices to help prevent potential cross contamination and spread of infection.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made on December 1, 2014 at approximately 10:00 AM and on December 5, 2014 at approximately 12:30 PM, it was determined that the facility failed to maintain resident call bells in good working condition as	F 463	**483.70(f) Resident Call System - Rooms/Toilet/Bath** 1. The call bell in room 103B was repaired immediately upon discovery. 2. All call bells on that unit were tested to ensure proper working order. 3. Maintenance staff was inserviced on the proper techniques for call bell maintenance and repair. The Maintenance Supervisors and Maintenance Quality Improvement Team will monitor the proper functioning of the call bell system on a monthly basis. They will report their findings to the Director of Facilities for his analysis. 4. The Director of Facilities will present his findings and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/5/14 12/5/14 1/12/15 1/12/15

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F 463	Continued From page 61 evidenced by a call bell in one (1) of 63 resident's rooms that did not alarm when tested. The findings include: 1. The call bell in resident room #103 (B) did not function as intended, one (1) of 68 resident's rooms surveyed. These observations were initially made in the presence of Employee #3 on December 1, 2014 at approximately 10:00 AM and confirmed by Employee #19 on December 5, 2014 at approximately 12:30 PM.	F 463		
F 492 SS=D	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: Based on record review and staff interview for three (3) of 17 sampled physician records, it was determined that the facility staff failed to ensure that physicians #46, 47, and 48 had annual physical examinations, which were maintained in his/her personnel records, in accordance to Title 22 District of Columbia Municipal Regulations, 2615.8, Personnel.	F 492	**483.75(b) Comply with Federal/ State/Local Laws/Prof Std** 1. Physician's files found to be lacking an annual physical have been updated. 1/12/15 2. All Physicians file are complete with annual physicals. 1/12/15 3. The Medical Records Quality Improvement Team will monitor Physician Credentials for completeness on a monthly basis and report their findings to the Director of Medical Records. 1/12/15 4. The Director of Medical Records will present her findings and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. 1/12/15	

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F 492	Continued From page 62 The findings include: The facility staff failed to ensure that physicians #46, 47, and 48 had annual physical examinations; and maintained them in his/her personnel records. 1. A review of physician #46's personnel record revealed that the physical examination was last completed on December 4, 2012. There was no evidence of an annual physical examination. 2. A review of physician #47's personnel record revealed that the physical examination was last completed on July 15, 2013. There was no evidence of an annual physical examination. 3. A review of physician #48's personnel record lacked evidence of an annual physical examination. A face-to-face interview was conducted on December 8, 2014 at approximately10:30 AM with Employee #20 who acknowledged the aforementioned findings. There was no evidence that the facility staff ensured that physicians' #46, 47, and 48 had annual physical examinations; and maintained them in his/her personnel records. The records were reviewed on December 8, 2014.	F 492		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	**483.75 (l)(1) Res Records – Complete/Accurate/Accessible**	

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F 514	Continued From page 63 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 five (5) of 53 sampled residents, it was determined that facility staff failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented, readily accessible, and systematically organized as evidenced by: failure to ensure that restraint orders were transcribed onto the November and December 2014 Physician's Orders for one (1) resident; failure to document in the plan of care findings related to psychotropic drug usage and frequent falls for one (1) resident, failure to document in the active clinical record hospice certification orders for one (1) resident who was admitted to the hospice program; failure to ensure that one (1) resident's name was documented on the facility ' s against medical advice form before departing the facility and failure to document one (1) resident's participation in the ' Restraint Reduction Program as recommended by a physician's order dated October 3, 2014. Residents' #52, #54, #102,	F 514	**483.75 (l)(1) Res Records – Complete/Accurate/Accessible (cont.)**	

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F 514	Continued From page 64 156, and 357. The findings include: 1. Facility staff failed to document in the plan of care findings related to psychotropic drug usage and frequent falls. Resident #52 A review of the physician orders dated May 20, 2014 directed for a psych consult for medication review to rule out medication induced weight gain (25 lbs (pounds) [times] 12 months and multiple falls x 6 (six) months. A review of the physician ' s orders dated November 28, 2014 revealed that Resident #52 was prescribed the antidepressant medications Prozac10 mg tablet and Stelazine 2mg tablet everyday for depression (originated March 14, 2013). The psychiatry consultation dated May 22, 2014 revealed; " Report requested regarding Psych (Psychiatry) consult- Medication Review to R/O (Rule Out) medication induced weight gain [25 pounds times 12 months] and multiple falls] [times] 6 months.; Findings: [History of] Schizoaffective [Disorder] for which she was placed on Remeron, Depakote, Prozac and Stelazine to which she continued to response but seems to be gaining some [pounds] recently. Most recent Depakote level = 44- R/O Depakote- Induced weight gain. Recommendations:	F 514	**483.75 (l)(1) Res Records – Complete/Accurate/Accessible (cont)** **1. Resident #52** 1. The Plans of Care for Psychotropic drug usage and falls were updated. 2. Medical records for other residents were reviewed to ensure that al Plans of Care were complete and accurate. Corrections were made when necessary. 3. Inservice training was provided to the nursing staff to ensure their proficiency in updating Plans of Care to reflect the issues of each resident. The Nursing Quality Improvement Team and the QA Nurse will monitor the Care Plans to ensure on-going compliance. They will forward the results of their monitoring efforts to the Director of Nurses for his review and analysis. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/12/12 1/12/15 1/12/15 1/12/15

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F 514	Continued From page 65 Decrease Remeron to 7.5mg po (by mouth) [every] HS (hour of sleep) [times] 2 (two) weeks then 7.5 mg po three times weekly (HS) times 2 weeks then stop, If weight gain continues despite off Remeron, have PMD (Primary Medical Doctor) consider another anticonvulsant, Continue to weight patient per floor routine, Next visit PRN (as needed). " A review of the medical record revealed Resident #52 had two (2) falls prior to the psychiatric consult on May 20, 2014 and four (4) falls post the psychiatric consult. All falls were without injury and unwitnessed. The clinical record lacked evidence that the psychiatrist addressed the psychotropic medications usage and the resident ' s frequent falls in his/her plan of care. A face-to-face interview was conducted with Employee # 3 on December 8, 2014 at approximately 2:00 PM. He/she stated that the psychiatrist stated; " I did review the resident medications for falls. The medication has been reduced to the lowest. His/her falls are not related to the psychotropic medications. I just forgot to write it in the notes. The clinical record was reviewed on December 8, 2014. Facility staff failed to document in the plan of care findings related to psychotropic drug usage and frequent falls.	F 514	**483.75 (l)(1) Res Records – Complete/Accurate/Accessible (cont)**	

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F 514	Continued From page 66 2. Facility staff failed to ensure that an order to use soft seat restraint belt, while in the wheel chair for positioning was transcribed onto the November and December 2014 Physician's Orders for Resident #54. A History and Physical signed by the physician January 14, 2014 revealed Resident #54's diagnoses included: "Diabetes Mellitus, Seizure Disorder, Encephalopathy, Psychosis, Dementia, Muscle spasms..." A physician's interim order dated December 24, 2013 directed, " Resident to continue use soft seat belt while in wheelchair for positioning ...remove seat belt every 2 hrs [hours] for incontinent care and activities. " A review of the November and December 2014 Physician ' s Orders lacked evidence that the order to continue the soft seat restraint belt care was transcribed onto the order sheets. A face-to-face interview was conducted with Employee #7 on December 9, 2014 at approximately 12:30 PM. He/she acknowledged the aforementioned findings. The medical record was reviewed on December 9, 2014. 3. Facility staff failed to ensure that Resident #102 ' s name was documented on the facility ' s against medical advice form before departing the	F 514	**483.75 (l)(1) Res Records – Complete/Accurate/Accessible (cont)** **2. Resident #54** 1. An updated order was obtained from the Attending Physician and transcribed per the order. Retrospectively, the medical record cannot be changed to correct the orders for November and part of December. However, there were no untoward effects on the resident. 2. Medical records for other residents were reviewed to ensure that all orders written in one month were edited forward to the next month. Corrections were made when necessary. 3. Inservice training was provided to the nursing staff to ensure their proficiency in reviewing Physician orders from month to month. The Nursing Quality Improvement Team and the QA Nurse will monitor the transcribing of Physician orders to ensure on-going compliance. They will forward the results of their monitoring efforts to the Director of Nurses for his review and analysis. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. **3. Resident #102** 1. This resident has been discharged from the facility. Retrospectively, the medical record cannot be changed. There were no untoward effects on the resident.	12/16/14 1/12/15 1/12/15 1/12/15 11/21/14

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F 514	Continued From page 67 facility. Resident #102 was admitted to the facility on October 13, 2014 for sub acute rehabilitation status post inpatient admission for " Fatigue, Urinary Retention, and Urinary Tract Infection. " A review of the " Leaving Facility Against Medial Advice " form dated November 21, 2014 revealed; the following: " This is to Certify that (I) [Resident's Responsible Party ' s Name] patient/resident at [facility named] (am) (is) leaving against the advice of the attending physician and Facility policy. I acknowledge that I have been informed of the risk(s) involved and hereby release the attending physician and the Facility from all responsibility for any ill effects which may result from such voluntary action. Signed: [Resident' s Responsible Name]/Patient or Responsible Party/Nearest Relative; Date November 21, 2014; Witness [Social Worker named]-November 21, 2014 ... " The clinical record lacked evidence that Resident #102 name was documented on the against medical advice form. A face-to-face interview was conducted with Employee # 54 on December 8, 2014 at approximately 11:00 AM regarding the aforementioned concern. He/she acknowledged that Resident #102 ' s name should have been documented on the form indicating that [he/she]	F 514	**483.75 (l)(1) Res Records – Complete/Accurate/Accessible (cont)** **3. Resident #102 (cont.)** 2. A review of the Leaving Against Medical Advice forms has been completed and all were filed out correctly utilizing the resident's name. 3. The Social Worker involved was counseled to ensure understanding of the form and how it must be filled out. The Director of Social Work will monitor the Against Medical Advice forms on an on-going basis to ensure compliance. 4. The Director of Social Work will report the findings of these monitoring efforts to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	1/12/15 1/12/15 1/12/15

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	095022	A. BUILDING _____ B. WING _____	12/09/2014

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F 514	Continued From page 68 was the resident at the facility. Facility staff failed to ensure that the resident ' s name was documented on the facility ' s against medical advice form before departing the facility. The clinical record was reviewed on December 8, 2014. 4. Facility staff failed to document, in the active clinical record, hospice program certification orders for Resident #156 for the months of September, October, November, and December 2014. A review of Resident #156 ' s medical record revealed physician's orders dated June 6, 2014 through August 14, 2014 for Hospice Care and Services. There was no evidence that facility staff documented the attempts to obtain physician hospice certification orders for the months of September, October, November, and December 2014. A face-to-face interview was conducted on December 9, 2014 at approximately 10:00AM with Employee #3. After review of the medical record, he/she acknowledged the findings. The record was reviewed on December 9, 2014. 5. Facility staff failed to document Resident #357's participation in the ' Restraint Reduction	F 514	**483.75 (l)(1) Res Records – Complete/Accurate/Accessible (cont)** **4. Resident #156** 1. The 60 day Hospice Program Certifications are current and in the resident's medical record. 2. There are no other residents who are covered under the Hospice Program. 3. Inservice training was provided to the nursing staff and unit clerks to ensure their understanding about Hospice Program certifications. The hospice Program was counseled about the need to file their paper-work in a timely manner. The Nursing Quality Improvement Team and the QA Nurse will monitor the Hospice Certifications to ensure on-going compliance. They will forward the results of their monitoring efforts to the Director of Nurses for his review and analysis. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. **5. Resident #357** 1. The resident was seen by the Attending Physician and the order for the Restraint Reduction program was clarified. The Care Plan, Care Card and TAR were	1/12/15 1/12/15 1/12/15 1/12/15 12/31/14

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F 514	Continued From page 69 Program.' A review of the medical records revealed a physician order dated October 3, 2014 with a recommendation for the 'Resident to be on Restraint Reduction Program.' A face to face interview with Employee #9 was conducted on December 8, 2014 at approximately 9:30 AM. Employee #9 was asked to clarify the 'Restraint Reduction Programme.' He/she explained that it was a ' program for people with constant falls where the seat belt is removed and the resident is observed while performing activities such as listening to music, drawing, coloring and engaging ' with staff and other residents. Resident #357 was observed participating in three (3) 'Restraint Reduction Program' sessions on December 2, 4 and 8, 2014. A review of the Treatment Administration Record (TAR) revealed that staff was not documenting Resident #357 participation in the 'Restraint Reduction Programme.' A face to face interview with Employee #3 was conducted on December 8, 2014 at approximately 10:30 AM. He/she was queried regarding staff documenting Resident #357 participation in the 'Restraint reduction Programme.' After reviewing the resident's medical records, Employee #3 said that it was only documented in the 'team notes dated October 4, 2014, but not after that. He/she stated that he/she was unaware that a Physician's order had been written for that activity and agreed that	F 514	**483.75 (l)(1) Res Records – Complete/Accurate/Accessible (cont)** **5. Resident #357(cont.)** updated to reflect the residents participation. 2. The medical records of other residents who participate in the Restraint Reduction Program were reviewed to ensure a clear Physician's order, up-to-date Care Plan and Care Card, and documentation on the TAR to reflect participation. 3. Inservice was given to the nursing staff regarding the Restraint Reduction Program and its accompanying documentation. Compliance auditing will be conducted by the Quality Assurance Nurse on a routine basis to ensure the complete and accurate documentation for those residents in the Restraint Reduction Program. The results of those audits will be forwarded to the Director of Nurses for his evaluation. 4. The Director of Nurses will review the data from these monitoring efforts done by the Quality Assurance Nurse and present his analysis and any action plans for improvement to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator. .	1/12/15 1/12/15 1/12/15

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F 514	Continued From page 70 staff should be documenting the resident's participation in the Restraint Reduction Program.' There was no evidence that facility staff documented Resident #357 frequent participation in the 'Restraint Reduction Program.' The record was reviewed on December 2, 2014 and on December 8, 2014. B. Based on record review and staff interviews, it was determined that facility staff failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented, readily accessible, and systematically organized as evidenced by: failure to provide the State Agency Representatives with closed clinical records in a timely manner. The findings include: The facility failed to maintain clinical records that were readily accessible and systematically organized as evidenced by failing to provide clinical records in a timely manner when requested by surveyors to complete the survey process. On December 1, 2014 at approximately 10:10 AM, the State Agency (SA) Representative provided the Employee #1 with written and verbal instruction regarding the Admission Sample Closed Records.	F 514	**483.75 (l)(1) Res Records – Complete/Accurate/Accessible (cont)** **B.** 1. The closed records requested were owned by and being stored by the previous owners of the facility in an off site storage facility in New Jersey. The Administrator drove to New Jersey, retrieved the closed records and provided them to the Survey Team. 2. All medical records closed under the new ownership of Transitions Healthcare will be stored onsite and will be readily and immediately accessible upon request. 3. The Medical Records Quality Improvement Team will monitor the storage of Medical Records and report their findings to the Director of Medical Records. 4. The Director of Medical Records will report the findings of this audit to the Quality Assurance/Performance Improvement Committee which meets monthly and is chaired by the Administrator.	12/3/14 9/1/14 1/12/15 1/12/15

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F 514	Continued From page 71 On December 1, 2014 at approximately 11:40 AM, the SA Representative provided the Employee #1 with a copy of the "Admission Sample Report for Facility." The records listed were to be returned to the conference room (where the state agency survey team was located). On December 3, 2014 at approximately 11:00 AM the SA Representatives had not received five (5) admission closed records. An inquiry was made with Employee #1 regarding the whereabouts of the missing admission closed records. Employee # 1 was notified of the missing records at the time of the observation. At approximately 11:10 AM Employee # 51 informed the survey team that the five (5) missing records were taken by the previous owners and the facility does not have access to the records. On December 4, 2014 at approximately 8:30 AM the five (5) missing records were available for review by the SA Representatives. A face-to-face interview was conducted with Employee #1 on December 9, 2014 at approximately 11:00 AM. He/she acknowledged that the records were not available in a timely manner. The facility failed to maintain clinical records that were readily accessible and systematically	F 514		

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F 514	Continued From page 72 organized.	F 514		