STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	08/05/2014

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CAROLYN BOONE LEWIS HEALTH CARE CENTER	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 48 residents free from unnecessary drugs as evidenced by two (2) residents receiving excessive doses of insulin. Residents' #143, and 187. The findings include: 1.Facility staff failed to keep the resident free from unnecessary drugs as evidenced by Resident #143 receiving excessive doses of insulin. A review of the phyician's order revealed, [Humalog KwikPen] Insulin Lispro (Human) [fast-acting insulin in injectable pen form] 100units/ml [milliliter] Solution Pen-injector sub-Q [subcutaneous] t.i.d. [three times a day] 6:30 AM 11:30 AM 4:30 PM; Less than 150 = 0 units; 151-200 = 2 units; 201-250 = 4 units; 251-300 =6 units; 301-350 = 8 units; 351-400 = 10 units; <60 or >400 please call MD " On July 31, 2014 at approximately 3:40 PM, a Medication Administration Record [MAR] review revealed an order for Resident #143 directed the following: " [Humalog KwikPen] Insulin Lispro (Human) [fast-acting insulin in injectable pen form] 100units/ml [milliliter] Solution Pen-injector sub-Q [subcutaneous] t.i.d. [three times a day] 6:30 AM 11:30 AM 4:30 PM Less than 150 = 0 units 151-200 = 2 units 201-250 = 4 units 251-300 =6 units 301-350 = 8 units 351-400 = 10 units <60 or >400 please call MD "	F 329	Continued From page 48 **1, 2** #1 Due to the type deficiency we cannot retroactively and correct the deficiency for Residents' # 143 and 187. The staff however has been counseled and a one to one competency has been provided for the staff. #2 To identify other residents that may have the potential to be affected, we have reviewed all Medication Administration Records, to ensure that residents do not receive unnecessary drugs, and that all insulin based on sliding scale ordered are given as ordered. #3 We have put a system in place for the Education Director to conduct one to one Identified during the survey competency for nurses identified by their managers as needing further teaching on insulin administration, and sliding scale orders. Our Education Department has also increased the frequency of clinical competencies for nurses from annual to semi-annual in the area of medication administration, particularly insulin and sliding scale orders. In additional we will have a list of residents with diagnosis of Diabetes per unit location in the facility. The list will be utilized by the charge nurses to review per shift for and	8/29/14 9/9/14 9/10/14 9/10/14 9/10/14 & On-going Monthly x3

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F 329	Continued From page 49 A review of the July 2014 MAR revealed that on July 6, 2014 at 5:00 PM the resident's blood sugar result of "150" was recorded. The insulin dose administered was " 2u[units], " to " LA " [Left Arm] as documented on the MAR. According to the physician's order the resident should not have received insulin. There was no evidence that facility staff administered insulin in accordance with the physician ' s order. A face-to-face interview was conducted with Employee #4 on July 31, 2014 at approximately 3:40 PM. He/she acknowledged the aforementioned findings. The record was reviewed on July 31, 2014. There was no evidence that facility staff kept the resident free from unnecessary drugs. 2. Facility staff failed to keep Resident #187 free from unnecessary drugs as evidenced by the resident recieving an excessive dose of insulin. A review of the physician's order revealed, " Sliding scale finger stick with Aspart [fast- acting insulin] Insulin sub-Q [subcutaneous] AC [before meals] and HS [at night] as follows 6:30 AM 11:00 4:30 PM 9:00 PM; 201-250 = 2 units; 251-300 =4 units; 301-350 = 6 units; 351-400 = 8 units; <60 or >400 = call MD/NP " A review of the July 2014 Medication Administration Record [MAR] for Resident #187 revealed the following: " Sliding scale finger stick with Aspart [fast- acting insulin] Insulin sub-Q [subcutaneous] AC [before meals] and HS [at night] as follows 6:30 AM 11:00 4:30 PM 9:00 PM	F 329	Continued From page 49 observed return demonstration for accuracy of insulin administration ordered by the physician. The charge nurses will report to the Unit Manager, the findings of the shift review. #4 The Unit Managers will compile the results of the reports to the Director of Nursing weekly for further review. This will be presented to the QAPI Committee meetings monthly for analysis of compliance for 3 months.	9/11/14, Monthly & On-going Monthly x3

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F 329	Continued From page 50 201-250 = 2 units 251-300 =4 units 301-350 = 6 units 351-400 = 8 units <60 or >400 = call MD/NP " A further review of the MAR revealed that on July 30, 2014 at 6:30 AM, the resident's blood sugar result was recorded as " 190 ". The Insulin dose administered was " 2u[units], " to " LLQ " [Left Lower Quadrant] as documented on the MAR. According to the physician's order the resident should not have received insulin. There was no evidence that facility staff administered insulin in accordance with the physician ' s order. A face-to-face interview was conducted with Employee #4 on July 31, 2014 at approximately 3:40 PM. He/she acknowledged the aforementioned findings. The record was reviewed on July 31, 2014. There was no evidence that facility staff kept the resident free from unnecessary drugs.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observations made on July 28, 2014 between 9:00 AM and 3:00 PM , it was determined that the facility failed to store, prepare and serve food under sanitary conditions as evidenced by two (2) of three (3) open bags of pasta that were stored undated in the dry food storage area, one (1) of one (1) steamer that was covered with spilled grease, one (1) of one (1) soiled deep fryer, two (2) of two (2) convection units that were covered with dust and sticky particles, damaged lids from one (1) of one (1) ice cream freezer, one (1) of two (2) soiled convection units and torn air curtains from the walk-in freezer. The findings include: 1. Two (2) of three (3) bags of pasta were stored in the dry food storage area open and undated. 2. The top of one (1) of one (1) steamer unit was soiled with liquid grease. 3. One (1) of one (1) deep fryer was soiled with a week old grease and fried food particles. 4. The tops of two (2) of two (2) convection oven units were soiled with dust and sticky particles.	F 371	**1, 2, 3, 4, 5, 6, 7, 8** #1 The pasta bags were dated. All labeling and dating were completed The top of the steamer unit has been cleaned, and liquid grease removed. The deep fryer was cleaned and sanitized, grease particles removed, and the grease was replaced. The tops of the two convection oven units have been cleaned. The ice cream freezer lid has been replaced The convection unit soiled on the inside was cleaned The Air Curtains to the walk-in freezer has been replaced Due to the type of deficiency, we cannot correct the deficiency of the staff failing to sanitize the thermometer as oppose to wiping the thermometer with napkins. #2 To identify other equipments that may have the potential to be affected, a walkthrough was conducted in the kitchen to make sure all equipments are clean, and in order.	7/28/14 7/28/14 7/28/14 7/28/14 8/28/14 7/28/14 9/11/14 8/15/14

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F 371	Continued From page 52 5. One (1) of two (2) lid to the ice cream freezer was falling apart and needed to be repaired or replaced. 6. One (1) of two (2) convection unit was soiled internally with burnt food particles. 7. Air curtains to the walk-in freezer were torn in several areas. 8. One (1) of one (1) food service employee failed to sanitize the food thermometer in between uses during food temperature testing at lunch time on the second floor dining room on July 28, 2014. The food service employee used a napkin to wipe the thermometer between use. These observations were mede in the presence of Employee #29 who confirmed the findings.	F 371	Continued From page 52 #3 We have put a system in place to increase the frequency of environment of care rounds in the kitchen from weekly to three times a week. A special monitoring tool will be used that identifies areas that usually need cleaning. The monitoring tool will be completed based on compliance with cleanliness of the equipments, etc. The results of the monitoring will be assessed by the Director Food Service and corrective measures taken. #4 The Environment of care rounds, team will present the compilation and analysis of the results of the kitchen rounds at the QAPI Committee meeting monthly. The Food Services Director and Administrator will monitor for compliance for 3 months.	9/11/14 Monthly Monthly x3
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425		

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F 425	Continued From page 53 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews for one (1) of 41 sampled residents, it was determined that the pharmacy failed to provide pharmaceutical services to assure that Resident #172 received of all his/her drugs prescribed by the attending physician. The findings include: On July 29, 2014 at approximately 11:34 AM, a face-to-face interview was conducted with Resident #172. The resident stated that he/she had not received the resident's medications in three days. When asked why he/she hadn't received medications for three days, he/she stated, "The nurse said they [the medications] hadn ' t come from pharmacy." On July 29, 2014 at approximately 11:40 AM, a face-to-face interview was conducted with Employee #34 concerning the resident ' s missing medications. He/she stated he/she noticed the medication "quantity running low" on July 26, 2014 and faxed communication to the pharmacy. He/she continued to explain that he/she did not	F 425	Continued From page 53 #1 The contract pharmacy Services was called by staff and pharmacist provided the medication on and medication was given to Resident #172. #2 To identify other residents that have the potential to be affected by this, medication administration records have been reviewed to ensure there are no missing medications. #3 We have put a system in place to generate and utilize the "exception report" per shift to review and account for accuracy of medications administered as ordered. The charge nurses will review the exception report and report findings to the Unit Manager and/or Shift Supervisors.	7/29/14 8/29/14 9/10/14

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F 425	Continued From page 54 work the next day, but could visualize in the computer that the following medications: Slow Magnesium [magnesium supplement], Norvasc [antihypertensive], Namenda [MNDA receptor antagonist to treat dementia], Multivitamin, Vitamin C, and Celexa [anti-depressant], were not given because they were unavailable on July 27, 28, and 29th. When asked if he/she had contacted pharmacy regarding the unavailable medications, he/she responded, " No. " He/she added that he/she would call pharmacy after he/she finished passing medications. When asked if he/she had informed the charge nurse, manager, or the doctor that the resident had missed medications for three days, he/she stated, " Not yet. " A review of the ' 24 Hour Report ' revealed no documentation of the missing medications for the resident. On July 29, 2014 at approximately 12:05 PM, a face-to-face interview was conducted with Employee #4 concerning the aforementioned findings. He/she stated that he/she was unaware of the situation, but would look into it. On July 29, 2014 at approximately 12:07, a face-to-face interview was conducted with Employee #30 concerning the aforementioned findings. He/she stated that he/she was unaware of the situation up until now. He/she explained that normally when medications are missing, they fax the information to pharmacy. If the medications aren ' t available by next day, they would call pharmacy concerning the issue and notify the doctor for possible substitutions. He/she acknowledged that the process had not been followed.	F 425	Continued From page 54 We have also put a system in place to have the charge nurse record on the 24-Hour Report any medications that are not delivered by pharmacy as required. After faxing of the orders this information will also be included on the 24-Hour report for effective follow-up and follow-through if medication is not received during the shift; so the shift supervisor will follow up with pharmacy. This will ensure that residents' medications are delivered without interruption. **#4** Results of the exception reports will be presented and analyzed at the monthly QAPI meetings. Unit Managers and Supervisors will also report the results of analysis to Director of Nursing and Assistant Director of Nursing. Follow through with Pharmacy will also be presented at the monthly QPI meetings. compliance will be determined for corrective action as required.	Monthly & On-going Monthly x3 Monthly On-going Monthly x3

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F 425	Continued From page 55 On July 29, 2014 at approximately 2:20 PM, Employee #34 communicated that a call was made to pharmacy and the pharmacy personnel told him/her that the resident was " accidentally discontinued out of the system, but they would put him back in the system. " He/she stated that Employee #37 was informed and follow-up orders were obtained. On July 30, 2014 at approximately 2:30PM, a telephone interview was conducted with Employee #35 regarding the missing medications. He/she acknowledged that a " pharmacy technician (new in position) accidentally discontinued the resident from the system on July 27, 2014. He/she continued explaining that the resident was re-admitted the same day, but the " refills were thrown out and the medications were not loaded on the profile. " When asked if this information was communicated to the staff, he/she stated pharmacy faxed notification to the facility that the medications had been discontinued, but acknowledged that no one clarified or verbally communicated that pharmacy actually discontinued the medications and the medications needed to be re-ordered. There was no evidence that the contract pharmacy provided ongoing pharmaceutical services to assure that Resident #172 received of all his/her drugs prescribed by the attending physician.	F 425	Continued From page 55	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 56 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview during the evaluation of medication storage, it was determined that facility staff failed to consistently document the monitoring of	F 431	Continued From page 56 #1 Due to the type of deficiency we cannot retroactively correct this deficiency. Employees/nurses however have been instructed to ensure that the Refrigerator Monitoring Log" is maintained daily per shift with the refrigerator temperature, and signed/initialed by the nurse who observe the temperature. #2 To identify other dates that may have the potential for this deficiency, the refrigerator monitoring log has been reviewed to ensure temperatures are recorded going forward. #3 We have put a system in place that requires the incoming shift nurse to check the "Refrigerator Monitoring Log" as part of the hand-off inter-shift communication, to ensure that the outgoing shift nurse checked the refrigerator and recorded the temperature. Also we have put in place a system of daily check by the Unit Manager or designee and the Night Shift Supervisor who will review the monitoring log to double-check that the log has the temperatures per shift. #4 The Assistant Director of Nursing, will review the " Refrigerator Monitoring Log" bi-weekly and report to the Director of Nursing. The Assistant Director of Nursing and the Director of Nursing will monitor for compliance. The report and findings will be presented monthly to the QAPI Committee meeting to assess for compliance.	8/15/14 8/28/14 9/10/14 9/11/14 9/11/14 & Monthly x3

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F 431	Continued From page 57 temperature of the Medication refrigerator located in the nurse ' s station medication room in one (1) of one (1) refrigerator used to store medications. The findings include: A review of the " Refrigerator Monitoring Log " for July 2014 revealed that there were no temperature recordings on the following days: July 1, 5, 8, 9, 12,13,14,15, 16 17, 18, 19, 20, 30, 31, 2014 There was no documented evidence that facility staff consistently monitored of temperature of the Medication refrigerator located in the nurse ' s station medication room. A face-to-face interview was conducted with Employee #3 at the time of the observation and he/she acknowledged the findings.	F 431	Continued From page 57	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on July 28, 2014 at approximately 9:30 AM and on July 29, 2014 at approximately 9:15 AM, it was determined that the facility failed to maintain essential equipment in safe operating condition as evidenced by one (1) of one (1) reach-in refrigerator that failed to maintain an internal temperature of 41 degrees F	F 456	**1, 2** #1 The internal temperature of the reach-in refrigerator used to store grapes and orange juice has been corrected. The refrigerator has been repaired by a refrigerator company and the temperature is maintained at 40 degrees and below.	8/6/14

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F 456	Continued From page 58 or less, a convection oven from one (1) of two (2) convection units that was out of service and a feeding pump that did not alarm during an alarm condition. The findings include: 1. The internal temperature of one (1) of one (1) reach-in refrigerator used to store grape and orange juice was as high as 52 degrees Fahrenheit, well above the recommended temperature of 41 degrees F. 2. The top convection oven from one (1) of two (2) convection units was no longer functional. 3. A feeding pump in use in room #115 did not produce an audible alarm when a flow error occurred. The pump was checked by staff in material management. These observations were made in the presence of Employee #29 who acknowledged the findings.	F 456	Continued From page 58 To identify other equipments that have the potential to be affected, we did a walk-through in the kitchen and inspected the ovens and other equipments. #3 We have put a system in place to increase the frequency of our "Environment of Care Rounds" to include observations of the kitchen equipments. The leader of the Environment of Care Team will report observations of the rounds to the Food Service Director. Also the Director of Food Service will continue to assess independently the equipments used in the kitchen. #4 The team leader of the Environment of Care Rounds will report the findings to the QAPI Committee meetings monthly to assess Food Service will also continue to monitor for compliance for the equipments. The Food Services Director and Administrator will monitor for compliance.	9/10/14 9/11/14 Monthly & On-going Monthly x3
F 463	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on an observation made on July 29, 2014		#1. The call bell in Room 143(a) and the call bell in the bathroom of Room 246 have been repaired. Both call bells are now working. #2. In order to identify other residents who may be affected, we did a walkthrough and tested call bells in the facility to make sure they are working properly.	7/29/14 8/29/14

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F 463	Continued From page 59 at approximately 10:30 AM, it was determined that the facility failed to maintain the resident call/communication system (call bell) in good, functional condition as evidenced by the failure of the call bell system failed to operate correctly in one (1) of 32 resident rooms and one (1) of 32 resident bathrooms. The findings include: On July 29, 2014 at approximately 10:30 AM, the call bell, when activated did not sound an audible alarm in resident room #143 (A side); and in the resident bathroom #246. However the visual indicator illuminated in room #143 and #246 when the call bell was activated. According to facility staff the when the call bells are activated the visual indicator and the audible alarm should be seen and heard by staff. These observations were made in the presence of Employee #28 who acknowledged the finding. There was no evidence that facility staff ensured that all aspects of the call system was functioning as intended when the call bell system was activated.	F 463	Continued From page 59 3. We have put a system in place for the Environmental of Care Rounds team to Increase rounds to three rounds a week for testing of the call bells for a month and observations. Also we have put a system in place of Have the Unit Secretaries checking call bells in resident's room once a week for one month and record. The results of the check will be recorded in the monitoring log. #4. Results of the Environmental of Care Rounds will be reported to the QAPI Committee monthly meeting. Results of The Unit Secretaries monitoring will be reported to the Assistant Director of Nursing and the Director of Nursing, then to the QAPI Committee meeting. The Assistant Director of Nursing and Director of Nursing will monitor for compliance for one month to determine compliance.	9/11/14 & Weekly Weekly x1 month
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 469		

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	095015	A. BUILDING _____ B. WING _____	08/05/2014

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F 469	Continued From page 60 Based on observation for four (4) of 41 resident rooms, it was determined that facility staff failed to maintain the environment free of pests as evidenced by flying insects observed in resident rooms # 113,114,140, and 145. The findings include: On July 29, 14 at approximately 1:27 PM, during an interview with Resident #113, a flying pest was observed in the resident ' s room. During an interview with Resident #114 at approximately 3:00 PM, a flying pest was observed in the resident ' s room. During an interview with Resident #140 at approximately 3:43 PM, a flying pest was observed in the resident ' s room. On July 30, 14 at approximately 9:45 AM, during an interview with Resident #113, a flying pest was observed in the resident ' s room. Facility staff failed to maintain the environment free of pests as evidenced by flying insects observed in rooms 113, 114, 140, and 145.	F 469	Continued From page 60 #1 The pest control company did come in and treated rooms – 113, 114, 140, 145 #2 In order to identify other residents that may have the potential to be affected we did a walkthrough to observe the residents areas. #3 We have put a system in place of having the pest control company treat the resident rooms more frequently. We also have put a system in place of having staff record in the Pest Control book any flying pests that they observe. The unit manager will review the book weekly and communicate more frequently to the Director of Environmental Services the need for more frequent treatment by pest control company. #4 The Director of Environmental Services, the Unit Manager and the Administrator will monitor for compliance.	8/10/14 8/29/14 9/11/14 & Weekly for 1 Monthly Monthly Monthly x3
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.			

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F 492	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that facility staff failed to meet 0.6 [six tenths] hour for Registered Nurses/APRN [Advanced Practice Registered Nurse] hours on eight (8) of the eight (8) 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 5, 2014 at approximately 2:30 PM. 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. 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 eight of eight days reviewed as outlined below. July 25, 2014 RN 0.5	F 492	Continued From page 61 1. No residents were affected by this alleged deficiency. 2. Residents of CBL have not been affected by this alleged deficiency. 3. Facility has increased recruiting efforts for RN and nursing personnel in order to achieve mandated staffing pattern. 4. Administrative staff will monitor and audit efficacy of recruitment efforts for RNs weekly until mandated staffing pattern is achieved. Changes to recruitment will be completed as needed based on results of recruiting. Results of audits and efficacy of recruitment efforts will be reviewed via QAPI meetings with recommendations made as needed.	8/15/14 Weekly Monthly x3 Months

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F 492	Continued From page 62 July 26, 2014: RN 0.2 July 27, 2014: RN 0.3 July 28, 2014: RN 0.45 July 29, 2014: RN 0.57 July 30, 2014: RN 0.57 July 31, 2014: RN 0.55 Aug 01, 2014: RN 0.55 The facility also failed to meet the four and one tenth (4.1) hours of direct nursing care per resident per day for eight of eight days reviewed as outlined below. July 25, 2014: 3.6 July 26, 2014: 3.36 July 27, 2014: 3.48 July 28, 2014: 3.63 July 29, 2014: 3.53 July 30, 2014: 3.58 July 31, 2014: 3.48 Aug 01, 2014: 3.43 The review was made in the presence of Employee #36 who acknowledged the findings.	F 492		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		

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F 514	Continued From page 63 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 41 sampled residents, it was determined that the facility staff failed to maintain clinical records for Resident #11 in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized as evidenced by failure to include the route for administration in the transcribed order for Insulin and Heparin for Resident # 11. The findings include: a). The facility staff failed to accurately transcribe the physician ' s order for Heparin on the Medication Administration Record for Resident # 11. A review of Resident #11's clinical record on August 1, 2014, revealed that he/she was admitted to the facility on April 3, 2014 with diagnoses which included Diabetes Mellitus, Right Foot Abscess, Peripheral Vascular Disease, Right Below Knee Amputation, Left Second Toe Amputation, Hypertension (HTN), and Dementia. Further review of Resident #11's Medication	F 514	1. No residents were affected by this alleged deficiency. 2. Residents of CBL have not been affected by this alleged deficiency. 3. Facility has increased recruiting efforts for RN and nursing personnel in order to achieve mandated staffing pattern. 4. Administrative staff will monitor and audit efficacy of recruitment efforts for RNs weekly until mandated staffing pattern is achieved. Changes to recruitment will be completed as needed based on results of recruiting. Results of audits and efficacy of recruitment efforts will be reviewed via QAPI meetings with recommendations made as needed.	8/15/14 Weekly Monthly x3 Months

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F 514	Continued From page 64 Administration Record for the time frame of June 1, 2014 to June 31, 2014 revealed "...Heparin 5000 units q [every] 12 h [hours]..." for DVT [Deep Vein Thrombosis] prophylaxis. Additional review of Resident #11's clinical record on August 1, 2014, revealed a Physician's order dated June 25, 2014 directed, "...Heparin 5000 units Sub Q [Subcutaneous Injection], q [every] 12 h [hours]..." for DVT prophylaxis. The Medication Administration Record lacked documented evidence of the route for the administration of Heparin as was included in the physician's order for Resident # 11. A face-to-face interview was conducted with Employee #6 on August 5, 2014 at approximately 12:50 PM. He/she acknowledged the findings. The record was reviewed on August 1, 2014. The facility staff failed to accurately transcribe the physician's order for Heparin on the Medication Administration Record for the time frame. b). The facility staff failed to accurately transcribe the physician's order for Insulin on the Medication Administration Record for Resident # 11. A physician's order dated July 23, 2014 directed: "...Sliding Scale: Humalog Insulin coverage sub Q [Subcutaneous Injection] as follows: 6:30 AM and 4:30 PM; Blood Sugar of 150- 200= 2 Units, 201-250= 3 Units, of 251- 300= 4 Units, of 301- 350=	F 514	Continued From page 64 #1 Due to nature of allege deficiency, this cannot be corrected. However staff have been instructed to transcribe orders correctly, also to administer insulin as ordered by the physician. One to one competency was conducted for the nurses Involved. #2 To identify other residents with orders for insulin and with orders for heparin, medication administration records was reviewed. #3 We have put a system in place to conduct one to one competency for nurses identified during the survey as need the competency. Also our Education Department has increased the frequency of competency for nurses from annual to semi-annual in the area of medication and administration, semi-annual including transcribing orders.	8/18/14 8/18/14 9/11/14

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F 514	Continued From page 65 5 Units, > [greater than] 351 units = 6 Units, < [less than] 60 and > 400 call MD..." A review of the Medication Administration Record for the time frame of June 1, 2014 to June 31, 2014 revealed "...Sliding Scale: Humalog Insulin coverage as follows: 6:30 AM and 4:30 PM; Blood Sugar of 150- 200= 2 Units, 201- 250= 3 Units, of 251- 300= 4 Units, of 301- 350= 5 Units, > [greater than] 351 units = 6 Units, < [less than] 60 and > 400 call MD ... " The Medication Administration Record lacked documented evidence of the route for the administration of the Insulin as included in the physician's order for Resident # 11. A face-to-face interview was conducted with Employee #6 on August 5, 2014 at approximately 12:50 PM. He/she acknowledged the findings. The record was reviewed on August 1, 2014. The facility staff failed to accurately transcribe the physician's order for Insulin on the Medication Administration Record.	F 514	Continued From page 65 In addition the charge nurse will observe the nurse(s) identified during survey doing medication administration per shift for one week and report to Unit Manager findings of the observation. #4 The Unit Manager will compile the charge nurse's reports and present to the Director of Nursing for further review. This will be presented to monthly QAPI Committee meetings. The Assistant Director of Nursing and Director of Nursing will monitor for compliance.	Monthly & On-going x3 Months