Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0030	A. BUILDING _____ B. WING _____	01/20/2012

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

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L 000	Initial Comments The annual Licensure survey was conducted on January 9 through January 20, 2012. The following deficiencies were based on observations, record review, resident and staff interviews for 40 sampled residents.	L 000		
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on observations and staff interviews, it was determined that the nursing facility failed to comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, Section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia as evidenced by failure to: manage residents' accounts consistent with generally accepted accounting principles as evidenced by: failure to maintain interest-bearing accounts, variable monthly service fees charged against resident accounts; failure to disperse funds and close resident accounts after discharge from the facility, and residents' lack of knowledge of banking hours and methods to access funds, convey funds and provide a final accounting within 30 days of one (1) resident's death. Additionally, there was a failure to: promote dignity during dining as evidenced by serving the meals on disposable ware, honor one (1) resident's food preferences by failing to	L 001		

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L 001	Continued From page 1 provide preferred foods requested; respect the rights and/or wishes of all residents in the dayroom as evidenced by one staff member turning the television channel while a group of residents were watching the television, act upon one (1) resident ' s sub-therapeutic phenytoin level, cleanse a cut on one (1) resident ' s finger in accordance with accepted professional standards, ensure the availability of prescribed insulin, and ensure the accuracy of a Preadmission Screening and Resident Review [PASRR] for one (1) resident. Lastly, the physician failed to include a diagnosis for the use of a CPAP (Continuous Positive Airway Pressure) machine for one (1) resident. Residents 23, 67, 78, 83, 116 and 119. The findings include: 1. The facility failed to maintain and managed residents' funds in interest-bearing accounts. A review of documentation related to residents' personal fund accounts revealed that the facility managed accounts for twenty-eight (28) residents residing in the facility. A review of the monthly Patient Fund Master Account statements from a local banking institution for the period of September - November 2011 that revealed residents' funds were maintained in a pooled/combined account. A record of the monthly Trust Statements generated by the facility revealed a separate accounting of each resident's funds. A review of the monthly Trust Statements [individual financial statements] and Patient Master Account statements lacked evidence of interest accrual for the residents' personal fund accounts.	L 001	**1 & 2 Plan of Correction** The resident trust fund was changed to an interest bearing fund account. Communication from Wells Fargo indicated that funds were transferred from Client Fund Manager Government Checking to a new account at Wells Fargo: Wells Fargo Commercial Checking with Interest – Public Funds. The Department of Finance is working with the financial institution to eliminate resident monthly service fees. **Prevention of Future Occurrences** Department of Finance and Legal staff have worked with Resident Fund Management Services to manage resident funds in accordance with regulation.	

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L 001	Continued From page 2 During a face-to-face interview with Employees #1 and 8 on January 19, 2012 at approximately 1:00 PM, it was acknowledged that residents' funds were not managed in interest-bearing accounts. 2. The Facility was unable to give the rationale for variable rate service fees charged against resident accounts. The Patient Fund Master Account statements [banking institution statements] for the period of September through December 2011 revealed that variable rate service fees were charged against resident accounts. The fees were identified as "Commercial Service Charges" and were charged as follows: The statement for September 2011 revealed a commercial service charge fee of $452.81 (for August 2011). The October 2011 statement lacked evidence of a commercial service charge (for September 2011). The November 2011 statement revealed a commercial service charge of $81.61 (for October 2011) and the December 2011 statement revealed a commercial service charge of $12.49 for November 2011. An interview was conducted with Employees #8 and 13 on January 19, 2012 at approximately 1:00 PM. They were not able to explain the reasoning for the variable fees associated with the commercial service charges. Employees #8 and 13 stated that accounts were opened and authorized by an administrative division and the terms or conditions associated with the accounts were not available. The Facility was unable to give the rationale for variable rate service fees charged against	L 001	**Performance Monitoring** Resident Financial Services staffs will monitor the process to ensure that resident funds continue to be maintained in an interest-bearing account and that residents are not charged a monthly service fee. **Responsible Individual(s)** The Administrator and Resident Financial Services will ensure compliance.	3/15/12

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L 001	Continued From page 3 resident accounts. The record was reviewed January 19, 2012. 3. Facility failed to disperse account balances for six (6) residents for whom the facility managed personal fund accounts and the residents no longer resided in the facility. A review of facility's documentation related to resident funds revealed facility staff failed to disperse account balances for six (6) residents for whom the facility managed personal fund accounts and the residents no longer resided in the facility. The Trust statements delineated " closing balances " and dates of discharge as follows: Resident #K1 was discharged from the facility on July 26, 2011, closing balance $280.03 Resident #K2 was discharged from the facility on October 22, 2011, closing balance $224.41 Resident #K3 was discharged from the facility on March 25, 2011, closing balance $248.94 Resident #K4 was discharged from the facility on February 21, 2011, closing balance $2,112.45 Resident #K5 was discharged from the facility on July 1, 2011, closing balance $1,232.34 Resident #K6 was discharged from the facility on October 14, 2011, closing balance $218.11 Interviews conducted with Employees #8 and 13 on January 19, 2012 at approximately 1:00 PM revealed that the residents no longer resided in the facility, the personal account monies	L 001	**3 Plan of Correction** Funds for residents K1-K6 were disbursed following an account review of resident who no longer reside at the facility on February 28, 2012. **Prevention of Future Occurrences** Trial balances will be conducted on the 15th and last day of each month, and submitted to the administrator for review and to ensure timely disbursement of funds following discharge. **Performance Monitoring** Performance will be monitored, reported, and acted upon when necessary by Business Office staff. Compliance will be reported to the QA and PI Committees on a monthly basis until at least 3 months of sustained compliance is observed. **Responsible Individual(s)** The Administrator and Business Office staff will ensure compliance.	3/15/12

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L 001	Continued From page 4 remained in the possession of the facility and the funds had not been dispersed to the residents and/or their responsible party(s). In response to a query as to why the accounts balances had not been dispersed, they replied that the matter needed to be researched. Facility staff failed to disperse account balances for six (6) residents for whom the facility managed personal fund accounts and the residents no longer resided in the facility. The record was reviewed January 19, 2012. 4. Facility staff failed to ensure that residents were knowledgeable regarding the established methods to access their personal funds. Interviews conducted with Residents #4, 8, 53, 68 and 111 during the survey period revealed that residents were not knowledgeable regarding banking hours and/or the methodology associated with accessing their personal funds. A review of Resident Council meeting minutes for November 2011 revealed documentation that residents expressed discontent in their ability to access funds and a lack of knowledge regarding banking days. A face-to-face interview conducted with Employees #1 and 8 on January 19, 2012 at approximately 1:00 PM revealed banking days were on Mondays and Fridays. Resident funds were accessible on weekends and hours aside from the designated banking days per resident request. The resident was to inform nursing staff who in turn would notify business office staff so that accommodations could be made for fund dispersal. In response to a query as to how residents were made aware of banking	L 001	**4 Plan of Correction** Banking hours were posted in the Dining/Activity areas, within each resident's room and on the monthly activity calendar to ensure residents are knowledgeable about methods to access their funds. **Prevention of Future Occurrences** Any changes in banking or Business Office hours will be communicated to the residents in a timely manner. Information regarding resident availability of funds will be provided in each resident's admission packet. Such information will be verbally communicated to each resident upon admission and as needed. **Performance Monitoring** Performance will be monitored, reported, and acted upon when necessary by Business Office staff. Compliance will be reported to the QA and PI Committees on a monthly basis until at least 3 months of sustained compliance is observed.	

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L 001	Continued From page 5 information related to accessing personal funds, they stated that the information was shared during the initial admission conference. Facility staff failed to ensure that residents were knowledgeable regarding the established methods to access their personal funds. The record was reviewed January 19, 2012. 5. Facility staff failed to convey funds and provide a final accounting within 30 days of one (1) resident's death. A review of documentation related to resident personal fund accounts revealed that Resident #K7 expired on August 10, 2011. A review of the resident's personal fund account revealed that there was a balance of $1,553.32 as of January 12, 2012. The facility failed to convey the deceased resident's funds within 30 days of death. The findings were confirmed during a face-to-face interview on January 13, 2012 at approximately 11:00 AM with Employee #8. 6. Based on observations and staff interview, it was determined that facility staff failed to promote dignity during dining as evidenced by serving the residents their lunch meals on disposable ware. On January 9, 10, 11, 12, 13, and 17, 2012 during lunch meals, it was observed that residents dining in the 6th and 7th floors received: plastic cutlery to eat their meal and foam cups to drink.	L 001	**Responsible Individual(s)** Administrator and Business Office will ensure compliance. **5 Plan of Correction** Resident K7 personal funds were reconciled. The personal fund of residents who expired were reviewed and brought into compliance. **Prevention of Future Occurrences** Current systems and processes were revised to ensure timely conveyance of resident's funds within 30 days of death. A Trial balance will be completed on the 15th and the last day of each month and submitted to the administrator for review. Corrective actions will be taken as necessary. **Performance Monitoring** Performance will be monitored, reported and acted upon when necessary by Business Office staff. Compliance will be reported to the QA and PI Committees on a monthly basis until at least 3 months of sustained compliance is observed. **Responsible Individual(s)** Administrator and Business Office staff will ensure compliance.	3/15/12

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L 001	Continued From page 6 A face-to-face interview was conducted with Employee #39 on January 20, 2012 at 3:55 PM. He/she stated we don't use glassware. For breakfast we use the burgundy cups. For lunch and dinner the residents receive foam cups for their tea or coffee. The employee also acknowledged that glass wares were not available for residents' use during meals. 7. The food services department failed to honor the resident's food preferences by failing to provide him/her with foods that he/she had requested for Resident #23. In response to the interview question, "Are you able to participate in making food choices on January 10, 2012 at approximately 12:30 PM, the resident responded " No." When asked to elaborate the resident stated, "I hate the food; that's why I don't eat. I've talked to them several times but it doesn ' t help. What's the point of talking about it? I still will not get what I want." A face-to-face interview was conducted with Employee #16 at approximately 11:00 AM on January 18, 2012. When queried whether the resident received his/her food choices the employee responded, "He/she keeps changing his/her food preferences but he/she only complained about not receiving his/her ensure. At the time the facility was out of ensure and Glucerna was substituted." The employee was queried whether the resident was informed about the substitution. He/she responded, "No. I don ' t think it ' s the policy here to do that." Per the employee, the resident also complained that he/she did not receive beef stew as requested. "I explained to him/her that he/she dislikes peas and the beef stew contained peas and that was the reason he/she did not receive the stew. Now, I remove the peas before	L 001	**6 Plan of Correction** All plastic ware was removed and replaced with flatware. **Prevention of Future Occurrences** Dining observations were made of all residents eating on the 6th and 7th floor to ensure plastic cutlery and Styrofoam cups were not being used. All dietary staff was in-serviced that all residents on the 6th and 7th floor must be served food and using non-disposable dinnerware. Burgundy plastic mugs for hot beverages and clear plastic tumblers for cold beverages were purchased. Only metal utensils are now used for all meals unless otherwise specified for a resident with special needs. Paper and plastic ware will be used only in emergency situations (e.g. dishwasher malfunctioning). **Performance Monitoring** Caregivers will check trays at the point of delivery and to account for trays with disposable, report to Clinical Manager. The Clinical Manager or designee will monitor compliance and report performance to the QA and PI monthly meetings. **Responsible Individual(s)** Administrator and DON will ensure compliance.	3/15/12

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L 001	Continued From page 7 sending him/her the beef stew. Sometimes he/she wants PB & J (Peanut butter and jelly) and other times he does not want it." The food services department failed to honor the resident's food preferences by failing to provide him/her with foods that he/she had requested. The record was reviewed on January 18, 2012. 8. The nursing employees failed to respect the rights and/or wishes of all residents in the dayroom as evidence by one staff member turning the television while a group of residents were watching the television. A face-to-face interview was conducted with Resident #83 on January 19, 2012 at 11:30 AM. He/she stated, "Some of them. We were in the dayroom watching television and Employee #12 came in and changed the channel. He/she did not ask us if he/she could change the channel. I don't know why he/she changed the channel." A face-to-face interview was conducted with Employees #5 and #9 on January 20, 2012 at 11:40 AM. When the employees were queried as to their knowledge of the aforementioned incident, they both acknowledged being aware of the complaint from Resident #83. Employee #9 stated that they spoke to Employee #12 and informed him/her that the television is for all the residents and if someone requests a channel change, he/she needs to check with all the residents to make sure it was okay with all of them. Additionally, they told Employee #12 that if the behavior is ever repeated he/she would be subject to disciplinary actions. There was no evidence that the residents had the right to choose what television channel they wanted to watch or continue watching. 9. Facility staff failed to act upon Resident# 67's Dilantin level prior to it becoming less than 2.5	L 001	**7 Plan of Correction** The process for making an alternative meal choice was explained to the involved resident. Food options available to each resident regardless of main course meals prepared was further explained. The resident was assisted with choosing an alternative meal. **Prevention of Future Occurrences** Each resident's diet was reviewed. All residents allowed food preferences were identified and communicated to the dietary department. Provision was made for each resident allowed alternative food choices to receive menus listing additional food options. Food Service Management team attended a resident council meeting to reinforce food choice information. Additional copies of menus were provided to residents upon request. The Food Service Management team will attend Resident Council meetings over the next 3 months. Staff will be provided educational reinforcement on entering food preferences into the dietary module of the electronic computer system. An in-service on resident diets and availability of alternative food choices will be provided to clinical care providers. The in-service will also include reviewing each resident's tray ticket to ensure food preferences are honored. **Performance Monitoring** The Clinical Manager of designee will monitor compliance and report performance to the QA and PI monthly meetings.	

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L 001	Continued From page 8 mcg/ml. Resident #67 was admitted to the facility on June 7, 2011 with diagnosis of Seizure Disorder, Hepatitis C, and Status Post Cerebrovascular Accident, Left Side Hemiparesis, Depression, Bipolar Disorder, and Psychosis. A review of the laboratory report results revealed the followings: [Test-Phenytoin/ Reference 10.0-20.0 mcg/ml] September 5, 2011, Phenytoin-21.0, High September 8, 2011, Phenytoin-10.0, within normal limits October 5, 2011, Phenytoin-9.0, Low November 6, 2011, Phenytoin-6.0 Low December 9, 2011, Phenytoin - <2.5, Low December 12, 2011, Phenytoin-7.0, Low December 13, 2011, Phenytoin-9.0, Low January 9, 2012, Phenytoin -10.0 within normal limits The laboratory reports dated October 5, and November 6, 2011 were noted by facility staff and indicated that the Medical Doctor was notified of the laboratory results and no order given. Also the laboratory reports lacked the medical doctor and/or nurse practitioner signature(s) and date of review of the low results. The physician orders directed the following: September 5, 2011 at 9:00 AM, "1. Hold Dilantin times one day, 2. Start Dilantin 100 mg in AM and 200 mg in PM. Post 24 hours Dilantin level. Prealbumin and albumin level on 9/8/11." December 9, 2011 at 1:15 PM, "Give 200 mg Dilantin QD [everyday] times three days ...Repeat Dilantin level on Monday 12/12/11, Call	L 001	At least 10 tray preference observations per week will be made. **Responsible Individual(s)** The Administrator and DON will ensure compliance. **8 Plan of Correction** On June 2011 an apology was extended to the residents regarding the violation of their rights to personal choice (watching TV). The involved staff member was counseled on honoring the residents' rights to watch their preferred television programs. **Prevention of Future Occurrences** All other areas where residents watch television were observed to ensure programs displayed were in accordance with the resident's preferences. No other complaints or observations regarding the aforementioned were noted. All Staff will be re-educated on upholding resident rights. Resident rights and personal choice will be emphasized during new employee orientation and during annual competencies. **Performance Monitoring** Leadership/Managerial Staff will monitor compliance and take immediate corrective action. Findings will be reported to monthly QA meeting. **Responsible Individual(s)** The Administrator and DON will ensure compliance.	3/15/12 3/15/12

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L 001	Continued From page 9 result to NP [Nurse Practitioner] or MD [Medical Doctor]" December 12, 2011 at 1:30 [AM/PM not indicated] "1. Give 200 mg Dilantin PO [by mouth] and one (1) dose. 2. Repeat Dilantin levels in the am on 12/13/11. 3. Call MD or NP with results." December 13, 2011, "1. Dilantin 200 mg times one (1) day; 2. Repeat Dilantin level on Monday 12/19/11." A review of the physician progress notes revealed that the physician was in to visit the resident on October 8, November 3, and December 6, 2011; on November 16, 2011 the nurse practitioner was in to visit with the resident. After reviewing the notes there was no documented evidence that the attending physician or the nurse practitioner addressed the Dilantin laboratory values in his/her review/plan of care for Resident #67. On December 9, 2011 the, Phenytoin results were <2.5, Low. There was no evidence that the attending physician or the nurse practitioner addressed the resident's Phenytoin levels when they were less than the therapeutic range of 10.0-20.0 mcg/ml. Additionally, there was no evidence that the Dilantin level was repeated as directed by the order on December 19, 2011. According to the nursing notes Resident #67 had no seizure activity from October to December 2011.	L 001	**9 Plan of Correction** Staff was re-educated on policy and procedure for managing critical/abnormal lab values, physician notification, documentation, and follow-up. Resident #67 was assessed and no seizure activity was noted. The Dilantin level for resident #5 was obtained and results are below therapeutic range. The involved clinical staff was informed that the resident's Dilantin levels that exceeded acceptable parameters had not been addressed. They were counseled on fully addressing, documenting, and communicating resident critical lab values including Dilantin levels. **Prevention of Future Occurrences** To prevent future occurrences physicians were informed at the Medical Staff meeting of the regulations requiring follow-up with abnormal labs. **Performance Monitoring** The Administrator and/or Designee will conduct weekly reviews of the lab reconciliation forms. Observations will be documented, reported to QA/Risk Management and corrective actions will be taken as indicated. **Responsible Individual(s)** Administrator and/or DON will ensure compliance.	3/15/12

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L 001	Continued From page 10 A review of the physician's notes failed to reveal documented evidence that the attending physician or the nurse practitioner addressed the Dilantin laboratory values in his/her review/plan of care for Resident #67. A face-to-face interview was conducted on January 17, 2012 with Employee #9 at approximately 4:25 PM. after a review of the resident's clinical record, he/she acknowledged that the labs were not addressed [October 5 and November 6, 2011] and the phenytoin levels were not obtained as per order on 12/19/11. The record was reviewed on January 17, 2012. 10. Facility staff failed to ensure that Insulin was available to be administered for Resident #78. During a medication pass observation conducted on January 9, 2012 with Employees #31 and #32, at approximately 12:52 PM, the following occurred: After obtaining the finger stick (Blood Glucose) results of Resident #78, measuring 216 the resident required (four) 4 units of Insulin based on the physician's order which directed "Novolog Inj [injection] 100 U/ML, Monitor Blood Glucose Via Finger stick before meals and at bedtime with sliding scale coverage Sub Q (subcutaneous) as follows: 150-199= 2 Units, 200-249= 4 Units, 250-299= 6 Units, 300-349= 8 Units, Greater than 349=10 Units - Call MD (Medical Doctor) if Blood Sugar is Less than 60 or greater than 4000." Original order was dated March 2, 2011. Employee #32 made an observation of the medication cart, the cart lacked evidence of the	L 001	**10 Plan of Correction** The resident was not negatively affected by the deficient practice. The physician was notified and the resident was monitored for signs and symptoms of hyperglycemia. Pharmacy was called to send the medication. The repeat finger stick did not require insulin coverage. Insulin was delivered the same day. **Prevention of Future Occurrences** Each resident with the potential to be impacted by the deficient practice was checked. No issues were identified. The insulin was added to stock medication supply on the 6th and 7th floors. Insulin was also added to the inventory log. **Performance Monitoring** A daily monitoring tool was developed and will be utilized to ensure that all residents' medications are refilled in a timely manner. Staff will receive educational reinforcement on guidelines for medication refills.	

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L 001	Continued From page 11 medication. Further observation was made of unit house stock which also lacked evidence of the medication. A call was placed to pharmacy at 1:20 PM. The pharmacy indicated that a STAT (immediately) delivery of the medication would be made in four (4) hours. Pharmacy also indicated that the last order for the Medication was made December 5, 2011. A review of the medication order indicated that the resident received the last dose of Novolog Insulin on January 8, 2012 at 4:30 PM. A call was also placed to the physician: Order given, to omit lunch, and dinner, and call the physician if blood sugar rises above 250 mmHg. A follow-up review of the resident's blood sugar conducted on January 9, 2012 revealed that the blood sugar level did not rise above 250. A reminder follow-up call was placed to the pharmacy to send medications as ordered. Facility staff failed to ensure that Insulin was available to be administered to resident #78 as per the physician's order. The record was reviewed January 9, 2012. 11. Facility staff failed to cleanse a cut on Resident #83 ' s finger in accordance with accepted professional standards.	L 001	**Responsible Individual(s)** Administrator or DON will ensure compliance. **11 Plan of Correction** The facility now ensures residents are provided clinical care in accordance with their specific physical requirements. Each resident treatment issue identified by the surveyor was fully addressed since the survey.	3/15/12

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L 001	Continued From page 12 A review of the nurse's notes revealed that on May 20, 2011 at 12:00 PM: "Resident reported that his/her left thumb [was] bleeding post taking a shower. He/she noticed it when he/she had put his/her [under garment] [on] and he/she noted spots of blood on it. I went to assess [the] resident ' s thumb with 2 other nurses ...noticed a small clean cut open area on his/her thumb beside a pin point site from a finger stick. Resident stated that he/she shaved his/her [body part] post showering, but he/she is stating that the small cut from his/her thumb was from a finger stick to check his/her blood sugar. Site was cleansed with alcohol prep, applied Bacitracin and covered with band aid. No bleeding noted and he/she complains of mild pain but refused to be medicated for pain. " A review of the care plans for Resident #83 lacked evidence that facility staff developed a care plan to address the resident's sustained cut to his/her finger while shaving. According to "Medline Plus, Health Tip: Clean a Wound Carefully " ... The American Academy of Family Physicians offers these suggestions for cleaning a minor wound: "Run cool water over the wound, either by pouring from a cup or holding the area under running water; Using a soft washcloth and soap, gently clean the skin; Avoid applying soap directly in the wound ... Avoid using strong cleansing solutions such as hydrogen peroxide or iodine. Use plain water unless otherwise directed by a doctor." Retrieved January 30, 2012, from	L 001	The cut on the resident's finger was cleaned in accordance with accepted professional standards, physician order, and the wound care policy after the issue was identified by the surveyor. The resident's care plan was updated to reflect the appropriate care provided to the residents finger in accordance with professional standards of care, skilled nursing facility policy, and the physician's order. **Prevention of Future Occurrences** A Clinical Care Education Module has been developed and used to facilitate staff education. The Module included Wound Care. **Performance Monitoring** 30 Chart audits per month will be conducted to evaluate whether or not clinical care is provided in accordance with each residents comprehensive assessment, plan of care, and physician orders. The audits will be conducted until 3 consecutive months of sustained performance is observed. Overall performance will be reported to the QA and PI Committees monthly. **Responsible Individual(s)** The Administrator and DON will ensure compliance.	3/15/12

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L 001	Continued From page 13 <http://www.nlm.nih.gov/MedlinePlus/news/fullstory_121180. Html> The facility's policy entitled, "Wound Care Management of Pressure Ulcer " Policy No. SNS 74 reviewed: 8-22-2011 stipulated, "...Protocol: All skin breaks will be cleansed with NSS [normal saline solution]/wound cleanser then cover with dry gauze..." A telephone order from the physician dated May 29, 2011 directed, "Apply Bacitracin ointment to left thumb cut bid [two times a day] and cover with clean gauze or band aid until healed." There was no evidence that Employee #5 followed the standard of practice, the facility's policy or clarified the physician's order for a cleansing agent to clean the cut to Resident #83's left thumb. A face-to-face interview was conducted with Employee # 5 on January 19, 2012 at 11:00 AM. He/she acknowledged that the aforementioned incident happened and stated that it happened while the resident was shaving. I cleaned it with an alcohol prep pad. " Employee # 5 failed to use the standards of practice and or the facility's policy when cleaning Resident #83's cut on his/her finger. The record was reviewed on January 19, 2012. 12. Facility staff failed to ensure that the	L 001		

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L 001	Continued From page 14 Preadmission Screening and Resident Review [PASRR] was accurate and failed to ensure that a Level II screening was completed for Resident #116. A review of the Preadmission Screening and Resident Review [PASRR] completed September 19, 2011 revealed that Resident #116 had a diagnosis of mental retardation; was diagnosed prior to age 18; and displayed evidence (cognitive or behavior functions) that indicated that the resident has mental retardation or related condition. A review of the History and Physical examination signed September 23, 2011 included the following diagnoses: Mental Retardation, Seizure Disorder, Bilateral Deep Vein Thrombosis, Right Below the Knee Amputation, and Traumatic Brain Injury. A review of the Admission MDS completed September 29, 2011 revealed that Section A 1500 [Preadmission Screening and Resident Review] was coded as " No " , indicating that Resident #116 had not been evaluated for Level II PASRR nor determined to have a serious mental illness and/or mental retardation or a related condition. Furthermore, Section A 1550 [Conditions Related to MR/DD (mental retardation/developmental disability) Status] was coded as "None of the above. " Section I8000 [Additional Active Diagnoses] was not coded for MR/DD.	L 001	**Plan of Correction** The facility now ensures MDS is accurately coded for residents with MR/DD and other diagnoses. The involved residents MDS was re-coded to accurately reflect the MR/DD diagnosis. **Prevention of Future Occurrences** A review of each resident's documentation will be done to ensure accurately coded MDS. Each review will be focused on presence or absence of an MR/DD diagnosis. Any coding omissions will be corrected. The MDS Coordinator will receive educational reinforcement on accurately coding all resident diagnoses, including MR/DD. **Performance Monitoring** 30 charts per month will be conducted to evaluate accurately coded MDS until 3 consecutive months of improved performance is observed. Overall performance will be reported to the QA and PI Committees monthly. **Responsible Individual(s)** The Administrator and DON will ensure compliance.	3/15/12

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L 001	Continued From page 15 On January 9, 2012 at 3:18 PM a MDS correction assessment was completed. Section A 1500 was coded as "Yes" which indicated that the resident had been evaluated by Level II PASRR. A review of the resident ' s clinical record on January 13, 2012 at 3:41 PM lacked evidence of a Level II screen for Intellectual Developmental Disability (IDD - formerly known as Mental Retardation). A face-to-face interview was conducted with Employee #5 on January 13, 2012 at 4:45 PM. He/she stated that a Level II screen had not been performed for Resident #116. Facility staff failed to ensure that the Preadmission Screening and Resident Review [PASRR] was accurate and failed to ensure that a Level II screening was completed for Resident #116. A face-to-face interview was conducted with Employee #7 on January 17, 2012 at 11:23 AM. He/she acknowledged the aforementioned findings. The record was reviewed on January 13, 2012. 13. The physician failed to review Resident #119's total plan of care as evidenced by failure to include a diagnosis for the use of a CPAP (Continuous Positive Airway Pressure) machine at hour of sleep and naptime. The history and physical examination dated September 22, 2012 revealed Resident #119's diagnoses included [CVA-Cerebrovascular	L 001	**13 Plan of Correction** The facility now ensures each resident's plan of care is reviewed by the physician and includes a complete listing of every applicable diagnosis and treatment. The involved resident's care plan was updated to include the additional diagnosis and use of the CPAP machine.	

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L 001	Continued From page 16 Accident; HIV- Human Immunodeficiency Virus; DM-Diabetes Mellitus; HTN-Hypertension; Bipolar Disorder; Migraine and Dyslipidemia]. According to the Admission Order Sheet and Physician Plan of Care dated September 22, 2011, directed: Apply CPAP on 3.5 setting [every hour of sleep and naptime]. According to a nurse's note dated September 21, 2011 at 10:00 PM revealed: "CPAP on at 3.5 setting. No respiratory distress noted." A further review of the resident's clinical record revealed a Nurse Practitioner note dated January 10, 2012 at [3:45 PM] that directed: "[Past Medical History]: History of HIV, HTN, DM, and Obesity- On C-PAP..." A review of interdisciplinary progress notes dated December 29, 2011 at 2:00 PM revealed: "CPAP machine used nightly for sleep apnea. Resident re-educated on the importance of using the CPAP machine at night." The physician failed to review Resident #119's total plan of care as evidenced by failure to include a diagnosis for the use of a CPAP (Continuous Positive Airway Pressure) machine at hour of sleep and naptime. A face-to-face interview was conducted with Employees #3 and #9 on January 19, 2012 at approximately 11:00 AM. Both stated that the	L 001	**Prevention of Future Occurrences** A review of each resident's chart will be reviewed to ensure every applicable diagnosis and treatment regimen is included. Each review will focus on the presence or absence of missed diagnoses and applicable equipment (e.g. CPAP machine). Any missed diagnoses or equipment use will be corrected. The physician and other relevant staff will receive educational reinforcement on accurately documenting diagnoses and equipment in the resident's care plan. **Performance Monitoring** A minimum of 30 chart audits will be conducted to evaluate accurately documenting diagnoses and use of patient care equipment until 3 consecutive months of improved performance at 90% or above is observed. Overall performance will be reported to the QA and PI Committees monthly. **Responsible Individual(s)** The Administrator and DON will ensure compliance.	3/15/12

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L 001	Continued From page 17 resident had sleep apnea and uses a CPAP machine at hour of sleep. Both employees acknowledged the aforementioned findings. The record was reviewed January 19, 2012.	L 001		
L 031	3207.6 Nursing Facilities The physician shall prescribe a planned regimen of medical care which includes the following: (a)Medications and treatments; (b)Rehabilitative services; (c)Diet; (d)Special procedures and contraindications for the health and safety of the resident; (e)Resident therapeutic activities; and (f)Plans for continuing care and discharge. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 40 sampled residents, it was determined that the physician failed to prescribe a planned regimen of medical care to include orders, at the time of admission, to address one (1) resident's immediate needs status post hip replacement. Resident #48. The findings include: A review of the clinical record for Resident #48 revealed that the resident was admitted to the facility on October 25, 2011 with diagnoses that included post operative (left) total hip arthroplasty [THA]. On November 2, 2011 the resident was diagnosed with a dislocation of the	L 031	**Plan of Correction** The record for resident #48 cannot be corrected retrospectively; however, the DON and/or Administrator conferred with the attending physician regarding appropriate admission orders. All physician admission orders will be reviewed by the nurse managers within 24 hours of admission to ensure details that adhere to standards of	

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L 031	Continued From page 18 surgical hip subsequent to " an allegation of " rough handling " by staff. A review of physician 's admission orders dated October 25, 2011 (signed October 28, 2011) lacked evidence of orders to address the resident 's immediate care requirements associated with his/her post surgical hip. A review of the admission History and Physical Examination dated October 27, 2011 revealed Resident #48 was admitted with a left hip surgical wound and required physical and occupational therapy. A review of the Transfer Summary report [from the transferring facility] dated October 25, 2011, revealed that Resident #48 underwent a total hip replacement in August 2011 and sustained a traumatic dislocation of the surgical hip on September 27, 2011 after falling while participating in skilled rehabilitation. The September 2011 dislocation was repaired with a closed reduction procedure. According to a face-to-face interview with Resident #48 on January 19, 2012 at approximately 9:30 AM, he/she stated that on November 1, 2011 at approximately 11:30 PM (near the end of the shift), he/she was assisted to bed by a nursing assistant [CNA] whose attitude seemed " hurried. " During the transition, [his/her] legs were swung onto the bed and the surgical leg was twisted. S/he heard a " pop " and experienced pain of the left hip and suspected that the surgical leg was dislocated. According to a nurse ' s entry dated November 2, 2011 at 8:30 AM (late entry) " ...observed resident holding [his/her] left hip and appears in pain ...[he/she] stated that [he/she] thinks [his/her] left hip is out ...Dr [name] notified and	L 031	care (i.e., use of leg abductor , and no weight- bearing, post hip surgery). Close reduction was performed in the operating room. No further complication post reduction was observed. The employee was identified, interviewed, and placed on administrative leave pending investigation. Allegation of abuse was not substantiated. **Prevention of Future Occurrences** An assessment of each resident was done to determine whether or not he or she had a surgical procedure, including a total hip arthroplasty (THA). No residents were identified. A status post THA protocol will be developed to provide physician written directives and clinical guidance for a resident who've had a THA. A CAN task kardex will be developed and used to communicate specific plan of care interventions. A THA Care Plan will be developed, implemented, and specific to resident transfer, mobility, and positioning. Each of the newly created tools will be used when residents with status post THA are identified. Staff will be educated on the tools prior to implementation. **Performance Monitoring** Sample random weekly chart audits will be conducted to determine compliance with the use of the task kardex in communicating and administering safe clinical care to residents who've had THA and other surgical procedures. Chart audits will be performed until 3 consecutive months of improved performance at 90% or above is observed. Overall performance will be reported to the AQ and PI Committees monthly. **Responsible Individual(s)** ADON/Rehab will report implementation and	

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L 031	Continued From page 19 gave order for stat x-ray of left hip to rule out dislocation ... " In accordance with physician's orders, an x-ray of the left hip was obtained January 2, 2012 and the report concluded "dislocation of the left femoral prosthesis." The resident underwent a closed reduction surgical procedure of the left hip on November 3, 2011 and a revision of the left total hip arthroplasty was performed on November 8, 2011 to repair the "traumatic dislocation. " The resident was status post THA and status post traumatic dislocation of the surgical hip at the time of admission. The physician's admission orders lacked written directives to address the immediate care requirements associated with the resident's post surgical hip. The resident subsequently sustained a second "traumatic" dislocation of the surgical hip approximately seven (7) days post admission. The record was reviewed January 20, 2012.	L 031	outcomes of the systemic change to the QA and PI Committees monthly.	3/15/12
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising	L 051		

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L 051	Continued From page 20 them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview for 14 of 40 sampled residents, it was determined that the charge nurse failed to review residents' plans of care for appropriate goals, approaches and revisions as required as follows: two (2) residents diagnosed with Schizophrenia; one (1) resident on aspiration precautions who required mechanically altered liquids, and preferred in-room activities; one (1) resident that sustained a cut during shaving; three (3) residents for activities, one (1) resident for non-compliance and refusal of care and services; one (1) resident for dental care needs; one (1) resident for the potential adverse drug interaction in the use of more than 9 medications; one (1) resident who sustained a hip dislocation after being assisted during return to bed; one (1) resident for weight loss; one (1) resident with altered skin integrity; one (1) resident for discharge planning; one (1) resident for tracheostomy management; participation in care planning for one (1) resident and one resident who sustained a fall. Residents 3, 23, 38, 39,41, 48, 58, 62, 68, 75, 83, 96, 111 and 116. The findings include:	L 051		

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L 051	Continued From page 21 1. (a) The charge nurse failed to develop a care plan with appropriate goals and approaches to address Resident #3's preference to stay in his/her room during activities. An interview was conducted with Resident #3 on January 12, 2012 at approximately 1:58 PM. The resident indicated that he/she did not want to attend activities outside of his/her room. A review of the resident's care plan last updated December 20, 2011 lacked evidence that the charge nurse initiated a care plan with appropriate goals and approaches to address the residents desire not to attend activities outside of his/her room. A face-to-face interview was conducted with Employee #9 on January 12, 2012 at approximately 2:05 PM, he/she indicated that the resident would come outside of his/her room on occasions, and that the resident likes to sing, listen to music, and watch movies, but prefers to stay in his/her room. During a face-to-face interview conducted with Employee #14 on January 12, 2012 at approximately 2:30 PM, a query was made regarding Resident #3's preference to stay in his/her during activities and the facility's attempts to address the resident's preference. Employee #14 indicated that the resident had a care plan in his/her clinical record that addressed the resident's activities. However, a reviewed of the clinical record lacked evidence of a care plan developed to address Resident #3's in room activities. Employee #14 acknowledged the findings.	L 051	**1A - 1D & 2-13 Plan of Correction** Each resident's care plan was updated to fully address his or her needs in accordance with physician orders, and to include appropriate goals and approaches: ▪ Resident with positive diagnosis with Schizophrenia (2) ▪ Resident who is on thickened liquids/nectar thickened liquids, aspiration precaution, and prefers to stay in his/her room during activities (1) ▪ Resident that possibly sustained a cut during shaving (1) ▪ Resident for activities (1) ▪ Resident for non-compliance and refusal of care and services (1) ▪ Resident for dental care needs (1) ▪ Resident for potential for adverse drug interaction for use of more than 9 medications (1) ▪ Resident for weight loss (1) ▪ Resident with right foot wound (1) A review of each resident's record will be done to ensure his or her plan of care is fully addressed and includes appropriate goals and approaches. The review will be expanded to include an assessment of whether or not care provided is consistent with the residents' plan of care. Resident plans of care that do not meet the requirements will be updated to ensure compliance. A care plan learning module will be developed and used to provide staff with educational reinforcement. **Performance Monitoring** Chart audits (30 records per month) will be conducted to determine whether or not resident plans of care are fully executed until 3 consecutive months of improved	

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L 051	Continued From page 22 Another face-to-face interview was conducted with Employee #9 on January 12, 2012 at approximately 3:00 PM. After a review of the care plans he/she acknowledged the aforementioned findings. The charge nurse failed to develop a care plan with appropriate goals and approaches to address Resident #3's preference to stay in his/her room during activities. The record was reviewed on January 18, 2012. (b). The charge nurse failed to develop a care plan for Resident #3's need for thickened liquids. A hand written instruction to staff placed over the resident's bed head was observed on January 11, 2012 at approximately 10:00 AM in room 727. The instruction directed: "No Thin Liquids Pt. [Patient] can Aspirate" signed Thanks Rehab. An observation was made of the resident's lunch tray on January 13, 2012 1:00 PM. The tray lacked evidence of the thickened liquids, and or nectar thick liquids. Also, there was no thickener in the resident's tea. The observation was made in the presence of Employee #9. A second observation was made on January 17, 2012 at approximately 9:40 AM, the breakfast tray lacked evidence of thickened liquids and or nectar thick liquids. The observation was made in the presence of Employee #16. A review of the Dietary-Nursing Communication Sheet dated January 9, 2012 identified Clarifying diet order to be 2 gm Na+, soft, nectar thick liquids.	L 051	performance is observed. Overall performance at 90% compliance or greater will be reported the QA and PI Committees monthly. **Responsible Individual(s)** The Administrator and DON will ensure compliance.	3/15/12

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L 051	Continued From page 23 Further review of the medical record revealed a diet change to include Thickened Liquids. Nectars Thickened Liquids does not appear on the January 2012 POS (Physician Order Sheet) or MAR (Medication Administration Record). A query was made to Employee #9 on January 12, 2012 at approximately 2:30 PM as to when the resident's initial order for thickened liquids. He/she provided the original Interim order sheet dated August 19, 2011 which indicated: Diet change: Thickened Liquids, nectar thick liquids. A call was then placed to pharmacy which indicated the order was never received. A face-to-face interview was conducted with Employee #16 on January 17, 2012 at approximately 8:50 AM. He/she indicated that he/she knows that the resident was receiving thickener beginning July through September 2012, and that the resident was discharged from speech therapy on September 21, 2011. The charge nurse failed to develop a care plan with appropriate goals and approaches for Resident #3 who received thickened liquids/nectar thickened liquids. The record was reviewed January 17, 2012. (C). The charge nurse failed to develop a care plan with appropriate goals and approaches for risk of aspiration for Resident #3. An observation was made on January 11, 2012 at approximately 10:00 AM. A hand written sign was observed over the head of the resident's bed which instructed "No Thin Liquids Pt. [Patient] can Aspirate" ; signed "Thanks Rehab."	L 051		

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L 051	Continued From page 24 A review of the Speech Screen dated July 26, 2011 " Normal Swallowing" indicated that the resident had some difficulty [with] bolus formation and transit coughing on thin liquids. A query was made to Employee #9 on January 12, 2012 at approximately 2:30 PM as to the resident ' s initial order for thickened liquids. He/she provided the original Interim order sheet dated August 19, 2012 which indicated: "Diet change: Thickened Liquids, nectar thick liquids." A call was then placed to pharmacy to clarify the order. The Pharmacist responded that the order was never received. A face-to-face interview was conducted with Employee #16 on January 17, 2012 at approximately 8:50 AM. He/she indicated that a bedside screen was conducted on July 25, 2012. The resident was placed on thickener beginning in July through September and then the resident was discharged from Speech Therapy September 21, 2011. At this time an observation of the breakfast tray was conducted. The tray did not contain thickened nectar on tray. A review of the resident's diet slip indicated that nectar thicken liquids was listed as part of the meal. Employee #16 indicated there are times when there is an inconsistency sending up the thickener. A review of the January 2012 Physician Order sheet and the January 2012 MAR (Medication Administration Record) lacked evidence of an order for Thickened Liquids Nectar thick liquids. The resident clinical record lacked evidence that facility staff developed a care plan with appropriate goals and approaches for risk for aspiration for Resident #3.	L 051		

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L 051	Continued From page 25 A further face-to-face interview was conducted with Employee #16 on January 17, 2012 at approximately 2:45 PM. He/she acknowledged the aforementioned findings and indicated that a diet clarification order was completed on January 9, 2012. The record was reviewed on January 17, 2012. (d). The charge nurse failed to develop a care plan for Resident #3 with a positive diagnosis for Schizophrenia. Review of the PASSAR form dated October 3, 2011 identified Resident #3 in Section Part B Evaluation Criteria for Mental Illness/Mental Retardation as positive for a Mental Illness (Schizophrenia). The Level II Screen: Treatment Recommendations indicated that the resident requires nursing home placement because of physical and cognitive disabilities. He/she is psychiatrically stable and cooperative with staff and ward routine. Review of the care plans lacked evidence of appropriate goals and approaches for a resident with Schizophrenia. The charge nurse failed to develop a care plan for Resident #3 with a positive diagnosis for Schizophrenia. A face-to-face interview was conducted with Employee #9, on January 12, 2012 at approximately 2:55 PM after a review of the resident's clinical record; he/she acknowledged the aforementioned findings. The record was reviewed on January 12, 2012.	L 051		

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L 051	Continued From page 26 2 A. The charge nurse failed to develop a care plan with goals and approaches to address Resident #23's dental care needs. A review of the resident's admission data base revealed that the resident was admitted to the facility on September 22, 2011 with partial dentures. During a face-to-face interview on January 10, 2012 the resident confirmed that he/she wears partial dentures. The resident also informed the surveyor that he/she has some broken teeth and some mouth pain. The resident was queried whether he/she had reported the pain to the staff. The resident responded, "No. I did not tell anyone` The resident was queried whether he/she had seen a dentist. The resident responded, "No, I have not." A face-to-face interview was conducted with Employee # 4 at approximately 4:00 PM on January 11, 2012. The employee acknowledged that they (the facility) was aware that the resident wore partial dentures but added, "He/she never complained of oral pain. We are in the process of getting everyone seen by the dentist. I think he is scheduled to be seen in another week or two but we will call the dentist and have him/her seen immediately." On January 12, Employee # 4 reported to the surveyor that Resident # 23 was going to be seen by the dentist on January 14, 2012. A review of the care plans on the resident's clinical record revealed that the record lacked a care plan to address the resident's dental needs. Another face-to-face was conducted with Employee # 4 at approximately 4:00 PM on January 18, 2012. The employee acknowledged that the record lacked a care plan to address the	L 051		

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L 051	Continued From page 27 resident's dental care. The record was reviewed on January 18, 2012. 2B. The charge nurse failed to review and update one resident ' s discharge care plan to include a discharge location. Resident # 23. A review of the resident ' s admission record revealed that he/she was admitted to the facility on September 22, 2011 with a primary diagnosis of Generalized Muscle Weakness and other diagnoses which included Varicose Veins of Lower Extremities with Ulcers. A review of the resident ' s clinical record revealed a care plan for discharge planning which was initiated on September 23, 2011. A review of the discharge planning care plan revealed that it was reviewed and updated on December 20, 2011. Review of the updated care plan revealed that the discharge location was still blank after the last quarterly Minimum Data Set (MDS) assessment was completed on December 27, 2012. The following information was noted on the care plan under the heading of " Problem/Need " and dated September 23, 2011: " Resident needs discharge planning to be able to return to _____. " The following information was noted under the heading of " goal " , for the same date, " Resident will be discharged to _____ with all necessary services and equipment. " Under the heading of " Problem/Need " the documentation dated December 20, 2011 stated, " Updated. Continue with intervention x 90 days. " No new or additional information was noted on the	L 051		

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L 051	Continued From page 28 updated care plan of December 20, 2011. A review of the resident ' s admission record revealed that he/she was admitted to the facility from an area hospital on September 22, 2011. In a face-to-face interview with the resident on January 10, 2012 at approximately 1:15 PM the resident informed this surveyor that he/she resided in a shelter prior to being hospitalized (before his/her admission to the facility.) A face-to-face interview was conducted with Employee # 10 at approximately 3:30 PM on January 18, 2012. He/she acknowledged that facility staff failed to update the resident ' s discharge planning care plan to include the location to which the resident would be discharged after he/she leaves the facility. The record was reviewed on January 18, 2010. 2C. The charge nurse failed to update Resident # 23's rehabilitation care plan after the resident was discharged from the "rehab." department. A review of the resident's admission record revealed that he/she was admitted to the facility on September 22, 2011 to received occupational and physical therapy sessions in the rehabilitation department. According to Resident #23's clinical record, his/her primary diagnosis included of Generalized Muscle Weakness and other diagnoses which included Varicose Veins of Lower Extremities with Ulcers. A review of the physical therapist's documentation which was signed on September	L 051		

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L 051	Continued From page 29 27, 2011, revealed that the following four (4) goals were developed for the resident: "(1) to perform lower body dressing with no assistive device, (2) To increase functional activity tolerance to 30 minutes in order to perform self care tasks, (3) To increase strength of B UE [Both Upper Extremities], and (4) To perform all functional transfers increasing to stand by assistance (close enough to reach patient if assist needed.)" The certification dates of the therapy were documented as September 23, 2011 through November 3, 2011. A face-to-face interview was conducted with Employee # 19 at approximately 3:00 PM on January 20, 2011. The employee was queried regarding the status of the resident ' s therapy. The employee stated, "He/she is no longer on therapy. His doctor wrote an order to discontinue the sessions after the doctor was informed of the resident's refusal to attend most sessions and that when he/she does attend he/she refuses to participate." Review of the care plans on the resident's record failed to reveal any rehabilitation therapy goals (review/update) beyond the resident's discharge date from physical therapy on October 28, 2011. A face-to-face interview was conducted with Employee # 4 at approximately 3:30- PM on January 18, 2012. The employee acknowledged that there was no care plan to manage the resident's rehabilitation needs and/or his noncompliance with the rehabilitation therapy. The record was reviewed on January 18, 2012. 3. The charge nurse failed to develop a care plan with appropriate goals and approaches for the	L 051		

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L 051	Continued From page 30 potential for adverse drug interactions for use of more than 9 medications for Resident #38. Review of medical record POS (Physician Order Sheet) and the MAR (Medication Administration Record) revealed that the resident is on 17 different medications (including two forms: of Tylenol and Lorazepam). Pharmacy review was last performed December 23, 2011. The charge nurse failed to develop a care plan with appropriate goals and approaches for the potential for adverse drug interactions for use of more than 9 medications for Resident #38. A face-to-face interview was conducted with Employee #26 on January 13, 2012 at approximately 4:30 PM. After review of the care plans he/she acknowledged the aforementioned findings. The record was reviewed on January 13, 2012. 4A. The charge nurse failed to revise and review the tracheostomy plan of care plan for Resident #39. A review of the medical records on January 12, 2012 at 10:00 AM revealed an admission date of April 20, 2011 and a diagnosis of Respiratory Failure, Atrial Fibulation, and Intractable Seizure Disorder. A review of the admission order sheet and physician plan of care dated September 2, 2011 revealed under Respiratory section number one (1) an order that directed "Oxygen as needed two (2) liters/minutes for shortness of breaths" A review of the Respiratory care plan initiated May 31, 2011 revealed it was initiated with target	L 051		

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L 051	Continued From page 31 date of August 22, 2011 for diagnosis of respiratory failure, "tracheostomy related to impaired breathing mechanics. There was no evidence that the care plan was revised and reviewed for diagnosis of respiratory failure since August 22, 2011. A face-to-face interview was conducted on January 12, 2012 at approximately 11:30 AM with Employee #4. After looking through the care plans in the medical record he/she acknowledged the findings. The record last review January 12, 2012. 4B. The charge nurse failed to develop care plan for activity for Resident #39. On January 12, 2012 at 10:00 AM a review of Resident #39's clinical records revealed a diagnosis of Respiratory Failure, Atrial Fibulation, and Intractable Seizure Disorder. On January 12, 2012 at 10:00 AM a review of the quarterly "Recreational progress note " for activity revealed a note dated October 22, 2011 that read "No significant changes, during the last review period (July 20, 2011), alert to self understood at times, most of the time she speaks, it is word salad, has loved ones and friend that visits 1-2 x a month, long and short term memory cannot be assessed. following plan of care for the next x 90 days will be provided 1-1 visits for comfort care 3-4x a week, will escort to the dayroom 1-2 x a week to passively participate in structured activities and will be invited and encouraged to participate in 1 special event a month during the next reviewed period, will continue to monitor." The resident record and staff interview lack evidence that the charge nurse staff developed a	L 051		

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L 051	Continued From page 32 care plan for activities. A face-to-face interview was conducted on January 12, 2011 at approximately 2:35 PM with Employee #14. After a review of the resident's clinical record, he/she acknowledged the aforementioned findings. The record was on reviewed on January 12, 2012. 5A The charge nurse failed to afford Resident # 41 and /or his/her responsible party an opportunity to participate in the care planning process. A face-to-face interview was conducted with Resident #41 on January 10, 2011 at 10:00 AM. He/she responded " no " to a query regarding his/her involvement in decisions about daily care. The record revealed interdisciplinary team (IDT) care planning meetings were held in October 2011 and January 2012. The record lacked evidence that the resident and/or the responsible party was afforded an opportunity to participate in the care planning process during the October 2011 meeting. The charge nurse failed to afford Resident # 41 and or his/her responsible party an opportunity to participate in the care planning process. A face-to-face interview was conducted with Employee #9 on January 13, 2012 at approximately 1:00 PM. In response to a query regarding whether or not the resident or responsible party was afforded an opportunity to participate in the care planning process, he/she reviewed the record and acknowledged that the	L 051		

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L 051	Continued From page 33 record lacked documented evidence of an invitation for October 2011; however stated the responsible party attended the January 2012 meeting. The record was reviewed January 13, 2012. 5B. A review of Resident #41's comprehensive care plan, most recently updated on October 28, 2011, lacked problem identification, goals, and approaches to address the behaviors of non-compliance and/or refusal of care exhibited by the resident. The record revealed that the resident refused to have his/her weight assessed during the months of June, September, November, December 2011 and January 2012. According to the unit manager's appointment record book, Resident #41 refused to attend scheduled appointments for an ophthalmology consult in March 2011 and dental consult in May 2011. The monthly Medication and Treatment Administration records revealed that Resident #41 occasionally refuses routine laboratory assessments. The aforementioned findings were acknowledged during a face-to-face interview with Employee #5 on January 13, 2012 at approximately 3:00 PM. The record was reviewed on January 13, 2012. 6. The charge nurse failed making daily resident visits to assess physical and emotional status and implementing any required nursing intervention for Resident # 48 who subsequently sustained a hip dislocation after being assisted during transfer to bed. A review of the clinical record for Resident #48 revealed that the resident was admitted to the	L 051		

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L 051	Continued From page 34 facility on October 25, 2011 with diagnoses that included post operative (left) total hip arthroplasty. On November 2, 2011 the resident was diagnosed with a dislocation of the surgical hip subsequent to an allegation of "rough handling" by staff. According to a face-to-face interview with Resident #48 on January 19, 2012 at approximately 9:30 AM, he/she stated that on November 1, 2011 at approximately 11:30 PM (near the end of the shift), he/she was assisted to bed by a nursing assistant [CNA] whose attitude seemed "hurried." During the transition, [his/her] legs were swung onto the bed and the surgical leg was twisted. he/she heard a "pop" and experienced pain of the left hip and suspected that the surgical leg was dislocated. According to a nurse's entry dated November 2, 2011 at 8:30 AM (late entry) "...observed resident holding [his/her] left hip and appears in pain...[he/she] stated that [he/she] thinks [his/her] left hip is out ...Dr [name] notified and gave order for stat x-ray of left hip to rule out dislocation ..." In accordance with physician's orders, an x-ray of the left hip was obtained January 2, 2012 and the report concluded "dislocation of the left femoral prosthesis." The resident underwent a closed reduction surgical procedure of the left hip on November 3, 2011 and a revision of the left total hip arthroplasty was performed on November 8, 2011 as follows: According to an operative note dated November 3, 2011, Diagnosis: "traumatic dislocation of the left hip." Procedure: "Closed reduction of the left	L 051		

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L 051	Continued From page 35 hip with C-arm." Brief history included: "...[resident] underwent left total hip replacement approximately 2 months ago(August 30, 2011) ...was doing well in rehabilitation at [hospital] until [he/she] slipped and fell (approximately 2-3 weeks post surgery while in rehab), sustaining a traumatic posterior dislocation of hip [he/she] was treated with a closed reduction and placement of an abduction brace ...was transferred to [current facility]...Apparently, the day before yesterday, [resident] was sitting on a commode without [his/her] brace on. When it was time to go back to bed, an aide came and rotated [his/her] legs with legs flexed and [resident] felt a dislocation of [his/her] hip...on physical exam, [he/she] does have [his/her] hip flexed and internally rotated ...this is [his/her] second dislocation ..." According to an operative note dated November 8, 2011, Diagnosis: "Instability of left total hip arthroplasty." Operative procedure: "Revision left total hip arthroplasty." Intraoperative findings: "... [resident] was properly reduced in the operating room. There was no gross malposition of the implant; however, given the second dislocation, [I] felt that a revision would be warranted possibly to constrain liner or to assess and evaluate the diversion ..." According to the admission Minimum Data Set [MDS] signed October 31, 2011, Resident #48's diagnoses included, but was not limited to hip joint replacement, anemia, deep venous thrombosis (DVT), hypertension, gastroesophageal reflux disease, arthritis and muscle weakness, (Section I, Active Diagnoses). The resident required extensive assistance of one (1) person for bed mobility and extensive assistance of two (2) persons for transfer and	L 051		

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L 051	Continued From page 36 toilet use, (Section G, Functional Status). A face-to-face interview was conducted with Employee #5 on January 20, 2012 at approximately 11:00 AM, it was stated that the incident occurred approximately 7-days following admission and a comprehensive care plan was not fully developed for Resident #48. A care plan had been initiated, however; was not scheduled for completion until 7 days following completion of the comprehensive assessment [consistent with §483.20(k)(2)(i)]. Employee #5 stated that direct care staff were apprised of the resident's diagnoses and care needs for the safe delivery of care. In response to a query related to the utilization of hip precautions considering that the resident was post-op arthroplasty, he/she responded, "yes" the staff were to utilize hip precautions during mobilization and transfer. A face-to-face interview was conducted with Employee #43 on January 19, 2012 at 1:00 PM. S/he acknowledged that s/he assisted the resident to bed on the evening of November 1, 2012 after the resident used the bedside commode. The employee stated that he/she was not assigned to provide care for Resident #48 on November 1, 2012. S/he responded to a call light request for assistance because his/her assigned CNA was occupied. The employee stated that he/she was not aware of the resident's care requirements or diagnosis of post operative hip replacement. Employee #43 assisted the resident, who was reportedly sitting on the side of the bed, into bed by moving his/her feet. The employee acknowledged that he/she had been assigned to provide care for Resident #48 prior to November 1, 2012.	L 051		

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L 051	Continued From page 37 An interview with Employee #44 was conducted on January 20, 2012 at 3:15 PM. He/she stated that he/she was assigned to Resident #48 on the evening of November 1, 2012. He/she was aware of the resident's diagnosis and that hip precautions were required when assisting Resident #48. The employee stated that it was necessary to know a resident ' s care requirements when providing care. A review of the staffing schedule for October 2011 revealed Employee #43 was assigned to provide care for Resident #48 on October 25, 26 and 27, 2012. There was no evidence that two (2) persons assisted Resident #48 with toilet use as stipulated in the admission MDS dated October 31, 2012. There was no evidence that hip precautions were utilized while assisting the resident during transition. The resident sustained a "traumatic dislocation" of the surgical hip subsequent to being assisted/transfer to bed. The charge nurse failed making daily resident visits to assess physical and emotional status and implementing any required nursing intervention for Resident # 48 who subsequently sustained a hip dislocation after being assisted during transfer to bed. The record was reviewed on January 20, 2012. 7. The charge nurse failed to initiate a care plan with goals and approaches to address Resident # 58's (R) foot wound. A review of the clinical record revealed that the	L 051		

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L 051	Continued From page 38 resident was admitted to the facility on June 1, 2012 with an open area on right foot identified as a right plantar foot ulcer. The wound was also described as a non-healing Diabetic Foot Ulcer on his /her right 1st metatarsal head (plantar surface). A review of the care plans revealed that there was no care plan to address the resident ' s right foot ulcer. A face-to-face interviewed was conducted on January 18, 2011 at approximately 4:15 PM with Employee #4. After a review of the resident's clinical record, he/she acknowledged the aforementioned findings. The record was on reviewed on January 18, 2012. 8. The charge nurse failed to develop a comprehensive care plan that includes measurable objectives and timetables to address Resident #62's weight loss. A review of the Weight Record for Resident #62 revealed the following weights: July 2011- weight 249 pounds August 2011-weight 229 pounds September 2011-weight 234 pounds October 2011-weight 205 pounds There was a 44 pound weight loss between July and October 2011. A review of Resident #62's current clinical records (attending physician, nurse practitioner, nursing and registered dietitian) lacked entries that addressed the 44 pound weight loss. A further review of the record revealed that	L 051		

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L 051	Continued From page 39 facility staff failed to develop a comprehensive care plan that included measurable objectives and timetables to address Resident #62's weight loss. A face-to-face interview with Employee #16 was conducted on January 23, 2012 at approximately 9:00 AM. He/she stated that as the new Registered Dietician (RD) was assigned to Resident #62 on October 4, 2011. He/she immediately initiated a plan of care for the resident to address his/her unintentional weight loss, diet, and eating habits as there was no previous nutritional care plan. A face-to-face interview with Employee #46 was conducted on January 18, 2012 at approximately 9:55 AM. He/she stated that he/she noticed a significant drop in Resident #62's weight between the months of July and August 2011 but felt that the scale was not functioning properly and that the resident did not appear to be suffering from a significant weight loss. As a result, no care plan for the significant weight loss between the months of July and August 2011 was implemented. The charge nurse failed to develop a comprehensive care plan that includes measurable objectives and timetables to meet Resident #62's weight loss. Both Employees #16 and # 46 acknowledged the aforementioned findings. The record was reviewed on January 18, 2012. 9. The charge nurse failed to afford Resident #68 the opportunity to participate in planning care.	L 051		

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L 051	Continued From page 40 A face-to-face interview was conducted with Resident #68 on January 11, 2012 at approximately 10:37 AM; he/she responded " no " to a query regarding his/her involvement in decisions about daily care. He/she stated also; " When I first came I use to take a shower two times a week, but now I don ' t. It is not because I don ' t want to; it ' s because they do not offer me a shower. " Section F, Preferences for Customary Routine and Activities, of the Annual MDS [Minimum Data System] with a reference date of March 9, 2011 revealed the resident was coded as 2 for question, "How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?", indicative that it is somewhat important. According to a shower schedule posted in the nursing unit revealed Resident #68 was scheduled for showers on Mondays, Wednesdays, and Fridays. A nurse ' s care conference note dated December 6, 2011, no time indicated revealed " This nurse spoke with resident regarding the care conference. Resident has cognitive impairment due to medical diagnosis dementia. Resident however can communicate his/her needs with staff and others. Continue to receive limited to extensive assistance in different aspects of ADL functions. " A review of ADL (Activities of Daily Living) flow sheets for January 2012; revealed that there were checks in the designated boxes for bed bath from January 1-12, 2012. There were no checks in the designated boxes for showers /or resident ' s refusals to shower.	L 051		

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L 051	Continued From page 41 A face-to-face interview was conducted with Employee #4 on January 13, 2012 at approximately 12:30 PM. In response to a query regarding whether or not the resident was afforded an opportunity to participate in his/her care planning process. After reviewing the clinical record, he/she acknowledged that the record lacked documented evidence of such. The record was reviewed January 13, 2012. 10. The charge nurse failed to revise and review care plan for resident #75 ' s activities. A review of the medical records on January 12, 2012 at 10:00 AM revealed an admission date of September 1, 2011 and a diagnosis of Diabetes Mellitus type 2, Cerebral Vascular Accident, Hypertension, Vertigo, and Sellar Brain Mass. On January 12, 2012 at 10:00 AM a review of the "Admission order sheet and physician plan of care dated September 2, 2011 revealed under the activities section number six an order that directed "Activities as tolerated." On January 12, 2012 at 10:00 AM A review of the quarterly " Recreational progress note " for activity revealed a note dated June 22, 2011 that read "Continues to receive comfort care; she is suffering with generalized weakness, was placed on hospice a couple of review periods back and has since been discharged, does not wear glasses or hearing aids, receives 1:1 room visits 2-3 x wk, During her 1:1 room visits she will be provided bible reading, memory trivia, and soft music is provided, has family support, sister visits 3-4xwk, plan of care for the next 90 days is as follows: will continue to provide 1:1 room	L 051		

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L 051	Continued From page 42 visits 4-5 x a wk, Recreation therapy will continue to monitor this resident " . On January 12, 2012 at 10:00 AM a review of Activity Care plan on chart revealed it was initiated April 11, 2011 with a target date of April 8, 2012. There was no evidence that the care plan was revised and reviewed since April 11, 2011. A face-to-face interview was conducted on January 12, 2012 at 11:25 AM with Employee #4. After review of the care plans; he/she acknowledged the findings. The record was reviewed on January 12, 2012. The charge nurse staff failed to develop a care plan to address Resident #83's small cut to finger while shaving. A review of the nurse's notes revealed that on May 20, 2011 at 12:00 PM resident reported that his/her left thumb [was] bleeding post taking a shower. He/she noticed it when he/she had put his/her [under garment] [on] and he/she noted spots of blood on it. I went to assess [the] resident's thumb with 2 other nurses ...noticed a small clean cut open area on his/her thumb beside a pin point site from a finger stick. Resident stated that he/she shaved his/her [body part] post showering, but he/she is stating that the small cut from his/her thumb was from a finger stick to check his/her blood sugar. Site was cleansed with an alcohol prep, applied Bacitracin and covered with band aid. No bleeding noted and he/she complains of mild pain but refused to be medicated for pain."	L 051		

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L 051	Continued From page 43 A review of the care plans for Resident #83 revealed that the charge nurse failed to develop a care plan to address Resident #83's small cut to his/her finger while shaving. A face-to-face interview was conducted with Employee #5 on January 19, 2012 at approximately 11:00 AM. He/she acknowledged that the aforementioned incident happened and stated that it happened while the resident was shaving ... " Employee #5 also acknowledged that a care plan was not developed. The record was reviewed on January 19, 2012. 11. The charge nurse failed to develop a care plan to address Resident #83's small cut to finger while shaving. A review of the nurse's notes revelaed that on May 20, 2011 at 12:00 PM resident reported that his/her left thumb [was] bleeding post taking a shower. He/she noticed it whe he/she had put his/her [under garment] [on] and he/she noted spots of blood on it. I went to assess [the] resident's thumb with 2 [two] other nurses... noticed a small clean cut open are on his/her thumb beside a pin point site from a finger stick. Resident stated that he/she shaved his/her [body part] post showering, but he/she is stating that the small cut from his/her thumb eas from a finger stick to check his/her blood sugar. Site was cleansed with an alcohol prep, applied Bacitracin and covered with band aid. No bleeding noted and he/she complains of mild pain but refused to be medicated for pain." A review of the care plans for Resident #83	L 051		

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L 051	Continued From page 44 revealed facility staff failed to develop a care plan to address Resident #83's small cut to his/her finger while shaving. A face-to-face interview was conducted with Employee #5 on January 19, 2012 at approximately 11:00 AM. He/she acknowledged that the aforementioned incident happened and stated that it happened while the resident was shaving ..." Employee #5 also acknowledged that a care plan was not developed. The record was reviewed on January 19, 2012. 12A. The charge nurse failed to revise and review Resident #96 ' s care plan with appropriate goals and approaches for diagnosis of Schizophrenia. According to an Admission MDS [Minimum Data Assessment], with a reference date of June 9, 2011, Resident #96 was coded in Section I (Active Diagnosis) as having Schizophrenia as a psychiatric/mood disorder. A review of the " Care Conference Summary note " dated September 22, 2011; no time indicated, revealed: " Some cognitive impairment due to medical diagnosis of Schizophrenia." A review of the care plan revealed: The resident has impaired cognitive function/dementia or impaired thought processes; date initiated August 26, 2011 with a target date of December 13, 2011. A review of the care plan; with a goal target date of December 13, 2011 lacked evidence of modifications to account for the diagnosis of Schizophrenia.	L 051		

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L 051	Continued From page 45 A face-to-face interview was conducted with Employee #4 on January 20, 2012 at approximately 2:30 PM. He/she acknowledged the findings on the care plan. The record was reviewed on January 20, 2012. 12B. The charge nurse failed to initiate a care plan for Resident #96 with a positive diagnosis for Schizophrenia. A review of the PASSAR (Pre-Admission Screening and Resident Review) form dated October 26, 2010 identified Resident #96 as having a major mental illness(Schizophrenia-Paranoid Type by history) in Part B: Evaluation Criteria for Mental Illness/Mental Retardation. An " Admission Order Sheet and Physician Plan of Care" signed February 18, 2011 revealed a diagnosis of "Schizophrenia". A nurse's admission note dated February 18, 2011 at 1:00 PM revealed: "Resident admitted from [acute hospital]. [History] of Schizophrenia ... " Review of the care plans lacked evidence of appropriate goals and approaches for a diagnosis of Schizophrenia. The charge nurse failed to develop a care plan with appropriate goals and approaches for Resident #96 with a diagnosis of Schizophrenia.	L 051		

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L 051	Continued From page 46 A face-to-face interview was conducted with Employee #4 on January 20, 2012 at approximately 10:00 AM. He/she acknowledged the aforementioned findings. The record was reviewed on January 20, 2012. 13. The charge nurse failed to revise and review care plan for resident 111 ' s Discharge planning. A review of the medical records on January 17, 2012 at 11:30 AM revealed an admission date of September 1, 2011 ;which included diagnoses of Cerebral Vascular Accident, Hypertension, Anemia, Bipolar Disorder, and history of a leg fracture. A review of the " Admission order sheet and physician plan of care dated July 22, 2011 revealed under Discharge plan section number one (1) and number five (5) revealed order that read " No plans at present/ unable to care for self in community, needs continued nursing facility services " . A review of discharge plan of care revealed a care plan initiated January 10, 2012 that was incomplete. Under the problem section the care plan stated that the resident needed discharge planning to be able to return to (area left blank); and under the goal section read resident will be discharged to (area left blank) all with necessary services and equipment. A face-to-face interview was conducted on January 19, 2012 at 9:20 AM with Resident #111. He/she stated, " When I came here I was in a shelter. Yesterday is when I saw the social worker for a short time and he/she is looking for	L 051		

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L 051	Continued From page 47 a residence for me to go." The charge nurse failed to revise and review care plan for resident 111's Discharge planning. A further face-to-face interview was conducted on January 19, 2012 at 11:00 AM with Employee #10. After review of the care plans he/she acknowledged the findings. He/she stated " I started working at the facility November 2011. Yesterday I had a care conference with the resident and his/her two (2) brothers (representative) to talk about referring resident to "money follow the person program" residence was interviewed by that agency on January 18, 2012. I am working to bring all clients into compliance." The record was last reviewed on January 19, 2012. 14. The charge nurse failed to update the "falls" care after Resident #116 was lowered to the floor. A review of the nursing notes revealed: " On January 6, 2012 at 4:00 PM ...Resident was being assisted to stand, to weight, became [weak] while standing; has Rt (right) BKA (below the knee amputation) was standing on left leg. Staff assisted [him/her] to the floor into kneeling position. Was then assisted by two staff back into w/c (wheel chair). Active ROM (range of motion) to all extremities and denies pain. Assisted to bed ...no acute distress ... " On January 6, 2012 ...NP (nurse practitioner) made aware of fall. New order received for Stat x-ray of [right] leg stump second to pt (patient) C/O (complaint of) pain. Pt medicated times one for	L 051	**14 Plan of Correction** Each resident's care plan was updated to fully address his or her needs in accordance with physician orders. **Prevention of Future Occurrences** A review of each resident's record will be done to ensure his or her plan of care is fully addressed and includes appropriate goals and approaches. Resident plans of care that do not meet the requirements will be updated to ensure compliance. **Performance Monitoring** Chart audits (30 records per month) will be conducted to determine whether or not resident plans of care are fully executed until 3 consecutive months of improved performance is observed. Overall performance will be reported to the QA and PI Committees monthly. **Responsible Individual(s)** The Administrator and/or DON will ensure compliance.	

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L 051	Continued From page 48 pain. " According to the x-ray exam dated January 6, 2012 the right lower leg x-ray was negative for fracture. A review of the "At risk for falls R/T (related to) right below the knee amputation" care plan revealed that it was last updated on November 28, 2012. There was no evidence that the aforementioned care plan was updated after the resident was lowered to the floor. A face-to-face interview was conducted with Employee #5 on January 13, 2012 at 4:45 PM. After a review of the resident's clinical record, he/she acknowledged that the care plan was not updated. The record was reviewed on January 13, 2012.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned	L 052		

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L 052	Continued From page 49 and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review and staff interview for six (6) of 40 sampled residents, it was determined that the nursing administration failed to ensure that sufficient nursing time was given to each resident as follows: one (1) resident who sustained a hip dislocation after being assisted	L 052		

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L 052	Continued From page 50 during return to bed; one (1) resident who had a sub-therapeutic phenytoin level; one (1) resident who sustained a finger laceration; one (1) resdient whose prescribed treatment orders were not followed; one (1) resident with an indwelling catheter that was inconsistently monitored and (1) one resident who requied assistance with oral hygiene. Residents #48, 67, 83, 103, 114, and 116. The findings include: 1. The charge nurse staff failed to provide care and services to attain or maintain the highest practicable physical well-being, for Resident # 48 who subsequently sustained a hip dislocation after being assisted during transfer to bed. A review of the clinical record for Resident #48 revealed that the resident was admitted to the facility on October 25, 2011 with diagnoses that included post operative (left) total hip arthroplasty. On November 2, 2011 the resident was diagnosed with a dislocation of the surgical hip subsequent to an allegation of " rough handling" by staff. According to a face-to-face interview with Resident #48 on January 19, 2012 at approximately 9:30 AM, he/she stated that on November 1, 2011 at approximately 11:30 PM (near the end of the shift), he/she was assisted to bed by a nursing assistant [CNA] whose attitude seemed "hurried." During the transition, [his/her] legs were swung onto the bed and the surgical leg was twisted. He/she heard a "pop" and experienced pain of the left hip and suspected that the surgical leg was dislocated. According to a nurse's entry dated November 2, 2011 at 8:30 AM (late entry) "...observed resident	L 052	**1-5 Plan of Correction** The facility now ensures residents are provided clinical care in accordance with there specific physical, mental, and psychosocial requirements. Each resident treatment issue identified by the surveyor was fully addressed since the survey. 1. The employee who handled the patient in a rough manner was placed on administrative leave pending investigation. The results of the investigation revealed that abuse had not occurred. Rather, it was determined that the employee lacked knowledge providing care to a resident who had hip surgery. The employee was provided education on transferring patients after orthopaedic procedures. A comprehensive care plan was developed to provide clinical staff guidance on providing care to the patient who had hip surgery. To ensure safe clinical care is provided, a task kardex was developed for the certified nursing assistants as a tool to communicate components of residents' care plans. 2. The resident was assessed and no seizure activity was noted. The resident's Dilantin levels were evaluated. The involved nurses, medical director, and nurse practitioner were informed that the resident's Dilantin levels that exceeded acceptable parameters had not been addressed. They were counseled on fully addressing and communicating resident critical lab values including Dilantin levels.	

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L 052	Continued From page 51 holding [his/her] left hip and appears in pain...[he/she] stated that [he/she] thinks [his/her] left hip is out ...Dr [name] notified and gave order for stat x-ray of left hip to rule out dislocation ..." In accordance with physician's orders, an x-ray of the left hip was obtained January 2, 2012 and the report concluded "dislocation of the left femoral prosthesis." The resident underwent a closed reduction surgical procedure of the left hip on November 3, 2011 and a revision of the left total hip arthroplasty was performed on November 8, 2011 as follows: According to an operative note dated November 3, 2011, Diagnosis: "traumatic dislocation of the left hip." Procedure: "Closed reduction of the left hip with C-arm." Brief history included: "...[resident] underwent left total hip replacement approximately 2 months ago(August 30, 2011) ...was doing well in rehabilitation at [hospital] until [he/she] slipped and fell (approximately 2-3 weeks post surgery while in rehab), sustaining a traumatic posterior dislocation of hip [he/she] was treated with a closed reduction and placement of an abduction brace ...was transferred to [current facility]...Apparently, the day before yesterday, [resident] was sitting on a commode without [his/her] brace on. When it was time to go back to bed, an aide came and rotated [his/her] legs with legs flexed and [resident] felt a dislocation of [his/her] hip...on physical exam, [he/she] does have [his/her] hip flexed and internally rotated ...this is [his/her] second dislocation ..." According to an operative note dated November 8, 2011, Diagnosis: "Instability of left total hip arthroplasty." Operative procedure: "Revision left	L 052	3. The cut on the resident's finger was cleaned in accordance with accepted professional standards, physician order, and the wound care policy after the issue was identified by the surveyor. The resident's care plan was updated to reflect the appropriate care provided to the residents finger in accordance with professional standards of care, skilled nursing facility policy, and physician orders. 4. The resident's perineal area was treated in accordance with physician orders after the issue was identified by the surveyor. Specifically, Calmoseptine ointment was applied to the resident's perineum after washing the area with water as specified in the physician order. The treatment administration record was updated to reflect treatment administered. 5. The resident's catheter drainage was monitored every shift after the issue was identified by the surveyor and the treatment administration record was updated to reflect the catheter output, in accordance with the physician order. Involved staff were re-educated on consistently monitoring and documenting catheter output. **Prevention of Future Occurrences** Each resident was assessed to determine whether or not the aforementioned deficient clinical practices were observed. Any identified deficiencies were corrected. Clinical staff will be provided educational reinforcement on providing treatments in accordance with residents' clinical requirements, comprehensive assessments, care plans, and physician orders.	

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L 052	Continued From page 52 total hip arthroplasty." Intraoperative findings: "... [resident] was properly reduced in the operating room. There was no gross malposition of the implant; however, given the second dislocation, [I] felt that a revision would be warranted possibly to constrain liner or to assess and evaluate the diversion ..." According to the admission Minimum Data Set [MDS] signed October 31, 2011, Resident #48's diagnoses included, but was not limited to hip joint replacement, anemia, deep venous thrombosis (DVT), hypertension, gastro esophageal reflux disease, arthritis and muscle weakness, (Section I, Active Diagnoses). The resident required extensive assistance of one (1) person for bed mobility and extensive assistance of two (2) persons for transfer and toilet use, (Section G, Functional Status). A face-to-face interview was conducted with Employee #5 on January 20, 2012 at approximately 11:00 AM, it was stated that the incident occurred approximately 7-days following admission and a comprehensive care plan was not fully developed for Resident #48. A care plan had been initiated, however; was not scheduled for completion until 7 days following completion of the comprehensive assessment [consistent with §483.20(k)(2)(i)]. Employee #5 stated that direct care staff were apprised of the resident's diagnoses and care needs for the safe delivery of care. In response to a query related to the utilization of hip precautions considering that the resident was post-op arthroplasty, he/she responded, " yes" the staff were to utilize hip precautions during mobilization and transfer.	L 052	A Clinical Care Education Module will be developed and used to facilitate staff education. The Module will include the following: ▪ Care of the resident with a post-operative orthopedic procedure(s) ▪ Communication and follow up of critical lab values (e.g. Dilantin) ▪ Wound Care ▪ Administering clinical treatments in accordance with physician orders ▪ Monitoring and documenting catheter output ▪ Applicable policies, procedures and documentation forms **Performance Monitoring** A minimum of 30 chart audits will be conducted to evaluate whether or not clinical care is provided in accordance with each residents comprehensive assessment, plan of care, and physician orders. The audits will be conducted until 3 consecutive months of sustained performance is observed. Overall performance will be reported to the QA and PI Committees monthly. **Responsible Individual(s)** The Administrator and DON will ensure compliance.	3/15/12

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L 052	Continued From page 53 A face-to-face interview was conducted with Employee #43 on January 19, 2012 at 1:00 PM. She/he acknowledged that s/he assisted the resident to bed on the evening of November 1, 2012 after the resident used the bedside commode. The employee stated that he/she was not assigned to provide care for Resident #48 on November 1, 2012. S/he responded to a call light request for assistance because his/her assigned CNA was occupied. The employee stated that he/she was not aware of the resident's care requirements or diagnosis of post operative hip replacement. Employee #43 assisted the resident, who was reportedly sitting on the side of the bed, into bed by moving his/her feet. The employee acknowledged that he/she had been assigned to provide care for Resident #48 prior to November 1, 2012. An interview with Employee #44 was conducted on January 20, 2012 at 3:15 PM. He/she stated that he/she was assigned to Resident #48 on the evening of November 1, 2012. He/she was aware of the resident's diagnosis and that hip precautions were required when assisting Resident #48. The employee stated that it was necessary to know a resident ' s care requirements when providing care. A review of the staffing schedule for October 2011 revealed Employee #43 was assigned to provide care for Resident #48 on October 25, 26 and 27, 2012. There was no evidence that two (2) persons assisted Resident #48 with toilet use as stipulated in the admission MDS dated October 31, 2012. There was no evidence that hip precautions were utilized while assisting the resident during transition. The resident sustained	L 052		

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L 052	Continued From page 54 a " traumatic dislocation" of the surgical hip subsequent to being assisted/transfer to bed. The facility staff failed to provide care and services to attain or maintain the highest practicable physical well-being, for Resident # 48 who subsequently sustained a hip dislocation after being assisted during transfer to bed. The record was reviewed on January 20, 2012. 2. Charge nurse failed to act upon Resident # 67's Dilantin level prior to it becoming less than 2.5 mcg/ml. Resident #67 was admitted to the facility on June 7, 2011 with diagnosis of Seizure Disorder, Hepatitis C, and Status Post Cerebrovascular Accident, Left Side Hemiparesis, Depression, Bipolar Disorder, and Psychosis. A review of the laboratory report results revealed the followings: [Test-Phenytoin/ Reference 10.0-20.0 mcg/ml] September 5, 2011, Phenytoin-21.0, High September 8, 2011, Phenytoin-10.0, within normal limits October 5, 2011, Phenytoin-9.0, Low November 6, 2011, Phenytoin-6.0 Low December 9, 2011, Phenytoin - <2.5, Low December 12, 2011, Phenytoin-7.0, Low December 13, 2011, Phenytoin-9.0, Low January 9, 2012, Phenytoin -10.0 within normal limits The laboratory reports dated October 5, and November 6, 2011 were noted by facility staff and indicated that the Medical Doctor was notified of the laboratory results and no order given. Also the laboratory reports lacked the medical doctor and/or nurse practitioner signature(s) and date of review of the low results. The physician orders directed the following: September 5, 2011 at 9:00 AM, "1. Hold Dilantin	L 052		

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L 052	Continued From page 55 times one day, 2. Start Dilantin 100 mg in AM and 200 mg in PM. Post 24 hours Dilantin level. Prealbumin and albumin level on 9/8/11." December 9, 2011 at 1:15 PM, "Give 200 mg Dilantin QD [everyday] times three days ...Repeat Dilantin level on Monday 12/12/11, Call result to NP [Nurse Practitioner] or MD [Medical Doctor]" December 12, 2011 at 1:30 [AM/PM not indicated] "1. Give 200 mg Dilantin PO [by mouth] and one (1) dose. 2. Repeat Dilantin levels in the am on 12/13/11. 3. Call MD or NP with results." December 13, 2011, "1. Dilantin 200 mg times one (1) day; 2. Repeat Dilantin level on Monday 12/19/11." A review of the physician's progress notes revealed that the physician was in to visit the resident on October 8, November 3, and December 6, 2011; on November 16, 2011 the nurse practitioner was in to visit with the resident. After reviewing the notes there was no documented evidence that the attending physician or the nurse practitioner addressed the Dilantin laboratory values in his/her review/plan of care for Resident #67. On December 9, 2011 the, Phenytoin results were <2.5, Low. There was no evidence that the attending physician or the nurse practitioner addressed the resident's Phenytoin levels when they were less than the therapeutic range of 10.0-20.0 mcg/ml. Additionally, there was no evidence that the Dilantin level was repeated as directed by the order on December 19, 2011. According to the nursing notes Resident #67 had no seizure activity from October to December 2011. A face-to-face interview was conducted on January 17, 2012 with Employee #9 at	L 052		

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L 052	Continued From page 56 approximately 4:25 PM. after a review of the resident's clinical record, he/she acknowledged that the labs were not addressed [October 5 and November 6, 2011] and the phenytoin levels were not obtained as per order on 12/19/11. The record was reviewed on January 17, 2012. 3. The charge nurse failed to obtain a method of cleaning the cut to Resident #83's finger. A review of the nurse's notes revealed that on May 20, 2011 at 12:00 PM resident reported that his/her left thumb [was] bleeding post taking a shower. He/she noticed it when he/she had put his/her [under garment] [on] and he/she noted spots of blood on it. I went to assess [the] resident's thumb with 2 other nurses...noticed a small clean cut open area on his/her thumb beside a pin point site from a finger stick. Resident stated that he/she shaved his/her [body part] post showering, but he/she is stating that the small cut from his/her thumb was from a finger stick to check his/her blood sugar. Site was cleansed with an alcohol prep, applied Bacitracin and covered with band aid. No bleeding noted and he/she complains of mild pain but refused to be medicated for pain." A review of the care plans for Resident #83 revealed that the charge nurse failed to develop a care plan to address the resident sustaining a small cut to his/her finger while shaving. The facility's policy entitled, "Wound Care Management of Pressure Ulcer" Policy No. SNS 74 reviewed: 8-22-2011 stipulated, "...Protocol: All skin breaks will be cleansed with NSS [normal saline solution]/wound cleanser then cover with dry gauze..."	L 052		

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L 052	Continued From page 57 A telephone order from the physician dated May 29, 2011 directed, "apply Bacitracin ointment to left thumb cut bid [two times a day] and cover with clean gauze or band aid until healed." The aforementioned order failed to include a cleansing agent to clean the cut to Resident #83 's left thumb. A face-to-face interview was conducted with Employee #5 on January 19, 2012 at 11:00 AM. He/she stated, "I cleaned it with an alcohol prep pad." Employee # 5 further acknowledged that there was no cleansing agent included in the physician's order. The record was reviewed on January 19, 2012. 4. The charge nurse failed to administer Calmoseptine ointment as per the physician 's order for Resident # 103. A review of Resident #103 's clinical record revealed an " Interim Order Form " that included an order dated December 6, 2011 that directed " Calmoseptine ointment to peri area BID [Twice Daily] and PRN [As needed] after washing area [with] water. " A further review of Resident #103 ' s clinical record revealed a "Treatment Administration Record " [TAR] dated December 6, 2011 that revealed "Calmoseptine ointment to peri area twice daily after washing area [with] water. " The TAR lacked evidence that the charge nurse administered Resident # 103 the Calmoseptine ointment as per the physician ' s order as evidenced by lack of initials across from the entry on the TAR for Calmoseptine ointment.	L 052		

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L 052	Continued From page 58 Furthermore, a review of the "Nurse's Notes" revealed the followings: December 6, 2011 at 2:00 PM after the order for Calmoseptine was written the nurse wrote: "Resident alert and verbally responsive, complain of burning in her perinea area, staff wash area with soap and water, lotion apply, [he/she] stated that [he/she] feels much better..." December 7, 2011 at 3:00 PM "...Incontinent care provided with skin barrier [applied] to each change to prevent skin break down..." The charge nurse failed to follow the physician's order for administration of Calmoseptine ointment for Resident # 103. A face-to-face interview was conducted with Employee #4 on January 17, 2012 at approximately 11:00 AM. After a review of the resident's clinical record, Employee # 4 acknowledged the aforementioned findings. The record was reviewed January 17, 2012. 5. The charge nurse failed to ensure that Resident #114 was assisted with oral hygiene care. A face-to-face interview was conducted with Resident #114 on January 11, 2011 at approximately 10:05 AM; he/she responded "weekly" to a query regarding frequency of teeth/dentures/mouth (routine oral care). A review of Resident #114's "ADL[Activities of Daily Living]" care plan dated August 10, 2011	L 052		

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L 052	Continued From page 59 revealed: "Alteration in ADL's secondary to weakness and decreased in mobility; " Under interventions revealed: "Assist resident with his ADL's." A review of the resident's ADL flow sheet dated January 1 through 12, 2012 lacked evidence that the resident was provided personal hygiene(included teeth and denture care) for January 1 (days and evenings); January 3 (days and evenings); January 5 (days and evenings); January 6 (nights and days); January 7 (nights and days), and January 10 (nights), as evidenced by the absence of checks [indicating that the services were provided] in the boxes for the aforementioned dates. A face-to-face interview was conducted with Resident #114 in the presence of Employee #4 on January 12, 2012 at approximately 3:21 PM. When asked, "If he/she brushed his/her teeth today;" he/she responded, "I brushed my teeth yesterday afternoon [1/11/12]. A face-to-face interview was conducted with Employee #41 on 1/12/12 at approximate 3:30 PM regarding Resident #114's AM (including brushing resident's teeth) care. He/she stated, "Resident #114 brushed his/her teeth. He/she has to be encouraged to do things for himself." Upon asking and obtaining the resident's permission to look in the resident's bedside stand drawers for the resident's toothbrush, Employee #4 opened the drawers and found no toothbrush, toothpaste, or mouthwash inside the drawer. Employee # 4 immediately consulted with Employee #41 regarding assisting the resident with brushing his/her teeth oral hygiene care. Employee #41 returned to the room to assist with	L 052		

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L 052	Continued From page 60 Resident #114's oral hygiene care. The record, observation and interview lacked evidence that Resident #114 was given the appropriate treatment and services to maintain or improve his/her abilities to maintain his/her oral hygiene care. The findings were reviewed and confirmed during the interview with Employee #4. The record was reviewed January 12, 2012. 6. The charge nurse failed to consistently monitor catheter drainage and record output every shift per the attending physician's order for Resident #116. The physician's order dated December 7, 2011 at 5:00 PM directed, "Monitor Lt (left) thigh surgical site for signs and symptoms of infection QS (every shift). Monitor catheter drainage every shift and record output." A review of the nursing notes and the Treatment Administration Record revealed that there was no drainage output recorded on January 3, 4, 6 and 7, 2012. A face-to-face interview was conducted with Employee #2 on January 13, 2012 at 4:50 PM. He/she acknowledged that the drainage output was not consistently recorded. The resident's clinical record lacked evidence that the charge nurse consistently monitored the drainage and recorded the output as ordered by the attending physician. The record was reviewed on January 13, 2012.	L 052		

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L 091	Continued From page 61	L 091		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the Infection Control Committee ensured that infection control policies and procedures were implemented in accordance with the requirements of this chapter as evidenced by a failure to ensure that employees providing direct care were free from communicable disease and/or tracked for illness. The findings include: During a lunch meal dining observation on January 9, 2011 at approximately 11:45 AM, Employee #45 was observed seated at a table in the multi-purpose room. Two (2) residents were seated at the table with the employee and approximately ten (10) additional residents occupied the room. The employee was overtly coughing, sneezing and blowing his/her nose. He/she used a tissue and/or paper towel to wipe his/her brow. He/she stated to another staff member in the room, " I don't feel good, look how I'm sweating, I must have a fever." In response to this surveyor's query regarding the entry door being propped open with a chair, he/she responded: "Forgive me, I don't feel so good. I have a really bad	L 091	**Plan of Correction** The involved employee was removed from the work area, assessed, and counseled by Occupational Health. The assessment revealed that the employee did not have a communicable or transmission-based disease. The importance of implementing infection control practices was emphasized to the employee. **Prevention of Future Occurrences** Each employee was informed about his or her responsibility to proactively obtain medical care to determine whether or not he or she has a communicable disease or illness, when clinical signs and symptoms suggest that a communicable disease or illness may exist. .	

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L 091	Continued From page 62 cold." The employee began to apply aprons to residents seated at tables awaiting their lunch meals. This surveyor brought the observations to the attention of the facility administration. The employee was removed from his/her duties and referred to occupational health. A "Certification of Medical Care" revealed: "Date: January 9, 2012...may return to work approximately January 11, 2012." In a face-to-face interview with Employee #42; the facility's Infection Control Coordinator on January 19, 2012 at approximately 1:00 PM; the aforementioned observations were conveyed and asked if the facility had a tracking system for employees' illness. He /she stated that he/she "does not track employees" illness; that is Occupational Health's responsibility." The infection control program lacked evidence that the facility established and maintained an infection control program to ensure that employees are being tracked for illness and ensure that staff providing direct care were free from communicable disease. A face-to-face interview was conducted with Employee #2 on January 20, 2012 at approximately 3:30 PM. He/she acknowledged that the facility does not have a tracking/trending system to monitor employees' illness.	L 091	Each employee was also informed of the importance of complying in order to prevent transmission of communicable diseases to the resident population, as well as to the employee workforce. Staff was also reminded to deploy effective infection control techniques (e.g. hand washing, protective coughing) at all times to prevent spread of infection. Supervisory staff was directed to monitor the resident care environment to ensure signs and symptoms of communicable disease or illness were not observed in the environment. Occupational Health and Infection Control staff collaborated to develop and implement a process to track the health statuses of clinical care providers. Process elements to be tracked will include the following: ▪ Identified reasons for employee absences ▪ Identified absences related to potentially communicable illnesses ▪ Identified illnesses to be reported to supervisory/management staff during call-in procedures ▪ Employee clearance from Occupational Health prior to returning to work ▪ Tracking and reporting of employee illnesses by Infection Control staff **Performance Monitoring** Performance will be incorporated into the Infection Control and Performance Improvement programs and compliance will be monitored and reported accordingly.	
L 124	3223.4 Nursing Facilities Each therapist's treatment plan and progress notes for each resident shall be signed, dated,	L 124	**Responsible Individual(s)** The Administrator and/or DON will ensure compliance.	3/15/12

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L 124	Continued From page 63 and placed in the resident's medical record, and shall provide sufficient information so that the resident's activity can be maintained and supported by nursing employees. This Statute is not met as evidenced by: Based on record review for one (1) of 40 sampled residents, it was determined that the facility failed to ensure that each therapist's treatment plan and progress notes for each resident was signed, dated, and inclusive of sufficient information in the medical record so that the resident's activity can be maintained and supported by nursing employees as evidenced by a failure to document the treatment and care provided by respiratory services for one (1) resident. Resident #39. The findings include: The respiratory therapist failed to document treatment and care provided by respiratory services for Resident #39. On January 13, 2012 at approximately 10:00 AM, a review of the resident's medical record revealed that he/she has a diagnosis of Respiratory Failure and a care plan for Tracheostomy related to impair breathing mechanics was initiated on May 31, 2011. A review of the respiratory care treatment form ("Respiratory Care adult patient evaluation/care plan.") used to document the resident's daily respiratory treatments and care by the respiratory therapist was conducted on January 13, 2012 at 10:00 AM. The last documented treatment and care was dated January 10, 2012 at 8:41 AM. A face-to-face interview was conducted on January 13, 2012 at approximately 10:15 AM	L 124	**Plan of Correction** The facility now ensures Respiratory Therapy Staff document treatment and care provided. A review of the surveyor's findings was discussed with involved Respiratory Therapy staff and the involved staff was informed of the requirement to document daily respiratory assessments, therapy treatments, and care. The Care Treatment Form was used to facilitate the educational reinforcement. **Prevention of Future Occurrences** To prevent future occurrences, a proactive process was developed by Nursing and Respiratory Therapy to ensure timely respiratory therapy treatment and documentation. A Respiratory Care Evaluation Form will be incorporated into the 24-hour nightly chart audit process. Any identified deficiencies will be addressed.	

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L 124	Continued From page 64 with Employee #19. He/she was unable to provide appropriate documentation of the resident's respiratory care; but offered to provide someone from the respiratory team who administered the resident's treatments. A further face-to-face interview was conducted on January 13, 2012 at approximately 2:00 PM with Employee #23. He/she stated that the assessment was completed but was not placed on the resident's chart, at that time he/she presented the resident's treatment sheet for January 12 and 13, 2012. Employee # 23 failed to present the resident's treatment sheet for January 11, 2012. The respiratory therapist failed to document treatment and care provided by respiratory services for Resident #39. The record was reviewed on January 13, 2012.	L 124	**Performance Monitoring** A minimum of 30 chart audits (or 100% if fewer than 30 residents receiving respiratory therapy are present) will be conducted to evaluate timely and complete respiratory care treatment and documentation until 3 consecutive months of improved performance is observed. Overall performance will be reported to the QA and PI Committees monthly. **Responsible Individual(s)** The Administrator and/or DON will ensure compliance.	3/15/12
L 138	3225.5 Nursing Facilities The attending physician shall record on the resident's medical record each condition for which the medication has been ordered. This Statute is not met as evidenced by: Based on record review and interview for two (2) of 40 sampled residents, it was determined that the attending physician failed to identify the indication for use for Phenytoin for one (1) resident and an indication for the use of CPAP Continuous Positive Airway Pressure) machine for one (1) resident. Residents #38 The findings include: 1. The physician failed to identify the indication	L 138		

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L 138	Continued From page 65 for use for Phenytoin for Residents #38 and 48. A Review of Resident 38#'s current January 2012 POS (Physician Order Sheet), and January 2012 MAR (Medication Administration Record) lacked evidence of the indication for use for the medication Phenytoin. Review of the original POS dated November 4, 2011 directed: Phenytoin Ext Cap 100mg: Take 2 capsules (200mg) by mouth twice daily. The order lacked evidence of the indication for use of the medication. A face-to-face interview was conducted with Employee #26 on January 13, 2012 at approximately 12:30 PM. After review of the Interim orders, POS and MAR he/she acknowledged the finding. The physician failed to identify the indication for use of Phenytoin. The record was reviewed on January 13, 2012. 2. 13. The physician failed to review Resident #119's total plan of care as evidenced by failure to include a diagnosis/indication for the use of a CPAP (Continuous Positive Airway Pressure) machine at hour of sleep and naptime. The history and physical examination dated September 22, 2012 revealed Resident #119's diagnoses included [CVA-Cerebrovascular Accident; HIV- Human Immunodeficiency Virus; DM-Diabetes Mellitus; HTN-Hypertension; Bipolar Disorder; Migraine and Dyslipidemia]. According to the Admission Order Sheet and Physician Plan of Care dated September 22,	L 138	**1- 2 Plan of Correction** The facility now ensures indications for medication use and parameters for multiple pain medications administered are documented. Physician documentation for use of Phenytoin was obtained and parameters for use of multiple pain medications were set and documented by the physician. Involved physicians and clinical staff were informed of the requirement to ensure documentation indicating use of medications and specifying parameters for use of multiple pain medications. **Prevention of Future Occurrences** Each resident was assessed to determine whether or not the aforementioned deficient clinical practices were observed. Any identified deficiencies were corrected. Clinical staff will be provided educational reinforcement on documentation requirements regarding indication for use of medications and parameters for use of multiple pain medications. The pain medication policy and medication-related documentation forms will be used to facilitate staff education. **Performance Monitoring** A minimum of 30 chart audits will be conducted to evaluate whether or not clinical care is provided in accordance with each residents comprehensive assessment, plan of care, and physician orders. The audits will be conducted until 3 consecutive months of sustained performance is observed. Overall performance will be reported to the QA and PI Committees monthly.	

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L 138	Continued From page 66 2011, directed: Apply CPAP on 3.5 setting [every hour of sleep and naptime]. According to a nurse's note dated September 21, 2011 at 10:00 PM revealed: "CPAP on at 3.5 setting. No respiratory distress noted." A further review of the resident's clinical record revealed a Nurse Practitioner note dated January 10, 2012 at [3:45 PM] that directed: "[Past Medical History]: History of HIV, HTN, DM, and Obesity- On C-PAP..." A review of interdisciplinary progress notes dated December 29, 2011 at 2:00 PM revealed: "CPAP machine used nightly for sleep apnea. Resident re-educated on the importance of using the CPAP machine at night." The physician failed to review Resident #119's total plan of care as evidenced by failure to include a diagnosis for the use of a CPAP (Continuous Positive Airway Pressure) machine at hour of sleep and naptime. A face-to-face interview was conducted with Employees #3 and #9 on January 19, 2012 at approximately 11:00 AM. Both stated that the resident had sleep apnea and uses a CPAP machine at hour of sleep. Both employees acknowledged the aforementioned findings. The record was reviewed January 19, 2012.	L 138	**Responsible Individual(s)** The Administrator and/or DON will ensure compliance.	3/15/12

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L 179	Continued From page 67	L 179		
L 179	3229.1 Nursing Facilities The facility shall provide social services to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This Statute is not met as evidenced by: Based on observations, record review, staff and resident interviews for five (5) of 40 sampled residents , it was determined that the facility failed to provide social services to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Residents 23, 67, 68, 103 and 114. The findings include: 1. The social worker failed to complete and document an initial social service assessment for Resident #23. A review of the resident 's admission record revealed that he/she was admitted to the facility from an area hospital. In a face-to-face interview with the resident on January 10, 2012 at approximately 1:15 PM the resident stated that he/she resided in a shelter prior to being hospitalized (before his/her admission to this facility.) A face-to-face interview was conducted with Employee # 10 at approximately 4:00 PM on January 18, 2012. The employee was queried regarding the resident ' s admission information and plans for his/her discharge. He/she responded, " I don't know him/her. I ' ve only been here a few months. I am trying to work on all of the records but I have not gotten to that one. " The social worker failed to complete and document an initial social service assessment for Resident #23. The record was reviewed on	L 179	**1-5 Plan of Correction** All resident social service needs identified during the survey were addressed. **Prevention of Future Occurrences** All other resident records were checked to determine presence of a social service needs. Those requiring social services have been identified and will be addressed accordingly. A Social Worker was hired to provide additional social services. The current and new social worker will ensure the following: ▪ Completing social services assessments and notes; ▪ Assisting residents with obtaining social security insurance; ▪ Following up on alleged maltreatment and physical abuse complaints; ▪ Providing medical related psychosocial needs; ▪ Addressing resident discharge social services needs; and ▪ Documenting the aforementioned	

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L 179	Continued From page 68 January 18, 2012. 2. The social worker failed to ensure that social services were provided for Resident #67 to attain or maintain the highest practicable physical, mental, and psychosocial well-being as evidenced by failure to follow up with assisting the resident in obtaining eligibility for Supplemental Security Income (SSI). On January 17, 2011 at 12:00 PM Resident #67 stated, "I want and need money to go places to get help to get out of here [the facility] as evidence by failure to A review of the Social Services notes revealed that the last entry was made June 6, 2011. A face-to-face interview was conducted on January 18, 2012 at approximately 3:33 PM with Employees #1, #8, and #10. Employee #8 stated, " Resident #67 is Medicaid and he/she has no personal account with the facility. We get payment from District of Columbia Medicaid. "Employee #10 stated, "He/she had a discharge number from the federal system. Resident #67 was receiving SSI because he/she was disable prior to going in to the federal system. According to the "DHS-1445" [he/she] does not have any income. [Resident #67] and I spoke with someone from Social Security Administration. They told us that he/she is eligible to receive a $70.00 month, but we have to call back and give them the discharge number." At the time of this interview there was no documentation as to the date and time that this conversation with the Social Security Administration took place and there is no evidence that the facility has followed up with assisting the resident in obtaining eligibility for SSI.	L 179	**Performance Monitoring** The Social Worker or designee will conduct sample random weekly chart audits to determine compliance. Chart audits will be performed until 3 consecutive months of improved performance at 90% or above is observed. Overall performance will be reported to the QA and PI Committees monthly. **Responsible Individual(s)** The Administrator and DON will ensure compliance.	3/15/12

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L 179	Continued From page 69 The social worker failed to ensure that social services were provided for Resident #67 to attain or maintain the highest practicable physical, mental, and psychosocial well-being as evidenced by failure to follow up with assisting the resident in obtaining eligibility for SSI. Employees #8 and # 10 acknowledged the aforementioned findings on January 18, 2012 at approximately 3:45 PM. The record was reviewed on January 18, 2012. 3.The social worker failed to ensure that Resident #68 was provided social services interventions as evidenced by failure to follow-up on an alleged maltreatment and physical abuse complaint. According to an annual history and physical examination signed and dated February 26, 2011 included diagnoses: "Cerebrovascular Accident-Right Hand Weakness, Hypertension, Hyperlipidemia and Depression." A "Psychiatric Examination" consultation form dated September 26, 2011 revealed: "Chief Complaint [and] Identification of all Problems: Maltreatment and Physical Abuse. General Appearance: Fair, well groomed, crying; Orientation: Fully Oriented, Mood/Affect Reviewed: Sad/Depressed, Psychotic Thoughts Reviewed: Delusional ("They want to take my privacy") Plan: "Patient need more personal care (braiding of hair, nail cutting, clean clothes), more socialization. No medication recommended for now." A review of the clinical record lacked evidence that social services interventions were provided for follow up on the above cited complaint.	L 179		

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L 179	Continued From page 70 A face-to-face was conducted with Employees #2 and #4 on January 17, 2012 at approximately 12:11 PM. When queried regarding the psychiatry's plan, Employee #4 stated; "We did not have a social worker at the time." Employee #2 and #4 acknowledged the aforementioned findings. The clinical record was reviewed on January 17, 2012. 4. The social worker failed to provide social services interventions to address Resident #103 medically-related psychosocial needs. A review of the clinical record for Resident #103 revealed the most recent documented social services assessment was dated May 23, 2011. According to the psychiatric assessment dated December 20, 2011, the resident expressed "anxiety about being here." The resident's diagnoses included Depression and his/her psychopharmacologic regimen was modified. An additional antidepressant, Prozac 20 mg daily was added to the current regimen of Lexapro 10 mg daily for depression. The record lacked evidence of interventions from social services to address the resident's medically-related psychosocial needs. The record was reviewed January 13, 2012. 5. The social worker failed to provide social services interventions to address Resident #114's desire to return to the community. Resident #114 was observed on January 18, 2012 at approximately 1:00 PM asking the licensed nurse if he/she can go home. Resident called his/her brother from the nurses' station telephone and asked his/her brother; "Come get	L 179		

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L 179	Continued From page 71 me, I want to go home." Resident #114 was initially admitted to the facility on August 2, 2011. The initial "History and Physical Examination" included diagnoses of: Cerebrovascular Accident, Hypertension, Chronic Renal Failure, Blind and Thrombocytopenia." According to an Admission MDS (Minimum Data Set) with a reference date of August 8, 2011, indicated in Section Q0500 (Return to Community); resident response was "yes" to the question "has the resident been asked about returning to the community?" Section V Care Area Assessment (CAA) Summary indicated that the care area "Return to Community Referral" triggered and would be addressed in the resident's care plan. A review of the care plan revealed: "Adjustment to nursing home placement- Interventions-Visits from different disciplines to introduce their programs and specialties, which included the social worker." A review of the clinical record, including the social worker section, revealed that no initial social work assessment was completed, nor was an ongoing quarterly social service assessments conducted since admission. The record lacked evidence that social services interventions were provided to address Resident #114 desire to return to the community. A face-to-face interview was conducted with Employee #4 on January 11, 2012 at approximately 12:00 Noon. He/she acknowledged that there were no social services notes on the resident's clinical record to address discharge planning to the community. He/she stated, "I don't think we had a social worker at this time." The record was reviewed on January 11, 2012.	L 179		

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L 187	Continued From page 72	L 187		
L 187	3230.3 Nursing Facilities A resident activities program shall include, but not be limited to, the following: (a)Active, passive, individual and group activities; and (b)Activities for residents who are unable to leave their rooms, which shall be directed toward maintaining and promoting the well-being of each resident. This Statute is not met as evidenced by: Based on observation, record review and staff interview for three (3) of 40 sampled residents, it was determined that the therapeutic activities staff failed to provide activities directed toward maintaining and promoting the well-being for residents who were unable to leave their rooms or who chose to stay in their room. Residents #2, 39, and 75. The findings include: 1. Therapeutic activities failed to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of Resident #2 as evidenced by the resident being observed lying in bed daily and not observed in any activities. The resident was observed lying in bed daily throughout the survey period on January 9, 10, 11, 12, 13, 17, 18, 19 and 20, 2012. Staff was observed proving personal care, wound care, turning and positioning and feeding the resident. At no time was the resident observed in any	L 187	**1 – 3 Plan of Correction** Each resident was not adversely affected by the deficient practice. The resident's 1:1 room activity program, specified in the care plan, was implemented and documented in the activity progress notes. **Prevention of Future Occurrences** Each bed bound resident was identified and his or her 1:1 room activity program was reviewed, updated where necessary, and implemented, in accordance with his or her care plan.	

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L 187	Continued From page 73 activity. A review of the resident's clinical record failed to reveal any information documenting that the resident had received any recreational activities since September 23, 2011. Further review of the record revealed an "Activities" progress note dated October 22, 2011 which stated "Q 3" (Quarter 3) "Progress Note for September 23, 2011." That was the last activities documentation noted on the record. A face-to-face interview was conducted with Employee #14 at approximately 3:00 PM on January 18, 2012. The employee was queried whether the resident participated in activities and to identify the activities. The employee responded, "We try to get [him/her] out of bed and once we do he/she socializes with the other residents in the day room." The activities staff usually provide 1:1 (one-to-one) visits in his/her room two to three times a week." Documentation of the resident's activities for January was requested but none was available. The employee continued, "I am out of compliance. I am behind in my documentation." Therapeutic activities staff failed to provide an ongoing program of activities to meet the resident's mental and psychosocial well being. The record was reviewed on January 18, 2012. 2. Therapeutic activities staff failed to provide continuous activity to meet the needs of Resident #39 who is bedfast. On January 12, 2012 at 10:00 AM a review of the medical records revealed a diagnoses of Respiratory Failure, Atrial Fibulation, and Intractable Seizure Disorder. On January 12, 2012 at approximately 10:00 AM a review of the quarterly " Recreational progress	L 187	All bedfast residents noted to have decreased awareness and lacking variety in activity were identified and had appropriate programming developed. Each Therapeutic Recreation Assistant will be re in-serviced on the following: ▪ Administering the 1:1 room activity program ▪ Implementing the care plan ▪ Documenting interventions on the daily activity record ▪ Filing the documents in the residents' medical record where indicated. **Performance Monitoring** Sample random weekly chart audits will be conducted to determine compliance. Chart audits will be performed until 3 consecutive months of improved performance at 90% or above is observed. Overall performance will be reported to the AQ and PI Committees monthly. **Responsible Individual(s)** The Administrator and DON will ensure compliance.	3/15/12

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L 187	Continued From page 74 note" for activity revealed a note dated October 22, 2011 that stated: " No significant changes, during the last review period (7/20/11), alert to self understood at times, most of the time he/she speaks, it is word salad, has loved ones and friend that visits 1-2 x a month, long and short term memory cannot be assessed. following plan of care for the next x 90 days will be provided 1-1 visits for comfort care 3-4 x a week, will escorted to the dayroom 1-2x a week to passively participate in structured activities and will be invited and encouraged to participate in 1 special event a month during the next reviewed period, will continue to monitor. " Observations of the resident for four (4) days are as follow: 1. January 9, 2012 resident was lying asleep in bed with the television on all day. 2. January 10, 2012 in morning resident was lying awake in bed and in the afternoon he/she was asleep in bed with the television playing. 3. January 11, 2012 resident was lying asleep in bed with the television on. 4. January 12 2012 resident was lying in bed with the television on, he/she was awake and was able to greet the surveyor "Hi" but unable to answer question about being visited by activity staff. A face-to-face interview was conducted with Employee #37 on January 12, 2012 at approximately 11:15AM. He/she stated that the resident gets up in Geri-chair and stays in his/her room and he/she is unaware of Activity 1:1 visits with the resident during January 9, 2012 to January 12, 2012. A face-to-face interview was conducted with	L 187		

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L 187	Continued From page 75 Employee #36 on January 12, 2012 at approximately 11:20 AM. He/she stated that resident gets up out of bed to sit in his/her Geri-chair in his/her room or dayroom. Employee #36 denied seeing the resident with 1:1 activity staff when up in Geri-chair in dayroom or his/her room. A face-to-face interview was conducted with Employee #4 on January 12, 2012 at 11:25 AM. He/she stated that activity staff was observed on the floor but he/she did not focus on which room he/she visited. Therapeutic activities staff failed to provide continuous activity to meet the needs of Resident #39 who is bedfast A further face-to-face interview was conducted on January 12, 2011 at 2:35 PM with Employee #14. He/she stated that it is his/her responsibility for providing 1:1 activities to bedfast residents, and monitors when residents are seen for activities by documenting visits on participation sheet or 1:1 book. He/she obtained and reviewed residents' participation/ monitor sheet but was unable to find any for Resident #39. Employee #14 state that he/she has the information documented in his/her personal 1:1 book. The record was reviewed on on January 12, 2012. 3. Therapeutic activities staff failed to provide continuous activity to meet the needs of Resident #75. A review of Resident #75's medical records January 13, 2012 at 10:00 AM revealed a diagnoses of Diabetes Mellitus type 2, Cerebral Vascular Accident, Hypertension, Vertigo, and Sellar Brain Mass.	L 187		

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L 187	Continued From page 76 A review of the quarterly " Recreational progress note " for activity on January 13, 2012 at 10:00 AM revealed a note dated June 22, 2011 that read, "Continues to receive comfort care; [he/she] is suffering with generalized weakness, was placed on hospice a couple of review periods back and has since been discharged, does not wear glasses or hearing aids, receives 1:1 room visits 2-3 x wk, During [his/her] 1:1 room visits [he/she] will be provided bible reading, memory trivia, and soft music is provided, has family support, sister visits 3-4 x wk, plan of care for the next 90 days is as follows: will continue to provide 1:1 room visits 4-5 x a wk, Recreation therapy will continue to monitor this resident. " Therapeutic activities staff failed to provide continuous activity to meet the needs of Resident #75. A face-to-face interview was conducted on January 13, 2012 with Employee #14. He/she stated that when residents are seen for activities they are monitored by documenting visits on the participation sheet or in my personal 1:1 book. Upon obtaining the residents' participation monitor sheet, he/she returned and stated he/she was unable to find any for Resident #75. He/she has the information documented in [his/her] personal 1:1 book that he/she stated was "personal." The record was last reviewed on January 13, 2012.	L 187		
L 235	3236.4 Nursing Facilities The temperature of hot water of each fixture that is used by each resident shall be automatically	L 235		

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L 235	Continued From page 77 controlled and shall not exceed one-hundred and ten degrees Fahrenheit (110 F) nor be less than ninety-five degrees Fahrenheit (95 F). This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that the engineering staff failed to ensure that the temperature of hot water used by residents shall not exceed one-hundred and ten degrees Fahrenheit (110 F) nor be less than ninety-five degrees Fahrenheit (95 F) as evidenced by cold water temperatures from the hot water faucet in one (1) of 16 resident's rooms. The findings include: Hot water temperature in resident room #655 could not exceed 81 degrees Fahrenheit (F) in one (1) of 16 resident rooms observed. These observations were made in the presence of Employee # 21 who confirmed the aforementioned findings.	L 235	**Plan of Correction** The Director of Facilities Management reviewed the finding cited in the Statement of Deficiency. The mixing valve (for hot and cold water) was changed. The water temperature now meets regulatory requirements. Water temperatures in all resident rooms were checked. Defective valves were replaced as needed. Building Services will monitor water temperatures and make necessary repairs on an ongoing basis. **Prevention of Future Occurrences** System changes for water temperatures will be evaluated during weekly walking safety rounds. Immediate action will be taken as required. **Performance Monitoring** The EOC Walking Rounds tool will be used to monitor. Compliance results will be reported to the QA and PI Committees. **Responsible Individual(s)** The Administrator and DON will ensure compliance.	3/15/12
L 292	3243.3 Nursing Facilities Each ramp, stairway,and corridor that is used by a resident shall be equipped with firmly secured handrails or banisters on each side. This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that maintenance staff failed to ensure that handrails used by residents were firmly secured as evidenced by broken handrails on one (1) of two (2) resident's floors and loose handrails on one (1) of two (2) resident's floors. The findings include:	L 292		

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L 292	Continued From page 78 1. The end pieces to the handrails located on the sixth floor across from room #625 were missing. 2. Handrails located across from room #759 A and at the entrance of dining room #749 were loose and needed to be tightened. These observations were made in the presence of Employee # 21 who confirmed the aforementioned findings.	L 292	**Plan of Correction** The Director of Facilities Management reviewed the finding cited in the Statement of Deficiency. The mixing valve (for hot and cold water) was changed. The water temperature now meets regulatory requirements. Water temperatures in all resident rooms were checked. Defective valves were replaced as needed. Building Services will monitor water temperatures and make necessary repairs on an ongoing basis. **Prevention of Future Occurrences** System changes for water temperatures will be evaluated during weekly walking safety rounds. Immediate action will be taken as required. **Performance Monitoring** The EOC Walking Rounds tool will be used to monitor. Compliance results will be reported to the QA and PI Committees. **Responsible Individual(s)** The Administrator and DON will ensure compliance.	3/15/12
L 415	3256.6 Nursing Facilities Each combustible, such as cleaning rags and compounds, shall be kept in a closed container when not in use. This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that maintenance staff failed to ensure that each combustible item, such as cleaning rags and compounds, shall be kept in a closed container when not in use as evidenced by unsecured chemical storage areas on two(2) of two (2) resident's floors. The findings include: The cleaning chemicals storage area located in the soiled utility room on the sixth and seventh floor is not secured and is easily accessible to the residents. These observations were made in the presence of Employee # 21 who confirmed the aforementioned findings.	L 415	**Plan of Correction** The chemical storage areas were inspected and are now secured using both, a key pad entry system and metal lock & key device. The areas are not accessible to residents and pose no direct potential hazard for residents. The need to maintain a safe and hazard free environment was emphasized to staff.	
L 421	3256.12 Nursing Facilities	L 421		

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L 421	Continued From page 79 Each building, each piece of equipment, and the grounds shall be regularly maintained and attended. This Statute is not met as evidenced by: Based on observations and interview, it was determined that the maintenance department failed to ensure that resident care equipment was regularly maintained and attended as evidenced by one (1) of one (1) wheelchair scale that consistently failed to function correctly and one (1) of one (1) suction machine that was not maintained annually. The findings include: 1. The patient scale located on the sixth floor provided incorrect, fluctuating weights and was off by as many as 15 pounds depending on the position of the subject. 2. According to the Preventive Maintenance (PM) sticker on the suction pump located on the sixth floor next to the scale, PM was last completed on August 8, 2008. The pump was not maintained on an annual basis to ensure the functionality as required. These observations were made in the presence of Employee # 23 who acknowledged the aforementioned findings.	L 421	**Prevention of Future Occurrences** An environmental assessment was undertaken to identify actual or potential hazards and the risk was removed. Staff were re-educated to increase their awareness for actual potential hazards during each shift and their continued responsibility to report and/or remove the hazard. **Performance Monitoring** Environmental Hazard assessment will be included as part of the environmental rounds checklist and assessments done at scheduled times. Any identified hazard will be addressed immediately with the appropriate personnel. **Responsible Individual(s)** The Administrator and DON will ensure compliance. **Plan of Correction** The resident scale was immediately calibrated and preventive maintenance was performed on the suction machine after the issue was identified by the surveyor. **Prevention of Future Occurrence** The scale and suction machine were added to the Preventive Maintenance Program. Preventive maintenance will be routinely performed as scheduled. **Performance Monitoring** Prompts within the Preventive Maintenance Program will be used to alert staff of upcoming maintenance. Compliance will be monitored by Biomedical Engineering and action will be taken when indicated. **Responsible Individual(s)** The Administrator or DON will ensure compliance.	4/19/12 Ongoing