| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495288 | A. BUILDING _____ B. WING _____ | C 04/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 04/11/17 through 04/14/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 68 certified bed facility was 47 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents 1 through 12 and 19) and 6 closed record reviews (Residents 13 through 18). | F 000 | | |
| F 225 SS=D | INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br>CFR(s): 483.12(a)(3)(4)(c)(1)-(4)<br><br>483.12(a) The facility must-<br><br>(3) Not employ or otherwise engage individuals who-<br><br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;<br><br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or<br><br>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.<br><br>(4) Report to the State nurse aide registry or | F 225 | | 5/19/17 |

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

Electronically Signed | 04/30/2017

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 225 | Continued From page 1 | F 225 | | |

licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate

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|---|---|---|---|---|
| F 225 | Continued From page 2<br>corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to report an injury of unknown origin to the state agency (SA) (Office of Licensure and Certification) for one Resident (Resident #3) in a survey sample of 19 Residents.<br><br>Resident #3's bruise of unknown origin was not reported to the SA.<br><br>The findings included:<br><br>Resident #3 was admitted to the facility 5/30/14. Diagnoses included Alzheimer's dementia, anemia, psychosis and seizure disorder.<br><br>Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/18/17 was coded as a quarterly assessment. She was coded as having a BIMS (brief interview of mental status) of "3" out of a possible 15, or severe cognitive impairment. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living. Resident #3 was coded as having behaviors including physical and verbal abuse one to three times a week.<br><br>On 4/12/17 at 8:20 AM, Resident #3 was observed in the dining room eating breakfast. The resident was feeding herself a boiled egg and cut up waffles.<br><br>Review of the clinical record revealed a nurses note dated 8/7/16, which described a "dark, | F 225 | 1) Current resident incidents for the past 30 days were reviewed for potential reporting if indicated.<br><br>2) All residents have the potential to be affected by the deficit practice.<br><br>3) Any injury of unknown origin will be investigated within 24-hours and reported to the state as required. Re-education of NHA/DON/ADON on reporting requirements within 1 month.<br><br>4) NHA will review all incident reports within 24 business hours to ensure compliance and will be reported to the Quality Improvement committee monthly. | |

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|---|---|---|---|---|
| F 225 | Continued From page 3<br>reddened bruise on the left upper arm, 4 cm (centimeters) diameter." The bruise's origin was unknown.<br><br>Review of the Risk Management Report dated 8/7/16 described the event as "no one witnessed the incident." The final conclusion on 8/10/16 was "determined cause of bruise appears to be caused by resident wheeling self into hallway railings." There were no witness statements.<br><br>Review of the facility's policy and procedure on Abuse, Neglect, Injuries of unknown source, and Misappropriation of Property included the following: Under Investigation (f): "The call to Law Enforcement and Survey Team must occur within 2 hours of forming a suspicion for any event that resulted in serious bodily injury of a skilled nursing resident. Otherwise report should occur within 24 hours of forming suspicion."<br><br>On 4/13/17 at at 1:40 PM, the DON (director of nursing) stated that the bruise occurred because the resident "hits her arms" on the handrails in the hallway." The Administrator stated, "No FRI" (facility reported incident) was done.<br><br>On 4/13/17 at the end of the day exit, the Administrator and DON were notified of above findings. | F 225 | | |
| F 279 SS=D | DEVELOP COMPREHENSIVE CARE PLANS<br>CFR(s): 483.20(d);483.21(b)(1)<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review | F 279 | | 5/19/17 |

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|---|---|---|---|---|
| F 279 | Continued From page 4 | F 279 | | |

and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) 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 §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

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|---|---|---|---|---|
| F 279 | Continued From page 5<br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation, clinical record review and in the course of a complaint investigation, the facility failed for one resident (Resident #18) in a survey sample of 19 residents, to develop a comprehensive care plan.<br><br>Resident #18 was not care planned for potential for altered nutrition with significant weight loss.<br><br>The findings included:<br><br>Resident #18 was admitted to the facility after a hospitalization on 2/11/17. Diagnoses included recent colon cancer with colostomy, ulcerative colitis, pneumonia, diabetes, chronic kidney disease, anemia and benign prostatic hypertrophy. The resident wore a condom catheter.<br><br>Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/18/17 was coded as an admission 5 day assessment. Resident #18 was coded as having | F 279 | 1) Resident has been discharged from our community.<br><br>2) All residents have the potential to be affected by the deficit practice.<br><br>3) Re-educate ADON and MDS regarding proper care plan completion. Conduct care plan audit for those residents at high risk for significant weight loss weekly for 4 weeks. Monthly reporting of weight loss to QI.<br><br>4) Conduct weekly audit of care plans for all new patients with potential of significant weight loss x 4 weeks. | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 279 | Continued From page 6 | F 279 | | |

no memory deficits and was able to make own daily life decisions. Resident #18 was also coded as requiring extensive to total assistance of one staff member to perform activities of daily living such as toileting and hygiene. The resident was coded as having both a condom catheter and a colostomy. The resident was coded as having no pressure areas.

Review of the resident's hospitalization from 1/24/17 to 2/11/17 revealed the following: "Admission for nausea, vomiting, large bowel obstruction secondary to sigmoid stricture, pan colitis. Review of the dietary notes revealed: "moderate malnutrition, 8.6 per cent weight loss times one and a half months, need for TPN (total parenteral nutrition).

This was a closed record, so no observations were made of the resident. Review of the initial dietary 72 hour data collection done on 2/13/17 revealed: "Most recent weight 139 pounds. Height 67 inches. BMI (body mass index) was 21.8 (normal 18.5- 24.9). Ideal body weight was 148 pounds. The question "Has the resident had any weight changes" was marked no. Boost plus was added once daily and the goal was "weight maintenance or slow gradual weight gain." On the 2/18/17 dietary data collection, the RD (registered dietician) notes, "Leaves 25 % or more of meal and that resident lost weight after surgery." Chopped meat was added to the current diabetic diet.

On 4/14/17 at 10:15 AM, an interview was conducted with the MDS coordinator/care planning. She stated, "I get information from the hospital records, POS (physician order

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| F 279 | Continued From page 7<br>summary), interviews." She went on to state that the 5 Day "spit out CAS" (care area summary) was to assist with generation of the care plan. The MDS coordinator stated, "Of course", that the resident was at high risk for weight loss, and that a care plan should have generated for potential weight loss. The care plan was not revised for actual weight loss.<br><br>On 4/13/17 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings. | F 279 | | |
| F 280 SS=D | RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br>CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan | F 280 | | 5/19/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495288 | A. BUILDING _____ B. WING _____ | C 04/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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|---|---|---|---|---|
| F 280 | Continued From page 8 | F 280 | | |

of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of

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|---|---|---|---|
| | 495288 | A. BUILDING _____ B. WING _____ | C 04/14/2017 |

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|---|---|
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|---|---|---|---|---|
| F 280 | Continued From page 9<br>the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation, clinical record review and in the course of a complaint investigation, the facility failed for one resident (Resident #18) in a survey sample of 19 residents, to review and revise the care plan.<br><br>Resident #18's care plan was not revised to reflect a significant weight loss.<br><br>The findings included:<br><br>Resident #18 was admitted to the facility after a hospitalization on 2/11/17. Diagnoses included recent colon cancer with colostomy, ulcerative colitis, pneumonia, diabetes, chronic kidney disease, anemia and benign prostatic hypertrophy. The resident wore a condom catheter.<br><br>Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/18/17 was coded as an admission 5 day | F 280 | 1) Resident has been discharged from our community.<br><br>2) All residents have the potential to be affected by the deficit practice.<br><br>3) Care plans for high risk residents will be reviewed by IDT at weekly Clinical at Risk to ensure compliance. Educate ADON, full time nurses and IDT on care plan compliance requirements. Conduct care plan audit for those residents at high risk for significant weight loss weekly for 4 weeks. Monthly reporting of weight loss to QI committee.<br><br>4) Conduct weekly audit of care plans for all new patients with potential of significant weight loss x 4 weeks. | |

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|---|---|---|---|---|
| F 280 | Continued From page 10 | F 280 | | |

assessment. Resident #18 was coded as having no memory deficits and was able to make own daily life decisions. Resident #18 was also coded as requiring extensive to total assistance of one staff member to perform activities of daily living such as toileting and hygiene. The resident was coded as having both a condom catheter and a colostomy. The resident was coded as having no pressure areas.

Review of the resident's hospitalization from 1/24/17 to 2/11/17 revealed the following: "Admission for nausea, vomiting, large bowel obstruction secondary to sigmoid stricture, pan colitis. Review of the dietary notes revealed: "moderate malnutrition, 8.6 per cent weight loss times one and a half months, need for TPN (total parenteral nutrition).

This was a closed record, so no observations were made of the resident. Review of the initial dietary 72 hour data collection done on 2/13/17 revealed: "Most recent weight 139 pounds. Height 67 inches. BMI (body mass index) was 21.8 (normal 18.5- 24.9). Ideal body weight was 148 pounds. The question "Has the resident had any weight changes" was marked no. Boost plus was added once daily and the goal was "weight maintenance or slow gradual weight gain." On the 2/18/17 dietary data collection, the RD (registered dietician) notes, "Leaves 25 % or more of meal and that resident lost weight after surgery." Chopped meat was added to the current diabetic diet.

The weights documented on the clinical record are as followed:

2/11/7 (admit) 139.2

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|
| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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|---|---|---|---|---|
| F 280 | Continued From page 11<br>2/12/17: 139.0<br>2/16/17: 138.0<br>3/2/17: 116.8<br><br>Resident #18 lost 21 pounds between 2/16/17 and 3/2/17. This is significant weight loss of 15.3% in two weeks. No weight was obtained between 2/16/17 and 3/2/17. The care plan was not revised to reflect the significant weight loss.<br><br>On 4/14/17 at 10:15 AM, an interview was conducted with the MDS coordinator/care planning. She stated, "I get information from the hospital records, POS (physician order summary), interviews." She went on to state that the 5 Day "spit out CAS" (care area summary) was to assist with generation of the care plan. The MDS coordinator stated, "Of course", that the resident was at high risk for weight loss, and that a care plan should have generated for potential weight loss. The care plan was not revised for actual weight loss.<br><br>On 4/13/17 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings. | F 280 | | |
| F 281 SS=D | SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br>CFR(s): 483.21(b)(3)(i)<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality. | F 281 | | 5/19/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495288 | A. BUILDING _____ B. WING _____ | C 04/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 281 | Continued From page 12<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review, and clinical record review the facility staff failed to follow professional standards of nursing for medication documentation for Resident #5.<br><br>The facility staff allowed four contradicting Percocet (narcotic painkiller) orders to be present on the Physician's Order Form with a physician signature for Resident #5.<br><br>Findings included:<br><br>Resident #5, a 68 year old female, was admitted to the facility on 2/8/2017. Her diagnoses included CVA (Cerebral Vascular Accident-stroke), communication defect, muscle weakness, difficulty walking, diabetes, depression, hypertension, hypothyroidism, high cholesterol, osteoarthritis, obesity and anemia.<br><br>Resident #5's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/18/2017 was coded as a 30 day assessment. Resident #5 was coded a BIMS (Brief Interview of Mental Status) score of 13/15, indicating no cognitive impairment. Resident #5 required extensive assistance of 2 persons for her activities of daily living and was coded as being frequently incontinent of bowel and bladder.<br><br>A clinical record review was conducted on 4/12/2017 at 10:00 AM. It revealed a Physician's Order Form for April 2017 with the following duplicate orders for the narcotic painkiller, Percocet (Oxycodone/APAP):<br><br>"2/21/2017 Oxycodone/APAP (acetaminophen) 5 | F 281 | 1) For resident #5, the physician order sheet was corrected on April 12, 2017.<br><br>2) All residents have the potential to be affected by the deficit practice.<br><br>3) Re-educate ADON and full time nurses on physician order sheet review. Physician order sheet reviewed by May 1, 2017 for all current residents.<br><br>4) Conduct an audit of 25% of physician order sheets monthly x 3 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495288 | A. BUILDING _____ B. WING _____ | C 04/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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| F 281 | Continued From page 13<br>mg (milligram)/325 mg tablet (Percocet) #R7549316 One tablet by mouth twice daily for pain.<br>3/16/2017 Oxycodone/APAP 5 mg/325 mg tablet #R5799449 2 tablets by mouth every four hours for pain.<br>3/16/2017 Oxycodone/APAP 5 mg/325 mg tablet #R7604767 2 tablets by mouth twice daily for pain.<br>3/16/2017 Oxycodone/APAP 5 mg/325 MG Tablet #R7604769 2 tablets every four hours as needed for pain."<br><br>The MAR (Medication Administration Record) for April 2017 reflects only one order for Percocet. See R7604767 above. It shows that R7549316 and R7599449 were discontinued on 3/14/17. The status of R7604767 is unknown and is not on the MAR or discontinued.<br><br>There is a physician signature dated 4/7/2017 approving this order.<br><br>On 4/13/2017 at 9:30 AM an interview was conducted with Administration B who verified this situation. She agreed that only one order remained on the MAR and was unsure of the status of R7604767. She further stated that an updated physician order form should have been presented to the physician for his signature.<br><br>The administration was informed of the findings on 4/14/2017 at 12:30 PM. | F 281 | | |
| F 325 SS=D | MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br>CFR(s): 483.25(g)(1)(3)<br><br>(g) Assisted nutrition and hydration. | F 325 | | 5/19/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 325 | Continued From page 14<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document and clinical record review, and in the course of a complaint investigation, the facility staff failed for one resident, Resident #18, in a survey sample of 19 residents, to accurately assess, monitor and evaluate nutritional parameters to prevent significant weight loss.<br><br>Resident #18 lost 21.2 pounds (15.3% significant weight loss) between 2/16/17 and 3/2/17. Risk factors and interventions for weight loss were not care planned. According to hospital records upon discharge to the hospital, the resident had complained of almost constant nausea for at least a week to two weeks and having to change the colostomy bag every two hours due to loose stools. There was no facility documentation that the resident had symptoms of nausea, vomiting or diarrhea. | F 325 | 1) Resident has been discharged from community.<br><br>2) All residents have the potential to be affected by the deficit practice.<br><br>3) Re-educate ADON and full time nurses on weight policy, documentation, notification of weight loss, regulations and current standards of practice for weight loss.<br><br>4) Conduct audit for residents at high risk for significant weight loss weekly x 4 weeks. Monthly reporting of weight loss to QI committee. | |

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|---|---|---|---|---|
| F 325 | Continued From page 15 | F 325 | | |

The findings included:

Resident #18 was admitted to the facility after a hospitalization on 2/11/17. Diagnoses included recent colon cancer with colostomy, ulcerative colitis, pneumonia, diabetes, chronic kidney disease, anemia and benign prostatic hypertrophy. The resident wore a condom catheter.

Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/18/17 was coded as an admission 5 day assessment. Resident #18 was coded as having no memory deficits and was able to make own daily life decisions. Resident #18 was also coded as requiring extensive to total assistance of one staff member to perform activities of daily living such as toileting and hygiene. The resident was coded as having both a condom catheter and a colostomy. The resident was coded as having no pressure areas.

Review of the resident's hospitalization from 1/24/17 to 2/11/17 revealed the following: "Admission for nausea, vomiting, large bowel obstruction secondary to sigmoid stricture, pan colitis. Review of the dietary notes revealed: "moderate malnutrition, 8.6 per cent weight loss times one and a half months, need for TPN (total parenteral nutrition).

This was a closed record, so no observations were made of the resident. Review of the initial dietary 72 hour data collection done on 2/13/17 revealed: "Most recent weight 139 pounds. Height 67 inches. BMI (body mass index) was 21.8 (normal 18.5- 24.9). Ideal body weight was 148 pounds. The question "Has the resident had

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495288 | A. BUILDING _____ B. WING _____ | C 04/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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|---|---|---|---|---|
| F 325 | Continued From page 16 | F 325 | | |

any weight changes" was marked no. Boost plus was added once daily and the goal was "weight maintenance or slow gradual weight gain." On the 2/18/17 dietary data collection, the RD (registered dietician) notes, "Leaves 25 % or more of meal and that resident lost weight after surgery." Chopped meat was added to the current diabetic diet. On 2/22/17 a care planning meeting was conducted. The RD did "clarify with resident that supplements are not received timely, and he often does not have appetite for it." On 2/26/17, the RD added sugar free jello and no salads ordered. On 3/1/17 graham crackers and peanut butter and a half turkey sandwich with fruit cup was added by the RD. There was no weight included in the assessment. The RD was no longer employed by the facility so an interview was conducted with the food service manager on 4/12/17 at 2:45 PM. She stated, "I talked with the resident, he was not enjoying his meals. He said he loved peanut butter and graham crackers and jello. We added a half turkey sandwich." She went on to state that dietary staff delivers snacks and the morning dietary supervisor will check the refrigerators and would report snacks still left in the refrigerator to the DON (director of nursing) and RD.

The MD documented a history and physical on 2/19/17. No mention of potential weight loss was made or nausea was in the notes. There was only one note from the physician.

The weights documented on the clinical record are as followed:

2/11/7 (admit) 139.2
2/12/17: 139.0
2/16/17: 138.0

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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|---|---|---|---|---|
| F 325 | Continued From page 17<br>3/2/17: 116.8<br><br>Resident #18 lost 21 pounds between 2/16/17 and 3/2/17. This is significant weight loss of 15.3% in two weeks. No weight was obtained between 2/16/17 and 3/2/17.<br><br>Review of the facility policy revealed: "Residents will be weighed as directed by the physician, federal/state regulations, or standards of practice." The Federal SOM (state operations manual) state, "Current standards of practice recommend weighing the resident on admission (to establish a baseline weight) , weekly for the first 4 weeks after admission and at least monthly thereafter." The weight after 2/16/17 was not obtained until 14 days later on 3/2/17, at which time the resident had lost 21 pounds.<br><br>On 4/14/17 at 9:45 AM, an interview was conducted with CNA (certified nursing assistant) A. CNA (A) stated, "I weigh in the morning, before they eat. I give the weight to the nurse."<br><br>Review of the care plan dated 2/12/17 revealed there was no care plan for the potential weight loss, risk factors for weight loss, nor interventions to address potential for, or actual weight loss for this resident.<br><br>On 4/14/17 at 10:15 AM, an interview was conducted with the MDS coordinator/care planning. She stated, "I get information from the hospital records, POS (physician order summary), interviews." She went on to state that the 5 Day "spit out CAS" (care area summary) was to assist with generation of the care plan. The MDS coordinator stated, "Of course", that the resident was at high risk for weight loss, and that | F 325 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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|---|---|---|---|---|
| F 325 | Continued From page 18 | F 325 | | |

a care plan should have generated for potential weight loss. The care plan was not revised for actual weight loss.

On 3/8/17, Resident #18 was sent to the colorectal surgeon on 3/8/17. Notes included the following: "weight 118, patient has had constant nausea and has had a poor appetite." Zofran (an antinausea medication ) was ordered three times a day for nausea.

On 3/10/17 at 9:00 AM, the resident was sent to the GI (gastrointestinal) doctor and was sent from this office to the emergency room. The resident was admitted with the diagnoses of high output colostomy, acute renal failure, severe dehydration and weight loss. The admission history and physical dated 3/10/17 contained: "The vomiting started intermittently 2 weeks ago and has gradually progressed, and over 5 days he has vomited almost every day. Per the patient the vomiting is caused by any kind of food. Pt (patient) has tried Zofran with no improvement of symptoms. Pt says in the past one to two weeks his ostomy output has increased and now has to change his bag every two hours. ...Pt has lost 24 pounds since discharge (from hospital)." Review of the meal consumption record for the time period of March 3 to March 10, 2017 revealed his intake ranged from 25 to 75 % of meals with over 500 cc (cubic centimeters) of fluid consumed at meals. The nurses notes contained only one documented episode of vomiting on 3/10/17 and was given Zofran. Colostomy output records revealed the resident had three episodes of loose stools from 3/3/17 to 3/10/17.

Skilled nursing notes dated from 3/5/17 to 3/9/17 contain no documentation of nausea or vomiting,

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|---|---|---|---|
| | 495288 | A. BUILDING _____ B. WING _____ | C 04/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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|---|---|---|---|---|
| F 325 | Continued From page 19 | F 325 | | |

or loss of appetite.

On 4/13/17 at 10:30 AM, the DON was questioned about the condition of Resident #18. The DON stated, "We had concerns about his appetite initially. We attempted food likes and more frequent meals." She went on to state that he did complain "the smell of food made him nauseous." She stated that he was "absolutely at risk for weight loss and nausea would affect his appetite." The DON reviewed the care plan and stated, "Not in there" for potential for weight loss. There was no goal for nutrition, risk factors or evaluation of interventions. The DON explained the weight process as followed: Weights were obtained by the CNA who cared for the resident. These weights were given to the dietician to record in the electronic record. The dietician then reviewed the weights.

On 4/14/17 at 9:45 AM, an interview was conducted with CNA (certified nursing assistant) A, who worked with Resident #18. CNA (A) stated, No nausea or vomiting, I would talk to the nurse."

On 4/14/17 at 9:50 AM, LPN (licensed practical nurse) A was interviewed. She stated, "No, no nausea or vomiting."

On 4/14/17 at 10:15 AM, the MDS coordinator was asked if the resident had reported nausea, vomiting or loose stools. She stated, "Not that I know of."

On 4/14/17 at 10:46 AM, an interview was conducted with the Activities Director. She stated, "I saw him for 1:1 activities, only complained once of nausea, I reported it to the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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|---|---|---|---|---|
| F 325 | Continued From page 20<br>nurse and dietician." She did not know date.<br><br>On 4/13/17 at the end of the day exit, the Administrator and DON were notified of above findings. | F 325 | | |
| F 385 SS=D | RESIDENTS' CARE SUPERVISED BY A PHYSICIAN<br>CFR(s): 483.30(a)(1)(2)<br><br>§483.30(a) Physician Supervision. The facility must ensure that--<br><br>(1) The medical care of each resident is supervised by a physician; and<br><br>(2) Another physician supervises the medical care of residents when their attending physician is unavailable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review and clinical record review, the facility staff failed to assure accurate physician supervision in the area of physician orders.<br><br>The facility staff allowed four contradicting Percocet (narcotic painkiller) orders to be present on the Physician's Order Form for April 2017. The attending physician approved these orders with his signature dated 4/7/2017.<br><br>Findings included:<br><br>Resident #5, a 68 year old female, was admitted to the facility on 2/8/2017. Her diagnoses included CVA (Cerebral Vascular Accident-stroke), communication defect, muscle weakness, difficulty walking, diabetes, | F 385 | 1) For resident #5, the physician order sheet was corrected on April 12, 2017.<br><br>2) All residents have the potential to be affected by the deficit practice.<br><br>3) Re-educate ADON and all full time nurses on physician order sheet review. Physician order sheet reviewed by May 1, 2017 for all residents.<br><br>4) Conduct an audit of 25% of physician order sheets monthly x 3 months. | 5/19/17 |

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|---|---|---|---|
| | 495288 | A. BUILDING _____ B. WING _____ | C 04/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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|---|---|---|---|---|
| F 385 | Continued From page 21 | F 385 | | |

depression, hypertension, hypothyroidism, high cholesterol, osteoarthritis, obesity, and anemia.

Resident #5's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/18/2017 was coded as a 30 day assessment. Resident #5 was coded a BIMS (Brief Interview of Mental Status) score of 13/15, indicating no cognitive impairment. Resident #5 required extensive assistance of 2 persons for her activities of daily living and was coded as being frequently incontinent of bowel and bladder.

A clinical record review was conducted on 4/12/2017 at 10:00 AM. It revealed a Physician's Order Form for April 2017 with the following duplicate orders for the narcotic painkiller, Percocet (Oxycodone/APAP):

"2/21/2017 Oxycodone/APAP (acetaminophen) 5 mg (milligram)/325 mg tablet (Percocet) #R7549316 One tablet by mouth twice daily for pain.
3/16/2017 Oxycodone/APAP 5 mg/325 mg tablet #R5799449 2 tablets by mouth every four hours for pain.
3/16/2017 Oxycodone/APAP 5 mg/325 mg tablet #R7604767 2 tablets by mouth twice daily for pain.
3/16/2017 Oxycodone/APAP 5 mg/325 MG Tablet #R7604769 2 tablets every four hours as needed for pain."

The MAR (Medication Administration Record) for April 2017 reflects only one order for Percocet. See R7604767 above. It shows that R7549316 and R7599449 were discontinued on 3/14/17. The status of R7604767 is unknown and is not on the MAR or discontinued.

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|---|---|---|---|
| | 495288 | A. BUILDING _____ B. WING _____ | C 04/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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|---|---|---|---|---|
| F 385 | Continued From page 22<br><br>There is a physician signature dated 4/7/2017 approving this order.<br><br>On 4/13/2017 at 9:30 AM an interview was conducted with Administration B who verified this situation. She agreed that only one order remained on the MAR and was unsure of the status of R7604767. She further stated that an updated physician order form should have been presented to the physician for his signature and that he should not have signed this one.<br><br>The administration was informed of the findings on 4/14/2017 at 12:30 PM. | F 385 | | |
| F 469 SS=E | MAINTAINS EFFECTIVE PEST CONTROL PROGRAM<br>CFR(s): 483.90(i)(4)<br><br>(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, facility documentation and through the course of a complaint investigation, the facility staff failed to maintain an effective pest control program.<br><br>1. Roaches were observed in the kitchen area and in Resident#2's room.<br><br>2. The facility staff failed to implement corrective actions, including kitchen repairs required by the pest control service provider.<br><br>The findings included: | F 469 | 1) On April 16, 2017, pest control company treated resident #2 room, and completed full flush of kitchen. Beginning, April 13, 2017, recommendations/corrective actions listed by pest control company have been prioritized and will be completed by May 19, 2017.<br><br>2) All areas in the community have the potential to be affected by the deficit practice.<br><br>3) Meet with pest control company regarding survey findings, and developed | 5/19/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495288 | A. BUILDING _____ B. WING _____ | C 04/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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| F 469 | Continued From page 23<br>On 4/11/17 at 3:35 PM, an observation of room 7 was conducted. There were two cardboard boxes piled on top of each other near the bed. Pictures and other items were piled in a corner. A third cardboard box was near the air conditioner. There was no signs of roaches or mice.<br><br>On 4/12/17 at 10:30 AM, the resident council met The council was asked several questions about their care, including if the facility had pest issues, including roaches or mice. Resident #2, with a BIMS (brief interview of mental status) of "14" out of a possible 15, or no cognitive impairment, reported: "I have seen roaches in my bathroom." The resident resided in Room 13.<br><br>On 4/12/17 at 11:00 AM, an observation of room 13's bathroom was conducted. The bathroom had accordion type doors, and when opened, a small roach ran across the floor and disappeared under the gap in the baseboard.<br><br>On 4/13/17 at approximately 8:30 AM, a review of the pest logs for March and April of 2017 were reviewed. These are the findings:<br><br>3/10/17: "Roaches everywhere"<br>3/13/17: Roaches HCC (health care center) dining room<br>3/22/17: Kitchen roaches<br>3/23/17: Room 46, cockroaches<br>3/10/17: Roach in sink, kitchen<br>4/11/17: Roaches (106)<br><br>On 4/13/17 at 9:00 AM, an interview was conducted with the pest control specialist (other F). He reported that he came in every Thursday to inspect rooms and bait. Another specialist would come in weekly at night to treat the kitchen. | F 469 | a plan of action on April 20, 2017. Reeducate staff who round with pest control company about reporting corrective actions. All recommendations are put in work order system at the conclusion of each visit.<br><br>4) Review compliance of recommendations to work orders and work orders to completion weekly for 6 weeks. Then monthly for 4 months. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE FOUNTAINS AT WASHINGTON HOUSE | 5100 FILLMORE AVENUE ALEXANDRIA, VA 22311 |

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| F 469 | Continued From page 24<br>He went on to state that the previous company did not deal with the issue and it had become an "infestation." He stated that roaches live in cracks and crevices and the facility had gaps everywhere and needed to be sealed. He stated, "The cracks and crevices are killing me."<br><br>On 4/13/17 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings.<br><br>2. The facility staff failed to implement corrective actions, including kitchen repairs required by the pest control service provider.<br><br>On 4/11/17, at 2:30 P.M. an observation was conducted of the facility kitchen. The kitchen floor nearest the sink had been flooded by water that had backed up from a drain in the floor. Facility staff used a wet vac to remove the water. Approximately 20 dead roaches were observed floating in the water, near the area where the beverage cabinet was next to the sink. The Food Service Director was present (Other A). She stated that the floor drain had backed up, and also said that the facility had a pest control company on contract.<br><br>The floor under the kitchen counter was soiled with a black colored substance. The kitchen walls had cracks and crevices along the top and bottom of the baseboards.<br><br>On 4/13/17 at 9:35 A.M. an interview was | F 469 | | |

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| F 469 | Continued From page 25<br>conducted with the facility's pest control company technician. Another tour of kitchen was conducted along with the technician. He pointed out all of the soiled floors, wall damage, cracks, and crevices that he had previously identified to the facility as requiring repairs. He submitted copies of repair recommendations he's made to the facility kitchen monthly since December, 2016. He was not told why the repairs had not been made. He stated that the repairs were necessary to have effective pest control.<br><br>The facility Maintenance staff supervisor was present. When asked why the repairs had not been made, he stated, "I put the work orders in at the front desk. I'm still waiting to hear from them."<br><br>On 4/13/17 at 9:45 A.M. an interview was conducted with the Infection Control Nurse, who was also the Director of Nursing. (Administration B). When asked about the importance of an effective pest control program, she stated, "Roaches carry disease. They carry a lot of bacteria and could be harmful to people who are immunocompromised (impaired immune system)."<br><br>On 4/13/17 at 4:00 P.M. the facility Administrator was informed of the findings. No further information was received. | F 469 | | |
| F 514 SS=D | RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>CFR(s): 483.70(i)(1)(5)<br><br>(i) Medical records.<br>(1) In accordance with accepted professional | F 514 | | 5/19/17 |

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| F 514 | Continued From page 26<br>standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review and clinical record review, the facility staff failed to ensure, for two residents (Resident #3 and Resident #4) of 19 residents in the survey sample, an accurate clinical record.<br><br>1. Resident #3's POS (physician's order sheet) | F 514 | 1) Physician order sheets for residents 3 & 4 have been corrected.<br><br>2) All residents have the potential to be affected by the deficit practice.<br><br>3) Re-educate full time nurses and ADON | |

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| F 514 | Continued From page 27<br>contained the wrong diet order.<br>2. Resident #4 had an incorrect diagnosis for the medication Advair<br><br>The findings included:<br><br>1. Resident #3's POS (physician's order sheet) contained the wrong diet order.<br><br>Resident #3 was admitted to the facility 5/30/14. Diagnoses included Alzheimer's dementia, anemia, psychosis and seizure disorder.<br><br>Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/18/17 was coded as a quarterly assessment. She was coded as having a BIMS (brief interview of mental status) of "3" out of a possible 15, or severe cognitive impairment. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living. Resident #3 was coded as having behaviors including physical and verbal abuse one to three times a week.<br><br>On 4/12/17 at 8:20 AM, Resident #3 was observed in the dining room eating breakfast. The resident was feeding herself a boiled egg and cut up waffles.<br><br>Review of the clinical record revealed a diet order dated on 2/10/17 to "change diet consistency to regular solids and thin liquids." Review of the POS dated 3/10/17 revealed the order for "pureed diet with thick liquids."<br><br>On 4/12/17 at the end of the day exit, the DON (director of nursing) stated the diet order was changed to finger type foods as the resident liked | F 514 | on physician order sheet review. Physician order sheet reviewed by May 1, 2017 for all residents.<br><br>4) Conduct an audit of 25% of physician order sheets monthly x 3 months. | |

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| F 514 | Continued From page 28 | F 514 | | |

to feed herself. The Administrator and DON were notified of above findings.

The DON presented a POS that was signed by the physician, but not dated by the physician. The DON stated that the physician had signed it on 4-13-17. The diet order had been corrected to strike out pureed diet, but thickened liquids remained.

2. Resident #4 had an incorrect diagnosis for the medication Advair.

Resident #4 was admitted to the facility 4/5/08. Diagnoses included schizophrenia, diabetes and COPD (chronic obstructive pulmonary disease).

Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/25/17 was coded as a quarterly assessment. She was coded as having a BIMS (brief interview of mental status) of "14" out of a possible 15, or no cognitive impairment. She was also coded as requiring extensive assistance of one staff member to perform her activities of daily living.

On 4/11/17 at 3:35 PM, Resident #4 was observed in her room, in bed with eyes closed. The bed alarm was in place and functional.

Review of the clinical record revealed a pharmacy recommendation dated 12/15/16 which read: "Medical record lists potential inappropriate diagnoses for the following medication: asthma, chronic bronchitis, COPD, emphysema."

On 12/15/16 a physician's order was obtained for the following: "Advair discus... for COPD."

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| F 514 | Continued From page 29<br>Review of the current signed POS dated 3/2/17 contained the order for "Advair discus inhale one puff twice daily for CAD (coronary artery disease)."<br><br>On 4/13/17 at the end of the day exit, the Administrator and DON were notified of above findings. | F 514 | | |