STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095039	A. BUILDING _____ B. WING _____	R 01/29/2015

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UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

(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 000}	INITIAL COMMENTS A Quality Indicator Survey (QIS) revisit was conducted January 23 through 29, 2015. The following deficiencies are based on observations, record reviews, resident and staff interviews for 21 sampled residents' and 10 supplemental residents'. A revisit to the complaint investigations for C-15-2014/DC- 2925 9 and C- 15-015/DC-2926 completed on November 24, 2014, was conducted during this survey period, January 23 through 29, 2015. An anonymous complaint investigation [DC~2941, I-15-3027] was conducted January 23 and 29, 2015. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations ADL - Activity of Daily Living AMS - Altered Mental Status ARD - Assessment Reference Date BID - Twice- a-day B/P - Blood Pressure BRP - Bath Room Privilege CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda C Culley, LNHA | TITLE: Interim Administrator | (X6) DATE: 2/5/15

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 Dl - Deciliter DMH - Department of Mental Health EMS - Emergency Medical Services (911) EKG - 12 lead Electrocardiogram G-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning ID - Intellectual Disability IDT - Interdisciplinary Team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record mcg/dl - micrograms per deciliter MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mg/dl - milligrams per deciliter mL - milliliters (metric system measure of volume) mm/Hg- millimeters of mercury Neuro - Neurological NP - Nurse Practitioner PASRR - Pre Admission Screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy POC - Plan Of Correction POS - Physician ' s Order Sheet PPE - Personal Protective Equipment Prn - As needed QIS - Quality Indicator Survey TAR - Treatment Administration Record	{F 000}		
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	F 157		

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F 157	Continued From page 2 injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 21 sampled residents, it was determined that facility staff failed to notify the physician and or responsible party of the presence of a potential clinical mood indicator for one (1) resident; and failed to notify the attending physician when Resident #106 failed to attend dialysis treatment as scheduled. Residents' #90 and #106.	F 157	1. Resident #90 was not harmed by the deficiency. The resident was assessed and determined to not be in any imminent physical or psychological danger. The physician & significant other were notified about the resident's verbalization of dying and potential clinical mood change. The resident received a BH referral and was followed up by a psychiatrist with added treatment. 2. Each resident was assessed for a significant change in status (e.g. mood indicators). Any identified issues were corrected. 3. To prevent future occurrences licensed nurses were retrained to notify, follow-up & document changes in residents' mood indicators / mental status. 4. Weekly MAR audits will be conducted to assess performance. Negative findings will be reported to the DON for follow-up action. Physician & significant other notifications will be added as a quality indicator for review during daily stand-up meetings and during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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F 157	Continued From page 3 The findings include: 1.Facility staff failed to notify the physician and or responsible party of a potential clinical mood indicator for Resident #90 who repeatedly verbalized " I ' m dying. " A review of Resident #90's Admission record revealed that he/she was admitted to the facility on June 20, 2012 with diagnoses which included: Atrial Fibrillation, Cerebral Vascular Accident, Diabetes Mellitus Type II Controlled, Gastritis, Unspecified Hemiplegia Affecting Dominant side and Hyperlipidemia. A review of the Nurse's Notes dated January 14, 2015 at 10:40 PM revealed, "...Resident keep[s] verbalization [verbalizing] I am paralyzed, I am dying. Resident reeducated about [his/her] diagnosis and stop to say [stop saying] I am dying and I want to sleep. " Further review of the Nurse ' s Notes lacked evidence that the physician and or the responsible party were notified of the above statement(s) made by the resident. A face-to-face interview was conducted on January 27, 2015 at approximately 11:00 AM with Employee #7. A query was made if the resident had made this statement previously and if so how often. Employee #7 stated, "The resident would talk about being paralyzed, but not about dying." A second query was made if the physician and the family were notified of the resident's statement. Employee #4 stated " No. " A face-to-face interview was conducted on January 27, 2015 at approximately 11:30 AM with	F 157		

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F 157	Continued From page 4 Employee #4. A query was made what is the process when a resident makes a statement regarding dying. The Employee stated, "The psych [psychiatrist] is normally called." There was no evidence in the clinical record that the facility notified the physician and the responsible party of the residents ' statement. Facility staff failed to notify the physician and or responsible party of statements made by the resident. 2. Facility staff failed to notify the attending physician when Resident #106 failed to attend scheduled dialysis treatment on Friday, January 16, 2015. A review of the nursing notes revealed the following: January 16, 2015 at 5:00 PM - " Resident alert & verbally responsive routine po [by mouth] meds [medications] administered, ADL [activities of daily living] care provided with assist, [right] external subclavian cath [catheter] intact with no s/s [signs or symptoms] of infection noted at 12:15 PM. Resident was handed the dialysis communication paper and left [the facility] for dialysis VS [vital signs] 110/70 [blood pressure], 62 [pulse], 20 [respirations], 98.7 [temperature], 97% [oxygen saturation]. " January 16, 2015 11:00 PM - "No acute distress noted, returned from dialysis at 9:00 PM, did not return with paper documentation, no signs and symptom of infection noted at dialysis site, no bleeding noted [unable to read] stable ... "	F 157	1. Resident #106 was not harmed by the deficiency. The resident was assessed and determined to not be in any imminent physical danger. The physician was notified about the resident's refusal to attend dialysis. Staff are now informed of notification requirements for treatment refusals. 2. Each resident was assessed for refusal of treatments. Any identified deficiencies were corrected. 3. To prevent future occurrences licensed nurses were retrained on the following: ▪ To notify, follow-up & document resident refusals of treatments ▪ To conduct hand-off communication with the Dialysis Center ▪ To inquire about & ensure the Dialysis Communication Log is completely filled out 4. Physician notifications of resident refusals will be added as a quality indicator for review during daily stand-up meetings and during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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F 157	Continued From page 5 January 17, 2015 at 3:00 PM-Resident alert and verbally responsive routine po meds administered. Right external subclavian cath assess, no s/s of infection noted at 11:30 AM. Resident signed self out for LOA [leave of absence] with v/s132/64, 60, 20, 98.8 ... " January 17, 2015 at 8:15 PM - Resident is alert and responsive returned from LOA at 8PM [8:00 PM], no change noted at that time. " The clinical record lacked documented evidence that nursing staff inquired regarding the status of the provision of dialysis treatment that was scheduled for January 16, 2015 nor did staff inquire regarding the location of the dialysis communication log. A face-to-face interview was conducted on January 26, 2015 at approximately 4:00 PM with Employee #4. He/she was questioned about the whereabouts of the dialysis communication form reflective of services provided on January 16, 2015. In response to the inquiry, Employee #4 stated, "A call was made to the dialysis center and we were told that [Resident #106] did not go [to dialysis on Friday, January 16, 2015]." The January 2015 Physician ' s Order revealed that Resident #106 was prescribed to receive dialysis treatments on Mondays, Wednesdays and Fridays. A review of the " dialysis communication " forms revealed that there was no dialysis communication form for Friday, January 16, 2015. There was no evidence that facility staff notified the physician that the resident did not attend	F 157		

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F 157	Continued From page 6 his/her scheduled dialysis treatment on Friday January 16, 2015. The last documented date that the resident underwent dialysis was January 14, 2015. The clinical record revealed Resident #106 sustained a fall on January 17, 2015 and was transferred to another level of care. A face-to-face interview was conducted on January 26, 2015 at approximately 4:00 PM with Employee #4. He/she acknowledged the findings. The record was reviewed on January 26, 2015.	F 157	1. The involved clinical staff was educated not to apply restraint devices (e.g. seat belt) inconsistent with facility policies & procedures & physician orders. The resident was not harmed by the deficient practice and staff are now educated on the issue. 2. All residents were checked to assess whether or not restraint devices (including seat belts) were utilized. No identified issues were noted. 3. To prevent future occurrences, clinical staff were trained on the following: ▪ Ensuring the definition of restraint & all restraint devices are understood ▪ Ensuring each type of restraint device (e.g. seat belt) is identified ▪ Ensuring restraint devices are used only as a last resort ▪ Ensuring restraint devices are used in accordance with residents' clinical conditions, law & regulations, and physician orders ▪ Ensuring residents in restraint are monitored in accordance with facility policies & procedures Ensuring responsible party's consent is obtained prior to use ▪ Ensuring residents in restraint are assessed in accordance with facility policies & procedures, law & regulation ▪ Ensuring restraint devices are discontinued when residents no longer meet criteria for restraint use and restraint devices are no longer justified 4. Quality indicators have been developed to address use of restraint devices & proper monitoring. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for one (1) of 21 sampled residents, it was determined that facility staff failed to ensure that the resident was free from any physical restraint as evidenced by Resident #7 who was observed wearing a seat belt while sitting in the day room area. The findings include: A review of the facility's current restraint policy number SNS.61, dated December 15, 2008 reviewed December 15, 2011 revealed the following information: It is the policy of UMNC to use mechanical restraints only upon the order of a licensed physician. Standing orders for	F 221		

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F 221	Continued From page 7 restraints are not allowed: PRN Orders are not permissible ... " Purpose" ... Restraints shall be used as interventions to protect residents from harming themselves or others. .. " Definition: Restraints: Use of physical, mechanical or chemical involuntarily restrains the movement of the whole or portion of resident ' s body as a means of controlling physical activities in order to protect him/her or others from injury. " On January 23, 2015 at 11:00 AM, Resident #7 was observed seated in a wheelchair in the day room area with a seat belt fastened across his/her lap. The resident ' s hands were noted in a clenched position. A face-to-face interview was conducted with Resident #7 on January 23, 2015 at 11:00 AM in the presence of his/her family member. The resident was unable to express his/herself. When asked if he/she could remove the seat belt resident ' s [family member] stated, "No; [he/she] can't". Employee #4 was asked to accompany the surveyor into the day room to witness the surveyor's observation. Employee #4 stated the resident ' s personalized wheel chair was delivered with the seat belt attached and that perhaps the staff did not realize they were not supposed to be attached. Employee # 4 further stated that the facility did not utilize restraints and verbalized that the resident's seat belt should not have been attached because [he/she] cannot self-release. Employee #4 released the seat belt from the resident. Employee #4 acknowledged the facility had not obtained the responsible party ' s consent to use the seat belt prior to its use.	F 221		

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F 221	Continued From page 8 A review of the clinical record revealed that there was no physician's order for the use of the seat belt. There was no care plan in place with goals or approaches to address the use of the seatbelt. There was no interdisciplinary review to determine if the seat belt was the least restrictive device; and there was no responsible party consent for use of the seat belt. The clinical record lacked evidence that facility staff assessed the resident ' s use of the seat belt and to determine if it was the least restrictive device for Resident #7 who was observed wearing a seat belt while sitting in the day room area. A face-to-face interview was conducted with Employee #4 on January 26, 2015 at approximately11:00 AM. He/she acknowledged the aforementioned findings. The record was reviewed January 26, 2015.	F 221		
{F 241} SS=C	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the facility's Plan of Correction from the QIS Annual recertification Survey completed November 5, 2014, it was determined that the facility failed to completely implement the plan of correction, as evidenced by failure to ensure that the greater	{F 241}		

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{F 241}	Continued From page 9 part of the facility staff members (as appropriate) were in-serviced. The findings include: A review of the facility ' s plan of correction with a compliance date of January 14, 2015 revealed that approximately less than 60% of the total designated staff (e.g. approximately 45 out of 93 staff members attended the in-services). The POC stipulated: "Staff will be trained on resident abuse and neglect to include resident ' s dignity and respect in speaking to residents ' in a professional manner." A face-to-face interview was conducted with Employee #2 on January 26, 2015 at approximately 2:43 PM related to the number of staff that attended the education/in-services as per the facility ' s Plan of Correction. There was no comment made in reference to the findings. There was no evidence that the facility ' s administration or the quality committee ensured that a greater part of facility staff (as appropriate) were in-serviced.	{F 241}	1. Clinical staff received the required POC training relative to resident abuse & neglect. Clinical staff are now educated on POC-related issues pertaining to abuse & neglect. 2. A review of the POC was done to determine the scope of staff educational needs. A curriculum was developed, staff were scheduled and attended the required educational sessions. Both staff scheduled to be at work and those scheduled off work attended the required sessions. 3. To prevent future occurrences, staff responsible for POC training will be educated on the following: ▪ Ensuring in-service content is developed in a manner to cover all required topics ▪ Ensuring staff schedules are coordinated to capture the majority of staff ▪ Ensuring additional training periods are identified to capture staff away from the facility 4. Quality indicators have been developed to address POC in-service monitoring. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	{F 279}		

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{F 279}	Continued From page 10 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 21 sampled residents, it was determined that facility staff failed to develop a care plan with goals and approaches to manage transmission based precautions for Resident #36 The findings include: Facility staff failed to develop a care plan with goals and approaches to manage transmission based precautions for Resident #36. A review of the Admission Order Sheet and Physician's Plan of Care dated September 10, 2014 revealed diagnoses which included Extended -Spectrum Beta-Lactamase Klebsiella [ESBL] Urinary Tract Infection. A review of nurses' progress notes dated January	{F 279}	1. Care plans for Resident #36 is now complete. Missing components (e.g. goals & approaches related to transmission based precautions-Contact Isolation) were added to the care plan. Resident care plans are now complete. 2. All residents' charts were reviewed for complete care plans including goals, & approaches to transmission-based precautions. Any identified deficiencies were corrected. 3. To prevent future occurrences licensed staff completing care plans will be in-serviced on the following: ▪ Ensuring care plans are timely, complete and incorporate goals and approaches to transmission-based precautions 4. All residents' admissions and re-admissions will be reviewed for complete care plans within 72 hours of admission. Monitoring will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed during quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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{F 279}	Continued From page 11 14, 2015 to January 23, 2015 revealed Resident #36 was on contact isolation for a diagnosis of ESBL Klebsiella that was confirmed by a urine culture (laboratory test) on September 10, 2014. A review of the Resident #36 ' s comprehensive care plan lacked evidence of problem identification, goals and approaches to manage transmission based [contact] precautions. A face-to-face interview was conducted on January 26, 2015 at approximately 10:00AM with the Employee # 4. He/she acknowledged the findings. There was no evidence that facility staff developed a care plan with goals and approaches to manage the care of Resident #36 who was on contact isolation. The record was reviewed on January 26, 2015.	{F 279}		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 12 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 21 sampled residents, it was determined that facility staff failed to review and revise a care plan with goals and approaches to address one (1) resident's safe transfer requirements. Resident #106. The findings include: A review of the falls care plan for Resident #106 dated November 9, 2014 lacked evidence of documentation of interventions for safe transfer and fall preventions. A review of the quarterly Minimum Data Set [MDS] dated November 11, 2014, under Section G, Functional Status, Toileting use was coded under Self-performance as " 3/3 " indicative of " Extensive assistance of two persons - resident involved in an activity, staff provides weight bearing support. " A review of the Resident 106's care plan dated November 9, 2014 revealed an intervention for toilet use as follows: "The resident requires one (1) staff participation to use toilet. " A review of the Physical Therapy Daily Treatment Note dated November 4, 2014 revealed the following: " w/c [wheelchair] > b/s [bedside]	F 280	1. Resident #106 was transferred. 2. All residents' charts were reviewed for complete care plans including consistency of assessment findings & interventions for safe transfer & fall precautions. Any identified deficiencies were corrected. 3. To prevent future occurrences licensed staff completing care plans will be in-serviced on the following: ▪ Ensuring interdisciplinary assessment findings are communicated ▪ Ensuring care plans are reviewed, revised and updated to reflect consistent approaches to safe transfer & fall precautions ▪ Ensuring the consistency of care plan approaches are documented ▪ Ensuring each interdisciplinary (MDS, PT, clinical staff, etc.) assessment & approaches to resident transfers are communicated, consistent & documented accordingly in the care plan 4. All residents' admissions and re-admissions will be reviewed for consistent care plans within 72 hours of admission. Monitoring will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed during quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095039	A. BUILDING _____ B. WING _____	R 01/29/2015

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F 280	Continued From page 13 toilets>bed with Max A [maximum assistance]. " A review of the ADL [Activities of Daily Living] sheet for December 2014 revealed " 0 " under " Toilet use; Resident perform " from December 1, 2014 - December 31, 2014, indicating " independent. " On January 29, 2015 at approximately 10:00AM, a face-to-face interview was conducted with Employee #9 regarding MDS coding for toilet transfer. He/she stated that Resident #106 was " ...coded for what care [he/she] was receiving at that time. On the door it states T2 [two (2) person transfer]. I spoke with the manager and charge nurse and they agreed on a two (2) person assist for transfer. " On January 29, 2015 at approximately 10:30AM, a face-to-face interview was conducted with Employee #4 regarding transfer requirements for Resident #106. He/she stated, the resident requires two (2) person assist for transfer. Employee #9 acknowledged the aforementioned findings. The clinical record lacked documented evidence that the interventions related to toilet use in the comprehensive care plan was revised to include two (2) person assist for safe transfer for Resident #106.The record was reviewed on January 29, 2015.	F 280		
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	{F 281}		

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{F 281}	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for one (1) of 21 sampled resident, it was determined that facility staff failed to ensure proper techniques were followed according to accepted standards of clinical practice as evidenced by failure to administer Heparin (anticoagulant) in accordance with professional standards and recapping a ' used ' needle following the administration of a subcutaneous injection. Resident #5. The findings include: Observation: On January 23, 2015 at approximately 9:30 AM, a medication administration observation revealed Employee #10 administered Heparin 1ml (5,000 units) subcutaneously (an injection that is given in the fatty layer of tissue just under the skin) to Resident #5's outer right thigh area. After the injection was administered, the employee removed the needle, placed it on the over-the-bed table and rubbed the injection site with the alcohol pad. Employee #10 then recapped the needle and placed it in the sharps' container located on the wall in the Resident 's room. A review of the January 2015 Physician's Orders directed, "Heparin inj [injection] 5000U/ML [milliliter]: inject 1 ML (5,000 units) sub Q [subcutaneous] every 12 hours for DVT [Deep Vein Thrombosis] Prophylaxis.	{F 281}	1. The licensed nurse who administered the Heparin dose was counseled on proper administration in accordance with professional standards. The resident was not harmed by the deficient practice. Heparin is now being administered in accordance with professional standards. 2. All nurses administering Heparin were reminded of the proper manner to administer the medication. Each resident on Heparin was checked for improper effects of Heparin administration. 3. To prevent future occurrences, nurses administering Heparin will be in-serviced on the following: ▪ Ensuring Heparin is administered safely in accordance with physician order ▪ Ensuring the injection area is not rubbed after Heparin is administered ▪ Ensuring needles are not re-capped 4. Quality indicators have been developed to monitor proper Heparin administration. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	

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{F 281}	Continued From page 15 A. Facility staff failed to administer Heparin in accordance with professional standards as evidenced by rubbing the injection site after the administration of Heparin. The facility's policy entitled "Administration of Subcutaneous Injection, " Policy No: PCS 02-011, page 1 of 1 Procedures: #9, and #10, stipulate: " (9) Place an alcohol wipe over the injection site when you have injected the medication. Withdraw needle at the insertion angle and apply gentle pressure with alcohol wipe; (10) massage the site with the alcohol wipe unless contraindicated. " The Lippincott Manual of Nursing Practice, Seventh Edition, page 406 stipulates: " Procedure-Guidelines 14-1 Subcutaneous Injection of Heparin - Nursing Action-Performance Phase: #1 Sponge the area gently with alcohol. Do not rub. Rationale: Rubbing or pinching skin might initiate damage to the tissue; heparin would aggravate any bleeding; #6 When injection has been made, withdraw needle gently at the same angle at which it entered, releasing skin roll on withdrawal of needle; #7: Press an alcohol sponge to the site for a few seconds. Rationale: To minimize oozing or bleeding ...Do not rub the area. Instruct patient not to rub area ...Rationale: Rubbing would increase the likelihood of bleeding ... " A face-to-face interview was conducted with Employees #5 and #10 on January 23, 2015 at approximately 11:30 AM. Both employees acknowledged the aforementioned findings. Facility staff failed to ensure that Heparin was administered in accordance with professional	{F 281}		

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{F 281}	Continued From page 16 standards as evidenced by rubbing the injection site after the administration. The observation was conducted and the record was reviewed on January 23, 2015. Cross reference to 42 CFR §483.25 and 483.25 (k) Quality of Care 2. Facility staff failed to follow acceptable standards of clinical practice when Employee #10 recapped a used needle following the administration of a subcutaneous injection. The facility's policy entitled "Administration of Subcutaneous Injection, " Policy No: PCS 02-011, page 1 of 1 Procedures: #11: Dispose of the needle and syringe in designated needle disposal box ... " The facility ' s policy entitled" Needle Sticks, Policy No: SNS 38, page 1 of 1 Policy: To reduce the incidence or needle stick, needles are not to be broken, cut or recapped. They are to discard in a sharps bucket ..." " The Lippincott Manual of Nursing Practice", Seventh edition, page 959 stipulates:" Care of Equipment: 4. Care must be taken to prevent injuries from needles...Used needles must never be recapped using both hands...Used needles and sharps must be disposed of into puncture resistant containers ... " A face-to-face interview was conducted with Employees #5 and #10 on January 23, 2015 at approximately 11:30 AM. Both acknowledged the aforementioned finding. Facility staff failed to follow accepted standards of	{F 281}		

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{F 281}	Continued From page 17 clinical practice as evidenced by recapping a used needle following the administration of Heparin a subcutaneous injection. The observation was conducted and the record was reviewed on January 23, 2015. Cross reference to 42 CFR §483.65 Infection Control	{F 281}	1. The inoperable suction machine was replaced with an operable one. Non-malfunctioning equipment is available for use. 2. Emergency equipment will be checked for intactness, operability and safety. Any identified deficiencies were corrected.	
{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: A. Based on observation, record review and staff interview of the sixth floor nursing unit, it was determined that facility staff failed to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical well-being as evidenced by failure to maintain essential equipment, a suction apparatus for emergency use, in proper working condition. The findings include: Facility staff failed to maintain essential equipment in proper working condition as evidenced by a malfunctioning suction machine that was designated for use in the event of an	{F 309}	3. To prevent future occurrences, clinical staff will be trained on the following: ▪ Immediately removing inoperable equipment from the clinical area ▪ Tagging inoperable equipment (e.g. "Broken-Do Not Use"). ▪ Immediately reporting inoperable or malfunctioning suction machines & other emergency equipment Coordinating equipment repair or Replacement with Biomed 4. Weekly monitoring of air mattresses and hoses will be incorporated into weekly environmental rounds. Negative findings will be reported to the DON for follow-up action. Broken equipment (including suction machines) monitoring will be added as a quality indicator for review during daily stand-up meetings and during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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{F 309}	Continued From page 18 emergency. The device was located at the code cart [A set of trays/drawers/shelves on wheels used for the dispensing of emergency medication/equipment at the site of a medical emergency to potentially save someone ' s life] on the sixth floor residential unit. During a tour of the sixth floor nursing unit, conducted on January 23, 2015 at approximately 9:30 AM the " code cart " was checked in the presence of Employees #7 and #9. A review of the facility ' s " Emergency Equipment log " [form utilized by licensed staff to verify the ' readiness ' of the code cart and accompanying supplies] identified " External Supplies." Item #2 was identified as a Suction Machine - set up ready for use. " The Emergency Equipment log was reviewed for the period of January 14, 2015 thru January 23, 2015. The log sheet included initials of licensed staff for each shift [day, night, evening] attesting that the code cart was equipped and ready for use in the event of an emergency. There were no initials to reflect that the cart was checked on January 22, 2015 (night shift) and January 23, 2015 (day shift). Employee #7 was asked to demonstrate that the suction machine was ready for use. Employee #7 prepared the suction equipment, switched the device to the ' on ' position but the suction device was inoperable. The observation was made in the presence of Employees #7 and #9. A face-to-face interview was conducted with Employees #7 and #9 who acknowledged the findings. The observation was made on January 23, 2015.	{F 309}		

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{F 309}	Continued From page 19 Facility staff failed ensure that essential equipment was maintained in proper working condition. The observation was made January 23, 2015. B.Based on staff interview and a review of the facility's Plan of Correction from the Quality Indicator Survey Annual recertification Survey completed November 5, 2014, it was determined that the facility failed to completely implement the plan of correction, as evidenced by failure to ensure that the greater number of the facility's staff members (as appropriate) were in-serviced. The findings include: A review of the facility 's plan of correction with a compliance date of January 14, 2015 revealed that in-services included approximately less than 60% of the total designated staff (e.g. approximately 45 out of 93 staff members attended the in-services). The POC stipulated: "An educational reinforcement packet was developed and was used to provide educational reinforcement to clinical staff on accurately transcribing & [and] administering medications and providing treatments in accordance with physician orders. Educational topics included the following: Medication transcription (including med changes), I&O [Intake and Output], fluid restrictions, aspiration precautions, oxygen assessments, etc ... "	{F 309}	1. Clinical staff received the required POC training relative to medication transcription & administration, I&Os, fluid restrictions, aspiration precautions, oxygen assessments and other treatment topics identified during the previous survey such as Heparin administration, sharps disposal and not storing medications, needles & syringes in isolation carts. Staff are now educated on the aforementioned requirements. 2. A review of the POC was done to determine the scope of staff educational needs. A curriculum was developed, staff were scheduled and attended the required educational sessions. Both staff scheduled to be at work and those scheduled off work attended the required sessions. 3. To prevent future occurrences, staff responsible for POC training will be educated on the following: ▪ Ensuring in-service content is developed in a manner to cover all required topics ▪ Ensuring staff schedules are coordinated to capture the majority of staff ▪ Ensuring additional training periods are identified to capture staff away from the facility 4. Quality indicators have been developed to address POC in-service monitoring. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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{F 309}	Continued From page 20 A face-to-face interview was conducted with Employee #2 on January 26, 2015 at approximately 2:43 PM related to the number of staff that attended the education/inservices as per the facility ' s Plan of Correction. There was no comment made in reference to the findings. There was no evidence that the facility's administration or the quality committee ensured that a greater part of the facility's staff (as appropriate) were in-serviced. C. Based on observations, record review and staff interview for one (1) of 21 sampled residents, it was determined that facility staff failed to ensure that anticoagulation medication (Heparin) was administered in accordance with accepted professional standards as evidenced by rubbing the injection site after the administration of Heparin. Resident #5. The findings include: Facility staff failed to ensure that anticoagulation medication (Heparin) was administered to Resident #5 in accordance with professional standards of practice. Observation: On January 23, 2015 at approximately 9:30 AM, a medication administration observation revealed the following: Employee #10 administered Heparin 1ml (5,000 units) subcutaneously (an injection that is given in the fatty layer of tissue just under the skin) to Resident #5 's outer right thigh area. After the injection, the employee	{F 309}	1. The licensed nurse who administered the Heparin dose was counseled on proper administration in accordance with professional standards. The resident was not harmed by the deficient practice. Heparin is now being administered in accordance with professional standards. 2. All nurses administering Heparin were reminded of the proper manner to administer the medication. Each resident on Heparin was checked for improper effects of Heparin administration. 3. To prevent future occurrences, nurses administering Heparin will be in-serviced on the following: ▪ Ensuring Heparin is administered safely in accordance with physician order ▪ Ensuring the injection area is not rubbed after Heparin is administered ▪ Ensuring needles are not re-capped 4. Quality indicators have been developed to monitor proper Heparin administration. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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{F 309}	Continued From page 21	{F 309}		

removed the needle, placed it on the over-the-bed table and rubbed the injection site with the alcohol pad. Employee #10 then recapped the needle and placed it in the sharps' container located on the wall in the Resident 's room.

A review of the January 2015 physician ' s orders directed, "Heparin inj [injection] 5000U/ML [milliliter]: inject 1 ML (5,000 units) sub Q [subcutaneous] every 12 hours for DVT [Deep Vein Thrombosis] Prophylaxis.

The facility ' s policy entitled "Administration of Subcutaneous Injection, " Policy No: PCS 02-011, page 1 of 1 Procedures: #9, and #10, stipulate: " (9) Place an alcohol wipe over the injection site when you have injected the medication. Withdraw needle at the insertion angle and apply gentle pressure with alcohol wipe; (10) massage the site with the alcohol wipe unless contraindicated. "

The Lippincott Manual of Nursing Practice, Seventh Edition, page 406 stipulates:

"Procedure- Guidelines 14-1 Subcutaneous Injection of Heparin - Nursing Action-Performance Phase: #1 Sponge the area gently with alcohol. Do not rub. Rationale: Rubbing or pinching skin might initiate damage to the tissue; heparin would aggravate any bleeding; #6 When injection has been made, withdraw needle gently at the same angle at which it entered, releasing skin roll on withdrawal of needle; #7: Press an alcohol sponge to the site for a few seconds. Rationale: To minimize oozing or bleeding ...Do not rub the area. Instruct patient not to rub area ...Rationale: Rubbing

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{F 309}	Continued From page 22 would increase the likelihood of bleeding ... " A face-to-face interview was conducted with Employees #5 and #10 on January 23, 2015 at approximately 11:30 AM. Both acknowledged the aforementioned findings. Facility staff failed to ensure that Heparin was administered utilizing accepted standards of professional practice. Cross referenced to 42 CFR §483.20(k)(3)(i).	{F 309}	1. The medication, syringe and needle were removed from the isolation cart and are no longer stored in isolation carts. The resident's bed was lowered and is now maintained at safe setting. 2. Nurses were reminded to not store medications, needles and syringes in isolation carts. Clinical staff were reminded to maintain resident beds low in safe settings. They were also reminded to incorporate any bed setting preferences in the resident's plan of care and to work with residents to educate them on safe bed settings. 3. To prevent future occurrences, clinical staff were in-serviced on the following: ▪ Ensuring medications, needles and syringes are not stored in isolation carts ▪ Ensuring resident beds are maintained low in safe Settings ▪ Ensuring resident bed preferences are incorporated into plans of care ▪ Ensuring residents are educated about safe bed settings when their preferences may contribute to an unsafe environment 4. Quality indicators have been developed to monitor safe bed settings. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15
{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 observation and staff interview for two (2) of 21 sampled residents, it was determined that facility staff failed to ensure that residents were free of potential accident hazards as evidenced by medication and a syringe/needle found stored in an unlocked isolation cart in the corridor outside of one (1) resident's room and an elevated bed of one (1) resident who prefers his/her bed to be elevated approximately three (3) feet from the floor. Residents #36 and #47. The findings include:	{F 323}		

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{F 323}	Continued From page 23 1. On January 23, 2015 at approximately 9:10 AM observed that an unsecured isolation cart located in front of room 628 contained a plastic bag of three (3) pre-filled 10ml syringes and a 22 gauge needle. Two (2) of the syringes were labeled normal saline and one (1) was labeled Heparin. This observation was made in the presence of Employee #6. A face-to-face interview was conducted with Employee #4 on January 23, 2015 at approximately 10:00AM. He/she acknowledged the findings and the plastic bag containing Heparin and 22guage needle were removed from the isolation cart that was located outside of the resident's assigned room. There was no evidence that facility staff ensured that the residents' environment remained as free of accident hazards as is possible. The observation was conducted on January 23, 2015 2. Facility staff failed to keep the Resident #47 ' s environment free from potential accidents as evidenced by an observation of the resident ' s bed elevated approximately three (3) feet from the floor. During a tour of the sixth floor unit conducted on January 23, 2015 at approximately 9:30 AM, Resident #47 was observed lying in his/her bed in semi-fowler's position. Both ¼ side rails were locked in the up position and the bed was elevated approximately three (3) feet from the floor. A review of the Quarterly MDS (Minimum Data Set) with an Assessment Reference Date of	{F 323}		

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{F 323}	Continued From page 24 November 12, 2014 revealed in Section C - Cognitive Patterns C0500: Brief Interview for Mental Status Summary Score measured " 15 " (meaning no cognitive impairment); Section J - Health Conditions J1800, Fall history, was coded " 0 " No. A review of Resident #47 ' s "Fall Risk Assessment" dated January 22, 2015 revealed the resident measured a "12" indicating that the resident was a "high fall risk." A face-to-face interview was conducted with Employees #5, #9, and #10 on January 23, 2015 at approximately 11:00 AM. A query was made regarding the resident's awareness of the potential fall risk associated with having his/her bed elevated. Employees #9 and #10 acknowledged the finding and Employee #9 stated, "[Resident #47 named] wants to have [his/her] bed up high. " " Facility staff failed to ensure Resident #47 ' s environment remained free of potential accidents as evidenced by the resident's bed elevated approximately three (3) feet from the floor.	{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.	{F 325}		

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{F 325}	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 21 sampled residents, it was determined that facility staff failed to consistently record percentages of meal consumption for one (1) resident and failed to ensure accuracy in the assessment of weights for one (1) resident identified with significant weight variances. Residents' #5 and #90. The findings include: 1. Facility staff failed to consistently record percentages of meal consumption for Resident #5. The facility ' s Plan of Correction with the compliance date of January 14, 2015- directed "Educational Sessions: Dietary Consumption and Recording Weights Educational Sessions: " Record how much the patient/resident has eaten for breakfast/lunch/dinner in the medical record; record meal consumption in percentages (%). For example: 25%, 50%, 75% or 100%... " The Facility's Meal Percentages Form directed, " Instructions: 1. Must be filled out for each resident; 2. This is part of the C N A (Certified Nursing Assistant) team binders; 3. This is mandatory and being monitored weekly, part of DOH (Department of Health) correction plan; 4. Day of the week; example: Monday, Tuesday, etc (other); 5. Please place resident label in the form; 6. Please inform the licensed person if the	{F 325}	1. The percentages of meal consumption for Resident #5 are now being recorded. 2. All residents' weight logs were audited to ensure percentages of consumed meals were recorded as prescribed. 3. To prevent future occurrences the responsible staff will be re-trained on the following: ▪ Ensuring percentages of resident meals are accurately and consistently assessed and recorded 4. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON.	2/8/15

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{F 325}	Continued From page 26 resident is refusing the bedtime snacks ... " A review of the clinical record revealed Resident #5 ' s diagnoses included Metabolic Encephalopathy, Recurrent UTI (Urinary Tract Infection), Anemia, Paraplegia, and History of Stroke with right sided [weakness]. A review of the ' Meal Percentages ' form for January 2015 revealed that meal consumption percentages for January 17 and 18, 2015 were not recorded. Further review of the record revealed Resident #5 ' s weight was stable and he/she historically consumed 75% - 100% of meals. A face-to-face interview was conducted with Employees #4 and #8 on January 23, 2015 at approximately 11:30 AM. Both acknowledged the aforementioned findings. Facility staff failed to consistently record percentages of meal consumption for one (1) resident. The record was reviewed on January 23, 2015. 2. Facility staff failed to ensure the accuracy of weight assessments for Resident #90. According to the facility ' s Policy entitled, "Resident ' s Weights" , Policy No: SNS 29, page 1 of 3, Effective Date: December 5, 2008, Review Date January 28, 2014: " Addressing Significant Weight Changes: ...1) Validation of significant weight changes: all residents with a significant weight change will be re-weighed under the supervision of a licensed nurse within 48 hours ...Conveying Information	{F 325}		

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{F 325}	Continued From page 27 about the Weight Change- [#] 3. The dietitian will review all related information and documentation to look for evidence of identified causes of the weight change...[#]6. Should it be determined that the weight loss is medically unavoidable based on the discussion by the physician, dietitian, nurse and other team members, a note by the respective disciplines containing supportive documentation should be written ...Follow-Up: [#] 1. The licensed nurse and dietitian will document the decisions related to a significant weight change in their respective section of the resident's record. The care plan will also be updated, with input from the dietitian and interdisciplinary team, to reflect new goals/approaches for managing the weight change ... " [#2] After four weekly weights, the dietitian or designee will determine if the resident's weight requires additional or modified interventions, or is stable or improved enough to return to routine monthly weights...Equipment Maintenance: ...[2] The nursing unit will use the same equipment, in order to maintain consistent weights ... " A review of the clinical record revealed Resident #90 ' s diagnoses included Atrial Fibrillation, Essential Hypertension, Esophageal Reflux, Diabetes and Hypercholesterolemia. A review of the resident ' s ' Weight Record ' for January 2015 revealed a monthly weight was recorded as "196.1 pounds. " A reweight assessment was recorded as " 184.7 pounds [11.4 pound weight variance - loss] w/c [wheelchair] scale." [No day of the month was recorded for either weight]. A face-to-face interview was conducted on	{F 325}	1. Resident #90 was re-weighed and the weight scale was verified for accuracy (calibrated) prior to use. 2. Each weight scale was checked for accuracy. All residents' weight logs were audited to ensure accurate weights were recorded. Significant weight changes were verified, documented and incorporated into the plan of care. Identified deficiencies were corrected. 3. To prevent future occurrences the weight team will be re-trained on the following: ▪ Ensuring resident weight monitoring is accurately performed and documented ▪ Ensuring all weight scales are calibrated and properly functioning before resident weights are taken ▪ Verifying & reporting significant weight changes ▪ Re-weighing residents with similar clothing, the same scale, time of day, etc. to obtain accurate measurements ▪ Reporting significant weight changes to the unit manager ▪ Documenting and incorporating significant weight changes, physician notifications & follow-up actions in the care plan Weight scales will be calibrated monthly to ensure accurate functionality. 4. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON.	2/8/15

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{F 325}	Continued From page 28 January 26, 2015 at approximately 10:00 AM with Employee #8 regarding the 11.4-pound weight discrepancy. He/she stated, "the reweight of 184.7 pounds documented for the month of January 2015 was not requested by me. The monthly weight was stable for November and December. There was no significant weight loss. The inaccuracies with the weights could be due to operator [staff] error. " SIC A review of the ' Nutrition Care Progress Notes ' dated January 9, 2015 indicated " weekly/monthly wt (weight) 196 [pounds]. Stable with UBW [Usual Body Weight]. Will continue to monitor per protocol following readmission." A review of the ' Nutrition Care Progress Notes ' dated January 16, 2015 indicated " weekly wt 178 pounds [6.7 pound variance - gain] ? [question mark] suspected inaccuracy and requested rewt [reweight] from staff. Staff reports rewt 205 pounds [27 pound variance - gain]; suspect accurate; stable with UBW. Will continue to monitor per protocol following readmission." There was no evidence that facility staff consistently documented the type of scale used [bed scale or chair scale] to obtain the Resident #90's weight. A review of the ' Nutrition Progress Notes ' dated January 23, 2015 indicated "weekly wt 175 pounds? Variances in wt. Resident with 75% po (oral) intake. Discussing with RN [Registered Nurse] Manager. Informed wt [weight] staff; requested rewt [reweight]. Will continue to monitor weekly wt with suspected inaccuracies, variance. "	{F 325}		

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{F 325}	Continued From page 29 A second face-to-face interview was conducted with Employee #8 on January 27, 2015 at approximately 12:00 PM regarding the additional weight discrepancy for Resident #90. Employee #8 stated " I do not believe [he/she] went from 196 pounds to 175 pounds in one (1) week. " A face-to-face interview was conducted with the Employee #11 on January 27, 2015 at approximately 1:00 PM regarding the weight discrepancies and mechanism used to obtain the weights for Resident #90. He/she stated, "I was not aware of the weight variances, this could be due to operator [staff] error." Facility staff failed to ensure accuracy in the assessment of Resident #90 ' s weight. The weight assessments conducted revealed significant variations in Resident #90's weight. The record was reviewed January 26, 2015.	{F 325}		
{F 328} SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by:	{F 328}		

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{F 328}	Continued From page 30 Based on record review and staff interview for two (2) of 21 sampled residents, it was determined that facility staff failed to ensure that residents received the proper treatment and care for the management of tracheostomy [trach] and respiratory care as evidenced by failure to consistently assess the respiratory status of two (2) resident's. Residents' #47 and 76. The findings include: 1. Facility staff failed to consistently assess Resident #47 ' s respiratory status, when interventions were implemented to manage complaints of shortness-of-breath [sob]. Physician's orders dated January 5, 2015 directed, " Iprat/Albut Inh sol 0.5/3 mg [Ipratropin/Albuterol inhalation solution used to treat bronchospasm associated with COPD] 1 vial via nebulizer every six (6) hours as needed for shortness of breath - Obtain oxygen saturation prior and post administration of each dose. Oxygen continuous 2L/min [liters]/ (minutes) for SOB/COPD [Shortness of Breath/Chronic Obstructive Pulmonary Disease]." A review of the January 2015 medication administration records [MAR] revealed Resident #47 received, Iprat/Albut In sol 0.5/3 mg [milligram], 1 vial every 6 hours for SOB on January 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25 and 31. On each occasion facility staff documented, "reason- SOB and the results were effective." A review of the Respiratory Care Adult Patient Evaluation Care Plans (Respiratory Therapist assessment form) and nursing progress notes for	{F 328}	1. Residents #47 and #76 respiratory statuses are now being assessed & documented when interventions are implemented to manage complaints of SOB and in accordance with physician orders. 2. Treatment administration records of other residents' with orders for oxygen saturation & assessment monitoring were reviewed. Any identified deficiencies were corrected. 3. To prevent future occurrences, licensed nurses and respiratory therapists were in-serviced on performing assessments and documenting respiratory statuses (e.g. oxygen saturation levels) before and after respiratory treatments and in accordance with physician orders. 4. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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{F 328}	Continued From page 31 the period of January 14 through January 23, 2015 lacked evidence that comprehensive respiratory assessments [for example, chest exam, secretions, airway clearance, and oxygen saturations] were conducted on the occasions that " as needed " Albuterol was administered for the management of ' shortness of breath. ' A face-to-face interview was conducted with Employees #1 and #11 on January 26, 2015 at approximately 11:30 AM. Both acknowledged the findings. Employee # 11 further stated; He/she further stated, " The therapists are to see residents with respiratory orders every day. After their assessments, they are to document it in the resident's clinical record." Facility staff failed to consistently assess Resident #47's respiratory status, when interventions were implemented to manage complaints of shortness-of-breath [sob]. The record was reviewed on January 26, 2015. 2. Facility staff failed to follow physician's orders to assess oxygen saturation levels every shift for Resident #76. A review of Resident #76's medical record revealed a physician's order dated January 11, 2015 which directed, " Tracheostomy humidifier O2 [oxygen] at 28% via trach collar to monitor O2 sat [saturation] more than 90% every shift, trach care every shift and as needed. " A review of the clinical record, Respiratory Care Adult Patient Evaluation Care Plans (Respiratory Therapist assessment forms), nursing progress notes and the Medication and Treatment Administration Records [MAR/TAR] for the period	{F 328}		

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{F 328}	Continued From page 32 of January 14 through January 23, 2014 lacked evidence that oxygen saturation levels were assessed on January 21 and 22, 2015 each shift as prescribed. A face-to-face interview was conducted with Employee #4 on January 26, 2015 at approximately 4:00 PM. He/she acknowledged the findings. Facility staff failed to assess oxygen saturation levels each shift for Resident #76 as prescribed by the physician. The record was reviewed January 26, 2015.	{F 328}		
{F 329} SS=C	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	{F 329}		

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{F 329}	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the facility's Plan of Correction from the QIS Annual recertification Survey completed November 5, 2014, it was determined that the facility failed to completely implement the plan of correction, as evidenced by failure to ensure that the greater part of the facility staff members (as appropriate) were in-serviced. The findings include: A review of the facility ' s plan of correction (POC) with a compliance date of January 14, 2015 revealed that in-services included approximately less than 60% of the total designated staff (e.g. approximately 45 out of 93 staff members attended the in-services). The POC stipulated: " An educational reinforcement packet was developed and was used to provide educational reinforcement to clinical staff on accurately transcribing & [and] administering medications and providing treatments in accordance with physician orders. Educational topics included the following: Medication transcription (including med changes), I&O [Intake and Output], fluid	{F 329}	1. Clinical staff received the required POC training relative to medication transcription & administration, I&Os, fluid restrictions, aspiration precautions, oxygen assessments, and other treatment topics identified during the previous survey. They have also been trained on not storing medications, needles and syringes in isolation carts. Staff are now educated on the aforementioned requirements. 2. A review of the POC was done to determine the scope of staff educational needs. A curriculum was developed, staff were scheduled and attended the required educational sessions. Both staff scheduled to be at work and those scheduled off work attended the required sessions. 3. To prevent future occurrences, staff responsible for POC training will be educated on the following: ▪ Ensuring in-service content is developed in a manner to cover all required topics ▪ Ensuring staff schedules are coordinated to capture the majority of staff ▪ Ensuring additional training periods are identified to capture staff away from the facility 4. Quality indicators have been developed to address POC in-service monitoring. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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{F 329}	Continued From page 34 restrictions, aspiration precautions, oxygen assessments, etc ... " During the survey, areas of concern related to Quality of Care included: CFR 483.20(k)(3) F281 Resident Assessment and CFR 483.25 Quality of Care F309 - Failure to administer medication in accordance with professional standards CFR 483.25 Quality of Care - Failure to secure medication and sharps (needles, syringes and medication stored in unsecured isolation cart) A face-to-face interview was conducted with Employee #2 on January 26, 2015 at approximately 2:43 PM related to the number of staff that attended the education/in-services as per the facility ' s Plan of Correction. There was no comment made in reference to the findings. There was no evidence that the facility ' s administration or the quality committee ensured that a greater part of facility staff (as appropriate) were in-serviced.	{F 329}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	{F 441}		

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{F 441}	Continued From page 35 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: A. Based on observations and staff interview for one (1) of 21 sampled resident, it was determined that facility staff failed to decrease the potential spread of infection as evidenced by recapping a used needle following the administration of a subcutaneous injection and failing to practice proper hand hygiene during medication administration. Resident #5.	{F 441}	1. Involved staff were counseled on practicing hand hygiene in accordance with facility policy and procedures. The resident was not negatively affected by the deficient practice. Staff are now practicing hand-hygiene in accordance with professional standards. 2. All staff were reminded to practice hand hygiene in accordance with facility policies & procedures. Signage was posted in key areas to remind staff to consistently practice hand-hygiene. 3. To prevent future occurrences, licensed nurses and CNAs will be in-serviced on performing hand-hygiene as follows: ▪ Prior to and after entering a resident's room ▪ Before & after resident contact or treatment ▪ When hands are visibly soiled ▪ For the defined period of time in accordance with hospital policy and type of cleaning agent used Weekly monitoring of hand-hygiene practices will be performed. Negative findings will be reported to the DON for follow-up action. Hand hygiene will be added as a quality indicator for review during daily stand-up meetings and during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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{F 441}	Continued From page 36 The findings include: 1. Facility staff failed to decrease the potential spread of infection evidenced by recapping a used needle following the administration of a subcutaneous injection. A review of the January 2015 Physician ' s Orders directed, "Heparin inj [injection] 5000U/ML [milliliter]: inject 1 ML (5,000 units) sub Q [subcutaneous] every 12 hours for DVT [Deep Vein Thrombosis] Prophylaxis. On January 23, 2015 at approximately 9:30 AM, a medication administration observation revealed: Employee #10 administered Heparin 1ml (5,000 units) subcutaneously (an injection that is given in the fatty layer of tissue just under the skin) to Resident #5's outer right thigh area. After the injection was administered, the employee removed the needle, placed it on the over-the-bed table and rubbed the injection site with the alcohol pad. Employee #10 then recapped the needle and placed it in the sharps' container located on the wall in the Resident 's room ... The facility's policy entitled "Administration of Subcutaneous Injection, " Policy No: PCS 02-011, page 1 of 1 Procedures: #11: Dispose of the needle and syringe in designated needle disposal box ... " The facility' s policy entitled" Needle Sticks, Policy No: SNS 38, page 1 of 1 Policy: To reduce the incidence or needle stick, needles are not to be broken, cut or recapped. They are to discarded in a sharps bucket ... "	{F 441}	1. Involved staff were counseled on recapping injection needles. The resident nor staff person was not negatively affected by the deficient practice. Staff are now practicing safe disposal of needles in accordance with professional standards. 2. All staff were reminded to refrain from recapping needles and disposing of them in accordance with facility policies & procedures. Signage was posted in key areas reminding staff of the requirement. 3. To prevent future occurrences, licensed nurses will be in-serviced on the following: ▪ Not recapping needles ▪ Using proper technique to disposal of used needles Weekly monitoring of proper needle disposals will be performed. Negative findings will be reported to the DON for follow-up action. Needle disposal observations will be added as a quality indicator for review during daily stand-up meetings and during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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	095039	A. BUILDING _____ B. WING _____	R 01/29/2015

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{F 441}	Continued From page 37 " The Lippincott Manual of Nursing Practice", Seventh edition, page 959 stipulates:" Care of Equipment: 4. Care must be taken to prevent injuries from needles, ...Used needles must never be recapped using both hands, ...Used needles and sharps must be disposed of into puncture resistant containers ... " A face-to-face interview was conducted with Employees #5 and #10 on January 23, 2015 at approximately 11:30 AM. Both acknowledged the aforementioned findings. Facility staff failed to decrease the potential spread of infection for Resident #5 as evidenced by recapping a used needle following the administration of a subcutaneous medication. The observation was conducted January 23, 2015. 2. Facility staff failed to decrease the potential spread of infection as evidenced by failing to practice proper hand hygiene during medication administration for Resident #5 On January 23, 2015 at approximately 9:30 AM a medication administration observation was conducted. Employee #10 prepared the resident ' s scheduled medications outside of his/her room. He/she then entered the resident's room and placed clear 30 ml cup [which contained several of the prepared medication] up to the resident's mouth to administer the medication without first sanitizing his/her hands. Employee #10 then left the room to retrieve an alcohol swab without first sanitizing his/her hands. The	{F 441}		

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{F 441}	Continued From page 38 employee then reentered the resident's room without first sanitizing his/her hands and donned disposable gloves. The employee then administered Heparin [an Injectable medication] to the resident...the employee removed gloves and discarded them in the trash receptacle and washed his/her hands at the sink located in the resident ' s room. There is was no evidence that Employee #10 sanitized his/her hands after each occurrence of direct resident contact for which handwashing is indicated by accepted professional practice. A face-to-face interview was conducted on January 23, 2015 with Employees #5 and #10. After review of the aforementioned both acknowledged the findings. Facility staff failed to decrease the potential spread of infection as evidenced by failing to sanitize hands during medication administration. B. Based on observations and staff interview on January 23, 2015 at approximately 9:30 AM and 3:30 PM, it was determined that facility staff failed to maintain a sanitary environment and decrease the potential spread of infection as evidenced by the observation of stained floor mats in three (3) of three (3) resident rooms and an improperly stored trash receptacle and bedside commode in one (1) of one (1) resident room. The findings include: 1. Floor mats used for fall precautions at the bedside of resident rooms #703B, 719A and 722B were stained in several areas.	{F 441}	1. The floor mats were cleaned once the deficiency was identified during the survey. The trash receptacle and bedside commode were placed in the appropriate location once identified during the survey. 2. Environmental rounds were conducted to identify and correct any deficiencies within resident rooms. 3. To prevent future occurrences, patient care staff were were in-serviced on ensuring floor mats are cleaned and trash receptacles and bed side commodes are properly stored. 4. Environmental issues will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed during quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible individual: DON	2/8/15

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{F 441}	Continued From page 39 2. A trash receptacle and a bedside commode were stored on top of a fall mat located at the resident bedside in room #722B. This observation was made on January 23, 2015 at approximately 9:30 AM and again at 3:30 PM. These observations were made in the presence of Employee #3 who acknowledged the findings. A face-to-face interview was conducted with Employees #1 and #14 on January 23, 2015 at approximately 11:30 AM. Both acknowledged the findings. The observation occurred on January 23, 2015. C. Based on observations made during a tour of the facility on January 23, 2015 at approximately 9:00 AM, it was determined that the facility staff failed to ensure that isolation precautions were maintained in order to prevent the potential spread of infection as evidenced by failing to post signage in a visible position to alert visitors not to enter the resident ' s room (resident isolation) without checking with the nursing staff. And by failing to ensure an adequate supply of Personal Protective Equipment [PPE] was readily available in the designated location (isolation cart). Resident #36. The findings include: A. Facility staff failed to post signage in a visible position to alert visitors not to enter the resident ' s room without checking with the nursing staff. During a Medication Pass on January 23, 2015 at	{F 441}	1. Staff received educational reinforcement on ensuring isolation signage is posted & sufficient PPE is maintained in isolation carts. Currently, there are no residents on isolation. The resident was not harmed by the deficient practice. 2. Every resident on isolation precautions was checked for proper posting of isolation signage and availability of sufficient PPE supplies. Currently, there are no residents on isolation. 3. To prevent future occurrences, licensed nurses will be in-serviced on the following: ▪ Ensuring isolation signage is visible & posted appropriately ▪ Sufficient isolation PPE supplies are maintained in isolation carts 4. Quality indicators have been developed to monitor posting of visible isolation signage and sufficient availability of PPE supplies. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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{F 441}	Continued From page 40 approximately 9:10 AM, Employee #6 (accompanied by a surveyor) attempted to administer medications to Resident #36. A cart was observed outside of the resident ' s room. No signage was visible warning staff and visitors to see the nurse before entering. A face-to-face interview was immediately conducted with Employee #6. The employee was asked whether the resident was on isolation. He/she responded " Yes " and pointed to a sign that was partially covered by a housekeeping department sign. The following sign: " STOP " Visitors report to Nurses ' station was only visible after it was pointed out by Employee #6. A face-to-face interview was also conducted with Employee #4 at approximately 10:00AM. The employee acknowledged the finding. B. Facility staff failed to utilize measures to prevent the potential spread of infection by failing to provide appropriate Personal Protective Equipment (PPE) for staff /visitors entering the room of one (1) resident who was on contact isolation. Resident #36 The findings include: On January 23, 2015 at approximately 9:30AM an isolation cart was observed outside of Resident #36 ' room. The following items were observed in the cart: One (1) yellow disposable gown One (1) portable blood pressure cuff and stethoscope A plastic bag that contained two (2) 10cc syringes	{F 441}		

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{F 441}	Continued From page 41 labeled normal saline One (1) 10cc syringe labeled Heparin, and one (1) 22 gauge needle. The cart lacked an adequate supply of PPE. No was no evidence of disposable gloves, face masks, bio-hazardous disposal bags and/or additional disposable gowns. The single gown that was on the cart was utilized for resident observation. The observations were made in the presence of Employee #6 who acknowledged the findings.	{F 441}	1. The inoperable suction machine was replaced with an operable one. Non-malfunctioning equipment is available for use. 2. Emergency equipment will be checked for intactness, operability and safety. Any identified deficiencies were corrected. 3. To prevent future occurrences, clinical staff will be trained on the following: ▪ Immediately removing inoperable equipment from the clinical area ▪ Tagging inoperable equipment (e.g. "Broken-Do Not Use"). ▪ Immediately reporting inoperable or malfunctioning suction machines & other emergency equipment Coordinating equipment repair or Replacement with Biomed 4. Weekly monitoring of air mattresses and hoses will be incorporated into weekly environmental rounds. Negative findings will be reported to the DON for follow-up action. Broken equipment (including suction machines) monitoring will be added as a quality indicator for review during daily stand-up meetings and during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15
{F 456} SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: A. Based on observation, record review and staff interview for one (1) of two nursing units, it was determined that facility staff failed to maintain essential equipment, a suction apparatus for emergency use, in proper working condition. The findings include: Facility staff failed to maintain essential equipment in proper working condition as evidenced by a malfunctioning suction machine that was designated for use in the event of an emergency. The device was located at the code cart on the sixth floor.	{F 456}		

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{F 456}	Continued From page 42 During a tour of the sixth floor nursing unit, conducted on January 23, 2015 at approximately 9:30 AM the "code cart" was checked in the presence of Employees #7 and #9. A review of the "Emergency Equipment log" identified "External Supplies." Item #2 was identified as a Suction Machine - set up ready for use. " Employee #7 was asked to demonstrate the functionality of the suction machine. Employee #7 prepared the suction equipment but the suction device was inoperable. The observation was made in the presence of Employees #7 and #9. A face-to-face interview was conducted with Employee #7 and #9 who acknowledged the findings. Facility staff failed to ensure that essential equipment was maintained in proper working condition. The observation was made on January 23, 2015. B. Based on observations and staff interview for ten (10) of nineteen (19) residents utilizing therapeutic air mattresses, it was determined that facility staff failed to follow the manufacturer ' s specifications related to safe operation and optimal performance of the devices. The findings include: A review of the manufacturer ' s ' Operations/Maintenance Manual ' under the section, " Installation and Operation for use, "	{F 456}	1. The involved residents were checked to determine whether or not the mattress setting caused development of pressure ulcers or any other negative outcome. The mattress setting were adjusted in accordance with the residents weights. No harm was noted. Residents' mattresses are now being inflated in accordance with their weights and manufacturer's recommendations. 2. Each resident on an air mattress was checked to ensure the air mattress was set in accordance with the resident's weight as required by the manufacturer's specifications. 3. To prevent future occurrences, licensed nurses and CNAs were in-serviced on the following: ▪ Ensuring air mattress settings are maintained in accordance with resident weights ▪ Checking air mattress settings when linen is changed, ADL care is provided or during other times ▪ Understanding the relationship between the mattress air pressure setting and resident weight in preventing pressure ulcers 4. Quality indicators have been developed to monitor resident weights and accurate air mattress settings. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON	2/8/15

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{F 456}	Continued From page 43	{F 456}		

the following guidance was documented for proper assembly: "Press the SET key located on the top control panel. Using the ' increase ' and ' decrease ' arrows, select the patient ' s height and weight and then press auto set."

A face-to-face interview was conducted with Employee #16 on January 26, 2015 at approximately 10:30 AM. When asked about the assembly and settings for therapeutic air mattresses, he/she responded that mattresses are set to the resident's weight.

On January 26, 2015 at approximately 1:00 PM, observations of residents utilizing therapeutic air mattresses revealed that weight settings of mattresses were inaccurate for therapeutic management in 10 of 19 residents reviewed. The variations of actual weight as compared to the setting of the device were as follows:

Resident Number	January Weight	Setting on Control Panel	Variation
Resident EW1	152.5 lbs. (pounds)	220 lbs.	the difference of 67.5 lbs.
Resident EW2	95.0 lbs.	150 lbs.	the difference of 55 lbs.
Resident EW3	170.5 lbs.	140 lbs.	the difference of 29.5 lbs.
Resident EW4	123.6 lbs.	280 lbs.	the difference of 156.4 lbs.
Resident EW5	140.0 lbs.	220 lbs.	the difference of 80 lbs.
Resident EW6	183.0 lbs.	270 lbs.	the difference of 87 lbs.
Resident EW7	136.2 lbs.	260 lbs.	the difference of 23.8 lbs.
Resident EW8	130.0 lbs.	175/200 lbs.	

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{F 456}	Continued From page 44 the difference of 45/70 lbs. Resident EW9 155.6 lbs. 120 lbs. the difference of 35.6 lbs. Resident EW10 147.6 lbs. 280 lbs. the difference of 133.4 lbs. There was no evidence that facility staff followed manufacturer's specifications for assembly to ensure safe operation and optimal performance. The weight settings observed on the device were inconsistent with residents ' assessed weight in ten (10) of 19 mattresses observed. These observations were made in the presence of Employees #9 and #16 who acknowledged the findings on January 26, 2015 at approximately 10:30 AM.	{F 456}		
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for	{F 514}	1. The involved clinician is no longer employed at the facility. 2. Each residents' documentation forms were reviewed for completeness. Any identified deficiency was corrected. 3. To prevent future occurrences, applicable clinical staff will be in-serviced on the following: ▪ Completing documentation forms in their entirety (e.g. Leave of Absence Form-leaving & returning to the facility, Hemodialysis Communication Form) ▪ Following up on missing documentation forms ▪ Consistency of documentation related to resident transfer 4. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON.	2/8/15

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{F 514}	Continued From page 45 two (2) of 21 sampled residents, it was determined that facility staff failed to maintain accurate, complete, and readily accessible clinical records in accordance with accepted professional standards and practices for one (1) resident as evidenced by failure to: maintain a documented account of entrance and exit to and from the facility; ensure completeness of Hemodialysis communication forms; ensure consistency in the documentation related to functional transfer requirements and document specifics related to the provision of safe transfer training and for another resident, staff failed to accurately void a medication administration entry. Residents' #106 and #144. The findings include: 1A. Facility staff failed to maintain a documented account of Resident #106 ' s exit and entrance from and to the facility as evidenced by an incomplete 'Release of Responsibility for Resident Leave of Absence' form. A review of the " History and Physical " examination dated May 7, 2014 revealed; Resident # 106 ' s diagnosis included: End Stage Renal on Hemodialysis, Congestive heart Failure, Hypertension, Respiratory Failure, Back Pain Respiratory Failure and status and history of Status Post Right above elbow amputation. A review of the nursing notes revealed the following: January 16, 2015 at 5:00 PM - " Resident alert [and] verbally responsive, routine po [by mouth] meds [medications] administered, ADL [activities of daily living] care provided with person assist,	{F 514}		

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{F 514}	Continued From page 46 [right] external subclavian cath [catheter] intact with no s/s [signs or symptoms] of infection noted at 12:15 PM. Resident was handed the dialysis communication paper and left for dialysis- VS [vital signs] 110/70 [blood pressure], 62 [pulse], 20 [respirations], 98.7 [temperature], 97% [oxygen saturation]. " January 16, 2015 11:00 PM - "No acute distress noted, returned from dialysis at 9:00 PM, did not return with paper documentation, no signs and symptom of infection noted at dialysis site, no bleeding noted [unable to read] stable ... " January 17, 2015 at 3:00 PM-Resident alert and verbally responsive routine po meds administered. Right external subclavian cath assess, no s/s of infection noted at 11:30 AM. Resident signed self out for LOA [leave of absence] with v/s-132/64, 60, 20, 98.8 ... " January 17, 2015 at 8:15 PM - Resident is alert and responsive returned from LOA at 8PM [8:00 PM], no change noted at that time. " A review of the " Release of Responsibility for Residential Leave of Absence " [LOA - leave of absence] form dated January 16, 2015 revealed that Resident #106 signed " Out " at 12:15. There was no time documented under the section for "Signing In. " There were no signatures for the "Manager Shift Review " for three shifts [07:00 AM, 03:00 PM and 11:00 PM]. A face-to-face interview was conducted on January 26, 2015 at approximately 3:00 PM with Employee #12. In response to a query regarding documentation of Resident #014 ' s leave of absence [recorded in nursing note] for January 17, 2015, he /she stated that the resident refused	{F 514}		

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{F 514}	Continued From page 47 to sign out when he/she left unit on January 17, 2015. Facility staff failed to follow the plan of corrections with a compliance date of January 14, 2015 as evidenced by a lack of a consistent documented account of Resident #106 ' s exiting [and entering] the facility on LOA. There was no reconciliation of the log [during change of shift report] to account for the resident exiting the facility. There was no evidence that facility staff documented the occasions Resident #106 ' s refused to sign in and or out, when he/she exited and or returned the facility. A face-to-face interview was conducted on January 26, 2015 at approximately 4:00 PM with Employee #4. He/she acknowledged the aforementioned findings. The record was reviewed on January 26, 2015. 1B. Facility staff failed to consistently document and complete the established communication log for coordination of services between the nursing facility and the dialysis center for Resident #106. The physician's orders for January 2015 revealed that Resident #106 ' s treatment regimen included Hemodialysis on Mondays, Wednesdays and Fridays. A review of the "dialysis communication" form dated January 14, 2015 revealed that the field for medications administered at dialysis and the field for the resident's pre-weight at the dialysis center	{F 514}		

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{F 514}	Continued From page 48	{F 514}		

were left blank on the form. In addition, there was no dialysis communication form on the clinical record for the subsequent scheduled dialysis appointment, January 16, 2015.

The clinical record lacked evidence of consistency in completion of the dialysis communication log book.

A face-to-face interview was conducted on January 26, 2015 at approximately 4:00 PM with Employee #4. He/she acknowledged the findings, and stated, in response to the surveyors query, "a call was made to the dialysis center, we were told that [the resident] did not go [to dialysis on January 16th]. Facility Staff failed to consistently document and /or complete the communication log book that was established for coordination of services between the nursing facility and the dialysis provider. There was no documented evidence in the clinical record to reflect that the resident did not attend dialysis on January 16, 2015. The record was reviewed January 26, 2015.

1C. Facility staff to consistently document the functional transfer requirements for Resident # 106. A review of the Quarterly MDS completed on November 11, 2014 revealed that the resident was admitted to the facility on May 7, 2014 with diagnoses that included: Anemia, Heart Failure, Hypertension and Upper Limb Amputation above the elbow.

Under Section G 0110(Functional Status) the resident was coded under self-performance and support as " 3/3 " which indicates- extensive

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	095039	A. BUILDING _____ B. WING _____	R 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 514}	Continued From page 49 assistance of two (2) persons. A review of the resident's care plan last revised on November 9, 2014 revealed an intervention for toilet use as follows " The resident requires one (1) staff participation to use toilet. " Review of the Physical Therapy Daily Treatment Note dated November 4, 2014 revealed the following: " w/c [wheelchair] > b/s [bedside] toilets>bed with Max A [assistance]." Review of the ADL [Activities of Daily Living] sheet for December 2014 revealed " 0" under " Toilet use; Resident perform " from December 1, 2014 - December 31, 2014, which indicated " independent. " Under "Toilet use; Staff perform " revealed " 1, " which indicated " set up help only. " On January 29, 2015 at approximately 10:00AM, a face-to-face interview was conducted with Employee #9 regarding MDS coding for toilet transfer. He/she stated that Resident #106 was " ...coded for what care he/she is receiving at that time. On the door it states T2 [two person transfer]. I spoke with the manager and charge nurse and they agreed on a two person assist for Resident# 106. " On January 29, 2015 at approximately 10:30AM, a face-to-face interview was conducted with Employee #4 regarding safe transfer. He/she stated, "Resident #106 required assistance of two (2) persons for transfer ... " On January 29, 2015 at approximately 10:55AM, a face-to-face interview was conducted with Employee #17 regarding how much assistance	{F 514}		

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{F 514}	Continued From page 50 was required for toileting. He/she stated that Resident #106 required "... a one person transfer to the commode. Basically, [he/she] wanted someone to pull [his/her] clothes down to get on the commode and to wipe [him/her] ... " There was no evidence that facility staff consistently and accurately documented safe toilet transfer on the MDS and care plan for Resident #106. Inconsistencies were identified in the MDS assessment as compared to the comprehensive care plan and ADL sheets. Employee #9 acknowledged the aforementioned findings. The record was reviewed on January 29, 2015. 1D. Facility staff failed to document specifics related to the provision of safe functional transfer training for Resident # 106 who sustained a fall from a bedside commode. A review of the clinical record for Resident # 106 revealed a rehabilitation progress note dated November 18, 2014 at 11:22 AM revealed " Patient seen for self-care including self-feeding, hygiene and grooming, bathing and caregiver training ... " A face-to-face interview was conducted with Employee #17 on January 29, 2015 at 11:00 AM. When queried regarding the transfer of the resident, he/she stated, Resident #106 only required one person to assist him/her. When further queried if he /she was trained in transfer of Resident #106 from wheel chair to bedside commode he/she stated, "No".	{F 514}		

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{F 514}	Continued From page 51 A face-to-face interview was conducted with Employee #18 on January 29, 2015 at 11:45 AM. When queried if he/she taught caregivers how to transfer residents safely, he/she stated, "If the caregiver happens to be present at the time of therapy, then he/she would be instructed. But no formal instructions were documented on the sign in sheets. " A face-to-face interview was conducted with Employee #19 on January 29, 2015 at 1:30 PM. When queried if he/she taught caregivers how to transfer residents safely, he/she stated, " If someone happens to be there, then they would be trained. " The aforementioned findings were acknowledged by the Employees' #18 and 19 on January 29, 2015. Both stated sign in sheets were only used for formal classroom training of staff, not informal bedside instruction. There was no documented evidence that the facility staff instructed caregivers in safe transfer techniques. The Clinical Record was reviewed on January 29, 2015. 2. Facility staff failed to accurately void a medication administration entry for Resident #144. A review of the January 2015 Medication Administration Record revealed the following printed medication entry:	{F 514}	1. The involved clinician was counseled on refraining from obliterating text when documenting. Specifically, not writing over previously written text was emphasized. 2. Each resident's medication administration record was reviewed for legibility. Any identified deficiency was corrected. 3. To prevent future occurrences, licensed nurses were in-serviced on the following: ▪ Ensuring documentation is legible ▪ Refraining from documenting over previously documented content; correcting documentation errors by striking one line through the erroneous content, writing the word "error" then initialing above the mistake 4. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 5. Responsible Individual: DON.	2/8/15

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{F 514}	Continued From page 52 Pepcid Tab [tablet] 20 mg daily - " 9 " [9:00 AM] was recorded [pre-printed] as the scheduled hour of administration for the medication. However, in red ink, the number 6 [six] was written over the 9 (nine) and encircled in red. A medication observation was conducted on January 23, 2015 at approximately 9:45 AM. During the observation, Employee #13 stated, "The resident usually gets [his/her] Pepcid at 9 AM. I do not know why it has a 6 (six) written over it. The resident did not get it at 6AM because it is in [his/her] pre-filled packet for the 9AM medications." A face-to-face interview was conducted with Employee #1 on January 23, 2015 at approximately 10:15 AM. He/she acknowledged the aforementioned findings. He/she stated the medication should have been rewritten with the time change, after getting clarification from the physician.	{F 514}		