STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	09/02/2014

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F 000	INITIAL COMMENTS The annual QIS survey was conducted on August 25 through September 2, 2014. The deficiencies are based on observations, record review and staff interviews for 39 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia D/C - discontinue DI - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning FU/FL Full Upper /Full Lower ID - Intellectual disability IDT - Interdisciplinary Team INR - International Normalised Ratio L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set	F 000	Stoddard Baptist Global Care Washington Center for Aging Services (SBGC), is filing this Plan of Correction in accordance with the Compliance requirements for Federal and State regulations. This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction does not constitute admission of facts or conclusions cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Denise Chadwick (Surveyor Licensed Nursing Home		10/31/14

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 Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MRR- Medication Regimen Review Neuro - Neurological NP - Nurse Practitioner OBRA - Omnibus Budget Reconciliation Act PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - Physician ' s Order Sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- responsible party RAI- Resident Assessment Instrument ROM- Range of Motion TAR - Treatment Administration Record CAA- Care Assessment Area QAA- Quality Assessment and Assurance	F 000	Continued from page 1	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the	F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES F 156 1. On 8/29/14 it was identified that the Admissions' Packet did not reflect a written description that the resident/responsible party were responsible for television, cable and telephone services, although this information was verbally communicated to residents/responsible parties. There were no negative outcomes to the residents/their responsible parties.	8/29/14

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F 156	Continued From page 2 resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of	F 156	Continued from page 2 2. The Admissions Contract was revised on 8/29/14 to indicate that the resident/responsible parties were responsible for the television, cable and telephone services. 3. The Admissions Department received an in-service on the required documentation in the Admission's Contracts to inform the resident/responsible party of services not covered by Medicare and Medicaid on 10/27/14. 4. Effective upon the completion of the survey on 9/2/14, a quality assurance program was implemented under the supervision of the Executive Clinical Director/Designated Representative to monitor the written communication of residents/responsible parties of services not covered by Medicare and Medicaid. Findings of the quality assurance checks will be documented and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.	8/29/14 10/27/14 10/31/14

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F 156	Continued From page 3 resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview during the facility's personal funds review, it was determined that facility staff failed to inform the	F 156	Continued from page 3	

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F 156	Continued From page 4 residents and/or responsible parties of items that were not covered by the facility and that they [residents/responsible parties] would be responsible for the cost of those services. The findings include: A personal funds review was conducted with Employee #30 on August 29, 2014 at approximately 1:00 PM. A query was made of how residents and/or the responsible parties were informed of the cost of the television, telephone, cable services and any change in those services. Employee #30 stated that information was found in the Admissions Packet, and any change in services were reviewed during Resident Council Meetings. A review of the Admission's Packet that is provided to residents on admission to the facility, lacked evidence that they were informed of the cost for television, telephone, and cable services. Facility staff failed to inform residents/responsible parties of items that were not covered by the facility and they would be responsible for the cost of those services.	F 156	Continued from page 4 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) F 157 1. It is the policy and practice of the facility to report changes in a resident's condition to the physician. There is no corrective action that can be done for deficiency observed with resident #262 during the timeframe identified due to resident being transferred to the hospital for medical evaluation on 4/20/14.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident;	F 157		

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F 157	Continued From page 5 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 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 interviews for one (1) of 39 sampled residents, it was determined that facility staff failed to notify the physician of Resident #262's complaint of a headache.	F 157	Continued from page 5 2. Because all residents experiencing changes are potentially affected by this cited deficiency on 8/29/14 all 24-Hour Nursing Reports and all residents Medication Administration Records (MARs) were reviewed for unresolved complaints of headache or other pain without written documentation notifying the physician. No other residents were affected. 3. An In-service was provided for licensed Nursing staff regarding Required Notification of Physician regarding resident medical complaints with focus on pain medication relief on 10/31/14. The assigned nurse to resident #262 was re-educated on physician notification and documentation of a resident's pain assessment. 4. Effective 9/19/14, a quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor the Notification of physicians regarding residents' medical complaints. Findings of the quality assurance checks will be documented and reported monthly to the Quality Improvement Committee for at least	8/29/14 10/31/14 9/19/14

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F 157	Continued From page 6 The findings include: According to the hospital "Discharge Summary" dated April 10, 2014 ... "[Resident #262] dose of Midodrine [Antihypotensive/ Vasopressor medication] should be decreased if [his/her] systolic blood pressure is routinely going above 150 or if [he/she] is symptomatic with headaches or chest pain. [He/she] will need continued monitoring and adjustment of these medications after discharge." A history and physical dated April 10, 2014 revealed that Resident #262 ' s diagnoses included: Worsening Tremors, Parkinson Disease and Orthostatic Hypotension. An interim physician 's order dated April 14, 2014 directed, " Please check B/P (Blood Pressure), Pulse every shift for Orthostatic Hypotension. " An electronic nursing note dated April 14, 2014 revealed the following: April 14, 2014 at 11:06 PM -" Temp (temperature) 98.2, 72(Pulse), 110/70 (Blood Pressure), Resident had c/o [complained of] headache and Tylenol PRN [as needed]medication was offered but resident refused to take. No other distress noted at this time." A review of the MAR/TAR (Medication Administration Record/Treatment Administration Record) revealed that Resident #262 was administered Tylenol 325mg - two (2) tabs [tablets] on April 14, 2014 (no time indicated) for, "Reason- c/o (complaint of) headache- pain	F 157	Continued from page 6 one year, prior to the committee determining to discontinue this monitor.	

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F 157	Continued From page 7 assessed as " 6/10 ", Result- effective " 2/10. " No blood pressure or pulse documented. The clinical record lacked evidence that the physician was notified regarding the resident ' s complaint of a headache. A face-to-face interview was conducted with Employee #2 on August 29, 2014 at approximately 3:46 PM. After reviewing the clinical record the employee acknowledged the aforementioned findings. The record was reviewed on August 29, 2014.	F 157	Continued from page 7 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY F 241 **A) Resident #29** 1. Resident #29 was assessed and condition was stable after an inappropriate comment was made to the resident #29 by staff on 8/29/14 in an effort to promote compassionate care and dignity for the resident.	8/29/14
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews for three (3) of 39 sampled residents, it was determined that facility staff failed to promote care for residents in a manner and in an environment that enhanced dignity as evidenced by the observation of an employee announcing in the common area (Solarium) among other residents/visitors; that one (1) resident was being toileted; failed to obtain permission prior to entering the room of one (1) resident and failed to respond to one (1) resident 's call bell/light in a timely manner. Residents #29, #152, and #165 The findings include:	F 241	2. All other residents were checked in the solariums on 8/29/14 to ensure that care was being provided in a manner to enhance resident's individual dignity and respect. No other residents were affected by this deficiency. 3. Nursing staff were provided in-service regarding Individualized Compassionate Care for Residents that promotes dignity and respect on 10/31/14. Employee #13 receive re-education regarding what is expected for providing care for Resident #29 and all other residents that reflects dignity and respect.	8/29/14 10/31/14

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F 241	Continued From page 8 1. Facility staff failed to promote dignity as evidenced by announcing out loud in the solarium that Resident #29 had to be toileted. During a resident observation conducted on August 29, 2014 at approximately 3:04 PM. Employee #43 announced out loud in the solarium to another staff member that Resident #29 had to use the commode. A face-to-face interview was conducted with Employee #13 on September 2, 2014 at approximately 9:50 AM who acknowledged the findings. Facility staff failed to promote dignity for Resident #29 as evidenced by announcing out loud in the solarium, in the presence of others that the resident had to be toileted. 2. Facility staff failed to wait to obtain permission to enter Resident #152's room. On August 26, 2014 at approximately 10:00 AM during an interview with Resident #152, Employee #36 knocked on the door to the resident's room and entered without waiting for permission to enter. Resident #152 commented, "They open the door without permission. Sometimes, they knock on the door and I say wait a minute... and they just come on in [without waiting]" A face-to-face interview was conducted with Employee #10 on August 28, 2014, at approximately 4:00 PM, in the presence of Employee #36. He/she acknowledged the	F 241	Continued from page 8 4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor the Caring for Residents with Dignity and Respect which will be monitored and reported monthly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor. **B) Resident #152** 1. Resident #152 was assessed and condition was stable on 8/26/14 after a nursing staff member knocked on the resident's door but did not wait to obtain permission to enter the resident #152 room. 2. Nursing rounds were conducted on all the nursing units to ensure that staff is waiting after knocking on the residents doors to receive permission from the resident before entering the room. 3. Nursing staff were provided in-service regarding "Obtaining Permission from Residents to enter their rooms before entering their rooms.	10/31/14 8/26/14 10/31/14 10/31/14

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F 241	Continued From page 9 aforementioned findings. Employee #10 further stated, "I did consult with Employee #36 at the time of the occurrence and informed [him/her] that [he/she] should have waited for the resident to give permission to enter the room. Facility staff failed to wait to receive permission to enter Resident #152's room. 3. Facility staff failed to respond to Resident 165's call bell/light in a timely manner. During a resident interview, conducted on August 26, 2014 at approximately 11:00 AM the resident's call bell/light was activated. The alarm was audible at the front desk, and blinking over the resident's door. No one answered the call bell/light. A face-to-face interview was conducted with Employee #7, who was at the nurse's station at that time. A query was made regarding the lack of attention given to the resident's call bell/light. No explanation was offered. At that time Employee #7 proceeded to respond to the call bell/light. Facility staff failed to respond to Resident 165's call bell/light in a timely manner.	F 241	Continued from page 9 4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor staff obtaining permission before entering the residents' rooms, and will be monitored monthly and reported to the Quality Improvement Committee. **C) Resident #165** 1. Resident #165 call light was activated on 8/26/14 but was not answered in a timely manner. There was no negative outcome to the resident as a result of this deficient practice. 2. Nursing rounds were made on all nursing units on 8/26/14 to ensure the residents call lights were being answered in a timely manner. 3. Nursing staff were provided in-service regarding Prompt Response to Resident Call Lights.	10/31/14 8/26/14 10/31/14 10/31/14
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by:	F 253	4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor the staff's response to residents' call lights which will be monitored and reported monthly to the Quality Improvement Committee	10/31/14

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F 253	Continued From page 10 Based on observations made during an environmental tour of the facility on August 25, 2014 at approximately 2:30 PM and on August 26, 2014 at approximately 2:15 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by torn privacy curtains in two (2) of 77 residents' rooms surveyed, non-functioning air vents in three (3) of 77 residents' rooms surveyed, soiled air vents in six (6) of 77 residents' rooms surveyed, burnt ceiling lights in two (2) of 77 residents' rooms surveyed, expired high protein nutrition bottles in one (1) of nine (9) units surveyed, a loose access door in one (1) of 77 resident's room surveyed and a non-functioning wall clock in one (1) of 77 resident's room surveyed. The findings include: 1. Three (3) of three (3) privacy curtains in resident's rooms #239 were torn and two (2) of three (3) privacy curtains in resident's room #337 were torn. The aforementioned findings were noted in two (2) of 77 residents' rooms surveyed. 2. Air vents were not functioning in the bathrooms of three (3) of 77 residents' rooms surveyed; Rooms #202, 220, and 305, and in the bathroom located in one (1) of two (2) activity rooms on 2 Blue. 3. Bathroom air vents in six (6) of 77 residents' rooms were soiled with dust. The rooms were	F 253	Continued from page 10 for at least one year, prior to the committee determining to discontinue this monitor. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES F253 1. Three (3) privacy curtains in room #239 were replaced and two (2) privacy curtains were replaced in room #337 upon notice on 8/25 and 8/26/14. Three (3) of the 77 resident's rooms air vents in rooms #202, #220 and #305 and one (1) of two (2) activity rooms on the 2 Blue Unit were not functioning. The Engineering department completed repair of these areas 9/3/14. Six (6) of 77 resident's rooms bathroom air vents in rooms #204, #306, #363, #386 were soiled with dust and were cleaned on 9/3/14 . One (1) of two (2) ceiling lights were out in the bathrooms of rooms #155 and #274 and was replaced upon observation. Two (2) of three (3) bottles of Jevity 1.2 cal high protein nutrition and fiber found on the 2 Green Unit was expired, which were discarded upon being located.	9/3/14

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F 253	Continued From page 11 #204, 306, 360, 363, 381 and 386. 4. One (1) of two (2) ceiling lights was out in the bathroom of resident room #155 and one (1) of two (2) ceiling lights was out in the bathroom of resident room #274, two (2) of 77 residents rooms surveyed. 5. Two (2) of three (3) bottles of Jevity 1.2 cal high protein nutrition with fiber stored in a cabinet in the storage room on 2 Green were expired as of August 1, 2014. 6. The access door located under the sink in the bathroom of resident room #189 was hanging loose and detached from the wall, one (1) of 77 residents rooms surveyed. 7. The wall clock was inoperative in room #355, one (1) of 77 residents rooms surveyed. These observations were made in the presence of Employee #36 and Employee #38 who acknowledged the findings.	F 253	Continued from page 11 The wall clock was inoperative in room #355. The Engineering department placed a battery on 8/26/14. 2. All privacy curtains were inspected and replaced if required, all vents were serviced, inspected and repaired if required, all air vents were inspected and cleaned if required, the two (2) bottles of expired Jevity were discarded, the access door under the sink was repaired and serviced, the wall clock was repaired. 3. An In-service was conducted for the Environmental staff on 10/28/14 and initiated on 10/31/14 for the Engineering staff regarding scheduled rounds to identify Environmental and Engineering concerns in resident rooms/areas, in addition to the Clinical staff being educated on the reporting process of areas in need of the environmental and/or engineering department's attention. 4. A quality assurance program to monitor environmental, nursing and engineering rounds was implemented under the supervision of the Director of Nurses; Director of Environmental Services and Director of Engineering	9/3/14 10/31/14 10/31/14
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272		

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F 272	Continued From page 12 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: A. Based on record review and staff interview for 6 (six) of 39 sampled residents, it was determined that facility staff failed to identify the location and date of the Care Area Assessment (CAA) information on the admission and annual Minimum Data Sets (MDS) under Section V0200A. Residents #12, 28, 80, 93, 129, and 138.	F 272	Continued From page 12 which will be monitored and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS F 272 1. Modification and proper coding was done for residents #12, #28, #80, #93, #129 and #138 to reflect accurate documentation for the Care Area Assessment (CAA) on admission and annual Minimum Data Sets (MDS) on 10/29/14. There were no negative outcomes to the residents as a result of this deficient practice. 2. All other residents Care Area Assessment (CAA) information on the admission and annual Minimum Data Sets (MDS) were checked and found to be accurate. 3. An in-service was provided for the MDS Coordinators with focus on Accuracy of Coding the Care Area Assessment (CAA) upon admission and annual Minimum Data Sets (MDS). Monthly CAA audits will be conducted by MDS Nurses.	10/29/14 10/31/14 10/31/14

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F 272	Continued From page 13 The findings include: According to Chapter 4 of the 'MDS 3.0 User Manual, ' " For each triggered care area, indicate the date and location of the CAA documentation...CAA documentation should include information on the complicating factors, risks and any referrals for the resident for this care area ... " 1. Facility staff failed to provide the location and/or date of Care Area Assessment [CAA] information under Section V [V0200A], 'Care Area Assessment Summary' of the annual Minimum Data Set [MDS] for Resident #12. A review of Resident #12's Annual Minimum Data Set dated January 16, 2014 revealed the Care Areas and the Care Planning Areas triggered for #2 Cognitive Loss/Dementia, #4 Communication, #6 Urinary Incontinence and Indwelling Catheter, #8 Mood State, #11 Falls, #12 Nutritional Status, #16 Pressure Ulcers and #17 Psychotrophic Drug Use. The record revealed the following: "See social services note" was documented in the space for the location of CAA information for care areas #2 and 8. "See CAA documentation 3/4/14" was	F 272	Continued From page 13 4. A quality assurance program to monitor Accuracy of Care Area Assessment (CAA) upon admission and an Minimum Data Sets (MDS) was initiated on 10/29/14 under the supervision of the MDS Manager/Director of Nurses/Designated Representative which will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14

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F 272	Continued From page 14 documented in the space for the location of CAA information for care areas #4, 11, 16, and 17. "See CAA documentation" was documented in the space for care area #6. There was no evidence that the facility staff documented the date for care areas #2 and 8, the location for care areas #4, 11, 16, and 17, and the date or location for care area #6 in the clinical record regarding information related to the CAA's. A face-to-face interview was conducted with Employee #31 on August 28, 2014 at approximately 3:30 PM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings.The clinical record was reviewed on August 28, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on the annual Minimum Data Sets (MDS) under Section V [V0200A]. 2. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], 'Care Area Assessment Summary' of the annual Minimum Data Set [MDS] for Resident #28. A review of Resident #28's Annual Minimum Data Set dated March 28, 2014 revealed that the	F 272	Continued From page 14	

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F 272	Continued From page 15 Care Areas and the Care Planning Areas triggered #4 Communication, #5 Activities of Daily Living, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutrition, #16 Pressure Ulcers, and #17 Psychotropic Medication Use. The record revealed that " CAA 3.0 " was documented as the location for the CAA information [for care areas #4, 5, 6, 11, 12, 16, and 17 dated 4/15/14]. However, there was no location documented on the 'CAA 3.0' sheet for the care areas identified. There was no evidence that the facility staff documented the location in the clinical record regarding information related to the CAA's. A face-to-face interview was conducted with Employee #31 on August 28, 2014 at approximately 3:30 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 28, 2014. Facility staff failed to provide the location of Care Area Assessment [CAA] information on the annual Minimum Data Sets (MDS) under Section V [V0200A]. 3. Facility staff failed to provide the location and	F 272	Continued From page 15	

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F 272	Continued From page 16 date of Care Area Assessment [CAA] information under Section V [V0200A], 'Care Area Assessment Summary' of the admission MDS for Resident #80. A review of Resident #80's Admission Minimum Data Set dated December 13, 2013 revealed that the Care Areas and the Care Planning Areas triggered for #2 Cognitive Loss/Dementia, #4 Communication, #5 ADL (Activity of Daily Living) Functional/Rehabilitation Potential, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, and #16 Pressure Ulcers. The record revealed that the location and date of CAA information [for care areas #2, 4, 5, 6, 11, 12, and 16] was left blank. There was no evidence that the facility staff documented the location and date in the clinical record regarding information related to the CAA's. A face-to-face interview was conducted with Employee #31 on August 28, 2014 at approximately 3:30 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 28, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information	F 272	Continued From page 16	

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F 272	Continued From page 17 on the admission Minimum Data Set (MDS) under Section V [V0200A]. 4. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], 'Care Area Assessment Summary' of the annual Minimum Data Set [MDS] for Resident #93. A review of Resident #93's Annual Minimum Data Set dated January 16, 2014 revealed that the Care Areas and the Care Planning Areas triggered for #2 Cognitive Loss/Dementia, #4 Communication, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, and #16 Pressure Ulcers. The record revealed "See CAA Summary" was documented in the space for the location of CAA information [for care areas #2, 4, 6, 11, and 16]. There was no evidence that the facility staff documented the location in the clinical record regarding information related to the CAA's. A face-to-face interview was conducted with Employee #31 on August 28, 2014 at approximately 3:30 PM regarding the CAA summary of the MDS. He/she acknowledged that the location information related to the CAA was not documented. The clinical record was reviewed on August 28, 2014.	F 272	Continued From page 17	

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F 272	Continued From page 18 Facility staff failed to provide the location of Care Area Assessment [CAA] information on the annual Minimum Data Sets (MDS) under Section V [V0200A]. 5. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], 'Care Area Assessment Summary' of the annual Minimum Data Set [MDS] for Resident #129. A review of Resident #129's Annual Minimum Data Set dated March 28, 2014 revealed that the Care Areas and the Care Planning Areas triggered #4 Communication, #5 Activities of Daily Living, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutrition, #16 Pressure Ulcers, and #17 Psychotropic Medication Use. The record revealed that " CAA 3.0 " was documented as the location for the CAA information [for care areas #4, 5, 6, 11, 12, 16, and 17 dated 6/24/14]. However, there was no location documented on the 'CAA 3.0' sheet for the care areas identified. There was no evidence that the facility staff documented the location in the clinical record regarding information related to the CAA's. A face-to-face interview was conducted with Employee #31 on August 28, 2014 at approximately 3:30 PM regarding the CAA	F 272	Continued From page 18	

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F 272	Continued From page 19 summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 28, 2014. Facility staff failed to provide the location of Care Area Assessment [CAA] information on the annual Minimum Data Sets (MDS) under Section V [V0200A]. 6. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], 'Care Area Assessment Summary' of the admission Minimum Data Set [MDS] for Resident #138. A review of Resident #138's Admission Minimum Data Set dated May 30, 2014 revealed that the Care Areas and the Care Planning Areas triggered #6 Urinary Incontinence and Indwelling Catheter, #12 Nutrition, and #16 Pressure Ulcers. The record revealed that " CAA 3.0 " was documented as the location for the CAA information [for care areas #6, 12, and 16]. However, there was no location documented on the 'CAA 3.0' sheet for the care areas identified. There was no evidence that the facility staff documented the location in the clinical record regarding information related to the CAA's.	F 272	Continued From page 19	

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F 272	Continued From page 20 A face-to-face interview was conducted with Employee #31 on August 28, 2014 at approximately 3:30 PM regarding the CAA summary of the MDS. He/she acknowledged that the date and location information related to the CAA was not documented. The clinical record was reviewed on August 28, 2014. Facility staff failed to provide the location of Care Area Assessment [CAA] information on the admission Minimum Data Sets (MDS) under Section V [V0200A]. B. Based on record review and staff interview for two (2) of 39 sampled residents, it was determined that facility staff failed to accurately code the quarterly Minimum Data Set (MDS) under Section M, Skin Condition for one (1) resident and failed to accurately code Section L (Oral/Dental Status) on the annual MDS for one (1) resident. Residents #155 and 218. The findings include: 1. Facility staff failed to accurately code Resident #155's quarterly MDS under Section M, Skin Condition. A Review of the "Wound and Skin Care Progress Notes " dated March 10, 2014 revealed the following:	F 272	Continued From page 20 **A) Resident #155** 1. Resident #155 quarterly MDS was checked for proper coding and modified to reflect accurate documentation under section (M) for Skin Condition. There were no negative outcomes to resident #155 as a result of this deficiency. 2. All other residents' MDS under section (M) were checked and found to be accurate. 3. An in-service was provided for the MDS Coordinators with focus on Accuracy of Coding Skin Condition. Monthly audits of coding skin condition will be conducted by the MDS nurses. 4. A quality assurance program to monitor Accuracy of Coding Skin Condition of the Minimum Data Sets (MDS) under the supervision of the MDS Manager/Director of Nurses/Designated Representative will be monitored and reported monthly to the Quality Improvement Committee prior to the committee determining to discontinue this monitor.	10/31/14 10/31/14 10/31/14 10/31/14 10/31/14

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F 272	Continued From page 21 " An open Stage 4 Sacral Pressure Ulcer measuring L[length]x W [width] 2.0 x 1.3 x 0.3cm [centimeters], undermining and tunneling 9 - 12 = 1.0cm, 12-3 = 4.2cm. " A review of the Quarterly MDS dated March 26, 2014 lacked evidence of coding related to the resident ' s Stage IV pressure ulcer. Section M, Skin Conditions was coded as " 0 " , indicative of no pressure ulcers. 2. Facility staff failed to code Resident #218's annual MDS under Section L [Oral/Denture] to reflect that the resident was edentulous. A review of the dental documentation in the resident's clinical record revealed that the resident had no teeth (was edentulous). Section L (Oral/Dental Status) of the annual MDS dated February 3, 2014, was coded as " none of the above were present. " The section designated to reflect no natural teeth (edentulous) was not coded. A face-to-face interview was conducted with Employee #31 at approximately 4:15PM on August 28, 2014. The employee reviewed the MDS and acknowledged the finding. The record was reviewed on August 28, 2014.	F 272	Continued From page 21 **B) Resident #218** 1. Resident #218 annual MDS was checked for proper coding and modified to reflect accurate documentation under section (L) Oral/Denture that the resident was edentulous. There was no negative outcome to resident #218 as a result of this deficiency. 2. All other residents MDS under section (L) were checked and found to be accurate. 3. In-service was conducted for the MDS Coordinators with focus on Accuracy of Coding Oral/Denture Assessment. Monthly audits of coding Oral/Denture assessments will be done by MDS nurses.	10/31/14 10/31/14 10/31/14
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		

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F 279	Continued From page 22 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on resident observation, record review, and staff interview for one (1) of 39 sampled residents, it was determined that facility staff failed to develop a care plan with goals and approaches for one (1) resident with excessive secretions and spitting. Resident #46 The findings include: 1. Facility staff failed to develop a care plan for Resident #46 with goals and approaches for excessive secretions and spitting. During a resident interview conducted on August 26, 2014 at approximately 3:00 PM, Resident #46 was observed holding sputum in his/her	F 279	Continued from page 22 4. A quality assurance program to monitor Accuracy of Coding Oral/Denture under the supervision of the MDS Manager/Director of Nurses/Designated Representative will be monitored monthly and reported monthly to the Quality Improvement Committee prior to the committee determining to discontinue this monitor. **483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS** **F 279** 1. Resident #46 Care Plan was developed with goals, individual approaches and interventions to address excessive secretions and spitting. 2. All care plans of residents with potential for excessive secretions or spitting were checked and updated as required. 3. In-service was provided on 10/ 31/14 for Resident Care Managers that focused on Review of the Resident Care Plans. .	10/29/14 10/31/14 10/31/14 10/31/14

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F 279	Continued From page 23 mouth. Before responding to a query, he/she spit clear sputum in a clear cup. On August 29, 2014 at approximately 11:00 AM, the resident was observed sitting in the common area, and again expelled sputum into a clear cup. A review of the medical record revealed a "Consultation Form" dated November 27, 2013 which stated: "Report Requested Regarding: GI [Gastrointestinal] consult for etiology of spitting. It is unclear why [he/she] chose to be spitting because [he/she] can easily swallow [his/her] saliva and [he/she] did in our presence. Esophagus was normal no evidence of obstruction; Routine: 1. Encourage pt [patient] to swallow [his/her] saliva; 2. f/u [follow up] ENT [Ear, Nose Throat] ..." A "Consultation Form" dated June 20, 2014 (seven months later) revealed: "Report requested regarding: ENT consult referred by GI for etiology of spitting. Diagnosis: Dysphagia-unknown etiology. Has PEG [percutaneous esophageal gastrostomy]. Routine: 1. Need modified Barium swallow to assess swallowing mechanism." A review of the Rehab [Rehabilitation] Services Requisition dated July 2, 2014 revealed the following: "Recommend Swallow test in house; no need for modified barium swallow suspect functional feeding D/o [disorder] related to	F 279	Continued From page 23 4. A quality assurance program to monitor the Resident Care Plan Review under the supervision of the Director of Nurses/Designated Representative which will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14

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F 279	Continued From page 24 Dementia..." A review of the care plan section of the clinical record revised May 21, 2014 lacked evidence of a care plan with goals and approaches to address Resident #46's excessive secretions and spitting. Facility staff failed to develop a care plan with goals and approaches for one (1) resident with excessive secretions and spitting.	F 279	Continued From page 24	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP F 280 **1) Resident #93** 1. Resident #93 Care Plan was developed with goals, individual approached and interventions to address his/her bilateral foot contractures on 8/28/14. 2. All care plans of residents with potential for foot contractures were checked and updated as required. 3. In-service was provided for Resident Care Managers that focused on updating the Residents' Care Plans. Unit Managers will audit care plans for residents with foot contractures monthly.	8/28/14 8/28/14 8/28/14

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F 280	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews for three (3) of 39 sampled residents, it was determined that facility staff failed to review and revise care plans for one (1) resident with bilateral foot contractures, one (1) resident with a history of orthostatic changes [Orthostatic Hypotension] and one (1) resident with a Venous Access device (Arteriovenous (AV) graft) which lacked approaches related to potential complications. Residents #93, #129, and #262. The findings include: 1. Facility staff failed to review and revise Resident #93's care plan to include goals and approaches to address his/her bilateral foot contractures. On August 26, 2014 at approximately 12:02 PM, Resident #93's feet were observed resting upon a footrest pointed in a downward position. On August 27, 2014 at approximately 9:43 AM during a staff interview, Employee #35 was asked, "Does the resident have a contracture ...? " He/she replied, " bilateral foot drop." A review of the current History and Physical dated July 8, 2014 revealed that the resident was admitted to the facility with a diagnosis that included "Old CVA with Dysphagia." The 'Physical Examination ' section revealed "abnormal orientation, motor deficits, joints, and gait."	F 280	Continued From page 25 4. A quality assurance program to monitor the Resident Care Plan Review under the supervision of the Director of Nurses/Designated Representative which will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14

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F 280	Continued From page 26 The nursing care plan initiated January 11, 2014 and updated on July 15, 2014 included the following: "Problem: Inadequate self-care [related to Cerebrovascular Accident [CVA] ... Approach: Nurse Aide---Support affected extremity with arm and/or leg rest when in a wheelchair, Check mouth for food/pocketing and remove food if found, Follow turning schedule, Provide clean clothing, free of food/drink/secretions, PROM (Passive Range of Motion) with AM [morning] and HS [night] care. Goal: No skin breakdown, no evidence of contractures, April 29, 2014 [updated] ... July 15, 2014, Resident dependent on staff for self -care. Turn and repositioning done every 2 hrs [hours] no skin breakdown this review. Plan of care continues. " There was no evidence that the care plan was updated to include approaches and goals to address the bilateral foot contractures. On August 28, 2014 at approximately 3:25 PM, a face-to-face interview was conducted with Employee #24 regarding the functional status of the resident's bilateral feet. He/she stated, " I just completed an assessment on the resident. He/she has bilateral foot contractures..." On September 2, 2014 at approximately 3:30 PM, a face-to-face interview was conducted with Employee #22 regarding the aforementioned findings. He/she acknowledged that there was	F 280	Continued From page 26	

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F 280	Continued From page 27 no care plan to address the resident's bilateral feet contractures. There was no evidence that facility staff reviewed and/or revised the care plan to include approaches and goals to address the resident's bilateral feet contractures. The record was reviewed August 28, 2014. 2. Facility staff failed to review and revise a care plan with goals and approaches to address potential complications from a Venous Access Device (AV graft) for Resident #129. A review of the resident's care plan revised on June 16, 2014 revealed the following: "Observe left arm access site every shift for bleeding, signs and symptoms of infection, bruit and thrill, document on ECS [electronic charting system]...monitor labs, Assess vascular access site for complications, report s/sx [signs and symptoms] [of] complications... " The care plan lacked evidence of approaches/interventions that should be implemented in the event that a complication such as bleeding occurred. A face-to-face interview was conducted with Employee #17 on August 28, 2014 at approximately 11:00 AM. After reviewing the resident's care plan, the employee acknowledged that it lacked evidence of approaches to be implemented to treat potential complication/s of bleeding and/or infection. The clinical record was reviewed on August 28, 2014. Facility staff failed to review and revise a care	F 280	Continued From page 27 **2) Resident #129** 1. Resident #129 Care Plan was developed with goals, individual approaches and interventions to address his/her Venous Access Device (AV graft) with potential complication of device. 2. All care plans of residents with Venous Access Devices (AV graft) were checked and updated as required. 3. Care plans for residents with Venous Access Devices will be monitored monthly by Unit Managers. In-service was provided for Resident Care Managers that focused on Review of the Resident Care Plan. 4. A quality assurance program to monitor the Resident Care Plan Review under the supervision of Director of Nurses/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14 10/31/14 10/31/14 10/31/14

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F 280	Continued From page 28 plan with goals and approaches for potential complication for Resident #129's Venous Access Device. 3. Facility staff failed to amend Resident #262's care plan to address specific interventions related to the management of orthostatic [Blood Pressure] changes. The " Facility's Policy" entitled, "Orthostatic Blood Pressure " stipulated ... " Count the pulse (P) and take the blood pressure in baseline position (supine or sitting). Move resident to next most upright position that can be maintained. Ask resident is [he/she] experiencing symptoms. Wait one minute if possible, recheck the pulse and blood pressure, restore resident to prior position....Orthostatic changes are reflected when: Pulse is increased by ten beats per minute or more, with or without blood pressure change, Systolic blood pressure is decreased by 15mm Hg or more, without change in diastolic blood pressure, diastolic blood pressure is decreased by 5mm Hg or more with or without change in systolic blood pressure or pulse..." An interim physician's order dated April 14, 2014 at 11:00 AM directed, "Please check B/P (Blood Pressure), pulse every shift for orthostatic hypotension." The care plan dated April 11, 2014 revealed; "Problem: Hypotension related to low B/P - Orthostatic /blood pressure - Approaches: Nurses-check B/P at 6AM, 10AM, 2PM prior to giving Midodrine (Antihypotensive vasopressor). Monitor for dizziness, confusion and [notify] MD (Medical doctor). "	F 280	Continued From page 28 **3) Resident #262** 1. Due to a closed medical record review for resident #262, no corrective action could be done for the resident #262 related to management of orthostatic (Blood Pressure) changes. The resident was transferred to the hospital on 4/19/14. 2. All other residents' medical records were checked for specific physician orders for orthostatic (Blood Pressure) and none were found. 3. An in-service was initiated for the nursing staff that focused on revised Policy and Procedure related to Orthostatic (Blood Pressure) as ordered by the physician. Unit Managers will conduct weekly audits for residents with orders for Orthostatic Blood Pressure.	10/31/14 10/31/14

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F 280	Continued From page 29 The care plan lacked evidence that it was amended to address specific interventions related to the position [s]of the resident when obtaining orthostatic blood pressure readings. The clinical record was reviewed on August 26, 2014. A face-to-face interview was conducted with Employee #10 on August 26, 2014 at approximately 2:00 PM. The employee acknowledged the aforementioned findings.	F 280	Continued From page 29 4. A quality assurance program to monitor Physician orders for residents in the future for orthostatic (Blood Pressure) changes under the supervision of Director of Nurses/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14
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 clinical record review and staff interview for one (1) of 39 sampled residents, it was determined that facility staff failed to ensure proper techniques were followed according to accepted standards of clinical practice in monitoring Resident #262's orthostatic blood pressures. The findings include: According to Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, " Measuring Orthostatic Blood	F 281	**483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **A) Resident #262** 1. Licensed nurses did not ensure proper techniques were followed by the accepted standards of clinical practice in monitoring Resident #262's orthostatic blood pressure. No corrective action can be done for Resident #262 due to physician orders to transfer the resident to the hospital for medical evaluation on 4/20/14. The resident did not return to the facility. 2. All other residents' medical records were checked for specific physician orders for orthostatic (Blood Pressure) and none were found in the facility.	10/31/14

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F 281	Continued From page 30 Pressure: 1. Have the patient lie down for 5 minutes. 2. Measure blood pressure and pulse rate. 3. Have the patient stand. 4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes. A drop in BP (blood pressure) of [greater than or equal to 20 mmHg] (millimeters of mercury), or in diastolic BP of [greater than or equal to] 10 mm Hg, or experiencing lightheadedness or dizziness is considered abnormal." <http://www.cdc.gov/homeandrecreationalsafety/pdf/steadi/measuring_orthostatic_bp.pdf> The facility ' s policy entitled, "Orthostatic Blood Pressure last updated [no date indicated], stipulated, " Count the pulses (P) and take the blood pressure in baseline position (supine or sitting). Move resident to next most upright position that can be maintained. Ask resident is he or she experiencing symptoms. Wait one minute if possible, recheck the pulse and blood pressure, restore resident to prior position...Orthostatic changes are reflected when: Pulse is increased by ten beats per minute or more, with or without blood pressure change, Systolic blood pressure is decreased by 15mm Hg or more, without change in diastolic blood pressure, diastolic blood pressure is decreased by 5mm Hg or more with or without change in systolic blood pressure or pulse..." According to Web MD.com " Midodrine (Common brand name: ProAmatine) ...Warning: Midodrine should be used in carefully selected patients. When you are lying on your back, this	F 281	Continued from page 30 3. Nursing Services Policy and Procedure for Orthostatic Blood Pressure was revised to reflect same as Center for Disease Control Prevention and the National Center for Injury Prevention/Control for Measuring Orthostatic Blood Pressure. Licensed Nurses received in-service on above Policy and Procedure for Clinical Management of residents with physician orders for Orthostatic Blood Pressure. Unit Managers will audit all care plans for residents with Orthostatic Blood Pressure orders. 4. A quality assurance program to monitor Residents with physician orders for Orthostatic Blood Pressures under the supervision of Director of Nurses/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14 10/31/14

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F 281	Continued From page 31 medication causes a significant increase in blood pressure. Your blood pressure will be monitored carefully during treatment. This medication is used for certain patients who have symptoms of low blood pressure. Side Effects ...this medication can cause your blood pressure to increase, especially when you are lying down (supine hypertension. Stop taking Midodrine and contact your doctor immediately if you experience the following signs of supine hypertension: pounding heartbeat, pounding in the ears, headache ...Notes ...Blood pressure checks (lying, sitting, and standing) should be routinely taken. Share the results with your doctor. " <http://webmd.com/drugs/2/drug-14042/midodrine-oral/details> A review of [rehabilitation hospital] discharge summary dated April 10, 2014 revealed the following: "Functional Status at the time of Discharge: With physical therapy, the patient required minimal assistance for bed mobility and stand-pivot transfers with and without the use of a rolling walker [He/she] was able to ambulate up to 25 feet with a rolling walker with minimal assistance. [He/she] was able to propel a wheelchair 20 feet with minimal assistance over tiled surfaces using [his/her] bilateral upper extremities ... [He/she] is limited by fatigue and orthostasis, and requires slow transitions from supine-to-sit and sit-to-stand. [He/she] is limited by fatigue and orthostatic hypotension.	F 281	Continued from page 31	

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F 281	Continued From page 32 Hospital course while at [rehabilitation hospital]... Cardiovascular- [Resident name] has a history of dysautonomia with significant orthostatic hypotension related to [his/her] Parkinsonism. [He/she] had been started on Midodrine in (Therapeutic Class: Anti hypotensive Vasopressor) the acute hospital on the day of transfer... Midodrine was titrated to a stepped dose of 7.5mg at 6 am, 10mg at 10 am, and 5mg at 2 pm ... The patient ' s blood pressure should be monitored to avoid supine hypertension. On [his/her] current regimen [his/her] blood pressure on routine vital signs ranged from 120s to 145. [His/her] dose of Midodrine should be decreased if [his/her] systolic blood pressure is routinely going above 150 or if [he/her] is symptomatic with headaches or chest pain. [He/she] will need continued monitoring and adjustment of these medications after discharge. " The history and physical dated April 10, 2014 revealed that Resident #262's had diagnoses which included: worsening tremors, hallucinations, Parkinson Disease Dystonia, Lewy Body Dementia, Parkinson ' s Dementia and Orthostatic Hypotension. Resident was admitted to the skilled nursing facility on April 10, 2014 for skilled speech, occupational and physical therapy. According to the admission MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of April 17, 2014 the resident was coded under Section G0300 - [Functional Status] Balance during Transitions and Walking as " Not steady, only able to stabilize with human assistance	F 281	Continued from page 32	

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F 281	Continued From page 33 when moving from seated to [a] standing position. The physician ' s admission orders dated April 10, 2014 directed, " Routine vital signs, Medications ... Midodrine 7.5mg po (by mouth) at 6AM, 10mg po at 10 AM and 5mg po at 2PM for orthostatic hypotension associated with Parkinson disease. Please reduce dosing if patient is experiencing supine hypertension. Acetaminophen [Tylenol-analgesic/antipyretic] 325mg- 2 (two) tabs [tablets] po [by mouth] [every] 6 hours as needed for pain. " An interim physician ' s order dated April 14, 2014 directed, " Please check B/P (Blood Pressure), Pulse every shift for orthostatic hypotension. " There was no evidence that the physician included parameters for monitoring the blood pressure and pulse rate for orthostatic hypotension. A review of the electronic nursing notes revealed the following: "April 14, 2014 at 2:50 AM- 132/80 (blood pressure), 78 (apical pulse), 20 (respirations), 97.6 (temperature) April 14, 2014 at 11:06 PM - Temp (temperature) 98.2, 72(Pulse), 110/70 (Blood Pressure), Resident had c/o [complain of] headache and Tylenol PRN medication was offered but resident refused to take. No other distress noted at this time. 4/15/14- Night shift - No vital signs recorded.	F 281	Continued from page 33	

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F 281	Continued From page 34 4/15/14- Day shift -No vital signs documented. 4/15/14- Evening- No vital signs documented. 4/16/14- Night shift- 12:03 AM, Temp 98.3- Pulse-88, Blood Pressure-124/78, Respiratory Rate-20 4/16/14- Night shift-2:53 AM -129/79 (Blood Pressure), 70 (apical pulse), 98.3 (temp), 20 (respiratory rate). 4/16/14- Evening shift at 5:13 PM - 98.2 Temp, 84- Pulse, Respiration Rate-20, Blood Pressuere-124/74. Resident is sitting in wheelchair with bedside table near and call light within reach. 4/17/14- Day shift- No vital signs documented. 4/17/14- Night shift-at 3:14 AM-129/70 (Blood Pressure), 77 (Pulse), 20-(Respiratory Rate), Temp-97.8. 4/17/14- No vital signs documented. 4/17/14- Evening shift at 9:54 PM- 142/80 (Blood Pressure), 78 (Pulse), 97.6 (Temperature) 4/17/14- Night shift - no vital signs documented. 4/18/14-Night shift at 02: 04 AM- 133/70 (Blood Pressure), 78 (Apical Pulse), 97.3 (Temperature), 18 (Respiratory Rate) 4/18/14- Evening shift at 3:26 PM- 126/74(Blood Pressure), 74 (Pulse), 18 (Respiratory Rate), 97.0 (Temperature)	F 281	Continued from page 34	

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F 281	Continued From page 35 4/18/14- Evening shift at 11:25 PM- 124/78 (Blood Pressure), 84 (Pulse), 20 (Respiratory Rate), 98.3 (Temperature) 4/19/14 - Night shift at 2:37 AM- 132/71(Blood Pressure), 80 (apical pulse), 97.9 (Temperature), 20 (Respirations) 4/19/14- Night shift- No vital signs documented. 4/19/14- Day shift- No vital signs documented. 4/19/14- Evening shift- No vital signs documented. 4/20/14 at 4:26 PM- Writer was called to room because resident [was] unresponsive. V/S (Vital Signs): Temperature 97.4, Heart Rate-114, Respiratory Rate- 12, Oxygen Saturation- 64%. CPR (Cardiopulmonary Resuscitation) started, 911, and MD (Medical Doctor) called and gave order to transfer resident to hospital for unresponsiveness. Resident left unit via EMT (Emergency Medical Team) at 1:15 PM." There was no evidence that the resident ' s blood pressure was obtained at the time of the transfer to the hospital. A review of the MAR/TAR (Medication Administration Record/Treatment Administration Record) revealed the following vital signs/medication: " 4/14/14- Tylenol administered [no time indicated] - Reason- c/o (complaint of)	F 281	Continued from page 35	

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F 281	Continued From page 36 headache- pain assessed as " 6/10. " Result- effective - " 2/10. " No blood pressure or pulse documented. 4/15/14- No vital signs recorded on night shift 4/15/14 - Day shift -vital signs documented- not legible to read. 4/15/14- Evening shift -120/70 (Blood Pressure) 4/16/14- Evening shift - writing not legible to read 4/17/14- Day shift- 129/70 (Blood Pressure) - Pulse- writing not legible to read 4/17/14- Evening shift- 130/74 (Blood Pressure)- Pulse- writing not legible to read 4/17/14- Night shift -writing not legible to read 4/19/14- Night shift- Blood Pressure - 106/75 4/19/14- Day shift- Blood Pressure: 125/70- Pulse-60 4/19/14 - Evening shift- Blood Pressure - 130/70. 4/20/14- Day shift according to MAR- 128/76 (Blood Pressure0, No pulse documented. " There was no evidence in the clinical record that the attending physician or nurse practitioner was informed of Resident #262 ' s complaint of a headache on April 14, 2014. In addition, the resident ' s blood pressure(s) were not taken every shift. When the blood pressures were taken, there was no evidence that the staff obtained orthostatic blood pressures as ordered	F 281	Continued from page 36	

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F 281	Continued From page 37 by the physician. A review of the Doctors Progress notes revealed the following: April 10, 2014- Nurse Practitioner's note - "... admitted to NH (nursing home) after hospital ... [Treatment] of Parkinson ' s disease with significant dysautonomia, Dementia, GERD (Gastro esophageal Reflux Disease) ... Orthostatic Hypotension, UTI (Urinary Tract infection) with ESBL (Extended Spectrum Beta-Lactamase) E. coli (Escherichia Coli). Alert- Weak." April 12, 2014 - "... Transferred to NH (nursing home) for further OT (Occupational Therapy), PT (Physical Therapy) and SLP (Speech Language Pathology)." Problem List: "Old [and] Chronic Problems ... Orthostatic Hypotension. Physical Examination: Temp (Temperature)- 97.6, Pulse-74, [Respiratory Rate] - 16, [Blood Pressure] - 120/72." April 18, 2014- Nurse Practitioner's note- "[Patient] with recent UTI [with] ESBL- [Status Post] Antibiotic Treatment. [History] of Parkinson, Dementia, GERD, Acute Kidney Disease, Orthostatic Hypotension. Plan... Calcium with Vitamin D 600/400- one QD (everyday). "	F 281	Continued from page 37	

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F 281	Continued From page 38 There was no evidence in the clinical record that the attending physician or the nurse practitioner addressed the resident's orthostatic hypotension in [his/her] total plan of care, after a physician's order was written on April 14, 2014 to " check B/P (Blood Pressure), Pulse every shift for orthostatic hypotension " in his/her total plan of care. A face-to-face interview was conducted with Employee #2 on August 29, 2014 at approximately 3:46 PM. After reviewing the clinical record. He/she acknowledged the aforementioned findings. A follow-up telephone interview was conducted with Employee # 32 on September 2, 2014 at approximately 2:18 PM in the presence of Employees #1 and 2. Employee #32 acknowledged that parameters should have been written for the orthostatic blood pressure reading(s). It was further stated that "Orthostatic blood pressure(s) are generally initially taken in the supine position before assuming a standing position. " In conclusion, there was no evidence that the facility consistently assessed and monitored Resident #262's orthostatic blood pressure and pulse despite the resident's diagnosis of Orthostatic Hypotension. In addition, there was no evidence that the facility staff indicated the position of the resident when the orthostatic blood pressure and pulse was obtained or	F 281	Continued from page 38 **B) Resident #262** 1. The attending physician did not consistently review the orthostatic blood pressure status in plan of care for resident #262. The resident was transferred to the hospital for medical evaluation on 4/20/14. 2. All resident medical records were reviewed and there were no other residents in the facility with orders for orthostatic blood pressures. 3. An in-service was provided by the Medical Director with the attending physician regarding Regulatory requirements in reviewing the residents' orthostatic blood pressures and total plan of care. 4. A quality assurance program to monitor residents that receive orders for orthostatic blood pressures under the supervision of Director of Nurses/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14 10/31/14 10/31/14

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F 281	Continued From page 39 notified the physician regarding the resident's complaint of a headache. On April 20, 2014, the resident was found unresponsive and was transferred to the nearest emergency room via 911. The clinical record was reviewed on September 2, 2014. A face-to-face interview was conducted with Employee #10 on August 28, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on August 28, 2014. Cross referenced to 483.25 Quality of Care	F 281	Continued from page 39	
F 309 SS=G	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 interviews for one (1) of 39 sampled residents, it was determined that facility staff failed to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care; as evidenced by: failure to consistently assess and monitor one (1) resident's orthostatic blood pressure(s) according	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** **A) Resident #262** 1. Licensed nurses did not consistently assess and monitor resident #262 orthostatic blood pressure (s) in accordance with the physician's orders. No corrective action could be done for the resident that was transferred to the hospital per 911 for medical evaluation on 4/20/14. 2. All other residents medical records were checked for specific physician orders for orthostatic blood pressures and none were found.	4/20/14

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F 309	Continued From page 40 to the physician 's orders. Residents #262. The findings include: Facility staff failed to consistently assess and monitor Resident #262's orthostatic blood pressure(s) in accordance with the physician's orders. According to the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, " Measuring Orthostatic Blood Pressure: 1. Have the patient lie down for 5 minutes. 2. Measure blood pressure and pulse rate. 3. Have the patient stand. 4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes. A drop in BP (blood pressure) of [greater than or equal to 20 mmHg] (millimeters of mercury), or in diastolic BP of [greater than or equal to] 10 mm Hg, or experiencing lightheadedness or dizziness is considered abnormal." <http://www.cdc.gov/homeandrecreationalsafety/pdf/steadi/measuring_orthostatic_bp.pdf> The facility's policy entitled, "Orthostatic Blood Pressure," last updated [no date indicated], stipulated, " Count the pulses (P) and take the blood pressure in baseline position (supine or sitting). Move resident to next most upright position that can be maintained. Ask resident is he or she experiencing symptoms. Wait one minute if possible, recheck the pulse and blood pressure, restore resident to prior position...Orthostatic changes are reflected when: Pulse is increased by ten beats per minute	F 309	Continued from page 40 3. Nursing Services Policy and Procedure for Orthostatic Blood Pressure was revised to reflect same as the Center for Disease Control and Prevention and the National Center for Injury Prevention/Control for Measuring Orthostatic Blood Pressure. Licensed Nurses received an in-service on above Policy and Procedure for clinical management of residents with physician orders for Orthostatic Blood Pressure. 4. A quality assurance program to monitor Residents with physician orders for Orthostatic Blood Pressures under the supervision of Director of Nurses/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14 10/31/14

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F 309	Continued From page 41 or more, with or without blood pressure change, Systolic blood pressure is decreased by 15mm Hg or more, without change in diastolic blood pressure, diastolic blood pressure is decreased by 5mm Hg or more with or without change in systolic blood pressure or pulse..." According to Web MD.com " Midodrine (Common brand name: ProAmatine) ...Warning: Midodrine should be used in carefully selected patients. When you are lying on your back, this medication causes a significant increase in blood pressure. Your blood pressure will be monitored carefully during treatment. This medication is used for certain patients who have symptoms of low blood pressure. " Side Effects "...this medication can cause your blood pressure to increase, especially when you are lying down (supine hypertension. Stop taking Midodrine and contact your doctor immediately if you experience the following signs of supine hypertension: pounding heartbeat, pounding in the ears, headache ...Notes ...Blood pressure checks (lying, sitting, and standing) should be routinely taken. Share the results with your doctor. " <http://webmd.com/drugs/2/drug-14042/midodrine-oral/details> A review of [rehabilitation hospital] discharge summary dated April 10, 2014 revealed the following: "Functional Status at the time of Discharge: With physical therapy, the patient required	F 309	Continued from page 41	

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F 309	Continued From page 42 minimal assistance for bed mobility and stand-pivot transfers with and without the use of a rolling walker [He/she] was able to ambulate up to 25 feet with a rolling walker with minimal assistance. [He/she] was able to propel a wheelchair 20 feet with minimal assistance over tiled surfaces using [his/her] bilateral upper extremities ... [He/she] is limited by fatigue and orthostasis, and requires slow transitions from supine-to-sit and sit-to-stand. [He/she] is limited by fatigue and orthostatic hypotension." Hospital course while at [rehabilitation hospital]... Cardiovascular- [Resident name] has a history of dysautonomia with significant orthostatic hypotension related to [his/her] Parkinsonism. [He/she] had been started on Midodrine in (Therapeutic Class: Anti hypotensive Vasopressor) the acute hospital on the day of transfer... Midodrine was titrated to a stepped dose of 7.5mg at 6 am, 10mg at 10 am, and 5mg at 2 pm ... The patient's blood pressure should be monitored to avoid supine hypertension. On [his/her] current regimen [his/her] blood pressure on routine vital signs ranged from 120s to 145. [His/her] dose of Midodrine should be decreased if [his/her] systolic blood pressure is routinely going above 150 or if [he/she] is symptomatic with headaches or chest pain. [He/she] will need continued monitoring and adjustment of these medications after discharge. " The history and physical dated April 10, 2014 revealed that Resident #262's diagnoses included: worsening tremors, hallucinations, Parkinson Disease Dystonia, Lewy Body	F 309	Continued from page 42	

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F 309	Continued From page 43 Dementia, Parkinson's Dementia and Orthostatic Hypotension. Resident was admitted to the skilled nursing facility on April 10, 2014 for skilled speech, occupational and physical therapy. According to the admission MDS (Minimum Data Set) dated April 17, 2014, the resident was coded under Section G0300 - [Functional Status] Balance during Transitions and Walking as "Not steady, only able to stabilize with human assistance when moving from seated to [a] standing position. The physician's admission orders dated April 10, 2014 directed, "Routine vital signs, Medications ... Midodrine 7.5mg po (by mouth) at 6AM, 10mg po at 10 AM and 5mg po at 2PM for orthostatic hypotension associated with Parkinson disease. Please reduce dosing if patient is experiencing supine hypertension. Acetaminophen [Tylenol-analgesic/antipyretic] 325mg- 2 (two) tabs po [every] 6 hours as needed for pain. " An interim physician's order dated April 14, 2014 directed, "Please check B/P (Blood Pressure), Pulse every shift for orthostatic hypotension. " There was no evidence that the physician included parameters for monitoring the blood pressure and pulse rate for orthostatic hypotension. A review of the electronic nursing notes revealed the following: "April 14, 2014 at 2:50 AM- 132/80 (blood pressure), 78 (apical pulse), 20 (respirations), 97.6 (temperature)	F 309	Continued from page 43	

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F 309	Continued From page 44 April 14, 2014 at 11:06 PM - Temp (temperature) 98.2, 72(Pulse), 110/70 (Blood Pressure), Resident had c/o [complaint of] headache and Tylenol PRN medication was offered but resident refused to take. No other distress noted at this time. 4/15/14- Night shift - No vital signs recorded. 4/15/14- Day shift -No vital signs documented. 4/15/14- Evening- No vital signs documented. 4/16/14- Night shift- 12:03 AM, Temp 98.3- Pulse-88, Blood Pressure-124/78, Respiratory Rate-20 4/16/14- Night shift-2:53 AM -129/79 (Blood Pressure), 70 (apical pulse), 98.3 (temp), 20 (respiratory rate). 4/16/14- Evening shift at 5:13 PM - 98.2 Temp, 84- Pulse, Respiration Rate-20, Blood Pressuere-124/74. Resident is sitting in wheelchair with bedside table near and call light within reach. 4/17/14- Day shift- No vital signs documented. 4/17/14- Night shift-at 3:14 AM-129/70 (Blood Pressure), 77 (Pulse), 20-(Respiratory Rate), Temp-97.8. 4/17/14- No vital signs documented. 4/17/14- Evening shift at 9:54 PM- 142/80 (Blood Pressure), 78 (Pulse), 97.6 (Temperature)	F 309	Continued from page 44	

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F 309	Continued From page 45 4/17/14- Night shift - no vital signs documented. 4/18/14-Night shift at 02: 04 AM- 133/70 (Blood Pressure), 78 (Apical Pulse), 97.3 (Temperature), 18 (Respiratory Rate) 4/18/14- Evening shift at 3:26 PM- 126/74(Blood Pressure), 74 (Pulse), 18 (Respiratory Rate), 97.0 (Temperature) 4/18/14- Evening shift at 11:25 PM- 124/78 (Blood Pressure), 84 (Pulse), 20 (Respiratory Rate), 98.3 (Temperature) 4/19/14 - Night shift at 2:37 AM- 132/71(Blood Pressure), 80 (apical pulse), 97.9 (Temperature), 20 (Respirations) 4/19/14- Night shift- No vital signs documented. 4/19/14- Day shift- No vital signs documented. 4/19/14- Evening shift- No vital signs documented. 4/20/14 at 4:26 PM- Writer was called to room because resident [was] unresponsive. V/S (Vital Signs): Temperature 97.4, Heart Rate-114, Respiratory Rate- 12, Oxygen Saturation- 64%. CPR (Cardiopulmonary Resuscitation) started, 911, and MD (Medical Doctor) called and gave order to transfer resident to hospital for unresponsiveness. Resident left unit via EMT (Emergency Medical Team) at 1:15 PM." There was no evidence that the resident's blood pressure was obtained at the time of the transfer	F 309	Continued from page 45	

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F 309	Continued From page 46 to the hospital. A review of the MAR/TAR (Medication Administration Record/Treatment Administration Record) revealed the following vital signs/medication: " 4/14/14- Tylenol administered [no time indicated] - Reason- c/o (complaint of) headache- pain assessed as " 6/10. " Result- effective - " 2/10. " No blood pressure or pulse documented. 4/15/14- No vital signs recorded on night shift 4/15/14 - Day shift -vital signs documented- not legible to read. 4/15/14- Evening shift -120/70 (Blood Pressure) 4/16/14- Evening shift - writing not legible to read 4/17/14- Day shift- 129/70 (Blood Pressure) - Pulse- writing not legible to read 4/17/14- Evening shift- 130/74 (Blood Pressure)- Pulse- writing not legible to read 4/17/14- Night shift -writing not legible to read 4/19/14- Night shift- Blood Pressure - 106/75 4/19/14- Day shift- Blood Pressure: 125/70- Pulse-60 4/19/14 - Evening shift- Blood Pressure - 130/70. 4/20/14- Day shift according to MAR- 128/76	F 309	Continued from page 46	

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F 309	Continued From page 47 (Blood Pressure "0," No pulse documented." There was no evidence in the clinical record that the attending physician or nurse practitioner was informed of Resident #262's complaint of a headache on April 14, 2014. In addition, the resident's blood pressure(s) was not taken every shift as prescribed. When the blood pressures were taken, there was no evidence that the staff obtained orthostatic blood pressures as ordered by the physician. A review of the Doctors Progress notes revealed: April 10, 2014- Nurse Practitioner's note - "... admitted to NH (nursing home) after hospital ... [Treatment] of Parkinson's disease with significant dysautonomia, Dementia, GERD (Gastro esophageal Reflux Disease) ... Orthostatic Hypotension, UTI (Urinary Tract infection) with ESBL (Extended Spectrum Beta-Lactamase) E. coli (Escherichia Coli). Alert- Weak." April 12, 2014 - "... Transferred to NH (nursing home) for further OT (Occupational Therapy), PT (Physical Therapy) and SLP (Speech Language Pathology)." Problem List: "Old [and] Chronic Problems ... Orthostatic Hypotension. Physical Examination: Temp (Temperature)- 97.6, Pulse-74, [Respiratory Rate] - 16, [Blood Pressure] - 120/72." April 18, 2014- Nurse Practitioner's note- "[Patient] with recent UTI [with] ESBL- [Status Post] Antibiotic Treatment. [History] of Parkinson, Dementia, GERD, Acute Kidney	F 309	Continued from page 47	

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F 309	Continued From page 48 Disease, Orthostatic Hypotension. Plan... Calcium with Vitamin D 600/400- one QD (everyday). " There was no evidence in the clinical record that the attending physician or nurse practitioner addressed the status of the Resident #262 ' s Orthostatic Hypotension in the total plan of care. Facility staff inconsistently and/or failed to assess the resident's orthostatic blood pressure as prescribed and there was no evidence that the medical team questioned clinical staff regarding the lack of orthostatic blood pressure assessments. A face-to-face interview was conducted with Employee #2 on August 29, 2014 at approximately 3:46 PM. After reviewing the clinical record. He/she acknowledged the aforementioned findings. A follow-up telephone interview was conducted with Employee # 32 on September 2, 2014 at approximately 2:18 PM in the presence of Employees #1 and 2. Employee #32 acknowledged that parameters may have been indicated for the orthostatic blood pressure reading(s). It was further stated that orthostatic blood pressure(s) are generally initially taken in the supine position before assuming a standing position. " In conclusion, there was no evidence that the facility consistently assessed and monitored Resident #262's orthostatic blood pressure and pulse (who had a diagnosis of Orthostatic Hypotension). In addition, there was no evidence that the facility staff indicated the position of the	F 309	Continued from page 48	

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F 309	Continued From page 49 resident when the orthostatic blood pressure and pulse were reportedly obtained or notified the physician regarding the resident's complaint of a headache. On April 20, 2014, the resident was found unresponsive and was transferred to the nearest emergency room via 911. The clinical record was reviewed on September 2, 2014.	F 309	Continued from page 49 **A) Resident #93** 1. Resident #93 was assessed and condition was stable on 8/28/14 for limited range of motion of bilateral feet. The attending physician was notified and orders were received to resume restorative nursing care with passive range of motion to bi-lateral feet.	8/28/14
F 318 SS=D	**483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION** Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 39 sampled residents, it was determined that facility staff failed to ensure that Resident #93 who was observed with limited range of motion of bilateral feet, received appropriate treatment and services to manage and or prevent further decline in range of motion. The findings include: On August 26, 2014 at approximately 12:02 PM, Resident #93's feet were observed resting upon a footrest flexed in a downward position. On August 27, 2014 at approximately 9:43 AM during a staff interview, Employee #35 was asked, "Does the resident have a contracture...?"	F 318	2. All other residents with limited range of motion of bilateral feet were checked. Physician orders for restorative care to manage and prevent decline in range of motion were done if needed. 3. An in-service was provided for nursing staff that focused on Documentation of Restorative Nursing Care. 4. A quality assurance program to monitor Residents that require restorative nursing care and passive range of motion to extremities under the supervision of Director of Nurses/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14 10/31/14 10/31/14

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F 318	Continued From page 50 He/she replied, "The resident has bilateral foot drop." The clinical record revealed the following: A review of the current History and Physical dated July 8, 2014 revealed the resident was admitted to the facility with diagnoses that included " Old CVA with Dysphagia. " The ' Physical Examination ' section revealed " abnormal orientation, motor deficits, joints, and gait." A review of the quarterly Minimum Data Set [MDS], with an Assessment Reference Date of July 8, 2014, revealed that under Section G, Functional Status, G0400, Functional Limitation in Range of Motion, the resident was coded as " 0 " [indicating no impairment] for B. Lower extremity (hip, knee, ankle, foot). Under Section I, Active Diagnoses, the resident was coded with diagnoses that included: Cerebrovascular Accident or stroke, Transient Ischemic Attack, and Hemiplegia or Hemiparesis " The ' Physician's Order Form ' signed and dated July 24, 2014 directed: " Rehabilitation: Evaluate and treat as indicated: PT [Physical Therapy], OT [Occupational Therapy], and SLP [Speech, Language, Pathology] Functional Level - Dependent For: bathing, dressing, eating, mobility, continence, weight bearing " A review of the quarterly ' Physical Therapy	F 318	Continued from page 50	

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F 318	Continued From page 51 Screen Forms ' revealed the following: July 29, 2013 - " Resident has no decline in status, requires total assist for all functional transfers " was documented in the ' Comments ' section. A check mark was observed in the blank for " Physical Therapy evaluation NOT indicated " section. April 13, 2014 - " No changes in patient status. Currently under restorative nursing " was documented in the 'Comments' section. A check mark was observed in the blank for "Physical Therapy evaluation NOT indicated " section. July 2, 2014 - " No change in condition at present. Resident requires total care and transfers from caregivers " was documented in the ' Comments ' section. A check mark was observed in the blank for " Physical Therapy evaluation NOT indicated " section. A review of the annual Occupational Therapy Screen Form ' revealed the following: January 15, 2014 - " [She/he] is dependent on caregivers for ADL's [Activities of Daily Living], transfer, and mobility " was documented in the ' Comments ' section. An " X " mark was observed in the blank for " Occupational Therapy evaluation NOT indicated " section. A review of the quarterly Occupational Therapy Screen Forms ' revealed the following: April 14, 2014 - " Resident is dependent on caregivers for ADL ' s [Activities of Daily Living],	F 318	Continued from page 51	

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F 318	Continued From page 52 transfer, and mobility " was documented in the ' Comments ' section. An " X " mark was observed in the blank for " Occupational Therapy evaluation NOT indicated " section. July 2, 2014 - " Resident remains dependent on caregivers for ADL ' s [Activities of Daily Living], transfer, and mobility " was documented in the ' Comments ' section. An " X " mark was observed in the blank for " Occupational Therapy evaluation NOT indicated " section. There was no evidence facility staff implemented measures [e.g. restorative services or passive range of motion] to manage the resident ' s functional impairment. Additionally, a Physical Therapy note of April 13, 2014 revealed that the resident was receiving restorative nursing. However, there was no physician ' s order, no recommendation from the Rehabilitation Department requesting the services, and no evidence that the resident received the restorative services. On August 28, 2014 at approximately 12:30 PM, a face-to-face interview was conducted with Employee #20. He/she was asked if Resident #93 was receiving services from Physical and Occupational Therapy. He/she stated, " No, the resident is not a skilled candidate and the nursing staff would make the referral to Physical Therapy or restorative nursing as needed. " On August 28, 2014 at approximately 3:25 PM, a face-to-face interview was conducted with Employee #24 regarding the functional status of the resident ' s bilateral feet. He/she stated, " I	F 318	Continued from page 52	

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F 318	Continued From page 53 just completed an assessment on the resident. He/she has bilateral foot contractures. "[Prior to this date, the progress notes do not reflect this finding]. Employee #24 was asked to provide the progress note, treatment orders, and any documentation related to the findings. He/she could not provide the requested documentation. On September 2, 2014 at approximately 1:18 PM, a face-to-face interview was conducted with Employee #22. A query was made regarding the restorative plan for the resident. He/she communicated that there were " no notes in the system or in his/her record for the past year and since [he/she] has been in charge of the program. " He/she added that the resident " was never picked up by restorative services. " On September 2, 2014 at approximately 2:30 PM, a face-to-face interview was conducted with Employee #34 who was asked if he/she performed range of motion exercises with Resident #93. He/she responded, " Range of motion? I am not his/her regular CNA [Certified Nursing Attendant usually assigned]." On September 2, 2014 at approximately 2:35 PM, the resident was observed as Employee #20 asked him/her to demonstrate the functional ability of his/her bilateral feet. The resident's bilateral feet were in a plantar position [the foot pointed downwards away from the leg]. The resident was unable to flex the left or right foot. He/she was unable to move the left toes. A slight wiggle to the right great toe was observed. There was no evidence the facility staff	F 318	Continued from page 53	

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F 318	Continued From page 54 consistently implemented approaches and goals to address Resident #93 ' s bilateral foot contractures. Facility staff failed to ensure that Resident #93, who was observed with limited range of motion of bilateral feet received appropriate treatment and services to manage and/or prevent further decline of his/her bilateral foot contractures. The record was reviewed on September 2, 2014.	F 318	Continued From page 54	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on August 25 at approximately 2:30 PM and on August 26, 2014 at approximately 2:15 PM, it was determined that the facility failed to ensure that it was free of accident hazards as evidenced by a frayed call bell cord in one (1) of 77 residents' rooms surveyed. The findings include: One (1) of three (3) call bell cords was frayed in	F 323	**483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES F323** 1. The frayed call bell cords in room #239 was replaced on the same day it was observed, 8/26/14. 2. All call bells in the facility were checked on 9/3/14 and none were found with frayed cords. 3. In-service was provided to the Engineering staff regarding, Effective Maintenance Rounds with focus on the call bells to maintain resident safety. 4. A quality assurance program to monitor the preventative maintenance program is in place for the inspection of all call bells under the supervision of Director of Engineering/ Designated Representative will be monitored and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.	8/26/14 9/3/14 10/31/14 10/31/14

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F 323	Continued From page 55 room #239 (C bed), one (1) of 77 residents' rooms surveyed. This observation was made in the presence of Employees #36 and 38 who acknowledged the findings.	F 323	Continued from page 55	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on August 25, 2014 at approximately 2:30 PM and on August 26, 2014 at approximately 2:15 PM, it was determined that the facility failed to serve food under sanitary conditions as evidenced by foods such as barbecue chicken, mixed greens, pureed chicken, pureed rice, pureed mixed greens and pureed vegetables that failed to reach 140 degrees Fahrenheit and 15 of 15 four-inch deep half pans and three (3) of three (3) four-inch one-third pans that were stored wet and ready for reuse. The findings include:	F 371	**483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY** **F 371** 1. Food that was served to residents on Unit 3 Orange did not meet the required standard of 140° degrees Fahrenheit; in addition, the milk that was served on the unit did not meet the required temperature of 40° degrees Fahrenheit. There were no negative outcomes to the residents as a result of this deficiency. 2. All other nursing units were checked to ensure food and liquid nourishment being served to the residents met regulatory guidelines. 3. An in-service was provided to the Dietary staff regarding measures being implemented to ensure that food and liquid being served to the residents meets regulatory guidelines.	10/31/14 8/28/14

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F 371	Continued From page 56 1. On August 25, 2014 at approximately 2:30 PM, hot foods from the test tray, such as barbecued chicken, mixed greens, pureed chicken, pureed rice, pureed mixed greens and pureed vegetables tested below 140 degrees Fahrenheit at the point of delivery. 2. On August 26, 2014 at approximately 2:15 PM, hot foods from the test tray such as pureed rice and pureed vegetables tested below 140 degrees Fahrenheit at the point of delivery. 3. On August 25, 2014 at approximately 2:30 PM a half-pint carton of milk from the test tray tested at 48 degrees Fahrenheit and on August 26, 2014 at approximately 2:15 PM, a half-pint carton of milk from the test tray tested at 54 degrees Fahrenheit at the point of delivery. 4. 15 of 15 four-inch deep half pans and three (3) of three (3) four-inch one-third pans were stored wet and ready for reuse. These observations were made in the presence of Employee #37 who acknowledged the findings.	F 371	Continued from page 56 4. A quality assurance program to monitor the temperature of residents' food and liquids being served under the supervision of Director of Food and Nutrition Services/ Designated Representative will be monitored and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor. **(2) Store, prepare, distribute and serve food under sanitary conditions** 1. 15 of 15 four (4) inch deep half pans and 3 of 3 four (4) inch pans were washed again in the dishwasher and placed on air drying racks until dry on 8/25/14. There were no negative outcomes to the residents. 2. All other pans in the kitchen were checked and washed again in the dishwasher and placed on the sir drying racks until dry as required. 3. In-service was provided to the Food and Nutrition staff on regarding Regulatory Requirements for washing and air drying pans.	10/31/14 8/25/14 10/31/14 8/28/14
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved	F 386		

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F 386	Continued From page 57 facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 39 sampled residents, it was determined that the physician failed to review Resident #262's orthostatic blood pressure status in the total plan of care. Resident #262 and #46. The findings include: 1. The physician failed to review Resident #262's orthostatic blood pressure status in his/her total plan of care. A review of Resident #262's clinical record revealed that the resident was admitted to the facility on April 10, 2014 and diagnoses included Orthostatic Hypotension. The history and physical examination dated April 10, 2014 revealed that Resident #262's diagnoses included: worsening tremors, hallucinations, Parkinson Disease Dystonia, Lewy Body Dementia, Parkinson's Dementia and Orthostatic Hypotension. The resident was admitted to the skilled nursing facility on April 10, 2014 for skilled speech, occupational and	F 386	Continued from page 57 4. A quality assurance program to monitor the Proper technique for washing pans served under the supervision of Director of Food and Nutrition Services/ Designated Representative will be monitored and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor. **483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS** **F 386** **A) Resident #262** 1. The attending physician did not consistently review the orthostatic blood pressure status in plan of care for resident #262. The resident was transferred to the hospital for medical evaluation on 4/20/14. 2. All resident medical records were reviewed and there were no other residents in the facility with orders for orthostatic blood pressures.	10/31/14 10/31/14

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F 386	Continued From page 58 physical therapy. The physician's admission orders dated April 10, 2014 directed, " Routine vital signs, Medications ... Midodrine 7.5mg po (by mouth) at 6AM, 10mg po at 10 AM and 5mg po at 2 PM for Orthostatic Hypotension associated with Parkinson disease. Please reduce dosing if patient is experiencing supine hypertension. Acetaminophen [Tylenol-analgesic/antipyretic] 325mg- 2 (two) tabs po [every] 6 hours as needed for pain. " An interim physician's order dated April 14, 2014 directed, "Please check B/P (Blood Pressure), Pulse every shift for Orthostatic Hypotension." There was no evidence that the physician included parameters for monitoring the blood pressure and pulse rate for Orthostatic Hypotension. A review of the electronic nursing notes revealed the following: April 14, 2014 at 2:50 AM- "132/80 (blood pressure), 78 (apical pulse), 20 (respirations), 97.6 (temperature)" April 14, 2014 at 11:06 PM - "Temp (temperature) 98.2, 72(Pulse), 110/70 (Blood Pressure), Resident had c/o [complain of] headache and Tylenol PRN medication was offered but resident refused to take. No other distress noted at this time." 4/15/14- Night shift - No vital signs recorded. 4/15/14- Day shift -No vital signs documented. 4/15/14- Evening- No vital signs documented.	F 386	Continued from page 58 3. In-service was provided by the Medical director with the attending physician on regarding Regulatory Requirements in reviewing the residents' orthostatic blood pressures and total plan of care. 4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor monthly and report monthly to the Quality Improvement Committee all residents that receive orders for orthostatic blood pressures. Findings of the quality assurance checks will be documented and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor. **Resident #46** 1. Resident #46 was assessed on 8/28/14 and the attending physician was notified. The attending physician did not consistently review the clinical documentation regarding excessive secretions/spitting and the plan of care for resident #46.	10/31/14 10/31/14 10/31/14

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F 386	Continued From page 59 4/16/14- Night shift- 12:03 AM, Temp 98.3- Pulse-88, Blood Pressure-124/78, Respiratory Rate-20 4/16/14- Night shift-2:53 AM -129/79 (Blood Pressure), 70 (apical pulse), 98.3 (temp), 20 (respiratory rate). 4/16/14- Evening shift at 5:13 PM - 98.2 Temp, 84- Pulse, Respiration Rate-20, Blood Pressuere-124/74. Resident is sitting in wheelchair with bedside table near and call light within reach. 4/17/14- Day shift- No vital signs documented. 4/17/14- Night shift-at 3:14 AM-129/70 (Blood Pressure), 77 (Pulse), 20-(Respiratory Rate), Temp-97.8. 4/17/14- No vital signs documented. 4/17/14- Evening shift at 9:54 PM- 142/80 (Blood Pressure), 78 (Pulse), 97.6 (Temperature) 4/17/14- Night shift - no vital signs documented. 4/18/14-Night shift at 02: 04 AM- 133/70 (Blood Pressure), 78 (Apical Pulse), 97.3 (Temperature), 18 (Respiratory Rate) 4/18/14- Evening shift at 3:26 PM- 126/74(Blood Pressure), 74 (Pulse), 18 (Respiratory Rate), 97.0 (Temperature) 4/18/14- Evening shift at 11:25 PM- 124/78 (Blood Pressure), 84 (Pulse), 20 (Respiratory	F 386	Continued from page 59 2. All other residents with excessive secretions or frequent spitting were assessed and the attending physician was notified if indicated. 3. In-service was provided for the licensed nurse regarding ongoing Clinical Assessment of Residents. 4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor the Clinical assessment of residents with excessive secretions be monitored monthly and reported quarterly to the Quality Improvement Committee. Findings of the quality assurance checks will be documented and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14 10/31/14 10/31/14

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F 386	Continued From page 60 Rate), 98.3 (Temperature) 4/19/14 - Night shift at 2:37 AM- 132/71(Blood Pressure), 80 (apical pulse), 97.9 (Temperature), 20 (Respirations) 4/19/14- Night shift- No vital signs documented. 4/19/14- Day shift- No vital signs documented. 4/19/14- Evening shift- No vital signs documented. 4/20/14 at 4:26 PM- "Writer was called to room because resident [was] unresponsive. V/S (Vital Signs): Temperature 97.4, Heart Rate-114, Respiratory Rate- 12, Oxygen Saturation- 64%. CPR (Cardiopulmonary Resuscitation) started, 911, and MD (Medical Doctor) called and gave order to transfer resident to hospital for unresponsiveness. Resident left unit via EMT (Emergency Medical Team) at 1:15 PM." There was no evidence that the resident's blood pressure was obtained at the time of the transfer to the hospital. A review of the MAR/TAR (Medication Administration Record/Treatment Administration Record) revealed the following vital signs/medication: " 4/14/14- Tylenol administered [no time indicated] - Reason- c/o (complaint of) headache- pain assessed as " 6/10. " Result- effective - " 2/10. " No blood pressure or pulse documented.	F 386	Continued from page 60	

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F 386	Continued From page 61 4/15/14- No vital signs recorded on night shift 4/15/14 - Day shift -vital signs documented- not legible to read. 4/15/14- Evening shift -120/70 (Blood Pressure) 4/16/14- Evening shift - writing not legible to read 4/17/14- Day shift- 129/70 (Blood Pressure) - Pulse- writing not legible to read 4/17/14- Evening shift- 130/74 (Blood Pressure)- Pulse- writing not legible to read 4/17/14- Night shift -writing not legible to read 4/19/14- Night shift- Blood Pressure - 106/75 4/19/14- Day shift- Blood Pressure: 125/70- Pulse-60 4/19/14 - Evening shift- Blood Pressure - 130/70. 4/20/14- Day shift according to MAR- 128/76 (Blood Pressure0, No pulse documented. " There was no evidence in the clinical record that the attending physician or nurse practitioner was informed of Resident #262 ' s complaint of a headache on April 14, 2014. In addition, the resident ' s blood pressure(s) were not taken every shift. When the blood pressures were taken, there was no evidence that the staff obtained orthostatic blood pressures as ordered by the physician.	F 386	Continued from page 61	

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F 386	Continued From page 62 A review of the Doctors Progress notes revealed: April 10, 2014- Nurse Practitioner's note - "... admitted to NH (nursing home) after hospital ... [Treatment] of Parkinson ' s disease with significant dysautonomia, Dementia, GERD (Gastro esophageal Reflux Disease) ... Orthostatic Hypotension, UTI (Urinary Tract infection) with ESBL (Extended Spectrum Beta-Lactamase) E. coli (Escherichia Coli). Alert- Weak." April 12, 2014 - " ... Transferred to NH (nursing home) for further OT (Occupational Therapy), PT (Physical Therapy) and SLP (Speech Language Pathology). Problem List: Old [and] Chronic Problems ... Orthostatic Hypotension. Physical Examination: Temp (Temperature)- 97.6, Pulse-74, [Respiratory Rate] - 16, [Blood Pressure] - 120/72." April 18, 2014- Nurse Practitioner's note- "[Patient] with recent UTI [with] ESBL- [Status Post] Antibiotic Treatment. [History] of Parkinson, Dementia, GERD, Acute Kidney Disease, Orthostatic Hypotension. Plan... Calcium with Vitamin D 600/400- one QD (everyday). " There was no evidence in the clinical record that the attending physician or the nurse practitioner addressed the resident's Orthostatic Hypotension in [his/her] total plan of care.	F 386	Continued from page 62	

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F 386	Continued From page 63 A face-to-face interview was conducted with Employee #24 on August 28, 2014 at approximately 11:30 AM. Employee #24 stated, "I looked at the documented blood pressures. However, I did not address them in the progress notes." Employee #24 acknowledged the findings. A follow-up telephone interview was conducted with Employee # 32 on September 2, 2014 at approximately 2:18 PM in the presence of Employees #1 and #2. Employee #32 acknowledged that parameters should have been written for the Orthostatic Blood Pressure reading(s). It was further stated that "Orthostatic Blood Pressure(s) are generally initially taken in the supine position before assuming a standing position. " The record was reviewed on August 28, 2014.	F 386	Continued from page 63 **483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** **F431** The Facility's practice is to discard of expired medications, which was not exhibited in the below findings. These findings were corrected upon observation. 1. Unit 1 Orange Resident M #2 19 tablets of Acetaminophen/Codeine 300mg/30mg that was found stored in the medication cart. There were no negative outcomes to the resident beyond expiration date.	8/29/14
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 431	Continued From page 64 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to discard biologicals stored in the refrigerator and medication cart on four (4) of 10 nursing units observed (Units 1 Orange, 2 Orange, 1 Green, and 3 Blue). The findings include: On August 29, 2014 the medication storage observations revealed the following:	F 431	Continued from page 64 Unit 1 Orange Resident M #5 30 tablets of Lorazepam 0.5mg was found stored in the medication cart. Unit 2 Orange Resident M #3 13 tablets of Lorazepam 0.5mg was found stored in the medication cart. Unit 1 Green Resident M #1 16 tablets of Lorazepam 1 mg were found stored in the medication cart. Unit 3 Blue Resident M #4 two (2) of two (2) bags of Vancomycin 500mg [milligram]/100ml solution was found in the refrigerator. 2. All other residents' cassettes in the medication carts were checked for stored or expired medications and none were found in the residents' medication cassettes. 3. In-service was provided for the Licensed Nurses regarding Policy and Procedure for expired narcotic medications and refrigerated antibiotics. Unit Managers will audit narcotics and refrigerators weekly.	9/2/14 10/31/14

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F 431	Continued From page 65 1. On Unit 1 Orange: Resident M #2 had 19 tablets of Acetaminophen/Codeine 300mg/30mg stored for use. The use before date on the package was 6/13/2014. The observation was made in the presence of Employee #8. He/she acknowledged the findings. 2. On Unit 1 Orange: Resident M #5 had 30 tablets of Lorazepam 0.5mg stored for use. The use before date on the package was 8/4/2014. The observation was made in the presence of Employee #8. He/she acknowledged the findings. 3. On Unit 2 Orange: Resident M #3 had 13 tablets of Lorazepam 0.5mg stored for use. The use before date on the package was 8/18/2014. The observation was made in the presence of Employee #10. He/she acknowledged the findings. 4. On Unit 1 Green: Resident M #1 had 16 tablets of Lorazepam 1 mg stored for use. The use before date was 6/13/2014. The observation was made in the presence of Employee # 15. He/she acknowledged the findings. 5.On Unit 3 Blue: Resident M #4 had two (2) of two (2) bags of Vancomycin 500mg [milligram]/100ml solution stored with a discard date of August 23, 2014. The observation was made in the presence of Employee # 12 who acknowledged the findings. Employee #12 also	F 431	Continued from page 65 4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor expired narcotics and refrigerated antibiotics will be monitored monthly and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14

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F 431	Continued From page 66 stated, "The aforementioned medications were discontinued on August 11, 2014".	F 431	Continued from page 66	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on August 25 at approximately 2:30 PM and on August 26, 2014 at approximately 2:15 PM, it was determined that the facility failed to maintain the call bell system in proper working condition as evidenced by one (1) of one (1) call bell cord that was too short to be readily accessible in the bathroom of Room #305, one (1) of three (3) call bells that was too short to be readily accessible in the shower room located on 3 Orange and a call bell that was wrapped around the grab bar in one (1) of 77 resident's room surveyed. The findings include: 1. One (1) of one (1) cord to the call bell in the bathroom of room #305 was just a few inches long and was not readily accessible. 2. One (1) of three (3) call bell cords in the shower room on 3 Orange was short and was not readily accessible. 3. The call bell cord was wrapped around the grab bar in room #106 and could not be activated	F 463	**483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH** **F463** 1. The call bell cord in the bathroom of room #305 was too short. One (1) of three (3) call bell cords in the shower room on 3 Orange Unit was short and not accessible. The call bell cord was wrapped around the grab bar in room #106 and could not be activated. All of the call bell cords in room #305, #106 and in the shower room on 3Orang Unit were replaced. There were no negative outcomes to the residents. 2. All call bell cords in the facility were checked on 9/3/14 and replaced as required. 3. In-service was provided to the Engineering staff on regarding the on-going Preventative Maintenance Program to inspect all call bells and cords.	8/26/14 8/26/14 10/31/14

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F 463	Continued From page 67 if needed in one (1) of 77 residents' rooms surveyed. These observations were made in the presence of Employees #36 and 38 who acknowledged the findings.	F 463	Continued From page 67 4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative The call bells/cords will be monitored and reported monthly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview during a staffing review [direct care per resident day hours], it was determined that the facility failed to meet 0.6 [six tenth] hour for Registered Nurses/APRN [Advanced Practice Registered Nurse] hours on two (2) of the seven (7) days and four and one tenth (4.1) hours of direct nursing care per resident per day for one (1) of seven (7) days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on August 29, 2014 at approximately 11:00AM. Seven (7) days were reviewed; August 23	F 492	**483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD F 492** A. Staffing - 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse 1. The regulatory requirement of 0.6 (six tenth) hour of nursing care per resident day of Registered Nurse was not met on August 23, 2014 0.4 and August 24, 2014 0.4. On August 25, 2014 the overall nursing care coverage required of 4.1 hours was not met at 4.0. 2. All residents have the potential to be affected when the resident care for a Registered Nurse is not met, however there were no negative outcomes to the residents.	11/2/14

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F 492	Continued From page 68 through August 29, 2014. According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenth (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. The facility failed to meet the 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] for two (2) of seven days reviewed as outlined below. On Saturday, August 23, 2014 it was determined that the facility provided RN coverage at a rate of 0.4 hours. On Saturday, August 24, 2014 it was determined that the facility provided RN coverage at a rate of 0.4 hours. The facility also failed to meet the four and one tenth (4.1) hours of direct nursing care per resident per day for one of seven days reviewed as outlined below. On Saturday, August 25, 2014 it was determined that the facility provided direct nursing care coverage at a rate of 4.0 hours.	F 492	Continued From page 68 3. Recruitment plans are in place to hire required staffing levels with focus on hiring Registered Nurses. In addition to, the review of wage/salary surveys as a component of the facility's retention plan. 4. A quality assurance program was implemented under the supervision Director of Human Resources and Director of Nurses to monitor and report monthly Registered Nurses and other nursing vacancies to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.	11/2/14 10/31/14

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F 492	Continued From page 69 The review was done in the presence of Employee #2. He/she acknowledged the finding. B. Based on observations and staff interviews, it was determined that facility staff failed to comply with State regulations as evidenced by a Licensed Practical Nurse not practicing within his/her scope of duty as evidenced by orienting a Registered Licensed Nurse. The findings include: Title 17 DCMR Chapter 55, 5514.4(b) stipulates: " A practical nurse shall not ...Supervise the clinical practice of a registered nurse. " A review of the facility's policy entitled, " Orientation for Licensed Nurses; Policy No: EDU01-001 stipulates; " Policy: The Registered Nurse will be provided with the education by a Registered Nurse on the unit. The staff development department will oversee the orientating of the RN/LPN and will assist as deemed necessary. " During initial tour on August 25, 2014 at approximately 9:00 AM on Unit 3 Orange. Employee #39 was observed orienting Employee	F 492	Continued from page 69	

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F 492	Continued From page 70 #40. A second observation occurred on August 26, 2014 at approximately 10:00 AM on Unit 3 Orange. Employee #39 was observed orienting Employee #40. A face-to-face interview was conducted with Employee #41 on August 26, 2014 at approximately 10:30 AM. When queried, whether Employee #40 was in orientation and who was orienting him/her He/she responded; " Yes, [he/she] is in orientation." Employee #41 stated that Employee #40 was in classroom training the first week and started working on the unit the second week. He/she also stated that Employee #39 was orienting Employee #40. A face-to-face interview was conducted with Employee #2 on August 29, 2014 at approximately 1:00 PM. He/she stated Employee #40 should have been orienting under Employee #41 and that Medication oversight should have been with Employee #5. A follow-up face-to-face interview was conducted with Employee #2 at approximately 2:00PM on August 29, 2014. He/she stated that Employee #39 acknowledged that [he/she] had been orienting Employee #40. The observations occurred on August 25 through 26, 2014. Facility staff failed to comply with State	F 492	Continued from page 70 **B. Employee #39 was observed orienting Employee #40.** The practice of the facility is for a Registered Nurses to supervise on board Registered Nurses. 1. Nursing Services did not comply with State Regulations on August 25, 2014 and August 26, 2014 by allowing employee #39, a Licensed Practical Nurse, to provide orientation at the medication cart for employee #40. There was no negative outcome to the resident a result of this practice. 2. All nursing units were checked and it was validated that all new hired Registered Nurses in orientation were being orientated on the nursing units by another registered nurse. 3. In-services was provided to all Resident Care Managers and Nursing Supervisors regarding State Regulations requiring that all Registered Nurses receive orientation from a Registered Nurse.	10/31/14 10/31/14

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F 492	Continued From page 71 regulations as evidenced by a Licensed Practical Nurse not practicing within his/her scope of duty as evidenced by orienting a Registered Licensed Nurse.	F 492	Continued from page 71 4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor and report monthly to the Quality Improvement Committee the orientation of Registered Nurses for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14
F 514 SS=E	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 observation, record review, and staff interviews for three (3) of 39 sampled residents, it was determined that the facility staff failed to maintain complete, accurate, and organized clinical records for one (1) resident; to document regarding the provision of dental service for one (1) resident; to documnet that the wound treatment had been completed for one (1) resident. Residents 40, #93, and #129. The findings include: 1.Facility staff failed to maintain clinical records in accordance with acceptable professional	F 514	**483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE** **F514** 1. Correction of spelling of Resident #40 his/her last name was corrected on 8/29/14. There were no negative outcomes to the resident as a result of this deficient oversight. 2. All residents' medical records were checked to validate spelling of last name and all were found to be correct. 3. In-service was provided regarding required validation of all spelling and all residents complete name.	8/29/14 9/2/14 10/31/14

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F 514	Continued From page 72 standards and practice for Resident #40 who had four (4) different spellings of his/her last name on record. A review of the Physician's Progress notes dated July 2, 2013 revealed the last name spelled "Biven." A review of the resident's 'Admitting and Discharge Record ' dated July 7, 2014 revealed the last name spelled "Bivens." A review of the 'Interim Order Form' dated of July 29, 2014 revealed the resident's last name spelled "Bivin." A review of the 'Hospice Pharmacia [Active Medication Profile]' dated August 8, 2014 revealed the last name spelled "Bivins." A review of the resident's 'Significant Change In Status Assessment' dated August 8, 2014 revealed the last name spelled "Bivens." A review of the 'Nursing-Initial /Updated Comprehensive Assessment' dated August 29, 2014 revealed the last name spelled "Bivins." A face-to-face interview was conducted with Employee #2 on August 28, 2014 at approximately 3:00PM. After reviewing the above documents, he/she acknowledged the findings. 2. Facility staff failed to document the provision of dental service for Resident #93. A review of the Physician's Progress note dated	F 514	Continued from page 72 4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor monthly and report quarterly to the Quality Improvement Committee the correct spelling of all residents' names for at least one year, prior to the committee determining to discontinue this monitor. **1. Resident #129** 1. Resident #129 was assessed and condition was stable on 8/28/14. On September 1, 2014 the licensed nurse assigned to Resident #129 did not initial the Treatment Administration Records (TARs) to indicate that a wound treatment was performed on Resident #129. There were no negative outcomes to the resident.	10/31/14 8/28/14

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F 514	Continued From page 73 July 8, 2014 and the July 2014 Physician's Orders revealed that Resident #93 was admitted to the facility on February 14, 2011 with the following diagnoses: Hypertension, Cerebral Vascular Accident, Atherosclerotic Disease, Depression, Seizure Disorder, Dysphagia, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. On August 28, 2014 at approximately 10:00 AM, a clinical record review for Resident #93 revealed the following: An 'Interim Order Form' dated June 2, 2014 directed an order for a dental consult. A dental consult dated June 15, 2014 indicated that treatment was "refused." A dental consult dated June 28, 2014 indicated that an oral exam was completed and another exam was scheduled for July 9, 2014. An 'Interim Order Form' and a 'Controlled Substance Prescription' dated August 25, 2014 for Ativan to be given prior to a dental procedure on September 15, 2014. According to the documentation, there was no evidence that the dentist evaluated the resident on July 9, 2014; and there was no documentation regarding the dental findings on August 25, 2014. On August 29, 2014 at approximately 10:00 AM, a telephone interview was conducted with Employee #19 regarding the aforementioned findings. The employee acknowledged that he/she did evaluate the resident on July 9, 2014 and August 25, 2014, but did not write a note in	F 514	Continued from page 73 2. The Treatment Administration Records (TARs) were checked on all nursing units for missing initials to validate all wound treatments were done for the residents. No missing initials were found on the Treatment Administration Records (TARs). 3. In-service was provided for licensed nurses regarding policies related to documenting the care provided to residents. 4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor and report monthly to the Quality Improvement Committee the Treatment Administration Records (TARs)for at least one year, prior to the committee determining to discontinue this monitor.	10/31/14 10/31/14 10/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	09/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 74 the chart about the findings or plan of dental care for Resident #93. The record was reviewed on August 28, 2014. Facility staff failed to maintain complete, accurate, and organized clinical records. 3. Facility staff failed to document that a wound treatment was completed for Resident #129. A review of the wound treatment orders dated August 28, 2014 directed, "Remove Snap Vac [wound dressing] at nursing home on Monday September 1, 2014...Apply rescue dressing of hydrofera blue foam [bacteriostatic wound dressing] and 3 layer compression wrap [bandaging wrap system]..." A review of the nursing treatment administration record [TAR] for September 1, 2014 lacked a signature in the box to indicate that the treatment was performed. A face-to-face interview was conducted with Employees #17, #25, and #26 on September 2, 2014 at approximately 10:00 AM. The employees acknowledged that the signature was missing, after reviewing the treatment sheet. The record was reviewed on September 2, 2014. Facility staff failed to document on the TAR that a wound treatment had been completed.	F 514	Continued from page 74 **2. Resident #93** 1. The resident was assessed and condition was stable on 8/29/14. The Dentist failed to document the dental finding conducted on July 9, 2014 for Resident #93. There were no negative outcomes to the resident. 2. All other residents with orders for Dental consults were reviewed and documentation was current. 3. Medical Director advised the Dentist of required Dental documentation for the residents on 10/31/14. 4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor resident dental documentation will be monitored monthly and reported monthly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.	8/29/14 10/31/14 10/31/14 10/31/14