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 _____	09/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	INITIAL COMMENTS A Quality Indicator Survey (QIS) was conducted on September 4 through September 11, 2012. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size included 37 residents.	F 000	"CBL", is filing this Plan of Correction in accordance with the compliance requirements for federal and state regulations. 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.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on an observation for one (1) of 32 sampled residents, it was determined that facility staff failed to promote care for Resident #77 in a manner that maintains or enhances his/her dignity and respect in full recognition of his/her individuality as evidenced by the resident being observed without appropriate footwear. The findings include: On September 4, 2012 at approximately1:00 PM Resident #77 was observed being transported via wheel chair from the second floor dining room to the second floor day room. The resident was observed with a black shoe on right foot and burgundy slipper on the left foot. The burgundy slipper was missing parts of the insole and outsole (the part of the shoe that comes in direct	F 241		

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

Denise Chadwick Wright — Administrator — 11/2/12

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 241	Continued From page 1 contact with the ground) exposing the resident ' s right toes. The writer asked the resident did he/she want to wear his/her shoes like this. The resident looked down at his/her feet and replied, " No. I want to go home. " At the time of this observation the writer asked the licensed staff assigned to the resident why he/she had on two different shoes. Employee #19 replied, " The certified nurse aide that dressed the resident went home for the day. I passed medication to him/her but he/she was in the room in the bed. I didn ' t see him/her when they brought him/her in the dayroom. " A staff person went to the laundry and got a new pair of sneakers. When the resident was asked about this pair of shoes, he/she said, " I like them." According to the quarterly Minimum Data Set last completed August 3, 2012 the resident was coded as requiring extensive physical assistance with one (1) person for Bed mobility, Transferring, Dressing, Personal Hygiene and Toilet Use. Facility staff failed to enhance Resident #77 ' s dignity as evidenced by the use of mismatched and damaged footwear.	F 241	Continued From page 1 **F241** 1. The corrections were made for resident #77 at the time of survey. 10/31/12 2. An audit has been completed of residents requiring assistance with dressing and corrections have been made and family members notified as indicated. 10/31/12 3. Staff has been educated on the need to monitor residents dress daily to identify concerns in dignity. The charge nurses will complete random audits daily and report provided to the unit manager of concerns identified, 11/2/12 4. A report of the above audits will be provided to the CQI committee quarterly. The CQI Committee will determine the need for further audits. 11/2/12 On going	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour on September 7, 2012 between 11:10 AM and 4:00 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: two (2) of 40 resident rooms were malodorous; marred walls in four (4) of 40 resident rooms; a damaged wall in one (1) of three (3) dayrooms; broken baseboard tiles in two (2) of 40 resident rooms; a broken clock and a stained and malfunctioning toilet in one (1) of 40 resident bathrooms; a missing cover to the ceiling light in (1) of 40 resident bathrooms and a broken curtain rod in one (1) of 40 resident rooms. The findings include: 1. An offensive, unclean odor was evident in two (2) of 40 resident rooms including room #230 and #335. 2. Walls were marred in four (4) of 40 resident rooms including rooms #111, #135, #145 and #220. 3. There was a hole in the wall under the window in one (1) of three (3) dayrooms specifically the 2nd floor dayroom. 4. Baseboard tiles were broken in two (2) of 40	F 253	Continued From page 2 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES **F253** 1. The corrections were made in each of the identified rooms at the time of survey. 2. A review was completed of other resident's rooms corrections were made as indicated. 3. Housekeeping and maintenance staff were educated on the facility policy of reporting broken and items in disrepair in resident's room. Weekly rounds will be completed by a departmental director as part of Environmental Care rounds (EVC). 4. Results of the rounds will be reported to the CQI committee monthly of problems identified and corrective action implemented. The CQI committee will determine the need for further audits.	9/7/12 10/26/12 10/26/12 10/26/12 On going

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F 253	Continued From page 3 resident rooms including room #114 and #230. 5. The wall clock was no longer functioning and the toilet was stained and did not flush properly in Room #127. 6. The cover to the bathroom ceiling light was missing in Room #135. 7. The curtain rod was completely detached from the wall Room #238. These observations were made in the presence of Employee #18 who acknowledged the findings.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		

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F 272	Continued From page 4 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 37 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for weight loss for one (1) resident and restorative programs for one (1) resident. Residents #62 and #156. The findings include: 1. The facility staff failed to accurately code the MDS, Section K- Swallowing/Nutritional Status for the Resident's #62. A review of the annual MDS with an Assessment Reference Date (ARD) of July 18, 2012 revealed that Section K0300 (Weight Loss) was coded as " No " indicating that Resident #62 had no	F 272	Continued From page 4 483.20(b)(1) COMPREHENSIVE ASSESSMENTS **F272 #1 & #2** 1. The MDS for resident #62 and #156 was corrected at the time of survey. 2. An audit was completed of resident receiving restorative services and with weight loss and corrective actions implemented as needed. 3. A review of the weight loss and restorative nursing policy and process was reviewed with the MDS Coordinators. Random audits of the MDS will be completed by the ADON monthly for proper coding. 4. A report of the results of the above audits will be provided to the CQI committee by the ADON quarterly. The CQI Committee will determine the need for further audits.	11/01/12 10/26/12 10/26/12 11/02/12 On going

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F 272	Continued From page 5 weight loss of 10% or more in the last 6 months. According to a dietary note dated May 24, 2012 at 4:16 PM, " Nutrition Diagnosis/Assessment: Weight loss of 10% in 180 days. " A face-to-face interview was conducted on September 7, 2012 at approximately 2:30 PM with Employees #7 and #15. After reviewing the record; the weight loss sustained by Resident #62 was not coded on the MDS. . The clinical record was reviewed on September 7, 2012. 2. The facility staff failed to code the MDS Section O - Restorative programs for Resident #156. A review of Residents #156 ' s clinical record revealed that he/she was admitted to the facility on June 5, 2012 with diagnoses which included Cerebrovascular Accident (CVA), Hypertension (HTN), and Dementia, Obesity, Gout and Non Hemorrhage-stroke. Physician ' s order dated July 7, 2012 at 1:10 PM directed, " D/C resident from skilled PT services, Restorative nursing to follow through FMP [functional maintenance Program] for strengthening for 6x/ wk x 90 days in AM shift. " Another order dated July 14, 2012 at 1:45 PM directed, " Restorative to follow up with FMP for strength and conditioning 6x wk x 30 days " A review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of July 15, 2012 revealed Section O - Special Treatments and Procedures, Part O-0500 Restorative	F 272	Continued From page 5	

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F 272	Continued From page 6 Nursing Programs was coded " 0, indicative that no restorative services were provided." There was no evidence that facility staff failed coded the MDS to include restorative services provided for Resident #156. A face-to-face interview was conducted on September 6, 2012 at approximately 10:00 AM with Employee #11. He/she acknowledged the findings. The record was reviewed September 6, 2012.	F 272	Continued From page 6	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS **F279 #1, #2, #3, #4, #5, #6, #7 & #8** 1. Corrections were made to the care plans for residents #5, #16, #23, #87, #99, #107, #125, #152, #156 and#179. 2. An audit will be completed of resident care plan to assure that all diagnosis have been addressed. Corrective actions have been implemented as indicated. 3. Education has been completed with the unit managers by the educator regarding completion of the care plan. An audit of care plans will be completed by the ADON monthly. 4. Results of the above audits will be provided to the CQI committee quarterly of problems identified and corrective actions implemented. The CQI committee will determine the need for further audits.	10/31/12 11/02/12 11//2/12 On going

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F 279	Continued From page 7 by: Based on record review and staff interview for 10 of 37 sampled residents, it was determined that facility staff failed to develop care plans with goals and approaches to address: Anticoagulant therapy for two (2) residents; medication allergies for two (2) residents; polypharmacy for one (1) resident; integrated hospice planning for one (1) resident; visual impairment for resident two (2) residentsRestorative Care for two (2) residents. Residents #5, #16,#23, #87, #99, #107, #125, #152, #156 and#179. The findings include: 1. Facility staff failed to initiate a a care plan for Resident #5 to address the care and services associated with the use of an anticoagulant medication, Coumadin. A physician ' s order, dated August 8 2012 (originated June 21, 2012) directed, " Warfarin Sodium (Coumadin) 5mg tablet via GT (Gastrostomy Tube) [every day] at 6 PM-[Diagnosis-Deep Vein Thrombosis]. According to the August 2012 Medication Administration Record, Coumadin 5 mg was administered daily at 6 PM as evidenced by staff signatures in the allotted spaces [indicating that the medication was administered]. The clinical record lacked evidence that a care plan with goals and approaches was initiated to address the use of Coumadin.	F 279		

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F 279	Continued From page 8 A face-to-face interview was conducted with Employee #10 on September 7, 2012 at approximately 4:30 PM. After reviewing the chart, both acknowledged the aforementioned findings. The clinical record was reviewed on September 7, 2012. 2. Facility staff failed to initiate a care plan to address Resident #16 ' s use of eyeglasses and the use of ophthalmic medications. A face-to-face interview was conducted with the Responsible Party for Resident #16 on September 6, 2012 at 11:48 AM. He/she stated, "He/ she can see very well and he/she needs someone to feed him/her. " On September 7, 2012 at approximately 9:30 AM the resident was observed resident being fed breakfast by the facility staff. The resident was observed without eye glasses on September 5, 2012 at approximately 12:20 PM; September 6, 2012 at approximately 11:48 AM and on September 7, 2012 at approximately 3:00 PM. A face-to-face interview was conducted with Employee s# 25 and #26 on September 7, 2012 at approximately 3:00 PM. He/she stated, "The resident doesn ' t want to wear the glasses. We offer them to him/ her but he/she doesn ' t want to wear them. His/her eye glasses are in the drawer. " A review of the ophthalmology "Report of	F 279		

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F 279	Continued From page 9 Consultation " dated June 4, 2012 revealed, " Report- Diagnosis: Pseudophakia os (left eye) ... Recommendations: Continue Tobradex, Prednisolone Acetate and ...qid (four times a day) for a total of 1 month post op (operative). To office at 6 weeks post op (operative) for refractum. " A review of the ophthalmology " Report of Consultation " dated July 9, 2012 revealed, " Recommendations: " Cont (continue present glasses. F/u (follow up) in 6 mos (months). " According to the physician ' s orders signed and dated August 1, 2012, "Continue present glasses, follow-up in 6 months. Remove eye pad shield in AM and wear dark sunglasses. " A review of the "Report of Consultation" dated August 9, 2012 revealed, " Findings: Left eye sore difficulty opening eye lids in AM.Diagnosis: Ectropion left lower lid ...Recommendations: To [hospital] for plastic surgery on lower lid to correct Ectropion. D/c Tobradex drops after a total use for 7 days. " A review of the care plan section of the active clinical record revealed that there was no care plan initiated with goals and approaches to address the resident ' use of eyeglasses and the use of ophthalmic medications. A face-to-face interview was conducted with Employee # 3 on September 7, 2012 at approximate 4:30 PM. He/she acknowledged	F 279		

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F 279	Continued From page 10 that there was no care plan initiated to address the resident ' use of glasses, the use of ophthalmic medications, and impaired vision related to diagnoses. The record was reviewed on September 7, 2012. 3. Facility staff failed to initiate a care plan for the use of the anticoagulant medication, Lovenox for Resident #23. A review of the Physician ' s Order Sheet and Plan of Care, dated August 31, 2012 directed: " Lovenox 40mg Sub-Q (subcutaneous) daily for DVT (Deep Venous Thrombosis) prophylaxis. " According to the August 2012 Medication Administration Record, Resident #23 received Lovenox daily. A review of the clinical record lacked evidence that a care plan was initiated with goals and approaches to address the use of Lovenox. A face-to-face interview was conducted with Employees #3 and #7 on September 7, 2012 at approximately 4:00 PM. After reviewing the active clinical record, both employees acknowledged the aforementioned findings. The clinical record was reviewed on September 7, 2012. 4. Facility staff failed to initiate a care plan with goals and approaches to address Resident #87 ' s history of a medication allergy to Pneumovax. An " Admitting Evaluation History " dated May	F 279		

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F 279	Continued From page 11 5, 2012 revealed: " Allergies: Pneumovax. " According to a " Physician ' s Order Form " dated and signed by the physician on August 1, 2012 directed, " Immunizations: No Pneumovax [secondary] to Allergy." A review of Resident #87 ' s care plans lacked evidence that a care plan with goals and approaches was initiated to address the allergy to Pneumovax. A face-to-face interview was conducted with Employee #10 on September 10, 2012 at approximately 12 Noon. He/she acknowledged that there was no care plan in place to address the resident ' s allergy to Pneumovax. The record was reviewed September 10, 2012. 5. Facility staff failed to initiate a care plan with goals and approaches for restorative care for Resident #99. A review of the medical record revealed that Resident #99 was admitted to the facility on April 12, 2012 with diagnoses of Hypertension, Diabetes Mellitus, Cerebrovascular Accident, Osteoporosis, and Dementia, History of left ankle fracture s/p (status post) -ORIF (Open Reduction Internal Fixation) April 5, 2012. Physician ' s orders dated August 23, 2012 at 4:00 PM directed, " D/C [discontinue] OT [occupational therapy] services. Begin FMP [functional Maintenance program] for August 24, 2012 5x/wk x 90 days." A review of the "Therapy Follow-up Recommendations " revealed an " x " next to	F 279		

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F 279	Continued From page 12 Restorative... " maintain current functional strength and endurance, maintain B/L [Bilateral] UE [upper extremities] strength... 5x/wk x 90 days; wheelchair mobility: self propel w/c [wheelchair] 50' [50 feet] or down one (1) hallway 1-2xs, Transfer: from chair to chair or bed to chair 1-2xs (times). " There was no evidence in Resident # 99 ' s chart that a care plan with goals and approaches for Restorative Care was initiated. A face-to-face interview was conducted on September 7, 2012 at approximately 10:30 AM with the Employee #11. He/she acknowledged the findings. The record was reviewed on September 7, 2012. 6. Facility staff failed to initiate a care plan with goals and approaches to address Resident #107 ' s medication allergy to Penicillin. Physician ' s orders signed and dated August 23, 2012 revealed, " Allergy History: Penicillin." The resident ' s care plan initiated July 19, 2012, lacked evidence that a care plan with goals and approaches was initiated to address the resident ' s medication allergy. A face-to-face interview was conducted on September 10, 2012 with Employee #10 at approximately 11:34 AM. He/she acknowledged that there was no care plan for Penicillin allergy for Resident #107. The record was reviewed September 10, 2012. 7.Facility failed to develop a comprehensive care	F 279		

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F 279	Continued From page 13 plan to address visual impairment for Resident #125. A review of the annual Minimum Data Set (MDS) for Resident #125 with an Assessment Reference date of October 11, 2011 and the subsequent quarterly MDS assessments dated March 26 and June 19, 2012, revealed that the resident was identified as being visually impaired in Section B, B1000 (Vision). A review of Section V [Care Area Assessment] of the annual MDS dated October 13, 2011 showed that " Vision Function " triggered as a care area that will be addressed in the care plan. The IDT (interdisciplinary team) note from the meeting dated March 27, 2012 (where Resident #125 was present and the responsible party (RP) participated via a telephone conference) revealed that Resident #125 refused to see the ophthalmologist. However, a care plan for " Vision " was not initiated to address the resident's refusal to see an ophthalmologist. An interview was conducted with Resident #125 at 12:50 PM on September 10, 2012. When the resident was asked if he/she had seen the eye doctor, Resident #125 replied, " No. " When asked if he/she wanted to go see an ophthalmologist, the resident stated, " The only place I want to go is home. That's where I was born. " When asked if he/she had trouble seeing he/she answered, " I can see out of one eye, the other one is blurred " as he/she covered his/her right eye and reiterated that he/she did	F 279		

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F 279	Continued From page 14 not want to see an eye doctor or a dentist. A face-to-face interview was conducted with Employee #11 on September11, 2012 at approximately 9:30 AM. After review of the above he/she acknowledged findings. The record was reviewed on September 11 2012. 8. Facility staff failed to develop a care plan for nine (9) or more medications to address the potential for adverse drug interactions for Resident #152. A review of the resident ' s Physician Order Form dated and signed by the physician on August 3, 2012 revealed that the resident is on the following medications: Amiodarone, Amlodipine, Aspirin, Carbidopa, Enalapril, Furosemide, Levothyroxin, Mapap, Methocarbamol, Potassium Chloride, Sertraline, Warfarin, Oxycodone, Enoxaparin, Albuterol. Review of the residents care plans last update August 16, 2012 lacked evidence of a care plan to address the potential for adverse drug interactions associated with the use of nine (9) or medications. A face-to-face interview was conducted with Employee #9 on September 11, 2012 at approximately 11:00 AM. After review of the above he/she acknowledged findings. 9. Facility staff failed to develop a care plan with	F 279		

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F 279	Continued From page 15 appropriate goals and approaches for Resident #156 who was receiving Restorative Care. A review of the medical record revealed that Resident #156 was admitted to the facility June 5, 2012 with diagnoses which included Cerebrovascular Accident (CVA), Hypertension (HTN), and Dementia, Obesity, Gout and Non Hemorrhage -Stroke. A review of the physician ' s order dated July 7, 2012 at 1:10 PM, directed, " D/C resident from skilled PT [physical therapy] services, Restorative nursing to follow through FMP [functional maintenance program] for strengthening for 6x/ wk x 90 days in AM shift. " Another order dated July 14, 2012 at 1:45 PM directed, "Restorative to follow up with FMP for strength and conditioning 6x wk x 30 days." A review of the " Therapy Follow-up Recommendations " revealed an " x " next to Restorative. Under overall goals " UE [upper extremities] conditioning functional maintenance ...Tricep Press #07 wt [weight] plate Height 4-5, 4 sets x10 reps. Compound Row #07 wt plate 4 sets x10 reps. For 60 days x 6 day [days]. " There was no evidence in Resident # 156 ' s chart that a care plan with goals and approaches for Restorative Care was initiated. A face-to-face interview was conducted on September 6, 2012 at approximately 10:00AM with the Employee #11. He/she acknowledged the findings. The record was reviewed on September 6, 2012.	F 279		

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F 279	Continued From page 16 10. Facility staff failed to develop a care plan with goals and approaches for Resident #179 who was receiving Hospice services. Physician ' s orders dated May 2, 2012 at 1:10 PM directed," Admitted to Hospice Service: Hospice to provide comfort care. " " May 14, 2012 at 2:10 PM directed, " Hospice CNA [Certified Nursing Assistant] Orders: Hospice CNA 3-5 times week to assist with ADL [Activities of Daily Living] care " " May 15, 2012 at 11:59 AM directed, " Change primary Hospice Diagnosis from Alzheimer to Adult Failure to Thrive. " A review of the resident ' s care plans last updated on September 4, 2012 lacked evidence that an integrated Hospice care plan was initiated to identify needed services to include measureable goals, objectives and approaches to provide comprehensive care to Resident #179. A face-to-face interview was conducted with Employee #21 on September 7, 2012 at approximately 11:30 AM. A query was made regarding where he/she documents the plan of care given to the resident while he/she is in the facility.	F 279		

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F 279	Continued From page 17 Employee #21 indicated that once information is loaded into his/her hand held device, it is then down loaded to the hospice facility computer, the information is then printed out on a care plan and placed in the medical record. Employee #21 was unsuccessful in locating the care plan for the resident. He/she then placed a call to the Hospice RN [Registered Nurse] who indicated that he/she would be in to the facility within the hour. A face-to-face interview was conducted with Employee #20 on September 7, 2012 at approximately 12:30 PM. He/she acknowledged that a Hospice care plan was not in the medical record, and proceeded to place a copy in the medical record. The record was reviewed on September 7, 2012.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and	F 280		

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F 280	Continued From page 18 periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 37 sampled residents, it was determined that facility staff failed to update the care plan for 9 or more medications to address the potential for adverse reactions for Resident # 62. The findings include: A review of the clinical record for Resident #62 lacked evidence that facility staff updated the care plan with goals and approaches for the use of nine (9) or more medications and an antidepressant medication. A review of the August 2012 physician ' s orders revealed the resident ' s medication regimen included : Fosamax 70mg every week; Aspirin 81mg daily; Colace 10ml twice daily; Enulose 30ml 2 (two) times a week; Lisinopril 20mg every day; Remeron 7.5mg every day; Oscal + D 500mg-200mg twice daily; Zoloft 100mg every day; Zocor 40mg every day and Multi-Vitamin 1 (one) tablet every day. The comprehensive care plan dated March 22, 2011 included the problems " 9 or more medications and Depression related to Antidepressant Use " and goals and approaches were developed, however; there was no	F 280	Continued From page 18 **F280** 1. The care plan for resident #62 was updated to include the potential for adverse reactions related to the use of 9 or more medications. 2. An audit will be completed of resident care plan to assure that residents receiving 9 or more medications have been addressed. Corrective actions have been implemented as indicated. 3. Education has been completed with the unit managers by the educator regarding completion of the care plan. An audit of care plans will be completed by the ADON monthly. 4. Results of the above audits will be provided to the CQI committee quarterly of problems identified and corrective actions implemented. The CQI committee will determine the need for further audits.	10/31/12 10/15/12 11/02/12 11/02/12 On going

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F 280	Continued From page 19 evidence that the care plan was revised since that date. A face-to-face interview was conducted with Employee #10 on September 7, 2012 at approximately 10:15 AM. He/she acknowledged the care plan was not updated since March 22, 2011. The record was reviewed September 7, 2012.	F 280	Continued From page 19	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview of three (3) of 37 sampled residents, it was determined that facility staff failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care as evidenced by a failure to: obtain a hospice evaluation per physician's orders for one (1) resident; obtain a hemoglobin A1C as per the physicians order for one (1) resident; and follow a physician's order for weekly weights for one (1) resident with weight loss. Residents #107, #148, and #197.	F 309		

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F 309	Continued From page 20 The findings include: 1. Facility staff failed to obtain a hospice evaluation for Resident #107 in accordance with the physician ' s order. An " Admitting Evaluation History " dated July 22, 2012 included diagnoses of Hypertension, Asthma/ [Chronic Obstructive Pulmonary Disease] and Metastatic Prostate Cancer. " A physic ian ' s "Interim Order " dated July 24, 2012 directed, "Do Not Resuscitate, No Chest Compression, No Intubation, No Cardiac Shock... DX (Diagnosis) Metastatic Prostate Cancer, Admit to hospice Service. " According to the Social Service note dated July 29, 2012, " Purpose for Note: Late entry for July 26, 2012 Initial Assessment-the resident is a DNR (Do Not Resuscitate) and the physician has already signed the order. Resident is posing no behavior problems at this time. " An IDT [Interdisciplinary Team] note dated July 26, 2012 at 5:20 PM revealed, " ... Resident is a DNR. Responsible party will clarify about hospice status. " A review of the clinical record including the Nursing Notes lacked evidence that facility staff followed through on physician ' s orders for hospice services for Resident #107. A face-to-face interview was conducted with Employees #10 and #23 on September 10, 2012	F 309	Continued From page 20 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING **F309 #1** 1. A hospice consult has been obtained for resident #107. 2. An audit of physician's orders has been completed for the past 30 days. Corrective actions have been implemented as indicated. 3. Nursing Staff Education regarding the facility policy on daily physician order audits has been completed by the educators. A daily report of physicians orders will be reviewed via the daily nursing trace meeting. 4. A result of the above reports will be provided to the DON daily by the ADON of problems identified and corrective actions implemented. The DON will determine the need for further actions.	9/7/12 10/31/12 10/27/12 11/02/12 On going

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F 309	Continued From page 21 at approximately 11:00 AM. Employee #23 stated, " Resident ' s name] was on home hospice before he/she was admitted to the hospital. I called [name of hospice service], but they never called me back. Also, the facility does not have a contract with that particular hospice." Employees #10 and #23 acknowledged they did not follow up with coordination of hospice services for the resident. The clinical record was reviewed on September 10, 2012. 2. Facility staff failed to obtain a hemoglobin A1C (HGA1C) as per the physician ' s order for Resident #148. The physician ' s orders signed and dated September 7, 2012 directed, " HGA1C every 3 months May/Aug/Nov/Feb " A review of the active clinical record revealed the following: February 2012- no laboratory results found; May 2012 =HGA1C results=6.0; August 2012 HGA1C results=5.9 There was no evidence that the facility ensured that the laboratory tests were conducted as per the physician ' s orders. A face-to-face interview was conducted on September 9, 2012 at 1:33 PM with Employee #11. He/she acknowledged that the laboratory test was not conducted as per the physician ' s order. The record was reviewed on September 9, 2012.	F 309	Continued From page 21 **F309 #2** 1. The physician was notified of the missed lab that has been obtained for resident #148. 2. An audit of physician's orders has been completed for the past 30 days. Corrective actions have been implemented as indicated. 3. Nursing Staff education regarding the facility policy on daily physician order audits has been completed by the educators. A daily report of physicians orders will be reviewed via the daily nursing trace meeting. 4. A result of the above reports will be provided to the DON daily by the ADON of problems identified and corrective actions implemented. The DON will determine the need for further actions.	9/7/12 10/31/12 10/27/12 11/02/12 On going

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F 309	Continued From page 22 3. Facility staff failed to follow a physician's order to obtain weekly weights for Resident #197. The Physician's order sheet and plan of care dated July 24, 2012 directed, "Weight on admission, then 72 hours thereafter. An interim physician's order dated August 22, 2012 at 12 Noon directed, "Weekly weight x 4 [times four]." According to weight record retrieved from the electronic medical record, the resident's weight history was as follows: July 23, 2012 - 126 pounds (admission weight) August 9, 2012 - 116 pounds (10 pounds less from admission weight - 7.9% loss weight loss within 30 days) September 3, 2012 - 114 pounds (12 pounds less from admission weight - 9.5% weight loss) According to the " Weekly Weight Flow Sheet " book located on the nursing unit, the resident ' s weight history was as follows: July 23, 2012- 126 pounds July 26, 2012 - 124 pounds August 6, 2012- 116 pounds (10 pounds less from admission weight- 7.9% weight loss within 30 days) August 13, 2012- 116 pounds There was no evidence that facility staff obtained weekly weights after August 22, 2012 for Resident #197 in accordance with the physician ' s order. Additionally, A review of the facility ' s policy " Weight Loss/Gain Protocol " revised February 3,	F 309	Continued From page 22 **F309 #3** 1. The physician was notified of the missed weights for resident #197. The resident has been placed on weekly weights. 2. An audit of physician's orders has been completed for the past 30 days. Corrective actions have been implemented as indicated. 3. Nursing Staff education regarding the facility policy on daily physician order audits and the weight policy has been completed by the educators. A daily report of physician's orders will be reviewed via the daily nursing trace meeting. 4. A result of the above reports will be provided to the DON daily by the ADON of problems identified and corrective actions implemented. The DON will determine the need for further actions.	9/12/12 10/31/12 10/27/12 11/02/12 On going

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F 309	Continued From page 23 2011 revealed: " 3. If resident has a 5% (percent) weight loss resident will be reweighed with the charge nurse and unit manager present to verify weight. 8. The disciplines responsibilities are as follows: a. Nursing- Put resident on weekly weights x4 (times 4) on Mondays. Appendix II- Any resident with a weight variance will be assessed by the Dietitian." The facility failed to follow its policy regarding a weight change. Resident #197 ' s weight loss was greater than 7.9%; but there was no evidence that the resident was reweighed and that weekly weights were obtained according to the physician ' s order. A review of the electronic dietary progress notes revealed the following: July 27, 2012- Late entry for July 26, 2012- Assessment Type: Initial- Weight 126 lbs. Increased need for protein; disease process Dysphagia. Goals: Provide adequate nutrition and hydration, no weight loss; gain least 2-4 pounds in 90 days. Intervention: Change formula to Glucerna1.5- start at 30 ml/hour; increase as tolerated to goal of 55 ml/hr. August 7, 2012- Dietary progress notes: tolerating tube feeding well, resident receiving Glucerna 1.5 @ 55 ml/ hr x 18 hours. August weight: No new weight available at this time; July admission weight 126 pounds. Discussed with [Employee #10 name] today. Will continue to monitor weight trends. Plan: continue tube feeding regimen as tolerated. August 16, 2012- Weekly weight/wound note: current weight: 116 pounds. Date: 08/03/2012;	F 309		

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F 309	Continued From page 24 Diet: Jevity 1.5 @ 55 ml/hr x 18 hours. Weight concerns triggers for: weight loss 8.0% in 30 days. Intervention: Increased tube feeding from Jevity 1.2 to Jevity 1.5 @ 55 ml/hr. August 28, 2012- Weekly Weight/Wound note: Follow-up; current weight: (8/6) 116 [pounds] re-weight- none; Supplements: Prosource No Carb 30 ml [twice a day]. Weight concerns trigger for: significant weight loss. Interventions: Decrease Prosource; No carb to 30 ml via GT (Gastrostomy tube) daily. Change TF to Glucerna 1.5 @ 55 ml/hr. Current [tube feeding] increased to 65 ml/hr of Jevity for unplanned weight loss, etiology?? Glucerna 1.5 at 55 per hour hanging at this timed ...Closely monitoring intake and weight. " A face-to-face interview was conducted with Employees # 3 and #7 on September 10, 2012 at approximately 4:00 PM. After reviewing the chart, both acknowledged that the weights were not recorded as ordered. A telephonic interview was conducted with Employee #15 on September 13, 2012 at approximately 10:00 AM. Employee # 15 stated that he/she spoke to Employees #10 and #28 regarding the weight not being recorded. I was told by Employee #28 that the resident was currently on weekly weights. Employee #15 stated Resident #197 ' s weight did trigger and interventions were put in place. I am not in the facility everyday; but I communicate with the staff and the nurse practitioner/doctors closely regarding residents who are having weight issues. The record was reviewed September 10, 2012.	F 309		

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F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for five (5) of 19 sampled residents, it was determined that facility staff failed to ensure that residents with pressure sores receive necessary treatment and services to promote healing as evidenced by eight residents noted to not have a documented assessment of the wound at least weekly. Resident ' s # 8, #50, #82, #117 and #149. The findings include: The policy entitled: " Wound Care Program " Policy and Procedure number 1000, revised 7/29/10 stipulated: " Procedure for Breaks in Skin Integrity- 6. The charge nurse will complete weekly documentation of all wounds Skin breakdown, (abrasions, lacerations, rashes, surgical), stasis, non-pressure wound or pressure report sheets. "	F 314		

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F 314	Continued From page 26 1. Facility staff failed to measure wounds at least every seven days from August 2012 through September 2012 for Resident #8. A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the resident ' s skin impaired areas were measured on the following dates: Left Buttock Stage IV- August 2, 16, and 30, 2012 There was no evidence that facility staff measured the resident ' s aforementioned wound at least every seven (7) days. 2.Facility staff failed to measure wounds at least every seven days from June 2012 through September 2012 for Resident #50. A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the residents skin impaired areas were measured on the following dates: Lower Sacrum Unstageble due to necrosis- June 2, 8, 21, and 28, 2012 Lower Sacrum Stage IV- July 12, 26, August 16, 23, and September 6, 2012 There was no evidence that facility staff measured the residents aforementioned wound at least every seven (7) days.	F 314	Continued From page 26 **F314 #1, 2, 3, 4, 5** 1. There is no correction possible for the missed measurements for resident #8, #50, #82, #117, and #149. The resident's wound is measured weekly to date. 2. An audit of the measurements of resident with wounds has been completed by the ADON. Corrections have been made as indicted. 3. A review of the facility policy "Wound Care Program" has been completed with the nursing staff by the educator. Nursing Staff have also been educated on wound measurement. An audit of wound measurements will be completed weekly by the ADON. 4. The results of the above audit will be provided to the DON weekly of problems identified and corrective actions implemented. A report will be provided to the CQI committee by the DON of problems identified and corrective implemented. The CQI committee will determine the need for further audits and actions.	10/26/12 10/31/12 11/2/12 On going

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F 314	Continued From page 27	F 314		

3. Facility staff failed to measure wounds at least every seven days from June 2012 through September 2012 for Resident #82.

A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the resident ' s skin impaired area was measured on the following dates:

Lower Sacrum Stage III- June 14, 28, August 16, 23, and September 6, 2012

There was no evidence that facility staff measured the residents aforementioned wound at least every seven (7) days.

4. A review of Resident # 117 ' s record revealed that facility staff failed to measure wounds at least every seven days from April 2012 through Sept 2012.

A review of the " Wound Care Specialist Evaluation " form from April 26, 2012 through September 6, 2012 revealed the resident ' s skin impaired areas were measured on the following dates:

Lower Coccyx Stage IV - June 8, 28 July 12, 26, August 9, 23, and September 6, 2012
Right Hip- Stage IV- June 8, 28, July 12, 26,

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F 314	Continued From page 28 August 9, 23, and September 6, 2012 There was no evidence that facility staff measured the resident ' s aforementioned wounds at least every seven (7) says. 5. Facility staff failed to measure a wound at least every seven days from June 2012 through September 2012 for Resident #149. A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the resident ' s skin impaired area was measured on the following dates: Medial Sacrum Stage IV- June 28, July12, 26, August 16, 30, 2012 There was no evidence that facility staff measured the resident ' s aforementioned wound at least every seven (7) days. A face-to-face interview was conducted with Employees #2 and # 29 on September 11, 2012 at approximately 11:00 PM. They acknowledged the findings.	F 314	Continued From page 28 **F325** 1. Corrections cannot be made for resident #106. Resident was discharged 7/15/12. 2. An audit of resident's weights over the past 30 days has been completed by the dietician and corrective actions implemented as indicated. 3. A review of the facility Weight Policy has been completed with the dieticians by the educator. An audit of resident weights will be completed weekly by the food service manager. 4. A report will be provided to the DON of problems identified and corrective actions. The DON will determine the need for further action.	7/15/12 10/26/12 10/31/12 11/02/12 On going
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical	F 325		

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F 325	Continued From page 29 condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the dietician failed to fully assess the nutritional status for one (1) of 37 sampled residents as evidenced by a failure to act on weight variances indicative of significant weight change. Resident #106. The findings include: Resident #106 was admitted to the facility on June 15, 2012. According to a " History and Physical " dated June 19, 2012; resident ' s diagnoses included CVA (Cerebral Vascular Accident), Hypertension, Renal Insufficiency and Congestive Heart Failure. Progress note dated July 12, 2012 revealed: " [Patient] is to go home soon; had short rehab in [facility]. CVA [with] left weakness. " According to the medical record; resident was discharged home July 15, 2012 with home health services. A review of Resident #106 ' s clinical record revealed an " Electronic Weight Record " which revealed the following documentation: 06/15/2012 - Weight (lbs): 195 (Admission) 06/18/2012- Weight (lbs) - 152 06/26/2012 - Weight - 171.3 lbs. There was a documented 42 pound weight loss	F 325		

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F 325	Continued From page 30 72 hours post admission; and a documented 19.3 pound weight gain 8 days later.. According to the June 2012 Medication Administration Record: June 15, 2012- 195 lbs (pounds) June 18, 2012 - 182.5 lbs (72 hours after admission) June 22, 2012- 191 lbs. (8.5 lbs weight gain) June 26, 2012- 171.3 lbs (17.7 lbs weight loss) There was a 12.5 lbs weight loss 72 hours post admission; and a 24 lbs weight loss 15 days from admission. A review of the facility ' s policy " Weigh Loss/Gain Protocol " revised February 3, 2011, " If resident has a 5 lb or 5% weight loss, resident will be reweighed with the charge nurse and unit manager present to verify weight. If resident continues to lose weight ... weight gains that are not planned will be evaluated for edema or change in condition. ..the IDT (Interdisciplinary Team) will need to write a note in their section of the chart regarding weight and what is being done or changed and the residents response to their interventions. Appendix II Weight Protocol: Any resident with a weight variance will be assessed by the Dietitian. " A review of progress notes lacked evidence that the resident ' s weight variances were monitored and assessed in accordance with facility policy. A face-to- face interview was conducted with Employee #7 on September 10, 2012 at approximately 5:00 PM. In response to a query regarding the documented weight variations, he/she acknowledged the variations. It was stated that the variations recorded in the	F 325		

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F 325	Continued From page 31 electronic record and medication administration record were likely errors. A telephonic conversation was conducted with Employee #3 on September 13, 2012 at approximately 10:00 AM. After further review of the clinical record; he/she stated that " it appears that there is possibly an error in documenting his/her weight. The dietitian who assessed the resident is no longer employed at the facility. " The dietitian failed to act on a significant weight variance indicative of a significant weight change for Resident #106. The record was reviewed on September 10, 2012.	F 325	Continued From page 31	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made during a tour of Dietary Services on August 4, 2012 at approximately 9:30 A.M. and on August 7, 2012 at approximately 9:05 A.M.it was determined that the facility failed to store, prepare and serve food under sanitary conditions as evidenced by: tray	F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY **F371 #1** 1. Corrections for the temperature documentation is not possible at this time. 9/4/12 2. An audit of temperatures was completed by Dietary Manager and corrective actions implemented as needed. 9/7/12 3. Staff training has been completed by the Dietary Manager with the staff regarding dietary policy on cleaning equipment. An of equipment will completed daily by the dietary manager/designee. 9/7/12 4. A report of the above audits will be provided to the facility administrator weekly of problems identified and corrective actions implemented. The administrator will determine the need for further actions. 9/11/12 On going	

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F 371	Continued From page 32 line, freezer, refrigerator and dishwashing machine temperature logs that were incomplete; the observation of soiled equipment such as four (4) convection ovens, one (1) tilt skillet, one (1) grill and one (1) gas oven. Additionally, the facility failed to ensure that food prepared for distribution was maintained at the proper temperature as evidenced by one (1) half-pint carton of 2% milk from the lunch meal test tray that measured at 48.4 degrees Fahrenheit (F). The findings include: 1. Food temperatures from the tray line, temperatures for one (1) of one (1) freezer, one (1) of one (1) walk-in refrigerator and one (1) of one (1) dishwashing machine were not consistently documented for the months of February 2012 through September 2012. 2. Equipment such as four (4) of four (4) convection ovens, one (1) of one (1) tilt skillet, one (1) of one (1) grill and one (1) of one (1) gas oven were soiled. 3. One (1) of one (1) half-pint of 2% milk from the test tray exceeded 41 degrees F and was measured at 48.4 degrees (F) on August 7, 2012 at approximately 1:40 PM. These observations were made in the presence of employee # 17 who acknowledged the findings.	F 371	Continued From page 32 **F371 #2** 1. The soiled equipment were cleaned at the time of survey. — 9/4/12 2. An audit of dietary equipment was completed by the Dietary Manager and corrective actions implemented as indicated. — 9/7/12 3. Staff training has been completed by the Dietary Manager with the staff regarding dietary policy on cleaning equipment. An of equipment will completed daily by the dietary manager/designee. — 9/7/12 4. A report of the above audits will be provided to the facility administrator weekly of problems identified and corrective actions implemented. The administrator will determine the need for further actions. — 9/11/12 **F371 #3** 1. The milk on the test tray was replaced at the time of survey. — 9/11/12 2. A test tray audit will be completed weekly by the dietician/Dietary Manager for the next 30 days and corrective actions implemented as indicated. — 10/26/12 3. Staff training has been completed by the Dietary Manager with dietary staff regarding timeliness of tray service completion and temperature monitoring of food items on the tray line. — 9/7/12 4. A report of the above audits will be provided to the facility administrator weekly of problems identified and corrective actions implemented. The — 10/26/12	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428		

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F 428	Continued From page 33 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 37 sampled residents, it was determined that facility staff failed to act on a Pharmacy recommendation to evaluate the need for the combined use of both Plavix, and Aspirin for one (1) resident, and failed to act upon the recommendation to obtain hemoglobin A1c (HGA1C) for one (1) resident. Residents #57, and #134. The findings include: 1. Facility staff failed to act on a Pharmacy recommendation to evaluate the need for the combined use of both Plavix, and Aspirin. Resident #57 A review of the " Consultation Report " for the pharmacist dated August 14, 2012 revealed: " Comment: ... receives Aspirin and Clopidogrel (Plavix) concomitantly. "	F 428	Continued From page 33 administrator will determine the need for further actions. 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON **F428 #1 & #2** 1. The physician was notified of the pharmacy recommendation by the unit manager and corrective actions were implemented as ordered. — 9/7/12 2. An audit of pharmacy reviews for the past 60 days has been completed by the ADON and corrective actions implemented as indicated. — 10/26/12 3. Staff education has been completed by the educator regarding follow-through on pharmacy recommendation. The ADON will review the pharmacy recommendations monthly. — 10/26/12 4. A report of findings on the above audits will be provided monthly to the DON of problems identified and corrective actions implemented. The DON will determine the need for further action. — 11/2/12 On going	

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F 428	Continued From page 34 " Recommendation: Please re-evaluation the continued use of this combination. " " Rationale for Recommendation: Literature suggest an increased risk of moderate-to-severe bleeding events with combined aspirin/clopidogrel use in individuals with recent ischemic stroke or transient ischemic attack (TIA) and in individuals with clinically evident cardiovascular disease or multiple risk factors for cardiovascular disease without a recent history of acute coronary syndrome. If the therapy is continued, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences such as bleeding and bruising. " A review of the Consultation Report dated August 14, 2012 lacked a signature and date indicating that the recommendation was reviewed and acted upon. According to the September 2012 Medication Administration Record, Resident # 57 received both Plavix and Aspirin from August 14 through September 6, 2012. A face-to-face interview was conducted with Employee #9 on September 7, 2012 at approximately 3:30 PM. A query was made regarding whether the Consultation Report was	F 428	Continued From page 34	

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F 428	Continued From page 35 addressed. Employee #9 referred to Employee #2. Employee #2 was unable to identify if the report was addressed or acted upon. Facility staff failed to act upon a pharmacy recommendation to re-evaluate the continued use of this combination. The chart was reviewed on September 7, 2012. 2. Facility staff failed to act on a Pharmacy recommendation to obtain Hga1c for Resident #134. The physician ' s order form signed and dated August 3, 2012 directed, " HGBA1C every 3 months Jan/Apr/Jul/Oct- Dx: IDDM (Insulin Dependent Diabetes Mellitus)." A review of the active clinical record revealed that January and July 2012 HGA1C laboratory results were available. A review of the Drug Regimen Review conducted on August 14, 2012 revealed: Comment: " ...has orders for labs to be drawn, but at the time of this review they were not available in the residents record. The missing lab values include: A1c due April, July " Recommendation: "Unless otherwise indicated, Please follow up with the lab and have results forwarded to the facility."	F 428		

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F 428	Continued From page 36 On August 31, 2012 [no time indicated], Employee # 2 responded to the recommendation by documenting, " July A1c in the chart; will obtain April 2012 report. " There was no evidence that the April 2012 HgbA1c results were obtained. A face-to-face interview was conducted with Employee #2 on September 10, 2012 at 10:00 AM. He/she acknowledged that the laboratory results were not available. The record was reviewed on September 10, 2012.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 37 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: 1. Based on a review of the facility ' s Infection Control Program and through staff interview, it was determined that facility staff failed to ensure the implementation of an infection control program that included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. The findings include: A review of the facility ' s infection control surveillance documentation, " Infection Control Log, "lacked evidence of a methodology to consistently collect, analyze, interpret and disseminate data related to infections in the facility. The log lacked evidence of the organism type, source of acquisition (whether community	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	

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F 441	Continued From page 38 or facility acquired), predisposing factors, treatment and/or date of resolution. A Line Listing of the facility ' s infections for the past six (six) months was requested. The facility presented documentation for August 2012 and gave a verbal report for January, February and June 2012. The August 2012 report failed to indicate the mode of treatment for the infections, as well as any predisposing factors and the date of resolution of the infections. The verbal reports for January, February and June 2012 failed to include the source of acquisition (whether community or facility acquired), identify the infecting organism, predisposing factors, the treatment and/or the date of resolution of the infections. All of the reports were incomplete. They lacked all of the necessary components of a Line Listing as aforementioned. A face-to-face interview was conducted with Employee #2 at approximately 11:50AM. The employee acknowledged that the Line Listing was incomplete. The employee also stated, " We are in the process of changing our documentation system. We documented on paper previously and are now in the process of documenting electronically. " The facility failed to ensure the implementation of an infection control program that included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. 2. Based on observation and staff interview for	F 441	Continued From page 38 **F441 #1** 1. The facility is unable to correct data for the previous months. 2. An audit of the September line listing has been completed by the ADON and the corrections have been made as indicated. 10/15/12 3. A review of the facility Infection Control policy has been completed with the staff by the educator. An audit of the infection control line listing will be completed by the Administrator monthly. 10/31/12 4. A report of the above audits and any problems identified will be reported the CQI committee by the administrator. The CQI committee will determine the need for further audits. 11/2/12 On going **F441 #2** 1. Staff was educated at the time of survey. No corrections can be done for resident #5 at this time. 2. An audit of residents on contact isolation has been completed and a medication observations to these resident has been completed by the ADON. Corrective actions implemented as indicated. 3. Staff education regarding the proper procedures for managing the medication administration for residents on Isolation has been completed by the educator. An audit medication pass of residents on isolation will completed weekly by the educator.	

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F 441	Continued From page 39 one (1) of 37 sampled residents, it was determined that facility staff failed to ensure that acceptable Infection Control standards were utilized during Gastrostomy tube managment. Resident #5. The findings include: An observation of a Medication Administration was conducted on September 6, 2012 at approximately 9:15 AM with Employee # 14. The observation was of Resident #5 who was currently on contact isolation. Employee# 14 sanitized his/her hands, prepared the medications to be administered to the resident, donned protective personal equipment, knocked on the Resident 's door and awaited a response. He/she then entered the room, washed his/her hands and placed the silver tray containing medications to be administered on the over-the bed table. The employee disconnected the enteral feeding and checked the resident ' s Gastrostomy tube (g-tube) for placement. Upon doing so Employee #14 assessed that the tube was clogged. The employee left the room to get a " Declogger " [a device used to clear a Gastrostomy tube]. Upon return, Employee #14 opened the package and inserted the yellow " Declogger " into Resident #5 ' s Gastrostomy tube and manipulated it to clear the obstruction. He/she then removed the yellow declogger and placed it uncovered on top of a paper towel and the silver	F 441	Continued From page 39 4. A report of findings for the audits audits will be provided to the DON by the educator weekly and a report to the CQI committee monthly of problems identified and corrective actions implemented.	11/2/12 On going

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F 441	Continued From page 40	F 441		

tray which contained medications to be administered to the resident.

The nurse then manipulated the resident ' s Gastrostomy tube and reinserted the Declogger into Resident #5 ' s Gastrostomy tubing and again attempted to clear the tubing.

The nurse then removed the Declogger from the Gastrostomy tubing; rinsed it off at the sink in the resident ' s room and placed it back on the paper towel and silver tray uncovered. He/she repeated this sequence of events three more times.

At this time, Employee # 3 entered the room to assist Employee #14 with clearing the Gastrostomy tube. Employee #3 told Employee #14 to continue passing medications (to the other residents) and that he/she would assign another nurse to clear the Gastrostomy tube.

Employee # 14 disposed of the medications by pouring them into the sink in the resident's room, he/she rinsed the silver tray with water and wiped it dry with a paper towel, washed his/her hands and left the room with the tray. When the writer queried Employee #3 as to the type of isolation the resident was on. He/she replied, " MRSA (Methicillin-resistant Staphylococcus Aureus) at the g-tube site. "

There was no evidence that the staff practiced appropriate infection control standards while attempting to clear Resident #5 ' s Gastrostomy tube. The Declogger apparatus was not properly contained during the procedure and the silver medication tray was intended for reuse after

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F 441	Continued From page 41 contamination. Employees # 3 and #14 acknowledged the findings at the time of the observation.	F 441	Continued From page 41 **F456 #1 & #2**	
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 during a tour of Dietary Services on August 4, 2012 at approximately 9:30 A.M. and on August 7, 2012 at approximately 9:05 A.M., it was determined that the facility failed to maintain essential equipment in safe, operating condition as evidenced by one inoperable refrigerator and Two (2) of four (4) convection ovens were not functioning as intended. The findings include: 1. One (1) of one (1) reach-in refrigerator used for produce storage was inoperative. 2. Two (2) of four (4) convection ovens were not functioning as intended. One was completely inoperative and the double doors to another would not remain fully closed. These observations were made in the presence of Employee #18 who acknowledged the findings.	F 456	1. The equipment identified has been serviced and parts have been ordered and scheduled to be installed by 11/6/12. 2. An audit of dietary equip has been completed by the administrator and corrective actions implemented as indicated. 3. Review of the facility policy regarding equipment in disrepair has been completed by the administrator with the Dietary Manager. The Dietary Manager will complete an audit of equipment weekly. 4. The results of the above audits will be provided to the administrator weekly and the CQI committee monthly of problems identified and corrective actions implemented. The CQI committee will determine the need for further action.	9/14/12 9/17/12 9/14/12 9/14/12 10/26/12
F 463	483.70(f) RESIDENT CALL SYSTEM -	F 463		

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F 463 SS=D	Continued From page 42 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 observations made during an environmental tour of the facility on September 7, 2012 between 11:00 AM and 4:00 PM, it was determined that the facility failed to ensure that call bells were functioning properly in three (3) of 40 residents rooms as evidenced by one (1) call bell pull cord that was wrapped around a grab bar in the bathroom of room #230, one (1) call bell cord that was too short in the bathroom of room #223 and a non-functioning call bell in room #318. The findings include: 1. The call bell in the bathroom of room #230 was wrapped around the grab bar in one (1) of 40 residents rooms. 2. The call bell cord was too short in one (1) of 40 residents room (#223). 3. The call bell in room #318 did not activate when tested in one (1) of 40 resident's rooms.	F 463	Continued From page 42 **F463 #1, #2 & #3** 1. Corrections for the call bells were completed at the time of survey. 9/7/12 2. An audit has been completed by the maintenance director of call bells. Corrective actions implemented as indicated. 10/26/12 3. During weekly environment of care rounds (EOR) of call bells will be checked to ensure they are operable by the Unit manager,/ADON/ departmental director/designee, 10/26/12 4. The results of the above environmental care rounds will be reported to the Administrator on a monthly basis with problems identified and corrective actions implemented. The Administrator will determine the need for further action. 10/26/12 On going	

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F 463	Continued From page 43 These observations were made in the presence of Employee #18 who acknowledged the findings.	F 463	Continued From page 43 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS	
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour, it was determined that the facility failed to ensure that handrails were firmly secured as evidenced by loose handrails on the three (3) of three (3) residents care units observed. The findings include: Handrails were not secured in as the following locations: a. On the first floor next to the service elevator b. Between rooms #113 and #114 c. Outside of rooms #115 and room #117 d. Across from room #142 e. Outside of rooms #222, #227, #229 and #322. These observations were made in the presence of Employee #18 who acknowledged the findings.	F 468	**F468** 1. Corrections for the hand rails were completed at the time of survey. — 9/7/12 2. A physical assessment has been completed by the maintenance staff of handrails. Corrective actions implemented as needed. — 10/26/12 3. A physical assessment of hand rails will be completed weekly as part of environmental care rounds by a designated department director/designee. — 10/26/12 4. The results of the above environmental care rounds will be provided to the Administrator of problems identified and corrective actions implemented. The Administrator will determine the need for further action. — 10/26/12 On going	
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	F 469		

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F 469	Continued From page 44 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: Based on observations made during the survey and during a tour of the Dietary Services on August 4, 2012 at approximately 9:30 A.M. and on August 7, 2012 at approximately 9:05 AM, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects observed in five (5) of 40 resident rooms and in the kitchen on two (2) of two (2) occurrences. The findings include: 1. Flying insects were seen in resident rooms #111, #125, #324, #325 and #342. 2. Flying insects were seen in dietary services on two (2) of two (2) occasions on August 4 and August 7, 2012. These observations were made throughout the survey.	F 469	Continued From page 44 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM **F469** 1. Resident rooms identified were treated by the pest control company on 10/26/12. The kitchen area was treated on 9/14/12 and 10/12/12. 2. Pest control service was provided to the facility on 10/26/12, which entailed rounds on all residential floors. This service was provided in addition to the biweekly services. 3. The pest control service conducted educational sessions with the staff during the month of September on preventative pest control measures and the development of flying insects. A light that attracts flying insects has Been installed in the ground floor Common area on 09/08/12. The need For additional lights near door openings Will be assessed. 4. A biweekly pest control report will be provided to the Director of Environmental Services/designee with finding and Recommendations. The Director of Environmental Services/designee will Report the findings and corrective Action(s) to the CQI committee on a Monthly basis.	10/26/12 10/26/12 10/26/12 10/26/12 On going
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted	F 514		

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F 514	Continued From page 45 professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: A. Based on record review and staff interview of two (2) of 32 sampled resident, it was determined that the facility staff failed to ensure that one (1) resident was informed about his/her wheelchair being broken and the availability of alternative measures for the resident to get out of bed and failed to ensure that the established communication log for both the facility and dialysis center was recorded consistently for one (1) resident. Residents #27 and #54. The findings include: 1. Facility staff failed to document that Resident #27 was informed about his/her wheelchair being broken and record the alternative measures available for the him/her to get out of bed and attend activities. A face-to-face interview was conducted with Resident # 27 on September 4, 2012 at approximately 1:50 PM. He/she stated, " They	F 514	Continued From page 45 **F514 #1** 1. Resident #27 wheelchair was repaired and returned to the resident. 2. An audit of broken equipment and documentation of notification was reviewed by the unit managers. 3. Education was completed by the educator with staff regarding resident rights, notification of change, and documentation of notification. An audit of broken resident equipment and documentation will be completed weekly by the unit manager. 4. The result of the above audits will be Reported to the ADON with problems Identified and corrective actions Implemented. The ADON will determine the need for further action.	09/19/12 10/31/12 10/26/12 11/02/12 On going

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(facility staff) took my wheelchair. They said it was broken. They didn ' t ' t leave me another one (wheelchair). I ' m stuck in this bed and they haven ' t said anything about when the wheel chair would be back. I guess in a few weeks, I hope it won ' t be that long. I don ' t like being stuck in this bed. "

The resident was observed in bed from 1:50 PM to 5:00 PM. Also during this time the writer heard the resident place three calls to the nurses ' station and ask " When am I going to get up (out of the bed)."

A face-to-face interview was conducted with Employee #9 on September 4, 2012 at approximately 2:00 PM. He/she stated, " The resident had a seizure yesterday. I was told that the wheelchair broke at that time and it was sent for repair. I don ' t know how long it will take to be repaired, because it is a special chair. "

A nurses note dated September 3, 2012 at 12:33 PM revealed, " ...apparent seizure activity Grad Mal, time lasted activity unsure of time. The seizure was of such force the back of [his/her] wheel chair was observed broken. "

A nurse ' s note dated September 4, 2012 at 11:49 PM revealed, " Wheel chair broken. Down for repairs. Resident concerned about getting up. PT (physical therapy) notified for alternate wheelchair. "

A face-to-face interview was conducted on September 5, 2012 at 12:00 PM with Employee #24. He/she stated, " The facility is trying to get

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F 514	Continued From page 47 a wheel chair for the resident. Resident #27 requires a special wheel chair. " According to the rehabilitation note dated September 5, 2012 [no time indicated], Occupational Therapy Screen Form revealed, "Pt (patient) seen for w/c (wheel chair) consult secondary to pt's current w/c requires repair. Pt has custom chair second to hx (history) of seizures... OT recommends standard w/c with seat belt as a temporary chair for pt ..." A review of the 24-Hour Report, the Social Services notes and the Nursing Progress notes for September 3 - 5, 2012 at 1:00 PM revealed that there was no documented evidence that the resident and/or his/her representative was informed about his/her wheelchair being broken, how long it was going to take to repair the wheelchair and alternative measures to be taken for the resident to get out of bed and attend activities and dining outside of the resident ' s room. A face-to-face interview was conducted with Employee #9 on September 10, 2012 at approximately 11:00 AM. He/she acknowledged that the resident and/or his/her representative was not informed about his/her wheelchair being broken, how long it was going to take to repair the wheel chair and alternative measures to be taken for the resident to get out of bed and attend activities and dining outside of the resident ' s room. The record was reviewed September 10, 2012	F 514		

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F 514	Continued From page 48 2. Facility staff failed to ensure that the established communication log for coordination of services between the facility and the dialysis center was consistently recorded for Resident #54. A review of the medical record revealed that Resident #54 received dialysis treatments on Monday, Wednesday and Friday during the afternoon shift. A review of the dialysis communication book revealed pre and post dialysis weights, dry weight, the amount of fluid removed, nurse signature and date, labs drawn, medication(s) administered and post dialysis nursing assessments were not consistently documented for the period of May 25, 2012 to September 7, 2012. A face-to-face interview was conducted September 7, 2012 at 10:00 AM with Employee #11. He/she acknowledged that the findings. The record was reviewed September 7, 2012. B. Based on observation, record review and staff interview for 70 of 70 sampled records it was determined that facility staff failed to maintain electronic and active clinical record information in a systematically organized and readily accessible manner. The findings include:	F 514	Continued From page 48 **F514 #2** 1. Corrections of findings are not possible for resident #54. 10/26/12 2. An audit of dialysis records for other residents have been completed and corrective actions implemented as indicated. 10/26/12 3. Staff education has been completed by the ADON regarding review of the dialysis communication books by the staff. An audit of dialysis communication books will be completed by the unit manager weekly. 10/26/12 4. A report on the findings will be provided to the ADON weekly of problems identified and corrective actions implemented. The ADON will determine the need for further action. 10/26/12 On going	

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F 514	Continued From page 49 Throughout the survey period of September 4, 2012 through September 11, 2012 the survey team made requests of facility staff for current computerized information, active clinical records and thinned record information. The requests included but were not limited to: progress notes, nursing assessments sheets, care plans, skin measurements sheets, physician order sheets, medication administration records, treatment administration records and the like. Staff were not able to readily access the information and there were significant delays in obtaining the requested documents. A face-to-face interview was conducted with Employees #1, #2 on September 11, 2012 at approximately 2:00 PM. A query was made regarding measures to be implemented to allow for efficient access to the medical records and needed information regardless of the format. After review of the above Employee #1, and #2 acknowledged the findings and indicated that the facility implemented the electronic medical records system beginning in January 2012 for nursing documentation, social services, dietary and activity records, and that other departments information will be introduced in phases until all of the medical record is computerized. Employee #2 also acknowledged that staff will be re-inserviced on handling the medical record information in a more systematic manner.	F 514	Continued From page 49	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	Continued From page 50 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to maintain a quality assessment and assurance committee that developed and implemented appropriate plans of action to correct identified quality deficiencies as evidenced by a failure to identify that residents with pressure ulcers received weekly skin assessments for five (5) of 19 sampled residents. Residents #8, 50, 82, 117 and 149.	F 520	Continued From page 50 **F520 #1, 2, 3, 4 & 5** 1. There is no correction possible for the missed measurements for resident #8, #50, #82, #117, and #149. The resident's wound is measured weekly to date. 2. An audit of the measurements of resident with wounds has been completed by the ADON. Corrections have been made as indicted. 3. A review of the facility policy "Wound Care Program" has been completed with the nursing staff by the educator. Nursing Staff have also been educated on wound measurement. An audit of wound measurements will be completed weekly by the ADON. 4. The results of the above audit will be provided to the DON weekly of problems identified and corrective actions implemented. A report will be provided to the CQI committee by the DON of problems identified and corrective implemented. The CQI committee will determine the need for further audits and actions.	10/26/12 10/26/12 10/31/12 11/02/12 On going

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 _____	09/11/2012

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F 520	Continued From page 51 The findings include: A review of the facility ' s documentation for skin assessments revealed that the facility failed to document weekly wound measurements while monitoring the wounds for five (5) of 19 sampled residents. A copy of the reports for the five (5) residents is outlined below. The policy entitled: entitled: " Wound Care Program " Policy and Procedure number 1000, revised 7/29/10 stipulated: " Procedure for Breaks in Skin Integrity- 6. The charge nurse will complete weekly documentation of all wounds Skin breakdown, (abrasions, lacerations, rashes, surgical), stasis, non-pressure wound or pressure report sheets. " 1. Facility staff failed to measure wounds at least every seven days from August 2012 through September 2012 for Resident #8. A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the resident ' s skin impaired areas were measured on the following dates: Left Buttock Stage IV- August 2, 16, and 30, 2012 There was no evidence that facility staff measured the resident ' s aforementioned wound at least every seven (7) days. 2.Facility staff failed to measure wounds at least	F 520		

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F 520	Continued From page 52 every seven days from June 2012 through September 2012 for Resident #50. A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the residents skin impaired areas were measured on the following dates: Lower Sacrum Unstageble due to necrosis- June 2, 8, 21, and 28, 2012 Lower Sacrum Stage IV- July 12, 26, August 16, 23, and September 6, 2012 There was no evidence that facility staff measured the residents aforementioned wound at least every seven (7) days. 3. Facility staff failed to measure wounds at least every seven days from June 2012 through September 2012 for Resident #82. A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the resident ' s skin impaired area was measured on the following dates: Lower Sacrum Stage III- June 14, 28, August 16, 23, and September 6, 2012 There was no evidence that facility staff measured the residents aforementioned wound at least every seven (7) days. 4. A review of Resident # 117 ' s record revealed	F 520		

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F 520	Continued From page 53 that facility staff failed to measure wounds at least every seven days from April 2012 through Sept 2012. A review of the " Wound Care Specialist Evaluation " form from April 26, 2012 through September 6, 2012 revealed the resident ' s skin impaired areas were measured on the following dates: Lower Coccyx Stage IV - June 8, 28 July 12, 26, August 9, 23, and September 6, 2012 Right Hip- Stage IV- June 8, 28, July 12, 26, August 9, 23, and September 6, 2012 There was no evidence that facility staff measured the resident ' s aforementioned wounds at least every seven (7) says. 5. Facility staff failed to measure a wound at least every seven days from June 2012 through September 2012 for Resident #149. A review of the " Wound Care Specialist Evaluation " form from August 2012 through September 2012 revealed the resident ' s skin impaired area was measured on the following dates: Medial Sacrum Stage IV- June 28, July12, 26, August 16, 30, 2012 There was no evidence that facility staff measured the resident ' s aforementioned wound at least every seven (7) days.	F 520		

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F 520	Continued From page 54 The facility failed to maintain a quality assessment and assurance committee that developed and implemented appropriate plans of action to correct identified quality deficiencies as evidenced by failure to identify that all residents with pressure ulcers received weekly skin assessments. A face-to-face interview was conducted with Employees #2 and # 29 on September 11, 2012 at approximately 11:00 PM. The employees acknowledged the findings.	F 520		