STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	06/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOME	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

(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 000	INITIAL COMMENTS A recertification Quality Indicator Survey (QIS) was conducted on June 16 through June 23, 2014. The deficiencies are based on observation, record review, resident and staff interviews for 27 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia D/C discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - emergency medical services (911) g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass)	F 000	**THIS PLAN OF CORRECTION IS SUBMITTED FOR PURPOSES OF REGULATORY COMPLIANCE AND AS PART OF THE METHODIST HOME'S ONGOING EFFORTS TO CONTINUOUSLY IMPROVE THE CARE AND SERVICES PROVIDED. AS SUCH IT DOES NOT CONSTITUTE AN ADMISSION OF THE FACTS OR CONCLUSIONS CITED IN THE SURVEY REPORT FOR ANY PURPOSE WHATSOEVER.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Savoy RN LNHA	Administrator	Aug. 6, 2014

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 mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy P/F- Preservative Free PO-by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- responsible party TAR - Treatment Administration Record	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview for two (2) of 27 sampled residents, it was determined that facility staff failed to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial	F 309		

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F 309	Continued From page 2 well-being, in accordance with the comprehensive assessment and plan of care as evidenced by a failure to clarify physician ' s orders for the administration of antihypertensive medications for one (1) resident and follow physician ' s orders for the administration of an anxiolytic medication [Ativan] for one (1) resident. Residents #52 and 69. The findings include: 1. Facility staff failed to clarify physician's orders for the administration of antihypertensive medications for Resident #52. Review of the medical record revealed that Resident #52 was admitted to the facility on September 10, 2013 with diagnoses that included Hypertension. Further review of the clinical record revealed the resident ' s medication regimen included Amilodipine 2.5mg for hypertension, Furosemide 20mg for hypertension and Metoprolol ER [Extended Release] 50mg for hypertension. A review of physician's order signed and dated June 19, 2014 directed, "Take blood pressure prior to administering BP [blood pressure] medications." Review of the Medication Administration Record [MAR] for June 2014 revealed that Resident #52 ' s blood pressure was checked prior to administering the blood pressure medications from June 1 through 19, 2014; however, the order lacked evidence of parameters for	F 309	309 Failure to Clarify Orders for Administration of Antihypertensive Meds **1. Corrective Action for Affected Residents:** Resident #52 was not negatively affected by this practice, therefore no corrective action was indicated. **2. Identification of Other Residents Potentially Affected by Same Practice:** Residents with potential to be affected by this deficient practice were identified via chart and MAR audit. Incomplete orders/orders that required clarification were identified and B/P parameters documented. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Policy re: antihypertensive meds was updated to reflect need for parameters. Licensed staff were in-serviced on policy update. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Chart audits to be completed monthly for all residents receiving antihypertensives. Audit results to be reported to QA Committee quarterly. Compliance threshold is 100%.	6/25/14 6/25/14 8/1/14 8/1/14

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F 309	Continued From page 3 administration [e.g. if there were an occasion to ' hold ' the medication(s) based on a less than optimal blood pressure reading, hypotension] A face-to-face interview was conducted on June 19, 2014 at approximately 1:00 PM with Employees #3 and #4. After reviewing the documentation, both employees acknowledged the findings. Facility staff failed to clarify physician's orders for Resident #52 to include parameters of administration for the administration of antihypertensive medications. The record was reviewed on June 19, 2014. 2. Facility staff failed to follow physician's orders for the administration of an anxiolytic [Ativan] prescribed for Resident #69. A review of Resident #69 ' s clinical record revealed a physician ' s order dated June 4, 2014 which directed, " Give Ativan 0.125 mg [milligram] PO [by mouth] QD [daily] PRN [as needed] for Anxiety/Insomnia. A review of the resident ' s Medication Administration Record [MAR] revealed that on June 5, 2014 the resident received the prescribed dose [0.125mg] of Ativan at 12:00AM for Insomnia and at 6:00 PM on the same day for Anxiety. Further review of the resident ' s record failed to reveal any documentation that the nursing staff had conferred with the physician prior to administering the second dose of Ativan to the	F 309	309 Failure to Follow Orders for Administration of Ativan **1. Corrective Action for Affected Residents:** Deficient practice occurred June 5, 2014 with no adverse affect on the resident. No retrospective corrective action was implemented. **2. Identification of Other Residents Potentially Affected by Same Practice:** Three residents were identified with orders for PRN Ativan. Reviews of their charts (Jan 1-June 23, 2014) revealed that all doses were administered as prescribed by the physician. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a. All licensed personnel were re-educated on facility's chart check procedures and preparation of Medication Error Reports. b. Education will be provided as part of New Employee Orientation for licensed personnel, and annually for all licensed staff. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Random chart audits will be completed monthly for residents receiving PRN medications ; results will be reported quarterly to the QA Committee. Compliance threshold is 100%.	6/25/14 6/25/14 6/27/14 8/1/14

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F 309	Continued From page 4 resident or that the physician had ordered an additional dose of Ativan for the resident. Nursing documentation dated 3:00 PM on June 5, 2014 read, " No anxiety or agitation observed. There was no documentation for 6:00 PM on June 5, 2014 (when the second dosage of Ativan was administered within a 24-hour period). The next nurse ' s entry was recorded at 10:00 PM on June 5, 2014 and made no reference to the Ativan that was administered at 6:00 PM on June 5, 2014. A face-to-face interview was conducted with Employee #3 at approximately 11:30AM on June 19, 2014. The employee acknowledged that the medication was ordered once daily and that it was administered twice on June 5, 2014. Facility staff failed to follow physician's orders for the administration of Ativan. The record was reviewed on June 19, 2014.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 27 sampled residents, it was determined that facility staff failed to provide the necessary care and services to maintain or improve the ability of one (1) resident to eat independently.	F 311	F 311 Failure to Provide Care/Services to Improve Resident's Ability to Eat Independently **1. Corrective Action for Affected Residents:** Resident was screened for use of adaptive device. 6/10/14 **2. Identification of Other Residents Potentially Affected by Same Practice:** All LTC residents screened for services needed to improve/maintain ADLs. 6/25/14 **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Residents will be systematically screened on a quarterly basis, coincident with MDS review. Evaluations will be completed, as appropriate. 6/25/14 **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Residents with improvement/decline in ADLS will be monitored monthly. Reports will be submitted to QA Committee quarterly. 8/1/14	

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F 311	Continued From page 5 Resident # 53. The findings include: During a lunch observation on June 9, 2014 at approximately 1:00 PM, Resident #53 was noted having difficulty eating a slice of pie with a standard spoon from a flat dish. The pie was observed moving across the plate onto the table as the resident attempted to lift it with a spoon. Resident #53 was observed having difficulty, maneuvering the food from the dish to his/her mouth without it falling from the dish onto the table and his/her clothing protector. The observation was immediately bought to the attention of Employee #3. When queried if Resident #53 had been assessed for assistive feeding devices the employee stated, "No, this should be discussed with Rehab [Rehabilitation Department]." A review of the Minimum Data Set (MDS) Quarterly with an Assessment Reference Date (ARD) of May 26, 2014 revealed that Resident #53 was coded under Section G (Activities of Daily Living Assistance) ADL Functional Status as requiring limited assistance with eating with impairment to upper extremity on one side. A face-to-face interview was conducted with Employee #19 on June 19, 2014 at approximately 3:00 PM. When queried whether Resident # 53 was assessed for assistive/ supportive devices for eating, the employee stated, " No, nursing has not submitted the resident for screening. "	F 311		

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F 311	Continued From page 6 A second observation was done during the breakfast meal on June 20, 2014 at approximately 9:00AM with Employee #2. At this time Resident #53 was observed having difficulty completing the meal using standard dishes and utensils. Employee # 2 acknowledged the findings. Facility staff failed to provide necessary care and services to promote Resident #53 ' s independence with eating ability. The clinical record was reviewed on June 20, 2014.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on June 20, 2014 at approximately 2:00 PM, it was determined that the facility failed to ensure that the resident environment remains free of accident hazards as evidenced by unsecured oxygen tanks observed in two (2) of two (2) clean utility rooms. The findings include:	F 323	323 Failure to Ensure Accident Free Environment **1. Corrective Action for Affected Residents:** There were no negative outcomes to the residents as a result of this practice. **2. Identification of Other Residents Potentially Affected by Same Practice:** Deficient practice occurred in a non-resident care area. Residents are not affected by this practice. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed nurses were re-educated on Oxygen Safety, including proper storage/placement of oxygen tank(s) in the rack/cart . **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Shift rounds will include O_2 storage areas. Findings will be reported quarterly to the QA Committee. Compliance threshold is 100%.	6/20/14 6/20/14 8/1/14 8/1/14

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F 323	Continued From page 7 1. Two (2) of two (2) oxygen tanks were observed stored on the floor of the clean utility room located on the first floor. 2. One (1) of one (1) oxygen tank was observed stored unsecured on the floor of the clean utility room located on the second floor. These observations were made in the presence of Employee #3 who acknowledged the findings.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews for one (1) of 27 sampled residents, it was determined that facility staff failed to administer the prescribed dosage of oxygen and clarify physician ' s orders for the assessment of oxygen saturation levels for one (1) resident receiving continuous oxygen therapy. Resident #13. The findings include:	F 328	328 Failure to Administer/Clarify Oxygen Orders A. Oxygen Administration **1. Corrective Action for Affected Residents:** Primary physician was notified. Resident was assessed and monitored for oxygen toxicity x3days after occurrence. **2. Identification of Other Residents Potentially Affected by Same Practice:** No other residents were affected by this deficient practice. In addition to Resident #13, one other resident uses an oxygen concentrator which was were checked and found to be set at the ordered flow rate. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** O_2 policy was updated to include monitoring liter flow during shift rounds. In-service was provided for all licensed nurses regarding the appropriate administration of oxygen at the physician ordered flow rate. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Compliance with policy change will be documented and reported quarterly to the QA Committee. Compliance threshold is 100%.	6/24/14 6/24/14 6/24/14 8/1/14 8/1/14

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F 328	Continued From page 8 1(a). Facility staff failed to administer the correct dose of oxygen continuously for Resident # 13. On June 16, 2014 at approximately 9:45AM Resident #13 was observed lying in bed receiving, oxygen (O2) at three (3) liters (L) per minute (min) via nasal cannula (nc) continuously. A second observation was done on June 18, 2014 at approximately 3:00 PM. Resident #13 was observed receiving O2 at 3L via nasal cannula continuously. This observation was made in the presence of Employee #7 who observed the oxygen flow meter and acknowledged that the oxygen was set at a rate of 3 liters per minute. Employee #7 adjusted the flow- meter to administer 2 liters of oxygen per minute. Physician ' s orders signed and dated June 12, 2014 directed; " O2 at 2L/min via nasal cannula continuously for COPD (Chronic Obstructive Pulmonary Disease). " There was no evidence that facility staff administered Resident #13 ' s continuous oxygen at 3 liters per minute in accordance with the physician's order. A face-to-face interview was conducted with Employee #7 on June 18, 2014 at approximately 4:00 PM. When queried he/she stated, "Resident #13 is supposed to receive the Oxygen at 2 liters not 3 liters. " A face- to- face interview was conducted with	F 328		

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F 328	Continued From page 9 Employee #3 on June 19, 2014 at approximately 9:30 AM. The employee acknowledged the aforementioned findings. Facility staff failed to administer the correct dose of oxygen for Resident #13. The clinical record was reviewed on June 19, 2014. 1(b). Facility staff failed to clarify physician ' s orders for the assessment of oxygen saturation levels for Resident #13. The orders lacked evidence of parameters for notification. A review of Resident #13's clinical record revealed a physician ' s order signed and dated June 12, 2014 which directed, " Check pulse oximetry every shift. " The orders lacked evidence that facility staff queried the medical team to clarify the order(s) as it relates to the parameters for notification based on the pulse oximetry levels. A face-to-face interview was conducted with Employee #7 on June 20, 2014 at approximately 10:30 AM. When queried, the employee stated, "We check pulse his/her pulse oximetry levels every day and no, we don ' t have parameters for physician notification." During a face -to- face interview conducted on June 20, 2014 at approximately 11:00 AM, Employee #3 acknowledged the aforementioned findings. Facility staff failed to obtain pulse oximetry parameters specific to Resident #13 who received continuous oxygen therapy with oxygen	F 328	328 Failure to Clarify Oxygen Orders **1. Corrective Action for Affected Residents:** Order for the assessment of oxygen saturation level for resident #13 was reviewed and clarified, and parameters for notifying MD were obtained. **2. Identification of Other Residents Potentially Affected by Same Practice:** TARs were checked to identify other residents with O_2 orders to ensure that parameters for MD's notification were documented. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** O_2 policy was updated to include documenting parameters as part of physician orders for O2 administration. All licensed nurses were re-educated . **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Compliance with policy change will be monitored through monthly review of TARs for residents with orders for O_2 administration. Findings will be reported quarterly to the QA Committee. Compliance threshold is 100%.	6/24/14 6/24/14 8/1/14 8/1/14

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F 328	Continued From page 10 saturation monitoring. The medical record was reviewed on June 20, 2014.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 27 sampled residents, it was determined that facility staff failed to ensure that residents were free of unnecessary medications as evidenced by failure to consistently monitor	F 329	329 Freedom from Unnecessary Drugs A. Failure to Consistently Monitor Residents Receiving Antidepressant Meds for Worsening Depression or Suicidal Behavior **1. Corrective Action for Affected Residents:** Psychiatric Physician's Assistant reviewed meds for Residents #26 & 52 and documented appropriateness of medications as ordered. **2. Identification of Other Residents Potentially Affected by Same Practice:** Progress notes by the psychiatric staff and/or social worker for all residents receiving anti-depressant meds were reviewed to determine if behaviors warranting the use of antidepressant medication were documented. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** New policy has been developed which includes updated behavior tracking procedure to better monitor residents' behaviors. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Random chart reviews of residents on psychoactive medications will occur quarterly and results will be reported to QA. Compliance threshold is 100%.	7/25/14 7/31/14 8/1/14 8/1/14

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F 329	Continued From page 11 two (2) residents receiving antidepressant medication for signs of worsening depression and/or suicidal behavior; and failed to document the specific circumstance to warrant the use of an ' as needed ' anxiolytic medication [Ativan] and whether or not the medication was effective. Residents #26, 52, and 69. The findings include: 1. Facility staff failed to monitor Resident #26 for signs of worsening of depression and/or suicidal behavior while he/she was receiving antidepressant medication; Zoloft. A review of the resident ' s clinical record revealed that he/she was admitted to the facility on May 2, 2014 with diagnoses which included Depression. According to physician's orders Resident #26 was started on Zoloft 50mg PO [by mouth] QD [daily] for Depression on May 27, 2014. According to the Medication Administration Record [MAR] the resident received Zoloft daily June 1, 2014 through June 18, 2014. Further review of the resident's clinical record [Nurses' notes] and or Treatment Records failed to reveal any evidence that the resident was being monitored for signs of worsening depression and/or suicidal behavior. A face-to-face interview was conducted with Employee #5 on June 20 2014 at 10:45AM. He/she stated that the facility does not record Resident behaviors on a "Behavior Monitoring	F 329		

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F 329	Continued From page 12	F 329		

Flow Sheet" and that facility staff document behaviors in the progress and nurses notes accordingly.

Another face-to-face interview was conducted with Employee #3 at approximately 2:30PM on June 20, 2014. The employee was informed of the aforementioned findings which he/she acknowledged. The record was reviewed on June 18, 2014.

2. Facility staff failed to consistently monitor Residents #52 for signs of worsening of depression and/or suicidal behavior while he/she was receiving antidepressant medication; Zoloft.

A review of Resident #52's clinical record revealed a physician ' s order dated and signed June 19, 2014 which directed, "Sertraline 50 mg tab (Zoloft) PO daily for depression. "

A face-to-face interview was conducted with Employee #4 on June 23, 2014 at 11:00AM. A query was made how the facility monitors a resident while receiving antidepressant medication. Employee #4 stated, "The nurse will write any changes in the progress notes. We do not have behavior monitoring tools."

Upon further review of Resident #52 ' s nurse' notes there was no evidence of documentation related to the monitoring for signs of worsening of depression and/or suicidal behavior. .

After review of the above, Employee #4

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	095038	A. BUILDING _____ B. WING _____	06/23/2014

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F 329	Continued From page 13 acknowledged the findings. 3. A review of Resident #69 ' s clinical record revealed facility staff failed to document the specific circumstance to warrant the use of as needed [prn] Ativan. There was no evidence regarding the effectiveness of the medication. Physician ' s orders dated June 4, 2014 directed, " Give Ativan 0.125 mg [milligram] PO [by mouth] QD [daily] PRN [as needed] for Anxiety/Insomnia. A review of the Medication Administration Record [MAR] for June 2014 revealed Ativan was administered on June 5 (2 doses), June 9, June 16, June 17 and June 18. Further review of the MAR and nurse ' s progress notes lacked evidence of the specific circumstance demonstrated by the resident to warrant the administration of the ' prn ' Ativan. Additionally, there was no evidence of an assessment of the effectiveness or lack thereof of the intervention. A face-to-face interview was conducted with Employee #2 at approximately 2:30 PM on June 19, 2014. The employee was queried regarding the lack of documentation related to the administration of prn Ativan. The employee responded that when/if the resident demonstrates specific behaviors they are entered into the computer and that the entries prompt a specific response from the Care Tracker. The employee added that he/she will review the Care Tracker to determine if more definitive information can be	F 329	329 Freedom from Unnecessary Drugs B. Failure to Document Need for/Effectiveness of PRN Ativan **1. Corrective Action for Affected Residents:** Deficient documentation involving Resident #69 occurred on June 5,9,16,17,18, 2014. Resident demonstrated no untoward effects as a result. No retrospective corrective action available. **2. Identification of Other Residents Potentially Affected by Same Practice:** Three residents have physician orders for PRN Ativan. Reviews of their charts (Jan 1- June 23, 2014) revealed that all doses were administered for documented symptoms as prescribed by the physician. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a. All licensed personnel were in-serviced on documentation required when PRN meds are administered, including anxiolytic drugs. b. This in-service will be provided as part of New Employee Orientation for licensed personnel, and annually for all licensed staff. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Random chart audits will be completed monthly for 20% of residents receiving PRN antidepressant medications; results will be reported to the QA Committee quarterly.	6/24/14 6/24/14 6/27/14 8/1/14

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F 329	Continued From page 14 recorded. The record was reviewed on June 18, 2014.	F 329	371 Failure to Store, Prepare, Distribute and Serve Food Under Sanitary Conditions	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on June 16, 2014 at approximately 9:30 AM and on June 20, 2014 at approximately11:15 AM, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by six (6) of 13 sheet pans and two (2) of five (5) six-inch half pans that were stored wet and ready for reuse, one (1) of one (1) soiled convection oven, a dusty shelf located above the stove, one (1) of one (1) improperly stored large spoon, one (1) of one (1) undated container of prunes, one (1) of one (1) open case of chocolate chip cookies and a soiled air vent above the ice machine located in the main kitchen. The findings include: 1. Six (6) of 13 sheet pans and two (2) of five (5) six- inch half pans were stored wet and ready for reuse.	F 371	A. Six (6) of 13 sheet pans and two (2) of five (5) six-inch half pans stored wet and ready for reuse. **1. Corrective Action for Affected Residents/Equipment:** All pans and Trays were placed on extra new Dry racks . **2. Identification of Other Residents/Equipment Potentially Affected by Same Practice:** Management team will inspect air drying of pans after each Shift. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Review and in-service on Policies and Procedures. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Dietary Services Director will monitor Open-Close Checklist findings weekly to ensure corrective actions are effective and sustained. The Dietary Director will report findings to the QA Committee quarterly. B. One (1) of one (1) soiled convection oven. **1. Corrective Action for Affected Residents/Equipment:** Oven was cleaned June 20, 2014. **2. Identification of Other Residents/Equipment Potentially Affected by Same Practice:** All ovens were inspected and found clean. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Dietary Services shift supervisors will monitor cleanliness of the oven daily, as part of Open-Close Checklist. The Master Cleaning List will be revised to increase frequency of oven cleanings to weekly. The Oven cleaning will be added to the closing cook's daily cleaning assignment. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Dietary Services Director will monitor Open-Close Checklist findings weekly to ensure corrective actions are effective and sustained. The Dietary Services Director will report findings to QA Committee quarterly.	6/20/14 6/20/14 6/20/14 6/20/14 6/20/14 6/20/14 6/20/14

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F 371	Continued From page 15 2. One (1) of one (1) convection oven was soiled with burnt food residue. 3. The shelf located above the stove was soiled with dust particles. 4. One (1) of one (1) large serving spoon was touching books located on the storing shelf. 5. One (1) of one (1) container of prunes was stored undated in the reach-in four-door cooler. 6. One (1) of one (1) open case of chocolate chip cookies was stored in the walk-in freezer Unlabeled. 7. The air vent located above the ice machine was soiled with accumulated dust particles. These observations were made in the presence of Employee #9 and Employee #10. They both acknowledged the findings.	F 371	371 (Cont'd) Failure to Store, Prepare, Distribute and Serve Food Under Sanitary Conditions C. One (1) of one (1) improperly stored large spoon **1. Corrective Action for Affected Residents/Equipment** : The Spoon was stored properly on ceiling rack to air dry. **2. Identification of Other Residents/Equipment Potentially Affected by Same Practice:** All staff was in-serviced and policies and procedures reviewed. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Dietary Services shift supervisors will monitor storage of utensils daily, as part of the Weekly Checklist. Inspection of storage of all utensils will be added to the Monthly Sanitation Audit. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Weekly Checklists and Monthly Sanitation Audits will be reviewed by Dietary Director and reported to the QA Committee quarterly. D. One (1) of one (1) open case of chocolate chip cookies and undated Prunes **1. Corrective Action for Affected Residents/Equipment** : Chocolate chip cookies were discarded immediately **2. Identification of Other Residents/Equipment Potentially Affected by Same Practice:** All staff was in-serviced and policies and procedures reviewed. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Dietary Services shift supervisors will monitor Labeling and dating practices daily, as part of the Weekly Checklist. Inspection of Labeling and Dating will be added to the Monthly Sanitation Audit. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Weekly Checklists and Monthly Sanitation Audits will be reviewed by Dietary Director will be reported to the QA Committee quarterly.	6/20/14 6/20/14 6/20/14 6/20/14 6/20/14 6/20/14 6/20/14
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on an observation made during a tour of the outside garbage disposal area on June 18, 2014 at approximately 3:30 PM, it was determined that the facility failed to dispose of garbage and refuse properly as evidenced by one (1) of one (1) trash receptacle that was			

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F 372	Continued From page 16 observed overflowing with garbage. The findings include: One (1) of one (1) trash receptacle was observed uncovered and overflowing with garbage. A face-to-face interview was conducted with Employee #12 on June 20, 2014 at approximately 3:00 PM regarding the aforementioned finding. He/she stated that the person generally responsible for the area was reassigned. The employee was queried on how often the garbage gets picked up. He/she responded, "They pick up the garbage every Monday, Wednesday, Friday and Saturday." The observation was made on a Wednesday, June 18, 2014. Employee #12 acknowledged the finding.	F 372	371 (Cont'd) Failure to Store, Prepare, Distribute and Serve Food Under Sanitary Conditions E/F. Soiled air vent above the ice machine located in the main kitchen. Soiled shelf above stove. **1. Corrective Action for Affected Residents/Equipment**: Air vent and shelf were cleaned immediately. **2. Identification of Other Residents/Equipment Potentially Affected by Same Practice:** Management team will inspect air vent and shelf during daily walk through. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Review and in-service staff on cleaning Policies and Procedures. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Dietary Services Director will monitor Open-Close Checklist findings weekly to ensure corrective actions are effective and sustained. The Dietary Director will report findings to the QA Committee quarterly. 372 Dispose of Garbage and Refuse Properly **1. Corrective Action for Affected Residents:** No residents were affected. No corrective action indicated. **2. Identification of Other Residents Potentially Affected by Same Practice:** MH does not have an external garbage disposal area as referenced in the deficiency. Waste Management pick up log indicates that trash pick-up on Wednesday, June 18 occurred at 10:02 AM; observation was made at 3:30 PM. No corrective action indicated. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Current system for trash pick -up will be maintained and monitored weekly. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Logs will be monitored monthly to ensure consistency in pick-up days/times. Results will be reported to QA Committee quarterly.	6/201/4 6/20/14 6/20/14 6/20/14 6/24/14 6/24/14 6/24/14 8/1/14
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	F 386		

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F 386	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 27 sampled residents, it was determined that the physician failed to review Resident #31's total plan of care as evidenced by failure to act on recommendations communicated by the radiologist via diagnostic [radiology] report. The findings include: According to a history and physical examination dated May 29, 2014 the Resident #31's diagnoses included Osteoarthritis, COPD (Chronic Obstructive Pulmonary Disease), Depression, and Hyperlipidemia. A review of Nurse's notes dated September 12, 2013 at 3:00 PM revealed the following: "Resident seen by attending [medical doctor] for left shoulder pain. Ordered x-ray [left] shoulder. [Diagnostic contractor named] notified. " A radiology report dated September 12, 2013 revealed: " Reason: Pain shoulder joint; Exam: Shoulder Left 2 views. Impression: Degenerative joint disease of the acromioclavicular joint with cephalad migration of the humeral head. A rotator cuff tear must be ruled out. " There was no evidence in the clinical record that the physician acted on the recommendations documented by the radiologist. There was no documentation by the physician to reflect that	F 386	**F386** 483.40(b) Failure to Act on Radiologist's Recommendations **1. Corrective Action for Affected Resident:** Resident #31 has been referred to Therapy. Family does not agree with more extensive diagnostic studies (MRI), since resident is not candidate for surgical repair if injury is identified. **2. Identification of Other Residents Potentially Affected by Same Practice:** Twenty-one residents (42% of the resident population) had X-rays performed between Oct, 2013-June 30, 2014. No X-ray included recommendations from the radiologist. No other residents were affected by the deficient practice. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a. Recommendations that may be included on radiology reports will be circled by the nurse and brought to the physician's attention for review and comment, as appropriate. b. Licensed staff have been trained on the implementation of this practice. c. Newly employed nurses will be trained on this practice during New Employee Orientation. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** All X-ray reports received during the month will be reviewed, with results reported quarterly to the QA Committee. Compliance threshold is 100%.	8/1/14 8/1/14 8/1/14 8/1/14

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F 386	Continued From page 18 he/she agreed or disagreed with the radiologist ' s recommendations to rule out a rotator cuff tear. The clinical record lacked evidence of any untoward effects to the resident. A follow-up telephone interview was conducted on June 23, 2014 at approximately 9:30 AM with Employee #2 regarding the aforementioned findings. He/she acknowledged that the prescribing physician reviewed the radiology report of September 12, 2013. However, he/she confirmed that there was no evidence in the clinical record of further action regarding the radiologist ' s recommendation. The clinical record was reviewed on June 23, 2014.	F 386		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review for one (1) of 27 sampled residents, it was determined that facility staff failed to follow-up on a dental recommendation for dentures. Resident #23.	F 412	**F412** 483.55(b) Failure to Follow Up on Dental Recommendation **1. Corrective Action for Affected Resident:** Resident #23 was seen by dentist on 6/21/14 and 7/22/14 and is in the process of getting full lower dentures. **2. Identification of Other Residents Potentially Affected by Same Practice:** Resident charts were reviewed and social worker spoke with dental services to clarify notes. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** New policy has been developed in which the Social Worker will coordinate dental appointments and review dental notes after dental visits. Social Worker will coordinate any needed follow up. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Charts of residents receiving in house dental services will be randomly selected quarterly and audited to determine compliance with the policy. Findings will be reported to QA Committee. Compliance threshold is 100%	7/22/14 7/31/14 7/31/14 8/1/14

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F 412	Continued From page 19 The findings include: During a resident interview conducted on June 17, 2014 at approximately 2:36 PM with Resident #23 a query was made if the resident had chewing or eating problems (could be due to: no teeth, missing teeth, oral lesions, broken or loose teeth). The resident responded " Yes , I do not have my lower dentures. That is why I have chewing problems." A review of the medical record revealed a Dental Record, dated January 28, 2014 which indicated: Dentures "Full Upper /yes; Full Lower/No"; Examination Results/Comments: "Edentulous ...; Abnormal Soft tissue findings [within normal limits] WNL. Recommendations: Possible fabrication /FL [full lower] dentures... " A telephone interview was conducted on June 19, 2014 at approximately 11:30 AM with Employee #31. A query was made regarding the recommendation for possible fabrication of the full lower dentures as noted in the January 28, 2014 dental consultation note. Employee #31 stated, " We will add [the resident] to the schedule for Tuesday June 24, 2014." There was no evidence in the clinical record that Resident #23 received a follow up dental examination to explore ' possible ' lower dentures. Approximately six (6) months lapsed since the dentist recommended the possibility of lower dentures for Resident #23. The record was reviewed June 17, 2014.	F 412		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 20 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 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	F 441		

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F 441	Continued From page 21 by: A. Based on observations during an environmental tour on June 20, 2014 at approximately 11:00 AM, it was determined that the facility failed to prevent the spread of disease and infection as evidenced by the following items: one (1) of one (1) ice scooper observed lying on top of ice in the ice machine located on the first floor pantry room; three (3) of three (3) ice machines did not have a backflow preventer. The findings include: 1. One (1) of one (1) ice scooper was stored inside the ice machine located on the first floor pantry room. 2. Three (3) of three (3) ice machines did not have a backflow preventer. These observations were made in the presence of Employee #12 who acknowledged the findings. B. Based on observation, and staff interviews, it was determined that the facility staff failed to practice proper hand hygiene when administering medications to Resident #13. The findings include: Facility staff failed to utilize proper hand hygiene practices during medication administration for	F 441	1. **Corrective action for residents affected by deficient practice**: No resident was affected by the lack of back-flow preventers. 2. **Method to identify other residents at risk for deficient practice**: Air gap present in drain lines of 3 of 3 ice machines. Back flow preventer installed in lines to 3 of 3 ice machines. 3. **Measure of systematic changes to ensure deficient practice does not recur:** Maintenance will check Plumbing in Health Care Center during preventative maintenance rounds. 4. **Performance monitoring to ensure solutions are sustained:** The facility will monitor the above through quality assurance- by reviewing on safety rounds. Discussion of finding will be presented at QA meeting.	06/20/14 08/29/14 08/20/14 08/29/14

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F 441	Continued From page 22 Resident #13. During a medication administration observation conducted on June 19, 2014 at 10:00 AM, Employee #5 was observed preparing Resident #13 ' s medications for administration. The employee was observed using hand sanitizer prior to obtaining and preparing the medications for administration. Upon completion of the preparation of medications, the employee was observed leaving the medication cart, opening the pantry door, touching and turning the knob to fill a cup with tap water. Upon returning to the medication cart, Employee #5 gathered medications and knocked on the door prior to entering the resident 's room. Upon entering the room the employee proceeded to mix the medications in apple sauce and administered it to Resident #13, using a tongue depressor. After the medications were administered Employee #5 entered the resident 's bathroom and washed his /her hands. At the time of the observation Employee #5 was queried regarding the observations of him/her touching multiple surfaces prior to administering the resident's medication/s. He/she responded, "I should have washed my hands before I gave Resident #13 his/ her medications." Employee	F 441	B. Proper hand hygiene when administering meds **1. Corrective Action for Affected Residents:** Deficient practice occurred June 19, 2014 during survey. Resident #13 experienced no untoward effects. No retrospective corrective action indicated . **2. Identification of Other Residents Potentially Affected by Same Practice:** Nurses have been randomly observed for use of proper hand hygiene while passing medications. No violations of infection control practices have been observed. No potential for other residents to be affected by the deficient practice has been identified. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a. All licensed personnel were re-educated on proper handwashing when meds are administered. b. This in-service will continue part of New Employee Orientation for licensed personnel, and annually for all licensed staff. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Random return demonstrations of proper handwashing technique will be conducted for nurses during med passes; results will be reported quarterly to the QA Committee. Compliance threshold is 100%.	6/19/14 6/19/14 6/19/14 8/1/14 8/1/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOME	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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F 441	Continued From page 23 #5 acknowledged the findings.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to ensure that essential equipment was maintained in a safe operating condition as evidenced by the inability to assure the proper functioning of the dish machine in that water temperatures during the rinse cycles were undetermined due to a malfunction of the temperature gauge apparatus. The findings include: During an inspection of the kitchen on June 20, 2014 at approximately 10:00 AM, an observation of the dish machine revealed that the needle of the temperature gauge remained in the " 0 " position during the final rinse cycle of the dish washing process. A query was made to Employee #9 who was present during the observation, regarding the method utilized to detect water temperatures, particularly during the final rinse cycle. He/she stated that the final rinse temperature gauge was not functional.	F 456	**1. Corrective Action for Affected Residents:** Upon discovery of gauge malfunction the facility began using paper and called contracted vendor for service **2. Identification of Other Residents Potentially Affected by Same Practice:** Gauges are checked upon every meal, 3 times a day **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Dietary shift supervisors will monitor temperatures daily, as part of the Weekly Checklist. Inspection of the dish machine will be added to the Monthly Sanitation Audit. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Weekly Checklists and Monthly Sanitation Audits will be reviewed by Dietary Director and reported to the QA Committee quarterly.	6/24/14 6/24/14 6/24/14 6/24/14

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F 456	Continued From page 24 During a follow-up interview with Employee #17, he/she stated that the gauge was working earlier because the temperature log was recorded as 180 degrees during the final rinse cycle. Final rinse temperatures recorded from June 1, 2014 through June 20, 2014 were all within the normal range of 180 degrees Fahrenheit or greater. There was no evidence that the staff were able to determine the functionality of the dishwasher as evidenced by a failure of the temperature gauge to detect and display water temperatures during the final rinse cycle. These observations were made in the presence of Employee #9 who acknowledged the findings.	F 456		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on June 20, 2014 at approximately 12:00 PM, it was determined that the facility failed to provide a safe, functional and sanitary environment for residents and staff as evidenced by: incomplete temperature logs for one (1) of one (1)	F 465		

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F 465	Continued From page 25 hydrocollator located in Rehabilitation Department, low hydrocollator temperatures for two (2) of 28 days in May 2014 and six (6) of 15 days in June 2014 and pre-filled lint traps cleaning logs from June 21, 2014 through July 13, 2014. The findings include: 1. Temperature and cleaning logs for the hydrocollator located in Rehabilitation Department were incomplete for the months of May and June 2014. Temperatures were not documented for one (1) of 28 days during the month of May, 2014 and for two (2) of 15 days during the month of June 2014. 2. The " Hydrocollator Temperature and Cleaning Log " Policy effective date: April 16, 2007 revealed, " Temperature must be between 160 and 166 degrees Fahrenheit. " A review of the Hydrocollator Temperature and Cleaning Log temperatures were below 160 degrees Fahrenheit for two (2) of 28 days in May 2014 and for six (6) of 15 days in June 2014. 3. Lint traps cleaning logs for two (2) of two (2) dryers located in the laundry room were pre-filled with dates, time and initials throughout the remaining days of June 2014 and up to July 13, 2014. These observations were made in the presence of Employee #16 and Employee #18 who acknowledged the findings.	F 465	465 Safe, Functional, Sanitary, Comfortable Environment A. Temperature Logs for Hydrocollator **1. Corrective Action for Affected Residents:** No residents were affected. **2. Identification of Other Residents Potentially Affected by Same Practice:** The hydrocollator temperature will be taken daily when the hydrocollator is in use before the hydrocollator packs are used for resident treatments. This will be recorded on the "Hydrocollator Temperature Log". **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** The log will be reviewed daily by Site Manager to ensure accuracy of temperature and timeliness of recording. The policy and procedure for proper hydrocollator temperature will be reviewed with site manager and staff. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** The process will be monitored for the next 3 months and reported as a QA focus quarterly. B. Pre-Filled Lint Trap Cleaning Logs for Laundry **1. Corrective Action for Affected Residents/Equipment:** The lint traps for the dryers were cleaned and logged on June 28, 2014. **2. Identification of Other Residents Potentially Affected by Same Practice:** A new lint trap log was created on June 28, 2014 to accurately reflect lint trap cleaning. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Staff in-service conducted. Random reviews of logs by Housekeeping Director. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Monitoring results to be reported to QA Committee quarterly x4 quarters.	6/26/14 6/26/14 6/16/14 6/26/14 6/28/14 6/28/14 6/28/14 6/28/14

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F 514 SS=D	483.75(I)(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 two (2) of 27 sampled residents, it was determined that facility staff failed to document the rationale for the continued use of an antidepressant medication [Lexapro] for one (1) resident; and failed to accurately document the stage of one (1) resident's pressure ulcer. Residents' #31 and #60. The findings include: 1. Facility staff failed to accurately document the rationale for the continued use of Lexapro (an antidepressant) in the absence of a gradual dose reduction for Resident #31. A history and physical exam form dated May 29, 2014 revealed that Resident #31's diagnoses included depression.	F 514	F 514 Failure to Document Rationale for Continued Use of Lexapro **1. Corrective Action for Affected Residents:** Psychiatrist documented rationale for continuing Resident #31's Lexapro in the medical record. **2. Identification of Other Residents Potentially Affected by Same Practice:** Pharmacy recommendations and notes from psychiatrist were reviewed for all residents receiving antidepressant meds. Indications for continued use were documented for these residents. No residents were affected by the deficient practice cited. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** New policy was developed to reflect monitoring activity implemented by Nursing to ensure consultant pharmacist and contract psychiatrist document need for GDR, or justification to continue psychoactive medication. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Random chart audits will be completed monthly for residents receiving psychoactive meds, including antidepressants; results will be reported quarterly to the QA Committee. Compliance threshold is 100%.	8/1/14 8/1/14 8/1/14 8/1/14

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F 514	Continued From page 27 On June 16, 2014 at approximately 3:30 PM an attempt was made to conduct an initial interview with Resident #31. The resident stated, " I am taking a nap. You can come back in the morning. " A follow-up attempt was made on June 17, 2014. This time the resident stated, " I just finished eating and I want to go to bed and rest. " Several more attempts were made to interview the resident. However; he/she was asleep in his/her bed. A Physician ' s Order Sheet dated May 29, 2014 directed, " Escitalopram 20mg tab (also known as: Lexapro) - Give one [tablet] by mouth every day [for] depression. " A review of the Medication Administration Record (MAR) dated July 2013 through December 2013 and January 2014 through June 15, 2014 revealed that Resident #31 had been receiving Lexapro 20mg at 9:00 PM daily for depression. A psychiatrist's progress note dated July 12, 2013 included, "Assessment/Plan: Lexapro 10mg po [by mouth] daily." Resident ' s current dose was 20mg. Follow-up psychiatrist progress notes revealed the following: September 27, 2013 revealed, " Assessment Plan: At baseline continue present management. Prescriptions: Lexapro 20 mg po [by mouth] daily, Affect: Constricted." October 15, 2013- Mental Status Exam: Consciousness: boxes checked for "somnolent	F 514		

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F 514	Continued From page 28 [and] lethargic. " A behavioral science note dated April 30, 2014 at 9:15 AM revealed, " Current Medical Issues: COPD (Chronic Obstructive Pulmonary Disease), CHF (Congestive Heart Failure), HLD (Hyperlipidemia), Anxiety, Depression- [Patient] very sleepy this AM but denies issues with mood, sleep or appetite. [Patient] too tired to answer orientation questions at this time. " A face-to-face interview was conducted on June 18, 2014 at approximately 2:00 PM with Employee #4. When queried if the resident 's Lexapro was to be decreased from 20mg to 10mg as noted with the contrasting psychiatric notes between July 2013 and September 2013, he/she replied [the resident] is still on Lexapro 20mg. I will have to call the psychiatrist to see if the resident is on the correct dose. " A follow-up face-to-face interview was conducted with Employee #4 on June 19, 2014 at approximately 12:00 PM. He/she stated, " [Psychiatrist named] stated [he/she] talked to [Resident #31's responsible party] and concluded not to change the dose. " Facility staff failed to document the rationale for the continued use of Lexapro (an antidepressant) in the absence of a gradual dose reduction. The clinical record was reviewed on June 19, 2014. 2. Facility staff failed to accurately document the stage of Resident #60 ' s pressure ulcer. According to a history and physical dated	F 514		

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F 514	Continued From page 29 February 19, 2014, Resident #60 's diagnoses included: " Advanced Dementia, Osteoporosis, Pulmonary Hypertension, Hypertension and Hyperlipidemia. " The physician 's admission orders dated February 17, 2014 and signed February 19, 2014 directed, " Treatment Orders: Cleanse [right] heel [with] NSS (Normal Saline Solution). Pat dry. Granulex spray, Cover [with] 4X4 gauze, wrap [with] kling QD [everyday] until redness resolves. Cleanse [left] heel with NSS. Pat dry. Granulex spray. Cover with 4X4 gauze, wrap with kling QD [and] tape until redness resolves. " The " Admission Nursing Assessment " form dated February 17, 2014 revealed an anatomical diagram depicting Resident #60 had redness on the right posterior heel. There was no indication on the admission assessment that the resident had any redness on the left posterior heel. A " Nurse ' s Notes " dated February 17, 2014 at 10:00 PM revealed, " ... resident will wear bunny boots to protect [his/her] heels from rubbing against the sheets. " A review of the " Skin Condition Record " for Non-pressure Ulcer skin conditions revealed the following: " Date - 2/17/14- Site/Location: Right Heel; Size: Immeasurable; depth- 0; Exudate-0; Surround Skin Color- Redness, reddish area. Resolved- 2/19/14 Date 2/19/14- Site/Location: Left heel; Size-	F 514	F 514 Failure to Accurately Document Stage of PU **1. Corrective Action for Affected Residents:** Deficient documentation occurred 2/17/14. PU was healed 2/19/14. Skin was observed intact during survey. Resident #60 experienced no negative outcome as a result of deficient documentation. No retrospective corrective action was implemented.	6/25/14
			2. Identification of Other Residents Potentially Affected by Same Practice: 26 residents were admitted between Jan. 1-June 30, 2014. Two had PU upon admission. Chart reviews for these 2 residents revealed accurate staging and documentation for the PUs upon admission and during subsequent assessments.	8/1/14
			3. Systemic Changes to Ensure Deficient Practice Does Not Recur: a. All licensed personnel were re-educated on documentation of PUs including, but not limited to, staging, location of ulcer, and use of correct forms.	8/1/14
			4. Performance Monitoring to Make Sure Solutions Are Sustained: Random chart audits will be completed monthly for residents with PUs; results will be reported quarterly to the QA Committee. Compliance threshold is 100%.	8/1/14

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F 514	Continued From page 30 immeasurable, depth- 0; exudates- 0; surrounding skin color_ redness [left blank]. Resolved- 2/19. " There was no evidence that facility staff documented the alteration in skin integrity on the correct skin sheet form. The facility documented the Stage I pressure ulcer on the Non-Pressure Ulcer Skin sheet instead of the Pressure Ulcer Skin sheet. The comprehensive care plan with goal (s) and approaches dated February 24, 2014 revealed: " Problem- Category: Pressure Ulcer; [History] of both heels stage I: acquired pre admission, resolved on 2/19/14 with effective treatment. An observation of Resident #60 ' s heels was conducted on June 20, 2014 at approximately 2:30 PM in the presence of Employee #6. No alteration in skin integrity was observed on the heels. The clinical record lacked evidence that Resident #60 ' s pressure ulcer (s) was accurately documented on admission and successive assessments. A face-to-face interview was conducted with Employees #3 and #4 on June 20, 2014 at approximately 3:00 PM. After reviewing the admission nursing assessment and the skin condition records; both acknowledged that the resident's alteration in skin integrity should have been documented on the " pressure ulcer skin sheet as a Stage 1 pressure ulcer. " The clinical record was reviewed on June 20, 2014.	F 514		

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F 514	Continued From page 31 B. Based on observations made during an environmental tour of the facility on June 20, 2014 at approximately 12:00 PM, it was determined that facility failed to accurately document lint trap cleaning information on the " lint trap cleaning logs " from June 21, 2014 through July 13, 2014. The findings include: Lint traps cleaning logs for two (2) of two (2) dryers located in the laundry room were pre-filled with dates, time and initials throughout the remaining days of June 2014 and up to July 13, 2014. These observations were made in the presence of Employee #16 and Employee #18 who acknowledged the findings.	F 514	B. Pre-Filled Lint Trap Cleaning Logs for Laundry **1. Corrective Action for Affected Residents/Equipment**: The lint traps for the dryers were cleaned and logs completed on June 28, 2014. **2. Identification of Other Residents Potentially Affected by Same Practice:** A new lint trap log was created to accurately reflect lint trap cleaning. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** Staff in-service and random reviews of logs by Housekeeping Director to be conducted monthly. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Monitoring results to be reported to QA Committee quarterly x4 quarters.	6/28/14 6/28/14 6/28/14 6/28/14