

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

PRINTED: 04/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DEANWOOD REHABILITATION AND WELLNESS CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5000 BURROUGHS AVE. NE WASHINGTON, DC 20019</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A Quality Indicator Survey (QIS) recertification survey was conducted at your facility on February 18, 2014 through March 7, 2014. The following deficiencies are based on observations, record reviews, resident and staff interviews for 51 sampled residents.</p> <p>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:</p> <p>Abbreviations  AMS - Altered Mental Status  ARD - assessment reference date  BID - Twice- a-day  B/P - Blood Pressure  cm - Centimeters  CMS - Centers for Medicare and Medicaid Services  CNA- Certified Nurse Aide  CRF - Community Residential Facility  D.C. - District of Columbia  D/C discontinue  DI - deciliter  DMH - Department of Mental Health  EKG - 12 lead Electrocardiogram  EMS - emergency medical services (911)  g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning  ID - Intellectual disability  IDT - interdisciplinary team  L - Liter  Lbs - pounds (unit of mass)  MAR - Medication Administration Record  MD- Medical Doctor  MDS - Minimum Data Set</p>	F 000	Please begin typing your responses here:	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X8) DATE <i>5/9/14</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury 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 TAR - Treatment Administration Record	F 000			
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.  The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the	F 156	F-156  1. Retrospectively nothing can be done as there is no documentation to prove the resident received notice per regulations. The resident was not affected by this deficient practice.  2. To identify other residents having the potential to be affected by this deficient practice, a 100% audit of all current Medicare A residents was done on 4/24/2014.		

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F 156	<p>Continued From page 2</p> <p>time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;  A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p>	F 156	<p>3.To ensure the deficient practice does not recur, a new policy on the process for issuing Medicare notice of non-coverage benefits was developed and all Social Services staff will be educated on new policy by May 13, 2014. Ongoing monthly education will be done as well. A new audit tool has been developed by the Social Services Director.</p> <p>4. The new tool will be used to monitor and track findings which will be reported In April 's QAPI meetings and subsequent monthly QAPI meetings.</p>	5/13/14	

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F 156	<p>Continued From page 3</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for one (1) of 51 sampled resident, it was determined that facility staff failed to ensure that the " Notice of Medicare Non-coverage " letter was provided to Resident #19 ' s responsible party.</p> <p>The findings include:</p>	F 156		

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F 156	<p>Continued From page 4</p> <p>According to a " Physician History and Physical " dated September 6, 2013 revealed; [Resident #19] was admitted to the facility for rehabilitation and continuity of care status post a mechanical fall with a left hip fracture.</p> <p>A review of the clinical record revealed Resident #19 had reached his/her maximum potential for physical therapy and occupational therapy and was discharged from skilled services on September 30, 2013.</p> <p>A review of the clinical record was conducted and lacked evidence that a "Notice of Medicare Non-coverage" letter was submitted/provided to the Resident or Representative to give notification that the last day of Physical therapy and Occupational Therapy was September 30, 2013. Additionally, there was no documented evidence in the clinical record that verbal notification was provided.</p> <p>A face-to-face interview was conducted with Employee #38 on March 6, 2014 at approximately 9:15 AM. He/she stated, " I can ' t find a copy of the cut-letter that was mailed to the resident ' s responsible party. " He/she acknowledged that the appeal notice was not a part of the clinical record; or in his /her files.</p> <p>The record lacked documented evidence that</p>	F 156			

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F 156	Continued From page 5 facility staff ensured that the "Notice of Medicare Non-coverage" letter was submitted to the resident and/or responsible party, to indicate that notification was provided regarding physical therapy and occupational services ending on September 30, 2013.	F 156			
F 157 SS=E	<b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b>  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 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	F 157	<b>F-157</b>  1. Resident #402 no longer resides at the facility. Resident #145 and #290 did not have negative outcomes related to the deficient practice from the facility not notifying both the physician and the responsible party for refusal of dental examination. All concerns identified were addressed with the specific residents.  2. All residents have the potential to be affected by the deficient practice of not notifying both the physician and the responsible party of refusal for dental examinations. Nursing management will review resident's records to ensure that the physician and the responsible party will be notified of residents refusal for dental examination.  3. Licensed nurses will be educated on timely notification of resident's refusal for dental examination to physician and responsible party utilizing the SBAR. Licensed nurses will be educated to document resident refusal for dental examination on the 24-hour report in order for review of the SBAR (physician/family notification) in daily clinical meetings.		

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F 157	<p>Continued From page 6 legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for two (2) of 51 sampled residents, it was determined that facility staff failed to notify the responsible party [RP] of one (1) residents' refusal to have a dental exam, failed to notify physician and responsible party for one (1) resident's refusal to have a dental exam and one (1) resident's condition at admission (that the resident was experiencing respiratory difficulty and was cyanotic upon admission.) Resident #145, #290 and #402.</p> <p>The findings include:</p> <p>1. Facility staff failed to notify the responsible party [RP] for Resident #145's refusal to have a dental exam.</p> <p>A review of the facility's dental record for Resident #145 revealed a scheduled dental appointment on [January 6, 2014] with the word "refused" written in two (2) places on the form, the top right corner of the form and in the space designated for comments.</p> <p>There was no evidence in the clinical record of a reason for the refusal, nor was there evidence of notification of the RP.</p>	F 157	<p>4. Compliance with follow through will be monitored monthly through the QAPI process by nurse management to ensure compliance and to identify areas for further education as needed.</p>	5/13/14

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F 157	<p>Continued From page 7</p> <p>A face-to-face interview was conducted with Employee #9 on March 4, 2014 at approximately 10:30 AM. A query was made regarding notification of the family of the Resident #145 refusal to have a dental exam. Employee #9 acknowledged that the RP should have been notified of the refusal and that often times the dentist will place their evaluation in the medical record and it can be missed.</p> <p>Facility staff failed to notify the responsible party] of the residents ' refusal to have a dental examination.</p> <p>2. Facility staff failed to notify the physician and responsible party for Resident #290's refusal for dental examinations. During an isolated interview with Resident #209 ' s responsibility party on February 21, 2014 at approximately 12:45 PM. He/she expressed concern regarding no dental follow up for Resident #290 for one and one-half years (1 ½ years). According to the care plan; updated December 17, 2013 included the problem: " The resident has oral/dental health problems related to poor nutrition, missing teeth. Intervention: coordinate arrangements for dental care. "</p> <p>A review of the dental notes revealed the following:</p> <p>" April 22, 2013- " FMD- #28 OL Comp #29 to be determined</p>	F 157		

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F 157	<p>Continued From page 8</p> <p>April 30, 2013- Patient refused treatment September 11, 2013- Annual exam- Patient refused exam. "</p> <p>According to a nurses note -1314 (1:14 PM revealed: " Note Text: Residents care conference held today with Guardian in attendance. Residents chart reviewed to include areas of dental. "</p> <p>A review of the clinical record lacked evidence that the physician and the responsible party were notified that the resident refused his/her dental examinations.</p> <p>Facility staff failed to notify the physician and the responsible party that the resident refused dental examinations.</p> <p>A face-to-face interview was conducted with Employee #7 on February 28, 2014 at approximately 12:00PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on February 28, 2014.</p> <p>3. Facility staff failed to notify the attending physician of Resident #402's condition at admission (that the resident was experiencing respiratory difficulty and was cyanotic upon admission.)</p> <p>Per nursing documentation in the nursing note the resident was admitted to the unit at 7:15AM on 2/18/14 " with expiratory wheezes, barrel</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>chest, hyperventilating and using accessory muscles to breathe with respirations of 22. Bilateral hands and all fingers cyanotic. Both feet shiny and toes cyanotic. "</p> <p>Review of the Discharge Transfer Summary revealed that the resident was admitted to an area hospital on February 10, 2014 with diagnoses which included Atrial Fib and a blood clot in the heart. A review of the nurse ' s admission documentation which was written at 23:49 [11:49PM] on February 18, 2014 revealed the following: " Resident was discharged to [named] facility with the diagnoses of Supratherapeutic INR [International Normalized Ratio], Non-ST elevation, MI [Myocardial Infarction], CHF [Congestive Heart Failure] exacerbation, Acute on Chronic Kidney Disease, Dehydration, Afib. [Atrial Fibrillation], HTN [Hypertension], Moderate Pulmonary HTN [Hypertension], Hypoalbuminemia and Cataracts. ... Lung sounds noted with expiratory wheezing, noted with barrel chest. Resident is hyperventilating and [he/she] was using accessory muscles to breathe with respirations of 22. Resident is on oxygen 3l/min [three liters per minute] via NC [by way of nasal cannula for SOB [Shortness of Breath] ... Bilateral heels are noted with SDTI [Suspected Deep Tissue Injury]. ... Bilateral hands and fingers are cyanotic. Both feet are shiny and toes are cyanotic. ... All meds clarified with [named attending] and faxed to pharmacy. "</p> <p>A face-to-face interview was conducted with Employee #(Mohamed/Supervisor) at approximately 4:30PM on February 27, 2014. The employee acknowledged that he/she had</p>	F 157			

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F 157	Continued From page 10 notified the attending physician of the resident ' s admission and had clarified the medications with him/her. However, when queried whether he/she had notified the physician of the resident ' s condition " [Expiratory wheezing, noted with barrel chest. Resident is hyperventilating and [he/she] was using accessory muscles to breathe ... SOB [Shortness of Breath] ... Bilateral heels are noted with SDTI [Suspected Deep Tissue Injury]. ... Bilateral hands and fingers are cyanotic. [And] both feet are shiny and toes are cyanotic. " The employee stated, " No. I did not. " The employee offered no response to a further query of why he/she did not notify the physician of the resident ' s condition. The record was reviewed on February 25, 2014.  Facility staff failed to notify the attending physician of the resident ' s condition at admission (that the resident was experiencing respiratory difficulty and was cyanotic upon admission.)	F 157			
F 160 SS=E	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH  Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.  This REQUIREMENT is not met as evidenced by:  Based record review and staff interview for eight (5) of eight (8) closed records, it was determined that facility staff failed to convey within 30 days	F 160	F-160  1.The business office conveyed the funds and closed out the accounts of residents #T2, T3, T5, T5, and T8 by 3/21/ 2014.  2. An audit was conducted of all other discharged residents to ensure funds were conveyed within the 30 days. All other resident accounts were found to have this deficient practice funds were conveyed and accounts were closed.		

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F 160	<p>Continued From page 11</p> <p>the residents ' to the individual or probate jurisdiction administering the residents ' estate. Residents' # T2, T3, T5, T6, and T8.</p> <p>The findings include:</p> <p>1.Facility staff failed to convey Resident #T2 ' s funds and provide a final accounting within 30 days the residents' death.</p> <p>According to the Admission Census Record Resident #T2 expired on January 3, 2014 at [hospital].</p> <p>The " Trial Balance " dated February 19, 2014 revealed a " pending balance " of \$210.01</p> <p>2.Facility staff failed to convey Resident #T3 ' s funds and provide a final accounting within 30 days the residents' death.</p> <p>According to the Admission Census Record Resident #T3 expired on October 2, 2013.</p> <p>The " Trial Balance " dated February 19, 2014 revealed a " pending balance " of \$140.03</p> <p>3.Facility staff failed to convey Resident #T5 ' s funds and provide a final accounting within 30 days the residents' death.</p> <p>According to the Admission Census Record Resident #T5 expired on October 14, 2013.</p>	F 160	<p>3. The business office staff were all in-serviced on the deficient practice on April 23, 2014. An audit tool was created for the business office to utilize monthly in reporting to the QA committee. The business office will now report monthly and not quarterly any and all findings.</p> <p>4. The business office will conduct monthly audits of all discharged residents and findings will be reported to the monthly QAPI Committee.</p>	5/13/14

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F 160	Continued From page 12 The " Trial Balance " dated February 19, 2014 revealed a " pending balance " of \$70.75.  4. Facility staff failed to convey Resident #T6 ' s funds and provide a final accounting within 30 days the residents' death.  According to the Admission Census Record Resident #T6 expired on December 20, 2013.  The " Trial Balance " dated February 19, 2014 revealed a " pending balance " of \$1,011.75.  5. Facility staff failed to convey Resident #T8 ' s funds and provide a final accounting within 30 days the residents' death.  According to the Admission Census Record Resident #T8 expired on December 30, 2013.  The " Trial Balance " dated February 19, 2014 revealed a " pending balance " of \$620.60.  There was no evidence that Residents' #T2, T3, T5, T6, and T8 funds were conveyed within 30 days of the residents' death.  A face-to-face interview was conducted with Employee #24 on February 25, 2014 at approximately 12:23 PM. He/she acknowledged the findings. The records were reviewed on February 25, 2014.	F 160			
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166	F-166 1.GP1 is deceased, and GP4 is discharged from facility therefore retrospectively no corrective action can be done for either residents.		

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F 166	<p>Continued From page 13</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on a review of records and staff interview for four (4) of 51 sampled residents, it was determined that the facility failed to make prompt effort to resolve grievances made by the four (4) residents in a timely manner. Residents' # GP1, GP2, GP3, and GP4.</p> <p>The findings include:</p> <p>A review of the report of four (4) of 10 grievances presented by the facility revealed that the facility failed to resolve/conclude the investigations and or report the findings to the residents/responsible parties.</p> <p>1. On June 10, 2013, Resident GP1 filed a report of a missing \$10.00. The resident's report stated that he/she placed \$10.00 in an envelope in his/her drawer and later discovered the money missing. The facility documented in their report that the matter would be resolved by June 14, 2014. Under the heading of Action Taken the facility documented " Business Office notified. " However, at the time of the review of the grievances, March 6, 2014 there was no documented resolution of the matter.</p> <p>In response to a query regarding the resolution of the matter, Employee #44 acknowledged (during a face-to-face interview at 2:00PM on March 6, 2014) that the matter was never resolved.</p>	F 166	<p>GP2 will have either a replacement charger or monetary compensation for the amount of the charger. GP3 Will receive monetary compensation for missing clothing item.</p> <p>2. An audit of all other grievances and abuse log has been completed to ensure no other residents are affected by this deficient practice.</p> <p>3. The Director of Social Services has developed a new grievance policy and will in-service all social workers on the policy. The Administrator wrote an abuse prohibition policy and all employees were in-serviced on the policy and had to sign off on the acknowledgment sheet and all were placed in their employee files. Moving forward if abuse is identified in house the new policy and protocol will be implemented immediately and an in-service education, counseling, and/or termination will occur with reporting to the appropriate boards. All new hires will be in-serviced during orientation as to grievance and new abuse policy.</p> <p>4. The Social Services Director will report all deficient practices to monthly QAPI and QA Nurse will ensure compliance.</p>	5/13/14	

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F 166	Continued From page 14 2. On September 12, 2013 Resident GP2 reported missing his/her phone charger. A review of the documentation failed to reveal an investigation of the missing charger and the area designated for a completion date of the investigation was blank. A face-to-face interview was conducted with Employee #44 at approximately 2:00PM on March 6. The employee acknowledged that there was no documented resolution of the resident ' s complaint. 3. On November 19, 2013 Resident GP3 reported losing items of clothing. A review of the report failed to reveal any documentation regarding an investigation or a resolution of the matter. A face-to-face interview was conducted with Employee #44 at approximately 2:00PM on March 6. The employee acknowledged that there was no documented resolution of the resident ' s complaint. 4. A review of a report filed by a guardian for Resident GP4 revealed that the resident complained that a CNA pulled his/her sore arm. According to the Social Worker ' s documentation the resident stated that the CNA may not have known that he/she had recently had a port changed in the arm, that he forgave the CNA and did not want the matter pursued. A face-to-face interview was conducted with employee #38 at approximately 10:00AM on March 7, 2014. The employee stated the facility did not investigate the matter because the resident and the guardian asked that the matter be dropped.	F 166			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246	<b>F-246</b>  1. On February 25, 2014 when it was brought to the attention of the FNS Director and Dietician by surveyors as they spoke to resident #70 about food preferences. The resident's tray ticket was updated with additional preferences and preferred food items were delivered to the resident on the same day.		

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F 246	<p>Continued From page 15</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and record review for one (1) of 51 sampled residents, it was determined that the facility staff failed to ensure that Resident #70 received the foods that he/she preferred.</p> <p>The findings include:</p> <p>Facility staff failed to ensure that Resident #70 received the foods that he/she preferred.</p> <p>During a resident observation conducted on Monday February 25, 2014 at approximately 9:30 AM it was observed that the resident #70 had hot cereal and rice on his/her tray. The hot cereal was (grits). The LCS Renal slips indicated Dislikes/Do Not Serve: Hot Cereal, Rice...</p> <p>A face-to-face interview was conducted with the resident at the time of the observation. A query was made regarding eating his/her meal. He/she stated that he/she "did not want the food, they</p>	F 246	<p>2.An audit of residents with preference was conducted and no other resident was found to be affected by this same deficient practice. All Dieticians were provided a copy of diet cards to review menu preferences.</p> <p>3.An in-service on reading tray cards was done. The Dieticians will attend new resident orientation meetings with interdisciplinary team and identify menu preferences at that time. All Dieticians will be in-serviced quarterly and all newly hired dieticians will be trained upon hire. Test trays and meal rounds will be conducted weekly by the FNS Director.</p> <p>4. All findings will be reported by the FNS Director to report monthly to the QAPI Committee.</p>	5/13/14

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F 246	Continued From page 16 serve me what I do not like all the time."  According to the 2/21/14 17:32 Dietary Note: "[Registered Dietitian] RDN met with [Interdisciplinary Team] IDT and [relatives] to review resident's plan of care. RDN also met with resident at the bedside. Resident's dietary concerns were food preferences and the request to have meals re-heated when necessary. Food preferences obtained. Resident has requested cold cereal of any kind and coffee, no rice, string beans, hot cereals, sausage or magic cup...Nursing made aware of residents request to have food re-heated...will follow up next quarter."  A face-to-face interview was conducted with Employees #15 and 16, on February 25, 2014 at approximately 9:45 AM. Both observed that the resident received foods that were listed as disliked and acknowledged the findings. Employee #15 stated that "[he/she] will make sure that the resident gets the foods that the resident 's likes and that [he/she] will re-in-service [his/her] staff about the dislikes"	F 246			
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.	F 253	F253-1,2,3,5 &6  1.All privacy curtains found missing, torn, hanging off the hooks, were fixed immediately on February 25, 2014. The dusty blinds were cleaned the same day as well. The litter and debris behind washer was removed and drain pipes behind the washing machine were also cleaned the same day.		

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F 253	Continued From page 17  This REQUIREMENT is not met as evidenced by:  Based on observations made during an environmental tour of the facility on February 25, 2014 at approximately 11:00 AM and on February 26, 2014 at approximately 11:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by: hooks were loose or detached from the privacy curtains in five (5) of 43 resident's rooms; torn privacy curtains in two (2) of 43 resident's rooms; there were no privacy curtains in one (1) of 43 resident rooms; dusty window blinds in two (2) of 43 resident's rooms; the area behind the washing machine was unclean in one (1) of one (1) laundry room; and the toilet stall door was missing in one (1) of eight (8) shower rooms.  The findings include:  1. Privacy curtains were hanging off the hooks in resident rooms # 202 (Beds C and D), #223 (Bed A), #225 (Bed B), #402 (Beds A and D), and #417 (Beds B and C), five (5) of 43 resident's rooms surveyed.  2. Privacy curtains were torn in two (2) of 43 resident's rooms including rooms #417 (Beds A and D) and room #527(Bed A).  3. Window blinds were dusty in rooms #319, #324, #402, #404, and #417, five	F 253	2. Rounds were made on every unit to ensure the deficient practice was not on any other units. Administrator will conduct monthly rounds with Housekeeping Director beginning in April. Privacy curtains in stock were also examined to ensure deficient practice would not recur.  3. A carbonized schedule of all rooms was created for staff to clean each facility room. Staff were in-serviced on proper cleaning techniques on 3/20/14. Staff were in-serviced on privacy curtains deficiencies. A new QA tool was developed for housekeeping to utilize monthly and Report to QA. The schedules of the Housekeeping Director and Manger were changed to stagger staff and have more accountability during the day and evening shifts.  4. All deficient practices will be reported monthly to QAPI committee using new tool.  F253-#4 1. The bathroom staff in shower room stall was repaired by maintenance on 4/7/2014.	5/13/14	

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F 253	Continued From page 18 (5) of 43 resident's rooms surveyed.  4. The toilet stall door was missing to the shower room located on 5 South.  5. The area located behind the three (3) washing machines in the laundry room was littered with various debris, the drain pipes were covered with lint and the floor was soiled.  6. On February 26, 2014 at 10:20 AM three (3) of four (4) privacy curtains were missing in room 502.  These observations were made in the presence of Employee #30 who acknowledged the findings.	F 253	2. All other bathroom stall doors were evaluated by the Director of Maintenance no other stall doors were found with the same deficient practice.  3. The Maintenance Director will conduct weekly rounds to ensure all bathroom staff doors are maintained in good repair in all 8 shower rooms. A new QA audit tool was created. Maintenance staff assigned to each unit were In-serviced on putting maintenance Items into the Reqger system if they are unable to fix issues.  4. The new tool will be utilized by the Maintenance Director to report all findings monthly to the QAPI committee.	5/13/14	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272	F-272 #1 and #7  1. Section H 0300 of MDS 12/1/13 for resident #19 was modified on 2/28/14 to reflect the accurate urinary continence status during the look back period (2) frequently incontinent. Section H0300 of MDS 11/25/13 for Resident #348 was modified on 4/16/14 to reflect the accurate urinary continence status during the look back period (2) frequently incontinent. Section H0300 of MDS		

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F 272	<p>Continued From page 19</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for eight (8) of 51 sampled residents, it was determined that facility staff failed to accurately code one (1) resident quarterly [Minimum Data Set] MDS Assessment for ROM [ Range of Motion], code one (1) resident ' s quarterly Minimum Data Set (MDS) for the use of a psychotropic medication, code one (1) resident's quarterly MDS for Urinary Tract Infection and Range of Motion, accurately code the quarterly [Minimum Data Set] MDS for Section M: Skin Condition for one (1) resident, Section I: Active Diagnoses for one (1) resident and Section H: Urinary Incontinence for two(2) residents and one</p>	F 272	<p>2. All current residents most recent OBRA MDS will be audited for accurate coding of section H0300 per the RAI instructions. Corrections to MDS will be made accordingly</p> <p>3. MDS Coordinators will receive formal education on the accurate coding per the RAI guidelines. When completing the MDS, the MDS Coordinators will interview the resident, review the nursing clinical bladder Assessment as well as caret tracker reports Section H to determine the residents' urinary continence status. The prior MDS will be reviewed to determine if there was any change in continence. Discrepancies in findings and or changes in urinary continence status will be discussed with the Nursing team at Daily Clinical Meetings to determine the need for further evaluation and or intervention.</p> <p>4. MDS Coordinators will complete audits to include all OBRA assessments weekly x 4 then monthly until compliance is achieved. Audits and findings will be reported to QAPI.</p>	5/13/14

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F 272	<p>Continued From page 20</p> <p>(1) resident's quarterly MDS for goal setting . Residents #19, #50, #78, #290 , #311, #347, #348 and #399.</p> <p>The findings include:</p> <p>1.Facility staff failed to accurately code the admission Bladder and Bowel Evaluation Assessment, the quarterly Bladder and Bowel Evaluation Assessment and the MDS. Resident #19.</p> <p>A review of the initial (admission) Bladder and Bowel Evaluation Assessment report dated September 5, 2013, revealed that the resident was coded as being continent of urine under ' Continance Status ' .</p> <p>Question ' g ' under ' Continance Status ' asked: " Has there been a recent change in continence status " and it was answered " no " . Question ' i ' asked for a " summary of resident ' s current level of incontinence " and it was answered " continent "</p> <p>A review of the quarterly Bladder and Bowel Evaluation Assessment report dated December 5, 2013 indicate that the resident was coded as being incontinent of urine under the same section.</p> <p>Question ' g ' under ' Continance Status ' asked: " Has there been a recent change in continence status " and it was answered " no " . Question ' i ' asked for a " summary of resident ' s current level of incontinence " and it was</p>	F 272	<p><b>F-272 #2 and #4</b></p> <p>1. Section O 0500 a+b, of MDS 12/30/13 for Resident #50 was modified on 4/16/14 to reflect the accurate number of days the resident received AROM in the look back.(4) Section O 0500 a+b of MDS 1/17/14 for resident # 290 was modified on 2/29/14 to reflect the accurate number of days the resident received AROM in the look back.(7)</p> <p>2. All current residents most recent OBRA MDS will be audited for accurate coding of Section O0500 per RAI instructions. Corrections will be made accordingly. All current residents' Restorative Programs will be audited for all components of documentation are present to include Care tracker entries, Restorative evaluation notes monthly and care planning.</p> <p>3. MDS Coordinators and Restorative Nurse will receive formal education on the restorative components required to qualify for coding on the MDS per RAI Guidelines. MDS Coordinators will review the Care tracker restorative reports, monthly notes and care plan to ensure all components are present to ensure accurate coding of the MDS. Restorative Nurse will pull Group Restorative Report daily and review residents participation with the Clinical team at the Daily Clinical Meetings to determine the need for further evaluation and or intervention.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>DEANWOOD REHABILITATION AND WELLNESS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5000 BURROUGHS AVE. NE WASHINGTON, DC 20019</b>		
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F 272	<p>Continued From page 21 answered " unchanged " .</p> <p>A review of the admission MDS for Resident #19 dated September 12, 2013, revealed that subsection H0300 of section H - Bladder and Bowel, #2 was flagged to indicate that the resident is ' frequently incontinent ' . On the quarterly MDS dated December 5, 2013, in subsection H0300 of section H - bladder and Bowel, #3 was flagged to indicate that the resident is ' always incontinent ' .</p> <p>In a face to face interview with Employee #12 was conducted on February 28, 2014 at approximately 1:00 PM. He/she admitted that the resident has always been incontinent of urine since he/she was admitted and the Bladder and Bowel Evaluation Assessment report was wrongly coded. When told that the admission MDS for resident #19 was coded a ' 2 ' (frequently incontinent) and the quarterly MDS coded a ' 3 ' (always incontinent), Employee # (MDS) responded that it was a mistake.</p> <p>There was no evidence that facility staff accurately coded Resident #19's incontinence status on the initial Bladder and Bowel Evaluation Assessment, the quarterly Bladder and Bowel Evaluation Assessment and on the Admission (MDS).</p> <p>Further review of Resident #19 ' s medical records show that a care plan ' The resident has an ADL (Activities of Daily Living) Self Care performance deficit r/t limited mobility, pain " states that " the resident is totally dependent on staff for toilet use " The care plan was initiated on September 12, 2013. The record was</p>	F 272	<p>4. Restorative Nurse will complete audits to include all OBRA assessments , Care Tracker, Monthly notes and Care plans weekly x 4 then monthly until compliance is achieved. Audits and findings will be reported to QAPI.</p> <p><b>F-272 #3</b></p> <p>1. Section N0410 a,b,c,d of MDS 9/8/13 and 12/2/13 for Resident #78 were modified on 4/18/14 to reflect the accurate coding of the number of days the resident received Antidepressants in the look back. (7)</p> <p>2. All current residents receiving psychotropic medications most recent OBRA MDS will be audited for accurate coding of Section N0410 per the RAI instructions. Corrections will be made to the MDS accordingly.</p> <p>3. MDS Coordinators will receive formal education on the accurate coding of Section N per the RAI guidelines; to include the various classifications of Psychotropic medications when completing the MDS the MDS Coordinators will review the physician orders and MAR to determine the accurate number of days the resident received medications.</p> <p>4. MDS Coordinators will complete audits to include all OBRA assessments weekly x 4 then monthly until compliance is achieved. Audits and findings will be reported to QAPI.</p>	5/13/14	

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F 272	<p>Continued From page 22 reviewed during the week of February 24, 2014.</p> <p>2. Facility staff failed to accurately code Resident's #50 quarterly MDS Assessment for ROM.</p> <p>A review of resident #50 's History of Present illness for March, 2014 revealed diagnosis of End Stage Renal Disease, Diabetic without complication type 2/ Unspecified not stated uncontrolled, Unspecified Quadriplegia, Acute but ill-defined Cerebrovascular disease, Unspecified infantile Cerebral Palsy, Unspecified Essential Hypertension, Paraplegia, Unspecified Glaucoma, Esophageal Reflux, Unspecified Anemia, Insomnia unspecified, Renal Dialysis Status, Unspecified Backache and Spinal Stenosis, Lumbar region without nuerogenic claudication.</p> <p>Review of the quarterly MDS assessment dated December 30, 2013 revealed that Section O0500 Restorative Nursing Program was coded " B. Range of motion (Active) - 4 days and A. Range of motion (Passive) - 0 days " . The program coded " 0 is indicative that restorative service for Range of motion (Passive) was not provided."</p> <p>The "Restorative Nursing Orders found on the active record revealed the following:</p> <p>April 3, 2013 directed, " Passive Range of Motion to all 4 extremities, 5 - 10 reps as tolerated during AM/PM care- complex. "</p> <p>December 30, 2013 directed, " Passive Range of Motion to b/l [bilateral] upper extremities at</p>	F 272	<p><b>F-272 #5</b></p> <ol style="list-style-type: none"> <li>Section I of MDS 1/24/14 for Resident # 311 was modified on 4/16/14 to reflect the Active Diagnosis in the look back.(HTN, Seizures,agitation)</li> <li>All current residents most recent OBRA MDS will be audited for accurate coding of Section I per the RAI instructions. Corrections will be made to the MDS accordingly.</li> <li>MDS Coordinators will receive formal education on the accurate coding of Section I active diagnosis. MDS will review the physician orders, consults , physician progress notes to determine the residents' active diagnosis that impact current functional ,psychosocial and medical status in the look back to ensure accurate coding. section I in MDS software will be reviewed prior to closing to ensure all applicable diagnosis pulled over and all non-applicable diagnosis are unchecked.</li> <li>MDS Coordinators will complete audits to include all OBRA assessments weekly x 4 then monthly until compliance achieved Audits and findings will be reported to QAPI.</li> </ol>	5/13/14

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F 272	<p>Continued From page 23</p> <p>each joint (shoulders, elbows, wrist, fingers) w/2x10 reps of flexion/extension as tolerated - complex. "</p> <p>December 31, 2013 directed, " Passive Range of Motion to b/l [bilateral] lower extremities 15 reps x 3 sets all shifts 7days/wk - complex</p> <p>The evidence revealed that facility staff failed to accurately code the quarterly MDS Section O0500 Restorative Nursing Services as " A. Range of motion (Passive) ". The MDS was coded " Range of motion (Active) " .</p> <p>A face-to-face interview was conducted on February 27, 2014 with Employee # 8 at approximately 11:50AM. He/she acknowledged the findings. The record was reviewed on February 27, 2014.</p> <p>3. Facility staff failed to code Resident #78's quarterly Minimum Data Set (MDS) for the use of a psychotropic medication.</p> <p>A review of the resident ' s clinical record revealed that the resident ' s diagnoses included Schizophrenia, Paranoid Type, Unspecified and Depression. The medications included Remeron 30mg q (every) HS (Hour of Sleep) for depression and Haldol 2 (two) mg q 12 hours for agitation.</p> <p>Review of Section N (Medications) of the quarterly MDS for September 8, 2013 and the quarterly MDS for December 2, 2013 revealed that both documents were coded 0 (zero) in response to the statement, " Indicate the number of days the resident received the following</p>	F 272	<p><b>F-272 #6</b></p> <p>1. Sections M 0300D, 0610, 0700,0800, 0900,1200 of MDS 1/22/14 for resident #347 was modified on 3/8/14 to reflect the accurate coding of 2 stage 4 pressure ulcers.</p> <p>2. All current residents with pressure ulcers most recent OBRA MDS will be audited for accurate coding per RAI instructions. Corrections to the MDS will be made accordingly.</p> <p>3. MDS Coordinators will receive formal education on the accurate coding of Section M , Skin Conditions per the RAI Guidelines. MDS Coordinators will review Nursing Admission Assessments , Pressure Ulcers UDAs, treatment records and interview nurse to determine the accurate staging and coding of pressure ulcers. The prior MDS will be reviewed to determine if present areas worsened or healed. Discrepancies in wound documentation will be discussed with the Nursing team at Daily Clinical meetings to determine the need for further evaluation and or intervention.</p> <p>4. MDS Coordinators will complete audits to include all OBRA assessments weekly x 4 then monthly until compliance is achieved. Audits and findings will be reported to QAPI. 5/13/14</p>	5/13/14	

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F 272	<p>Continued From page 24</p> <p>medications during the last 7 (seven) days or since admission/entry or reentry if less than 7 days. " The medications were identified as: A. Antipsychotic, B. Antianxiety, C. Antidepressant and D. Hypnotic. Each of the aforementioned medications was coded with a zero to indicate that the resident never received any of the medications. However, review of the " Consolidated Orders Report " (Physicians Order Sheet) revealed that the order for Haldol was received on February 4, 2013 when the resident was first admitted to the facility and the order for Remeron 30mg oral (by mouth) once daily every day for Depression with poor appetite was first ordered by the Certified Registered Nurse Practitioner on October 10, 2013.</p> <p>A face-to-face interview was conducted with Employee # (Ms. Watson) at approximately 3:50PM on March 4, 2014. The employee reviewed the MDS documentation and acknowledged the finding. The record was reviewed on March 4, 2014.</p> <p>4. A. Facility staff failed to accurately code the quarterly MDS for a UTI (Urinary Tract Infection and Range of Motion) for Resident #290.</p> <p>During a review of the quarterly MDS dated January 17, 2014, it was noted that Section I (Active Diagnoses) was not coded to indicate that Resident #290 had a UTI.</p> <p>According to a physician ' s interim order dated October 11, 2013 at 1930 (7:30 PM) directed: " Cipro 250mg [via] GT (Gastrostomy Tube) BID (twice a day) [times] 5 (five) days for UTI</p>	F 272	<p><b>F-Tag 272 #8</b></p> <p>1.To correct the identified deficiency for Resident #399 dated 2/21/14 in section Q0300 (Resident's overall expectation for discharge), the assessment was modified on the date of notice, 4/16/14 to accurately reflect the resident's expectations to be discharged back to the community.</p> <p>2.To identify other residents having the potential to be affected by the same deficient practice a 100% Medicare audit of section Q0300 was done for all residents and no other residents were affected by this deficient practice.</p> <p>3.Social Services Department was provided education by the Corporate MDS Nurse on the correct process for completing section Q0300 of the MDS. Additionally, a new audit tool has been developed to provide ongoing monitoring of this issue.</p> <p>4. Section Q0300 will be audited monthly to ensure the section accurately reflects the residents expectation of discharge to the community. Findings will be brought to the monthly QAPI committee meetings.</p>	5/13/14	

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F 272	<p>Continued From page 25</p> <p>A review of the Medication Administration Record (MAR) for the month of October 2013, revealed that Resident #290 was administered Cipro 1 tablet by mouth daily for five (5) days.</p> <p>A face-to-face interview was conducted with Employees #12 and #13 on February 28, 2014 at approximately 12:00 PM. Both acknowledged that the original MDS was incorrectly coded in Section I (Active Diagnoses) for UTI.</p> <p>There was no evidence that the quarterly MDS dated January 17, 2014 was accurately coded for UTI. The record was reviewed on February 28, 2014.</p> <p>B. Facility staff failed to accurately code the quarterly MDS for range of motion for Resident #290.</p> <p>During a review of the quarterly MDS dated January 17, 2014, it was noted that Section O (Special Treatments and Programs) was not coded to indicate that Resident #290 was receiving range of motion to upper and lower extremities.</p> <p>According to the physician ' s orders dated December 31, 2013 directed: " Restorative Nursing Orders: Active Assist range of motion to [bilateral] upper and lower extremities, 5-10 reps as tolerated during AM/PM Care. "</p> <p>A review of the restorative log sheet reflected that Resident #290 was receiving range of motion seven (7) days of week.</p> <p>There was no evidence that facility staff coded</p>	F 272		

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F 272	<p>Continued From page 26</p> <p>the resident for range of motion on the quarterly MDS.</p> <p>A face -to-face interview was conducted with Employees #12 and #13 on February 28, 2014 regarding the aforementioned findings. The clinical record was reviewed on February 28, 2014.</p> <p>5. Facility staff failed to code Resident #311 ' s Quarterly [Minimum Data Set] MDS Section I: Active diagnoses for Seizure Disorders, [Hypertension] HTN, and Agitation.</p> <p>According to the History and Physical (H&amp;P) conducted on February 7, 2014 the resident was admitted with the following diagnoses which included: Falls, AMS [Altered Mental Status], Alzheimers, HTN, Seizure Disorders, Dyslipidemia, Cataract, Debility, Glaucoma.</p> <p>According to the [Medication Administration Record] MAR within the last seven days the received medications which included: Aricept, Ativan (agitation); Cozar (HTN); Keppra: seizure, Primidone: seizure, Tegretol: seizure ... "</p> <p>Review of the residents quarterly MDS with an Assessment Reference Date [ARD] of January 24, 2014 lacked coding in Section I Active Diagnoses to include HTN, Seizure Disorder, and Agitation.</p> <p>A face-to-face interview was conducted with Employee #12. After review of the above and</p>	F 272			

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F 272	<p>Continued From page 27</p> <p>the quarterly MDS he/she acknowledged the findings.</p> <p>6. Facility staff failed to accurately code the quarterly [Minimum Data Set] MDS for Section M: Skin Condition. Resident #347</p> <p>According to the Admissions Note dated September 12, 2013 21:34 " Resident was admitted to the unit ...Lt [left] buttock observed with open area 2.5cm [centimeter] x [by] 3.5cm, no drainage ... "</p> <p>According to the facility ' s Initial Quality Assurance: Skin Integrity Assessment dated September 13, 2013 " ...Left ischium, un-stageable wound measured 3x2.5x0 50% red, 50% black, no exudates, the wound bed moist, no foul odor present. Treatment [Tx] Hydrocolloid every 2 days x PRN [As needed].</p> <p>According to the " Pressure Ulcer Evaluation form " dated January 15, 2014 the resident was admitted with a " Community Acquired left ischium [under the left buttock area], stage 4 measuring 4.5cm [centimeter] length; 2.9cm width and 0.7 depth. Serous: clear or light-yellow in color thin watery exudates, with moderate: drainage on old dressing is the same size as the wound bed; no odor, [around] peri-wound intact, wound bed hyper-granulated; wound edges defined, no tunneling, no undermining.</p>	F 272			

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F 272	<p>Continued From page 28</p> <p>According to the most recent " Pressure Ulcer Evaluation form " date January 22, 2014 the resident was admitted with a " Community Acquired left ischium [under the left buttock area], stage 4 measuring 4.2cm [centimeter] length; 2.1cm width and 1 depth. Exudate: type/color Serous: clear or light-yellow in color thin watery; amount: minimal/small drainage, smaller than size of the wound bed; peri-wound intact, wound bed 100% granulated, wound edges defined, no tunneling, no undermining ...</p> <p>Review of the Quarterly MDS with an [Assessment Reference Date] ARD of January 22, 2014 Section M: Skin condition revealed the following:</p> <p>M0210: Unhealed Pressure Ulcer(s) was coded " 0 " indicating " No " and to skip to M0900, Healed Pressure, which indicated:</p> <p>M0900: Healed Pressure Ulcers A. Were ulcers present on the prior assessment (OBRA or scheduled PPs) was coded 1 " yes ". Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage the prior assessment (OBRA) or scheduled), enter " 0 " D. stage 4 the number entered was " 2 "</p> <p>However, M0300: current Number of Unhealed Pressure Ulcers at Each Stage was left blank; D</p>	F 272		

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F 272	<p>Continued From page 29</p> <p>stage 4: Full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling , was left blank.</p> <p>M0610. Dimensions of unhealed Stage 3 or 4 Pressure Ulcers or Eschar was left blank; M0700. Most severe Tissue Type for Any Pressure Ulcer was left blank M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPs) or last Admission/entry or Reentry (complete only if A0310E=0) was left blank. M1200. Skin and Ulcer Treatment: B. Pressure reducing device for bed was left unchecked.</p> <p>Face-to-face interview was conducted with Employee #13 on March 4, 2014 at approximately 3:20 PM. After review of the above Sections of the quarterly MDS Employee #13 acknowledged that the area were coded incorrectly and acknowledged the findings.</p> <p>7. Facility staff failed to accurately code Resident #348 's quarterly MDS Section H0300 for Urinary Incontinence.</p> <p>According to the initial Bladder and Bowel Evaluation dated September 12, 2013 the resident was evaluated as continent of urine on admissions (9/12/13). Predisposing diagnosis: Diabetes; resident is alert, vision adequate, does not request toileting, (Assistive Devices) bedpan,</p>	F 272		

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F 272	<p>Continued From page 30 upon admissions...Mobility: Transfer status/sit and stand, requires one [1] person assist..., no contractures...Bladder History: always continent... Bladder Evaluation Summary: Bladder Evaluation Summary: (not checked)</p> <p>According to the quarterly Bladder and Bowel Assessment: dated December 12, 2013: The resident is continent of urine...there has been no change in continence status .... Pre-disposing diagnosis: Diabetes; Communication: alert and oriented, Assistive Devices: wheelchair; Transfer Status: sit/stand, 1 [one] person assist...no contractures. Bladder history: occasionally incontinent (less than 7 episodes/week). Diagnosis contributing to urinary incontinence: CVA [Cerebral Vascular Accident]/Stroke, Diabetes...Bladder Evaluation Summary: continent.</p> <p>According to the Admissions MDS [Minimum Data Set] with ARD [Assessment Reference Date] of September 19, 2013 Section H0300 Urinary Continence the resident was coded (2) for Frequently Incontinent, Section G: toilet use: 3/extensive assistance 2/one person assist 9/19/13</p> <p>According to the Quarterly MDS with an ARD date of November 25, 2013 Section H0300 Urinary Continence the resident was coded (3) for Always Incontinent. Section G: Functional status toilet use was coded 4/ total dependent and 2/one person assist 11/25/13</p>	F 272		

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F 272	<p>Continued From page 31</p> <p>According to the CT [Care tracker] the resident had six (6) days of continent voiding and three (3) to four (4) days of night time incontinence. For coding to reflect "always continent", there are no episodes of continent voiding.</p> <p>A face-to-face interview was conducted with Employee #9 (the UM.) He/she stated "upon admissions the resident was incontinent of urine, to my recollection the resident became continent around November. The resident was not on a toileting program, staff would assist [him/her]"</p> <p>A face-to-face interview was conducted with Resident #347 on February 25, 2014 at approximately 10:00 AM the resident stated that "[he/she] was incontinent upon admissions, but can use the bathroom now and is continent of bladder and bowel."</p> <p>A face-to-face interview was conducted on February 27, 2014 at approximately 11:30 AM with Employee #12. A query was made regarding the coding of Section H Urinary Continence status of the resident and how is information gathered in order to the completed the MDS. He/she stated that "the MDS Coordinator will ask the CNA of the status at that time."</p> <p>8. Facility staff failed to accurately code the Minimum Data Set (MDS) as it relates to goal setting for Resident #399.</p> <p>A review of the clinical record for Resident #399</p>	F 272		

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F 272	<p>Continued From page 32</p> <p>included documentation that conveyed the resident ' s expectation for community discharge as follows: a social work admission assessment dated February 18, 2014 included, " ...Discharge Planning- [Resident] is a short stay admission. "</p> <p>According to a social services note dated February 21, 2014- 08:54 revealed; " ... Resident has equipment (hospital bed, wheelchair, lift) and is currently [obtaining home] health services, but wishes to utilize another home health company. Per, [responsible party named], resident is short term care and will be returning back to the community after treatment. "</p> <p>A review of the admission MDS dated February 21, 2014 in Section Q0300 (Resident ' s Overall Expectation) was not coded to reflect the resident ' s expectation to be discharged back to the community. The clinical record lacked evidence of a discharge care plan.</p> <p>A face-to-face interview was conducted with Employee #13 on February 28, 2014 at approximately 1:30 PM. He/she acknowledged the admission MDS should have been coded for returning back to the community.</p> <p>The admission MDS of February 2014 failed to accurately convey the resident ' s desire for return to the community. The clinical record was reviewed on February 28, 2014.</p>	F 272			
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's</p>	F 279	<p><b>F-279</b></p> <p>1. Resident # 401 no longer resides at the facility. None of the other residents identified had negative outcomes related to the deficient practices of initiating care plans with appropriate goals and approaches. All concerns were addressed with residents #50, #121, #222, #265 and #316.</p>		

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F 279	<p>Continued From page 33 comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview for six (6) of 51 sampled residents, it was determined that the facility staff failed to initiate a care plan with appropriate goals and approaches for one (1) resident use of bilateral resting hand splint, assessment and follow up care of dialysis access site pr and post dialysis and dependent feeding, one (1) resident for assessment with follow up care of dialysis access site pre and post dialysis and nine (9) or more medications to address the potential for adverse drug interactions and one (1) resident for restorative nursing program; and failed to develop a care plan for management of a Right Upper Arm PICC [Peripherally Inserted Central] Line for one (1) resident. Based on record review</p>	F 279	<p>2. All residents have the potential to be affected by the deficient practice of not initiating care plans with appropriate goals and approaches. Care plan education has been provided to license nursing staff by nursing administration and staff development.</p> <p>A. Nursing management and restorative nursing will review resident's records to ensure that restorative nursing care plans address splinting devices, as appropriate and identify areas of education as needed.</p> <p>B. Nursing management will review resident records to ensure that ADL care plans addresses resident's needs for assistance with feeding, make updates as necessary, and identify areas of education as needed. Ensure that staff is aware and adhering to plan of care.</p> <p>C. Nursing management will review residents records to ensure that dialysis care plans are initiated with appropriate goals and approaches, including assessment and follow up care of dialysis access site, pre and post dialysis.</p> <p>D. Nursing management will review resident's record to ensure that Poly- pharmacy care plans are initiated with appropriate goals and approaches addressing the potential for drug interaction. Care plans will be updated as necessary and education to be provided as needed.</p> <p>E. Nursing management will review resident's records to ensure care plans are developed to address resident's refusal to the use of nicotine patch. Social work, medical and nursing will provide education to residents regarding the benefits of nicotine patch. Make updates as necessary and identify areas of education as needed.</p>		

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F 279	<p>Continued From page 34</p> <p>and staff interview for one (1) of 43 sampled residents, it was determined that facility staff failed to develop a care plan with goals and approaches to address: The use of CPM (Continuous Passive Motion) machine to treat one (1) resident as ordered by the physician. Residents' #50, #121 and #222, 265, 316 and 401.</p> <p>The findings include:</p> <p>1A. Facility staff failed to initiate a care plan with appropriate goals and approaches for one resident use of bilateral resting hand splint. Resident #50</p> <p>A review of resident #50 's History of Present Illness for March, 2014 revealed diagnosis of End Stage Renal Disease, Diabetic without complication type 2/ Unspecified not stated uncontrolled, Unspecified Quadriplegia, Acute but ill-defined Cerebrovascular Disease, Unspecified infantile Cerebral Palsy, Unspecified Essential Hypertension, Paraplegia, Unspecified Glaucoma, Esophageal Reflux, Unspecified Anemia, Insomnia unspecified, Renal Dialysis Status, Unspecified Backache and Spinal Stenosis, Lumbar region without Nuerogenic Claudication.</p> <p>Physician ' s orders Sheet for March, 2014 revealed that the "Restorative Nursing Order dated December 30, 2013 directed, " Apply b/l</p>	F 279	<p>F. Nursing management will review all care plans on residents with PICC lines on proper documentation including goals and approaches, to manage focused areas of a PICC line. Updates will be made when necessary and education to be provided as needed. G. Nursing management will review all residents' records for care plan initiation, which have an order for a CPM machine and proper documentation to include the daily use and management of the CPM machine.</p> <p>3.A. Nursing management and staff development has provided in-servicing on care planning to licensed nurses and restorative nursing. Residents care plan have been initiated to reflect appropriate goal and approaches for the use of splinting. Care plans to be audited by restorative nursing to ensure completion and compliance. B. Care plans have been initiated with appropriate goals and approaches to include assessments and follow up care of dialysis access site pre and post dialysis. Care plans to be audited by nursing management weekly to ensure completion and compliance. C. ADL care plans have been developed with appropriate goals and approaches to address assistance with feeding to dependent residents. Education was provided to license nursing staff on care plan development and updates. ADL care plans will be audited by nursing management weekly to ensure completion and compliance.</p>	

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F 279	<p>Continued From page 35</p> <p>resting hand splints daily to be worn every 6 hours on , 2 hours off during each shift as tolerated without redness or skin breakdown, except during ADL ' s ongoing - Complex. "</p> <p>There was no evidence in Resident # 50 ' s chart that a care plan was initiated with goals and approaches for the use of bilateral hand resting splint.</p> <p>A face-to-face interview was conducted on February 27, 2014 with Employee # 8 at approximately 11:55AM. He/she acknowledged the findings. The record was reviewed on February 27, 2014.</p> <p>1B. Facility staff failed to initiate a careplan with appropriate goals and approaches for assessment and follow up care of dialysis access site pre and post dialysis. Resident #50</p> <p>A review of resident #50 ' s history of present illness for March, 2014 revealed diagnosis of End Stage Renal Disease, Diabetic without complication type 2/ Unspecified not stated uncontrolled, Unspecified Quadriplegia, Acute but ill-defined Cerebrovascular Disease, Unspecified infantile Cerebral Palsy, Unspecified Essential Hypertension, Paraplegia, Unspecified Glaucoma, Esophageal Reflux, Unspecified Anemia, Insomnia unspecified, Renal Dialysis Status, Unspecified Backache and Spinal Stenosis, Lumbar region without Nuerogenic Claudication</p> <p>A review of the physician order on " the Consolidated Orders (Chart) Report " for</p>	F 279	<p>D. Poly pharmacy care plan was initiated with appropriate goals and approaches to address the potential for adverse drug interactions. Medication review was done by physician and pharmacist consultants and recommendation as appropriate. Nursing Management will conduct weekly audits for completion and compliance, make updates as necessary, and provide education as needed. E. Care plan initiated to address residents refusal to the use of nicotine patch. Nicotine patch discontinued by the physician due to resident's refusal. Educated residents on the importance of cessation. Nursing management to conduct audit weekly to ensure appropriate documentation and completion. F. Policy and procedures and documentation for central lines were reviewed by Nursing Administration. All residents with central line care plans were reviewed by Nursing Administration for proper documentation including goals and approaches to manage focused areas of PICC Line. Audits will be performed weekly by Nursing Management to ensure proper documentation, completion and compliance. G. Care plan for CPM machine was initiated which addressed daily use and management of the CPM machine. Education was given to nursing staff by the Therapy Department on the daily use and management of the CPM machine. Continued education will be given to licensed nursing staff prior to any prospective admission to the facility with an order of the application and use of a CPM machine. Audits will be performed weekly by Nursing Management when there is an order for the use and application of a CPM machine to ensure compliance.</p>		

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F 279	<p>Continued From page 36</p> <p>February 2014 revealed a order that directs, " Dialysis: Mondays, Wednesdays, Fridays - once daily Specific days of week: Mon Wed Fri [Monday Wednesday Friday] "</p> <p>There was no evidence that a care plan was initiated with goals and approaches for assessment and follow ups care of dialysis access site pre and post dialysis found in Resident # 50 ' s chart.</p> <p>A face-to-face interview was conducted on February 25, 2014 with Employee # 8 at approximately 9:30AM. He/she acknowledged the findings. The record was reviewed on February 25, 2014.</p> <p>1C.Facility staff failed to initiate a care plan with appropriate goals and approaches for one resident dependent feeding. Resident #50</p> <p>A review of resident #50 ' s history of present illness for March, 2014 revealed diagnosis of End Stage Renal Disease, Diabetic without complication type 2/ Unspecified not stated uncontrolled, Unspecified Quadriplegia, Acute but ill-defined Cerebrovascular Disease, Unspecified infantile Cerebral Palsy, Unspecified Essential Hypertension, Paraplegia, Unspecified Glaucoma, Esophageal Reflux, Unspecified Anemia, Insomnia unspecified, Renal Dialysis Status, Unspecified Backache and Spinal Stenosis, Lumbar region without Nuerogenic Claudication</p> <p>A review of dietary quarterly notes dated October 8, 2013 revealed a note that reads, " ... Renal diet and nepro supplement tolerated 75 - 100% as staff assist with feeding ... "</p>	F 279	<p>4. Audits will be reviewed by Nursing Administration on a weekly basis. Compliance with follow through will be monitored monthly through the QADI process by the QAPI department/ Nurse. Education will be provided as needed.</p>	5/13/14	

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F 279	<p>Continued From page 37</p> <p>On February 28, 2014 resident# 50 was observed in his/her assigned room seated in a geri-chair. His/her post dialysis snack was on the table. Resident asked this surveyor " if you do not mind can you give me the drink on the table and leave the sandwich for later. " Employee#8 called staff to assist resident.</p> <p>There was no evidence a careplan was initiated with goals and approaches for resident #50 ' s dependent feeding.</p> <p>A face-to-face interview was conducted on February 28, 2014 at approximately 11:55AM with Employee # 8. He/she acknowledged the findings. The record was reviewed on February 28, 2014.</p> <p>2A. Facility staff failed to initiate a careplan with appropriate goals and approaches for assessment with follow up care of dialysis access site pre and post dialysis. Resident #121</p> <p>A review of resident #121 ' s History of Present Illness dated November 29, 2013 revealed diagnosis of End Stage Renal Disease on dialysis, Diabetes, Hypertension, Coronary artery disease status post by pass graft, Anemia, hyperlipidemia and delusional depressive disorder.</p> <p>A review of the physician order on " the Consolidated Orders (Chart) Report " for February 2014 revealed a order that directs, " Dialysis: Tuesdays, Thursdays, Saturdays - once daily Specific days of week "</p>	F 279		

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F 279	<p>Continued From page 38</p> <p>There was no evidence that a care plan was initiated with goals and approaches in Resident # 121 ' s chart for assessment with follow up care of dialysis access site pre and post dialysis.</p> <p>A face-to-face interview was conducted on February 25, 2014 at approximately 10:50AM with Employee #8. He/she acknowledged the findings. The record was reviewed on February 25, 2014.</p> <p>2B. Facility staff failed to initiate a care plan with appropriate goals and approaches for nine (9) or more medications to address the potential for adverse drug interactions for Resident #121.</p> <p>A review of the resident ' s Physician Order Form dated and signed by the physician on February 3, 201 revealed that the resident is on the following medications: Claritin, Mucinex, Diabetic Robitussin, Diphenhydramine, Risperidone, Trental, Humalog (Insulin Lispro (Human), Tylenol, Docusate Sodium, Zithromax, Aspirin, Cozaar, Lipitor, Omeprazole, Remeron, Ambien, Calcium carbonate-vitamin-D, Coreg, Albuterol, Tylenol #3.</p> <p>There was no evidence that a care plan was initiated with goals and approaches to address the potential for adverse drug interactions associated with the use of nine (9) or medications found in resident # 121 ' s chart.</p> <p>A face-to-face interview was conducted on February 25, 2014 at approximately 10:50AM</p>	F 279		

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F 279	<p>Continued From page 39 with Employee # 8. He/she acknowledged the findings. The record was reviewed on February 25, 2014.</p> <p>3. Facility staff failed to initiate a care plan with goals and approaches for restorative care for Resident #222.</p> <p>A review of the medical record revealed that Resident #222 was admitted to the facility on September 20, 2013 with diagnoses of CHF, peripheral vascular disease, Heart Failure, Hypertension, Anemia, Hyperkalemia, Rhabdomyolysis, Chronic Kidney, Pressure Ulcer and History of hip fracture.</p> <p>Physician ' s orders dated November 4, 2013 at 2:30 PM directed as follow:</p> <p>" Pt [patient] D/C [discharged] from skilled OT [occupational therapy] services to RNP [Restorative program] for BUE [bilateral upper extremity] AROM [Active Range of motion] ex. for all j ' ts [joints] in all plains 20 reps x2 sets: L/E [lower extremities] Dressing with SBA to pull his pants to his waist to maintain current functional level.</p> <p>" Pt [Physical Therapy] order to start restorative nursing program for - (1) AROM of b/l [bilateral] LE hip/knee flex /ext [extension], hip abduction/adduction &amp; [and] ankle plantar dorsiflex 15reps x 3 sets, all shifts 7 days a week during am/pm care &amp; (2) Ambulation program with fww for 100feet with CGA or with min assist as needed for active participation in activities of</p>	F 279		

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F 279	<p>Continued From page 40</p> <p>choice/hobbies &amp; for walk to dine % walk to activities program. Resident to transfer from bed to w/c with SBA &amp; encouraged to maintain sitting position for at least 4 - 5 hrs daily "</p> <p>A review of the " Therapy to Nursing Rehab Program Communication Form revealed a note signed by therapist and dated November 5, 2013that reads, " under the section Problems/Needs: Resident requires Nursing rehab program to maintain current bilateral upper extremity range of motion and to maintain decreased assistance for ADLS [activity of daily livings] for lower body dressing/bathing and functional mobility. Also to reduce the risk for falls and injury "</p> <p>A review of the "Restorative Program Plan and Summary revealed that on November 8, 2013 resident #222 started " Restorative Program: Active Range of Motion (BUE). Goals: To maintain and enhance current level of function and to reduce risks of falls. Intervention: Resident to start on the program for active range of motion to the bilateral upper extremities at the shoulders, elbows, wrists and fingers with 2 sets of 20 repetitions. Range of motion should be incorporated in am care " .</p> <p>There was no evidence that a care plan was initiated with goals and approaches for Restorative Care in Resident #222 ' s chart.</p> <p>A face-to-face interview was conducted on February 24, 2014 at approximately 11:00AM with Employee # 8. He/she acknowledged the findings. The record was reviewed on February 24, 2014.</p>	F 279			

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F 279	<p>Continued From page 41</p> <p>4. Facility staff failed to implement a care plan to address Resident #265 ' s refusal to use a nicotine patch.</p> <p>A review of the Physician ' s order dated January 14, 2014 directed, " Nicotine patch 21 mg/hr [per hour] [topical] once daily every day " .</p> <p>A review of the February 2014 Medication Administration Record revealed that on the following days the resident refused the nicotine patch: February 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25.</p> <p>A review of the care plan section of the active clinical record revealed that there was no care plan initiated to address the resident ' s refusal to use the nicotine patch.</p> <p>A face-to-face interview was conducted on February 25, 2014 at approximately 4:20 PM with Employee #11. He/she acknowledged the findings. The record was reviewed on February 25, 2014.</p> <p>5. Facility staff failed to develop a care plan with goals and interventions to manage Resident</p>	F 279		

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F 279	<p>Continued From page 42 #316's PICC Line.</p> <p>According to the " Admissions Progress Notes " dated January 3, 2014 19:11 [7:11 AM] " [Resident #316] was readmitted to the facility...Resident was sent for stent removal [Follow/up] F/up and was admitted for monitoring after stent removal ...On assessment [he/she] is alert, verbally responsive and oriented x [time] 3 [three], skin warm to touch, Right upper arm with single lumen PICC ... "</p> <p>Review of the " Physician ' s Order " signed January 6, 2014 revealed Ertapenem [Antibiotic] 1g [gram] via [by] PICC line every 24 hours x 10 days for UTI [Urinary Tract Infection]. ", and review of the MAR [Medication Administration Record] revealed that the medication was received on January 4, 2013 through January 10th, 2014.</p> <p>A review of the resident ' s care plan last updated October 11, 2013 lacked evidence of a focus area with goals and approaches to manage a resident with a PICC line.</p> <p>A face-to-face interview was conducted with Employee #8. After review of the care plans he/she acknowledged the findings.</p>	F 279		

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F 279	Continued From page 43  6. Facility staff failed to initiate a care plan with goals and approaches to address the use of a CPM machine to treat Resident #401 who had a right total knee replacement. Resident #401 was admitted on February 12, 2014 with a continuous order to receive CPM treatments for five (5) hours per day on his/her right lower extremity. A written order dated February 18, 2014 read " PT clarification order for pt to start on CPM daily for 3-5 hrs for knee ROM 0-60 (degrees) as per physician ' s orders, within pain limits ... " A review of the care plans for Resident #401 lacked evidence that a care plan to address the daily use of a CPM machine was initiated. A face to face interview was conducted on March 7, 2014 at approximately 2:00 PM with Employee #25. He/she acknowledged the findings. The record was reviewed on February 21, 2014.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the	F 280	F-280  1. Resident #290 did not have negative outcomes related to the deficient practice of not amending care plans to reflect specific intervention for a right arm splint and refusal of dental treatments. Resident #384 did not have negative outcomes related to the deficient practice of the facility not reviewing and revising residents care plan to reflect resident's current continent voiding status. All concerns identified were addressed with the specific residents.		

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F 280	<p>Continued From page 44</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for two (2) of 51 sampled residents, it was determined that facility staff failed to review and revise one (1) residents care plan to include specific interventions for a right arm splint and refusal of dental treatment and one (1) resident 's care plan to reflect their current status of continent voiding. Residents #290 and #348</p> <p>The findings include:</p> <p>1. Facility staff failed to amend Resident #290 ' s care plan to include specific interventions for a right arm splint and refusal of dental treatment.</p> <p>A. During the course of the survey, Resident #290 was observed on February 20, 21, 27 and 28, 2014 during the hours of 10:00 AM to 4:00 PM with a splint applied to his/her right upper arm. According to an interim physician order dated January 22, 2014 at 5:30 PM directed; " OT [Occupational Therapy] Discharge Order: [Patient] discharged from skilled OT intervention to rehab nursing program for [right] elbow extension splint application daily [times] 7 (seven) days per week. [Right] elbow extension</p>	F 280	<p>2.All residents have the potential to be affected by the deficient practices of not amending care plans to reflect specific residents interventions. Care plan education has been provided to license nursing staff by nurse management and staff development with emphasis on updates, revising, and amending care plans.</p> <p>3.Nursing Management and Restorative Nursing reviewed/revised and amended care plans to reflect specific interventions for splinting devices. Nursing Management reviewed and revised care plan to address resident's refusal of dental treatment. Nursing Management assessed residents current bowel and bladder status and revised care plan to reflect residents' current voiding status. Nursing Management will review resident current voiding status daily in clinical meetings. Nursing Management will conduct weekly audits for compliance; amend and revise care plans as necessary and provide education as needed.</p> <p>4.Audits to be reviewed weekly by nursing administration. Compliance with follow through will be monitored monthly through the QAPI process by the QA Nurse for the next three months. Education will be provided as needed.</p>	5/13/14	

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F 280	<p>Continued From page 45</p> <p>splint to be applied to [right] elbow after PROM (Passive range of motion) to RUE (right upper extremity ) shoulder, elbow, wrist [and] hand. Application of [right] elbow extension splint times: on 10 am- 4PM; off 4PM-6PM; on 6Pm-12AM; off 12AM-2AM; on 2AM-8AM. "</p> <p>The comprehensive care plan most recently updated, December 17, 2013 lacked evidence of a revision to include the specific interventions to manage Resident #290 ' s right arm splint. Facility staff failed to amend Resident #290 ' s care plan to include specific interventions for his/her right arm splint.</p> <p>A face-to-face interview was conducted with Employees #3, #7 and #25 on March 5, 2014 at approximately 10:30AM. After reviewing the care plan, all aforementioned employees acknowledged the findings. The clinical record was reviewed on March 5, 2014.</p> <p>B. Facility staff failed to amend care plan to include Resident #290 ' s refusal of treatment. A review of the clinical record for Resident #290 revealed the resident repeatedly refused dental treatment as follows: " April 22, 2013- " FMD- #28 OL Comp #29 to be determined April 30, 2013- Patient refused treatment September 11, 2013- Annual exam- Patient refused exam. "</p> <p>The comprehensive care plan most recently updated, December 17, 2013 lacked evidence of a revision to include the specific interventions to manage Resident #290 ' s right arm splint. Facility staff failed to amend care plan to include Resident #290 ' s refusal of treatment. A face-to-face interview was conducted with</p>	F 280			

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F 280	<p>Continued From page 46</p> <p>Employee #7 on March 5, 2014 at approximately 10:30AM. After reviewing the care plan, he/she acknowledged the findings. The clinical record was reviewed on March 5, 2014.</p> <p>2. Facility staff failed to review and revise Resident #348 ' s care plan to reflect the resident ' s current continent voiding status.</p> <p>According to the resident ' s quarterly bladder and bowel assessment dated December 12, 2013 the resident is continent of bowel and bladder. The resident has no change in continence status.</p> <p>Review of the residents care plan last updated September 18, 2013 revealed that the resident has an ADL [Activities of Daily Living] Self Care Performance Deficit r/t [related/to] Stroke, Limited Mobility with interventions to include: Toilet use: resident is totally dependent on staff for toileting...</p> <p>A face-to-face interview was conducted with Resident #348 on February 25, 2014 at approximately 10:00 AM. A query was made if [he/she] was able to void when needed. The resident stated " When I first came here I was incontinent, but now I can use bathroom on my own, I am continent of both bladder and bowel. "</p> <p>A face-to-face interview was conducted with Employee #9 at approximately 10:30 AM. He/she stated " the resident was incontinent</p>	F 280		

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F 280	Continued From page 47 upon admissions [September 18, 2013], and according to my recollection the resident has been continent of urine since November. "	F 280	<b>F-281</b>  1. Resident #50 did not present with negative outcome related to the employee's failure to follow established protocols for hand washing and proper technique for administration of eye drops. Resident #50 upon assessment, dialysis site was patent and bruit and thrill and present. No signs or symptoms of redness/ infection or bleeding noted. Employee #8 was educated regarding the pre and post assessment of the dialysis access site. Employee #37 was educated by ADON on 3/13/14 on the prevention of infection with proper hand hygiene technique and the administration of eye drops.  2. All residents have the potential to be affected by failure to follow CDC guidelines for hand hygiene in the healthcare setting and the correct administration of eye drops. Nursing Management, and IC Nurse will review The IC guidelines and protocols to ensure compliance with all State and Federal requirements for the prevention of spreading infection as it relates to Hand hygiene an correct administration of eye drops to a resident per facility policy. Dialysis residents have the potential to be affected by the failure to follow standard protocols regarding the care and monitoring of the dialysis access sites. Nursing Management will review the hemodialysis access site care policies and protocols to identify any areas where further education is needed.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and staff interview for one (1) of 51 sampled resident, it was determined that facility staff failed to meet professional standard of care for administration of eye drops and pre and post assessment of one (1) resident on dialysis. Resident #50  The findings include:  A. facility staff failed to meet professional standard of care for administration of eye drops for one resident. Resident #50  During a medpass on March 3, 2014 at approximately 9:35 AM employee #37 was observed administering medication to resident #50. After administration of medication by mouth Employee #37 in preparation to administer eye drops did not wash his/her hands or don on gloves. Employee #37 continued by instructing the resident to look up with eyes open, then	F 281		

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F 281	<p>Continued From page 48</p> <p>pulled the lower lid down with bare fingers, exposed the conjunctiva sac and instills clear eye solution. Employee #37 after instilling the solution had resident closed his eyes and immediately proceeded to wipe resident eyes in a backward and forward manner with paper towel. Resident #50 complained that his eyes felt like something fell in it from the manner in which Employee #37 wiped his/her eyes.</p> <p>Physician ' s orders dated December 12, 2013 directed the administration of Artificial Tears (artificial tears solution) 0.1 - 0.3% Ophthalmic, three times daily Everyday: one (1) drop to both eyes three times daily for dry eyes.</p> <p>According to the " 2010 Lippincott ' s Nursing Procedure Manual, page 583 under " Instillation of eye medications; Preparatory Phase - Wash hands before instilling medication; Performance Phase - ... using forefinger, pull on skin below lower lid, instruct patient to look upward, drop medication amount into the center of lower lid (cul-de-sac), without touching the eye with the end of the tube [dropper], instruct patient to close eyes slowly but not to squeeze or rub them. Open eye. Clear any excess medication with gauze or tissues. "</p> <p>The evidence revealed that facility staff failed to meet professional standard of care during observation of him/her administering resident 50 ' s of eye drops.</p> <p>A face-to-face interview was conducted on March 3, 2014 at approximately 9:39 AM with Employees# 9 and # 37 regarding the</p>	F 281	<p>3.Nursing and IC Nurse have reviewed infection control policies and protocols and made modifications as necessary to be compliant with State and Federal requirements. Licensed nurses will be educated by IC Nurse, Staff Development and/or Nurse Manages on proper administration of eye drops. All staff will be educated on the guidelines for hand hygiene. Nurse Management will conduct random eye drop administration observations weekly x4 to identify where further education is needed. Nursing Management/Infection Control Nurse will conduct random hand washing observation on all departments to ensure compliance with proper hand hygiene. IC Nurse scheduled quarterly IC in-services for the rest of the year. Nursing Management has reviewed and updated the policy and protocols for Hemodialysis access site care. Licensed nurses will be educated on the protocols for pre and post assessment regarding the care and monitoring of the dialysis access site. Nurse Management will audit dialysis communication books and documentation regarding the monitoring of the dialysis access site.</p> <p>4. Results of all audits will be reviewed by the IC Nurse and brought to monthly QAPI to ensure compliance and identify other areas where further education is needed. Audits will be reviewed for a minimum of 3 months to ensure compliance is being maintained.</p>	5/13/14	

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F 281	<p>Continued From page 49 aforementioned observations. The finding was acknowledged by Employees. The record was reviewed on March 3, 2014.</p> <p>1B. Facility staff failed to meet professional standard of care for pre and post assessment of one (1) resident on dialysis. Resident #50</p> <p>On February 26, 2014 at approximately 10:00AM resident was observed picked up by staff and taken off unit for dialysis.</p> <p>Resident was observed by this surveyor and Employee #8 returning from dialysis. Employee #8 wrote the time for resident #50 arrival on unit 2:45PM on the communication log for coordination of services between the facility and the dialysis center. This surveyor left the unit at 4:45PM and Employee #29 charge nurse of resident# 50 was not observed providing pre or post assessment per dialysis protocol and in accordance with accepted professional standards.</p> <p>A face- to- face interview was conducted on February 26, 2014 at 9:00AM concerning the process for the continuation of care post dialysis. He/she stated, " Resident assessment to include listening for bruit and feeling thrill and bleeding, correct time is to be placed on communication sheet to assess time to take dressing off in 4 hours after dialysis. There is a kit at bedside if there is bleeding to apply pressure and call for assistant if needed. "</p> <p>A review of the pre-dialysis nurses ' note dated February 26, 2014 at 2:11PM reads " Resident</p>	F 281		

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F 281	<p>Continued From page 50</p> <p>alert and oriented left for dialysis at 10:00AM with stable condition, AVG site intact no bleeding and no swelling noted. Skin assessment done no new open area noted ... "</p> <p>A review of the post- dialysis nurses ' note dated February 26, 2014 at 3:42PM reads, " Resident remains stable, returned from dialysis at 14:45PM with stable condition, AVG site intact no bleeding or swelling noted ... "</p> <p>A review of the 3-11 nurses ' note dated February 26, 2014 at 9:55PM reads, " Resident is alert and verbally responsive skin warm and dry to touch. Resident is post dialysis with no distress noted AV shunt site is intact with no bleeding noted. Resident ate with good appetite with fluid encourage. All medication given as ordered. Resident is in bed, kept clean and dry. No pain and no sign of distress. "</p> <p>The evidence revealed that facility staff failed to meet professional standard of care for pre and post assessment with follow up care for resident dialysis access site.</p> <p>The facility ' s policy: Care of Patients on Hemodialysis; Purpose: To insure that all patients receiving outpatient Hemodialysis are monitored appropriately by both licensed and non licensed staff. Facility will have systems in place to provide Dialysis education to their licensed nurses, CNA ' s and dietary staff on an annual and PRN basis.</p> <p>Procedure:</p>	F 281		

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F 281	<p>Continued From page 51</p> <p>4. Patients on hemodialysis will be observed daily, at a minimum, for signs and symptoms of complications r/t hemo dialysis (redness, warmth, pain and or/ bleeding at the site, fever, N/V, hypotension, increased confusion, etc). Careplans will be developed for all patients receiving hemodialysis to address complications and will include communications between facility and dialysis Center.</p> <p>5. Shunt site will be monitored every shift by palpating for thrill and auscultating for bruit. Physician will be notified of the absence of a thrill or bruit.</p> <p>Rushing Jill MSN, RN Nursing Management: The Journal of Excellence in Nursing Leadership: Caring for a Patient ' s Vascular Access for Hemodialysis; October 2012 - Volume 41 issue 10 p.47&lt;<a href="http://journals.lww.com/nursingmanagement/Fulltext/2010/10000/Caring_for_a_patient_s_vascular_access_for.11.aspx">http://journals.lww.com/nursingmanagement/Fulltext/2010/10000/Caring_for_a_patient_s_vascular_access_for.11.aspx</a>&gt;</p> <p>" Follow your facility's policies and procedures and these clinical tips to protect and preserve the vascular access and avoid complications such as infection, stenosis, thrombosis, and hemorrhage: Remove any restrictive clothing or jewelry from the arm. To prevent injuries, place an armband on the patient or a sign over the bed that says no BP measurements, venipunctures, or injections on the affected side. When blood flow through the vascular access is reduced, it can clot. Perform hand hygiene before you assess or touch the vascular access ... dons gloves. Position the patient's arm so the vascular access is easily visualized. Assess for patency at least every 8 hours. Palpate the vascular access to</p>	F 281		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>DEANWOOD REHABILITATION AND WELLNESS CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5000 BURROUGHS AVE. NE WASHINGTON, DC 20019</b>		
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F 281	Continued From page 52 feel for a thrill or vibration that indicates arterial and venous blood flow and patency. Auscultate the vascular access with a stethoscope to detect a bruit or "swishing" sound that indicates patency. Check the patient's circulation by palpating his pulses distal to the vascular access; observing capillary refill in his fingers; and assessing him for numbness, tingling, altered sensation, coldness, and pallor in the affected extremity. Notify the healthcare provider promptly if you suspect clotting. Assess the vascular access for signs and symptoms of infection such as redness, warmth, tenderness, purulent drainage, open sores, or swelling. Patients with end-stage kidney disease are at increased risk of infection. After dialysis, assess the vascular access for any bleeding or hemorrhage. "  A face-to-face interview was conducted on February 26, 2014 at approximately 4:39PM with Employees# 8 regarding the aforementioned observations. The finding was acknowledged by Employee. The record was reviewed on February 26, 2014.	F 281	<b>F-282</b>  1. Resident #121 did not have any negative outcomes related to the deficient practice. A GYN appointment was scheduled immediately and the resident has been seen the GYN specialist.  2. All residents have the potential to be affected by the deficient practice of not scheduling resident's appointments. Resident's records were reviewed by Nursing Administration and Unit Secretaries to ensure that all recommended appointments were scheduled accordingly.  3. Licensed nurses and Unit Secretaries will be educated on a revised and updated process for scheduling resident's consults and appointments. Review of appointment log will be conducted as well by Nursing Management and Medical Records Manager.  4. An appointment log will be reviewed and audited by the ADONs and medical records department weekly for 3 months. Compliance with follow through will be monitored monthly through the QAPI process by the QA Nurse. Further education and/or counseling will be provided when identified by compliance.		
F 282 SS=D	<b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>  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 of one (1) of 51 sampled resident it was determined	F 282		5/13/14	

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F 282	<p>Continued From page 53</p> <p>that facility staff failed to ensure that one (1) resident underwent a gynecologic consultation as prescribed. Resident #121</p> <p>The findings include:</p> <p>Facility staff failed to ensure that Resident #121 obtained a gynecologic [GYN] consultation.</p> <p>Resident #121 underwent a GYN consultation on November 8 2013, the consultants plan included a course of antibiotics for Vaginitis and for the resident to undergo a Pelvic sonogram to rule out a pelvic mass and screening mammography; follow up appointment in 6 weeks.</p> <p>The Primary Care Physician signed the consult acknowledging the Gynecologists ' recommendations.</p> <p>A review of resident #121 ' s clinical record revealed that the GYN follow up appointment was scheduled for December 17, 2013. The results of the follow up consult was not available for review in the residents ' chart.</p> <p>On February 28, 2014 at 9:00AM an inquiry regarding resident ' s GYN follow up appointment was conducted with Employee# 8. He/she was unable to provide evidence of the results of the GYN follow up visit. Upon further review, Employee #8 determined that the appointment scheduled for December 17, 2013 was ' missed. ' No reason was provided for the missed appointment and there was no evidence that the appointment had been rescheduled.</p>	F 282		

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F 282	Continued From page 54  Greater than three (3) months had lapsed and the follow up GYN appointment had not been obtained for Resident #121.  Facility staff failed to ensure that Resident #121 obtained a GYN consultation related to a possible pelvic mass. The record was reviewed on March 5, 2014.	F 282			
F 309 SS=H	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and interviews for seven (7) of 51 sampled residents, it was determined that facility staff failed to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being as evidenced by failure to: consistently assess, monitor and report to the physician the respiratory status of one (1) resident who subsequently expired; consistently conduct skin assessments for one (1) resident who subsequently developed a facility acquired dry gangrene of the toe; consistently assess, monitor and manage a peripherally inserted central catheter (PICC) for one (1) resident who	F 309	<b>F-309</b>  1. Resident #402, no longer resides at center. Resident #290 was seen by Nephrology, Podiatry, and Wound Care Consultant. An Appointment was made with infectious Disease MD. Skin sweep sheets are in place For resident and primary care physician has addressed recommendations by consultants. A turning and repositioning schedule is in place and staff were in-serviced on addressing and documenting the care needs of this resident. Resident #316 is no longer receiving antibiotics and no longer has a PICC line in place. The central line protocol and documentation will be reviewed for all residents receiving medication/fluids through this device to ensure protocols are followed and identify any areas of education needed. Resident #180 had a respiratory log added to resident record. Staff educated on the use of the form. Resident #303 parameters for use of hydralazine were reviewed with the physician and clarified with the record. Resident #399 no longer resides at the center. Resident #401 no longer resides at the center. There are currently no residents receiving CPM treatment. The primary care physician for Resident #121 was notified about resident not seen by cardiologist as ordered. An appointment was scheduled for the resident to see the cardiologist		

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F 309	<p>Continued From page 55</p> <p>subsequently sustained an infection at the site; act with timeliness on physician ' s orders for one (1) resident to undergo a nephrology consultation; turn and reposition one (1) resident with altered skin integrity in accordance with the comprehensive plan of care; consistently assess the respiratory status of one (1) resident prior to and post the administration of respiratory treatments; administer antihypertensive medication in accordance with physician ' s orders for one (1) resident; assess weights in accordance with physician ' s orders for one (1) resident and administer controlled passive range of motion as prescribed for one (1) resident. Residents' # 402, 290, 316, 80, 303, 399, 401</p> <p>The findings include:</p> <p>1. Facility staff failed to consistently assess, monitor and report to the physician, the status of Resident #402 ' s condition at the time admission.. The resident was assessed with respiratory wheezing, use of accessory muscles to breathe and cyanosis of fingers and toes at the time of admission. He/she was assessed with unresponsiveness and expired within twelve (12) hours of admission to the facility.</p> <p>Resident #402 was admitted to the facility on February 18, 2014 at 7:15 PM from an acute care hospital. According to the " Discharge/Transfer Summary " from the hospital, the resident ' s discharge diagnoses included " Mycardial Infarction, Congestive Heart Failure exacerbation, Acute on Chronic Kidney Disease, Dehydration, Atrial fibrillation, Hypertension, moderate Pulmonary Hypertension, Hypoalbuminemia and</p>	F 309	<p>2.All residents have the potential to be affected by the failure to ensure the resident have received necessary care and services to attain or maintain the highest practicable well being. Charts will be reviewed to address all concerns identified and education to be provided as applicable.</p> <p>3.Chart reviews will be done to ensure all consultant referrals have been completed and MD has followed up on all recommendations. Nurses have been educated on following thru on Consultant referrals timely by Staff Development/ Nursing Management. Charts will be audited during nightly clinical review to ensure orders have been addressed weekly by Nursing Management. All residents on respirator treatments were reviewed to ensure treatment/assessment logs are in place. Education was provided to all licensed staff on respiratory treatment and evaluations by a licensed respiratory therapist(RT). The RT will audit the logs to ensure compliance. All residents were reviewed to identify those who will need assistance with turning and positioning. The care plans and karkex were reviewed and updated as necessary. CNAs were in-serviced on turning and positioning residents who was identified as needing this intervention. Compliance will be monitored by Nursing Management during care rounds. Central line catheter protocol was reviewed by Nursing Administration to identify further areas of education needed for licensed staff.</p>		

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F 309	<p>Continued From page 56</p> <p>Supratherapeutic INR [International Normalized Ratio]. " According to the Certificate of Death noted in the clinical record, the resident expired on February 19, 2014 at 6:20 AM; cause of death " Fatal Cardiac Arrhythmia due to or as a consequence of Non Valvular Atrial Fibrillation. "</p> <p>Nursing Notes: The Admission Note written on February 18, 2014 at 23:49 [10:49 PM] revealed, " [Resident #402] arrived at the facility from an area hospital at 7:15 PM on February 18, 2014 ... " On admission resident is alert and oriented x 3[times], on [continuous] oxygen for SOB [Shortness of Breath], no acute distress or discomfort noted ...Lung sounds noted with expiratory wheezing, noted with barrel chest, resident is hyperventilating and [he/she] was using accessory muscles to breathe with respiration of 22. Resident is on oxygen 3l/min [three liters per minute] via NC [nasal cannula] for SOB. Skin is warm to touch skin is tinted, bi lateral hand and all fingers are cyanotic, both feet are shiny [and] toes are cyanotic. All meds (medications) clarified with [attending physician] and faxed to pharmacy. Emergency contact was in the unit. V/S (vital signs) 129/66 [blood pressure], Pulse 94, temp (temperature) 98.8, rr (respiratory rate) 22, SPO2 [Saturation Percentage of Oxygen] 97% with O2 (oxygen) 3l/min and wt (weight) 110 lbs (pounds). "</p> <p>The nursing note dated February 19, 2014 at 02:55 AM revealed, " Writer went to give the resident PPD [Purified Protein Derivative]. Resident was sleeping. Writer attempt[ed] to wake [the] resident. [The] roommate stated, 'Do not wake [him/her] up. ' Supervisor made</p>	F 309	<p>Licensed staff were educated on the requirement related to documentation of the use of PICC lines for medication/fluid administration on initiation of medication/fluid administration, during its use, and removal of device. Education was provided by Nursing Administration and the facility PICC line Insertion Team. Unit Managers will audit residents PICC line documentation on initiation of the use of the device, weekly, on completion of the medication and/or fluids administration, and when the device is removed. The residents who are currently receiving medications that require monitoring parameters will be reviewed to ensure parameters are in place and being followed. Nurses have been in-serviced on parameters for medications by Nursing Management and Staff Development. Compliance will be monitored by Unit Managers on a weekly basis. Policies, procedures and protocols for assessing and reporting changes in condition were reviewed by Nursing Management. All Nurses will be in-serviced on protocols to assess residents for changes in condition, how to complete as SBAR, and how to report changes in condition appropriately. The wound care protocols, policies, treatment protocols and documentation requirements were reviewed by the Wound Care Team and Nursing Management and updated as necessary. Nurses have been educated on the requirements for consistent and accurate skin sweeps to be completed at</p>		

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F 309	<p>Continued From page 57 aware. Will follow up in the morning."</p> <p>The nursing note dated February 19, 2014 at 08:44, revealed, " Writer called to the room ... to find the resident unresponsive with the charge nurse performing CPR (Cardiopulmonary resuscitation). The EMS [Emergency Medical Services] team came to the resident's room [and] performed EKG (electrocardiogram) with result showing asystole (that the resident expired). [He/she] was pronounced dead at 06:20 AM ... "</p> <p>A face-to-face interview was conducted with Employee #35 on March 5, 2014 at approximately 3:30PM. During the interview the employee acknowledged writing the aforementioned statement [nurse ' s note February 19, 2014 at 2:55 AM]. He/she also stated that the resident was awake and verbally responsive while the supervisor was admitting [him/her]. The employee also stated that the resident was asleep when he/she was attempting to administer the PPD. The employee was queried at what time [he/she] had attempted to administer the PPD. He/she stated, " It was around 2:00AM. "</p> <p>A face-to-face interview was conducted with Employee #34 at approximately 9:00AM on March 5, 2014. The employee stated that he/she was the supervisor on duty when the resident expired. The employee was queried regarding the events that led up to the resident ' s death. He/she stated that the report he/she received was that there were two admissions to the facility. One admission had been completed by the evening supervisor and one needed to be completed by him/her. He/she became involved</p>	F 309	<p>A minimum weekly, wound care policies, protocols, treatment protocols, and wound care prevention. Policies and protocols for weight monitoring were reviewed by the Dietician and Nurse Management. Resident records were reviewed to ensure facility protocols for weight monitoring have been followed. Nurses and CNAs were in-serviced on facility protocols for weight monitoring. The dieticians will review weight documentation weekly to ensure compliance.</p> <p>4. Compliance with follow through will be Monitored monthly through QAPI process. Further education and/or counseling will be provided when identified by the compliance audits.</p>	5/13/14

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F 309	<p>Continued From page 58</p> <p>with the admission of the assigned resident and was unaware of the expired resident ' s respiratory problems until he/she was called to the unit at around 6:00AM on February 19, 2014.</p> <p>A face-to-face interview was conducted with Employee #33 at approximately 4:30PM on February 27, 2014. The employee was queried whether he/she was the nurse who documented the following information [nurse ' s note February 18, 2014 at 10:49 PM]: " Lung sounds noted with expiratory wheezes, barrel chest, hyperventilating and using accessory muscles to breathe; utilizing O2 at 3l/min [three liters per minute] via NC [nasal cannula] for SOB [Shortness of Breath.] Bilateral hands and all fingers were cyanotic, both feet were shiny and toes cyanotic. " The employee was asked whether the resident ' s condition (as described by him/her) warranted immediate medical attention. The employee did not respond to the question.</p> <p>A review of the record lacked documented evidence of an assessment for the resident between the time of admission 7:15 PM on February 18, 2014 and the time that the resident was pronounced dead at 6:20AM on February 19, 2014. The Admission Assessment documented by the nurse revealed that Resident #402 was experiencing respiratory difficulty upon arrival to the facility as evidenced by the following note: " Lung sounds noted with expiratory wheezes, barrel chest, hyperventilating and using accessory muscles to breathe; utilizing O2 at 3l/min via NC for SOB. Bilateral hands and all fingers were cyanotic, both feet were shiny and toes cyanotic. "</p>	F 309		

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F 309	<p>Continued From page 59</p> <p>The nurse ' s note also indicated that the nurse spoke with the attending physician regarding the resident ' s medication regimen; however, there was no evidence that the resident ' s condition, assessed at the time of admission was conveyed to the primary care provider.</p> <p>The only vital signs recorded in the clinical record prior to assessing the resident as unresponsive were obtained at the time of admission at 7:15 PM on February 18, 2014. There was no evidence that facility staff consistently assessed and monitored Resident #402 once he/she was assessed with respiratory difficulty at the time of admission. The primary care physician was not informed regarding the respiratory status of the resident. The record was reviewed on February 27, 2014.</p> <p>2. Facility staff failed to consistently conduct skin assessments on Resident #290, who subsequently developed a facility acquired dry gangrene of the toe; failed to obtain a nephrology consultation with timeliness and failed to turn and reposition the resident in accordance with the comprehensive plan of care.</p> <p>A. Facility staff failed to consistently conduct skin assessments on Resident #290, who was subsequently diagnosed with dry gangrene of the toe.</p> <p>The Facility ' s Procedure Policy: " Skin and Wound Management " [no date indicated] stipulates: " Each resident is evaluated by the interdisciplinary team to determine his or her risk</p>	F 309		

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F 309	<p>Continued From page 60</p> <p>for skin compromise or the presence of wounds and/or pressure ulcers. A plan of care is developed and implemented based on this evaluation with ongoing review. Procedure: 3. Residents will be monitored weekly for skin integrity and documentation will be completed on the Weekly Skin Assessment form. "</p> <p>According to a re-admission history and physical dated June 5, 2013, Resident #290 ' s diagnoses included: " Seizure Disorder, Hypertension, [Status Post] PEG (Percutaneous Endoscopic Gastrostomy) and Diabetes Type II. "</p> <p>MDS: According to the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of January 17, 2014, Resident #209 was coded in Section G as being totally dependent requiring one person physical assist in personal hygiene. Under Section M (Skin Conditions) the resident was coded as having no venous and arterial ulcers and no foot problems; however, he/she was coded as being at risk of developing pressure ulcers.</p> <p>Care Plan: The care plan entitled ADL [Activities of Daily Living] Self Care Performance Deficit [related to] stroke, Musculoskeletal Impairment, Limited Mobility last updated on December 17, 2013 revealed: Interventions: Skin Inspection- The resident requires skin inspection [every] shift. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse.</p> <p>The care plan entitled Diabetes Mellitus Type II last updated December 17, 2013 revealed...</p>	F 309			

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F 309	<p>Continued From page 61</p> <p>Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness.</p> <p>Physician ' s Orders:</p> <p>The Physician ' s Order Sheet dated December 31, 2013 revealed, " Skin Checks by Licensed Nurse twice a week on Shower Days Tuesdays and Fridays (3pm-11pm) "</p> <p>Interim order dated February 7, 2014 at 3:30 PM, directed, " Arterial Doppler- [Rule out] PAD/BLE (Peripheral Arterial Disease - Bilateral Lower Extremities). "</p> <p>Interim order dated February 10, 2014 directed, "Apply skin prep to left 2nd toe gangrene. "</p> <p>Interim order dated February 14, 2014 at 2:46 pm, directed, " Schedule vascular consult with a vascular doctor for a plan of treatment to lt [left] foot 2nd toe gangrene. "</p> <p>A radiology report dated February 10, 2014 revealed the following: Procedure: Arterial Duplex Doppler to lower extremities- " Impression: No evidence of significant stenosis is within either lower extremity arterial tree. "</p> <p>Skin Reports:</p> <p>The "Bath [and] Skin Report" revealed the following:</p> <p>January 13, 2014- Bed Bath Given- Skin intact-No documentation on the sheet. No charge nurse signature</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER  <b>DEANWOOD REHABILITATION AND WELLNESS CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5000 BURROUGHS AVE. NE WASHINGTON, DC 20019</b>		
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F 309	<p>Continued From page 62</p> <p>January 16, 2014- Bed Bath Given- Skin intact- No charge nurse signature. "</p> <p>The " Skin Sweeps" sheets revealed the following:</p> <p>" November 9, 2013- No new skin impairment- signed by licensed practical nurse December 7, 2013- No new skin impairment- signed by licensed practical nurse December 12, 2013- No new skin impairment- signed by licensed practical nurse January 5, 2014- No new skin impairment- signed by licensed practical nurse January 12, 2014- No new skin impairment- signed by licensed practical nurse. "</p> <p>The " Non-Pressure Ulcer Skin Conditions Sheet " dated February 10, 2014 at 13:01 revealed, " Date of Onset: February 8, 2014, Origin of Wound: Facility Acquired, Type of Evaluation: Initial Onset, Site of Skin Condition: Left 2nd (second) toe, Type of Skin Condition: Other: Dry Gangrene, Document Measurement in centimeters: Length: 3.6, Width: 4.9, Depth: 0, Presence of Pain: No, Progress: A dry gangrene. Black and dry with no drainage. Treatment: - Apply skin prep daily, Physician Notified of Change: - Yes. Vascular consult was scheduled for February 19, 2014; resident refused to go. Guardian made aware. Appointment rescheduled for March 9, 2014. "</p> <p>The clinical record lacked evidence that skin assessments were consistently conducted on shower days in accordance with the physician's orders and the facility ' s policy. Additionally, there were no skin sweep sheets nor bath and</p>	F 309		

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F 309	<p>Continued From page 63</p> <p>skin report sheets in Resident #209 ' s record for the month of February 2014.</p> <p>The Physician's Progress Notes revealed the following:</p> <p>December 11, 2013- Section C: Physical Examination: Check below [check mark] if normal and [+] if abnormal. Under Skin: check mark was placed after no rash. Extremities: No edema. Under skin care section - there was no documentation indicating there was no skin alteration.</p> <p>January 13, 2014- Skin-check mark [no rash]; Extremities: no edema, no documentation under skin care section. Plan/Recommendations: IV (Intravenous Fluids) - Continue [water] through PEG, Repeat electrolytes.</p> <p>January 31, 2014- Skin- check mark placed- [no rash], no documentation under skin care section. Plan/Recommendations: IV fluids.</p> <p>February 7, 2014 at 3:15 PM- Resident [with] Diabetes Mellitus, Seizure Disorder, Hypertension, [Status Post ] PEG and Paranoid Schizophrenia seen today for evaluation of abnormal labs ... [Extremities]- No edema, [left] foot 2nd toe necrotic. Assessment/Plan: [Left] foot 2nd toe necrotic- Arterial Doppler- [Rule out] PAD- (Peripheral Arterial Disease.) "</p> <p>According to a " Patient Podiatric Service report " dated January 13, 2014 revealed: " Assessment, Procedures Performed &amp; Plan of Treatment: Professional treatment is required of [check in box for] toe nails to prevent exposing</p>	F 309		

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F 309	<p>Continued From page 64</p> <p>patient to medically significant risk related to wound healing, complications and possible loss of limbs, due to : Diabetic and/or Peripheral Vascular Disease; Follow-Up- Patient should be treated in 60 days for foot care due to systemic conditions or sooner should complications arise. "</p> <p>There was no evidence that the physician included the podiatrist follow-up recommendations in his/her plan of care prior to February 7, 2014, when the " gangrene toe " was discovered.</p> <p>Nursing Notes:</p> <p>January 18, 2014-12:53 PM - ADL (Activities of Daily Living) care provided by assigned CNA (Certified Nursing Assistant). Skin assessment done, no new skin issue.</p> <p>February 5, 2014 at 12:18 PM - Skin warm and dry to touch.</p> <p>February 6, 2014 at 07:35 AM - ADLs- total care given.</p> <p>February 7, 2014 at 09:19 AM- ADLs, total care given.</p> <p>February 7, 2014 at 19:50 PM- Resident has an order for bilateral lower extremities, Arterial Doppler study [related to] dark discolored left second. "</p> <p>February 8, 2014 at 16:52 PM - Arterial Doppler study to [rule out] PAD (Peripheral Artery Disease) of bilateral lower extremities. Skin</p>	F 309		

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F 309	<p>Continued From page 65 warm and dry to touch.</p> <p>February 9, 2014 at 08:06- Skin dry and warm to touch. AM ADL care given.</p> <p>February 10, 2014 at 12:20- Note Text- Resident was transferred from [unit and bed named]. Was noted with black dry gangrene on left 2nd toe- 3.6 x 4.9 x 0 x 0 cm. This was reported to [attending doctor named] on February 8, 2014 who ordered arterial Doppler to rule out peripheral artery disease. Doppler was scheduled for [February 10, 2014] by [radiology company]. In the meantime skin prep to left 2nd toe daily.</p> <p>February 10, 2014 at 17:05- Note Text- Late entering for resident. On February 7, 2014, resident was noticed with darkness on left second toe. [Nurse Practitioner] was notified and an order for arterial Doppler- [Rule out bilateral lower extremities] was given. Will continue to monitor.</p> <p>February 10, 2014 17:10- Note Text: Resident was transferred from [room number written] to [room number written] at 14:00 (2:00 PM). No sign of distress noted. [Vital Signs]:104/70 [Blood Pressure], 66, [Pulse] 18 [Respiration], 97.4 [Temperature].</p> <p>The clinical record lacked evidence that skin assessments were consistently conducted twice a week in accordance with physician ' s orders and facility policy.</p> <p>A review of the 24 hours nursing report from February 7, 2014 through February 10, 2014 lacked evidence that Resident #290 had any type</p>	F 309		

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F 309	<p>Continued From page 66 of alteration in skin integrity.</p> <p>Consulted with Employee #41 telephonically on February 28, 2014 at approximately 4:20 PM regarding the necrotic toe. When queried regarding the necrotic toe on assessments; he/she stated, "The necrotic toe was discovered and I was informed. They stated that he/she had a vascular appointment. "</p> <p>A face-to-face interview was conducted with Employee #7 on February 28, 2014 at approximately 3:00 PM regarding the weekly skin assessments. After reviewing the skin sheets; he/she acknowledged the aforementioned findings. The clinical record was reviewed on February 28, 2014.</p> <p>Facility staff failed to consistently conduct skin assessments on Resident #290, who subsequently developed a " facility acquired dry gangrene " of the left 2nd toe.</p> <p>B. Facility staff failed to act with timeliness on an order to reschedule a nephrology appointment for Resident #290, who exhibited abnormal renal laboratory values. Greater than seven (7 months) lapsed before the order was acted upon.</p> <p>According to a re-admission history and physical dated June 5, 2013 revealed, Resident #209 ' s diagnoses included: " Seizure Disorder, Hypertension, [Status Post] PEG (Percutaneous Endoscopic Gastrostomy), Diabetes Type II and Bili (Biliary) Non obstructing Renal Calculi. "</p> <p>According to an interim physician ' s order dated</p>	F 309		

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F 309	<p>Continued From page 67</p> <p>August 9, 2013 [unable to read time] directed; " [Follow up with] Nephrology [specialist physician named] ASAP (As Soon As Possible) for renal insufficiency. "</p> <p>A nurses note dated August 28, 2014 at 14:02 (2:02PM) read: " Note Text: Resident was scheduled for nephrology appt with [nephrologists ' named] at [hospital named] at 10:30 AM. At 8:45 AM ... from [ambulance company] called and stated that they will come around 9:30 AM to pick the resident [up] for the appointment. At 9:45 AM, the writer called ambulance company], the operator stated that they are running behind schedule. That they will come around 10:10 AM and that they will call the doctor ' s office first to find out if they will still see the resident if they get him/her there late. Later the operator returned call and stated that they are cancelling the pick up because the doctor ' s office said they will not see the resident if he is late. Responsible party made aware. [Appointment] to be rescheduled " [SIC].</p> <p>An interim physician ' s order dated August 29, 2013 directed; " Reschedule resident for Nephrology with [specialist named] secondary [to] elevated BUN (Blood Urea Nitrogen) and Creatinine. " [Normal Range- BUN-8-23, BUN/Creatinine- 3.60-50.0]</p> <p>A review of the doctor ' s progress notes revealed the following:</p> <p>" August 8, 2013 at 1:30 PM- [chief complaint] - [follow-up] labs .... Resident labs came back and NP [nurse practitioner] for review: BUN/Creatinine- 89/1.90; Assessment/Plan:</p>	F 309		

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F 309	<p>Continued From page 68</p> <p>[Diagnosis] - Renal Insufficiency, Diabetes 2, [Status Post] PEG Placement secondary to poor po [by mouth] intake .... Increase GT flushes to 500 cc [times] 72 hours then [every] 6 hours [times] 24 hours. Repeat labs after flushes. Follow up with nephrology for renal insufficiency ... Signed Nurse Practitioner</p> <p>August 13, 2013- 1:40 PM- ... CC follow up labs ... BMP (Basic Metabolic Panel) with BUN/Creat 75/1.80 improving as compared to last labs- 89/1.90, Assessment/Plan: ... Renal Insufficiency, DM 2, Follow-up Nephrology appointment. Repeat BMP [every] month .... Signed Nurse Practitioner</p> <p>August 17, 2013- Problem List (New) - Dehydration ..., BUN-75, Crt-1.8. Plan/Recommendations: [Increase] flushes, Repeat BMP. Signed: Attending Physician.</p> <p>August 20, 2013 at 7:00 PM- CC- follow up labs .... BMP with BUN/Creat 72/1.60; Assessment/Plan: Renal Insufficiency, Diabetes .... Signed by Nurse Practitioner.</p> <p>September 18, 2013- ... Lab Tests: BUN/Crt= 73/1.8; Plan/Recommendations: Push Fluids, Repeat BMP. Signed: Attending Physician.</p> <p>October 4, 2013- Lab work: ... BUN -72/ Crt- 1.7; Assessment: Dehydration; Plan: Start IV fluids- ½ [normal saline] 50 ml/hour; Repeat BMP- Signed: Attending Physician</p> <p>October 8, 2013-.. Lab work- BUN-70, Crt- 1.4- Continue flushes and IV (Intravenous Fluid) fluids; Assessment: Dehydration, P- Continue IV</p>	F 309		

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F 309	<p>Continued From page 69 fluid [increase] rate- Continue water flushes. Signed: Attending Physician.</p> <p>October 16, 2013- 3:00 PM- CC- follow up labs- ... BMP- BUN/Crt- 55- improved from 76, Creat 1.6, Assessment Plan: DX (Diagnosis) - Renal Insufficiency; Continue GT flushes, Completed IVF (IV Fluids). Signed- Nurse Practitioner.</p> <p>November 4, 2013- ...No lab values documented. Plan/Recommendations: Please resend Urology, Repeat Lab. Signed: Attending Physician.</p> <p>December 11, 2013- ...No lab values documented. Plan/Recommendations: Surgery Consult- Distended Gallbladder... Signed: Attending Physician.</p> <p>January 13, 2014- Problem List (New) - Dehydration, Renal Insufficiency, and Plan/Recommendations: IV fluids- Continue [water] through PEG, Repeat Electrolytes. Signed: Attending Physician.</p> <p>January 31, 2014- ... BUN/CRT- 76/1.70, Plan/Recommendations: IV fluids. Signed: Attending Physician</p> <p>According to a request form for consults and/or appointments form dated February 26, 2014 revealed; " Type of Appointment: Nephrology; Reason for Appointment: for high BUN that has not been responding to treatments. Consults and /or Appointments Arranged: Date of Appointment: March 12, 2014; Time: 11:30 AM.</p> <p>There was no evidence in the clinical record that</p>	F 309		

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F 309	<p>Continued From page 70</p> <p>Resident #290 had an appointment scheduled prior to March 12, 2014.</p> <p>There was no evidence that the physician or the nurse practitioner included the resident ' s nephrology consultation in his/her total plan of care.</p> <p>A review of the medical record revealed that the attending physician made visits on September 18, October 4, October 8, November 4, December 11, 2013 and January 13 2014 and January 31, 2014. There was no evidence that the physician addressed the request for nephrology consultation.</p> <p>A face-to-face interview was conducted on February 26, 2014 at approximately 1:00 PM with Employee #7. When queried if the nephrology appointment had been rescheduled per physician ' s orders prior to the state agency inquiry; he/she stated that the appointment was not rescheduled as ordered and that he/she would investigate what happened.</p> <p>A face-to-face interview was conducted on February 28, 2014 at approximately 1:30 PM with Employee #40. When he/she was queried; " What is the facility ' s process on scheduling appointments and arranging transportation for residents? " He/she stated; " I make transportation arrangements after the unit secretary schedules the appointment. The unit secretary schedules the appointment and the referral with the appointment date and time is faxed to me. Upon receiving the fax; transportation is arranged. I record the</p>	F 309		

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F 309	<p>Continued From page 71 information in the referral/transportation log book. "</p> <p>Facility staff failed to act with timeliness on a physician ' s order for Resident #290 to undergo a nephrology consultation. The resident renal laboratory values were abnormal. Greater than seven (7 months) lapsed before the order was acted upon.</p> <p>C. Facility staff failed to turn and reposition Resident #290 in accordance to the comprehensive plan of care. During an isolated interview with Resident #290 ' s responsibility party on February 21, 2014 at approximately 12:45 PM. He/she expressed concerns regarding resident not being repositioned every two (2) hours.</p> <p>According to the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of January 17, 2014 revealed that Resident #209 was coded in Section M (Skin Conditions) as having no venous and arterial ulcers and no foot problems; however, he/she was coded as being at risk of developing pressure ulcer(s).</p> <p>A review of the " Braden Scale for Predicting Pressure Ulcer Risk " dated December 3, 2013; the resident ' s score was 14 indicating he/she was at moderate risk for developing a pressure ulcer.</p> <p>A review of the comprehensive care plan most recently updated, December 17, 2013 revealed , " Problem: The resident is potential for pressure ulcer development related to immobility ; Interventions: The resident needs assistance to</p>	F 309		