STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095005	A. BUILDING _____ B. WING _____	05/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

(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 was conducted May 11, 2015 through May 22, 2015. The following deficiencies are based on observation, record review, resident and staff interviews for 37 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 DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass)	F 000	The Washington Home makes its best effort. To operate in substantial compliance with both Federal and State law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following Plan of Correction constitutes the facility's written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gloria C. Odunsade	Director of Nursing	Aug. 18, 2015

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 MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000	**F157** 1. Nurses caring for resident #23 were counseled and re-educated on facility policy for notifying Medical Staff on resident changes in condition. The resident's wound did not worsen in the time period addressed by the deficiency and is resolved. The resident received treatment for the wound, although the medical staff were not notified. The staff associated with this incident received counseling and received education regarding the organization's protocol as to what information needs to be communicated to the physician or Advanced Practice Nurse. 2. An audit of all residents with pressure ulcers was completed. Medical Staff notifications and initiation of treatment orders were in compliance with facility policy. Opportunities for improvement were completed at time of audit. An audit of the medical record of all residents with pressure ulcers was conducted to determine if the physician or Advanced Practice Nurse was notified about the wound and if orders were obtained for appropriate treatment of the wound(s). Any remarkable instances were corrected at the time of the audit.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or	F 157		

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F 157	Continued From page 2 clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview for one (1) of 37 sampled residents, it was determined that facility staff failed to notify the physician when a second area of skin impairment was first noted on Resident #23's left buttocks. The findings include: Through staff interview it was determined facility staff observed a new wound on Resident # 23 ' s left buttock on the weekend of May 9 to 10, 2015; however, notification to a physician or nurse practitioner was not made. Treatment orders for	F 157	3. Clinical Managers will be educated to audit the electronic healthcare record (EHR) of all residents with pressure ulcers weekly, using criteria added to the weekly Skin Integrity Audit Tool. All licensed nurses will be educated on Medical Staff notification and complete a Skin/Wound Competency. Clinical Managers will conduct a weekly audit of the medical record of all residents with pressure ulcers. The criteria for the audit will be added to the weekly Skin Integrity Audit Tool. All Clinical Managers will receive education as to how the audit tool is to be used. All licensed nurses will receive education on facility protocol of Notification of Physician (Advanced Practice Nurse) and will be administered a Skin/Wound Care Competency. 4. Clinical Managers will report findings of Skin Integrity Tool to Focus Quality Improvement (QI)-Interdisciplinary Team (IDT) weekly for review and identification of opportunities for performance improvement (OPI). All licensed nurses will complete a mandatory biannual education on physician notification protocol and successfully complete the annual Wound Care Competency.	

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F 157	Continued From page 3 management of the wound were initiated on May 13, 2015 (approximately 4 days later) after the area was assessed as a stage 3 pressure ulcer during routine wound rounds by the Nurse Practitioner. On May 13, 2015 (Wednesday) incontinence care was observed for Resident #23. It was noted that the resident had two (2) dressings on his/her left buttock and one (1) on the right buttock all initialed by a licensed nurse and dated May 12, 2015. A review of the most recent " Skin Condition Report " dated May 4 and 7, 2015 revealed that Resident #23 had two (2) wounds: left buttock (abscess) and right buttock (abrasion). There was no documentation of a second skin integrity concern on the left buttock as observed on May 13, 2015. Subsequent to the observation of incontinence care on May 13, 2015 the following progress notes were recorded. An Interdisciplinary Progress Note dated May 13, 2015 at 11:15 AM, by the Nurse Practitioner Student revealed the following, " ... Pt. (patient) has not been out of bed ...Skin breakdown - wound care rounds - new orders. L (left) Buttock abscess 2 x 1 x .01cm healing; R (right) buttock 1.5 x 2.5 x .01 cm unstageble, L buttock Stage	F 157	Data Analysis of the Skin Integrity tool will be discussed weekly at the Focus Quality Improvement meeting and reported quarterly by the QI manager to the Quality Improvement Team. The facility protocol of Notification of Physician (Advanced Practice Nurse) will be conducted as a twice mandatory education session for all Licensed Nurses. All Licensed Nurses will be administered and must successfully pass an annual Wound Care Competency. 5. Compliance Date:	7/22/2015

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F 157	Continued From page 4 III 2 x 1 x .01cm ...ordered alternating pressure mattress ... " A review of the Nurse Practitioner ' s note dated May 13, 2015 [no time indicated] revealed, ... Abscess to L butt is healing s/p antbx (antibiotics) - has new pressure ulcers - will order alternating pressure mattress and PT (physical therapy) to evaluate seating for new cushions. " Interviews A face-to-face interview was conducted with Employees #22 (Certified Nurse Aide) on May 15, 2015 at approximately 3:40 PM. He/she stated, " I observed three (3) areas on the resident this weekend May 9, and 10, 2015." A face-to-face interview was conducted with Employees # 20 and 29 (License Practical Nurses) on May 15, 2015 at approximately 3:43 PM. They stated, " We treated the new area on the left buttocks the same as we did the other areas. It looked the same. We treated it with warm compress and dry dressing. A face-to-face interview was conducted on May 15, 2015 at 3:45 PM with Employee #6. He/she reviewed the physician ' s orders and acknowledged that there was no order to treat three (3) open areas on the resident ' s buttocks. There was no evidence in the clinical record that facility staff notified the physician, when there was a second area of skin impairment identified on Resident #23's left buttock. The record was reviewed on May 22, 2015.	F 157		
F 167	483.10(g)(1) RIGHT TO SURVEY RESULTS -	F 167		

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F 167 SS=C	Continued From page 5 READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for six (6) of six (6) areas in which the facility posts the survey results, it was determined that facility staff failed to ensure that the survey results were located in an accessible location as evidenced by unavailable survey results in the lobby area of the facility and a lack of signage to indicate the availability and location in five (5) of five (5) resident care units. The findings include: A tour of the facility to confirm the availability of the survey results was conducted with Employee # 1 on May 21, 2014 at approximately12:10 PM. Entrance- A sign posted in the lobby area indicated that the survey results were available at	F 167	**F 167** 1. The most recent plan of correction survey results will be made available for examination and be posted in the front lobby of The Washington Home, readily accessible to residents. 2. A notice of the availability of the most recent plan of correction survey results will be posted on each nursing unit. 3. During the monthly Resident Council meeting on July 20th, 2015, residents will be notified about the location of the most recent plan of correction survey results. 4. Administration will monitor monthly for three consecutive months that the most recent plan of correction survey results are available for examination and a notice of availability is posted. 5. Compliance Date:	7/22/2015

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F 167	Continued From page 6 the front desk, however Employee #1 could not locate them. Unit 1A, first floor- The survey results were located in a common area at the entrance of Unit 1A and were readily available but there was no notice posted to indicate the availability or location. Unit 2A, second floor- The survey results were found at the nursing station on 2A, however there was no notice posted to indicate the availability or location.	F 167		
	Unit 2B, second floor- The survey results on 2B were placed in a common area at one (1) of two (2) entrances to the unit, however there was no notice posted to indicate the availability or location. Unit 3A, third floor- The survey results on 3A were placed in a common area at one (1) of two (2) entrances to the unit, however there was no notice posted to indicate the availability or location. Unit 3B, third floor- The survey results on 3B were placed in a common area at one (1) of two (2) entrances to the unit, however there was no notice posted to indicate the availability or location. These findings were confirmed by Employee # 1 who was present at the time of the observations.			
F 174	483.10(k),(l) RIGHT TO TELEPHONE ACCESS	F 174		

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F 174 SS=D	Continued From page 7 WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews for two (2) of 37 sampled residents, it was determined that facility staff failed to provide a private area when residents can make and receive telephone calls without being overheard. Residents' # 66 and #164 The findings include: 1. Facility staff failed to provide Resident #66 a private area to make and receive telephone calls without being overheard. A resident interview was conducted on May 12, 2015 at approximately 4:35PM. In response to a query, " Do you have privacy when on the telephone? " The resident responded, " No " and added that everyone can hear his/her conversations. The telephone for resident use was located on a wall directly across from the nursing station on Unit 1A. The telephone was also located in an	F 174	**F174** 1. Identified residents #66 and #174 were offered privacy, in a private area, for telephone access. 2. Nursing Administration will purchase a cordless phone, to be available to all residents that would be accessible for phone calls in a private area. 3. A resident may request from Nursing, the cordless phone to make and receive phone calls, in a private area. All residents will be informed of the cordless phone availability at Resident Council. 4. Nursing and/or designee will monitor any negative outcomes of the private, cordless phone usage and report to QAPI on a monthly basis. 5. Compliance Date:	7/22/2015

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F 174	Continued From page 8 area where calls can be overheard by residents, staff and visitors. A face-to-face interview was conducted on May 18, 2015 with Employee #4 at approximately 3:00PM. He/she acknowledged the aforementioned findings. 2. Facility staff failed to provide Resident #164 a private area to make and receive telephone calls without being overheard. A resident interview was conducted on May 13, 2015 at approximately 4:26PM. In response to a query, " Do you have privacy when on the telephone? " The resident responded, " No " and added that everyone can hear his/her conversations. The telephone for resident use was located on a wall directly across from the nursing station on Unit 1A. The telephone was also located in an area where calls can be overheard by residents, staff and visitors. A face-to-face interview was conducted on May 18, 2015 with Employee #4 at approximately 3:00PM. He/she acknowledged the findings.	F 174		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;	F 225		

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F 225	Continued From page 9 and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for 16 of 46 " Resident/Family Communication " forms reviewed, it was determined that facility staff failed to implement policies and procedures to ensure that allegations of mistreatment and/or abuse were reported to the State Agency.	F 225	**F225** 1. All identified allegations of mistreatment and/or abuse were investigated and appropriate actions completed in a timely manner. All allegations of mistreatment and/or abuse were reported to the State Agency. 2. All new allegations of mistreatment and/or abuse will be reported to the State Agency. 3. The Abuse Investigation Policy was updated to protect residents. Administration and/or Nursing Administration will review all allegations of mistreatment and/or abuse and verify it is reported to the State Agency. Staff will receive education on the updated policy. 4. Administration and/or Nursing Administration will report any negligent findings (not reported) to QAPI Committee monthly. 5. Compliance Date:	7/22/2015

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F 225	Continued From page 10 The findings include: The Code of Federal Regulations 483.13 (b) defines abuse as: · "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. (42 CFR 488.301) This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. · "Verbal abuse" is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again. · "Mental abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. A review of the facility ' s Resident/Family Communication forms revealed 46 forms that were recorded as "concerns". 16 of the 46	F 225		

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F 225	Continued From page 11 forms identified as " concern " revealed allegations of mistreatment and/or abuse by staff that ranged from failure to provide timely incontinent care, rough handling, speaking in a harsh tone to missing property. Examples of allegations are as follows: 1.Relative reported to facility on December 8, 2014 that their [mother/father] was crying and holding the call bell because no one came to assist their [mom/dad.] It was reported by staff that they were under staffed. Resident #186 2.Resident reported on May 21, 2014 an allegation of verbal abuse with a [male/female] Registered Nurse. Resident #6 3..Relative reported to the facility on January 2, 2015 that a Certified Nursing Assistant came into his/her mom/dad ' s room woke him/her up to put him/her on a bed pan. The resident screamed " No, No, No " that he/she did not need to go to the bathroom. The resident was left flat on his/her back and had a difficult time breathing and his/her back was in pain. Resident #186 4.Resident reported to the facility on January 19, 2015 that his/her significant other was wearing the same clothes for two (2) days and was soaking wet after having lunch. Resident #139 5.Relative reported to the facility on January 21, 2015 that night aide was verbally abusive and called his/her mom " crazy " and that [his/her] [mom/dad] was a trouble maker. Resident #14 6.Resident reported on July 19, 2014 that he/she felt intimidated by the staff assigned to [him/her] on the 3-11 shift. TSD#2	F 225		

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F 225	Continued From page 12 The records lacked evidence that the allegations were fully investigated and reported to the State Agency. A face-to-face interview was conducted with Employee #37 on May 21, 2015 at approximately 2:00 PM. Employee #37 was designated to manage allegations of abuse in the facility and stated that he/she was not aware of the 16 allegations of mistreatment illustrated on the " Resident/Family Communication " forms. Employee #37 stated that the Department of Nursing was responsible for reviewing the forms and would forward to his/her department as necessary. He/she denied having knowledge of the concerns recorded in the 16 forms reviewed, that alleged mistreatment/abuse. A face-to-face interview was conducted with Employee #2 on May 21, 2015 at approximately 3:30 PM. He/she stated that he/she would research whether or not the allegations of mistreatment and/or abuse recorded on the " Family/Relative Communication " forms were reported to the Department of Health. There was no evidence provided by Employee #2 to reflect that the allegations of abuse were reported. The records were reviewed May 21, 2015.	F 225	**F226** 1. All identified allegations of mistreatment, neglect and/or abuse have been investigated thoroughly and each resident was protected from further abuse. All allegations of mistreatment, neglect, and/or abuse have been reported to the State Agency. 2. Any new allegations of mistreatment, neglect and/or abuse will follow specific abuse policies and procedures to ensure residents are protected in the event of an allegation of abuse. The Abuse Investigation Policy has been updated to protect all residents. 3. Specific procedures for staff to follow in the event of allegations involving mistreatment, neglect and/or abuse will be outlined in the TWH Abuse Investigation policy and procedure. The policy and procedure will be distributed in the facility. Staff will receive education on the revised policy. 4. Nursing Administration or designee will report any adverse outcomes from an abuse investigation to QAPI monthly. 5. Compliance Date:	7/22/2015
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226		

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	095005	A. BUILDING _____ B. WING _____	05/22/2015

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F 226	Continued From page 13 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 of the facility's policy regarding Abuse and Neglect, it was determined that facility staff failed to develop specific procedures to ensure that allegations of mistreatment, neglect and/or abuse are thoroughly investigated, the means by which residents would be protected from further abuse and that the allegations are reported to the State Agency. The findings include: A review of the facility ' s policy on " Abuse and Neglect " lacked evidence of a systematic process for staff to follow in the event of alleged abuse. For example, under the facility ' s Abuse policy Number " TX-00001.97, section " VI Protection; protect residents from harm during an investigation, " lacked evidence of specific procedures that staff should follow to " protect " the resident(s) in the event of an allegation of abuse. A face-to-face interview was conducted with Employee #1 on May 21, 2015 at approximately 3:30 PM who confirmed the abuse policy had been	F 226	**F241 #1** 1. Hand sanitizer and hand wipes were removed from table of Resident #200. Nursing staff present were educated to keep hand cleaning products separate from resident dining tables. Resident #200's food was not contaminated by the cleaning supplies. The cleaning supplies were removed from the dining area during the Survey observation. Nursing staff present during the meal received education regarding the subject of not having cleaning supplies present on a table where resident meals are being served. Resident # 157 was annoyed with nursing assistant was counseled and received education to respect resident # 157's and all resident's dignity by knocking before entering their room and waiting for a reply prior to entering a resident room. During the Survey observation Resident #162 acknowledged that the sign in her room was placed there at a time when the resident was not to get up on their own. During the Survey observation the sign was removed from the wall of the resident's room by employee #6. 2. An inspection of all facility dining areas identified hand cleaning products located separately from resident dining tables.	

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F 226	Continued From page 14 provided to the survey team. Facility staff failed to develop abuse policies with specific procedures for staff to follow in the event of allegations involving mistreatment, neglect and/or abuse.	F 226	All nursing staff was re-educated on appropriate locations for hand cleaning supplies. All nursing staff have received education to not having any cleaning supplies present on dining tables during service of resident meals. All nursing staff have received education regarding knocking and waiting for an answer prior to entering a resident's room. All nursing staff have received education regarding the proper placement of signage in a resident room in a manner that respects the resident's dignity and privacy. 3. All nursing staff will be re-educated two (2) times annually on correct location of hand cleaning supplies during resident dining. Mandatory education sessions with the topics maintaining resident dignity and respect (to include knocking and waiting for a response prior to entering a resident room, not having cleaning supplies stored along with food items in the same area, proper placement of signage in resident room) will be conducted two times per year for all nursing staff. 4. Clinical Managers, or designee, and Infection Control Preventionist will monitor location of hand cleaning products during dining service during nursing unit rounds and report variances to Focus QI-IDT meetings monthly.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview for three (3) of 37 sampled residents, it was determined that facility staff failed to ensure a resident's dignity was promoted as evidenced by, failing to enhance dignity during dining for one (1) resident and failing to knock before entering one (1) resident ' s room and maintain an environment free of signage with personal information for (1) one resident ' s #200 # 157 and #162. The findings include: 1. Facility staff failed to provide an environment of dining with dignity for Resident #200. During the lunch observation conducted on May 11, 2015 at approximately 1:30 PM, facility staff was observed using table where Resident# 200 was seated as a central location area for sanitizing their hands and dispensing hand wipes	F 241		

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F 241	Continued From page 15 to sanitize other residents hands prior to serving their meals. These activities continued as Resident #200 sat eating his/her meal. During a second breakfast observation on May12, 2015 at approximately 8:50 AM Resident #200 was sitting alone eating his/her meal, as the facility staff use the area as central location for sanitizing their hands and dispensing hand wipes to sanitize other residents hands prior to serving their meals. A face-to-face interview was conducted with Employee #8 on March 12, 2015 at approximately 09:00 AM regarding the aforementioned observation. Immediately, Employee #8 instructed staff to remove items from the residents table acknowledging the findings. The observation was made on May 12, 2015 at approximately 09:00 AM. 2. Facility staff failed to knock and await permission prior to entering Resident #157 ' s room during an isolated observation. On May 13, 2015 at approximately 10:30 AM Employee #35 entered Resident #157 ' s room without knocking. A face-to-face resident interview was in progress and Resident # 157 immediately stated " this happens all the time " . A face-to-face interview was conducted on May 13, 2014 with Employee # 8 at approximately 12:30 PM. A query was made regarding the facility's practice when needing to enter a resident ' s room. Employee # 8 stated "They should have knocked and waited for permission prior to enter." The observation was made on May 13, 2015. 3. Facility staff failed to maintain Resident #162 '	F 241	The Quality Improvement (QI) Manager will report findings to QAPI Committee quarterly. The Clinical Educator will audit the education sessions for attendance each time they are presented and submit the audit to the Quality Improvement Manager. The Quality Improvement Manager will report the audit to the Quality Improvement Committee. 5. Compliance Date:	7/22/2015
			#2 1. Employee #35 was counseled and re-educated to knock and await resident's response prior to entering the room. 2. All other staff was observed knocking and awaiting resident's reply prior to entering a resident room. 3. The Clinical Educator or designee will re-educate all nursing staff on requirement to respect resident privacy by knocking and awaiting resident's response prior to entering a resident room. This in-service will be mandated for all nursing staff two (2) times a year. 4. Clinical Managers or designee will monitor compliance with knocking prior to entering resident rooms during nursing unit rounds and report variances to Focus QI-IDT monthly. The QI Manager will report findings to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015

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F 241	Continued From page 16 s environment in which there were no signs posted in the resident ' s area in view of other residents and visitors which included personal information. A resident room observation was conducted on May 13, 2015 at approximately 9:40 AM. Two (2) signs were observed on the wall inside the resident room. The sign indicated " Do not get up on your own " . One of the sign was posted on the wall adjacent to the resident ' s bed and on the wall to the right of the bathroom door. Several observations were made during the survey period. A face-to-face interview was conducted with Employee #6 on May 22, 2015 at approximately 1:00 PM. After the observation Employee #6 acknowledged the observation and removed the signs. The observation was made on May 13, 2015.	F 241	**#3** 1. The sign was removed from room wall of Resident #162. 2. A facility-wide check identified resident rooms with posted clinical signage that was then removed or documented in the medical record as posted at request of resident or family, and that staff informed resident or family that posting of clinical signs violates resident's privacy. 3. Clinical Mangers or designee will identify resident rooms with posted clinical signage during nursing unit rounds and request resident/family permission to remove signage. Denied permission will be documented in medical record as resident/family choice after privacy issue information was provided. 4. Clinical Mangers will report posted clinical signage variances to Focus QI-IDT monthly. QI Manager will report findings to QAPI Committee quarterly. Nursing staff will be re-educated two (2) times annually on protecting resident privacy related to signage. 5. Compliance Date:	7/22/2015
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review staff and resident interview for one (1) of 37 sampled residents, it was determined that facility staff failed to provide for an ongoing program of	F 248		

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F 248	Continued From page 17 activities designed to meet, in accordance with the comprehensive assessment, the interests and psychosocial well-being for Resident #19 who sat idle and not participating in activities. The findings include: A face-to-face interview was conducted with Resident #19 on May 12, 2015 at approximately 10:05 AM. The following questions were asked followed by the resident ' s response: · Do the activities meet your interests? He/she replied, " Some of them. " · Are the activities provided as often as you would like, including on weekends and evenings? He/she replied, " Yes, but they are the same thing. " · Does staff provide items so you can do activities on your own, like books or cards? " No " On May 15, 2015 Resident #19 was observed sitting idle on Unit 2B in his/her wheel chair at the table where he/she eats his/her meal. The television was on however the volume low from on Friday May 15, 2015 from 10:00 AM - 1:00 PM. At no time was the resident offer an activity by the Certified Nurse Aides assigned to provide care on the unit. On Monday, May 18, 2015 at approximately 10:15 AM Employee # 6 was asked who was providing activities to the resident today. He/she stated, there is no activity aide on duty today (Monday, May 18, 2015), [he/she] worked the weekend.	F 248	**F 248** 1. The Director of Activities and the Therapeutic Activity Assistant for Unit 2B met with Resident # 19 on 7/16/15 to identify current activity pursuits and patterns. 2. No other resident was affected by this practice. 3. All residents' interest and psychosocial well-being will be met as evidence of assessment of resident's activity pursuits and patterns. a) ensure resident is invited to attend and participate in activity of choice on a daily basis b) assess activity pursuits and patterns on a quarterly basis c) provide in-service to activity staff on protocols to meet the needs of interest of residents. 4. The Director of Activities will monitor compliance on a daily basis and will report any variance to the Monthly QI Committee. 5. Compliance Date:	7/22/2015

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F 248	Continued From page 18 On Monday, May 18, 2015 from 10:15 AM to 11:30 AM; and from 2:00 PM to 4:30 PM. The resident was observed sitting idle at no time was the resident offer an activity by the CNAs on the unit. A face-to-face interview was conducted with Employee # 24 on Tuesday May 19, 2015 at approximately 11:15 AM. He/she stated, " I was off on Friday (May 15, 2015) and Monday (May 18, 2015) " . A face-to-face interview was conducted on May 21, 2015 at 10:26 AM with Employee # 28. At this time he/she was made aware of the concerns related to the lack of activities provided to Resident #19 on Unit 2B. Employee #28 acknowledged the findings. There was no evidence that while the resident sat idle on the unit that facility staff provided resident with activities on May 15 and 18, 2015.	F 248	**F253** 1. Window blind replacements ordered for rooms 105, 144, and 249. 2. No other window blinds were found to be broken in residents' rooms. 3. All resident rooms with window blinds will be inspected during Weekly Maintenance Rounds; Maintenance technicians re-educated on checking, repairing/replacing blinds during weekly maintenance rounds. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly 5. Compliance Date: 1. Walls in rooms 123, 144, 237, 249, and 256 were repaired or repainted. Doors in rooms 104, 105, 106, 115, 116, 202-B, and 207B were repaired. 2. No other doors or walls were found to be marred. 3. All resident room walls and doors will be inspected during Weekly Maintenance Rounds and repairs completed. Maintenance technicians re-educated on checking, and/or repairing marred walls during weekly maintenance rounds. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015 7/22/2015
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on May 15, 2015 at approximately 11:30 AM, it was determined that the facility failed to provide housekeeping	F 253		

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F 253	Continued From page 19 and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by broken slats from window blinds in three (3) of 45 resident's rooms, marred walls in five (5) of 45 resident's rooms, marred entrance doors in seven (7) of 45 resident's rooms, loose wallpaper in the hallways of unit 2B, paint peeling from the ceiling above the resident ' s bed, clear pieces of tape stuck in several areas in the ceiling of room #251 and a missing floor tile in the bathroom of room #251, one (1) of 45 resident's rooms surveyed. The findings include: 1. There was one (1) broken slat from one (1) of one (1) window blind in room #105, two (2) broken slats from one (1) of two (2) window blinds in room #144 and one (1) broken slat from one (1) of two (2) window blinds in room #249, three (3) of 45 resident's rooms surveyed. 2. Walls in five (5) of 45 resident's rooms were marred including rooms #123, #144, #237, #249 and #256 and entrance doors in seven (7) of 45 resident's rooms were marred including rooms #104, #105, #106, #115, #116, #202B and #207B. 3. The wallpaper hanging in the hallways of unit 2B was loose in several areas. 4. The paint was peeling off an area from the ceiling above the resident's bed in room #251B and there were multiple pieces of clear tape stuck to other areas in the ceiling, one (1) of 45 resident's rooms surveyed.	F 253	1. Loose wall paper in 2-B hallway was removed. 2. During inspection, no other loose wallpaper was identified. 3. All Units will be inspected for loose wallpaper during Weekly Maintenance Round and loose wallpaper removed. Maintenance technicians re-educated on checking, and repairing/replacing loose wall paper during weekly maintenance rounds. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date: 1. Room 251B ceiling was repaired; tape removed and ceiling repainted. 2. No other ceiling was found to be peeling during inspection. 3. Ceilings in all resident rooms will be inspected during Weekly Maintenance Rounds; damaged ceilings will be repaired. Maintenance technicians re-educated on inspecting ceilings for any damages, mars, during weekly maintenance rounds. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015 7/22/2015

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F 253	Continued From page 20 5. There was a floor tile missing in the bathroom of resident room #251 on May 19, 2015 at approximately 12:05 PM, one (1) of 45 resident's rooms surveyed. These observations were made in the presence of Employee #11 and Employee #12 who acknowledged the findings. B. Based on observation and staff interview for one (1) of 37 residents it was determined that facility staff failed to decrease the spread of disease causing organisms as evidence by oxygen tubing lying uncovered on the floor, oxygen bag with tubing inside lying on the floor. Resident #106 The findings include: A resident room observation was conducted on May 15, 2015 at approximately 10:00 AM. The following was observed: In a chair adjacent to the resident ' s bed, was a BiPAP [bi-level positive airway pressure] machine with a face mask and long hose attached. Portions of the hosing was observed uncovered on the floor in front of the chair; oxygen tubing connected to the portable oxygen tank with portions coming in contact with the floor; extra oxygen tubing covered in a plastic bag observed on the floor. A face-to-face interview was conducted on May 22, 2015 with Employee #6 at approximately 11:30 AM. A second observation was made in the room. The tubing from the BiPAP was observed on the floor; the oxygen tubing connected to the portable oxygen tank was observed on the floor, and the oxygen tubing within a bag was observed on the floor. Employee #6 acknowledged the findings.	F 253	1. Bathroom floor tile in room 251 was replaced. 2. No other missing tile was identified during inspection. 3. Floor tiles in all resident bathrooms will be inspected during Weekly Maintenance Rounds and damaged tiles repaired. Maintenance technicians re-educated on observing and inspecting floor tile conditions during weekly maintenance rounds. 4. Plant Ops Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015

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F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 37 sampled residents, it was determined that facility staff failed to ensure adequate lighting in the resident ' s room closet. Resident #106 The findings include: A resident room observation was conducted on May 15, 2015 at approximately 10:00 AM. The closet light bulb failed to illuminate when activated. A face-to-face interview was conducted with Employee #6 on May 22, 2015 at approximately 11:30 AM. Employee made an attempt to turn the light on by pulling the light string. The light did not illuminate. Employee #6 acknowledged the findings at the time of the observation.	F 256		
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:	F 272		

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F 272	Continued From page 22 Identification and demographic information; 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 six (6) of 37 sampled residents, it was determined that facility staff failed to code the residents Quarterly [Minimum Data Set (MDS) for Other Health Conditions, to accurately complete the quarterly MDS to include a history of fall for two (2) residents; for one (1) resident who used a wheel chair for mobility and was admitted with an active diagnosis of urinary tract infection; to	F 272		

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F 272	Continued From page 23 accurately code one (1) resident's toileting program; for one (1) resident diagnosis of Anemia and Hyperlipidemia; for one (1) resident with Shortness of Breath and chronic disease prognosis; and to identify pressure ulcer dimensions on the Admissions MDS: Skin Condition for one (1) resident with a stage 3 pressure ulcer. Residents' #23, #125, #139, #161, #216 and #241. The findings include: 1. Facility staff failed to accurately code the quarterly MDS to include a history of fall's for Resident #23. Resident #23 was admitted on January 7, 2015 with diagnoses that included, Altered mental status, CVA, and right Hemiparesis. A review of an Incident Report dated February 10, 2015 revealed the following, " Resident called, upon entering the room immediately after answering call, found resident sitting on the floor and leaning on wheel chair. Assessment conducted [he/she] verbalized sliding off the wheel chair. Denies pain, denies hitting head. ROM (range of motion) within normal limit, no apparent injury noted. Remain alert and oriented at this time. A review of the care plan initiated on February 12, 2015 revealed the following, " Problem Statement - Resident was observed sitting on the floor on 2/10/2015. No injuries noted; Interventions and approaches - Resident will be transferred with a mechanical lift at all times by nursing staff, and will be assisted on a bed pan	F 272	**F253 B** 1. Oxygen tubing and facemask were replaced and stored in compliance with facility policy for Resident #106. Resident #106 did not sustain harm. The incident was corrected during the Survey observations. All nursing staff on the nursing unit were instructed to observe for instances where the spread of disease causing organisms may occur and to immediately correct the instances. 2. A facility-wide inspection of all residents with oxygen was completed; oxygen supplies stored in compliance with facility policy. All nursing staff were instructed regarding hazards to infection prevention and how to observe for instances where the spread of disease causing organisms may occur and to immediately correct the instances.	

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F 272	Continued From page 24 as needed. A review of the quarterly MDS dated April 1, 2015 revealed the following: Under Section J [Health Conditions] the resident was coded for having no falls since admission/entry or reentry or prior assessment. A review of the medical record showed that facility staff did not accurately code the quarterly MDS to include a fall that the resident sustained in February 2015. An interview was conducted with Employee #6 on May 15, 2015 at 4:30 PM. He/she acknowledged the findings. 2. Facility staff failed to accurately code Resident #125's admission Minimum Data Set (MDS) for diagnoses of Anemia and HLD [Hyperlipidemia]. A review of the Quarterly MDS with an ARD [Assessment Reference Date] of February 16, 2015 revealed that facility staff failed to accurately code Section I, Active Diagnoses - I0200 Anemia and I3300 Hyperlipidemia. The check boxes allotted next to the Sections were left " blank " indicating that the resident was not coded for the above diagnoses. A review of the History and Physical record for resident #125 60 day review dated September 24, 2014 revealed a note under HPI [History of Present Illness] that reads " ...Osteoporosis, Fe [iron] deficiency Anemia and HLD [Hyperlipidemia] ... "	F 272	3. All nursing staff will be re-educated on infection prevention related to oxygen supplies. Prevention of contamination of all respiratory equipment including oxygen tubing will be added Compliance with policy will be added to nursing unit rounds. Clinical Managers will round on their assigned nursing unit at least twice per shift and House Supervisors will observe for hazardous infection prevention incidents during rounds. 4. Clinical Managers or designee will conduct unit rounds a minimum of two (2) times per day and submit findings to Director of Nurses or designee weekly. House Supervisors will conduct unit rounds at least two (2) times per shift on a minimum of one (1) clinical unit and submit findings to Director of Nurses weekly. The Director of Nurses or designee will review the audits during weekly Nursing Management Team Meetings. Variances will be reported to Focus QI-IDT meeting monthly. The QI Manager will report findings to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015

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F 272	Continued From page 25 A face-to-face interview was conducted on May 18, 2015 at approximately 2:30 PM with Employee #15. He/she acknowledged the findings. The record was reviewed May 18, 2015. 3 (a).Facility staff failed to accurately code Resident #139's Admission MDS dated December 5, 2015 under Section G, Mobility Devices. A review of Resident #139 ' s clinical record revealed that he/she was admitted to facility on November 24, 2014. The admissions observation comments stated " gait unsteady ... [Gender] is up in wheel chair at this time in dining room for dinner ... " A review of the resident ' s Admission MDS with an Assessment Reference Date (ARD) of December 5, 2014 revealed that the MDS was coded " Z. None of the above were used " , in response to the question in Section G 0400 [Mobility Devices] " Check all that were normally used; cane/crutch, walker, wheelchair, limb prosthesis, none of the above were used " . A face-to-face interview was conducted with Employee # 30 at approximately 11:00 AM on May 22, 2015. After reviewing the MDS, the employee acknowledged the findings. The record was reviewed on May 22, 2015. 3(b). Facility staff failed to accurately code Resident #139's Admission MDS dated December 5, 2015 under Section I, Active Diagnoses.	F 272	**F256** 1. The closet light bulb was replaced for resident #106 room. 2. All residents' closets have working closet lights. 3. During environmental rounds bi weekly, residents closets will be checked for working light bulbs. Maintenance technicians re-educated on observing and inspecting closet lighting during weekly maintenance rounds. 4. Variances will be reported to QAPI committee on a monthly basis. 5. Compliance Date: **F272** 1. Resident #23 Quarterly MDS (dated 4-1-2015) was not coded for a fall the resident had in February 2015. This remarkable event can not be corrected. Resident did not sustain an injury from the fall. Resident # 125 Quarterly MDS (dated 2-16-2015) was not coded for diagnosis of Anemia and Hyperlipidemia. Resident # 139 Admission MDS (dated December 5, 2014) was not coded for Mobility Device under Section G. This remarkable event can not be corrected. Resident #139 Admission MDS was not coded under Section I 12300 (Infections) for UTI.	7/22/2015

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F 272	Continued From page 26 A review of Resident #139 ' s clinical record revealed that he/she was admitted to facility on November 24, 2014. The admission history and physical dated November 25, 2014 revealed, " 85 year old ...with PMH of HTN(Hypertension),DM(Diabetes Mellitus), BPH (benign Prostatic hyperplasia) and dementia, who was admitted to hospital recently with confusion, found to have UTI (Urinary Tract Infection) " . A review of the Interim Order form dated November 25, 2014 at 12:30 PM revealed Augmentin 875-1235 1(one) tab(tablet) po (by mouth) BID (two times a day) through November 26, 2014 first dose now for UTI " . A review of the nursing admissions observation section, Infections: Did Resident have any infections- Urinary Tract was checked. A review of the resident ' s Admission MDS with an Assessment Reference Date (ARD) of December 5, 2014 revealed that the MDS was not coded under section I [Infections] 12300 urinary tract infections (UTI) (Last 30 days) to indicate the resident was admitted with a urinary tract infection. A face-to-face interview was conducted with Employee #30 at approximately 11:00 AM on May 22, 2015. After reviewing the MDS, the employee acknowledged that the resident ' s MDS was not coded for resident ' s urinary tract infection. The record was reviewed on May 22, 2015. 4. Facility staff failed to accurately code Resident #161's admission Minimum Data Sets (MDS) for Toileting Program]. This was a closed record review.	F 272	The admission MDS (dated December 5, 2014) was not coded for UTI in section I 12300 (infections) because according to the CMS RAI Version 3.0 Manual information regarding the UTI did not meet all of the criteria to call it an infection: resident had not had UTI in 30 day look back period, resident did not have symptoms of a UTI: fever, pain, change in mental status, physician was treating resident empirically with an antibiotic but physician did not order urine culture (see page 1-8 of CMS RAI Version 3.0 Manual October 2011). Resident #161 Admission MDS was not coded for Toileting Program (Section H Bladder and Bowel-H0200 Urinary Toileting Program). Can not be corrected. Resident #216 Quarterly MDS (dated February 13, 2015) was not coded for shortness of breath in section J 110. Can not be corrected. Resident #216 Significant Change MDS was not coded for Prognosis in section J1400 (dated March 14, 2015) although resident was admitted to Hospice. Can not be corrected. Resident #241 Admissions MDS: Skin Condition failed to identify the dimensions of the stage III pressure ulcer section M Skin Conditions M0610. Can not be corrected.	

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F 272	Continued From page 27 A review of the Quarterly MDS with an ARD [Assessment Reference Date] of February 26, 2015 revealed facility staff failed to accurately code Section H, Bladder and Bowel - H0200 Urinary Toileting Program, A review of the care plan initiated January 12, 2015 revealed under Urinary Incontinence approaches " Toilet Program: Toilet resident upon rising, after meals, before bedtime, and ask/offer resident toilet throughout the day " The check box allotted next to Section H0200C - Current toileting program or trial was left " blank " indicating that the resident was not coded for " Toileting Program. " A face-to-face interview was conducted on May 15, 2015 at approximately 1:30 PM with Employee # 15. He/she acknowledged the findings. The record was reviewed May 15, 2015. 5a.Facility staff failed to code Resident #216 ' s quarterly MDS Section J110 Shortness of Breath. A review of the quarterly MDS with an Assessment Reference Date of February 13, 2015 revealed Section J110. Shortness of Breath (dyspnea) was coded (z) none of the above. A review of the Progress Notes Dated February 13, 2015 10:30 AM revealed " Acute Visit - pt	F 272	Resident # 139, 200, 208, 216, 236. For these residents the Care Area Assessment information did not have the location of and date of the information documented for the Care Area Assessment information. The review of this information was done on May 22, 2015 for all of these residents. During the Survey an interview was conducted with the MDS Nurse. The MDS Nurse explained during the Survey that the correct query was not done to obtain the needed information and volunteered to run the query immediately to give the Survey team member the needed documentation. The Survey team member as per a quote they made to the MDS Nurse said, "Don't bother you may change it." All MDS of residents were reviewed for coding. 2. The MDS Coordinator will attend twice weekly Clinical Managers Team Meeting in order to be aware of significant changes to resident care, new diagnosis, infections, and changes in resident status, etc. In turn they or their designee will accurately code the information into the correct section of the MDS (The Clinical Managers Team Meeting is an interdisciplinary clinical team meeting held twice per week to discuss clinical updates of all residents).	

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F 272	Continued From page 28 [patient] noted to have difficulty breathing shortly after having [him/her] breakfast. Pt [patient] states [he/she] was sitting upright while eating and recalls what [he/she] had ... " A face-to-face interview was conducted with Employee #6 who acknowledged the finding. 5b. Facility staff failed to code Resident #216 Significant Change MDS Section J1400 Prognosis. A review of the Significant Change MDS with and Assessment Reference Date of March 14, 2015 revealed J1400 Prognosis (Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 (six) months? (Requires physician documentation) was coded " 0 " No. A review of the Physicians Order Sheet signed by the physician on May 11, 2015 revealed that the physician direct the following: Order date March 6, 2015, Start date March 6, 2015, Order Details: " admit to hospice 1 [one] time per day during day. " A review of the Interdisciplinary Progress Notes dated 3/6/15 [March 6, 2015] no time indicated revealed, " A/P [Assessment/Plan] (3) End Stage Parkinson - admit to hospice. " A review of the Progress Notes By Resident 3/8/15 23:07 revealed " Comments: General Terminal Illness comments = alert and verbally responsive ...Hospice Nurse visited this evening. " A review of the Hospice (facility Sign-In Sheet)	F 272	3. The MDS Coordinator or their designee will conduct a monthly audit to ensure the resident Problem List/Diagnosis sheet matches the appropriate section of the MDS where this information should be coded. This audit will also include an audit of the CAA (Care Area Assessment) to ensure there is supporting documentation that matches information in the Care Area Assessment. The MDS Coordinator or their designee will educate all Clinical Managers and Unit Clerks on the procedure of running the correct query to print supporting documentation for the Care Area Assessment information. 4. The MDS Coordinator or designee will submit the monthly audits of the Problem/Diagnosis sheet matches and the supporting documentation for the CAA will be submitted to the Quality Improvement Manager. The Quality Improvement Manager will report on the audits the Quality Improvement Committee quarterly. 5. Compliance Date:	7/22/2015

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F 272	Continued From page 29 revealed a hospice representative visited the resident on March 9, and 12, 2015 as evidenced by a signature on the corresponding lines. A review of the Progress Notes by Resident 3/14/15 22:32 revealed " Comments: General Terminal Illness Comments = Resident continue on hospice care no changes in mental status noted ... " A face-to-face interview was conducted with Employee #6 May 21, 2015 at approximately 11:00 AM . He/she acknowledged the findings. Facility staff failed to code Resident #216 Significant Change MDS Section J1400 Prognosis. 6. Facility staff failed to identify pressure ulcer dimensions on the Admissions MDS: Skin Condition s for Resident #241 with a stage 3 pressure ulcer. The facility staff failed to identify pressure ulcer dimensions on the admissions MDS [Minimum Data Set]. A review of the Skin Condition Report with Images revealed that the resident was admitted on December 31, 2014 12:25 AM with a sacral pressure ulcer wound 6x7x0cm [centimeters.] A review of admissions MDS with an Assessment Reference Date of January 6, 2015 revealed: Section M Skin Conditions; M0610. Dimensions of Unhealed stage 3 or 4 pressure Ulcers or Eschar ...if the resident has one or more unhealed stage 3 or 4 pressure ulcers or an unstageble pressure ulcer due to slough or	F 272		

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F 272	Continued From page 30 eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters: 3.0 cm A. Pressure ulcer length: longest length from head to toe; 1.0 cm B. Pressure ulcer width of the same pressure ulcer, side-to-side perpendicular (90 degree angle) to length; 0.9 cm C. Pressure ulcer depth: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box.) A face-to-face interview was conducted on May 21, 2015 with Employee #30 at approximately 11:30 AM regarding the location of information pertaining to the dimensions of the sacral ulcer. Employee #30 indicated that the dimensions were consistent with what the nurse measured, however he/she failed to change it in the computer after obtaining the measurements. The facility staff failed to identify pressure ulcer dimensions on the admissions MDS. B. Based on record review and staff interview for four (4) of 37 sampled residents, it was determined that facility staff failed to identify the location and date of the Care Area Assessment (CAA) information on the admission, annual or significant change Minimum Data Sets (MDS) under Section V0200A for four (4) residents. Resident ' s #139, 200, 208, 216 and 236. The findings include: According to Chapter 4 of the MDS 3.0 Users '	F 272		

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F 272	Continued From page 31 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 admission Minimum Data Set [MDS] for Resident #139. A review of Resident #139 ' s admission MDS with an Assessment Reference Date (ARD) of December 05, 2014 revealed that "Care Area Triggered and the Care Planning Decision Area" selected were, #2 Cognitive Loss/Dementia, #3 Visual Function, #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence / Catheter, #11 Falls, #12 Nutrition, #15 Dental Care, and #16 Pressure Ulcers. The record revealed that the location and date of CAA information for care areas [#2, 3, 5, 6, 11, 12, 15, and 16] were recorded as " CAA Analysis -[Employee Name]12/06/14. " There was no evidence that facility staff documented the date and location where in the clinical record the information related to the triggered areas could be found. A face-to-face interview was conducted with Employee #30 on May 22, 2015 at 10:00 AM. He/she acknowledged the findings. The record was reviewed May 22, 2015. 2. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information	F 272		

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F 272	Continued From page 32 under Section V [V0200A], " Care Area Assessment Summary " of the admission Minimum Data Set [MDS] for Resident #200. A review of Resident #200 ' s admission MDS with an Assessment Reference Date (ARD) of November 25, 2014 revealed that "Care Area Triggered and the Care Planning Decision Area" selected were #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence / Catheter, #11 Falls, #12 Nutrition, #15 Dental Care, and #16 Pressure Ulcer. The record reflects that the location and date of CAA information for care areas [# 5, 6, 11, 12, 15, and 16] were recorded as " CAA Analysis - [employee name] 11/26/14. " There was no evidence that facility staff documented the date and location where in the clinical record the information related to the triggered areas could be found. A face-to-face interview was conducted with Employee #30 on May 22, 2015 at approximately 10:00 AM. He/she acknowledged the findings. The record was reviewed May 22, 2015. 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 admission Minimum Data Set [MDS] for Resident #208. A review of Resident #208 ' s admission MDS with an Assessment Reference Date (ARD) of March 04, 2015 revealed that "Care Area Triggered [and] the Care Planning Decision Area" selected were #2 Cognitive Loss/Dementia, #4 Communication, #7 Psychological, #9 Behavioral	F 272		

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F 272	Continued From page 33 , #12 Nutrition, and #19 Pain. The record reflects that the location and date of CAA information for care areas [#2, 4, 7, 9, 12, 12, and 19] were recorded as " CAA Analysis ... " . There was no evidence that facility staff documented the date and location where in the clinical record the information related to the triggered areas could be found. A face-to-face interview was conducted with Employee #30 on May 22, 2015 at approximately 10:00 AM. He/she acknowledged the findings. The record was reviewed May 22, 2015. 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 #236. A review of Resident #200 ' s admission MDS with an Assessment Reference Date (ARD) of December 25, 2014 revealed that "Care Area Triggered and the Care Planning Decision Area" were selected for#2 Cognitive Loss, #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence / Catheter,# 7 Psychological Well-being,#9 Behavioral Symptoms, #11 Falls, and #16 Pressure Ulcer. The record reflects that the location and date of CAA information for care areas [# 2, 6, 7, 9, 12, and 16] were recorded as " CAA Analysis - [Employee Name] .... " There was no evidence that facility staff documented the date and location where in the clinical record the information related to the	F 272		

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F 272	Continued From page 34 triggered areas could be found. A face-to-face interview was conducted with Employee #30 on May 22, 2015 at approximately 10:00 AM. He/she acknowledged the findings. The record was reviewed May 22, 2015.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 37 sampled residents, it was determined that facility staff failed to develop a care plan with goals and approaches for one (1) resident ' s diagnosis of insomnia. Resident # 4	F 279		

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F 279	Continued From page 35 The findings include: Facility failed to develop a care plan with goals and approaches for the care of a resident diagnosed with insomnia. Resident #4 A review of the physician ' s order sheet dated 4/23/2015 revealed, " Trazadone hcl (Desyrel), tablet 50 mg: Give 1 Tablet By Mouth 1 time per day at bedtime at 21:00 [9:00 PM], for Insomnia ... " A review of the plan of care for Resident #4 lacked evidence that a care plan with goals and approaches was developed to address resident #4 ' s diagnosis of Insomnia. A face-to-face interview with Employee #6 was conducted on May 19, 2015 at approximately 3:00 PM. He/she reviewed the care plans and acknowledged that a care plan for insomnia was not initiated for Resident #4. The record was reviewed on May 19, 2015.	F 279	**F279** 1. A care plan with goals and approaches for diagnosis of insomnia was completed for Resident #4. Resident #4 did not have a delay in treatment due to not having a care plan for their diagnosis of insomnia. The employee was counseled. 2. A facility-wide audit to verify all diagnoses addressed in care plan was completed and improvements done at time identified. 3. Nurses will be re-educated to address all diagnoses with a plan of care. Clinical Mangers will be educated on use of the Documentation Audit Tool to audit 20% of all current in-house resident records weekly and verify all active diagnoses and problems have a corresponding care plan. Clinical Mangers will submit completed Documentation Audit Tool forms to the Director of Nurses weekly. They will use the Documentation audit tool to complete the audit. 4. Clinical Managers will report variances to Focus QI-IDT meetings monthly. The QI Manager will report audit findings to the QAPI Committee quarterly. Clinical Managers will audit criteria will be added to the Clinical Managers Documentation Audit Tool. All Clinical Managers will receive education as to how the audit tool is to be used. 5. Compliance Date:	7/22/2015
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 36 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 record review and staff interview for three (3) of 37 sampled residents, it was determined that facility staff failed to review and revise resident care plans to reflect an integrated approach with the participation of hospice, the facility, and the resident or representative to the extent possible for (2) residents; and to address one (1) resident ' s activity needs. Residents ' #109, 120 and 216. The findings include: 1.Facility staff failed to review and revise Resident # 109 ' s care plan for hospice to reflect an integrated approach with the participation of hospice, the facility and the resident or representative to the extent possible. A review of the Physician Order Sheet for the month of `April 2015 directed: Admit to Hospice for End Stage COPD [Chronic Obstructive Pulmonary] start date [November 11, 2014].	F 280	**F 280** 1. Care plan d/c and updated for Resident # 120. Resident #120 did not suffer a lack of socialization. 2. No other resident was affected by this practice. 3. All residents care plans will be reviewed and updated to ensure needs are met. a) provide education and in-services to activity staff regarding update of the activity plan of care b) monitor activity care plans on a quarterly basis. 4. The Director of Activities will monitor compliance on a daily basis and will report any variance to the Monthly QI Committee. 5. Compliance Date:	7/22/2015

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F 280	Continued From page 37 A review of the residents care plan revealed a care plan for " Resident is Hospice Care " with goals and approaches initiated February 10, 2015. However, the care plan lacked specific identification of the disciplines responsible for the approaches/interventions with hospice, the facility, resident or the responsible party. Facility staff failed to review and revise the resident ' s care plan for hospice to reflect an integrated approach with the participation of hospice, the facility and the resident or representative to the extent possible. The record was reviewed on May 22, 3015. 2. Facility staff failed to updated the care plan with appropriate goals and approaches to address the resident ' s activity needs for Resident #120. A review of the clinical record revealed that the " Activities care plan " was last updated on May 3, 2015. Revealed " Problems: Patient is in an adjustment period due to recent admission to facility for rehab service. However, Resident #120 was admitted to the facility on May 10, 2013 and has resided in the facility for approximately two years. In addition, the " Evaluation " of goals and approaches related to the activity problem was s last updated on February 15, 2014. A face-to-face interview was conducted with Employee# 24 on May 19, 2015 at 11:15 AM. He/she stated, " I give [him/her] the choice in the morning by letting [him/her] know what the	F 280	#109 1. The hospice care plan for Resident #109 was integrated by participation of hospice, the facility, and the residents/family. 2. All hospice patients (3) on long term care (LTC) were reviewed and integrated hospice care plans identified on the Medical Record. 3. Hospice-LTC care plan integration will be verified by hospice and LTC nurses signing at time of care plan. LTC Social Worker will notify Hospice Manager of care plans scheduled for hospice patients on LTC; Hospice Manager will attend the care plan meeting. Hospice and LTC nurse will receive re-education on this integration process. 4. Hospice Quality Improvement Nurse will audit log tracking integration of care plans reviewed by Hospice interdisciplinary team every fourteen (14) days and Hospice Manager participation in care plan meeting of hospice residents on LTC monthly. Findings will be reported to the QAPI Committee quarterly. 5. Date of compliance:	7/22/2015

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F 280	Continued From page 38 activities are for the day ...The last thing [he/she] went to was happy hour ... [He/she] goes outside and collects the tennis balls that the schools hit over. [He/she] likes to read and [he/she] stays to [him/herself] a lot of the time. " There was no evidence that the care plan was updated to include current goals and approaches to address the resident ' s activities needs. During the aforementioned face-to-face interview with Employee # 24, he/she acknowledged the findings. The record was reviewed on May 19, 2015. 3.Facility staff failed to review and revise Resident #216 ' s care plan for hospice to reflect an integrated approach with the participation of hospice, the facility and the resident or representative to the extent possible. A review of the Physician Order Sheet for the month of May 2015 directed: Admit to Hospice for End Stage Parkinson ' s Disease. A review of the residents care plan revealed a care plan for " death with dignity, comfort and support care plan " with goals and approaches initiated March 6, 2015. However, the care plan lacked specific identification of the disciplines responsible for the approaches/interventions with hospice, the facility, resident or the responsible party. A face-to-face interview was conducted on May 22, 2015 with Employee #6 at approximately 11:30 AM. After review of the care plans he/she acknowledged the findings.	F 280	**#216** 1. The hospice care plan for Resident #216 includes specific identification of the disciplines responsible for the approaches and interventions with hospice, the facility, and resident or responsible party. (Copy of hospice care plan attached) 2. Care plans for all hospice patients (3) on LTC were reviewed. The signatures of disciplines responsible for approaches and interventions were present. Discipline signatures are viewed in computer; full screen too large to fit on chart. 3. Hospice Manager or designee will audit care plans for hospice residents on LTC for inclusion of disciplines responsible for approaches and interventions at hospice interdisciplinary team meeting every two (2) weeks. 4. Hospice Manager or designee will report audit findings to QAPI Committee quarterly. 5. Date of Compliance:	7/22/2015

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F 280	Continued From page 39 Facility staff failed to review and revise Resident # 216's care plan for hospice to reflect an integrated approach with the participation of hospice, the facility and the resident or representative to the extent possible. The record was reviewed on May 21, 2015.	F 280	**F282** 1. Resident #139's toileting schedule has been adjusted to reflect the resident's current needs and cognitive status. The care plan for this problem has been updated. 2. An audit was conducted of all resident's on a toileting schedule to ensure the toileting schedule and care plan reflect the resident's current level of care. 3. The Restorative Nurse will conduct a weekly audit and evaluation of all residents on a toileting plan to ensure the toileting plan meets the current level of care for the residents. They will use the Toileting Plan Audit Tool to review the toileting schedules and the corresponding care plan. The Restorative Nurse will receive education as to how the Toileting Audit Tool is to be utilized. Restorative Nurse will verify compliance with current toileting plan by a weekly review of toileting plan documentation in the electronic healthcare record (EHR).	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 37 sampled residents, it was determined that facility staff failed to implement toilet training as scheduled for one (1) resident with urinary incontinence. Resident #139 . The findings include: 1. Facility staff failed to follow toileting program for Resident # 139. A review of the resident's clinical record revealed that Resident #139 ' s Admission Observation Form dated November 24, 2014 revealed that the resident was occasionally incontinent of bowel and bladder and was on a urinary toileting program. A review of the Incontinent of urine care plan dated March, 10, 2015 revealed the following: Toileting Program: toilet resident upon rising,	F 282		

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F 282	Continued From page 40 after meals, before bedtime, and ask/offer resident toilet throughout the day. A review of the residents Bowel & Bladder Risk assessment dated April 3, 2015 revealed: Bladder Control Status as occasionally incontinent, Score 8 (Moderate Restorative Potential), 04/03/2015 Toileting programs selected (none were indicated) A review of the ADL Recordings by resident dated March 31 through - April 28, 2015 revealed resident was not toileted as care planned after meals upon rising and at bedtime. The scheduled unit meal times were as follows: 7:30 AM Breakfast 12:15 PM Lunch 4:30 PM Dinner A review of the ADL Recordings by Resident (Activities of Daily Living) for dates May 1, 2015 through May 14, 2015 revealed Resident # 139 was toileted at the following times: May 1, 2015 -7:05 PM May 2, 2015 -2:07 AM 10:58 AM/8:01 PM May 3, 2015 2:07 AM/10:52 AM/7:32 AM May 4 2015-2:18 AM/2:16 PM/7:33 PM May 5, 2015 -2:15 PM-8:37PM May 6, 2015-3:05 AM-2:33 PM-8:36 PM-2:33AM- May 7, 2015 2:39 PM/8:39 PM- May 8, 2015 10:48 AM- 8 12PM/*:16 PM/ May 9, 2015 12:15 PM-10:06 PM- May10, 2015 12:59 PM-1:49 PM-8:47 PM May 11, 2015 - 2;42 AM 2:45 PM-7:30 PM May 12, 2015-2:55 AM-2:09 PM-8:04 PM- May 13, 2015-2:19 AM 9:36 PM May 14, 2015- 2:35 AM 1:46 PM There was no evidence the facility staff addressed and modified Resident # 139 ' s toilet training schedule as the residents needs changed based on cognitive status.	F 282	4. The Restorative Nurse will submit Toileting Plan Audit Tools weekly to the Quality Improvement Manager who will report variances to Focus QI_IDT meeting monthly. The Quality Improvement Manager will report compliance to QAPI Committee quarterly. 5. Compliance Date: **F309** 1. Resident #120 did receive pain medication as per physician order and pain assessments were carried out, however documentation of pain assessment was inconsistent. This event(s) can not be corrected. Employee received education to improve pain assessment documentation. The Minimum Data Set Section J0300 (Pain Presence) and Section I (Additional Active Diagnoses) were updated to reflect current clinical status. 2. An audit was done of all residents receiving pain medication to ascertain to verify accuracy accurateness of pain assessments by licensed nurses. Nurses were re-educated and/or counseled, as indicated by audit findings.	7/22/2015

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F 282	Continued From page 41 A face-to-face interview was conducted with Employee #34 at approximately 10:00 AM on May 21, 2015. The employee was queried regarding the residents toileting schedule he/she stated Resident #139 does not follow instructions well and does not always listen when asked to go to toilet. " A face-to-face interview was conducted with Employee #5 at approximately 1:00 PM on May 21, 2015. The employee was queried regarding the toileting training program not being followed as scheduled. He/she acknowledged aforementioned findings. The record was reviewed on May 21, 2015.	F 282	Education and/or counseling given to licensed nurses if inconsistencies of documentation were observed. MDS assessments for all residents receiving pain medication was audited and updated, as indicated by resident's current clinical status. 3. All licensed nurses were re-educated on Pain Assessment and Documentation. This in-service and completion of Pain Assessment Competency with post-competency test, are mandated two (2) times annually. The Clinical Educator will report test scores to the Director of Nurses on staff who have received education on policy and procedure of Pain Assessment and documentation of Pain Assessment. The MDS nurse will audit residents on pain medication monthly to verify current pain status addressed in MDS Sections J and I. 4. The Clinical Educator will submit a summary of Pain Assessment Competency post-test pass/fail rate to QI Manager quarterly for quarterly reporting to the QAPI Committee. The MDS nurse will report Section J and I variances to QAPI Committee quarterly. All licensed nurses will receive a twice yearly Pain Assessment and documentation of Pain Assessment Competency education and examination.	
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 record review and staff interview for four (4) of 37 sampled residents, it was determined that facility staff failed to ensure that an initial nursing assessment for hospice was a part of the residents clinical active file for two (2) residents; assess for pain, monitor effectiveness of pain medication, and modify the approaches to pain as necessary for one (1) resident; ensure	F 309		

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F 309	Continued From page 42 that the physician ' s orders were transferred to the ETAR [electronic treatment administration record] for the use of a foot brace and that the physician orders for use of ted stockings was followed for one (1) resident. Residents #109, #120 #125 and #216. The findings include: 1. Facility staff failed to ensure that the initial nursing assessment for hospice was a part of Resident #109 active clinical file. A review of the Physician Order Sheet for the month of April 2015 directed: Admit to Hospice for End Stage COPD [Chronic Obstructive Pulmonary Disease] start date 11/11/14 [November 11, 2014]. Further review of the clinical record lacked evidence of the Admission-Initials and Comprehensive Assessment. A face-to-face was conducted on May 21, 2015 at approximately 11:00 AM with Employees #6, 17, 18, and 19. After review of the A review of the clinical all acknowledged the finding. 2. Facility staff failed to assess for pain, monitor effectiveness of pain medication, and modify the approaches to pain as necessary for Resident #120. Resident #120 was readmitted to the facility on March 13, 2015 with diagnoses that included neuropathic pain, depression, Diabetes Mellitus, and right foot Cellulitis. A face-to-face interview was conducted with	F 309	The examination scores will be submitted to the Quality Improvement Manager. The Quality Improvement Manager will report scores to the Quality Improvement Committee following each exam period. 5. Compliance Date: **F309 #2 309#3.a. & 3-b.** 1. The foot brace and knee high TED stockings were placed on Resident #125. Nursing staff assigned to Resident #125 was re-educated and counseled. Resident #125 order to for a foot brace to be worn on their left foot 1hour as tolerated was not carried over to the ETAR (electronic treatment record) and during several observation periods they were not wearing TED stockings as ordered. Resident did not sustain any decline in medical status. Licensed nurse(s) and nursing assistant(s) received counseling. 2. A facility-wide audit of all residents with orders for braces and TED stockings was completed. All residents were identified as receiving braces and TED stockings, as ordered. An audit was conducted on treatment orders of all residents with needs for braces, TED stockings or other appliances to ensure physician orders were carried over on the ETAR.	7/22/2015

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F 309	Continued From page 43 Resident #120 on May 18, 2015 at 11:50 AM. The resident stated, " Right now my pain is a 6/10 [range 0 is the lowest and 10 is the highest]. I always have pain. The medication helps but it doesn't ' t relieve the pain. The nurses don ' t ask me if I am in pain." This interview was held in the presence of Employee #6. A review of the quarterly MDS dated May 3, 2015 section J0300 [Pain Presence] " Have you had pain or hurting at any time" in the last 5 days?" The section was coded as " No " . Section I8000 [Additional active diagnoses] is coded for other Chronic pain. A review of the clinical record revealed a care plan updated on May 3, 2015 for Pain Management. The Problem is alteration in comfort related chronic pain (lower extremities). Resident has a history of Cellulites, right foot plantar ulcer, and DVT. A review of the electronic physician ' s order sheet dated April 1, 2015 directed, " Order and Start date March 14, 2015, Acetaminophen 500 mg give 2 tablets by mouth 3 times per day; Order and Start date March 16, 2015, Methadone 10 mg give 1 tablet by mouth 3 times per day at 06:00, 14:00, 22:00 for pain; Order and Start date March 16, 2015, Methadone 5 mg give 1 tablet by mouth 1 time per day at 06:00 for diabetic neuropathy; Order and Start date March 16, 2015, Methadone 5 mg give 1 tablet by mouth 1 time per day at 22:00 for pain " A review of the March, April and May 2015 Medication Administration Records revealed that the resident received Acetaminophen 500 mg,	F 309	Clinical Managers conducted daily nursing unit rounds to observe adherence to physician orders of residents needing TED stockings. 3. Nurses were re-educated on electronic healthcare record processing of physician orders to ETAR and all nursing staff re-educated on documenting care ordered is provided. All nursing staff will be re-educated to review closet care plans daily and ensure races and TED stockings are provided as ordered. Clinical Managers or designee will complete a minimum of two (2) rounds each shift to verify residents have braces and TED stockings in place as ordered. Findings will be documented on the Nursing Unit Rounds Audit Tool and submitted weekly to the Director of Nurses. House Supervisors will conduct unit rounds a minimum of two (2) times each shift on a minimum of one (1) clinical unit and submit completed Nursing Unit Rounds Audit Tool to the Director of Nurses. Unit Clerks will audit physician orders daily, matching new and/or existing orders to ETARS and/or EMARs. Audit findings will be reported to the Clinical Manager who will follow-up, as indicated. All nursing staff will receive education to daily review all residents Closet Care plans to ensure needs such braces, TED stockings,	

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F 309	Continued From page 44 Methadone 10mg and 5 mg as per the physician ' s order. Review of the nursing notes from March 16, 2015 to May 21, 2015 revealed pain assessments that contained inconsistent /inaccurate information for example: Pain assessment for March 18, 2015 · Cancer pain: Controlled by current interventions. The resident did not have a medical diagnosis of cancer Pain assessment for March 19, 2015 · Cancer pain: Levels unchanged in the last 6 months controlled by current interventions. The resident did not have a medical diagnosis · Observation: Chronic pain level=0/10 · Pain perceived as an ache, but pain level is recorded as 0/10 · Pain related to chronic process osteomyelitis Pain assessment for April 7, 2015 · History noted as cardiovascular pain, pain from emotional psychological distress · Pain is recorded as intermittent pain in the leg · Observation reveals that resident verbalizes pain, chronic pain level 0/10 relieved by medication Pain assessment for May 3, 2015 Cancer pain: Levels unchanged in the last 6 months controlled by current interventions. The resident did not have a medical diagnosis · Observation: Chronic pain level=0/10 · Pain perceived as an ache, but pain level is recorded as 0/10 · Pain related to chronic process osteomyelitis There is no evidence that facility staff consistently and accurately assessed Resident #120 ' s level of pain. A face-to-face interview was conducted with	F 309	other appliances are a part of care given to residents as per physician orders. 4. Clinical Managers will report audit findings to Focus QI-IDT meeting monthly. The QI Manager will report a summary of audit findings to QAPI Committee quarterly. Observations of residents needing braces, TED stockings, etc to ensure adherence to physician orders will be added as an observation to the Clinical Managers/House Supervisor Nursing Unit Rounds Audit Tool. Clinical Managers will round on their assigned nursing unit at least twice per shift to ensure appliances are being applied. The Nursing Unit Rounds Audit tool will be submitted weekly to the Director of Nursing or their designee. 5. Compliance Date:	7/22/2015

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F 309	Continued From page 45 Employee #6 on May 18, 2015 at approximately 12:30 PM. He/she acknowledged the findings. The record was reviewed on May 20, 2015. 3a.. Facility staff failed to ensure that the physician ' s orders transferred to the physician order sheet was continued and carried over to the ETAR [electronic treatment administration record] for one resident. Resident #125 A review of the Physician Order Sheet signed and dated January 7, 2015 revealed the following hand written transferred orders that directs, " Treatment staff for functional/maintenance program and foot brace to be worn on left foot for 1 hour as tolerated each day. " A review of ETAR [electronic treatment record] Report for the month of January, 2015 lacked evidence that the order " Treatment staff for functional/maintenance program and foot brace to be worn on left foot for 1 hour as tolerated each day " was carried over and was documented as discontinued. A face-to-face interview was conducted on May 20, 2015 at approximately 10:30AM with employee #4. He/she acknowledged the findings. The record was reviewed on May 20, 2015. 3b. Facility staff failed to ensure physician orders for one resident to use ted stockings was followed. Resident #125 A review of the physician order sheet signed and dated by the physician directed, " Knee High Ted Stockings on in AM 1 time per day, special	F 309	1. The initial nursing assessment for Resident #109 is on the medical record. 2. All hospice patients on LTC were reviewed and initial nursing assessments were identified on the medical record. Hospice EHR admission assessments are printed as part of the interdisciplinary team assessment. 3. Hospice Clinical Manager or designee will audit the to verify initial hospice nursing assessments are in chart timely. 4. All variances will be reported at the Weekly hospice IDT meetings. 5. Compliance Date:	7/22/2015

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F 309	Continued From page 46 instructions: Om [On] at 8AM and Off at 8Pm from [physician name] Medical Doctor, order entered by [nurse name] Licensed Practical Nurse. " Several observations on the following days May 18, 19 and 20, 2015 of resident #125 sitting in her wheel chair with foot on leg rest revealed that he/she was not wearing socks and not Ted stockings in accordance with the physician order. A review of ETAR [electronic treatment record] Report for the month of May, 2015 lacked evidence that the order " Knee High Ted Stockings on in AM 1 time per day, was documented as discontinued. A face-to-face interview was conducted on May 20, 2015 at approximately 10:30AM with employee #4. He/she acknowledged the findings. The record was reviewed on May 20, 2015. 4. Facility staff failed to ensure that the initial nursing assessment for hospice was a part of Resident #216 active clinical file. A review of the Physician Order Sheet for the month of March 2015 directed: Admit to Hospice start date 3/6/15[March 6, 2015]. Further review of the clinical record lacked evidence of the Admission-Initial and Comprehensive Assessment. A face-to-face was conducted on May 21, 2015 at approximately 11:00 AM with Employees #6, 17, 18, and 19. After review of the A review of the clinical all acknowledged the finding.	F 309	#216 1. The initial nursing assessment for Resident #216 is on the medical record. 2. All hospice patients on LTC were reviewed and initial nursing assessments were identified on the medical record. Hospice EHR admission assessments are printed as part of the interdisciplinary team assessment. 3. Hospice Clinical Manager or designee will audit the to verify initial hospice nursing assessments are in chart timely. 4. All variances will be reported at the Weekly hospice IDT meetings. 5. Compliance Date:	7/22/2015
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 47 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 observation and staff interview for one (1) of 37 sampled residents, it was determined that facility staff failed to ensure that Resident #55, who is unable to carry out activities of daily living the necessary services received grooming to his/her face and nails. The findings include: According to the annual Minimum Data Set dated March 10, 2015 Resident #55 was coded as totally dependent with one (1) person physical assistance in personal hygiene under Section G110 Activities of Daily Living (ADL) Assistance. The resident ' s diagnoses under Section I (Active Diagnoses) included: the resident was coded as having a Neurogenic Bladder, Hypertension, Diabetes Mellitus, Non-Alzheimer's, and Dementia. On May 13, 2015 at approximately 3:11 PM Resident #55 was observed in the dayroom/television room seated in a recliner chair. His/her chin had gray hair on both sides and his/her finger nails on the left hand were	F 312	**F312** 1. Resident #162 did not receive services to ensure they were free of facial hair. Resident #55 had a dark substance underneath the nail beds of fingernails on left hand. Employees received counseling. Resident #162 was shaved and Resident #55's nails were cleaned. 2. No other resident was affected by this practice. All residents' plans of care were audited to ensure the removal of facial hair matched their care needs and to ensure nail care was part of the plan of care. 3. All nursing staff will receive education as to how encouragement can be given to the resident (especially those that are behavior challenged) to have their ADL care completed and what interventions to take if the resident remains resistant to receiving ADL care. Mandatory education sessions on the topic of resident dignity and respect (including why dignity is harmed when a resident is not groomed and how to encourage the resident to receive grooming) will be conducted two times per year for all nursing staff. 4. The Clinical Educator will audit the education sessions for attendance each time they are presented and submit the audit to the Quality Improvement Manager.	

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F 312	Continued From page 48 observed with a dark substance underneath the nail beds. Employee #6 was present at the time of the observation and acknowledged the findings. There was no evidence that facility staff carried out activities of daily living necessary to maintain good grooming for Resident #55.	F 312	The QI Manager will report the audit to the Quality Improvement Committee monthly. 5. Compliance Date:	7/22/2015
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview it was determined facility staff failed to notify a resident ' s physician/nurse practitioner when a new wound was identified at Stage III and failed to obtain orders for the immediate care and treatment of the wound for one (1) of 37 residents reviewed. Resident #23. The findings include: Through staff interview it was determined facility staff observed a new wound on Resident # 23 ' s left buttock on the weekend of May 9 to 10, 2015;	F 314	**F314** 1. Nurses caring for resident #23 were counseled and re-educated on facility policy for notifying Medical Staff on resident changes in condition. The resident's wound did not worsen in the time period addressed by the deficiency and is resolved. The staff associated with this incident received counseling and received education regarding the organization's protocol as to what information needs to be communicated to the physician or Advanced Practice Nurse. 2. An audit of all residents with pressure ulcers was completed. Medical Staff notifications and initiation of treatment orders were in compliance with facility policy. Opportunities for improvement were completed at time of audit. An audit of the medical record of all residents with pressure ulcers was conducted to determine if the physician or Advanced Practice Nurse was notified about the wound and if orders were obtained for appropriate treatment of the wound(s). Any remarkable instances were corrected at the time of the audit.	

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F 314	Continued From page 49 however, notification to a physician or nurse practitioner was not made. Treatment orders for management of the wound were initiated on May 13, 2015 (approximately 4 days later) after the area was assessed as a stage 3 pressure ulcer during routine wound rounds by the Nurse Practitioner. On May 13, 2015 (Wednesday) incontinence care was observed for Resident #23. It was noted that the resident had two (2) dressings on his/her left buttock and one (1) on the right buttock all initialed by a licensed nurse and dated May 12, 2015. A review of the most recent " Skin Condition Report " dated May 4 and 7, 2015 revealed that Resident #23 had two (2) wounds: left buttock (abscess) and right buttock (abrasion). There was no documentation of a second skin integrity concern on the left buttock as observed on May 13, 2015. Subsequent to the observation of incontinence care on May 13, 2015 the following progress notes were recorded. An Interdisciplinary Progress Note dated May 13, 2015 at 11:15 AM, by the Nurse Practitioner Student revealed the following, " ... Pt. (patient) has not been out of bed ...Skin breakdown - wound care rounds - new orders. L (left) Buttock abscess 2 x 1 x .01cm healing; R (right) buttock 1.5 x 2.5 x .01 cm unstageble, L buttock Stage III 2 x 1 x .01cm ...ordered alternating pressure	F 314	3. Clinical Managers will be educated to audit the electronic healthcare record (EHR) of all residents with pressure ulcers weekly, using criteria added to the weekly Skin Integrity Audit Tool. All licensed nurses will be educated on Medical Staff notification and complete a Skin/Wound Competency. Clinical Managers will conduct a weekly audit of the medical record of all residents with pressure ulcers. The criteria for the audit will be added to the weekly Skin Integrity Audit Tool. All Clinical Managers will receive education as to how the audit tool is to be used. All licensed nurses will receive education on facility protocol of Notification of Physician (Advanced Practice Nurse) and will be administered a Skin/Wound Care Competency. 4. Clinical Managers will report findings of Skin Integrity Tool to Focus Quality Improvement (QI)-Interdisciplinary Team (IDT) weekly for review and identification of opportunities for performance improvement (OPI). All licensed nurses will complete a mandatory biannual education on physician notification protocol and successfully complete the annual Wound Care Competency. 5. Compliance Date:	7/22/2015

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F 314	Continued From page 50 mattress ... " A review of the Nurse Practitioner ' s note dated May 13, 2015 [no time indicated] revealed, ... Abscess to L butt is healing s/p antbx (antibiotics) - has new pressure ulcers - will order alternating pressure mattress and PT (physical therapy) to evaluate seating for new cushions. " Skin Condition Reports A review of facility documents revealed licensed nurses conducted and recorded wound/skin assessments weekly on a form entitled " Skin Condition Report Without Images. " The " Skin Condition Report Without Images " for Resident #23 was reviewed for the period of May 1 - 13, 2015. The (wound/skin) forms lacked evidence of a wound assessment related to the ' new ' alteration in skin integrity that was initially observed on May 9, 2015. The alteration in skin integrity identified as one (1) of two wounds on the left buttocks was assessed by the Nurse Practitioner during routine scheduled wound rounds on Wednesday, May 13, 2015 wherein the wound was initially assessed at an advanced stage 3 (full thickness tissue los...slough may be present but does not obscure the depth of tissue loss ...). Physician Orders On May 13, 2015 (time not recorded) " Ulcers to bilateral buttocks ... New treatment 1 time per day at 09:00, ... clean ulcers with NS (normal saline) pat dry, cover with Sratasorb daily. " The prior physician orders for wound care were as follows: May 11, 2015 - Right Buttock clean with NS, pat dry apply Optifoam dressing every Monday and Thursday and PRN. On April 30,	F 314		

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F 314	Continued From page 51 2015 for the left buttock [note only one (1) wound identified on the Skin Condition Report at the time of this order] three times a day during day, evening, night - warm compress from the store room, apply 15 minutes. Staff Interviews A face-to-face interview was conducted with Employee #22 (Certified Nurse Aide) on May 15, 2015 at approximately 3:40 PM. He/she stated, "I observed three (3) areas on the resident this weekend (May 9, and 10, 2015)."	F 314		
	A face-to-face interview was conducted with Employees # 20 and 29 (License Practical Nurses) on May 15, 2015 at approximately 3:43 PM. Both employees stated, "Noticed the area a few days ago. Treated the new area on the left buttocks the same as the other areas. It looked the same. Treated it with warm compress and dry dressing." A face-to-face interview was conducted on May 15, 2015 at 3:45 PM with Employee #6. He/she reviewed the physician ' s orders and acknowledged that there was no order to treat three (3) open areas on the resident ' s buttocks. The resident ' s care needs are documented as dependent care and has incontinence on the most recent Minimum Data Set (MDS). A review of the quarterly MDS dated April 1, 2015 revealed the following: Under Section G [Functional Status] the resident required extensive assistance for Bed mobility, Transfers, Toilet Use, and Personal hygiene, two plus persons physical assist. Under section H [Bladder and Bowel] the resident was coded as being frequently incontinent of bladder			

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F 314	Continued From page 52 and bowel; Under section M [Skin Conditions], in response to the question " is this resident at risk for developing pressure ulcers " the resident was coded as "no". Under Skin and Ulcer Treatments the resident is coded for pressure reducing device for bed, turning/repositioning program, applications of ointments/medications other than to feet. Through staff interview it was determined that a second wound on the left buttock (the area superior to the abscess/furuncle on the left buttock) was first observed on May 9, 2015 by facility staff. Four (4) days lapsed without physician and/or nurse practitioner assessment and treatment orders. The record was reviewed on May 22, 2015.	F 314		
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 made on during the survey, it was determined that facility staff failed to ensure resident ' s environment was free of accident hazards as evidenced by a electric space heater observed in one (1) residents room; an extension cord observed in use to supply power to the fish tank on unit 2B, a wood plank	F 323		

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F 323	Continued From page 53 lifted from the floor in the hallway of the nursing unit and a splintered headboard that was attached to the wall in one resident's room. The findings include: 1. On May 18, 2015 at 10:50 AM, a space heater was observed on the floor of the resident ' s room between the bed and the window. The heater was plugged into the wall and actively circulating warm air about the room in one (1) of one (1) space heater observed. Employee #6 was present at the time of the observation and acknowledged the finding. 2. On May 13, 2015 at approximately 2:30 PM a extension cord was observed plugged in to the wall and to the fish tank located on unit 2B. This observation was made in the presence of Employee # 12, who acknowledged the finding. 3. On May 13, 2015 at 11:00 AM a wood plank was observed lifted from the floor in the hallway nearby the storage closet on unit 2B. Employee #6 was present at the time of the observation and acknowledged the findings. 4. On May 13, 2015 a headboard attached to the wall in one (1) residents room was observed to be splintered. A tour of Resident #162's room was conducted on May 13, 2015 at approximately 10:30 AM. It was observed that the wall in the resident ' s room adjacent to the residents bed (towards the foot of the bed) was splintered wood. A face-to-face interview was conducted with Employee #6 on May 22, 2015 at approximately 11:30 AM. After making an observation of the room, he/she acknowledged the findings.	F 323	**F323** 1. Space heater was removed immediately. 2. Maintenance inspection of all resident rooms identified no other space heaters. 3. Maintenance staff re-educated to inspect resident rooms weekly and will immediately report unauthorized electrical equipment in resident rooms. 4. Plant Operations Director or designee will report any repeat occurrences to QAPI Committee quarterly. 5. Compliance Date: 1. Extension cord was removed immediately. 2. No other extension cord was identified during inspection. 3. All fish tanks were inspected; no extension cords found. Maintenance staff educated to check fish tanks for unauthorized extension cords during Weekly Maintenance Rounds. 4. Plant Operations Director or designee will report any repeat occurrence to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015 7/22/2015

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F 323	Continued From page 54 B. Based on observation, record review, and staff and resident interview it was determined that facility staff failed to keep resident free from falls as evidenced by failure to transfer resident in accordance with the plan of care using two (2) persons and a mechanical lift. The findings include: Resident #23 was admitted on January 7, 2015 with diagnoses that included, Altered mental status, CVA, and right Hemiparesis. A review of an Incident Report dated February 10, 2015 revealed the following, " Resident called, upon entering the room immediately after answering call, found resident sitting on the floor and leaning on wheel chair. Assessment conducted [he/she] verbalized sliding off the wheel chair. Denies pain, denies hitting head. ROM within normal limit, no apparent injury noted. Remain alert and oriented at this time. Review of the care plan initiated on February 12, 2015 revealed the following, " Problem Statement - Resident was observed sitting on the floor on 2/10/2015. No injuries noted; Interventions and approaches - Resident will be transferred with a mechanical lift at all times by nursing staff, and will be assisted on a bed pan as needed. A review of the quarterly MDS dated April 1, 2015 revealed the following: Under Section G [Functional Status] the resident required extensive assistance for Bed mobility, Transfers, Toilet Use, and Personal hygiene, meaning the resident was involved in activity, staff provides weight bearing support, two (2) plus persons physical assist. Under section H [Bladder and Bowel] the resident was coded as being	F 323	1. Wood plank in flooring near 2B storage closet was repaired. 2. No other loose plank was found during inspection. 3. Maintenance inspection on all Units identified no other loose floor planks. Maintenance staff education to inspect hallway floors during Weekly Maintenance Rounds, and correct any damage identified. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015 1. The wall protector behind head of bed in room 162 was repaired. 2. Maintenance inspected protective wall boards behind head of bed in all resident rooms; none were splintered. 3. Maintenance staff will inspect protective wall board at head of bed during Weekly Maintenance Rounds. Maintenance staff re-educated on conducting inspection of walls in residents' rooms. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015	

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F 323	Continued From page 55 frequently incontinent of bladder and bowel meaning 7 or more episodes of urinary incontinence, but at least on episode of continent voiding. Under section J [Health Conditions] the resident was coded for having no falls since admission/entry or reentry or prior assessment. Review of the nursing note dated April 15, 2015 revealed the following, " ...Resident was transferred from unit #[unit letter] to [unit number] today during morning shift. Alert and verbally responsive. Denied pain and breathing normal. Resident is dependent with ADLs two (2) person assist and transfer by Hoyer lift ... " A review of the nursing note dated April 16, 2015 revealed, " General Pain Comments -Writer was called into room [room number] at 10 AM. Staff explained that resident told [him/her] [that] [he/she] can walk to the toilet, staff assisted resident to the toilet ...Upon assisting resident to the chair [he/she] slid to the floor in front of the toilet. No injury sustained. Resident was assisted to [his/her chair]. Denies pain/discomfort. " There is no evidence that facility staff followed the plan of care which stated that the resident was a two person assist with a Hoyer lift, for safe transfer and toileting. A face-to-face interview was conducted on May 15, 2015 at 3:43 PM with Employee #6. He/she also stated, " The [certified nurse aide] should have asked for help when transferring the resident from the commode. " The record was reviewed on May 15, 2015. Based on an observation made on May 11, 2015 at approximately 3:00 PM and on May 15, 2015 at approximately 11:30 AM, it was determined that the facility failed to ensure that it was free of accident hazards as evidenced by one (1) of one (1) oxygen tank stored unsecured in one (1) of 45	F 323	1. Resident #23 did not sustain harm. The nursing staff member was counseled to the highest extent. 2. All nursing staff received education on review of how to transfer residents according to the residents' plan of care. All residents plan of care were audited to ensure they included how the resident is to be transferred. 3. Clinical Managers will conduct medical record audits on admission, quarterly and with significant change to ensure a plan of care for resident transfers is part of the medical record. 4. The Clinical Manager or designee will update the closet care plan of the resident on admission, quarterly, and with significant change to ensure the residents transfer needs are clearly communicated to all caregivers. All nursing staff will receive quarterly education sessions on ADL care that will include transfer techniques and use of transfer equipment. The Clinical Educator will report the attendance of the education sessions quarterly to the QI Manager. The QI Manager will submit a quarterly report to the QI Committee. 5. Compliance Date:	7/22/2015

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F 323	Continued From page 56 resident ' s rooms (#324B) and a loose, in use extension cord located on the floor of room #211, one (1) of 45 resident rooms surveyed. The findings include: 1. An oxygen tank was observed in room #324B, on the floor and unsecured, one (1) of 45 resident ' s rooms surveyed. 2. An extension cord was observed in use, on the floor of room #211, one (1) of 45 resident ' s rooms surveyed. These observations were made in the presence of Employee #11 and Employee #12 who acknowledged the findings.	F 323	1. Resident #106 did not sustain harm. The incident was corrected during the Survey observations. All nursing staff on the nursing unit were instructed to observe for instances where the spread of disease causing organisms may occur and to immediately correct the instances. 2. All nursing staff was instructed regarding hazards to infection prevention and how to observe for instances where the spread of disease causing organisms may occur and to immediately correct the instances. 3. Prevention of contamination of all respiratory equipment including oxygen tubing will be added as an observation to the Clinical Managers/House Supervisor Nursing Unit Rounds Audit Tool. Clinical Managers will round on their assigned nursing unit at least twice per shift and House Supervisors will observe for hazardous infection prevention incidents during rounds.	
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	F 329		

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F 329	Continued From page 57 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 one (1) of 37 sampled residents, it was determined that facility staff failed to clarify the indication of use for the medication MAPAP [Acetaminophen] with the physician. Resident #133 The findings include: Facility staff failed to clarify the indication of use for the medication MAPAP with physician. Resident #133 During an Unnecessary Medication Review, it was noted on the Interim Order Form signed and dated April 7, 2015 that Resident #133 was placed on MPAP "(Acetaminophen Extra Strength) Tablet 500mg, Give 2 tablets by mouth every eight hours at 06:00, 14:00, 22:00, for Osteoarthritis " A review of Admission and Annual Physical Examination Form signed and dated August 15, 2014 revealed the following diagnosis under Summary Plan: HIV [human immunodeficiency	F 329	4. Clinical Managers will conduct unit rounds at least twice daily using the Nursing Unit Rounds Audit Tool and will submit the tool weekly to the Director of Nursing or their designee. House Supervisors will conduct unit rounds at least twice during their shift using the Nursing Unit Rounds Audit Tool for at least one unit and will submit the audit tool to the Director of Nursing weekly. The e Director of Nursing or their designee will review the audits during weekly Nursing Management Team Meetings. 5. Compliance Date:	7/22/2015

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F 329	Continued From page 58 virus], HIV Dementia, Thrombocytopenia, CKD [chronic kidney disease] stage 2, HTN [hypertension], Frequent falls, (R) tib/fib [tibia/fibula] fracture s/p [status post] ORIF [open reduction internal fracture]. A review of the Interdisciplinary progress note revealed Resident #133 ' s 60 day review dated April 6, 2015 at 1:40PM reads as follow: " HIV, HIV Dementia, Thrombocytopenia, CKD stage 2, HTN, Frequent falls, (R) tib/fib fracture s/p [status post] ORIF. " A/P [active /Plan] #6 reads " Back pain + [positive], pt [patient] c/o [complain of] mild intermittent achy pain, start scheduled Tylenol Q (every) 8 hours. " A review of the Minimum Data Set (MDS) dated February 17, 2015 revealed in Section 1 Active Diagnosis the following diagnoses: Anemia Hypertension, Other Fracture, Non Alzheimer ' s Dementia, Psychotic Disorder, Human Immunodeficiency Virus, Unspecified Thrombocytopenia, insomnia unspecified, Dementia Unspecified with behavior, Chronic Kidney Disease stage 2, Other Specified Paranoid States, Unspecified Vitamin B Deficiency, Unspecified Vitamin D Deficiency and Edema. Review of the EMAR [Electronic Medication Administration Record] for the month of April, 2014 revealed electronic order for " MAPAP Acetaminophen 500mg: Give 2 tablets by mouth every eight hours (from Pharmacy) at 06:00, 14:00, 22:00, for Osteoarthritis; from Nurse practitioner, order enter by registered nurse. "	F 329	**F329** 1. Osteoarthritis was added to list of diagnoses for Resident #133. In the Electronic Medical Record (EMR) and Minimum Data Set (MDS) Section I. 2. A facility-wide search of EMR identified all other residents on MAPAP Acetaminophen had a diagnosis specified with physician's order, on diagnoses list in medical record, and in MDS. 3. Medical Staff was educated to add new diagnoses to diagnoses list for inclusion in MDS Section I. Clinical Managers and MDS nurses will check for new diagnoses at time of each assessment. 4. Medical Director will monitor compliance during ongoing monthly reviews and report variances to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015

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F 329	Continued From page 59 The medical record lacked evidence of facility staff clarifying the indication for use of the MPAP with the physician's for a diagnosis of osteoarthritis. A face-to-face interview was conducted with Employee #4 on May 20, 2015 at approximately 2:30 PM. After review of the above, Employee #4 acknowledged the findings. The record was reviewed on May 20, 2015.	F 329	**F364** 1. Brown banana was removed from resident's breakfast tray. 2. No other residents were identified as receiving brown bananas. 3. Bananas are inspected for damages at time of delivery. Tray line staff was re-educated to recognize damaged bananas and remove from tray line. 4. Supervisor will visually spot check bananas on tray prior to delivery to Unit and report variances to Dining Services Director who will report findings to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		
	This REQUIREMENT is not met as evidenced by: Based on observation and resident interview for one (1) of 37 sampled residents, it was determined that a resident was served food that was palatable and attractive, as evidenced by failure to ensure that the Resident #19 received a breakfast meal that taste good an looked appetizing. The findings include:			

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F 364	Continued From page 60 A face-to-face interview was conducted with Resident # 19 on May 12, 2015 at approximately 10:17 AM. The resident was asked, Does the food taste good and looks appetizing? He/she replied, " No indeed. " The resident was observed having his/her breakfast on May 21, 2015 at 9:50 AM. The resident was asked how your breakfast is. He/she replied by shaking his/her head, then touched the banana and said it ' s [the banana] rotten. " On the resident ' s plate was, the edge of toast, a half eaten boiled egg, and an off white and deep brown colored banana. " This observation was made in the presence of Employee #6 who acknowledged the findings.	F 364	**F371** 1. Staff that prepared the food that morning was permitted by surveyor to label food with date. 2. No other unlabeled food identified. 3. All Staff re-educated on mandatory label system. Management will inspect food for current label on a daily basis. 4. Dining Services Director will report findings to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. Kitchen floor is scheduled for repair. 2. No other area identified during inspection. 3. Dining Services Director will inspect floors weekly and report variances to Plant Operations. Staff educated to observed floor conditions and report to maintenance/housekeeping staff for immediate cleaning/repair. 4. Dining Services Director will report inspection findings to QAPI Committee quarterly. 5. Compliance Date	7/22/2015
	This REQUIREMENT is not met as evidenced by: Based on observations made on May 11, 2015 at approximately 9:15 AM, it was determined that the facility failed to prepare and store food under sanitary conditions as evidenced by foods such as one (1) of four (4) bags of cheddar			

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F 371	Continued From page 61 cheese, one (1) of one (1) pan of tomato, ham and turkey breast chunks, one (1) of one (1) pan of roast beef slices, one (1) of one (1) pan of chopped meat, one (1) of one (1) pan of noodles and carrots slices, one (1) of one (1) pan of shredded lettuce and one (1) of one (1) pan of onions and celery slices that were stored in the walk-in refrigerator undated, a soiled floor in the main kitchen, dry food storage and dishwashing area, two (2) of two (2) convection ovens that were soiled on the inside and outside and one (1) of one (1) plate warmer with clean plates that was left uncovered. The findings include: 1. One (1) of four bags of cheddar cheese, one of (1) pan of tomato, ham and turkey breast chunks, one (1) of one (1) pan of roast beef slices, one (1) of one (1) pan of chopped meat, one (1)of one (1) pan of noodles and carrots slices, one (1) of one (1) pan of shredded lettuce and one (1) of one (1) pan of onions and celery slices were stored in the walk-in refrigerator undated. 2. The entire kitchen floor, including the floor in the dry food storage area and in the dishwashing area was marred, scarred and discolored. 3. The inside and the outside of two (2) of two (2) convection ovens were soiled. 4. One (1) of one (1) plate warmer with clean plates was observed uncovered in the main kitchen. These observations were made in the presence of Employee #9 and/or Employee #10 who acknowledged the findings.	F 371	1. Soiled ovens identified during survey were cleaned during survey. 2. These were no other ovens identified as soiled during survey. 3. Shift supervisors re-educated on Daily Checklist inspection requirement to inspect cleanliness of ovens daily. 4. Dining Services Director will review Daily Checklist inspections a minimum of weekly and report findings to QAPI Committee quarterly. 5. Compliance Date: 1. Uncovered clean plates in plate warmer were covered immediately. 2. No other plates were identified during survey. 3. Staff was re-educated on requirement to keep plates in plate warmer covered. Supervisors will monitor compliance at all meals. 4. Supervisors will report variances to Dining Services Director who will report findings to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015 7/22/2015

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F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 37 sampled residents, it was determined that the facility failed to maintain a resident ' s highest practicable level of functioning related to medication therapy to the extent possible as evidenced by its failure to provide a licensed pharmacist's review of each resident's regimen of medications at least monthly. Resident #4. The findings include: A review of the clinical record revealed a Medication Regimen Review (MRR) sheet from November 6, 2014 through May 6, 2015. The clinical record lacked a MRR sheet for the months of May 2014 through October 2014. A face to face interview with Employee #6 was conducted on May 20, 2015 at approximately 3:00 PM. When queried regarding the missing MRR sheet he/she responded That he/she did not know where the previous	F 428	**F428** 1. Resident #4 did not have a pharmacy drug review for May 2014 through October 2014. Documentation of the MRR for the dates in question does exist. 2. An audit was done to ensure all residents have a current MRR by a licensed pharmacist. 3. According to the policy and procedure of Remedi pharmacy an MRR will be conducted on all residents. 4. Unit Clerks re-educated to conduct a quarterly audit of all residents' medical record to ensure a MRR has been done by Remedi pharmacy and is available in the medical record of all residents. The audit will be submitted to the Director of Medical Records for review and follow- up. 5. Compliance Date:	7/22/2015

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F 428	Continued From page 63 MRR was and said " pharmacy takes care of that " . The record was reviewed on May 20, 2015.	F 428	**F431** 1. Expired blister pack of oxycodone observed for resident #95 and was removed from the medication cart. Resident did not suffer ill effects. Employee(s) responsible received counseling. 2. An audit was done of all medication carts and medication storage refrigerators and other medication storage containers to ensure all medications have current usage dates. Licensed nurses received education to follow the Medication Administration policy which includes checking the medication expiration dates prior to administering any medications. 3. Clinical Managers will conduct a weekly audit of medication carts, medication storage refrigerators, and other medication storage containers to ensure all medications have a current usage date. This observation will be a part of the Nursing Unit Rounds Audit Tool. Clinical Managers will receive education on how to conduct the audit and use the audit tool.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 64 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that facility staff failed to maintain medication storage in accordance with accepted professional principles as evidenced by: one (1) blister packet medication was stored beyond the expiration date for one (1) resident; two (2) unit refrigerator temperature log sheet was not consistently checked and recorded once a day and the Controlled Drug Count Verification (shift count sheet for Narcotics) was reconciled by two nurses ' signatures. The findings include: Facility failed to maintain medication storage in accordance with accepted professional principles as evidenced by: 1. One (1) blister packet medication was stored beyond the expiration date for one resident. (Resident #95) On May 21, 2015 at approximately 11:40AM one (1) blister packet medication was found stored beyond the expiration date. The medication storage observations revealed the following: On Unit 3A Resident# 95 had 28 tablets of Oxycodone 5mg stored for use. The expiration date on the package was March 2015. The observation was made in the presence of Employee #8. He/she acknowledged the findings. 2. Two (2) unit refrigerator temperature log sheet	F 431	4. The Nursing Unit Rounds Audit Tool with the weekly criteria to inspect medication usage dates will be submitted to the Director of Nursing weekly for follow up. The Director of Nursing will submit the Nursing Unit Rounds Audit Tool to the Quality Improvement Manager. The Quality Improvement Manager will report results of audit during the weekly Focus Quality Improvement meeting. 5. Compliance Date:	7/22/2015

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F 431	Continued From page 65 was not consistently checked and recorded once a day. (Unit 3A and 3B) On May 21, 2015 at approximately 11:45AM a review of the " Refrigerator Monitoring Log " on unit 3A and 3B revealed that the temperature recordings were left blank indicating not completed on the following month and days: Unit 3B: February 15, 16 17, 26, 2015 Unit 3A: April 12, 26, 27, 2015 Unit 3A: May 2, 13, 2015 Unit 3B: May 1, 3, 4, 8, 9, 20, 2015 There was no documented evidence that facility staff consistently monitored the temperature of the Medication refrigerator located in the nurse ' s station medication rooms on units 3A and 3B. 3. Facility staff failed to ensure that the Controlled Drug Count Verification (shift count sheet for Narcotics) was reconciled by two nurses ' signatures. (Unit 2B) A review of the Controlled Drug Count Verification records conducted on May 21, 2015 at approximately 11:55AM revealed the following Narcotics reconciliation concerns: On November 21, 2014 11:00 PM to7:00AM shift the Narcotic reconciliation had one (1) nurse's signature in the space allotted for going off duty. The space allotted for signature of nurse coming on duty was left blank indicating the narcotic reconciliation was conducted by one nurse.	F 431	**F431 (2)** 1. Recordings of refrigerator temperature logs were not consistent on units 3a and 3B. Employee(s) on unit 3a counseled. Unit 3B is closed for renovations. 2. An audit was conducted of all unit refrigerator temperature logs to ensure consistency of documentation. 3. Documentation of refrigerator temperature logs will be added to the Nursing Unit Rounds Audit Tool. The Clinical Managers will check consistency of documentation of refrigerator temperatures daily using the Nursing Unit Rounds Audit Tool. Clinical Managers will receive education as to how to use Nursing Unit Rounds Audit Tool. 4. The Nursing Unit Rounds Audit Tool with the documentation refrigerator temperatures are consistently observed will be submitted weekly to the Director of Nursing for review and follow up. The Director of Nursing will submit the Nursing Unit Rounds Audit Tool to the Quality Improvement Manager. The Quality Improvement Manager will report to the weekly Focus Quality Improvement team. 5. Compliance Date:	7/22/2015

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F 431	Continued From page 66 On November 21, 2014 3:00 PM to 11:00 PM shift the Narcotic reconciliation sheet had one (1) nurse's signature in the space allotted for coming on duty. The space allotted for signature of nurse going off duty was left blank indicating the narcotics reconciliation was conducted by one nurse. A face -to -face interview was conducted on May 21, 2015 at approximately 11:56AM with Employee #6. He/she stated that according to facility ' s Controlled Substances Policy " Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together and they must document and report any discrepancies. " There was no evidence that facility staff ensured the Controlled Drug Count Verification records had two nurse ' s signature for Narcotic reconciliation of controlled medications. Controlled substance reconciliation records were blank or signed by one (1) nurse as either ' off-going and on-coming ' [tour of duty] on the shifts delineated above. A face-to-face interview was conducted on May 21, 2015 at approximately 11:58AM with Employees #8. After reviewing the signature sheet forms, he/she acknowledged the aforementioned findings. The observation was conducted May 21, 2015.	F 431	**F431 (3)** 1. Controlled Substance reconciliation form not signed by two nurses: on coming nurse did not sign. Reconciliation count was accurate. Employee was counseled. 2. An audit was done of all Controlled Substance reconciliation forms. 3. The Clinical Manager or their designee will conduct a daily audit of the Controlled Substance reconciliation sheet. All nurses were re-educated on the controlled substance reconciliation process and the need for two signatures. 4. Consistency of two signatures on the Controlled Substance Reconciliation form will be added as an item to the Nursing Unit Rounds Audit Tool. The Nursing Unit Rounds Audit Tool will be submitted weekly to the Director of Nursing for review and follow up. The Director of Nursing will submit the Nursing Unit Rounds Audit Tool to the Quality Improvement Manager. The Quality Improvement Manager will report to the weekly Focus Quality Improvement team. 5. Compliance Date:	7/22/2015
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 67 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 by: Based on observation and staff interview, it was	F 441	**F441** 1. Resident #162 had multiple bedpans in a shared bathroom: bedpans were not labeled for any specific resident. Employee received infection prevention education regarding proper storage and labeling of resident supplies when supplies are in a shared area. The multiple bedpans were removed. 2. An audit was conducted of all care supplies used by residents that share a bathroom to ensure proper labeling and storage. All nursing employees will receive infection prevention education regarding proper storage and labeling of resident supplies when supplies are in a shared area. 3. The Clinical Manager will make daily nursing unit rounds to observe infection prevention relating to resident care items stored in shared resident bathrooms: items labeled and stored according to infection prevention standards. This observation will be added to the Nursing Unit Rounds Audit Tool.	

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F 441	Continued From page 68 determined that facility staff failed to help decrease the spread of infection as evidenced by having multiple unlabeled bed pans in one (1) resident ' s bathroom; failed to sanitize hands between feeding and assisting two (2) residents; and failed to ensure the toilet seat riser was stored properly when not in use. The findings include: 1.Facility staff failed to help decrease the spread of infection by not clearly labeling three (3) bed pans in Resident #162 ' s bathroom that was shared with another resident. An observation of resident #162's bathroom was conducted on May 13, 2015 at approximately 9:45 AM. It was observed that two (2) pink bedpans were observed stored in the resident ' s room. One (1) behind the commode on the floor; one (1) on the grab bar behind the toilet and one (1) white fracture bedpan observed stored on the grab bar to the left of the toilet. A face-to-face interview was conducted on May 22, 2015 at approximately 1:00 PM with Employee #6. At that time a second observation was made of the resident ' s bathroom. After making the observation Employee #6 acknowledged the finding. 2.Facility staff failed to decrease the spread of infection as evidenced by not sanitizing hands in between assisting two (2) residents. Employee #20 was observed on May 21, 2015 at approximately 12:45 PM feeding a male resident. Employee #20 observed that another resident at	F 441	4. The Nursing Unit Rounds Audit Tool will be submitted weekly to the Director of Nursing for review and follow up. The Director of Nursing will submit the Nursing Unit Rounds Audit Tool to the Quality Improvement Manager. The Quality Improvement Manager will report to the weekly Focus Quality Improvement team. 5. Compliance Date:	7/22/2015

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F 441	Continued From page 69 the table needed assistance, stopped and assisted that resident (touching the hands of the resident) and returned back to feeding the first male resident without sanitizing his/her hands. A face-to-face interview was conducted with Employee #6 on May 22, 2015 at approximately 11:40 AM. After review of the above scenario, he/she acknowledged the findings. 3. Facility staff failed to ensure the toilet seat riser was stored properly when not in use. On May 19, 2015 at 12:05 PM a tour of Resident #23 ' s bathroom was conducted. At this time a white toilet seat riser was observed on the floor in the bathroom. Employee #6 was present at the time of the observation and acknowledged the finding.	F 441	**F456** 1. Toaster oven knob replaced during survey. 2. No other broken toaster was identified during survey. 3. Staff re-educated to report broken equipment to supervisor promptly. Supervisor re-educated to add toaster oven to Daily Checklist inspection. 4. Dining Services Director will review Daily Checklist inspections a minimum of weekly and report findings to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015
F 456 SS=E	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 observations and interview on May 11, 2015 at approximately 9:10 AM, it was determined that the facility failed to maintain essential equipment in safe, operating condition as evidenced by: one (1) of one (1) toaster oven that lacked a temperature adjustment knob, one (1) of two (2) hand washing sinks housing with a loose cover, one (1) of one (1) ice machine with a	F 456	1. Hand washing sink cover housing repaired during survey. 2. No other hand washing sink housing was identified as loose during survey. 3. Staff re-educated to report broken equipment to supervisor promptly. Supervisor re-educated to add hand washing sink to Daily Checklist. 4. Dining Services Director will review Daily Checklist inspections a minimum of weekly and report findings to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015

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F 456	Continued From page 70 cracked plastic lid, one (1) of two (2) non-functioning garbage disposals and one (1) of one (1) reach-in box that has been out of order for more than a year. The findings include: 1. One (1) of one (1) toaster oven in the main kitchen was without a temperature adjustment knob. 2. The cover to the housing of one (1) of two (2) hand washing sinks hung loosely from the sink and needed to be repaired. 3. The plastic cover on the inside of the lid of one (1) of one (1) ice machine was cracked. 4. One (1) of two (2) garbage disposals was not functioning. 5. One (1) of one (1) reach-in box has been broken for over a year. During an environmental tour of the main kitchen on May 11, 2015 at approximately 9:30 AM, Employee #9 was asked about the reach-in box that was no longer operational and he/she responded that it had been out of service for over a year. These observations were made in the presence	F 456	1. Plastic cover on inside lid of ice machine is in process of being replaced. 2. No other cracked ice machine lid was identified during survey. 3. Supervisor was re-educated to inspect ice machine as part of Daily Checklist and report variances promptly. 4. Dining Services Director will review Daily Checklist inspections a minimum of weekly and report findings to QAPI Committee quarterly. 5. Compliance Date: 1. The non-functioning garage disposal was removed. 2. No other non-functioning garbage disposal was identified during survey. 3. Supervisor was re-educated to inspect garbage disposals as part of Daily Checklist and report malfunctions to Dining Services Director promptly. 4. Dining Services Director will report on any malfunctioning garbage disposals to QAPI Committee quarterly. 5. Compliance Date: 1. Broken reach-in box was removed. 2. No other broken reach-in box was identified during inspection. 3. Dining Services Director will report malfunctioning/broken equipment to Plant Operations promptly. Staff will also be educated to make reports if equipment is malfunctioning or has broken parts.	7/22/2015 7/22/2015

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F 456	Continued From page 71 of Employee #9 who acknowledged the findings.	F 456	4. Dining Services Director will report on broken equipment to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on an observations made on May 15, 2015 at approximately 11:30 AM, it was determined that the facility failed to maintain the call bell communication system in good working condition as evidenced by: call bell pull cords that were too short in three (3) of 45 resident's bathrooms, a non-functioning call bell in one (1) of 45 resident's rooms and a missing call bell in one (1) of 45 resident's rooms.	F 463	**F 463** 1. Call bell cords in bathrooms 135,146, and 227 were replaced with correct length cords immediately. 2. Maintenance inspected all bathroom call bell cords; all were correct length. 3. Maintenance staff re-educated to inspect length of bathroom call bell cords during Weekly Maintenance Rounds. Replace or adjust if needed. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly, and report variances to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015
	The findings include: 1. Call bell pull cords located in the bathroom of resident rooms #135, #146, and #227 were too short and could not function as intended in three (3) of 45 resident's rooms surveyed. 2. The call bell in resident rooms #78, #150 did not emit an alarm when tested, two (2) of 45		1. There is no room 78 in the facility. Call bell in room 150 was replaced immediately. 2. Maintenance inspected all call bells; all functioned correctly. 3. Maintenance staff re-educated to inspect call bells during Weekly Maintenance Rounds. Nursing staff also educated to inspect call bells during daily clinical rounds, and report if repair or replacement is necessary.	

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F 463	Continued From page 72 resident's rooms surveyed. 3. The call bell in resident room #214A was missing, one (1) of 45 resident's rooms surveyed. These observations were made in the presence of Employee #11 and/or Employee #12 who acknowledged the findings.	F 463	4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015
F 492 SS=E	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 of the facility's policy regarding Abuse and Neglect, it was determined that facility staff failed to implement policies and procedures to ensure that allegations of mistreatment and/or abuse were acted on, investigated, resolved and reported to the State Agency. The findings include: 22b DCMR 3232.4, Incident Reporting-	F 492	1. Call bell was located where resident had placed it (bed side stand drawer) and returned to wall. 2. Maintenance inspected all rooms for missing call bells; all call bells in place. 3. Maintenance staff re-educated to inspect call bells during Weekly Maintenance Rounds. Nursing staff also educated to inspect call bells during daily clinical rounds, and report if repair or replacement is necessary. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015

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F 492	Continued From page 73 Stipulates, " Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. " A review of the facility ' s Policy No: TX -00001.97 P&P [Policy and Procedure] Name: Abuse and Neglect identified the Resident Abuse and Neglect policy and procedures 7 [seven] step approach, however, the policy lacked procedures that allegations of mistreatment and/or abuse were acted on, investigated, resolved and reported to the State Agency. A review of page 2 of 4 of the Abuse and Neglect Policy, Procedure: lacked evidence of procedures to on how to protect the resident. A face-to-face interview was conducted with Employee #1 on May 21, 2015 at approximately 3:30 PM. A query was made regarding the policy on Abuse and Neglect the complete policy. Employee #1 responded " yes " , this is all we have. Facility staff failed to implement policies and procedures to ensure that allegations of mistreatment and/or abuse were acted on, investigated, resolved and reported to the State Agency.	F 492	**F492** 1. All identified allegations of mistreatment, neglect and/or abuse have been investigated thoroughly and each resident was protected from further abuse. All allegations of mistreatment, neglect and/or abuse have been reported to the State Agency. 2. Any new allegations of mistreatment, neglect and/or abuse will follow specific abuse policies and procedures to ensure residents are protected in the event of an allegation of abuse. The Abuse Investigation Policy has been updated to protect all residents. 3. Specific procedures for staff to follow in the event of allegations involving mistreatment, neglect and/or abuse will be outlined in the TWH Abuse Investigation policy and procedure. The policy and procedure will be distributed in the facility and staff re-educated on the policy. 4. Nursing Administration or designee will report any adverse outcomes from an abuse investigation to QAPI monthly. 5. Compliance Date:	7/22/2015

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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 37 sampled residents, it was determined that facility staff failed to consistently document characteristics and status of abrasions, open areas, and pressure ulcers for two (2) residents with multiple areas of skin impairment; and accurately document (1) one resident's race. Residents' #23, 139 and 241. The findings include: 1. Facility staff failed to consistently document the status of wounds/skin impairment for Resident #23. A review of the facility ' s documents revealed licensed nurses recorded wound/skin assessments weekly on a form entitled " Skin Condition Report Without Images. " The " Skin Condition Reports Without Images " for Resident	F 514		

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F 514	Continued From page 75 #23 were reviewed and revealed that licensed staff recorded conflicting documentation related to wound assessments as follows: "May 13, 2015 at 2:58 PM, Skin and Wound Update to Site - 340. Present on the Left Lower Buttocks is a Abrasion. The following findings were documented, Staging, Stage 3, Length in cm=2, Width in cm =1, Depth in cm=0.1, no odor is apparent, no drainage is apparent, Recent changes were made to the treatment orders for this site. This wound was not present on admission, Wound base is visible. Other color in wound base = 100%. General comments: New treatment order ... " " May 13, 2015 at 3:09 PM New (2nd recording) for Site 340. Present on the Left Lower Buttocks is a Pressure Ulcer. The following findings were documented, Unable to accurately stage - Slough and/or Eschar covered, Length in cm = 2, Width in cm = 1, Depth in cm = 0.1, no odor is apparent, no drainage is apparent, Wound base is visible, Slough tissue type = 100%, General Comments: New orders given ... " Facility staff failed to consistently document characteristics and status of skin impairment for Resident #23. 2. Facility staff failed to consistently document characteristics and status of abrasions, pressure ulcers and open areas for Resident #241 with multiple areas of skin impairment. According to the Skin Care Management policy No. 00035.01 The nursing staff performs skin assessments on admission and documents the	F 514	**F514** 1. Wound status inconsistently documented for Resident #23 and resident # 241. Employees counseled and given education regarding accurate and consistent documentation of wounds using wound protocol. No residents were affected by the inconsistent practices. 2. An audit was conducted for wound status documentation accuracy and consistency of all residents with a wound. 3. Clinical Managers will conduct a weekly audit of the medical record of all residents with wounds. The criteria for the audit will be added to the weekly Skin Integrity Audit Tool. All Clinical Managers will receive education as to how the audit tool is to be used. All nurses will receive re-education on using the wound protocol. 4. Data Analysis of the Skin Integrity tool will be discussed weekly at the Focus Quality Improvement meeting and reported quarterly by the QI manager to the Quality Improvement Team. A Wound Care competency has been developed. All Licensed Nurses will be administered the Wound Care Competency annually and must successfully pass the competency. 5. Compliance Date:	7/22/2015

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F 514	Continued From page 76 integrity on the skin. If there is disruption in skin integrity on admission then the area is measured and documented on the Decubitus Report sheet every week until healed. A review of the clinical record revealed that the resident was admitted to the facility on December 30, 2014 and discharged to another level of care on January 31, 2015. A review of the residents Skin Condition Report With Images sheet for date range from December 30, 2014 to January 31, 2015 revealed that the resident was assessed as having the following wounds: Left scapula (open); lower mid spine (thoracic) abrasion; lower spine (lumbar) abrasion; left upper buttock 3 x 4 x 0 centimeters; sacrum 6x7x0 cm; right lower buttocks 3.5x10x0 cm. Left Scapula - On January 14, 2015 there was no documentation recorded regarding the condition of the wound and the status of the area upon discharge; Lower mid spine- On January 7 and 14, 2015 there was no documentation recorded regarding the condition of the wound and the status of the area upon discharge; The lower spine (lumbar)- On January 7 and 14, 2015 there was no documentation recorded regarding the condition of the wound and the status of the area upon discharge; Left upper buttock- On January 31, 2015 there was no documentation recorded regarding the	F 514	1. There was a discrepancy of the ethnicity of resident #139 between their admission face sheet(s). The resident has dementia and is unable to verify the information. The resident's niece was contacted and has verified the ethnicity of the resident to be African-American. All corrections where applicable has been made. 2. No other resident's record was noted with similar discrepancies. Within 72 hours of all new admissions, the appropriate Social Worker will audit all Admission Face Sheets for accuracy. The Social Worker will verify the accuracy of information with the resident and/or the family, and will document the verification in the medical record. 3. The Social Worker will audit the Admission Face Sheet of all new admissions quarterly. The Director of Social Services will create an audit tool and will educate the Social Workers on the use of the audit tool. 4. The Director of Social Services will monitor the use of the audit tool and submit a quarterly report to the QI Manager. The QI Manager will report remarkable information gathered from the Admission Face Sheet audit tool quarterly to the QI Committee. 5. Compliance Date:	7/22/2015

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F 514	Continued From page 77 condition of the wound and the status of the area upon discharge; Sacrum - On January 31, 2015 there was no documentation recorded regarding the condition of the wound and the status of the area upon discharge; Right lower buttock- On January 31, 2015 there was no documentation recorded regarding the condition of the wound and the status of the area upon discharge; A face-to-face interview was conducted on May 22, 2015 at approximately 1:00 PM with Employee #8. After review of the above he/she acknowledged the findings. The record was reviewed on May 22, 2015. 3. Facility staff failed to accurately document the Resident # 139 ' s race. A review of the clinical record revealed Resident #139 was described on his/her Admissions information " Face Sheet in the ethnic background section as " African American " ...The Nursing Admission observation comments section written on November 24, 2014 at 17:24 documented " Resident is 85 year old male Caucasian new admitted ... " A review of the admission and annual physical examination form, history section documented " 85 year old Caucasian with PMH (past medical history) ... " The Minimum Data Set (MDS) dated December 25, 2014 section A. Identification information Section A 1000 Race /Ethnicity was coded as (c)	F 514		

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F 514	Continued From page 78 African American. A face-to- face interview was conducted with Resident# 139 ' s power of attorney on May 15, 2015 at approximately 11:00 AM. When queried he/ she stated that Resident is African American and that they have known each other over 20 years, Facility staff failed to accurately document Residents # 139 ' s Race and Ethnicity. A face-to-face interview was conducted with Employee #5 on May 15, 2013 at approximately 11:15 AM he/ she acknowledged the aforementioned findings. The clinical record was reviewed on May 15, 2015.	F 514		