STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	11/27/2013

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BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	2131 O STREET NW WASHINGTON, DC 20037

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F 000	INITIAL COMMENTS A Quality Indicator Survey (QIS) recertification survey was conducted at your facility on November 18, 2013 through November 27, 2013. The following deficiencies are based on observations, record reviews, resident 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 g-tube Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - emergency medical services (911) HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA Certified Nurse Aide DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L - Liter Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of	F 000	Brinton Woods Health and Rehabilitation Center at Dupont Circle is submitting this plan of correction in accordance with state and federal requirements. Submission of this plan of correction is not an admission to or an agreement with the alleged deficiencies cited within this statement of deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 1/27/14

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 volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury POS - physician ' s order sheet Prn - As needed TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- discontinue Rp, R/P- responsible party PO- By Mouth	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of five (5) employee records reviewed, it was determined that facility staff failed to ensure that abuse training was conducted prior to working on the nursing with residents. The findings include: The facility ' s policy entitled, " Resident Abuse and Staff Unethical Conduct Investigation and	F 226		

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F 226	Continued From page 2 Reporting Policy " last updated May 26, 2011 stipulated: " H. Abuse Training at Rock Creek Manor, 1. During application for employment at RCM (Rock Creek Manor), each applicant is given a pre-test for resident ' s rights and abuse evaluation. 2. Upon a offer of employment, the respective employee is given ...the RCM statement on the prohibition of Resident Abuse ... " 1.A review of the personal file for Employee #30 revealed that he/she was hired on August 29, 2013 to work in the " Environmental Services " Department. A review of the " Time Card " data for Employee #30 revealed that he/she work from September 11, 2013 through November 6, 2013 on assigned days. A review of the " Resident Abuse Post Test " revealed that Employee #30 completed the test on October 31, 2013 and there was no pre-test abuse evaluation. There was no evidence that facility staff received a pre-test for abuse during the application process or that he/she received abuse training in accordance with the facility ' s policy prior to working in the facility. A face-to-face interview was conducted on November 27, 2013 at approximately 3:30 PM with Employee #30. He /she acknowledged the findings.	F 226	1. Employee #30 was immediately identified and abuse training was re-conducted and signed. 2. A review of personnel files was conducted by HR and no deficient practice was noted. 3. Director of Human Resources was in-serviced on 1/17/14 on the training of employees on abuse prior to start date. QA/designee will conduct bi-weekly sampling of charts to identify and ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 226	Continued From page 3 2. A review of the personal file for Employee #31 revealed that he/she was hired on September 25, 2013 to work in the " Nursing " Department. A review of the " Time Card " data for Employee #31 revealed that he/she worked from August, 2013 to present on assigned days. A review of the " Resident Abuse Post Test " revealed that Employee #31 completed the test on October 16, 2013 and there was no pre-test abuse evaluation. There was no evidence that facility staff received a pre-test for abuse during the application process or that he/she received abuse training in accordance with the facility ' s policy prior to working in the facility. A face-to-face interview was conducted on November 27, 2013 at approximately 3:30 PM with Employee #31. He /she acknowledged the findings.	F 226	1. Employee #31 was immediately identified and abuse training was re-conducted and signed. 2. A review of personnel files was conducted by HR and no deficient practice was noted. 3. Director of Human Resources was in-serviced on 1/17/14 on the training of employees on abuse prior to start date. QA/designee will conduct bi-weekly sampling of charts to identify and ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings.	1/21/14
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 4 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 eight (8) of 39 sampled residents, it was determined that facility staff failed to identify the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V [V0200A] for eight (8) residents. Residents #84, 123, 152, 160, 179, 191, 192 and 242.	F 272		

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F 272	Continued From page 5 The findings include: According to Chapter 4 of the MDS 3.0 Users ' 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 identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the annual Minimum Data Set [MDS] for Resident #84. A review of Resident #84 ' s annual Minimum Data Set dated September 20, 2013 revealed that Care Areas and ' addressed ' in Care Plan triggered for #3 Visual Function, #5 ADL (Activities of Daily Living) Functional/Rehabilitation Potential, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, and #16 Pressure Ulcer. The record revealed that the location and date of CAA information [for care areas #3, 5, 6, 11, 12, and 16] were recorded as "CAA WS (worksheet) 8/30/13 " . There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. There were no " CAA worksheets " available for review.	F 272	1. The location and date of care area section V [V0200A] for resident #84 was identified on 11/29/13. 2. All other resident 's MDS were reviewed and those found with this deficient practice were corrected on 11/29/13. 3. The MDS coordinator upon completion of the MDS will immediately audit the MDS to ensure that the location and date of CAAs information is appropriate. QA/designee in-serviced MDS coordinators on 1/17/14 on location of CAA information in the MDS. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 6 The clinical record lacked evidence of documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #25 on November 26, 2013 at 2:20 PM. He/she acknowledged that the date and location where information related to the CAA can be found was not document on the CAA Summary. 2.Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the annual Minimum Data Set [MDS] for Resident #123. A review of Resident #123's annual Minimum Data Set dated November 10, 2013 revealed that Care Areas and ' addressed ' in Care Plan triggered for #2 Cognitive Loss/Dementia, #5 ADL (Activities of Daily Living) Functional/Rehabilitation Potential, #12 Nutritional Status, #14 Dehydration/Fluid Maintenance, and #16 Pressure Ulcer. The record revealed that the location and date of CAA information [for care areas #2, and 12] were recorded as " CAA WS 11/7/2013 " ; and [for care areas #5, 14, and 16] were recorded as " CAA WS 11/6/2013" . There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. There were no " CAA worksheets " available for review.	F 272	1. The location and date of care area section V [V0200A] for resident #123 was identified on 11/29/13. 2. All other resident 's MDS were reviewed on 11/29/13 for the location and care area for accuracy and none were noted with this deficient practice. 3. The MDS coordinator upon completion of the MDS will immediately audit the MDS to ensure that the location and date of CAAs information is appropriate. QA/designee in-serviced MDS coordinators on 1/17/14 on location of CAA information in the MDS. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 7 The clinical record lacked evidence of documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #25 on November 26, 2013 at 2:20 PM. He/she acknowledged that the date and location where information related to the CAA can be found was not document on the CAA Summary. 3. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the annual Minimum Data Set for Resident #152. A review of Resident #152 ' s annual Minimum Data Set dated December 27, 2012 revealed that Care Areas and ' addressed ' in Care Plan triggered for #02 Cognitive Loss/Dementia, #04 Communication, #05 ADL function, #06 Urinary incontinence and Indwelling Catheter, # 08 Mood State, #11 Falls, #12 Nutritional Status,# 14 Dehydration/Fluid Maintenance, #16 Pressure Ulcer and, #17 Psychotropic Drug Use. The record revealed that the location and date of CAA information [for care areas #2, 8 and 12] was recorded as " CAA WS " (worksheet). The location and date of CAA information [for care areas #4, 5, 6, 11, 16 and 17] were recorded as " CAA WS 11/09/2013 " and " See RAP " (Resident Assessment Protocol).	F 272	1. The location and date of care area section V [V0200A] for resident #152 was identified on 11/29/13. 2. All other resident 's MDS were reviewed on 11/29/13 for the location and care area for accuracy and none were noted with this deficient practice. 3. The MDS coordinator upon completion of the MDS will immediately audit the MDS to ensure that the location and date of CAAs information is appropriate. QA/designee in-serviced MDS coordinators on 1/17/14 on location of CAA information in the MDS. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 8 There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. There were no " CAA worksheets " available for review and/or the information on the worksheets [including RAP] lacked documentation related to complicating factors, risks and/or any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #25 on November 26, 2013 at 2:20 PM. He/she acknowledged that the date and location where information related to the CAA can be found was not document on the CAA Summary. 4. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the admission Minimum Data Set [MDS] for Resident #160. A review of Resident #160 ' s admission MDS dated November 8, 2013 revealed that Care Areas and ' addressed ' in Care Plan triggered for #02 Cognitive Loss/Dementia, #04 Communication, #05 ADL function,#06 Urinary incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, # 14 Dehydration/Fluid Maintenance, #15 Dental care, and #16 Pressure Ulcer. The location and date of CAA information for was recorded as " CAA WS [worksheet] 11/9/13. " There was no evidence that facility staff documented where in the clinical record	F 272	1. The location and date of care area section V [V0200A] for resident #160 was identified on 11/29/13. 2. All other resident 's MDS were reviewed on 11/29/13 for the location and care area for accuracy and none were noted with this deficient practice. 3. The MDS coordinator upon completion of the MDS will immediately audit the MDS to ensure that the location and date of CAAs information is appropriate. QA/designee in-serviced MDS coordinators on 1/17/14 on location of CAA information in the MDS. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 9 information related to the CAA ' s could be found. There were no " CAA worksheets " available for review and/or the information on the worksheets lacked documentation related to complicating factors, risks and/or any referrals related to the triggered care area(s). The findings were acknowledged during a face-to-face interview with Employee #6 on November 25, 2013 at approximately 2:45 PM. 5. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the annual Minimum Data Set [MDS] for Resident #179. A review of Resident #152 ' s annual Minimum Data Set dated December 14, 2012 revealed that Care Areas and ' addressed ' in Care Plan triggered for #1 Delirium, #2 Cognitive Loss/Dementia, #3 Visual Function, #5 ADL Functional/Rehabilitation Potential, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status and #16 Pressure Ulcer. The location and date of CAA information [for care areas #1, 2, 3, 5, 6, 11, 12, and 15] were recorded as " CAA WS 10/24/13". There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. There were no " CAA worksheets " available for review. The clinical record lacked evidence of	F 272	1. The location and date of care area section V [V0200A] for resident #179 was identified on 11/29/13. 2. All other resident 's MDS were reviewed on 11/29/13 for the location and care area for accuracy and none were noted with this deficient practice. 3. The MDS coordinator upon completion of the MDS will immediately audit the MDS to ensure that the location and date of CAAs information is appropriate. QA/designee in-serviced MDS coordinators on 1/17/14 on location of CAA information in the MDS. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings.	1/21/14

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F 272	Continued From page 10 documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #25 on November 26, 2013 at 2:20 PM. He/she acknowledged that the date and location where information related to the CAA can be found was not documented on the CAA Summary. 6. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the admission Minimum Data Set [MDS] for Resident #191. A review of Resident #191' s admission Minimum Data Set dated June 28, 2013 revealed that Care Areas and ' addressed ' in Care Plan triggered for #2 Cognitive Loss/Dementia, #5 ADL (Activities of Daily Living) Functional/Rehabilitation Potential, #6 Urinary Incontinence and Indwelling Catheter, #9 Behavioral Symptoms, #11 Falls, #12 Nutritional Status, #16 Pressure Ulcer, #17 Psychotropic Drug Use. The record revealed that the location and date of CAA information [for care areas #2 5, 6, 9, 11, 12, 16 and 17] were recorded as " CAA WS 6/28/13. There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. There were no " CAA worksheets " available for review.	F 272	1. The location and date of care area section V [V0200A] for resident #191 was identified on 11/29/13. 2. All other resident 's MDS were reviewed on 11/29/13 for the location and care area for accuracy and none were noted with this deficient practice. 3. The MDS coordinator upon completion of the MDS will immediately audit the MDS to ensure that the location and date of CAAs information is appropriate. QA/designee in-serviced MDS coordinators on 1/17/14 on location of CAA information in the MDS. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 11 The clinical record lacked evidence of documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #25 on November 26, 2013 at 2:20 PM. He/she acknowledged that the date and location where information related to the CAA can be found was not documented on the CAA Summary. 7. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the annual Minimum Data Set [MDS] for Resident #192. A review of Resident #192' s annual Minimum Data Set dated June 28, 2013 revealed that Care Areas and ' addressed ' in Care Plan triggered for #2 Cognitive Loss/Dementia, #4 Communication, #5 ADL (Activities of Daily Living) Functional/Rehabilitation Potential, #6 Urinary Incontinence and Indwelling Catheter, #11 Falls, #12 Nutritional Status, #15 Dental Care, #16 Pressure Ulcer, #17 Psychotropic Drug Use. The record revealed that the location and date of CAA information [for care areas #2, 4, 5, 6, 11, 12, 15, 16 and 17] were recorded as " CAA WS " (worksheet) 8/30/13. There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found.	F 272	1. The location and date of care area section V [V0200A] for resident #192 was identified on 11/29/13. 2. All other resident 's MDS were reviewed on 11/29/13 for the location and care area for accuracy and none were noted with this deficient practice. 3. The MDS coordinator upon completion of the MDS will immediately audit the MDS to ensure that the location and date of CAAs information is appropriate. QA/designee in-serviced MDS coordinators on 1/17/14 on location of CAA information in the MDS. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 12 There were no " CAA worksheets " available for review. The clinical record lacked evidence of documentation regarding complicating factors, risks and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #25 on November 26, 2013 at 2:20 PM. He/she acknowledged that the date and location where information related to the CAA can be found was not documented on the CAA Summary. 8. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the admission Minimum Data Set [MDS] for Resident #242. A review of Resident #242 ' s admission MDS dated August 16, 2013 revealed that Care Areas and ' addressed ' in Care Plan triggered for #05 ADL function, #06 Urinary incontinence and Indwelling Catheter, #08 Mood State, #11 Falls, #12 Nutritional Status, #16 Pressure Ulcer, #17 Psychotropic Drug Use and #20 Return to Community Referral. The location and date of CAA information was recorded as " CAA WS [worksheet] 8/19/13. " There was no evidence that facility staff documented where in the clinical record information related to the CAA ' s could be found. There were no " CAA worksheets " available for review and/or the information on the worksheets	F 272	1. The location and date of care area section V [V0200A] for resident #242 was identified on 11/29/13. 2. All other resident 's MDS were reviewed on 11/29/13 for the location and care area for accuracy and none were noted with this deficient practice. 3. The MDS coordinator upon completion of the MDS will immediately audit the MDS to ensure that the location and date of CAAs information is appropriate. QA/designee in-serviced MDS coordinators on 1/17/14 on location of CAA information in the MDS. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 13 lacked documentation related to complicating factors, risks and/or any referrals related to the triggered care area(s). The findings were acknowledged during a face-to-face interview with Employee #6 on November 25, 2013 at approximately 2:00 PM. B. Based on observations, record review and interview for four (4) of 39 sampled residents, it was determined that facility staff failed to code Minimum Data Sets (MDS) for: special treatments for one (1) resident; dental status for one (1) resident; Preadmission Screen and Resident Review (PASRR) for one (1) resident, and bladder status for one (1) resident. Residents #66, #133, #179 and #191. The findings include: 1. Facility staff failed to accurately code Section O, Special Treatments of the Quarterly MDS dated October 17, 2013 for Resident #66. A review of the clinical record for Resident #66 revealed the resident ' s plan of care included Hemodialysis treatments. The history and physical dated June 13, 2013 read: " ...done well on dialysis past year ...medical history ESRD [end stage renal disease]. " A review of the Quarterly MDS completed October 17, 2013 revealed that under Section O, [O0100 J] Special Treatments, Procedures, and Programs of the quarterly MDS, ' dialysis ' was not coded. Facility staff failed to code dialysis treatments	F 272	1. Resident #66 was identified and quarterly MDS was modified on 11/29/13 to include dialysis under section "O" of the MDS. 2. All other resident 's MDS were reviewed on 11/29/13 for inaccurate coding and none was found with this deficient practice. 3. The MDS coordinator upon completion will review source of information to ensure accurate coding. QA/designee in-serviced MDS coordinators on 1/17/14 on appropriate coding in general and dialysis residents in specific. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 14 under Section O, of the quarterly MDS for Resident #66. A face-to-face interview was conducted with Employee #7 on November 22, 2013 at approximately 12:00PM. After reviewing the MDS, the employee acknowledged the findings. The record was reviewed on November 22, 2013. 2. Facility staff failed to accurately code Section K, Oral/ Dental status of the Quarterly MDS dated November 8, 2013 for Resident #133. During a face-to-face interview with Resident #133 conducted on September 18, 2013 at approximately 1:30 PM, the resident ' s mouth was observed to have excessive tissue (gum overgrowth) where a tooth appeared to be missing. Resident #133 stated " I have seen the dentist and will be going for oral surgery. " A review of resident ' s Dental Record dated September 13, 2013 revealed exam result/comments: " Missing teeth, ... patient has large growth 6mm between #10, #12, " Abnormal soft tissue findings: " Raised lesion upper anterior ridge between #10 - #12, erythematous in nature ... " Recommendation: " Excision and Biopsy of lesion ... Pt referred to Washington Hospital center for removal of lesion. " The Quarterly MDS dated November 8, 2013 lacked evidence that facility staff coded [the section was blank] Section L, Oral/ Dental Status	F 272	1. Resident #133 was identified and MDS was modified on 11/29/13 to reflect section L (Oral/Dental Status). 2. All other resident 's MDS were reviewed on 11/29/13 for inaccurate coding and none was found with this deficient practice. 3. The MDS coordinator upon completion of MDS will review source of information to ensure accurate coding. QA/designee in-serviced MDS coordinators on 1/17/14 on appropriate coding of MDS to reflect oral dental status. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 15 [L0200-C] to include the abnormal mouth tissue that was observed and assessed by the dentist. The evidence revealed that facility staff failed to code Resident #133 ' s Quarterly MDS completed on November 8, 2013 to include dental status. A face-to-face interview was conducted with Employee #4 on November 20, 2013 at approximately 11:42 PM. After reviewing the MDS, the employee acknowledged the findings. The record was reviewed on November 20, 2013. 3. Facility staff failed to accurately code Section I, Active Diagnoses of the Significant Change in Status Minimum Data Set [MDS] dated October 22, 2013 for Resident #179. A review of Resident #179 ' s clinical record revealed that facility staff failed to include the resident ' s diagnosis of urinary tract infection (UTI) under Section I (I2300), " Active Diagnosis " on the Significant Change in Status MDS to reflect the UTI that was treated in the past 30 days. A physician ' s order dated September 22, 2013-8:00 AM directed, " Bactrim DS (Double Strength) - 1 (one) [tablet] po (by mouth) every 12 hours for UTI (Urinary Tract Infection). " A physician ' s note dated September 24, 2013 read: " Labs reviewed ... Impression: UTI (Urinary Tract Infection) - On Bactrim ... " A review of the residents ' Significant change in	F 272	1. Resident #179 was identified and MDS was modified on 11/29/13 to reflect section I (12300) for UTI. 2. All other resident 's MDS were reviewed on 11/29/13 for inaccurate coding and none was found with this deficient practice. 3. The MDS coordinator upon completion of MDS will review source of information to ensure accurate coding. QA/designee in-serviced MDS coordinators on 1/17/14 on appropriate coding of MDS to reflect UTI status. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 16 status assessment Minimum Data Set [MDS] with an Assessment Reference Date [ARD] of October 22, 2013 revealed: " I2300- Urinary Tract Infection (UTI) (Last 30 DAYS) was blank. Facility staff failed to accurately code the Significant change in status assessment Minimum Data Set [MDS] Section I2300 for Urinary Tract Infection. A face-to-face interview was conducted with Employee #25 on November 27, 2013 at approximately 12:50 PM. After reviewing the Significant change in status assessment MDS, he/she acknowledged the finding. 4. Facility staff failed to accurately code Section A, Identification Information of the Significant Change in Status Minimum Data Set [MDS] dated August 18, 2013 for Resident #191. A review of Resident #191 ' s Pre-Admission Screen/Resident Review for Mental Illness and/or Mental Retardation signed and dated June 20, 2013 revealed in Part B that the resident had a positive screen for mental illness, which required the resident to be referred to the District of Columbia Department of Mental Health for a Level II evaluation. A review of the PASRR - Level II signed and dated August 5, 2013 revealed that the resident required Specialized Services for Mental Illness. A review of the resident ' s Significant change in status Minimum Data Set [MDS] dated August	F 272	1. Resident #191 was identified and section "A " of the MDS was modified on 11/29/13 to reflect accurate information. 2. All other resident 's MDS were reviewed on 11/29/13 for inaccurate coding and none was found with this deficient practice. 3. The MDS coordinator upon completion of MDS will review source of information to ensure accurate coding. QA/designee in-serviced MDS coordinators on 1/17/14 on accurate coding of Section A MDS. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 272	Continued From page 17 18, 2013 revealed: Section A, Identification Information: A1500 Preadmission Screening and Resident Review (PASSR) was coded " 0 " indicating " No " : " Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (" mental retardation " in federal regulation) or a related condition? Section A1510 was not coded (remained blank): " Level II Preadmission Screening and Resident Review (PASRR) conditions" check all that apply: A. Serious mental illness B. Intellectual Disability (" mental retardation " in federal regulation); C. Other related conditions ... " A face-to-face interview was conducted on November 25, 2013 at approximately 10:10 AM with Employee #25. After review the Significant change in status assessment MDS, he/she acknowledged the finding.	F 272		
F 280 SS=E	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	F 280		

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F 280	Continued From page 18 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for four (4) of 39 sampled residents, it was determined that facility staff failed to update care plans to include: to update the care plan for the use of sunglasses for one (1) resident; to review and revise the care plan to include hospice services for one (1) resident; to update the care plan for one (1) residents refusal to have his/her nails trimmed; and to update the care plan to address one (1) resident's significant weight loss. Residents #84, 123, 179, and 230. The findings include: 1.Facility staff failed to update the care plan for the use of sunglasses for Resident #84. A review of the ophthalmology examination dated November 7, 2012 revealed, " Chief Complaint: Consult requested, pt (patient) states mild Photophobia in bright sun	F 280	1. Resident #84 care plan was immediately updated on 11/29/13 to reflect the use of sunglasses. 2. All other residents who require the use of sunglasses were reviewed, and none was found with this deficient practice.	

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F 280	Continued From page 19 OU (both eyes); Impression: 1.Blind painless eye OU. 2. Photophobia. Plan: ...Pt states sensitivity to light. Pt should have sunglasses for outdoors. " The October 2013 Physician ' s Orders signed and dated by the physician on October 10, 2013 directed, " Pt (patient) should have a pair of sunglasses for going out in sun due to Photophobia " . On November 25, 2013 at approximately 11:15 AM Resident # 84 was observed being escorted out of the facility on a sunny day by a staff member and the resident was not wearing sunglasses. A review of the " Visual Impairment " care plan initiated November 2, 2011 and last revised on September 13, 2013 lacked evidence the care plan was updated to address the resident's need to wear sunglasses for outdoors due to the resident ' s sensitivity to light. A face-to-face interview was conducted with Employee #6 on November 25, 2013 at approximately 11:45 AM. Employee #6 searched Resident #84 ' s room for sunglasses and did not locate them. He/she then stated, [Resident #84] has the sunglasses in [his/her] bag. A face-to-face interview was conducted with Resident #84 on November 25, 2013 at approximately 4:00 PM. He/she stated, " I didn ' t wear any sunglasses to the doctors. I don ' t have any sunglasses. I need to wear them	F 280	3. All nurse managers/RCC's were in-serviced on 1/17/14 on updating care plans for all residents who require the use of sunglasses while out in the sun. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 280	Continued From page 20 because I am blind and the sun light hurts my eyes. " A face-to-face interview was conducted with Employee # 6 on November 25, 2013 at approximately 11:45 AM. He/she acknowledged that the care plan was not updated to include the resident wearing sunglasses when outdoors. The record was reviewed on November 25, 2013. 2. Facility staff failed to review and revise the care plan to include hospice services for Resident #179. A. According to a physician ' s admission order dated October 14, 2013 " Resident is certified as Hospice. Admitted to [name of hospice]. " According to an interim physician ' s order dated October 14, 2013 at 9:15 PM, " Please admit resident to [name of Hospice] [with diagnosis]: Dementia. " A review of the active clinical record revealed an IDT (Interdisciplinary Team Meeting) was conducted on October 17, 2013 and the registered nurse from Hospice services was in attendance. The comprehensive care plan dated October 15, 2013 included the problem " Death with Dignity resident is on hospice. Intervention included, " hospice care orders will be considered; however, there was no evidence that the care plan was revised when it was determined that the resident was admitted to hospice services.	F 280	1. An integrative care plan was immediately put in place for resident #179 to reflect all IDT members and plan of care of resident on hospice. 2. Care plans for all other residents on hospice were reviewed on 11/29/13 and none was found with this deficient practice. 3. All RCC's/nurse managers were in-serviced on 1/17/14 on the implementation of an integrative care plan for hospice residents. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 280	Continued From page 21 A review of the clinical record lacked evidence that the care plan was revised to include goals and interventions to specify the various aspects of hospice care. Facility staff failed to review and revise the care plan to include hospice services. A face-to-face interview was conducted with Employees #6 and #12 on November 26, 2013 at approximately 10:30 AM. After reviewing the clinical record; both acknowledged that the care plan did not incorporate the hospice services. 3. Facility staff failed to update the care plan to include Resident #123's refusal to have his/her nails trimmed. During a face-to-face interview with Resident #123 on November 18, 2013 at approximately 4:10 PM, it was observed that his/her fingernails on his/her right hand were long and untrimmed. A face-to-face interview was conducted with Employee #32 (day shift staff) on November 21, 2013 at approximately 3:10 PM. He/she stated, " His/her nails are long, but [he/she] won ' t let me cut them, [he/she] refuses. " A face-to-face interview was conducted with Employee #6 on November 21, 2013 at approximately 4:30 PM. He/she stated, " I know that [his/her] nails are long, but [he/she] refuses to let us [facility staff] cut them. We have to call [his/her] [family member]. The [family member] will come to the facility and the resident will let	F 280	1. Resident #123 was immediately identified and nails care was provided. 2. All other residents had their nails assessed and none was noted with this deficient practice. 3. All nursing staff were in-serviced on 1/17/14 on nail care and grooming to meet the needs of residents. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 280	Continued From page 22 us cut [his/her] nails. A face-to-face interview was conducted with Employee #33 (evening shift staff) on November 22, 2013 at approximately 3:45 PM. He/she stated, " The resident ' s nails are long...[he/she] refuses, I don ' t cut them." A review of the " Self Care Deficit " care plan revealed that there were no interventions in place to address Resident #123 refusal to have his/her nails trimmed. A face-to-face interview was conducted with Employee # 6 on November 22, 2013 at approximately 4:00 PM. He/she acknowledged the findings. The record was reviewed on November 22, 2013. 4. Facility staff failed to update care plans to address Resident #230 ' s significant weight loss. A review of the " Weight Record " revealed the following: Initial weight July 15, 2013 - 218 pounds Weekly July 17, 2013- 221.4 pounds Weekly July 24, 2013- 200.2, reweight-199.6 pounds Weekly July 31, 2013- 193.8, reweight-193 pounds Monthly August 1, 2013- 191.8 pounds Weekly August 7, 2013 - 189.6 pounds Weekly August 14, 2013- 188.2 pounds Weekly August 21, 2013 - 194.8, reweight-195.2 pounds	F 280	1. Resident #230 was discharged on 8/30/13. 2. All other residents with significant weight change were reviewed on 11/29/13 and none was found with this deficient practice. 3. Registered dietician/nurse managers were in-serviced on 1/17/14 to care plan all triggered significant changes. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	2131 O STREET NW WASHINGTON, DC 20037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 23 The Nutritional Progress Notes revealed: " July 18, 2013 ...Addendum- admission wt 218 # (pounds), re-wt (weight) 221.4 #...mild wt. gain, will follow up with resident weight. " July 29, 2013 weekly weight x 4 ...7/24 200.2#, re-wt 7/25 199.6# weight change 18.4# decrease (8.4%) ... " " July 31, 2013, IBW (ideal body weight) 193.8# wt changes 5.8# decrease (2.9%) x 1 week moderate wt loss, resident admitted with edema on bilateral LE per NP note on 7/17. Weight changes possibly [secondary] to the edema ...PO meal intake 75 -100%.,,, will continue to monitor wt, labs, po intake and skin ... " " August 14, 2013 Resident review ...weekly wt x 4 ...8/1/13 191.8# [compared] to admission wt 7/15/13 218#, wt change 26.2# decrease (12.0%) x 2 weeks. Significant wt loss probably second to edema resolving. PO intake 76%-100%... " A review of the Progress Notes written by the Nurse Practitioner revealed: July 17, 2013 at 12:40 PM "...ext (extremity): +1 bil (bilateral) LE(lower extremity) edema. " July 22, 2013 at 2:45 PM " ...ext: +1 bil LE edema ... " July 30, 2013 at 9:00 PM " ...ext: (0) edema ... " August 12, 2013 at 14:15 " ...ext: (0) edema ... " August 15, 2013 at 16:00 " ...Evaluated for weight loss of 12% was 218# now 191.8 lbs (pounds)...on admission + [illegible] bilateral LE edema ... ext: (0) edema ... "	F 280		

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F 280	Continued From page 24 The Physician ' s Order dated July 16, 2013 directed that the resident receive NCS (no concentrated sweets), NAS (no added salt), Low fat/chol (cholesterol) diet, HS (hour of sleep) snack, encourage and document % consumed - 240 ml/fluid with meals for hydration. A review of the " Therapeutic Diet and Altered Nutrition " care plans initiated on July 16, 2013 lacked evidence that the resident ' s significant weight loss was included and addressed in the plan of care. A face-to-face interview was conducted with Employee #29 on November 22, 2013 at 11:20 AM. He/she acknowledged that the care plan was not updated to address the resident ' s significant weight loss. The record was reviewed on November 22, 2013.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for three (3) of 39 sampled resident, it was determined that the facility staff failed to: accurately assess the vascular access site for	F 309		

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F 309	Continued From page 25 dialysis and administer medications in accordance with the physician's order for one (1) resident; apply splints and adaptive devices as prescribed for one (1) resident; apply sun glasses as prescribed for one (1) resident and to clarify and administer an analgesic medication per physician ' s orders for one (1) resident. Resident ' s #2, #38, 84 and #242. The findings include: 1. Facility staff failed to accurately assess a venous access site and administer two (2) medications in accordance with physician ' s orders for Resident #2. 1A.Facility staff failed to accurately assess the [arteriovascular fistula] AVF (vascular access site) formally used for Hemodialysis treatment for Resident #2. A review of Admission Order Sheet and Physician Plan of Care records dated October 10, 2013 revealed that Resident #2 had Diagnoses that included: "ESRD [end stage renal disease] with initiation of dialysis], Glaucoma, Anemia of CKD [chronic kidney disease], and AV [arteriovascular] fistula malfunction ." A review of Physician progress note dated October 16, 2013 revealed, " R [right] ant [anterior] cw [chest wall] permacath in place ...2) ESRD on Dialysis. 3) RUE (right upper extremity) and AVF clotted-Now has permacath ..."	F 309	1. Resident #2 vascular access site on right anterior chest wall permacath was properly assessed and noted to be in place. The AVF site was clotted and no longer in use. The resident was not harmed by this deficient practice. 2. All other residents on Hemodialysis were reviewed on 11/29/13 and all were properly assessed. All charge nurses will assess permacath before and after dialysis. 3. All RCC's/nursing staff were in-serviced on 1/17/14 on proper assessment of permacath for all residents receiving Hemodialysis. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings.	1/21/14

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F 309	Continued From page 26 A review of nurses ' notes from October 10, 2013 to November 20, 2013 revealed that the nursing staff assessed Resident #2's clotted AVF as positive bruit and thrill [Bruit is the ' whooshing' noise that can be heard with a stethoscope if the fistula is functioning properly. Thrill is the vibration felt due to high blood flow and can also be felt in a fistula]. Facility staff failed to accurately assess the AVF (vascular access site) formally used for Hemodialysis treatment for Resident #2 from October 10, 2013 to November 20, 2013. A face-to-face interview was conducted with Employee #7 on November 22, 2013 at approximately 11:50AM. After reviewing the nurses ' notes in Resident #2 ' s record, Employee #7 acknowledged the findings. 1B. Facility staff failed to administer Renvela [Renvela is a medication used to control phosphorus levels in patients with chronic kidney disease on dialysis] medication in accordance with the Physician's Order for Resident #2. The Physician's Order dated September 10, 2013 directed, " Renvela tab 800mg, take 1 tab by mouth three times daily three times weekly on Tues [Tuesday], Thurs [Thursday], Sat [Saturday] (9AM, 5PM, 10PM). Renvela tab 800mg, take 1 tab by mouth three times daily four times weekly on Mon [Monday], Wed [Wednesday], Fri [Friday] and Sun [Sunday] (9AM, 1PM, 5PM) for ESRD.	F 309	1. Renvela medication was given, facility counted the doses and found that nursing staff failed to sign-off on medication administration record. Monthly follow up lab result done on 12/13/13 indicates phosphorus level at 3.7, which is normal. 2. All other residents on Renvela were reviewed on 11/29/13 and no other deficient practice was noted. 3. All RCC's/charge nurses were in-serviced on 1/17/14 on consistent medication administration and signing on medication. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings.	1/21/14

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F 309	Continued From page 27 A review of Dialysis Laboratory (lab) Report revealed the following: September 5, 2013 Phosphorous (Phos) lab result 5.7 ... Goal: 3.5 - 5.5, " We will check this again on 9/18. " September 20, 2013 Phos result abnormal 7.1 ... " Recent phos levels 5.7 - 7.1 " Please have pt. [patient] take one Renvela with each meal " signed by [dialysis doctor]. October 25, 2013 Phos result abnormal 6.9 ... " [Resident name] Phosphorus was higher again. Any thoughts re: diet changes ... timing of meds? " November 13, 2013 Phos result High 6.8 [normal 3.5 - 5.5], " Any ideas? Is [he/she] taking Renvela at Dialysis with meals?? Increase to 2 pills. A review of Physician's Progress notes dated September 25, 2013 read, " On 9/5 PO4 [phosphate] = 5.7 Repeat on 9/20 PO4= 7.1 Hyper-phosphatemia 2o [secondary to] ESRD ... Pt (patient) is presently receiving Renvela 800mg tid with meals, except on Dialysis days when given when pt returns ...Follow PO4 ... " A review of Physician's Progress note dated November 13, 2013 read, " PO4 = 6.8 (3.5 - 5.5) on Renvela 800mg TID [three times daily] ... ESRD on Dialysis, Hyper-phosphatemia - on Renvela 800mg tid supposed to be with meals -	F 309		

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F 309	Continued From page 28 not getting at dialysis with lunch. Notify Dialysis that elevated PO4 may be [second] to patient not getting Renvela at dialysis with meals. " A review of the Medication Administration records revealed the following: October, 2013 the allotted space for acknowledgement of administration of Renvela was left blank on October 4 at 12:00 PM, October11, 13, and 20 at 5:00PM. November, 2013 revealed that space allotted for acknowledgement of the resident's receipt of Renvela was left blank on November 16, 2013 at 10:00PM. There was no evidence that facility staff consistently administered Renvela to Resident #2 who was assessed with abnormal levels of phosphorus. A face-to-face interview was conducted with Employee #7 on November 22, 2013 at approximately 11:50AM. After reviewing the clinical record, he/she acknowledged the findings. The record was reviewed on November 22, 2013. 1C. Facility staff failed to administer Travatan Z Opth (ophthalmic) solution [eye drops] per the Physician ' s Order for Resident #2. A review of the October 2013 Physician's Order sheet directed, " Travatan Z Opth Soln 1 drop in	F 309	1. Interview with employee #7 indicated Travaton Z eye drops were not administered per physicians order. Employee #7 was educated on administration and signing off on administered medication. 2. All other resident receiving Travaton Z eye drops were reviewed on 11/29/13 and none were noted with this deficient practice.	

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F 309	Continued From page 29 each eye at bedtime for Glaucoma". A review of the October 2013 Medication Administration Record revealed that Travatan Z Opth Soln 1 drop in each eye at bedtime for Glaucoma was noted, however; the spaces allotted from October 10, 2013 to October 31, 2013 were left blank. There was no evidence that facility staff administered Travatan Z to Resident #2 in accordance with the physician's order for the period of October 10 - 31, 2013. A face-to-face interview was conducted with Employee # 7 on November 22, 2013 at approximately 11:50AM. After reviewing the October 2013 Medication Administration Records for Resident #2, Employee#7 acknowledged the findings. The record was reviewed on November 22, 2013. 2. Facility staff failed to ensure that Resident #38 received an analgesic medication, Tramadol in accordance with physician ' s orders. The November 2013 Physician ' s Order signed and dated November 4, 2013 revealed, " Clarification: Use Tramadol 50 mg bid for pain greater than 6/10. Tramadol 50 mg take 1 tablet by mouth twice daily for back pain. " A review of the November 2013 MARs revealed that Tramadol 50 mg PO for pain greater than or equal to 6/10 was administered at 9:00 AM and 5:00 PM on November 1, 2, 3 and at 5:00 PM on	F 309	3. All RCC's/charge nurses were in-serviced on 1/17/13 on consistent administration of Travanton Z eye drops. RCC's/designee will conduct bi-weekly audits on MAR to ensure consistent administration of Travaton Z. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings. 1. Resident #38 did not suffer any harm from this deficient practice. 2. All other residents on Tramandol were reviewed on 11/29/13 and none was noted with this deficient practice. 3. All RCC's/charge nurses were in-serviced on 1/17/14 on Tramadol administration within directed parameters. QA/designee will conduct bi-weekly audits on MAR/pain assessment to ensure that all pain medication in general and Tramadol in particular is administered with ordered parameters.	1/21/14

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F 309	Continued From page 30 the 4th. A review of the November 2013 pain assessment revealed that on the 11-7 shift, 7-3 shift and 3-11 shift ' N " [no] was documented in the designated area indicating that the resident did not have pain on assessment. There was no evidence that Tramadol was administered within the directed parameters (for pain greater than or equal to 6/10). A face-to-face interview was conducted with Employee #2 on November 27, 2013 at approximately 1:05 PM. He/she acknowledged the findings. The record was reviewed on November 27, 2013. 3. Facility staff failed to ensure that Resident #84 wore sunglasses when outdoors in the sun due to photophobia. A review of the ophthalmology examination dated November 7, 2012 revealed, " Chief Complaint: Consult requested, pt (patient) states mild Photophobia in bright sun OU (both eyes); Impression: 1.Blind painless eye OU. 2. Photophobia. Plan: ...Pt states sensitivity to light. Pt should have sunglasses for outdoors. " The October 2013 Physician ' s Orders signed and dated by the physician on October 10, 2013 directed, " Pt should have a pair of sunglasses for going out in sun due to Photophobia." On November 25, 2013 at approximately 11:15 AM Resident # 84 was observed being escorted	F 309	4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings. 1. Resident #84 sunglasses was located and placed by bedside for use in the sun due to photophobia as recommended on 11/7/12 by ophthalmology. 2. All other residents with sensitivity to light (photophobia) were reviewed on 11/29/13 and none were noted with this deficient practice. 3. All RCC's, charge nurses and CNA's were in-serviced on 1/17/14 on the use of sunglasses when outdoors for residents with photophobia if indicated by an ophthalmologist or physician. QA/designee will identify and conduct bi-weekly rounds on residents with photophobia to ensure that sunglasses are in use when outdoors if recommended. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings.	1/21/14 1/21/14

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F 309	Continued From page 31 out of the facility to an appointment on a sunny day by a staff member and the resident was not wearing sunglasses. A face-to-face interview was conducted with Employee #6 on November 25, 2013 at approximately 11:45 AM. He/she then stated, [Resident #84] has the sunglasses in [his/her] bag. A face-to-face interview was conducted with Resident #84 on November 25, 2013 at approximately 4:00 PM. He/she stated, " I didn ' t wear any sunglasses to the doctors. I don ' t have any sunglasses. I need to wear them because I am blind and the sun light hurts my eyes. " A follow-up interview was conducted with Employee #6 on November 25, 2013 at approximately 4:10 PM. Employee #6 acknowledged that Resident #84 went to an appointment and did not wear sunglasses as ordered by the physician. There was no evidence that facility staff ensured that Resident #84 wore a pair of sunglasses when he/she went outside on a sunny day for an appointment. The record was reviewed on November 25, 2013. 4. Facility staff failed to apply splints in accordance with physician ' s orders for Resident #242. The Physician's Order signed and dated November 03, 2012 directed, " Pt (patient) issued day time splint for R (right) and L (left) hand wrist support splint. Splint schedule on	F 309	1. Resident #242 hand/wrist splints, neck collar and seat belt were located and applied per physicians order and schedule. 2. All other residents on hand/wrist splints, neck collars and seat belts were reviewed on 11/29/13 and none noted with this deficient practice.	

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F 309	Continued From page 32 daytime at 9AM off 7PM. On November 20, 2013 at approximately 1:00 PM, Resident #242 was observed sitting in a wheel chair without hand /wrist splints. On November 21, 2013 at approximately 3:30 PM, November 22, 2013 at approximately 11:00AM and November 23, 2013 at approximately 3:00 PM resident # 242 was observed lying in bed without splints in place... Neck collar present on bedside table when queried resident stated he/she came to facility with the belt and neck collar. A review of the November 2012 Treatment Administration Record (TAR) revealed a physician's order was transcribed for upper extrimity splints as follows: 9am on/ 7pm off signage for time and check in box for (on) or (off). The November 2013 treatment administration record [TAR] was signed denoting that the upper extremity splints were applied on the dates (listed above) that the resident was observed without them. A face to face interview was conducted with Employee #16 [Rehabilitative staff] on November 25, 2013 at approximately 12:15 PM. When queried [he/she] stated " Physical Therapy is treating Resident#242 for sitting balance-resident is NWB (non-weight bearing) ...and can ' t support him-self ...Resident ' s upper trunk is weak--...unaware of splints or neck brace...Has seen belt on resident " ... A face to face interview was conducted with	F 309	3. All RCC's/charge nurses were in-serviced on 1/17/14 on the use of hand/wrist splints, neck collars and seat belts as directed by physician. QA/designee will conduct bi-weekly rounds to ensure that hand/wrist splints, neck collars and seat belts are consistently applied on residents per physicians order. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings.	1/21/14

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F 309	Continued From page 33 Employee #17 November 25, 2013 at 12:30 PM When queried employee #17 stated resident receives services for upper body strengthening and she was not aware of [the resident] having bilateral hand splints a neck brace or wheel chair belt. A face to face interview was conducted with employee #26 and # 27 at approximately 5:15PM on November 25, 2013 When queried Employee #26 and 27 states she is not very familiar with resident but has treated a couple of times ...today began with new assistive device, states resident is capable of using but will also request to be fed by CNA Residents upper body strength is weak and that he/she has noted a neck collar in room on bedside table ... but has not seen bilateral hand splints or a wheel chair belt ...He/She does treat resident out of bed. Employee # 27 stated he/she was not aware of neck brace , bilateral hand splints or wheel chair belt, but stated now aware, a full assessment for their use would be done and to determine need and effectiveness. A face to face interview was conducted with Employee #23 November 26, 2013 1:15PM when queried [he/she] stated " restorative services were in place under the old Rehab Company main function was assisting resident with his/her eating ...They did apply splints ...when old company left the restorative services for resident stopped ...has not been started again because resident is now a skilled ... resident is now receiving active Physical Therapy Services. Stated resident came	F 309		

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F 309	Continued From page 34 to facility with safety belt and it is placed on resident daily when out of bed ...Has also seen resident with neck collar on ...Has never been applied by [him/her]. There was no evidence that prior history was considered to provide consistency in treatment as evidenced by failure to follow through with splint therapy management for Resident #242 in accordance with the physician's order. A face-to-face interview was conducted with Employee #3 on November 23, 2013 at 4:25 PM. He/she stated, " [Resident #242] does wear hand splint most of the time." There was no evidence that facility staff followed physician ' s order to apply splints on November 20, 21, 22 and 25 and 26, 2013. A face-to-face interview was conducted with Employee #8 on November 26, 2013 at approximately 2:00: PM. He/she acknowledged the aforementioned findings. The record was reviewed on November 26, 2013.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on an observation, record review and	F 312	1. Resident #52 fingernails were identified, cleaned and trimmed. 2. All other residents fingernails were assessed on 11/29/13 and all were noted to be cleaned and trimmed. 3. All RCC's/charge nurses will be in-serviced by 1/17/14 on cleanliness and trimming fingernails to maintain good grooming and personal hygiene. QA/designee will conduct bi-weekly rounds to ensure nails are clean and trimmed.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 35 staff interview for one (1) of 39 sampled residents, it was determined that facility staff failed to provide the necessary care and services to maintain good grooming and personal hygiene for Resident #52 who was observed with soiled and untrimmed fingernails. The findings include: A review of Resident #52's Minimum Data Set (MDS) dated September 20, 2013 revealed that the resident was coded as cognitively impaired under Section C [Cognitive Patterns] and was totally dependent for ADLs (activities of daily living) under Section G0110 J [Personal Hygiene]. On November 20, 2013 at 9:15 PM Resident #52 was observed sitting in social room listening to music, with lengthy finger nails and a dark substance noted under the nail beds. On November 22, 2013 at approximately 3:00PM, Resident #52 was again observed with lengthy finger nails and a dark substance noted under the nail beds. Employees #6 and 18 were asked to observe Resident # 52's finger nails. At the time of the observation Employees #6 and 18 were queried about what is included in a resident ' s daily grooming routine. Both employees stated that nail care is included in daily grooming. Employee's #6 and 18 acknowledged findings at the time of the observation. Facility staff failed to ensured that Resident #52 ' s fingernails were clean and trimmed.	F 312	4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings.	1/21/14
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		

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F 315	Continued From page 36 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 39 sampled resident's, it was determined that facility staff failed to accurately assess bladder function and implement measures to restore as much bladder function as possible when it was determined that Resident #179 sustained a decline in urinary function. The findings include: The "Readmission Order Sheet and Physician Plan of Care " dated October 14, 2013 revealed diagnoses that included "Urinary Incontinence and Urinary Tract Infection. " A review of the " Assessment for Bowel and Bladder " for October 14, 2013 revealed, " Present Bladder History- Pattern: Frequency-Irreg (irregular) Amount: Adequate ...Comments: Resident is incontinent of bladder. " After reviewing the "Assessment for Bowel and Bladder " there was no evidence that facility staff accurately assessed and documented	F 315		

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F 315	Continued From page 37 what was noted to be " irregular " about the resident ' s urinary frequency pattern and there was no evidence as to how the assessor determined the amount of urine as " adequate. " Resident #179 sustained a decline in urinary function between September and October 2013 as evidenced by the MDS assessments as follows: The quarterly MDS completed September 8, 2013 revealed that Resident #179 was coded as " frequently incontinent " of the bladder in Section H (Bladder and Bowel). In contrast, Section H of the Significant Change MDS dated October 22, 2013 revealed the resident was coded as " always incontinent. " The care plan entitled " Potential for Urinary Tract Infection " initiated on October 10, 2013 included " Interventions ...Monitor and record incontinent episodes ...Toilet resident at specified intervals. " There was no evidence of recorded incontinent episodes and specified intervals for toileting in the active clinical record for Resident #179. When facility staff determined that Resident #179 sustained a noted decline in urinary continence, there was no evidence that staff conducted a comprehensive assessment of the resident ' s bladder function (e.g. Does the resident know when to go to the toilet? Does the resident co-operate with staff when they assist with toileting? During the day and night how many times does the resident need to pass urine? Does the resident drink adequate amounts	F 315	1. Resident #179 bladder function was reassessed and clarified on11/29/13 as currently incontinent and requires frequent diaper changes 2. All other residents bladder assessments were reviewed on 11/29/13 and noted to accurately reflect the residents urinary pattern. 3. All nurses were in-serviced on 1/17/14 on accurate assessment of bladder function of residents QA/designee will conduct bi-weekly audits to ensure accurate assessment of residents bladder function. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings.	1/21/14

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F 315	Continued From page 38 of fluids to maintain hydration? Indicate whether the resident takes a medication that may have an affect his or her continence); and failed to implement specific interventions to address the decline in urinary continence to attempt to restore bladder function. A face-to-face interview was conducted with Employee # 6 on November 26, 2013 at approximately 10:30 AM regarding the aforementioned findings. He/she stated, " Since the resident has returned from the hospital in October [2013], he/she is total care and is checked for incontinent episodes." After reviewing the clinical record, Employee#6 acknowledged the aforementioned findings. The clinical record was reviewed on November 26, 2013.	F 315		
F 323 SS=E	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, record reviews, staff and resident interviews, it was determined that facility staff failed to ensure that the resident environment remained as free of accident hazards as is possible as evidenced by: hot water temperatures that exceeded acceptable	F 323	1. Access to cold water was immediately Identified and tubs in room 315 were taken out of service Permanently on 11/22/13. 2. All other tubs in room 115abcd, 215abcd, 315abcd, 415abcd, 515abcd, 107P, 207P 307P, 407P, and 507P were also permanently taken out of service on 11/22/13 3. Director of Maintenance/designee will conduct daily checks during AM rounds to ensure no water access to the identified areas in the facility. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 323	Continued From page 39 ranges in 10 of 17 resident rooms and cold water faucets were not operational in two (2) of two (2) bathtubs in one (1) resident room. The findings include: 1. Facility staff failed to ensure that hot water temperatures were maintained in acceptable ranges as to not pose a burn hazard in 10 of 17 resident rooms observed. Water temperature readings were obtained from the sink in resident rooms located on the fourth floor. The water temperature readings were made in the presence of Employee #13 on November 19, 2013 at approximately 3:10 PM. Employee #13 used the facility ' s thermometer to assess for the temperatures. The water temperatures readings were as follows: Room #406 sink 116 F (degrees Fahrenheit) Room #408 sink 114 F Room #412 sink 111F Room #413 sink 113 F Room #414 sink 114 F Room #416 sink 112 F Room #417 sink 112 F Room #418 sink 113 F Room #419 sink 114 F Room #420 sink 113 F After the above observations, Employee #13 acknowledged the findings and made adjustments to the temperatures at the time of the observation.	F 323	1. Hot water temperatures in rooms 406, 408, 412, 413, 414, 416, 417, 418, 419 and 420 were immediately identified and restored back to compliance to the range of 95-110 degrees on 11/19/13. 2. Water temperatures throughout the facility were checked by the director of maintenance on 11/19/13 and non were noted with deficient practice. 3. Maintenance staff were in-service on 1/17/14 on water temperature maintaining regulation at 95-110 degrees. Director of Maintenance/designee during AM rounds will check water temperature daily during AM rounds, and logged in the facility's water temperature log book. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 323	Continued From page 40 2. Facility staff failed to ensure that cold water was available for use in two (2) of two (2) tubs observed in resident room number 315. The hot water faucets for each of the bathtubs were functional. On November 22, 2013 at approximately 3:30 PM a tour of the bathroom located in resident room 315 was observed. It was noted that in two (2) of two (2) tub facets the cold water did not release from the facet when the cold water was turned to the 'on' position. There was no evidence that cold water was available for use in two (2) bathtubs located in room 315, therefore prohibiting the ability of residents and/or staff to mix cold water with hot water for comfort. The observations were made in the presence of Employees # 8 and 9 who also acknowledged the findings.	F 323		
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 facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced	F 386		

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F 386	Continued From page 41 by: Based on record review and staff interview for one (1) of 39 sampled residents, it was determined that the physician failed to include in the total program of care, communication to the healthcare team regarding the course of treatment associated with managing abnormal laboratory values for Resident #179. The findings include: Resident #179 was assessed with an elevated BUN (Blood Urea Nitrogen) level on September 20, 2013 and the primary care physician failed to communicate to the healthcare team the course of treatment associated with managing the abnormal laboratory value. The resident ' s past medical history included elevated BUN for which the physician previously prescribed additional hydration in the resident ' s total plan of care. The resident ' s history also included chronic urinary tract infections as follows: According to the hospital discharge summary dated October 14, 2013, Resident #179 was admitted [to the hospital] October 1, 2013 and returned to the facility on October 14, 2013. The principal diagnosis (reason for admission after study) was " Urosepis/Urinary Tract Infection. " The history /present illness revealed: " ... nursing home resident with PMH (Past Medical History) of Hypertension (HTN), Congestive Heart Failure (CHF), dementia, anemia, and recurrent UTI ' s (Urinary Tract Infections) who was found this morning to be confused and altered with hypotension and tachycardia. Brought to the ED (Emergency Department) by EMS (Emergency Medical System), was found to	F 386	1. Resident abnormal values including elevated BUN was reviewed by the physician and Communicated to the nurses and hospice on 11/29/13. Resident is on hospice so all labs were d/cd on residents 2. All other residents with abnormal labs Including elevated BUN were all reviewed on 11/29/13 and were all addressed by the physicians with a course of treatment clearly communicated to the nurses on the unit. 3. All nurses were in-serviced on 1/17/14 to actively collaborate with physicians to address all abnormal labs with a plan of care and treatment. QA/designee will conduct bi-weekly audits of residents clinical records to ensure active collaboration between physicians and nurses in addressing abnormal labs with a treatment plan. 4. Further findings in this matter will be discussed in the weekly, monthly, and quarterly QA meetings.	1/21/14

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F 386	Continued From page 42 have AKI (Acute Kidney Injury) and elevated lactate in the emergency department ... " A review of Physician ' s orders included the following: September 13, 2013 [no time indicated] - " Dietary Supplements- Encourage 240 ml H20 [water] fluid every 4 hours while awake for increase BUN (Blood Urea Nitrogen). " September 22, 2013- 8:00 AM- " Telephone Order- Bactrim DS (Double Strength) - 1 (one) [tablet] po (by mouth) every 12 hours for UTI (Urinary Tract Infection). " October 1, 2013 [no time indicated] - " Transfer to ER (Emergency Room) via 911 for hypotension and altered mental status. " Physician's Notes: September 19, 2013- Physician's note- Pt- (Patient) returned from [hospital named] - was transferred there for either rectal or vaginal bleeding ...no further gross bleeding noted. Pt was sent back to [facility named] but not readmitted here [nursing home] due to poor condition. On return to [hospital named], [he/she] was found to have pulmonary embolus. Started on Lovenox.... " October 1, 2013- Physician's note- (No time indicated) " Patient found to be hypotensive with decreased cognitive abilities. Blood Pressure 70/34. Awake but not responsive to verbal or tactile stimuli.... Plan: Transfer to [Emergency Room] for evaluation. Rule out Sepsis, Stroke.	F 386		

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F 386	Continued From page 43 October 17, 2013- (no time indicated) Physician ' s note - Patient returns from [hospital named] - treated for urosepsis and hypotension ..." Laboratory Results: September 20, 2013- Specimen collected -Reported September 20, 2013 at 13:03 (1:03 PM) - BUN - (Urea Nitrogen) - 51 mg/dl (milligrams per deciliter) (high; normal range 7-25); Creatinine- 1.5 (high; normal range 0.6-1.3); BUN/Creatinine Ratio - 34 (high; normal range 6-25); Hemoglobin -7.5 (low; normal range 12.0-16.0); Hematocrit- 23.9 (low; normal range 36-48). Of note, the clinical record revealed that Resident #179's previous BUN was 26 mg/dl as assessed on July 5, 2013. The physician ' s initial's were observed in the lower right hand corner of lab the form, acknowledging that he/she reviewed the labs. September 21, 2013- 13:05 (1:05 PM) - Report status- [urine -Culture and Sensitivity report] - Specimen collected September 19, 2013. - Organism included Escherichia Coli >100,000. MD initialed report which indicated he/she reviewed the labs. A Note observed in the lower right hand corner of report read: " MD aware ...New order given. " A face-to-face interview was conducted with Employee #6 who stated the doctor was aware of the labs collected on September 21, 2013.	F 386		

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F 386	Continued From page 44 A follow-up telephone interview was conducted with Employee #37 (the primary care physician) on January 3, 2014 at approximately 1:00 PM. He/she stated that the elevated BUN value was acted on; an additional laboratory test; stool for occult blood was ordered. He/she acknowledged that the resident could have benefitted from additional hydration and that the order for hydration [September 13, 2013] was not continued on the current orders following the resident ' s readmission to the facility [post hospitalization]. However, he/she added that there was an unlikelihood that the elevation in BUN was associated with inadequate hydration. Employee #37 acknowledged that course of treatment associated with the elevated BUN was not specified in the clinical record " we just can ' t write everything. " The physician failed to communicate to the healthcare team in the total program of care, the course of treatment associated with abnormal laboratory values [elevated BUN] for Resident #179. The clinical record was reviewed on November 27, 2013.	F 386		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425	1. Resident #38 Tramadol was immediately requested by facility staff to pharmacy on 11/26/13 for immediate delivery. Resident medication is PRN and resident was not in pain , no harm caused. 2. All other residents on Tramadol PRN were reviewed on 11/29/13 and none were noted with this deficient practice.	

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F 425	Continued From page 45 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 39 sampled residents, it was determined that facility staff failed to ensure that PRN (as needed) medications were available to administer to Resident #38 in order to meet the needs of the resident. The findings include: A review of the Physician ' s Orders revealed the following: " September 30, 2014 at 18:40 ...3) Clarification: Use Tramadol 50 mg PO for pain greater than or equal to 6/10 PRN. " An observation of the third floor medication cart was conducted on November 26, 2013 at 9:15 AM in the presence of Employees #5 and #35. It was observed that Tramadol 50 mg tablets were not available for use for Resident #38. A review of medication administration records lacked evidence that the resident missed dosages and/or sustained any untoward effect from the	F 425	3. All nurses were in-serviced on 1/17/14 on provision of pharmacy services including acquiring, receiving, dispensing and administering mediation to meet the needs of each resident. QA/designee will conduct bi-weekly rounds to ensure that each resident has adequate supply and availability of recommended medication to meet their Needs and/or PRN. 4. Further findings in this matter will be discussed in the weekly, monthly, and quarterly QA meetings.	1/21/14

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F 425	Continued From page 46 lack of the availability of Tramadol. Facility staff failed to ensure that Tramadol 50 mg was available for use for Resident #38. The findings were acknowledged at the time of the observation by Employees #5 and #35.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		

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F 441	Continued From page 47 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that two (2) of three (3) sinks in the main kitchen had air gaps to prevent the backup of contaminated water and failed to ensure that Resident # 179 with a diagnosis of a Urinary Tract Infection was included on the Infection Control log for one (1) of 39 sampled residents. The findings include: 1. Facility failed to ensure that two (2) of three (3) sinks in the main kitchen had air gaps to prevent the backup of contaminated water. During a tour of the kitchen area on November 18, 2013 at approximately 9:40 AM, an observation of the sink in the dessert area and the hand wash/coffee area revealed that the drain pipes were below ground level. Employee #11 acknowledged the findings at the time of the observation. 2. Facility staff failed ensure that Resident #179 with a diagnosis of a Urinary Tract Infection was	F 441	1. The two air gaps in the kitchen were immediately identified and repaired by maintenance on 11/18/13. 2. The general inspection was conducted in facility for air gaps and none were found. 3. Maintenance staff were in-serviced on 1/17/13 on repairing air gaps. Air gaps will be checked daily during AM rounds and identified issues will be immediately addressed. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings	1/21/14

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F 441	Continued From page 48 included on the facility's September 2013 Infection Control surveillance log. The Interim Order dated September 22, 2013 at 8:00 AM for Resident #179 directed, " Bactrim DS (Double Strength) - 1 (one) [tablet] po (by mouth) every 12 hours for UTI (Urinary Tract Infection). " A review of the September 2013 MAR revealed that Resident #179 received the Bactrim DS as ordered. During the interview with the facility's Infection Control Practitioner (Employee #2) on November 27, 2013 at approximately 3:30 PM a review of the facility ' s Infection Control logs were conducted. A review of the " Infection Control " log for September 2013 was revealed that Resident #179 was not listed on the log or included in the surveillance to capture information such as, the "Date of the onset "; " Nosocomial (In house)"; "Culture "; "Identified organism "; "List control techniques to include isolation" and "Final progress/date resolved. " There was no evidence that Resident #179 was included in the facility ' s infection control surveillance for September 2013. A face-to-face interview was conducted with Employee #2 on June 13, 2012 at approximately 2:00 PM. He/she acknowledged that the resident was no listed on the Infection Control surveillance log.	F 441	1. Resident # 179 was identified with diagnosis of urinary tract infection and was immediately included in the facility infection control surveillance log. 2. Facilities infection control surveillance log was reviewed by infection control practitioner on 11/29/13 and was determined to be accurate including all infections. 3. All nurses were in-serviced on 1/17/14 on providing accurate and complete information each month to infection control practitioner for accurate updates of infection control surveillance log. QA/designee will conduct audits to ensure Accurate and complete information for the Infection control surveillance log. 4. Further findings in this matter will be discussed in the weekly, monthly, and quarterly QA meetings.	1/21/14

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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 review of staffing [direct care per resident day hours], it was determined that facility staff failed to meet 0.6 [six tenths] hours for Registered Nurses/APRN [Advanced Practice Registered Nurse] hours on seven (7) of the seven (7) days reviewed; and two (2) of the seven days reviewed failed to meet minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day 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 November 27, 2013 at approximately 3:00 PM. According 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 tenths (0.6)	F 492	1. Review of staffing records was done for the two days . Facility is actively recruiting RN's to meet the 0.6 and 4.1 staffing mandate by DC regulations. 2. Daily review of staffing records, status post survey indicate a consist pattern of 0.6 RN's and 4.1 direct care staff. 3. Staffing coordinator and supervisors will be in-serviced on 1/17/14 on staffing mandate to maintain 0.6 RN's and 4.1 direct care staff. DON/designee will conduct daily audits to ensure staffing is within mandated regulations. 4. Further findings on this matter will be discussed in weekly, monthly and quarterly QA meetings.	1/21/14

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F 492	Continued From page 50 hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. Of the seven (7) days reviewed, seven (7) of the days failed to meet the 0.6 [six tenths] hours of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] as follows: On Friday November 15, 2013, it was determined that the facility provided RN coverage at a rate of 0.42 hours. On Saturday November 16, 2013, it was determined that the facility provided RN coverage at a rate of 0.37 hours. On Sunday November 17, 2013, it was determined that the facility provided RN coverage at a rate of 0.37 hours. On Monday November 18, 2013, it was determined that the facility provided RN coverage at a rate of 0.52 hours. On Tuesday November 19, 2013, it was determined that the facility provided RN coverage at a rate of 0.52 hours. On Wednesday November 20, 2013, it was determined that the facility provided RN coverage at a rate of 0.53 hours. On Thursday November 21, 2013, it was determined that the facility provided RN coverage at a rate of 0.52 hours.	F 492		

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F 492	Continued From page 51 Of the seven (7) days reviewed, two (2) of the days failed to meet minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day as follows: November 16, 2013: 4.09 November 17, 2013: 3.9 The review was made in the presence of the Employee #2 who acknowledged the findings	F 492		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 39 sampled residents, it was determined that facility staff failed to maintain clinical records that are accurately documented and maintained in accordance with accepted professional standards as evidenced by failure to: document in the active clinical record,	F 514		

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F 514	Continued From page 52 attempts to notify the RP for one (1) resident who was admitted to the hospital; ensure that an order to provide Foley catheter care was transcribed onto the October and November 2013 Physician's Orders for one (1) resident and accurately document skin assessments for one (1) resident. Residents' #2, #114, and 242. The findings include: 1. Facility staff failed to document in the active clinical record attempts to notify the responsible party (RP) for Resident #2 when he/she was admitted to the hospital. A review of Resident #2 ' s clinical record revealed a physician ' s order dated October 4, 2013 at 5:30PM that directed, "Transfer resident to [name of hospital] under care of [doctor name] to be dialyzed [secondary to] clogged access site. " A nurses note dated October 5, 2013 at 7:00PM read, "Resident went to [Name of hospital] at 8:30AM for declog cath [catheter] of dialysis. Received a call at 4:30PM that resident [was] admitted in the ICU (intensive care unit). " A nurses ' note dated October 7, 2013 at 8:00 AM read, " Call placed to RP [Responsible Party Name] and got hold of [him/her] ... " A face-to-face interview was conducted on November 22, 2013 at approximately 11:50AM with Employee #7. He/she stated, " The staff told me that they tried to get in touch with resident's responsible party, but was not able to get [him/her] on the phone. After inquiring from	F 514	1. Resident #2 responsible party was notified that resident was admitted in the hospital on 10/7/13 as soon as he was available, then documentation done in the active clinical records . 2. All other residents records hospitalized were reviewed on 11/29/13 and none noted deficient practice. 3. All nurses were in-serviced on 1/17/14 on notifying responsible party during hospitalization and documenting attempts to notify responsible party in active clinical records. QA/designee will conduct bi-weekly audits to ensure that each attempt or actual notification of responsible party during hospitalization is properly documented in the active clinical record. 4. Further findings in this matter will be discussed in the weekly, monthly, and quarterly QA meetings.	1/21/14

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F 514	Continued From page 53 staff ... I called and notified the RP [on October 7, 2013] and documented it in the resident's chart. " There was no evidence that facility staff documented the attempts to immediately notify Resident #2's responsible party (October 5, and 6, 2013) when it was determined he/she was hospitalized in the intensive care unit. A face-to-face interview was conducted with Employee #2 on November 22, 2013 at approximately 12:42PM. He/she acknowledged the findings. The record was reviewed on November 22, 2013. 2. Facility staff failed to ensure that an order to provide Foley [indwelling urinary] catheter care was transcribed onto the October and November 2013 Physician's Orders for Resident #114. A " History and Physical signed by the physician August 7, 2013 revealed Resident #114 ' s diagnoses included: " Active Problems: BPH (Benign Prostate Hypertrophy) ... " A physician ' s interim order dated September 26, 2013 directed, " Continue with Foley catheter due to Partial Obstruction; Continue to monitor urine drainage every shift; Change Foley bag and tubing bi-weekly and as needed. " A review of the October and November 2013 Physician ' s Orders lacked evidence that the order to continue with Foley catheter care was transcribed onto the order sheets.	F 514	1. Resident #114 Foley catheter orders were identified and transcribed onto next month physicians orders. . 2. All residents on Foley catheters orders were reviewed on 11/29/13 and none noted with this deficient practice. 3. All nurses were in-serviced on 1/17/14 to ensure that all monthly physician orders are transcribed/carried over onto next months physician order sheet. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings in this matter will be discussed in the weekly, monthly, and quarterly QA meetings.	1/21/14

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F 514	Continued From page 54 A face-to-face interview was conducted with Employee #7 on November 26, 2013 at approximately 12:30 PM. He/she acknowledged the aforementioned findings. 3. Facility staff failed to accurately document Resident #242 ' s skin assessment. A review of Resident #242 ' s clinical record revealed that licensed staff documented skin assessments on three (3) dates prior to the resident ' s admission as follows: Resident #242's Minimum Data Set (MDS) dated August 8, 2013 revealed that the resident was coded as having no cognitive impairment under Section C [Cognitive Patterns] and was totally dependent for ADLs (activities of daily living) under Section G0110 J [Personal Hygiene]. Section I revealed the resident ' s diagnoses included Deep Vein Thrombosis (DVT), Hypertension, Cerebrovascular Accident (CVA), Quadriplegia, and Seizure Disorder .... A review of the Bath and Skin Report instructions stated: " C.N.A. is to perform skin check 2x (two times) weekly during resident ' s bath /shower; Record information above, place check- mark under any skin condition that applies (Normal, Redness/Rash, Peeling, Open Areas, Bruise). Check normal if no abnormal skin conditions are noted ...The Charge Nurse must sign skin report as indicated above and briefly describe action taken if abnormal skin condition exists. "	F 514	1. Resident #242 was identified, skin assessment done and accurate documentation .. 2. All other residents clinical record were reviewed on 11/29/13 and were noted to be accurate and reflective of the residents current skin condition. 3. All nurses were in-serviced on 1/17/14 on accurate assessment and documentation in the clinical record. QA/designee will conduct bi-weekly audits to ensure compliance. 4. Further findings in this matter will be discussed in the weekly, monthly, and quarterly QA meetings.	1/21/14

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F 514	Continued From page 55 Resident #242 ' s Bath and Skin Report included documentation on August 2, 2013, August 5, 2013 and August 7, 2013 " normal " [skin] signed by the licensed nurse. The " action taken " recorded by the certified nurses ' assistant (CNA) " received a shower. " The information recorded on the skin report was dated prior to the resident ' s admission to the facility on August 8, 2013. A face-to-face interview was conducted with Employee #6 on November 26, 2013 at 3:00 PM. He/ she] stated [Resident #242] does receive showers and when queried regarding the dates recorded on the skin sheets, wherein the resident was not in facility, Employee #6 provided no response. Employee # 8 acknowledged the documentation was inaccurate and that Resident # 242 was not in the facility at that time. The Medical Record was reviewed on November 26, 2013.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520		

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F 520	Continued From page 56 action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, resident and staff interviews, it was determined that the facility's Quality Assessment and Assurance (QAA) committee failed to develop, implement, and/or revise appropriate corrective actions for identified deficient practices as necessary. The findings include: During the survey, the following areas of concern were indentified: Facility staff failed to ensure that newly hired employees received Abuse training prior to working on the nursing units with residents; MDS ' were inaccurately coded under Section V, Care Area Assessment; facility staff failed to ensure the grooming of one (1) residents ' nails; failed to ensure that care plans were updated to address residents current status and failed to ensure that a resident's assistive devices were applied in accordance with the physician ' s	F 520	1. The facility Quality Assessment and Assurance Committee met and a plan was put in place whereby quality related issues pertaining to splints, neck brace and safety belts will be monitored daily by the restorative nurses. The committee also assigned nail care to the aid monitoring the social room. All the CAA area of the MDS will be reviewed by QA bi-weekly and issues rectified. This process will be re-evaluated and adjustments made accordingly to reflect these deficient practices and to ensure they do not re-occur.	

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F 520	Continued From page 57 orders. On November 27, 2013 at approximately 11:00 AM, the Director of Nursing was interviewed regarding their QAA Committee Meetings and identification of the concerns listed above. It was stated that they had not previously identified concerns related to the MDS-CAA summary. " We look at the coding of the MDS and we have not looked at the CAA area. The resident s nails are cleaned every day in the social room. We recommend that nails are done after Activities of Daily Living care because the nails are soft at this time. Splints, the old rehabilitation company ordered the splints and they were discontinued for that particular resident. We are working with the rehabilitation company regarding the splints but this fell through the cracks. We are constantly reviewing and updating the care plans. " Although the facility may have identified areas of concern in some of the aforementioned areas, there was no evidence that ongoing corrective action plans were implemented for the identified areas. Additionally, there was no evidence that revisions were made to plans when the corrective action was not effective.	F 520	2. The QA/designee will review and audit clinical records daily to gather verifiable facts to compile for quality improvement and training.. 3. QA/designee will develop and conduct scheduled in-services and training as needed based on the needs of the facility. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings and adjustments will be made as necessary.	1/21/14