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

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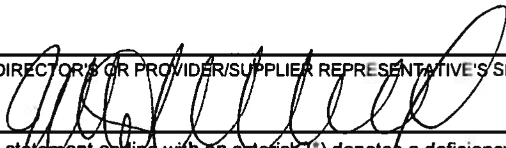
F 000	INITIAL COMMENTS Two incident investigations for C-15-2014/DC-2925 9 and C- 15-015/DC-2926 was initiated on November 17, 2014. The following deficiencies were based on staff interviews, observations and record review. The sample size was four (4) residents.	F 000	Please begin typing here:	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE Administrator

(X6) DATE 1/13/15

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

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of four (4) sampled residents, it was determined that facility staff failed to notify the physician that Resident #MS1 refused scheduled blood glucose assessments. Resident# MS1 The findings include: A Quarterly Minimum Data Set (MDS) dated August 28, 2014 revealed under Section I that Resident #MS1 ' s diagnoses included Anemia, Hypertension, Gastroesophageal Reflux Disease, Urinary Tract Infection, Hyperlipidemia, Diabetes Mellitus, Cerebrovascular Accident, Transient Ischemia Attack, and Non-Alzheimer ' s Dementia. Physician ' s orders dated October 1, 2014 included the following: " Novolog [insulin] Injection 100u/ml [unit/milliliters], monitor blood glucose via [by] fingerstick before meals and at bedtime with sliding scale coverage, Administer sub Q [subcutaneous] as follows: 150 -200 = 2units, 201-250= 4units, 251 -300 =6units, 301 - 350= 8units, 351 - 400 = 10units for blood sugar less than 60 or greater than 400, call MD for Diabetes Mellitus. " A review of the medication administration record [MAR] for November, 2014 revealed the nurse documented that Resident#MS1 refused his/her finger stick [blood glucose assessment] on November 9, 2014 at 5:00PM and 9:00PM.	F 157	1. Resident #MS1 was transferred to the hospital. 2. Each resident's Medication Administration Record (MAR) was reviewed to identify blood glucose monitoring orders. A review of each diabetic patient's blood glucose monitoring history was done to identify blood glucose refusals with physician notifications. Any identified deficiencies were corrected. All licensed staff will be retrained to notify the physician and document the refusal in the medical record (on the MAR and Plan of Care) when a resident refuses medical treatment including blood glucose monitoring. Residents refusing such treatments will also be reported to the nurse manager. 3. Weekly MAR audits will be conducted to assess performance. Negative findings will be reported to the DON for follow-up action. Refusal of blood glucose monitoring will be added as a quality indicator for review during daily stand-up meetings and during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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F 157	Continued From page 2 On November 12, 2014 the nurse documented the resident# MS1 refused the 5:00PM fingerstick blood glucose assessment. The clinical record lacked documented evidence that the physician was notified that Resident# MS1 refused his/her blood glucose assessments. A face- to- face interview was conducted on November 18, 2014 at approximately 10:45 AM with the Employee#3. He/she acknowledged the findings. The clinical record was reviewed on November 18, 2014.	F 157	1. Resident #MS1 was transferred to the hospital. 2. An analysis of incident reports filed over the last 60 days was done to identify whether or not CPR was performed in accordance with acceptable standards of practice. The incident report analysis revealed no deficient practice. An audit of involved staff was conducted to confirm evidence of current CPR training and certification of involved clinical staff. Each clinical staff involved in the code blue episode had evidence of current CPR training and certification in their employee file.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 4 sampled residents, it was determined that facility staff failed to implement life sustaining interventions consistent with acceptable standards of practice as evidenced by moving the resident from the bed to the floor to perform Cardiopulmonary Resuscitation [CPR]; positioning a back-board beneath the resident while on the floor and allegedly continuing CPR during a mechanical lift transfer from the floor to stretcher. Resident #MS1 The findings include: Facility staff failed to implement life sustaining	F 281	A CPR Refresher In-service Module was developed and used to provide educational reinforcement. The following topics were emphasized: ▪ Proper patient positioning during CPR ▪ Patient transport during a code blue ▪ episode ▪ Use of a cardiac board during CPR ▪ Activation of the air mattress emergency release function ▪ Availability of emergency equipment ▪ Daily functionality checks of emergency equipment ▪ Completion of the Code Blue Tracking Log Mock code blue drills will be held for 6 months (then as necessary) to improve staff response and reinforce with life sustaining interventions consistent with acceptable standards of practice.	

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F 281	Continued From page 3 interventions consistent with acceptable standards of practice when Resident #M1 was assessed as " unresponsive. " According to the "Lippincott's Nursing Procedures Fifth Edition " "Code Management Page 467..." the goals of any code are to restore the patient's spontaneous heart beat and respirations..." "Cardiopulmonary Resuscitation Page 474" Cardiopulmonary Resuscitation (CPR) seeks to restore and maintain the patient's respiration and circulation after his heartbeat and breathing have stopped. Basic life support (BLS) procedures should be performed according to the 2010 American Heart Association (AHA) guidelines. CPR is a BLS procedure that's performed on victims of cardiac arrest. Another BLS procedure is clearing the obstructed airway... Most adults who experience sudden cardiac arrest develop ventricular fibrillation and require defibrillation; CPR alone doesn't improve their chances of survival. Therefore, you must assess the victim and then contact emergency medical services (EMS) or call a code before starting CPR. Timing is critical because early access to EMS, early CPR, and early defibrillation greatly improve patient's chances of survival." On November 17, 2014 at approximately 9:30AM, a review of the clinical record for Resident MS1 revealed the following: A Quarterly Minimum Data Set (MDS) dated August 28, 2014 revealed the resident ' s diagnoses included Anemia, Hypertension, Gastroesophageal Reflux Disease, Urinary Tract	F 281	3. The facility crash cart is now checked daily on each shift by licensed staff to ensure availability of supplies and functionality of emergency equipment. Weekly verifications of the code carts will be done to ensure all medical equipment is available and operable. The code blue tracking log will be reviewed weekly for accuracy and completion. Negative findings will be reported to the DON for action. Emergency equipment monitoring and staff performance during a code will be added as quality indicators for review during daily stand-up meetings and addressed during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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F 281	Continued From page 4 Infection, Hyperlipidemia, Diabetes Mellitus, Cerebrovascular Accident, Transient Ischemia Attack, and Non-Alzheimer ' s Dementia. Under Section G - Functional Status, the record revealed the resident was totally dependent with Activities of Daily Living and Mobility. A review of the ' Emergency Equipment Log ' for the 6th floor revealed that the staff signed the log confirming that the Cardiac board [backboard], along with the rest of the ' External Supplies ' were in place on November 12, 2014. A nurse ' s note dated November 12, 2014, 11:00PM read: " ...the resident was not responding ...one of the nurses call for CPR board, it was just taking a little while, we suggested to bring the resident on the floor to enable us to continue with the CPR, one of the nurses brought lift [mechanical lift] so that we can transfer the resident to the ER in a stretcher, we continued with the CPR while she/he was being transferred to the ER [emergency room] ... " A nurse ' s note dated November 13, 2014, 3:00PM read, " ...I met the staffs performing CPR on the resident on the floor in [his/her] room. The staffs have put [him/her] on the floor to perform CPR because it was not easy to perform CPR on the air mattress ...The oral statement I got from the CNA [certified nurse assistant] and the nurse was that ...the resident was unresponsive ...The nurse with the other nurses helped to put the resident on the floor to perform CPR. I got there and the Hoyer [mechanical] lift was used to get the resident to the stretcher. [She/he] was transferred to the ER. " A face-to-face interview was conducted on	F 281		

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F 281	Continued From page 5 November 17, 2014 at 5:12PM with Employee #3 [licensed nurse assigned to resident on November 12, 2014]. He/she stated, "At about 8:40PM, I was at the nurses ' station; I heard the CNA [certified nurse ' assistant] yelling for help. I ran to the room and saw the resident face down on edge of the bed, with her leg dangling by the side of the bed. While the CNA was trying to pull her on her back, I tried to help her put the resident on her back, but she was unresponsive. I assessed her, there was no pulse, no respiration, I yelled for help from other nurses, including the supervisor while I was doing CPR. Then the nurses came right away and we continued with the CPR, put her on the stretcher and transferred her to the ER, while we were still doing CPR. The Resident RP [Responsible Party] was called and made aware. " A face-to-face interview was conducted on November 18, 2014 at 11:46AM with the Employee #2 [certified nurse assistant (CNA) assigned to the resident on November 12, 2014]. He/he stated that on that evening he/she was getting the resident cleaned up, he/she laid the bed flat and assisted the resident with turning to the left side towards the wall in the room. Facility staff then stated that he/she left the room for approximately three minutes, going to the nurses ' station to speak to the nurse. When he/she returned to the room he/she asked the resident to roll onto [his/her] back. He/she noticed that the resident was unresponsive. He/she began yelling for help. He/she stated that the nursing staff ran in and started CPR. When queried about the presence of a cardiac board during the emergency, he /she stated that he/she remembered seeing the CPR board because it was red.	F 281		

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A face-to-face interview was conducted with Employee #6 on November 17, 2014 at 5:59PM regarding the incident that occurred with Resident MS1 on November 12, 2014. He/she stated that he/she was sitting in the nursing office on the unit eating dinner, when he/she heard a noise. He/she went out to investigate and saw a crowd of people in and around the resident ' s room. Another resident informed [him/her] that a resident had fallen. He/she observed Resident MS1 on the floor and went to get the Hoyer lift. He/she also stated that there was no backboard present on the Emergency Cart. It was not until he/she returned to the unit that he/she was told that the resident did not fall, instead was lowered to the ground so CPR could be performed.

A face-to-face interview was conducted with Employee #1, on November 18, 2014 at 9:30AM, regarding emergency preparedness for the unit was held. He/she stated that when a code is called, everyone rushes into the room, someone grabs the emergency cart, someone calls the doctor, and the unit secretary starts making copies of the chart to transfer with the resident. He/she also stated that there should be only professionals in the room and around the scene. Someone should make sure that other residents are not involved. He/she continued by saying that RN on duty or the supervisor should complete a comprehensive assessment of the resident, and another nurse should be responsible for recording the emergency event.. When asked if the CPR button on the air mattress was activated [a function equipped on the air mattress used to quickly deflate the mattress in the event of an emergency], he/she stated that [him/herself] and the other nursing staff were unaware that the air

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mattress had an emergency CPR button that would immediately deflate the air. When asked if the cardiac board was present on the emergency cart, he/she stated that he/she was aware that there was no cardiac board on the emergency cart at the time of this incident but that he/she wasn ' t aware that the staff had signed the Emergency Equipment Log, verifying that all external supplies were present including the cardiac board.

A face-to-face interview was conducted on November 18, 2014 at 11:02 AM with Employee# 5. He/she stated " I was coming down elevator; people were running back and forth, saw all the staff and the supervisor crowding at room [number named]. I did a quick assessment and order them to put patient [resident] on the floor for CPR activation. I ran for the stretcher, call for Hoyer [mechanical] lift [staff name]. Supervisor to get backboard from crash cart, quickly hooked patient [resident] to Hoyer lift continued CPR [while placing onto Hoyer] transferred to stretcher and continued CPR while going to ER [emergency room]. Once in the ER, the ER nurse took over. " Queried concerning the presence of the backboard he/she stated " Patient was placed on backboard on the floor on Hoyer lift pad. Back board and Hoyer lift pad were on the stretcher. "

A face-to-face interview was conducted with Employee #7 on November 18, 2014 at 2:37 PM. He/she stated that [he/she] was at the nursing station when [he/she] heard someone calling for help. He/she and another staff member rushed into the room and saw the resident lying in the bed on her left side, unresponsive, with his/her] right leg dangling from the bed. He/she stated

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the nurses made the decision to transfer the resident to the floor for CPR. He/she also stated that the backboard was not on the emergency cart; so someone ran to the 7th floor to get one. The resident was then moved to the stretcher by the Hoyer lift and transferred to the Emergency Department by the evening shift supervisor and other staff.

Facility staff failed to implement life sustaining interventions consistent with acceptable standards of practice as evidenced by the following:

- the emergency cart was not equipped with a back board to provide a firm surface beneath the resident to ensure effective chest compressions for the performance of CPR while in bed
- Staff were unaware of the " CPR " function of the air mattress [for rapid deflation for emergency purposes]
- The resident was moved from the bed to the floor to initiate CPR
- A back board was positioned beneath the resident while on the floor, even though the floor surface was firm
- Facility staff verbalized that CPR continued as the resident was placed onto a mechanical lift and transferred from the floor to the stretcher for transport to the emergency department.

A face-to-face interview was conducted with the Director of Nursing on November 17, 2014, who stated that a full investigation would be conducted.

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F 281	Continued From page 9 Cross referenced to §483.25	F 281	1. Resident #MS1 was transferred to the hospital. 2. An analysis of incident reports filed over the last 60 days was done to identify whether or not CPR was performed in accordance with acceptable standards of practice. The incident report analysis revealed no deficient practice. An audit of involved staff was conducted to confirm evidence of current CPR training and certification of involved clinical staff. Each clinical staff involved in the code blue episode had evidence of current CPR training & certification in their employee file. A CPR Refresher In-service Module was developed and used to provide educational reinforcement. The following topics were emphasized: ▪ Proper patient positioning during CPR ▪ Patient transport during a code blue ▪ episode ▪ Use of a cardiac board during CPR ▪ Activation of the air mattress emergency release function ▪ Availability of emergency equipment ▪ Daily functionality checks of emergency ▪ equipment (functionality) ▪ Completion of the Code Blue Tracking Log Mock code blue drills will be held for 6 months (then as necessary) to improve staff response and reinforce with life sustaining interventions consistent with acceptable standards of practice. 3. Mock code blue critiques will be conducted to assess & monitor performance. Negative findings will be reported to the DON for follow-up action. Refusal of blood glucose monitoring will be added as a quality indicator for review during daily stand-up meetings and during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 4 sampled residents, it was determined that facility staff failed to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being as evidenced by failure to implement life sustaining interventions consistent with acceptable standards of practice as which consisted of moving the resident from the bed to the floor to perform Cardiopulmonary Resuscitation [CPR]; positioning a back board beneath the resident while on the floor and allegedly continuing CPR during a mechanical lift transfer from the floor to stretcher. Resident #MS1 The findings include: Facility staff failed to implement life sustaining interventions consistent with acceptable standards of practice when Resident #M1 was	F 309		

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assessed as " unresponsive. "
According to the "Lippincott's Nursing Procedures Fifth Edition "

"Code Management Page 467..." the goals of any code are to restore the patient's spontaneous heart beat and respirations..."

"Cardiopulmonary Resuscitation Page 474" Cardiopulmonary Resuscitation (CPR) seeks to restore and maintain the patient's respiration and circulation after his heartbeat and breathing have stopped. Basic life support (BLS) procedures should be performed according to the 2010 American Heart Association (AHA) guidelines. CPR is a BLS procedure that's performed on victims of cardiac arrest. Another BLS procedure is clearing the obstructed airway... Most adults who experience sudden cardiac arrest develop ventricular fibrillation and require defibrillation; CPR alone doesn't improve their chances of survival. Therefore, you must assess the victim and then contact emergency medical services (EMS) or call a code before starting CPR. Timing is critical because early access to EMS, early CPR, and early defibrillation greatly improve patient's chances of survival."

On November 17, 2014 at approximately 9:30AM, a review of the clinical record revealed the following:

A Quarterly Minimum Data Set (MDS) dated August 28, 2014 revealed the resident ' s diagnoses included Anemia, Hypertension, Gastroesophageal Reflux Disease, Urinary Tract Infection, Hyperlipidemia, Diabetes Mellitus, Cerebrovascular Accident, Transient Ischemia Attack, and Non-Alzheimer ' s Dementia. Under

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F 309	Continued From page 11 Section G - Functional Status, the record revealed the resident was totally dependent with Activities of Daily Living and Mobility. A review of the ' Emergency Equipment Log ' for the 6th floor revealed that the staff signed the log confirming that the Cardiac board [backboard], along with the rest of the ' External Supplies ' were in place on November 12, 2014. A nurse ' s note dated November 12, 2014, 11:00PM read: " ...the resident was not responding ...one of the nurses call for CPR board, it was just taking a little while, we suggested to bring the resident on the floor to enable us to continue with the CPR, one of the nurses brought lift [mechanical lift] so that we can transfer the resident to the ER in a stretcher, we continued with the CPR while she/he was being transferred to the ER [emergency room] ... " A nurse ' s note dated November 13, 2014, 3:00PM read, " ...I met the staffs performing CPR on the resident on the floor in [his/her] room. The staffs have put [him/her] on the floor to perform CPR because it was not easy to perform CPR on the air mattress ...The oral statement I got from the CNA [certified nurse assistant] and the nurse was that ...the resident was unresponsive ...The nurse with the other nurses helped to put the resident on the floor to perform CPR. I got there and the Hoyer [mechanical] lift was used to get the resident to the stretcher. [She/he] was transferred to the ER. " A face-to-face interview was conducted on November 17, 2014 at 5:12PM with Employee #3 [licensed nurse assigned to resident on November 12, 2014]. He/she stated, "At about	F 309		

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	095039	A. BUILDING ______ B. WING ______	C 11/24/2014

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F 309	Continued From page 12	F 309		

8:40PM, I was at the nurses ' station; I heard the CNA [certified nurse ' assistant] yelling for help. I ran to the room and saw the resident face down on edge of the bed, with her leg dangling by the side of the bed. While the CNA was trying to pull her on her back, I tried to help her put the resident on her back, but she was unresponsive. I assessed her, there was no pulse, no respiration, I yelled for help from other nurses, including the supervisor while I was doing CPR. Then the nurses came right away and we continued with the CPR, put her on the stretcher and transferred her to the ER, while we were still doing CPR. The Resident RP [Responsible Party] was called and made aware. "

A face-to-face interview was conducted on November 18, 2014 at 11:46AM with the Employee #2 [certified nurse assistant (CNA) assigned to the resident on November 12, 2014]. He/he stated that on that evening he/she was getting the resident cleaned up, he/she laid the bed flat and assisted the resident with turning to the left side towards the wall in the room. Facility staff then stated that he/she left the room for approximately three minutes, going to the nurses ' station to speak to the nurse. When he/she returned to the room he/she asked the resident to roll onto [his/her] back. He/she noticed that the resident was unresponsive. He/she began yelling for help. He/she stated that the nursing staff ran in and started CPR. When queried about the presence of a cardiac board during the emergency, he /she stated that he/she remembered seeing the CPR board because it was red.

A face-to-face interview was conducted with Employee #6 on November 17, 2014 at 5:59PM

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F 309	Continued From page 13 regarding the incident that occurred with Resident MS1 on November 12, 2014. He/she stated that he/she was sitting in the nursing office on the unit eating dinner, when he/she heard a noise. He/she went out to investigate and saw a crowd of people in and around the resident ' s room. Another resident informed [him/her] that a resident had fallen. He/she observed Resident MS1 on the floor and went to get the Hoyer lift. He/she also stated that there was no backboard present on the Emergency Cart. It was not until he/she returned to the unit that he/she was told that the resident did not fall, instead was lowered to the ground so CPR could be performed. A face-to-face interview was conducted with Employee #1, on November 18, 2014 at 9:30AM, regarding emergency preparedness for the unit was held. He/she stated that when a code is called, everyone rushes into the room, someone grabs the emergency cart, someone calls the doctor, and the unit secretary starts making copies of the chart to transfer with the resident. He/she also stated that there should be only professionals in the room and around the scene. Someone should make sure that other residents are not involved. He/she continued by saying that RN on duty or the supervisor should complete a comprehensive assessment of the resident, and another nurse should be responsible for recording the emergency event.. When asked if the CPR button on the air mattress was activated [a function equipped on the air mattress used to quickly deflate the mattress in the event of an emergency], he/she stated that [him/herself] and the other nursing staff were unaware that the air mattress had an emergency CPR button that would immediately deflate the air. When asked if the cardiac board was present on the emergency	F 309		

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F 309	Continued From page 14 cart, he/she stated that he/she was aware that there was no cardiac board on the emergency cart at the time of this incident but that he/she wasn ' t aware that the staff had signed the Emergency Equipment Log, verifying that all external supplies were present including the cardiac board. A face-to-face interview was conducted on November 18, 2014 at 11:02 AM with Employee# 5. He/she stated " I was coming down elevator; people were running back and forth, saw all the staff and the supervisor crowding at room [number named]. I did a quick assessment and order them to put patient [resident] on the floor for CPR activation. I ran for the stretcher, call for Hoyer [mechanical] lift [staff name]. Supervisor to get backboard from crash cart, quickly hooked patient [resident] to Hoyer lift continued CPR [while placing onto Hoyer] transferred to stretcher and continued CPR while going to ER [emergency room]. Once in the ER, the ER nurse took over. " Queried concerning the presence of the backboard he/she stated " Patient was placed on backboard on the floor on Hoyer lift pad. Back board and Hoyer lift pad were on the stretcher. " A face-to-face interview was conducted with Employee #7 on November 18, 2014 at 2:37 PM. He/she stated that [he/she] was at the nursing station when [he/she] heard someone calling for help. He/she and another staff member rushed into the room and saw the resident lying in the bed on her left side, unresponsive, with his/her] right leg dangling from the bed. He/she stated the nurses made the decision to transfer the resident to the floor for CPR. He/she also stated that the backboard was not on the emergency	F 309		

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F 309	Continued From page 15 cart; so someone ran to the 7th floor to get one. The resident was then moved to the stretcher by the Hoyer lift and transferred to the Emergency Department by the evening shift supervisor and other staff. Facility staff failed to implement life sustaining interventions consistent with acceptable standards of practice as evidenced by the following: · the emergency cart was not equipped with a back board to provide a firm surface beneath the resident to ensure effective chest compressions for the performance of CPR while in bed · Staff were unaware of the " CPR " function of the air mattress [for rapid deflation for emergency purposes] · The resident was moved from the bed to the floor to initiate CPR secondary to the lack of a back-board on the emergency cart · A back-board [once obtained] was positioned beneath the resident while on the floor, even though the floor surface was firm · Facility staff verbalized that CPR continued as the resident was placed onto a mechanical lift and transferred from the floor to the stretcher for transport to the emergency department. A face-to-face interview was conducted with the Director of Nursing on November 17, 2014, who stated that a full investigation would be conducted.	F 309		
F 456	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE	F 456		

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

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F 456 SS=D	Continued From page 16 OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of four (4) sampled residents, it was determined that the facility staff failed to ensure an air mattress was in safe operating condition. Resident #MS1 The findings include: 1. Facility staff failed to ensure that Resident #MS1 ' s air mattress was in safe operating condition. On November 17, 2014 at approximately 1:00PM, an observation of the room where Resident #MS1 resided was conducted. An air mattress was observed positioned atop the bed and attached to a mechanical pump. When pressure was applied to the inflated mattress, the hose connecting the mattress to the pump detached, causing the mattress to deflate. The end of the hose that was attached to the mattress had a residue of gray markings that felt sticky. A face -to- face interview was conducted on November 18, 2014 at approximately 11:46AM with Employee# 2 [who was assigned to the resident prior to his/her transfer from the unit]. He/she explained, " The bed came down [lost air] because the pump [air mattress pump] was not secure. Duct tape was wrapped around the	F 456	1. The broken air mattress pump was replaced with an operable one. 2. Each resident air mattress and accompanying hose were checked for intactness, operability and safety. Any identified deficiencies were corrected. Clinical staff will be trained on the following: ▪ Immediately removing broken equipment from the clinical area ▪ Tagging broken equipment (e.g. "Broken-Do Not Use"). ▪ Immediately reporting broken or malfunctioning air mattresses and hoses ▪ Not attempting to repair broken equipment (applying tape, etc.) ▪ Entering a work order into the electronic system for equipment repair or replacement 3. Weekly monitoring of air mattresses and hoses will be incorporated into weekly environmental rounds. Negative findings will be reported to the DON for follow-up action. Broken equipment (including air mattresses) monitoring will be added as a quality indicator for review during daily stand-up meetings and during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	 1/14/15

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F 456	Continued From page 17 hose to keep it secure but it popped off before I walked out to the nursing station. I put it back on while [the resident] was in bed. " Facility staff failed to ensure that the air mattress used for Resident #MS1 was in safe operating condition. The clinical record was reviewed on November 18, 2014.	F 456		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of four (4) sampled residents, it was determined that facility staff failed to maintain complete and accurate clinical records for one (1) resident as evidenced by an incomplete ' Release of Responsibility for Resident Leave of Absence ' form. Resident# MS2 The findings include:	F 514	1. Resident # MS2 did not return to the facility. The Release of Responsibility for Residents on LOA Form ("LOA Form") was revised to enhance residents' understanding of the form and to ease of completion.	

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F 514	Continued From page 18 Facility staff failed to ensure the completion of a form designated to account for the location and expected time of return for Resident #MS2 who departed for a ' Leave of absence. ' The facility ' s form entitled " Release of Responsibility for Resident Leave of Absence " was incomplete for Resident #MS2. A review of the " Release of Responsibility for Residential Leave Of Absence " completed by Resident #MS2 on November 7, 2014 lacked evidence of an applicable response under the section labeled " signature of person accepting responsibility. " " Outside " was recorded in the aforementioned section. The section of the form labeled " address/phone number of destination " remained blank. The form did not include a section to delineate duration of absence and/or expected time of return. On November 7, 2014 at approximately 8:00 PM, the state agency received an unusual incident notification that Resident #MS2 " signed out LOA [leave of absence] and did not return to the facility. " The facility notified the physician, responsible party and police regarding the resident ' s failure to return. Concurrent review of the facility ' s " Release of Responsibility for Residential Leave Of Absence " form revealed that the form was consistently blank in areas designated for completion by residents departing the facility for leave of absence. A face-to-face interview was conducted on November 18, 2014 at approximately 1:00PM	F 514	2. A count of each resident permitted LOA was conducted to validate his or her location and safety. Each resident capable of leaving the facility received information on completing the LOA Form entirely. Clinical staff received educational reinforcement on reviewing each resident's LOA Form and facilitating completion prior to the resident leaving the facility. A tracking log of each resident leaving the facility on LOA will be maintained. Reconciliation of the log will be done each shift (e.g. during change of shift report) to account for each resident leaving the facility. The notification and follow-up process will be executed when LOA patients do not return, in accordance with the facility policy. 3. Weekly monitoring of the process will be done for 3 months. Negative findings will be reported to the DON for follow-up. Completion of the Resident LOA Form will be added as a quality indicator for review during daily stand-up meetings and during Quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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F 514	Continued From page 19 with the Employee# 4. He/she acknowledged the aforementioned findings. The record was reviewed on November 18, 2014.	F 514		