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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095039 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | (X3) DATE SURVEY COMPLETED R 02/08/2017 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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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 | {F 000} | | |

A Quality Indicator Survey (QIS) revisit was conducted February 7 through 8, 2017 as a follow up to the annual recertification survey completed December 5, 2016. The following deficiencies are based on observations, record reviews, resident and staff interviews for 13 sampled residents.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations

ADL - Activity of Daily Living
AMS - Altered Mental Status
ARD - Assessment Reference Date
BID - Twice- a-day
B/P - Blood Pressure
BRP - Bath Room Privilege
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
Dl - Deciliter
DMH - Department of Mental Health
EMS - Emergency Medical Services (911)
EKG - 12 lead Electrocardiogram
G-tube Gastrostomy tube
HVAC - Heating ventilation/Air conditioning
ID - Intellectual Disability
IDT - Interdisciplinary Team
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda C Jeffrey
TITLE: Interim Administrator
(X6) DATE: 2/24/20

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

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| {F 000} | Continued From page 1<br>mcg/dl - micrograms per deciliter<br>MDS - Minimum Data Set<br>Mg - milligrams (metric system unit of mass)<br>mg/dl - milligrams per deciliter<br>mL - milliliters (metric system measure of volume)<br>mm/Hg- millimeters of mercury<br>Neuro - Neurological<br>NP - Nurse Practitioner<br>PASRR - Pre Admission Screen and Resident Review<br>Peg tube - Percutaneous Endoscopic Gastrostomy<br>POC - Plan Of Correction<br>POS - Physician ' s Order Sheet<br>PPE - Personal Protective Equipment<br>Prn - As needed<br>QIS - Quality Indicator Survey<br>TAR - Treatment Administration Record | {F 000} | | |
| {F 253} SS=D | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on February 7, 2017 at approximately 3:30 PM, it was determined that the facility failed to provide housekeeping services necessary to maintain an orderly interior as evidenced by two (2) of two (2) plastic tubes (used for delivery of oxygen) observed on the floor next to the resident's bed and not in use. | {F 253} | 1. The floor of room for Resident #63 was cleaned, stripped and waxed.<br><br>2. Resident room rounds were made on both units<br><br>3. Environmental Services will conduct daily rounds to ensure a sanitary, orderly and comfortable interior.<br><br>4. The Environmental Services Director will report the results of the monitoring outcomes and plans for improvement to an ad-hoc QA committee monthly for 3 months and then quarterly, to the Quality Assessment and Assurance committee. On-going<br><br>5. Completion date: 2/28/17 | |

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| {F 253} | Continued From page 2<br>The findings include:<br><br>During an observation of Resident # 63 on February 7, 2017 at approximately 3:30 PM the following was noted:<br><br>Two (2) of two (2) plastic tubes were observed on the floor next to the resident's bed and not in use. One (1) tube was dated January 30, 2017 and the other tube was not dated.<br><br>The observations were made in the presence of Employee # 4 and Employee # 8 who acknowledged the findings. | {F 253} | | |
| {F 309} SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interviews for one (1) of 13 sampled residents, it was determined that the facility staff failed to provide the necessary care and services to ensure that residents receive the highest practicable physical, mental, and/or psychosocial well-being, as evidenced by failure to assess the intensity of Resident #63's pain, who was receiving an analgesic medication [Tramadol] for pain. | {F 309} | 1. **Resident #63** was not harmed.<br><br>2. Residents receiving analgesic medications were identified. Medical records for identified residents were audited to ensure completion of pain assessments and documentation of location and intensity of pain.<br><br>3. Inservice training will be provided to Licensed Nursing staff on Assessment of Pain emphasizing documentation of location, intensity and pre/post assessment using numeric 0-10 numeric scale. Audits of pain assessments and documentation will be conducted by the Unit Manager/designee. | |

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| {F 309} | Continued From page 3<br><br>The findings include:<br><br>A review of the Physician ' s order signed and dated December 31, 2016 directed, Tramadol 50 mg - Administer 1 tablet per G-Tube (gastrostomy tube) every eight hours as needed for pain.<br><br>A review of the February 2017 Medication Administration Record revealed that Resident #63 received Tramadol 50 mg on February 1, 2017 at 5:00 AM and February 6, 2017 at 9:30 AM.<br><br>The back/reverse side of the February 2017 Medication Administration Record revealed the following:<br><br>February 1, 2017 at 5:00 AM, Medication: Tramadol 50 mg - Reason: c/o (complained of) pain - Result: effective [positive - effective]<br><br>February 6, 2017 at 9:30 AM, Medication: Tramadol 50 mg - Reason: c/o (complained of) pain - Result: effective [positive - effective]<br><br>A pain assessment should include the location of the patient's pain, to intensity of the pain is measured through the use of a numeric pain rating scale such as a 0 to 10 scale with 0= no pain to 10= the worst pain (Lippincott, Williams & Wilkins (2009). There was no evidence that facility staff conducted pain assessments for the resident that included the location and the intensity of the resident's pain (e.g. numeric scale | {F 309} | 4. Results of the audits and plans for improvement will be reported to an ad-hoc QA committee for 3 months and then quarterly to the QA/QA committee.<br><br>5. Date of Completion: 2/28/17 and on-going | |

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| {F 309} | Continued From page 4<br>- " 0 " no pain; 1-4 mild pain; 4-7 moderate pain; 8-10 severe pain.<br><br>A face-to-face interview was conducted on February 8, 2017 at approximately11:00 AM with Employee #4. He/she acknowledged the findings. The record was reviewed on February 8, 2017. | {F 309} | | |
| {F 323} SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations and staff and resident intervies made on February 7, 2017 at 10:00 AM and 1:30 PM, it was determined that the facility failed to maintain resident environment free of accident hazards as evidenced by: failure to repair cracked and broken floor tiles located in the shower stall in one (1) resident's room; and failed to ensure that a damaged handrail located on the residents' unit was intact and did not pose as a potential hazard to residents, staff and visitors.<br><br>The findings include: | {F 323} | | |

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| {F 323} | Continued From page 5<br><br>1. Facility staff failed to provide a shower floor that was free from accident hazard that posed as a potential hazard in resident room # 633.<br><br>During a tour of facility on February 7, 2017 at 10:00 AM the following was observed:<br><br>The shower stall flooring in room #633 had pointed tiles protruding upward, broken and cracked tiles surrounding the drain. Employee #5 was present at the time of the observation. He/she stated that [Resident #114] is alert and oriented and [he/she] showers [himself/herself] daily. We need to get that fixed."<br><br>A face-to-face interview was conducted on February 7, 2017 at 1:30 PM with Employee #9. He/she was shown the shower floor with the damaged tiles. At this time Employee #9 reached down and picked up a piece of pointed tile that was directed towards the ceiling. He/she stated, "Let me just get this off the floor, it could hurt someone. I will close the shower stall and have it repaired within 24 hours."<br><br>A face-to-face interview was conducted on February 8, 2017 at 10:20 AM with Residents' # 86 and #114 (occupants of room #633). Resident # 114 was queried regarding taking showers. He/she stated, "I take a shower every day. I have to watch where I step, the floor is broken." When asked how long the floor had been in disrepair. Residents' #114 and #86 responded, "A little while." | {F 323} | 1. The shower stall flooring in **room #633** was repaired<br><br>Handrails located next to physician's elevator and across from **room#630** were repaired/firmly secured to ensure they do not pose a potential hazard to residents, staff or visitors.<br><br>2. Flooring in the shower rooms of all other resident rooms were inspected to ensure all tiles were firmly affixed to the floor<br><br>3. To prevent future occurrences, the Zone maintenance program, assigning one maintenance technician responsibility for each unit. Environmental rounds will be conducted a minimum of 2x per week. Additionally environmental rounds are conducted weekly by a team headed by the Quality Department with Facilities management, Environmental services and the Unit Clinical Manager. All identified areas for improvement are reported to the responsible Department Manager and the Administrator for follow-up. | 2/9/17 |

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| {F 323} | Continued From page 6<br>2. Facility staff failed to ensure that handrails located on the 6th floor was intact and did not pose as a potential hazard to residents, staff and/or visitors.<br><br>The handrail located next to the physician's elevator and across from room #630 was cracked, perforated with jagged edges and posed an accident hazard to residents, staff and/or visitors.<br><br>A face-to-face interview was conducted on with Employee #9 on February 7, 2017 at 1:45 PM. He/she stated, "Everyone isn't careful with the carts around here; they keep bumping into the rails causing them to come loose. I will have to mention this to them again, and I need to get that hole fixed". Employee # 9 also acknowledged the finding. | {F 323} | 4. The Director of Facilities Management (Maintenance) will report the results of the monitoring outcomes and plans for improvement to an ad-hoc Quality Assurance/Quality Assessment monthly for 3 months and then quarterly to the Quality Assessment and Assurance committee.<br><br>5. Completion date: 2/28/17 and on-going | |
| F 328<br>SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff | F 328 | 1. **Resident#63** is consistently being assessed each shift by licensed nursing staff, for respiratory status with documented results (to include condition of the stoma, color, amount, consistency of mucus, frequency and reaction of resident to suctioning, rate and character of respiration and pertinent observations). A manual-resuscitator (Ambu bag) and suction catheters are assessable at bedside for immediate use, to provide manual ventilation or suction to maintain the resident's airway. | |

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| F 328 | Continued From page 7<br>interviews for one (1) of 13 sampled residents, it was determined that the facility staff failed to ensure that a resident received proper treatment and care for respiratory services as evidenced by: failure to consistently document respiratory assessments for Resident # 63 who requires tracheostomy care; to ensure that a manual resuscitator (Ambu bag) [a hand-held device used to provide positive pressure ventilation to patients with a compromised airway] and a suction catheter [used to suction secretion for the resident] was immediately available for use.<br><br>The findings include:<br><br>1. Facility staff failed to consistently document respiratory assessments for Resident # 63 who received tracheostomy care.<br><br>Policies:<br><br>Title: Tracheostomy Care, Procedure No. 83, Revised date: February 21, 2015.<br><br>"Purpose: To keep resident adequately ventilated by providing and maintaining a resident's airway. To decrease the possibility of infection at the tracheal sight and pulmonary system.<br><br>Responsibility: Registered Nurse, Licensed Practical Nurse<br><br>Procedure/Members Duties: 1.To be done at least one time on every shift and as necessary. 21. Chart: a. time; b. condition of the stoma; c. character of secretions; d. resident's reaction." | F 328 | 2. Respiratory assessments are consistently completed each shift for resident requiring tracheostomy care. Documentation of assessment will follow Tracheostomy Care, Procedure; documentation of time; condition of the stoma; character of secretions; and resident's reaction. A manual resuscitator (Ambu bag) and suction catheters are assessable at bedside to provide immediate manual ventilation or suction to maintain the resident's airway.<br><br>3. To prevent future occurrences, all licensed nurses and Respiratory therapy staff will be reeducated on consistent performance of respiratory assessments, documentation for residents who receive tracheostomy care and the Tracheostomy Care Procedure per policy guidelines. | |

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| F 328 | Continued From page 8<br><br>Title: Suctioning a Tracheostomy Tube, Procedure No. 84, Effective date December 1, 2015.<br>"Purpose: To maintain a resident's airway.<br>Responsibility: Registered Nurse, Licensed Practical Nurse<br>Procedure/Members Duties: ...25. Inner cannula should be removed every four hours or as often as necessary to keep airway patent. 27. Size of tracheostomy tube used and date trach tube is changed should be recorded on the Kardex. 28. After care:...c. Chart on the nurse's progress record: 1) color, amount, consistency of mucus; 2) frequency and reaction of resident to suctioning; 3) rate and character of respiration; 4) pertinent observations"<br><br>A review of the quarterly Minimum Data Set last completed January 2, 2017 revealed that Resident # 63 was coded as being totally dependent on staff to perform bed mobility, transfer, dressing, eating, toilet use, personal hygiene and bathing under section G (Functional Status). Under Section I (Active Diagnoses) the resident was coded as having diagnoses which included: hypertension, diabetes mellitus, cerebral vascular accident, hemiplegia, tracheostomy status, and gastrostomy status; and under Section O (Special treatments, Procedures and Programs) the resident was coded as receiving oxygen therapy, suctioning and tracheostomy care. | F 328 | 4. Monitoring of required documentation and necessary equipment at bedside has been added as a quality indicator for review at daily stand-up meetings. Results of the monitoring outcomes and plans for improvement will be reported monthly for 3 months to an ad-hoc Quality Assurance committee and then quarterly to the QAA committee by the DON.<br><br>5. Completion date: 2/28/17 and on-going | |

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| F 328 | Continued From page 9 | F 328 | | |

The physician's order last signed and dated December 31, 2017 directed, "Humidified O2 (oxygen) at 28% via trach collar mask; Trach care every shift; Suction trach every shift as needed".

A review of the February 2017 Treatment Administration Record revealed that tracheostomy care was performed on February 1 through 7 on the 11:00 PM-7:00 AM, 7:00 AM-3:00 PM, and 3:00 PM-11:00 PM shifts as indicated by staff signatures in the designated boxes.

There was no evidence that facility staff performed a complete respiratory assessment to include the condition of the stoma, character of secretions and resident's reaction post tracheostomy care.

A review of the Nursing Progress Notes revealed the following:

February 1, 2017 at 7:00 AM - " ...trach care provided ..."

February 2, 2017 at 3:00 PM- " ...trach care and suctioning done as needed with clear and odorless secretions ..."

February 3, 2017 at 7:00 AM- " ...trach care done. Suctioned no decannulation, O2 (oxygen) at 28% via connection to trach mask, inner cannula changed, trach collar change no signs and symptoms of infection noted ...lungs clear chest movement symmetrical."

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| F 328 | Continued From page 10<br><br>February 3, 2017 at 10:00 PM -" ...trach care done, secretion with O2 28% via connector to trach mask no decannulation ... lungs clear on [auscultation] ..."<br><br>February 4, 2017 at 11:45 PM -" ...trach intact and patent ...trach care provided ..."<br><br>February 5, 2017 at 7:00 AM- " ...trach care and suctioning done. No distress or discomfort noted. Clear and odorless sections noted from trach."<br><br>February 6, 2017 at 3:30 PM- " ...trach intact and patent. Suctioned [times two] as needed tolerated well ..."<br><br>February 6, 2017 at 11:00 PM-" ...trach care provided ..."<br><br>February 7, 2017 at 2:00 PM- " ...trach intact and patent, suctioned [times 1] this shift [with] minimal secretions noted..."<br><br>February 7, 2017 at 3:00 PM - " ...trach care done by respiratory therapy at this time, well tolerated."<br><br>There was no evidence that facility staff consistently performed a complete respiratory assessment each shift to include the color amount and consistency of mucous; the frequency and reaction of resident to suctioning; and rate and character of respiration post tracheostomy care.<br><br>A face-to-face interview was conducted with Employees #4 and #8 on February 8, 2017 at approximately 11:00 AM. They acknowledged the | F 328 | | |

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| F 328 | Continued From page 11<br>findings. The record was reviewed on February 8, 2017.<br><br>2) Facility staff failed to ensure that a manual resuscitator (Ambu bag) and a suction catheter was immediately available for use for Resident #63.<br><br>During an observation of Resident # 63 on February 7, 2017 at approximately 3:20 PM while staff were preparing to perform tracheostomy care the following was noted:<br><br>Employee #4 while preparing to provide trach care left the resident's bed side and exited the room at approximately 3:27 PM and returned at 3:31 PM with one (1) Ambu bag, one (1) bottle of sterile water and a 14 French suction catheter.<br><br>There was no evidence that facility staff maintained an Ambu bag and suction catheter readily accessible at the resident's bedside for immediate usage to provide manual ventilation or suction to maintain the resident's airway.<br><br>A face-to-face interview was conducted at the time of the observation with Employee #4. In regards to the absence the Ambu bag being at bedside. He/she stated, "I don't know where it is. It's normally at the bedside." | F 328 | | |
| F 468 SS=D | 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS<br><br>The facility must equip corridors with firmly | F 468 | | |

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| F 468 | Continued From page 12<br>secured handrails on each side.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made on February 7, 2017 at approximately 1:45 PM, it was determined that the facility failed to ensure that handrails located in the corridors were firmly secured to the wall as evidenced by the movement of the handrails when examined by the surveyor on the 6th floor.<br><br>The findings include:<br><br>On February 7, 2017 at approximately 10 AM the handrails located on the 6th floor outside resident rooms #617, #620, #630, #641 and #643 were observed. Upon examination the handrails were loose, moved upon touch and were not firmly affixed to the wall.<br><br>This observation was made in the presence of Employee # 9 who acknowledged the findings. | F 468 | 1. The handrails located outside **resident rooms #617, #620, #630, #641 and #643** were repaired.<br><br>2. All Handrails in corridors of 6th and 7th floors were inspected for cracks and broken pieces and were repaired/replaced to ensure that they do not pose a potential hazard to resident, staff and visitors<br><br>3. To prevent future occurrences, the Zone maintenance program, assigning one maintenance technician responsibility for each unit. Environmental rounds will be conducted a minimum of 2x per week. . Additionally environmental rounds are conducted weekly by a team headed by the Quality Department with Facilities management, Environmental services and the Unit Clinical Manager. All identified areas for improvement are reported to the responsible Department Manager and the Administrator for follow-up. | |
| {F 514} SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>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.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the | {F 514} | 4. The Director of Facilities Management will report the results of the monitoring outcomes and plans for improvement, if required, to the quarterly Quality Assessment and Assurance Committee.<br><br>Completion Date: 2/28/17 and | On-goin |

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| {F 514} | Continued From page 13<br>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on review the facility's documentation and staff interviews, for one (1) of 13 sampled residents, it was determined that the facility failed to ensure that medical records were complete and readily accessible. Resident #63.<br><br>The findings include:<br><br>A review of respiratory notes on February 8, 2017 at 11:37 AM revealed that all respiratory notes from February 1 - 7, 2017 were not readily accessible for review.<br><br>A face-to-face interview was conducted with Employee #8 at the time of this review. He/she was asked about the location of the missing respiratory notes. He/she stated, "The records are on the Med Tech computer system in the respiratory office downstairs. I need to go get them." In addition, he/she acknowledged the findings. The record was reviewed on February 8, 2017. | {F 514} | 1. **Resident #63** was not harmed.<br><br>2. The medical record of the resident with a tracheostomy was reviewed to ensure that documentation was complete and readily available.<br><br>3. To prevent future occurrence, In-service training will be provided for Licensed Nurses, Respiratory Therapists and Unit Clerks regarding the facility documentation policy for Respiratory Therapy and making it readily available.<br><br>4. Daily audits will be conducted by the Unit Clerks and forwarded to the Clinical Manager/Designee. The monitoring outcomes and any plans for improvement will be presented to an ad-hoc Quality Assurance Committee monthly for three months and then quarterly to the Quality Assurance and Assessment Committee by the DON.<br><br>5. Completion Date: 2/28/17 and on-going | |
| {F 520} SS=E | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS | {F 520} | | |

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| {F 520} | Continued From page 14<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on a review of the facility's documentation and staff interviews, it was determined that the facility failed to completely implement the corrective action plan as stated in the Plan of Correction submitted to the Department of Health with a compliance date of February 1, 2017 as evidenced by failure to ensure that all designated staff were in-serviced and their competencies verified to ensure deficient practice(s) were corrected and would not recur.<br><br>The findings include: | {F 520} | 1. Ensuring that verification of staff educational activities includes actual attendance record, date and time of training, Agenda, goals and objectives and evidence that staff were evaluated was discussed/reviewed with designated employee.<br><br>2. Inservices have been repeated for:<br><br>"Notification of Fall/Injury/Decline/Room Change"<br><br>"Neuro Check (Neuro Assessment...)"<br><br>"Safe Administration of Anti-hypertensive Medications"<br><br>"Wound and Foot Care"<br><br>""Treatment/Services to Prevent/Heal Pressure Ulcers" (included in Wound and Foot Care Inservice)<br><br>"Dental Services"<br><br>"Psychoactive Flow Sheet Documentation"<br><br>to ensure identification of date and time of training, agenda/goals and objectives and evidence that staff were evaluated for competency. | |

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| {F 520} | Continued From page 15<br><br>A review of the faciliy's plan of correction with a compliance date of February 1, 2017 revealed that topics for in-service education did not identify the following: the date and time of training, agenda, goals and objectives and evidence that staff were evaluated for competency.<br><br>CFR 483.10 (b)(11), Notify of Changes<br><br>F157- Review of the in-service Topic, "Notification of Fall/Injury/Decline/Room change" dated January 2017 revealed that the Signatures for RN (registered nurses) and LPNs (licensed practical nurse) were copied.<br><br>CFR 483.25 Provide Care/Services for Highest Well Being<br><br>F309- Review of the in-service Topic, "Neuro Check should be implemented with observed [unable to read]" dated January 2017 revealed that the Signatures for RN (registered nurses) and LPNs (licensed practical nurse) were copied.<br><br>Review of the in-service Topic, "When an Order Reads Hold for SBP< 110 or DBP [unable to read]; BP meds should be held either < 110f or < 60" dated January 2017 revealed that the Signatures for RN (registered nurses) and LPNs (licensed practical nurse) were copied.<br><br>Review of the in-service Topic, "Wound documentation/Rounds/Intervention" dated January 2017 revealed that the Signatures or RN (registered nurses) and LPNs (licensed practical nurse) were copied. | {F 520} | 3. To prevent future occurrences, the Clinical Nurse/Educator is being mentored by the Education Coordinator for hospital<br><br>4. Compliance monitoring will be conducted by the DON/designee. All Education Lesson plans will be reviewed to ensure compliance and accuracy.<br><br>Results of the compliance monitoring will be reported monthly to an ad-hoc Quality Assurance committee and to the quarterly Quality Assurance/Assessment committee by the DON.<br><br>5. Completion date: 2/28/17 | On-going |

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| {F 520} | Continued From page 16<br><br>CFR 483.25(a)(3) ADL Care Provided for Dependent Resident<br><br>F312 - There was no evidence that facility staff provided in-service and or training for staff as stipulated in the plan of correction.<br><br>CFR 483.25 Treatment/Services to prevent /heal pressure sores<br><br>F314 - There was no evidence that facility staff provided in-service and or training for staff as stipulated in the plan of correction.<br><br>CFR 483.55(b) Routine/Emergency Dental Services in NFS<br><br>F412 - Review of the in-service Topic, "All staff should follow up on recommendations from dentist and after outside resources" dated January 2017 revealed that the Signatures for RN (registered nurses) and LPNs (licensed practical nurse) were copied.<br><br>CFR 483.75 (l)(1) Resident Records-complete/accurate/accessible<br><br>F514 - Review of the in-service Topic, "Ensure accurate documentation especially after an episode occurs in the behavioral monitoring sheet" dated January 2017 revealed that the Signatures for RN (registered nurses) and LPNs (licensed practical nurse) were copied. | {F 520} | | |

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| {F 520} | Continued From page 17<br>A face-to-face interview was conducted with Employee # 6 on February 8, 2017 at approximately 2:30 PM. He/she acknowledged that the signatures were copied. | {F 520} | | |