

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2014
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L 000	<p>Initial Comments</p> <p>The annual Licensure survey was conducted on August 29 through September 2, 2014. The deficiencies are based on observations, record review and staff interviews for 39 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 FU/FL Full Upper /Full Lower ID - Intellectual disability IDT - Interdisciplinary Team INR - International Normalised Ratio L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of</p>	L 000	<p>Stoddard Baptist Global Care Washington Center for Aging Services (SBGC), is filing this Plan of Correction in accordance with the Compliance requirements for Federal and State regulations.</p> <p>This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction does not constitute admission of facts or conclusions cited.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Aleneuse Chadwick Wright Licensed Nursing Home Administrator 10/31/14

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L 000	Continued From page 1 mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MRR- Medication Regimen Review Neuro - Neurological NP - Nurse Practitioner OBRA - Omnibus Budget Reconciliation Act PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - Physician 's Order Sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- responsible party RAI- Resident Assessment Instrument ROM- Range of Motion TAR - Treatment Administration Record CAA- Care Assessment Area QAA- Quality Assessment and Assurance	L 000	Continued From page 1	
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: A. Based on observations and staff interviews, it was determined that facility staff failed to comply with State regulations as evidenced by a	L 001		

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L 001	<p>Continued From page 2</p> <p>Licensed Practical Nurse not practicing within his/her scope of duty as evidenced by orienting a Registered Licensed Nurse.</p> <p>The findings include:</p> <p>Title 17 DCMR Chapter 55, 5514.4(b) stipulates: " A practical nurse shall not ...Supervise the clinical practice of a registered nurse. "</p> <p>A review of the facility's policy entitled, " Orientation for Licensed Nurses; Policy No: EDU01-001 stipulates; " Policy: The Registered Nurse will be provided with the education by a Registered Nurse on the unit. The staff development department will oversee the orientating of the RN/LPN and will assist as deemed necessary. "</p> <p>During initial tour on August 25, 2014 at approximately 9:00 AM on Unit 3 Orange. Employee #39 was observed orienting Employee #40.</p> <p>A second observation occurred on August 26, 2014 at approximately 10:00 AM on Unit 3 Orange. Employee #39 was observed orienting Employee #40.</p> <p>A face-to-face interview was conducted with Employee #41 on August 26, 2014 at</p>	L 001	<p>3200.1 Nursing Facilities</p> <p>A)</p> <p>The practice of the facility is for a Registered Nurses to supervise on board Registered Nurses.</p> <p>1. Nursing Services did not comply with State Regulations on august 25, 2014 and August 26, 2014 by allowing employee #39, a Licensed Practical Nurse, to provide orientation at the medication cart for employee #40. There was no negative outcome to the resident a result of this practice.</p> <p>2. All nursing units were checked and it was validated that all new hired Registered Nurses in orientation were being orientated on the nursing units by another registered nurse.</p> <p>3. In-services was provided to all Resident Care Managers and Nursing Supervisors regarding State Regulations requiring that all Registered Nurses receive orientation from a Registered Nurse.</p>	<p>10/31/1</p> <p>10/31/14</p>

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L 001	<p>Continued From page 3</p> <p>approximately 10:30 AM. When queried, whether Employee #40 was in orientation and who was orienting him/her He/she responded; " Yes, [he/she] is in orientation." Employee #41 stated that Employee #40 was in classroom training the first week and started working on the unit the second week. He/she also stated that Employee #39 was orienting Employee #40.</p> <p>A face-to-face interview was conducted with Employee #2 on August 29, 2014 at approximately 1:00 PM. He/she stated Employee #40 should have been orienting under Employee #41 and that Medication oversight should have been with Employee #5.</p> <p>A follow-up face-to-face interview was conducted with Employee #2 at approximately 2:00PM on August 29, 2014. He/she stated that Employee #39 acknowledged that [he/she] had been orienting Employee #40. The observations occurred on August 25 through 26, 2014.</p> <p>Facility staff failed to comply with State regulations as evidenced by a Licensed Practical Nurse not practicing within his/her scope of duty as evidenced by orienting a Registered Licensed Nurse.</p> <p>B. Based on record review and staff interview during the facility's personal funds review, it was determined that facility staff failed to inform the residents and/or responsible parties of items that were not covered by the facility and that they</p>	L 001	<p>Continued from page 3</p> <p>4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor and report monthly to the Quality Improvement Committee the orientation of Registered Nurses for at least one year, prior to the committee determining to discontinue this monitor.</p> <p>B)</p> <p>1. On 8/29/14 it was identified that the Admissions' Packet did not reflect a written description that the resident/responsible party were responsible for television, cable and telephone services, although this information was verbally communicated to residents/responsible parties. There were no negative outcomes to the residents/their responsible parties.</p> <p>2. The Admissions Contract was revised on 8/29/14 to indicate that the resident/responsible parties were responsible for the television, cable and telephone services.</p>	<p>10/31/14</p> <p>8/29/14</p> <p>8/29/14</p>

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L 001	Continued From page 4 [residents/responsible parties] would be responsible for the cost of those services. The findings include: A personal funds review was conducted with Employee #30 on August 29, 2014 at approximately 1:00 PM. A query was made of how residents and/or the responsible parties were informed of the cost of the television, telephone, cable services and any change in those services. Employee #30 stated that information was found in the Admissions Packet, and any change in services were reviewed during Resident Council Meetings. A review of the Admission's Packet that is provided to residents on admission to the facility, lacked evidence that they were informed of the cost for television, telephone, and cable services. Facility staff failed to inform residents/responsible parties of items that were not covered by the facility and they would be responsible for the cost of those services. C. Based on clinical record review and staff interview for one (1) of 39 sampled residents, it was determined that facility staff failed to ensure proper techniques were followed according to	L 001	Continued From page 4 3. The Admissions Department received an in-service on the required documentation in Admissions Contracts to inform the resident/responsible party of services not covered by Medicare and Medicaid on 10/27/14. 4. 4. Effective upon the completion of the survey on 9/2/14, a quality assurance program was implemented under the supervision of the Executive Clinical Director/Designated Representative to monitor the written communication of residents/responsible parties of services not covered by Medicare and Medicaid. Findings of the quality assurance checks will be documented and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.	10/27/14 10/31/14

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L 001	<p>Continued From page 5</p> <p>accepted standards of clinical practice in monitoring Resident #262's orthostatic blood pressures.</p> <p>The findings include:</p> <p>According to Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, " Measuring Orthostatic Blood Pressure: 1. Have the patient lie down for 5 minutes. 2. Measure blood pressure and pulse rate. 3. Have the patient stand. 4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes. A drop in BP (blood pressure) of [greater than or equal to 20 mmHg] (millimeters of mercury), or in diastolic BP of [greater than or equal to] 10 mm Hg, or experiencing lightheadedness or dizziness is considered abnormal." <http://www.cdc.gov/homeandrecreationalafety/pdf/steadi/measuring_orthostatic_bp.pdf></p> <p>The facility ' s policy entitled, "Orthostatic Blood Pressure last updated [no date indicated], stipulated, " Count the pulses (P) and take the blood pressure in baseline position (supine or sitting). Move resident to next most upright position that can be maintained. Ask resident is he or she experiencing symptoms. Wait one minute if possible, recheck the pulse and blood pressure, restore resident to prior position...Orthostatic changes are reflected when: Pulse is increased by ten beats per minute or more, with or without blood pressure change,</p>	L 001	<p>Continued From page 5</p> <p>1. Licensed nurses did not ensure proper techniques were followed by the accepted standards of clinical practice in monitoring Resident #262's orthostatic blood pressure. No corrective action can be done for Resident #262 due to physician orders to transfer the resident to the hospital for medical evaluation on 4/20/14. The resident did not return to the facility.</p> <p>2. All other residents' medical records were checked for specific physician orders for orthostatic (Blood Pressure) and none were found in the facility.</p> <p>3. Nursing Services Policy and Procedure for Orthostatic Blood Pressure was revised to reflect same as Center for Disease Control Prevention and the National Center for Injury Prevention/Control for Measuring Orthostatic Blood Pressure. Licensed Nurses received in-service on above Policy and Procedure for Clinical Management of residents with physician orders for Orthostatic Blood Pressure. Unit Managers will audit all care plans for residents with Orthostatic Blood Pressure orders.</p>	10/31/14

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L 001	<p>Continued From page 6</p> <p>Systolic blood pressure is decreased by 15mm Hg or more, without change in diastolic blood pressure, diastolic blood pressure is decreased by 5mm Hg or more with or without change in systolic blood pressure or pulse..."</p> <p>According to Web MD.com " Midodrine (Common brand name: ProAmatine) ...Warning: Midodrine should be used in carefully selected patients. When you are lying on your back, this medication causes a significant increase in blood pressure. Your blood pressure will be monitored carefully during treatment. This medication is used for certain patients who have symptoms of low blood pressure. Side Effects ...this medication can cause your blood pressure to increase, especially when you are lying down (supine hypertension. Stop taking Midodrine and contact your doctor immediately if you experience the following signs of supine hypertension: pounding heartbeat, pounding in the ears, headache ...Notes ...Blood pressure checks (lying, sitting, and standing) should be routinely taken. Share the results with your doctor. " <http://webmd.com/drugs/2/drug-14042/midodrine-oral/details></p> <p>A review of [rehabilitation hospital] discharge summary dated April 10, 2014 revealed the following:</p> <p>"Functional Status at the time of Discharge: With physical therapy, the patient required minimal assistance for bed mobility and stand-pivot transfers with and without the use of</p>	L 001	<p>Continued From page 6</p> <p>4. A quality assurance program to monitor Residents with physician orders for Orthostatic Blood Pressures under the supervision of Director of Nurses/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor</p>	10/31/14

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L 001	<p>Continued From page 7</p> <p>a rolling walker [He/she] was able to ambulate up to 25 feet with a rolling walker with minimal assistance. [He/she] was able to propel a wheelchair 20 feet with minimal assistance over tiled surfaces using [his/her] bilateral upper extremities ... [He/she] is limited by fatigue and orthostasis, and requires slow transitions from supine-to-sit and sit-to-stand. [He/she] is limited by fatigue and orthostatic hypotension.</p> <p>Hospital course while at [rehabilitation hospital]... Cardiovascular- [Resident name] has a history of dysautonomia with significant orthostatic hypotension related to [his/her] Parkinsonism. [He/she] had been started on Midodrine in (Therapeutic Class: Anti hypotensive Vasopressor) the acute hospital on the day of transfer... Midodrine was titrated to a stepped dose of 7.5mg at 6 am, 10mg at 10 am, and 5mg at 2 pm ... The patient ' s blood pressure should be monitored to avoid supine hypertension. On [his/her] current regimen [his/her] blood pressure on routine vital signs ranged from 120s to 145. [His/her] dose of Midodrine should be decreased if [his/her] systolic blood pressure is routinely going above 150 or if [he/her] is symptomatic with headaches or chest pain. [He/she] will need continued monitoring and adjustment of these medications after discharge. "</p> <p>The history and physical dated April 10, 2014 revealed that Resident #262's had diagnoses which included: worsening tremors, hallucinations, Parkinson Disease Dystonia, Lewy Body Dementia, Parkinson ' s Dementia and Orthostatic Hypotension. Resident was admitted to the skilled nursing facility on April 10,</p>	L 001	Continued From page 7	

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L 001	<p>Continued From page 8</p> <p>2014 for skilled speech, occupational and physical therapy.</p> <p>According to the admission MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of April 17, 2014 the resident was coded under Section G0300 - [Functional Status] Balance during Transitions and Walking as " Not steady, only able to stabilize with human assistance when moving from seated to [a] standing position.</p> <p>The physician ' s admission orders dated April 10, 2014 directed, " Routine vital signs, Medications ... Midodrine 7.5mg po (by mouth) at 6AM, 10mg po at 10 AM and 5mg po at 2PM for orthostatic hypotension associated with Parkinson disease. Please reduce dosing if patient is experiencing supine hypertension. Acetaminophen [Tylenol-analgesic/antipyretic] 325mg- 2 (two) tabs [tablets] po [by mouth] [every] 6 hours as needed for pain. "</p> <p>An interim physician ' s order dated April 14, 2014 directed, " Please check B/P (Blood Pressure), Pulse every shift for orthostatic hypotension. " There was no evidence that the physician included parameters for monitoring the blood pressure and pulse rate for orthostatic hypotension.</p> <p>A review of the electronic nursing notes revealed the following: "April 14, 2014 at 2:50 AM- 132/80 (blood pressure), 78 (apical pulse), 20 (respirations), 97.6 (temperature)</p> <p>April 14, 2014 at 11:06 PM - Temp (temperature)</p>	L 001		

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L 001	<p>Continued From page 9</p> <p>98.2, 72(Pulse), 110/70 (Blood Pressure), Resident had c/o [complain of] headache and Tylenol PRN medication was offered but resident refused to take. No other distress noted at this time.</p> <p>4/15/14- Night shift - No vital signs recorded.</p> <p>4/15/14- Day shift -No vital signs documented.</p> <p>4/15/14- Evening- No vital signs documented.</p> <p>4/16/14- Night shift- 12:03 AM, Temp 98.3- Pulse-88, Blood Pressure-124/78, Respiratory Rate-20</p> <p>4/16/14- Night shift-2:53 AM -129/79 (Blood Pressure), 70 (apical pulse), 98.3 (temp), 20 (respiratory rate).</p> <p>4/16/14- Evening shift at 5:13 PM - 98.2 Temp, 84- Pulse, Respiration Rate-20, Blood Pressuere-124/74. Resident is sitting in wheelchair with bedside table near and call light within reach.</p> <p>4/17/14- Day shift- No vital signs documented.</p> <p>4/17/14- Night shift-at 3:14 AM-129/70 (Blood Pressure), 77 (Pulse), 20-(Respiratory Rate), Temp- 97.8.</p> <p>4/17/14- No vital signs documented.</p> <p>4/17/14- Evening shift at 9:54 PM- 142/80 (Blood Pressure), 78 (Pulse), 97.6 (Temperature)</p> <p>4/17/14- Night shift - no vital signs documented.</p>	L 001		

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L 001	<p>Continued From page 10</p> <p>4/18/14-Night shift at 02: 04 AM- 133/70 (Blood Pressure), 78 (Apical Pulse), 97.3 (Temperature), 18 (Respiratory Rate)</p> <p>4/18/14- Evening shift at 3:26 PM- 126/74(Blood Pressure), 74 (Pulse), 18 (Respiratory Rate), 97.0 (Temperature)</p> <p>4/18/14- Evening shift at 11:25 PM- 124/78 (Blood Pressure), 84 (Pulse), 20 (Respiratory Rate), 98.3 (Temperature)</p> <p>4/19/14 - Night shift at 2:37 AM- 132/71(Blood Pressure), 80 (apical pulse), 97.9 (Temperature), 20 (Respirations)</p> <p>4/19/14- Night shift- No vital signs documented.</p> <p>4/19/14- Day shift- No vital signs documented.</p> <p>4/19/14- Evening shift- No vital signs documented.</p> <p>4/20/14 at 4:26 PM- Writer was called to room because resident [was] unresponsive. V/S (Vital Signs): Temperature 97.4, Heart Rate-114, Respiratory Rate- 12, Oxygen Saturation- 64%. CPR (Cardiopulmonary Resuscitation) started, 911, and MD (Medical Doctor) called and gave order to transfer resident to hospital for unresponsiveness. Resident left unit via EMT (Emergency Medical Team) at 1:15 PM."</p> <p>There was no evidence that the resident ' s blood pressure was obtained at the time of the transfer to the hospital.</p> <p>A review of the MAR/TAR (Medication</p>	L 001		

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L 001	<p>Continued From page 11</p> <p>Administration Record/Treatment Administration Record) revealed the following vital signs/medication:</p> <p>" 4/14/14- Tylenol administered [no time indicated] - Reason- c/o (complaint of) headache- pain assessed as " 6/10. " Result- effective - " 2/10. " No blood pressure or pulse documented.</p> <p>4/15/14- No vital signs recorded on night shift</p> <p>4/15/14 - Day shift -vital signs documented- not legible to read.</p> <p>4/15/14- Evening shift -120/70 (Blood Pressure)</p> <p>4/16/14- Evening shift - writing not legible to read</p> <p>4/17/14- Day shift- 129/70 (Blood Pressure) - Pulse-writing not legible to read</p> <p>4/17/14- Evening shift- 130/74 (Blood Pressure)- Pulse- writing not legible to read</p> <p>4/17/14- Night shift -writing not legible to read</p> <p>4/19/14- Night shift- Blood Pressure - 106/75</p> <p>4/19/14- Day shift- Blood Pressure: 125/70- Pulse-60</p> <p>4/19/14 - Evening shift- Blood Pressure - 130/70.</p> <p>4/20/14- Day shift according to MAR- 128/76 (Blood Pressure0, No pulse documented. "</p> <p>There was no evidence in the clinical record that the attending physician or nurse practitioner was informed of Resident #262 ' s complaint of a</p>	L 001		
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L 001	<p>Continued From page 12</p> <p>headache on April 14, 2014. In addition, the resident ' s blood pressure(s) were not taken every shift. When the blood pressures were taken, there was no evidence that the staff obtained orthostatic blood pressures as ordered by the physician.</p> <p>A review of the Doctors Progress notes revealed the following:</p> <p>April 10, 2014- Nurse Practitioner's note - "... admitted to NH (nursing home) after hospital ... [Treatment] of Parkinson ' s disease with significant dysautonomia, Dementia, GERD (Gastro esophageal Reflux Disease) ... Orthostatic Hypotension, UTI (Urinary Tract infection) with ESBL (Extended Spectrum Beta-Lactamase) E. coli (Escherichia Coli). Alert-Weak."</p> <p>April 12, 2014 - "... Transferred to NH (nursing home) for further OT (Occupational Therapy), PT (Physical Therapy) and SLP (Speech Language Pathology)." Problem List: "Old [and] Chronic Problems ... Orthostatic Hypotension. Physical Examination: Temp (Temperature)- 97.6, Pulse-74, [Respiratory Rate] - 16, [Blood Pressure] - 120/72."</p> <p>April 18, 2014- Nurse Practitioner's note- "[Patient] with recent UTI [with] ESBL- [Status Post] Antibiotic Treatment. [History] of Parkinson, Dementia, GERD, Acute Kidney Disease, Orthostatic Hypotension. Plan...</p>	L 001		

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L 001	<p>Continued From page 13</p> <p>Calcium with Vitamin D 600/400- one QD (everyday). "</p> <p>There was no evidence in the clinical record that the attending physician or the nurse practitioner addressed the resident's orthostatic hypotension in [his/her] total plan of care, after a physician's order was written on April 14, 2014 to " check B/P (Blood Pressure), Pulse every shift for orthostatic hypotension " in his/her total plan of care.</p> <p>A face-to-face interview was conducted with Employee #2 on August 29, 2014 at approximately 3:46 PM. After reviewing the clinical record. He/she acknowledged the aforementioned findings.</p> <p>A follow-up telephone interview was conducted with Employee # 32 on September 2, 2014 at approximately 2:18 PM in the presence of Employees #1 and 2. Employee #32 acknowledged that parameters should have been written for the orthostatic blood pressure reading(s). It was further stated that "Orthostatic blood pressure(s) are generally initially taken in the supine position before assuming a standing position. "</p> <p>In conclusion, there was no evidence that the facility consistently assessed and monitored Resident #262's orthostatic blood pressure and pulse despite the resident's diagnosis of Orthostatic Hypotension. In addition, there was</p>	L 001		

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L 001	<p>Continued From page 14</p> <p>no evidence that the facility staff indicated the position of the resident when the orthostatic blood pressure and pulse was obtained or notified the physician regarding the resident's complaint of a headache. On April 20, 2014, the resident was found unresponsive and was transferred to the nearest emergency room via 911. The clinical record was reviewed on September 2, 2014.</p> <p>A face-to-face interview was conducted with Employee #10 on August 28, 2014 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on August 28, 2014.</p> <p>Cross referenced to 3211.1- Nursing Personnel and required staffing levels</p>	L 001		
L 035	<p>3207.10 Nursing Facilities</p> <p>Dated orders and dated progress notes in the resident's medical record shall be used to document medical supervision at the time of each visit and shall be signed and dated by the resident's physician or the resident's nurse practitioner or physician assistant, with countersignature by the resident's physician.</p> <p>This Statute is not met as evidenced by:</p> <p>Based on record review and staff interview for one (1) of 39 sampled residents, it was determined that the physician failed to review Resident #262's orthostatic blood pressure status in the total plan of care. Resident #262 and #46.</p> <p>The findings include:</p>	L 035	<p>3207.10 Nursing Facilities A) Resident #262</p> <p>1. The attending physician did not consistently review the orthostatic blood pressure status in plan of care for resident #262. The resident was transferred to the hospital for medical evaluation on 4/20/14.</p>	

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L 035	<p>Continued From page 15</p> <p>1. The physician failed to review Resident #262's orthostatic blood pressure status in his/her total plan of care.</p> <p>A review of Resident #262's clinical record revealed that the resident was admitted to the facility on April 10, 2014 and diagnoses included Orthostatic Hypotension.</p> <p>The history and physical examination dated April 10, 2014 revealed that Resident #262's diagnoses included: worsening tremors, hallucinations, Parkinson Disease Dystonia, Lewy Body Dementia, Parkinson's Dementia and Orthostatic Hypotension. The resident was admitted to the skilled nursing facility on April 10, 2014 for skilled speech, occupational and physical therapy.</p> <p>The physician's admission orders dated April 10, 2014 directed, " Routine vital signs, Medications ... Midodrine 7.5mg po (by mouth) at 6AM, 10mg po at 10 AM and 5mg po at 2 PM for Orthostatic Hypotension associated with Parkinson disease. Please reduce dosing if patient is experiencing supine hypertension. Acetaminophen [Tylenol-analgesic/antipyretic] 325mg- 2 (two) tabs po [every] 6 hours as needed for pain. "</p> <p>An interim physician's order dated April 14, 2014 directed, "Please check B/P (Blood Pressure), Pulse every shift for Orthostatic Hypotension." There was no evidence that the physician</p>	L 035	<p>Continued from page 15</p> <p>2. All resident medical records were reviewed and there were no other residents in the facility with orders for orthostatic blood pressures.</p> <p>3. In-service was provided by the Medical director with the attending physician on 10/31/14 regarding Regulatory Requirements in reviewing the residents' orthostatic blood pressures and total plan of care.</p> <p>4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor monthly and report monthly to the Quality Improvement Committee all residents that receive orders for orthostatic blood pressures. Findings of the quality assurance checks will be documented and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.</p>	<p>10/31/14</p> <p>10/31/14</p> <p>10/31/14</p>

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L 035	<p>Continued From page 16</p> <p>included parameters for monitoring the blood pressure and pulse rate for Orthostatic Hypotension.</p> <p>A review of the electronic nursing notes revealed the following: April 14, 2014 at 2:50 AM- "132/80 (blood pressure), 78 (apical pulse), 20 (respirations), 97.6 (temperature)"</p> <p>April 14, 2014 at 11:06 PM - "Temp (temperature) 98.2, 72(Pulse), 110/70 (Blood Pressure), Resident had c/o [complain of] headache and Tylenol PRN medication was offered but resident refused to take. No other distress noted at this time."</p> <p>4/15/14- Night shift - No vital signs recorded.</p> <p>4/15/14- Day shift -No vital signs documented.</p> <p>4/15/14- Evening- No vital signs documented.</p> <p>4/16/14- Night shift- 12:03 AM, Temp 98.3- Pulse-88, Blood Pressure-124/78, Respiratory Rate-20</p> <p>4/16/14- Night shift-2:53 AM -129/79 (Blood Pressure), 70 (apical pulse), 98.3 (temp), 20 (respiratory rate).</p> <p>4/16/14- Evening shift at 5:13 PM - 98.2 Temp, 84- Pulse, Respiration Rate-20, Blood Pressuere-124/74. Resident is sitting in wheelchair with bedside table near and call light within reach.</p> <p>4/17/14- Day shift- No vital signs documented.</p>	L 035	Continued From page 16	
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L 035	<p>Continued From page 17</p> <p>4/17/14- Night shift-at 3:14 AM-129/70 (Blood Pressure), 77 (Pulse), 20-(Respiratory Rate), Temp- 97.8.</p> <p>4/17/14- No vital signs documented.</p> <p>4/17/14- Evening shift at 9:54 PM- 142/80 (Blood Pressure), 78 (Pulse), 97.6 (Temperature)</p> <p>4/17/14- Night shift - no vital signs documented.</p> <p>4/18/14-Night shift at 02: 04 AM- 133/70 (Blood Pressure), 78 (Apical Pulse), 97.3 (Temperature), 18 (Respiratory Rate)</p> <p>4/18/14- Evening shift at 3:26 PM- 126/74(Blood Pressure), 74 (Pulse), 18 (Respiratory Rate), 97.0 (Temperature)</p> <p>4/18/14- Evening shift at 11:25 PM- 124/78 (Blood Pressure), 84 (Pulse), 20 (Respiratory Rate), 98.3 (Temperature)</p> <p>4/19/14 - Night shift at 2:37 AM- 132/71(Blood Pressure), 80 (apical pulse), 97.9 (Temperature), 20 (Respirations)</p> <p>4/19/14- Night shift- No vital signs documented.</p> <p>4/19/14- Day shift- No vital signs documented.</p> <p>4/19/14- Evening shift- No vital signs documented.</p> <p>4/20/14 at 4:26 PM- "Writer was called to room because resident [was] unresponsive. V/S (Vital Signs): Temperature 97.4, Heart Rate-114, Respiratory Rate- 12, Oxygen Saturation- 64%. CPR (Cardiopulmonary Resuscitation) started,</p>	L 035	Continued From page 17	

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L 035	<p>Continued From page 18</p> <p>911, and MD (Medical Doctor) called and gave order to transfer resident to hospital for unresponsiveness. Resident left unit via EMT (Emergency Medical Team) at 1:15 PM."</p> <p>There was no evidence that the resident's blood pressure was obtained at the time of the transfer to the hospital.</p> <p>A review of the MAR/TAR (Medication Administration Record/Treatment Administration Record) revealed the following vital signs/medication:</p> <p>" 4/14/14- Tylenol administered [no time indicated] - Reason- c/o (complaint of) headache- pain assessed as " 6/10. " Result- effective - " 2/10. " No blood pressure or pulse documented.</p> <p>4/15/14- No vital signs recorded on night shift</p> <p>4/15/14 - Day shift -vital signs documented- not legible to read.</p> <p>4/15/14- Evening shift -120/70 (Blood Pressure)</p> <p>4/16/14- Evening shift - writing not legible to read</p> <p>4/17/14- Day shift- 129/70 (Blood Pressure) - Pulse- writing not legible to read</p> <p>4/17/14- Evening shift- 130/74 (Blood Pressure)- Pulse- writing not legible to read</p> <p>4/17/14- Night shift -writing not legible to read</p> <p>4/19/14- Night shift- Blood Pressure - 106/75</p>	L 035	Continued From page 18	

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L 035	<p>Continued From page 19</p> <p>4/19/14- Day shift- Blood Pressure: 125/70- Pulse-60</p> <p>4/19/14 - Evening shift- Blood Pressure - 130/70.</p> <p>4/20/14- Day shift according to MAR- 128/76 (Blood Pressure0, No pulse documented. "</p> <p>There was no evidence in the clinical record that the attending physician or nurse practitioner was informed of Resident #262 ' s complaint of a headache on April 14, 2014. In addition, the resident ' s blood pressure(s) were not taken every shift. When the blood pressures were taken, there was no evidence that the staff obtained orthostatic blood pressures as ordered by the physician.</p> <p>A review of the Doctors Progress notes revealed:</p> <p>April 10, 2014- Nurse Practitioner's note - "... admitted to NH (nursing home) after hospital ... [Treatment] of Parkinson ' s disease with significant dysautonomia, Dementia, GERD (Gastro esophageal Reflux Disease) ... Orthostatic Hypotension, UTI (Urinary Tract infection) with ESBL (Extended Spectrum Beta-Lactamase) E. coli (Escherichia Coli). Alert- Weak."</p> <p>April 12, 2014 - " ... Transferred to NH (nursing home) for further OT (Occupational Therapy), PT (Physical Therapy) and SLP (Speech Language Pathology). Problem List: Old [and] Chronic Problems ... Orthostatic Hypotension. Physical Examination: Temp (Temperature)- 97.6,</p>	L 035	Continued From page 19	

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L 035	<p>Continued From page 20</p> <p>Pulse-74, [Respiratory Rate] - 16, [Blood Pressure] - 120/72."</p> <p>April 18, 2014- Nurse Practitioner's note- "[Patient] with recent UTI [with] ESBL- [Status Post] Antibiotic Treatment. [History] of Parkinson, Dementia, GERD, Acute Kidney Disease, Orthostatic Hypotension. Plan... Calcium with Vitamin D 600/400- one QD (everyday). "</p> <p>There was no evidence in the clinical record that the attending physician or the nurse practitioner addressed the resident's Orthostatic Hypotension in [his/her] total plan of care.</p> <p>A face-to-face interview was conducted with Employee #24 on August 28, 2014 at approximately 11:30 AM. Employee #24 stated, "I looked at the documented blood pressures. However, I did not address them in the progress notes." Employee #24 acknowledged the findings.</p> <p>A follow-up telephone interview was conducted with Employee # 32 on September 2, 2014 at approximately 2:18 PM in the presence of Employees #1 and #2. Employee #32 acknowledged that parameters should have been written for the Orthostatic Blood Pressure</p>	L 035	Continued From page 20	

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L 035	Continued From page 21 reading(s). It was further stated that "Orthostatic Blood Pressure(s) are generally initially taken in the supine position before assuming a standing position." The record was reviewed on August 28, 2014.	L 035	Continued From page 21	
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record review and staff interviews for one (1) of 39 sampled residents, it was determined that the charge nurse failed to notify the physician of Resident #262's complaint of a	L 051		

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L 051	<p>Continued From page 22</p> <p>headache.</p> <p>The findings include:</p> <p>According to the hospital "Discharge Summary" dated April 10, 2014 ... "[Resident #262] dose of Midodrine [Antihypotensive/ Vasopressor medication] should be decreased if [his/her] systolic blood pressure is routinely going above 150 or if [he/she] is symptomatic with headaches or chest pain. [He/she] will need continued monitoring and adjustment of these medications after discharge."</p> <p>A history and physical dated April 10, 2014 revealed that Resident #262 's diagnoses included: Worsening Tremors, Parkinson Disease and Orthostatic Hypotension.</p> <p>An interim physician 's order dated April 14, 2014 directed, " Please check B/P (Blood Pressure), Pulse every shift for Orthostatic Hypotension. "</p> <p>An electronic nursing note dated April 14, 2014 revealed the following: April 14, 2014 at 11:06 PM -" Temp (temperature) 98.2, 72(Pulse), 110/70 (Blood Pressure), Resident had c/o [complained of] headache and Tylenol PRN [as needed]medication was offered but resident refused to take. No other distress noted at this time."</p> <p>A review of the MAR/TAR (Medication Administration Record/Treatment Administration Record) revealed that Resident #262 was administered Tylenol 325mg - two (2) tabs [tablets] on April 14, 2014 (no time indicated) for, "Reason-c/o (complaint of) headache- pain</p>	L 051	<p>A) Resident #262</p> <p>1. It is the policy and practice of the facility to report changes in a resident's condition to the physician. There is no corrective action that can be done for deficiency observed with resident #262 during the timeframe identified due to resident being transferred to the hospital for medical evaluation on 4/20/14.</p> <p>2. Because all residents experiencing changes are potentially affected by this cited deficiency on 8/29/14 all 24-Hour Nursing Reports and all residents Medication Administration Records (MARs) were reviewed for unresolved complaints of headache or other pain without written documentation notifying the physician. No other residents were affected.</p> <p>3. An In-service was provided for licensed Nursing staff regarding Required Notification of Physician regarding resident medical complaints with focus on pain medication relief on 10/31/14.</p> <p>The assigned nurse to resident #262 was re-educated on physician notification and documentation of a resident's pain assessment.</p>	<p>4/20/14</p> <p>8/29/14</p> <p>10/31/14</p>

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L 051	<p>Continued From page 23</p> <p>assessed as " 6/10 ", Result- effective " 2/10. " No blood pressure or pulse documented.</p> <p>The clinical record lacked evidence that the physician was notified regarding the resident ' s complaint of a headache.</p> <p>A face-to-face interview was conducted with Employee #2 on August 29, 2014 at approximately 3:46 PM. After reviewing the clinical record the employee acknowledged the aforementioned findings. The record was reviewed on August 29, 2014.</p> <p>B. Based on resident observation, record review, and staff interview for one (1) of 39 sampled residents, it was determined that the charge nurse failed to develop a care plan with goals and approaches for one (1) resident with excessive secretions and spitting. Resident #46</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The charge nurse failed to develop a care plan for Resident #46 with goals and approaches for excessive secretions and spitting. <p>During a resident interview conducted on August 26, 2014 at approximately 3:00 PM, Resident #46 was observed holding sputum in his/her mouth. Before responding to a query, he/she spit clear sputum in a clear cup.</p>	L 051	<p>Continued From page 23</p> <p>4. Effective 9/19/14, a quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor the Notification of physicians regarding residents' medical complaints. Findings of the quality assurance checks will be documented and reported monthly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.</p> <p>B) Resident #46</p> <ol style="list-style-type: none"> 1. Resident #46 Care Plan was developed with goals, individual approaches and interventions to address excessive secretions and spitting. 10/31/14 2. All care plans of residents with potential for excessive secretions or spitting were checked and updated as required. 10/31/14 3. In-service was provided on 10/ 31/14 for Resident Care Managers that focused on Review of the Resident Care Plans. 10/31/14 	9/19/14

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L 051	<p>Continued From page 24</p> <p>On August 29, 2014 at approximately 11:00 AM, the resident was observed sitting in the common area, and again expelled sputum into a clear cup.</p> <p>A review of the medical record revealed a "Consultation Form" dated November 27, 2013 which stated: "Report Requested Regarding: GI [Gastrointestinal] consult for etiology of spitting. It is unclear why [he/she] chose to be spitting because [he/she] can easily swallow [his/her] saliva and [he/she] did in our presence. Esophagus was normal no evidence of obstruction; Routine: 1. Encourage pt [patient] to swallow [his/her] saliva; 2. f/u [follow up] ENT [Ear, Nose Throat] ..."</p> <p>A "Consultation Form" dated June 20, 2014 (seven months later) revealed: "Report requested regarding: ENT consult referred by GI for etiology of spitting. Diagnosis: Dysphagia-unknown etiology. Has PEG [percutaneous esophageal gastrostomy]. Routine: 1. Need modified Barium swallow to assess swallowing mechanism."</p> <p>A review of the Rehab [Rehabilitation] Services Requisition dated July 2, 2014 revealed the following: "Recommend Swallow test in house; no need for modified barium swallow suspect functional feeding D/o [disorder] related to Dementia..."</p> <p>A review of the care plan section of the clinical record revised May 21, 2014 lacked evidence of</p>	L 051	<p>Continued from page 24</p> <p>4. A quality assurance program to monitor the Resident Care Plan Review under the supervision of the Director of Nurses/Designated Representative which will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.</p>	10/31/14

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L 051	<p>Continued From page 25</p> <p>a care plan with goals and approaches to address Resident #46's excessive secretions and spitting.</p> <p>The charge nurse failed to develop a care plan with goals and approaches for one (1) resident with excessive secretions and spitting.</p> <p>C. Based on observation, record review, and staff interviews for three (3) of 39 sampled residents, it was determined that the charge nurse failed to review and revise care plans for one (1) resident with bilateral foot contractures, one (1) resident with a history of orthostatic changes [Orthostatic Hypotension] and one (1) resident with a Venous Access device (Arteriovenous (AV) graft) which lacked approaches related to potential complications. Residents #93, #129, and #262.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The charge nurse failed to review and revise Resident #93's care plan to include goals and approaches to address his/her bilateral foot contractures. <p>On August 26, 2014 at approximately 12:02 PM, Resident #93's feet were observed resting upon a footrest pointed in a downward position.</p> <p>On August 27, 2014 at approximately 9:43 AM during a staff interview, Employee #35 was asked, "Does the resident have a contracture ...? " He/she replied, " bilateral foot drop."</p>	L 051	<p>Continued From page 25</p> <p>C) Resident #93</p> <ol style="list-style-type: none"> Resident #93 Care Plan was developed with goals, individual approaches and interventions to address his/her bilateral foot contractures on 8/28/14. All care plans of residents with potential for foot contractures were checked and updated as required. In-service was provided for Resident Care Managers that focused on updating the Residents' Care Plans. <p>Unit Managers will audit care plans for residents with foot contractures monthly.</p>	<p>8/28/14</p> <p>8/28/14</p> <p>8/28/14</p>
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L 051	<p>Continued From page 26</p> <p>A review of the current History and Physical dated July 8, 2014 revealed that the resident was admitted to the facility with a diagnosis that included "Old CVA with Dysphagia." The 'Physical Examination' section revealed "abnormal orientation, motor deficits, joints, and gait."</p> <p>The nursing care plan initiated January 11, 2014 and updated on July 15, 2014 included the following:</p> <p>"Problem: Inadequate self-care [related to Cerebrovascular Accident [CVA] ...</p> <p>Approach: Nurse Aide---Support affected extremity with arm and/or leg rest when in a wheelchair, Check mouth for food/pocketing and remove food if found, Follow turning schedule, Provide clean clothing, free of food/drink/secretions, PROM (Passive Range of Motion) with AM [morning] and HS [night] care.</p> <p>Goal: No skin breakdown, no evidence of contractures, April 29, 2014 [updated] ...</p> <p>July 15, 2014, Resident dependent on staff for self-care. Turn and repositioning done every 2 hrs [hours] no skin breakdown this review. Plan of care continues. "</p> <p>There was no evidence that the care plan was updated to include approaches and goals to address the bilateral foot contractures.</p> <p>On August 28, 2014 at approximately 3:25 PM, a face-to-face interview was conducted with Employee #24 regarding the functional status of</p>	L 051	<p>Continued from page 26</p> <p>4. A quality assurance program to monitor the Resident Care Plan Review under the supervision of the Director of Nurses/Designated Representative which will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.</p>	10/31/14

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L 051	<p>Continued From page 27</p> <p>the resident's bilateral feet. He/she stated, " I just completed an assessment on the resident. He/she has bilateral foot contractures..."</p> <p>On September 2, 2014 at approximately 3:30 PM, a face-to-face interview was conducted with Employee #22 regarding the aforementioned findings. He/she acknowledged that there was no care plan to address the resident's bilateral feet contractures.</p> <p>There was no evidence that the charge nurse reviewed and/or revised the care plan to include approaches and goals to address the resident's bilateral feet contractures. The record was reviewed August 28, 2014.</p> <p>2. The charge nurse failed to review and revise a care plan with goals and approaches to address potential complications from a Venous Access Device (AV graft) for Resident #129.</p> <p>A review of the resident's care plan revised on June 16, 2014 revealed the following: "Observe left arm access site every shift for bleeding, signs and symptoms of infection, bruit and thrill, document on ECS [electronic charting system]...monitor labs, Assess vascular access site for complications, report s/sx [signs and symptoms] [of] complications..."</p> <p>The care plan lacked evidence of approaches/interventions that should be implemented in the event that a complication such as bleeding occurred.</p>	L 051	<p>Continued From page 27</p> <p>2) Resident #129</p> <p>1. Resident #129 Care Plan was developed with goals, individual approaches and interventions to address his/her Venous Access Device (AV graft) with potential complication of device.</p> <p>2. All care plans of residents with Venous Access Devices (AV graft) were checked and updated as required.</p> <p>3. Care plans for residents with Venous Access Devices will be monitored monthly by Unit Managers.</p> <p>In-service was provided for Resident Care Managers that focused on Review of the Resident Care Plan.</p>	<p>10/31/14</p> <p>10/31/14</p> <p>10/31/14</p>

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L 051	<p>Continued From page 28</p> <p>A face-to-face interview was conducted with Employee #17 on August 28, 2014 at approximately 11:00 AM. After reviewing the resident's care plan, the employee acknowledged that it lacked evidence of approaches to be implemented to treat potential complication/s of bleeding and/or infection. The clinical record was reviewed on August 28, 2014.</p> <p>The charge nurse failed to review and revise a care plan with goals and approaches for potential complication for Resident #129's Venous Access Device.</p> <p>3. The charge nurse failed to amend Resident #262's care plan to address specific interventions related to the management of orthostatic [Blood Pressure] changes.</p> <p>The " Facility's Policy" entitled, "Orthostatic Blood Pressure " stipulated ... " Count the pulse (P) and take the blood pressure in baseline position (supine or sitting). Move resident to next most upright position that can be maintained. Ask resident is [he/she] experiencing symptoms. Wait one minute if possible, recheck the pulse and blood pressure, restore resident to prior position....Orthostatic changes are reflected when: Pulse is increased by ten beats per minute or more, with or without blood pressure change, Systolic blood pressure is decreased by 15mm Hg or more, without change in diastolic blood pressure, diastolic blood pressure is decreased by 5mm Hg or more with or without change in systolic blood pressure or pulse..."</p>	L 051	<p>Continued from page 28</p> <p>A quality assurance program to monitor the Resident Care Plan Review under the supervision of Director of Nurses/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue the monitor.</p> <p>3) Resident #262</p> <p>1. Due to a closed medical record review for resident #262, no corrective action could be done for the resident #262 related to management of orthostatic (Blood Pressure) changes. The resident was transferred to the hospital on 4/19/14.</p> <p>2. All other residents' medical records were checked for specific physician orders for orthostatic (Blood Pressure) and none were found.</p>	<p>10/31/14</p> <p>10/31/14</p>

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L 051	<p>Continued From page 29</p> <p>An interim physician's order dated April 14, 2014 at 11:00 AM directed, "Please check B/P (Blood Pressure), pulse every shift for orthostatic hypotension."</p> <p>The care plan dated April 11, 2014 revealed; "Problem: Hypotension related to low B/P - Orthostatic /blood pressure - Approaches: Nurses-check B/P at 6AM, 10AM, 2PM prior to giving Midodrine (Antihypotensive vasopressor). Monitor for dizziness, confusion and [notify] MD (Medical doctor)."</p> <p>The care plan lacked evidence that it was amended to address specific interventions related to the position [s]of the resident when obtaining orthostatic blood pressure readings. The clinical record was reviewed on August 26, 2014.</p> <p>A face-to-face interview was conducted with Employee #10 on August 26, 2014 at approximately 2:00 PM. The employee acknowledged the aforementioned findings.</p>	L 051	<p>Continued from page 29</p> <p>3. An in-service was initiated for the nursing staff that focused on revised Policy and Procedure related to Orthostatic (Blood Pressure) as ordered by the physician.</p> <p>Unit Managers will conduct weekly audits for residents with orders for Orthostatic Blood Pressure.</p> <p>4. A quality assurance program to monitor Physician orders for residents in the future for orthostatic (Blood Pressure) changes under the supervision of Director of Nurses/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.</p>	<p>10/31/14</p> <p>10/31/14</p>
L 052	<p>3211.1 Nursing Facilities</p> <p>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:</p> <p>(a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;</p> <p>(b) Proper care to minimize pressure ulcers and</p>	L 052		

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L 052	<p>Continued From page 30</p> <p>contractures and to promote the healing of ulcers:</p> <p>(c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;</p> <p>(d) Protection from accident, injury, and infection;</p> <p>(e) Encouragement, assistance, and training in self-care and group activities;</p> <p>(f) Encouragement and assistance to:</p> <p>(1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;</p> <p>(2) Use the dining room if he or she is able; and</p> <p>(3) Participate in meaningful social and recreational activities; with eating;</p> <p>(g) Prompt, unhurried assistance if he or she requires or request help with eating;</p> <p>(h) Prescribed adaptive self-help devices to assist him or her in eating independently;</p> <p>(i) Assistance, if needed, with daily hygiene, including oral care; and</p> <p>j) Prompt response to an activated call bell or call for help.</p>	L 052	Continued From page 30	

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L 052	<p>Continued From page 31</p> <p>This Statute is not met as evidenced by: Based on record review and staff interviews for one (1) of 39 sampled residents, it was determined that sufficient nursing time was given to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care; as evidenced by: failure to consistently assess and monitor one (1) resident's orthostatic blood pressure(s) according to the physician 's orders. Residents #262.</p> <p>The findings include:</p> <p>Facility staff failed to ensure sufficient nursing time was given to consistently assess and monitor Resident #262's orthostatic blood pressure(s) in accordance with the physician's orders.</p> <p>According to the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, " Measuring Orthostatic Blood Pressure: 1. Have the patient lie down for 5 minutes. 2. Measure blood pressure and pulse rate. 3. Have the patient stand. 4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes. A drop in BP (blood pressure) of [greater than or equal to 20 mmHg] (millimeters of mercury), or in diastolic BP of [greater than or equal to] 10 mm Hg, or experiencing lightheadedness or dizziness is considered abnormal." <http://www.cdc.gov/homeandrecreationalafety/pdf/steady/measuring_orthostatic_bp.pdf></p> <p>The facility's policy entitled, "Orthostatic Blood</p>	L 052	<p>Continued From page 31</p> <p>1. Licensed nurses did not ensure proper techniques were followed by the accepted standards of clinical practice in monitoring Resident #262's orthostatic blood pressure. No corrective action can be done for Resident #262 due to physician orders to transfer the resident to the hospital for medical evaluation on 4/20/14. The resident did not return to the facility.</p> <p>2. All other residents' medical records were checked for specific physician orders for orthostatic (Blood Pressure) and none were found in the facility.</p>	

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L 052	<p>Continued From page 32</p> <p>Pressure," last updated [no date indicated], stipulated, " Count the pulses (P) and take the blood pressure in baseline position (supine or sitting). Move resident to next most upright position that can be maintained. Ask resident is he or she experiencing symptoms. Wait one minute if possible, recheck the pulse and blood pressure, restore resident to prior position...Orthostatic changes are reflected when: Pulse is increased by ten beats per minute or more, with or without blood pressure change, Systolic blood pressure is decreased by 15mm Hg or more, without change in diastolic blood pressure, diastolic blood pressure is decreased by 5mm Hg or more with or without change in systolic blood pressure or pulse..."</p> <p>According to Web MD.com " Midodrine (Common brand name: ProAmatine) ...Warning: Midodrine should be used in carefully selected patients. When you are lying on your back, this medication causes a significant increase in blood pressure. Your blood pressure will be monitored carefully during treatment. This medication is used for certain patients who have symptoms of low blood pressure. "</p> <p>Side Effects "...this medication can cause your blood pressure to increase, especially when you are lying down (supine hypertension. Stop taking Midodrine and contact your doctor immediately if you experience the following signs of supine hypertension: pounding heartbeat, pounding in the ears, headache ...Notes ...Blood pressure checks (lying, sitting, and standing) should be routinely taken. Share the results with your doctor. "</p> <p><http://webmd.com/drugs/2/drug-14042/midodrine-oral/details></p>	L 052	<p>Continued from page 32</p> <p>3. Nursing Services Policy and Procedure for Orthostatic Blood Pressure was revised to reflect same as Center for Disease Control Prevention and the National Center for Injury Prevention/Control for Measuring Orthostatic Blood Pressure. Licensed Nurses received in-service on above Policy and Procedure for Clinical Management of residents with physician orders for Orthostatic Blood Pressure. Unit Managers will audit all care plans for residents with Orthostatic Blood Pressure orders.</p> <p>4. Unit Managers will audit all care plans for residents with Orthostatic Blood Pressure orders.</p> <p>5. A quality assurance program to monitor Residents with physician orders for Orthostatic Blood Pressures under the supervision of Director of Nurses/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee commencing on November 21, 2014 for at least one year, prior to the committee determining to discontinue this monitor.</p>	<p>10/31/14</p> <p>10/31/14</p>

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L 052	<p>Continued From page 33</p> <p>A review of [rehabilitation hospital] discharge summary dated April 10, 2014 revealed the following:</p> <p>"Functional Status at the time of Discharge: With physical therapy, the patient required minimal assistance for bed mobility and stand-pivot transfers with and without the use of a rolling walker [He/she] was able to ambulate up to 25 feet with a rolling walker with minimal assistance. [He/she] was able to propel a wheelchair 20 feet with minimal assistance over tiled surfaces using [his/her] bilateral upper extremities ... [He/she] is limited by fatigue and orthostasis, and requires slow transitions from supine-to-sit and sit-to-stand. [He/she] is limited by fatigue and orthostatic hypotension."</p> <p>Hospital course while at [rehabilitation hospital]... Cardiovascular- [Resident name] has a history of dysautonomia with significant orthostatic hypotension related to [his/her] Parkinsonism. [He/she] had been started on Midodrine in (Therapeutic Class: Anti hypotensive Vasopressor) the acute hospital on the day of transfer... Midodrine was titrated to a stepped dose of 7.5mg at 6 am, 10mg at 10 am, and 5mg at 2 pm ... The patient's blood pressure should be monitored to avoid supine hypertension. On [his/her] current regimen [his/her] blood pressure on routine vital signs ranged from 120s to 145. [His/her] dose of Midodrine should be decreased if [his/her] systolic blood pressure is routinely going above 150 or if [he/she] is symptomatic with headaches or chest pain. [He/she] will need</p>	L 052	Continued From page 33	

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L 052	<p>Continued From page 34</p> <p>continued monitoring and adjustment of these medications after discharge. "</p> <p>The history and physical dated April 10, 2014 revealed that Resident #262's diagnoses included: worsening tremors, hallucinations, Parkinson Disease Dystonia, Lewy Body Dementia, Parkinson's Dementia and Orthostatic Hypotension. Resident was admitted to the skilled nursing facility on April 10, 2014 for skilled speech, occupational and physical therapy.</p> <p>According to the admission MDS (Minimum Data Set) dated April 17, 2014, the resident was coded under Section G0300 - [Functional Status] Balance during Transitions and Walking as "Not steady, only able to stabilize with human assistance when moving from seated to [a] standing position.</p> <p>The physician's admission orders dated April 10, 2014 directed, "Routine vital signs, Medications ... Midodrine 7.5mg po (by mouth) at 6AM, 10mg po at 10 AM and 5mg po at 2PM for orthostatic hypotension associated with Parkinson disease. Please reduce dosing if patient is experiencing supine hypertension. Acetaminophen [Tylenol-analgesic/antipyretic] 325mg- 2 (two) tabs po [every] 6 hours as needed for pain. "</p> <p>An interim physician's order dated April 14, 2014 directed, "Please check B/P (Blood Pressure), Pulse every shift for orthostatic hypotension. "</p> <p>There was no evidence that the physician included parameters for monitoring the blood pressure and pulse rate for orthostatic</p>	L 052	Continued From page 34	

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L 052	<p>Continued From page 35</p> <p>hypotension.</p> <p>A review of the electronic nursing notes revealed the following: "April 14, 2014 at 2:50 AM- 132/80 (blood pressure), 78 (apical pulse), 20 (respirations), 97.6 (temperature)</p> <p>April 14, 2014 at 11:06 PM - Temp (temperature) 98.2, 72(Pulse), 110/70 (Blood Pressure), Resident had c/o [complaint of] headache and Tylenol PRN medication was offered but resident refused to take. No other distress noted at this time.</p> <p>4/15/14- Night shift - No vital signs recorded.</p> <p>4/15/14- Day shift -No vital signs documented.</p> <p>4/15/14- Evening- No vital signs documented.</p> <p>4/16/14- Night shift- 12:03 AM, Temp 98.3- Pulse-88, Blood Pressure-124/78, Respiratory Rate-20</p> <p>4/16/14- Night shift-2:53 AM -129/79 (Blood Pressure), 70 (apical pulse), 98.3 (temp), 20 (respiratory rate).</p> <p>4/16/14- Evening shift at 5:13 PM - 98.2 Temp, 84- Pulse, Respiration Rate-20, Blood Pressuere-124/74. Resident is sitting in wheelchair with bedside table near and call light within reach.</p> <p>4/17/14- Day shift- No vital signs documented.</p> <p>4/17/14- Night shift-at 3:14 AM-129/70 (Blood Pressure), 77 (Pulse), 20-(Respiratory Rate),</p>	L 052	Continued From page 35	

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L 052	<p>Continued From page 36</p> <p>Temp- 97.8.</p> <p>4/17/14- No vital signs documented.</p> <p>4/17/14- Evening shift at 9:54 PM- 142/80 (Blood Pressure), 78 (Pulse), 97.6 (Temperature)</p> <p>4/17/14- Night shift - no vital signs documented.</p> <p>4/18/14-Night shift at 02: 04 AM- 133/70 (Blood Pressure), 78 (Apical Pulse), 97.3 (Temperature), 18 (Respiratory Rate)</p> <p>4/18/14- Evening shift at 3:26 PM- 126/74(Blood Pressure), 74 (Pulse), 18 (Respiratory Rate), 97.0 (Temperature)</p> <p>4/18/14- Evening shift at 11:25 PM- 124/78 (Blood Pressure), 84 (Pulse), 20 (Respiratory Rate), 98.3 (Temperature)</p> <p>4/19/14 - Night shift at 2:37 AM- 132/71(Blood Pressure), 80 (apical pulse), 97.9 (Temperature), 20 (Respirations)</p> <p>4/19/14- Night shift- No vital signs documented.</p> <p>4/19/14- Day shift- No vital signs documented.</p> <p>4/19/14- Evening shift- No vital signs documented.</p> <p>4/20/14 at 4:26 PM- Writer was called to room because resident [was] unresponsive. V/S (Vital Signs): Temperature 97.4, Heart Rate-114, Respiratory Rate- 12, Oxygen Saturation- 64%. CPR (Cardiopulmonary Resuscitation) started, 911, and MD (Medical Doctor) called and gave order to transfer resident to hospital for</p>	L 052	Continued From page 36	

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L 052	<p>Continued From page 37</p> <p>unresponsiveness. Resident left unit via EMT (Emergency Medical Team) at 1:15 PM."</p> <p>There was no evidence that the resident's blood pressure was obtained at the time of the transfer to the hospital.</p> <p>A review of the MAR/TAR (Medication Administration Record/Treatment Administration Record) revealed the following vital signs/medication:</p> <p>" 4/14/14- Tylenol administered [no time indicated] - Reason- c/o (complaint of) headache- pain assessed as " 6/10. " Result- effective - " 2/10. " No blood pressure or pulse documented.</p> <p>4/15/14- No vital signs recorded on night shift</p> <p>4/15/14 - Day shift -vital signs documented- not legible to read.</p> <p>4/15/14- Evening shift -120/70 (Blood Pressure)</p> <p>4/16/14- Evening shift - writing not legible to read</p> <p>4/17/14- Day shift- 129/70 (Blood Pressure) - Pulse- writing not legible to read</p> <p>4/17/14- Evening shift- 130/74 (Blood Pressure)- Pulse- writing not legible to read</p> <p>4/17/14- Night shift -writing not legible to read</p> <p>4/19/14- Night shift- Blood Pressure - 106/75</p> <p>4/19/14- Day shift- Blood Pressure: 125/70- Pulse-60</p>	L 052	Continued From page 37	

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L 052	<p>Continued From page 38</p> <p>4/19/14 - Evening shift- Blood Pressure - 130/70.</p> <p>4/20/14- Day shift according to MAR- 128/76 (Blood Pressure "0," No pulse documented."</p> <p>There was no evidence in the clinical record that the attending physician or nurse practitioner was informed of Resident #262's complaint of a headache on April 14, 2014. In addition, the resident's blood pressure(s) was not taken every shift as prescribed. When the blood pressures were taken, there was no evidence that the staff obtained orthostatic blood pressures as ordered by the physician.</p> <p>A review of the Doctors Progress notes revealed:</p> <p>April 10, 2014- Nurse Practitioner's note - "... admitted to NH (nursing home) after hospital ... [Treatment] of Parkinson's disease with significant dysautonomia, Dementia, GERD (Gastro esophageal Reflux Disease) ... Orthostatic Hypotension, UTI (Urinary Tract infection) with ESBL (Extended Spectrum Beta-Lactamase) E. coli (Escherichia Coli). Alert- Weak."</p> <p>April 12, 2014 - "... Transferred to NH (nursing home) for further OT (Occupational Therapy), PT (Physical Therapy) and SLP (Speech Language Pathology)." Problem List: "Old [and] Chronic Problems ... Orthostatic Hypotension. Physical Examination: Temp (Temperature)- 97.6, Pulse-74, [Respiratory Rate] - 16, [Blood Pressure] - 120/72."</p> <p>April 18, 2014- Nurse Practitioner's note-</p>	L 052	Continued From page 38	
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L 052	<p>Continued From page 39</p> <p>"[Patient] with recent UTI [with] ESBL- [Status Post] Antibiotic Treatment. [History] of Parkinson, Dementia, GERD, Acute Kidney Disease, Orthostatic Hypotension. Plan... Calcium with Vitamin D 600/400- one QD (everyday). "</p> <p>There was no evidence in the clinical record that the attending physician or nurse practitioner addressed the status of the Resident #262 ' s Orthostatic Hypotension in the total plan of care. Facility staff inconsistently and/or failed to assess the resident's orthostatic blood pressure as prescribed and there was no evidence that the medical team questioned clinical staff regarding the lack of orthostatic blood pressure assessments.</p> <p>A face-to-face interview was conducted with Employee #2 on August 29, 2014 at approximately 3:46 PM. After reviewing the clinical record. He/she acknowledged the aforementioned findings.</p> <p>A follow-up telephone interview was conducted with Employee # 32 on September 2, 2014 at approximately 2:18 PM in the presence of Employees #1 and 2. Employee #32 acknowledged that parameters may have been indicated for the orthostatic blood pressure reading(s). It was further stated that orthostatic blood pressure(s) are generally initially taken in the supine position before assuming a standing position. "</p> <p>In conclusion, there was no evidence that sufficient nursing time was given to consistently assess and monitor Resident #262's orthostatic blood pressure and pulse (who had a diagnosis</p>	L 052	Continued From page 39	

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L 052	Continued From page 40 of Orthostatic Hypotension). In addition, there was no evidence that the facility staff indicated the position of the resident when the orthostatic blood pressure and pulse were reportedly obtained or notified the physician regarding the resident's complaint of a headache. On April 20, 2014, the resident was found unresponsive and was transferred to the nearest emergency room via 911. The clinical record was reviewed on September 2, 2014.	L 052		
L 056	3211.5 Nursing Facilities Nursing personnel, licensed practical nurses, nurse aides, orderlies, and ward clerks shall be assigned duties consistent with their education and experience and based on the characteristics of the patient load. This Statute is not met as evidenced by: Based on record review and staff interview during a staffing review [direct care per resident day hours], it was determined that the facility failed to meet 0.6 [six tenth] hour for Registered Nurses/APRN [Advanced Practice Registered Nurse] hours on two (2) of the seven (7) days and four and one tenth (4.1) hours of direct nursing care per resident per day for one (1) of seven (7) days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on August 29, 2014 at approximately 11:00AM. Seven (7) days were reviewed; August 23 through August 29, 2014.	L 056	3211.5 Nursing Facilities L056 1. The regulatory requirement of 0.6 (six tenth) hour of nursing care per resident day of Registered Nurse was not met on August 23, 2014 0.4 and August 24, 2014 0.4. On August 25, 2014 the overall nursing care coverage required of 4.1 hours was not met at 4.0. 2. All residents have the potential to be affected when the resident care for a Registered Nurse is not met, however there were no negative outcomes to the residents. 3. Recruitment plans are in place to hire required staffing levels with focus on hiring Registered Nurses. In addition to, the review of wage/salary surveys as a component of the facility's retention plan.	11/2/14

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L 056	<p>Continued From page 41</p> <p>According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenth (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4.</p> <p>The facility failed to meet the 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] for two (2) of seven days reviewed as outlined below.</p> <p>On Saturday, August 23, 2014 it was determined that the facility provided RN coverage at a rate of 0.4 hours.</p> <p>On Saturday, August 24, 2014 it was determined that the facility provided RN coverage at a rate of 0.4 hours.</p> <p>The facility also failed to meet the four and one tenth (4.1) hours of direct nursing care per resident per day for one of seven days reviewed as outlined below.</p> <p>On Saturday, August 25, 2014 it was determined that the facility provided direct nursing care coverage at a rate of 4.0 hours.</p> <p>The review was done in the presence of</p>	L 056	<p>Continued From page 41</p> <p>4. A quality assurance program was implemented under the supervision Director of Human Resources and Director of Nurses to monitor and report monthly Registered Nurses and other nursing vacancies to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.</p>	10/31/14

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L 056	Continued From page 42 Employee #2. He/she acknowledged the finding.	L 056	Continued From page 42	
L 099	<p>3219.1 Nursing Facilities</p> <p>Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by:</p> <p>Based on observations made on August 25, 2014 at approximately 2:30 PM and on August 26, 2014 at approximately 2:15 PM, it was determined that the facility failed to serve food under sanitary conditions as evidenced by foods such as barbecue chicken, mixed greens, pureed chicken, pureed rice, pureed mixed greens and pureed vegetables that failed to reach 140 degrees Fahrenheit.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On August 25, 2014 at approximately 2:30 PM, hot foods from the test tray, such as barbecued chicken, mixed greens, pureed chicken, pureed rice, pureed mixed greens and pureed vegetables tested below 140 degrees Fahrenheit at the point of delivery. On August 26, 2014 at approximately 2:15 PM, hot foods from the test tray such as pureed rice and pureed vegetables tested below 140 degrees Fahrenheit at the point of delivery. On August 25, 2014 at approximately 2:30 PM a half-pint carton of milk from the test tray tested 	L 099	<p>3219.1 Nursing Facilities L099</p> <ol style="list-style-type: none"> Food that was served to residents on Unit 3 Orange did not meet the required standard of 140° degrees Fahrenheit; in addition, the milk that was served on the unit did not meet the required temperature of 40° degrees Fahrenheit. There were no negative outcomes to the residents as a result of this deficiency. All other nursing units were checked to ensure food and liquid nourishment being served to the residents met regulatory guidelines. An in-service was provided to the Dietary staff regarding measures being implemented to ensure that food and liquid being served to the residents meets regulatory guidelines. A quality assurance program to monitor the temperature of residents' food and liquids being served under the supervision of Director of Food and Nutrition Services/ Designated Representative will be monitored and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor. 	<p>8/28/14</p> <p>8/28/14</p> <p>10/31/14</p>

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L 099	Continued From page 43 at 48 degrees Fahrenheit and on August 26, 2014 at approximately 2:15 PM, a half-pint carton of milk from the test tray tested at 54 degrees Fahrenheit at the point of delivery. These observations were made in the presence of Employee #37 who acknowledged the findings.	L 099		
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations made on August 25, 2014 at approximately 2:30 PM and on August 26, 2014 at approximately 2:15 PM, it was determined that the facility failed to serve food under sanitary conditions as evidenced by foods such as barbecue chicken, mixed greens, pureed chicken, pureed rice, pureed mixed greens and pureed vegetables that failed to reach 140 degrees Fahrenheit. The findings include: 1. On August 25, 2014 at approximately 2:30 PM, hot foods from the test tray, such as barbecued chicken, mixed greens, pureed chicken, pureed rice, pureed mixed greens and pureed vegetables tested below 140 degrees Fahrenheit at the point of delivery.	L 108	1. Food that was served to residents on Unit 3 Orange did not meet the required standard of 140° degrees Fahrenheit; in addition, the milk that was served on the unit did not meet the required temperature of 40° degrees Fahrenheit. There were no negative outcomes to the residents as a result of this deficiency. 2. All other nursing units were checked to ensure food and liquid nourishment being served to the residents met regulatory guidelines. 3. An in-service was provided to the Dietary staff regarding measures being implemented to ensure that food and liquid being served to the residents meets regulatory guidelines.	10/31/14

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L 108	<p>Continued From page 44</p> <p>2. On August 26, 2014 at approximately 2:15 PM, hot foods from the test tray such as pureed rice and pureed vegetables tested below 140 degrees Fahrenheit at the point of delivery.</p> <p>3. On August 25, 2014 at approximately 2:30 PM a half-pint carton of milk from the test tray tested at 48 degrees Fahrenheit and on August 26, 2014 at approximately 2:15 PM, a half-pint carton of milk from the test tray tested at 54 degrees Fahrenheit at the point of delivery.</p> <p>These observations were made in the presence of Employee #37 who acknowledged the findings.</p>	L 108	<p>Continued from page 44</p> <p>4. A quality assurance program to monitor the temperature of residents' food and liquids being served under the supervision of Director of Food and Nutrition Services/ Designated Representative will be monitored</p>	10/31/14
L 161	<p>3227.12 Nursing Facilities</p> <p>Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to discard biologicals stored in the refrigerator and medication cart on four (4) of 10 nursing units observed (Units 1 Orange, 2 Orange, 1 Green, and 3 Blue).</p> <p>The findings include:</p> <p>On August 29, 2014 the medication storage observations revealed the following:</p> <p>1. On Unit 1 Orange: Resident M #2 had 19 tablets of Acetaminophen/Codeine 300mg/30mg stored for use. The use before date on the package was 6/13/2014. The observation was made in the presence of Employee #8. He/she</p>	L 161	<p>3227.12 Nursing Facilities L161</p> <p>The Facility's practice is to discard of expired medications, which was not exhibited in the below findings. These findings were corrected upon observation.</p> <p>1. Unit 1 Orange Resident M #2 19 tablets of Acetaminophen/Codeine 300mg/30mg that was found stored in the medication cart. There were no negative outcomes to the resident beyond expiration date.</p>	

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L 161	<p>Continued From page 45 acknowledged the findings.</p> <p>2. On Unit 1 Orange: Resident M #5 had 30 tablets of Lorazepam 0.5mg stored for use. The use before date on the package was 8/4/2014. The observation was made in the presence of Employee #8. He/she acknowledged the findings.</p> <p>3. On Unit 2 Orange: Resident M #3 had 13 tablets of Lorazepam 0.5mg stored for use. The use before date on the package was 8/18/2014. The observation was made in the presence of Employee #10. He/she acknowledged the findings.</p> <p>4. On Unit 1 Green: Resident M #1 had 16 tablets of Lorazepam 1 mg stored for use. The use before date was 6/13/2014. The observation was made in the presence of Employee # 15. He/she acknowledged the findings.</p> <p>5. On Unit 3 Blue: Resident M #4 had two (2) of two (2) bags of Vancomycin 500mg [milligram]/100ml solution stored with a discard date of August 23, 2014. The observation was made in the presence of Employee # 12 who acknowledged the findings. Employee #12 also stated, "The aforementioned medications were discontinued on August 11, 2014".</p>	L 161	<p>Continued from page 45</p> <p>Unit 1 Orange Resident M #5 30 tablets of Lorazepam 0.5mg was found stored in the medication cart.</p> <p>Unit 2 Orange Resident M #3 13 tablets of Lorazepam 0.5mg was found stored in the medication cart.</p> <p>Unit 1 Green Resident M #1 16 tablets of Lorazepam 1 mg were found stored in the medication cart.</p> <p>Unit 3 Blue Resident M #4 two (2) of two (2) bags of Vancomycin 500mg [milligram]/100ml solution was found in the refrigerator.</p> <p>2. All other residents' cassettes in the medication carts were checked for stored or expired medications and none were found in the residents' medication cassettes.</p> <p>3. In-service was provided for the Licensed Nurses regarding Policy and Procedure for expired narcotic medications and refrigerated antibiotics.</p> <p>Unit Managers will audit narcotics and refrigerators weekly.</p>	<p>9/2/14</p> <p>10/31/14</p>
L 214	<p>3234.1 Nursing Facilities</p> <p>Each facility shall be designed, constructed, located, equipped, and maintained to provide a</p>	L 214		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/02/2014
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L 214	<p>Continued From page 46</p> <p>functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public.</p> <p>This Statute is not met as evidenced by:</p> <p>Based on observations made during an environmental tour of the facility on August 25 at approximately 2:30 PM and on August 26, 2014 at approximately 2:15 PM, it was determined that the facility failed to ensure that it was free of accident hazards as evidenced by a frayed call bell cord in one (1) of 77 residents' rooms surveyed.</p> <p>The findings include:</p> <p>One (1) of three (3) call bell cords was frayed in room #239 (C bed), one (1) of 77 residents' rooms surveyed.</p> <p>This observation was made in the presence of Employees #36 and 38 who acknowledged the findings.</p>	L 214	<p>Continued from page 46</p> <p>4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative to monitor expired narcotics and refrigerated antibiotics will be monitored monthly and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.</p> <p>3245.10 Nursing Facilities L306</p> <p>1. The frayed call bell cords in room #239 was replaced on the same day it was observed, 8/26/14.</p>	10/31/14
L 306	<p>3245.10 Nursing Facilities</p> <p>A call system that meets the following requirements shall be provided:</p> <p>(a) Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents;</p> <p>(b) In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room;</p>	L 306	<p>2. All call bells in the facility were checked on 9/3/14 and none were found with frayed cords.</p> <p>3. In-service was provided to the Engineering staff regarding, Effective Maintenance Rounds with focus on the call bells to maintain resident safety.</p>	8/26/14 9/3/14 10/31/14

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L 306	<p>Continued From page 47</p> <p>(c)Be of a quality which is, at the time of installation, consistent with current technology; and</p> <p>(d)Be in good working order at all times.</p> <p>This Statute is not met as evidenced by:</p> <p>Based on observations made during an environmental tour of the facility on August 25 at approximately 2:30 PM and on August 26, 2014 at approximately 2:15 PM, it was determined that the facility failed to maintain the call bell system in proper working condition as evidenced by one (1) of one (1) call bell cord that was too short to be readily accessible in the bathroom of Room #305, one (1) of three (3) call bells that was too short to be readily accessible in the shower room located on 3 Orange and a call bell that was wrapped around the grab bar in one (1) of 77 resident's room surveyed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> One (1) of one (1) cord to the call bell in the bathroom of room #305 was just a few inches long and was not readily accessible. One (1) of three (3) call bell cords in the shower room on 3 Orange was short and was not readily accessible. The call bell cord was wrapped around the grab bar in room #106 and could not be activated if needed in one (1) of 77 residents' rooms surveyed. <p>These observations were made in the presence</p>	L 306	<p>Continued from page 47</p> <p>4. A quality assurance program to monitor the preventative maintenance program is in place for the inspection of all call bells under the supervision of Director of Engineering/ Designated Representative will be monitored and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.</p> <p>1. The call bell cord in the bathroom of room #305 was too short.</p> <p>One (1) of three (3) call bell cords in the shower room on 3 Orange Unit was short and not accessible.</p> <p>The call bell cord was wrapped around the grab bar in room #106 and could not be activated. All of the call bell cords in room #305, #106 and in the shower room on 3Orang Unit were replaced. There were no negative outcomes to the residents.</p>	<p>10/31/14</p> <p>8/26/14</p>
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L 306	Continued From page 48 of Employees #36 and 38 who acknowledged the findings.	L 306	Continued From page 48	8/26/14
L 410	<p>3256.1 Nursing Facilities</p> <p>Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner.</p> <p>This Statute is not met as evidenced by:</p> <p>Based on observations made during an environmental tour of the facility on August 25 at approximately 2:30 PM and on August 26, 2014 at approximately 2:15 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by torn privacy curtains in two (2) of 77 residents rooms surveyed, non-functioning air vents in three (3) of 77 residents rooms surveyed, soiled air vents in six (6) of 77 residents rooms surveyed, burnt ceiling lights in two (2) of 77 residents rooms surveyed, expired high protein nutrition bottles in one (1) of nine (9) units surveyed, a loose access door in one (1) of 77 residents rooms surveyed and a non-functioning wall clock in one (1) of 77 residents rooms surveyed.</p> <p>The findings include:</p> <p>1. Three (3) of three (3) privacy curtains in resident room #239 were torn and two (2) of three (3) privacy curtains in resident room #337 were torn, two (2) of 77 residents rooms surveyed.</p>	L 410	<p>2. All call bell cords in the facility were checked on 9/3/14 and replaced as required.</p> <p>3. In-service was provided to the Engineering staff on regarding the on-going Preventative Maintenance Program to inspect all call bells and cords.</p> <p>4. A quality assurance program was implemented under the supervision of the Director of Nursing/Designated Representative. The call bells/cords will be monitored and reported monthly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.</p> <p>1. Three (3) privacy curtains in room #239 were replaced and two (2) privacy curtains were replaced in room #337 upon notice on 8/25 and 8/26/14.</p> <p>Three (3) of the 77 resident's rooms air vents in rooms #202, #220 and #305 and one (1) of two (2) activity rooms on the 2 Blue Unit were not functioning. The Engineering department completed repair of these areas 9/3/14.</p>	<p>8/26/14</p> <p>8/26/14</p> <p>10/31/14</p> <p>9/3/14</p>

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L 410	<p>Continued From page 49</p> <p>2. Air vents were not functioning in the bathroom of residents' room #202, #220, and #305, three of 77 residents' rooms surveyed, and in the bathroom located in one (1) of two (2) activity rooms on 2 Blue.</p> <p>3. Bathroom air vents in six (6) of 77 residents rooms were soiled with dust including rooms #204, 306, 360, 363, 381 and 386.</p> <p>4. One (1) of two (2) ceiling lights was out in the bathroom of Room #155 and one (1) of two (2) ceiling lights was out in the bathroom of room #274, two (2) of 77 residents' rooms surveyed.</p> <p>5. Two (2) of three (3) bottles of Jevity 1.2 cal high protein nutrition with fiber stored in a cabinet in the storage room on 2 Green were expired as of August 1, 2014.</p> <p>6. The access door located under the sink in the bathroom of Room #189 was hanging loose and detached from the wall, one (1) of 77 resident's room surveyed.</p> <p>7. The wall clock was inoperable in room #355, one (1) of 77 resident's room surveyed.</p> <p>These observations were made in the presence of Employees #36 and 38 who acknowledged the findings.</p>	L 410	<p>Continued from page 49</p> <p>Six (6) of 77 resident's rooms bathroom air vents in rooms #204, #306, #363, #386 were soiled with dust and were cleaned on 9/3/14 .</p> <p>One (1) of two (2) ceiling lights were out in the bathrooms of rooms #155 and #274 and was replaced upon observation.</p> <p>Two (2) of three (3) bottles of Jevity 1.2 cal high protein nutrition and fiber found on the 2 Green Unit was expired, which were discarded upon being located.</p> <p>The wall clock was inoperative in room #355. The Engineering department placed a battery on 8/26/14.</p> <p>2. All privacy curtains were inspected and replaced if required, all vents were serviced, inspected and repaired if required, all air vents were inspected and cleaned if required, the two (2) bottles of expired Jevity were discarded, the access door under the sink was repaired and serviced, the wall clock was repaired.</p> <p>3. An In-service was conducted for the Environmental staff on 10/28/14 and initiated on 10/31/14 for the Engineering staff regarding scheduled rounds to identify Environmental and Engineering concerns in resident rooms/areas, in addition to the Clinical staff being educated on the reporting process of areas in need of the environmental and/or engineering department's attention.</p> <p>4. A quality assurance program to monitor environmental, nursing and engineering rounds was implemented under the supervision of the Director of Nurses; Director of Environmental Services and Director of Engineering which will be monitored and reported quarterly to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.</p>	<p>9/3/14</p> <p>10/31/14</p> <p>10/31/14</p>