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 ___	08/11/2010

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 387	Continued From page 121 A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for two (2) of 26 sampled residents, it was determined the physician failed to visit in accordance with the regulations. Residents #5 and 17. The findings include: 1. The physician failed to visit Resident #5 every 60 days. A review of Resident #5 ' s record revealed a physician ' s progress note dated March 29, 2010. The record lacked evidence of a progress note or visit by the primary care provider or his/her designee subsequent to March 2010. The findings were reviewed and confirmed during a face-to-face interview with Employee #6 on August 2, 2010 at approximately 4:00 PM. The record was reviewed August 2, 2010. 2. The physician failed to visit one (1) resident every 30 days for the first 90 days after a new admission to the nursing facility. Resident # 17. The findings include: The physician failed to visit Resident #17 every 30 days for the first 90 days after a new admission to the nursing facility	F 387	**483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT** **Ftag 387** 1. The physician visited Residents #5 on 9/10/10 and Resident# 17 was seen by the physician on 9/11/10.	09/11/10
			2. A physician compliance audit was conducted for all current resident's charts and correction were made as needed.	10/19/10
			3. Physicians were educated by the medical director regarding the requirements of physician visits and documentation. Unit secretaries were re-educated regarding the documentation requirements by physicians on new and long term care residents. Unit secretaries will complete monthly audits of physician documentation and provide a report to the director of nursing and medical director of findings.	10/19/10
			4. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly by the DON/ designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10

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F 387	Continued From page 122 A review of Resident #17's record revealed that the resident was admitted to the facility on December 30, 2009. An attending admission note and a history and physical examination was completed on December 31, 2009 . The physician saw the resident on December 31, 2009, January 14, March 19, and April 22, 2010 as evidenced by his/her progress notes in the resident's clinical record. The resident's clinical record lacked documented evidence that the physician saw the resident and wrote a progress note during the month of February 2010. The resident's clinical record lacked documented evidence that the physician saw the resident and wrote a progress every 30 days for the first 90 days after admission to the facility. A face-to-face interview was conducted with Employee #6 on August 9, 2010 at approximately 1:30 PM. After reviewing the resident's clinical record, he/she acknowledged the aforementioned findings. The record was reviewed August 9, 2010.	F 387		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for	F 411		

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F 411	Continued From page 123 routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 26 sampled residents and one (1) of 30 supplemental residents, it was determined that facility staff failed to ensure an annual dental screen was completed for Residents #4 and #CBL7 The findings include: A review of Resident #4's record revealed a dental screen dated May 7, 2009. There was no evidence that an annual dental screen was completed for 2010. A face-to-face interview was conducted with Employee #5 on August 4, 2010 at 10:30PM. He/she acknowledged that there was no dental evaluation for 2010. The record was reviewed August 4, 2010. 2. A review of Resident #CBL7 clinical record revealed a dental screen dated July 10, 2009. There was no evidence that an annual dental screen was completed for 2010. A face-to-face interview was conducted on August 9, 2010 with Employee #7 at approximately 2:30 PM. After review of the	F 411	**Continued From page 123** **483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS** **Ftag 411** 1. Resident #CBL7's dental screen was scheduled for 10/19/10, however the resident was hospitalized. Resident #4's annual dental screen was completed on 8/10/10. 2. All residents have the potential to be affected by this practice. An audit for dental screens was conducted by the unit secretaries. 3. A new dental services contract is being investigated. The current dentist has been re-educated by the medical director on the requirements. The unit secretaries will conduct monthly audits and schedule monthly dental visits for those residents requiring dental services. The results of these audits will be reported to the director of nursing. 4. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly by the DON/ designee. A report of problems identified and corrective actions implemented will be The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10 10/19/10 10/19/10 10/28/10

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F 411	Continued From page 124 clinical record he/she acknowledged that the clinical record lacked evidence of a routine dental evaluation. The clinical record was reviewed on August 9, 2010.	F 411		
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 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 and staff interview for one (1) of 26 sampled residents it was determined that facility staff failed to acquire medication as ordered by the physician in a timely manner. Resident #2. A review of the MAR (Medication Administration Record) for Resident #2 indicated Klonopin 0.25 1	F 425		

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

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F 425	Continued From page 125 tablet po (by mouth) q (every) 12 hours for agitated behavior, original order date July 22, 2010 revealed that dates July 24th, 25th, 26th, 6:00 AM and 6:00 PM doses were circled and that July 27th 6:00 AM doses was circled. Further review of the MAR revealed that in the " medication not administered reason " section identified that on: July 24th 6:00 am, Not yet received by pharmacy; July 25th 6:00 no AM or PM time identified, Pharmacy called awaiting del. (delivery); July 24th, 6:00 PM Klonopin 0.25 mg awaiting supply not given; July 25th 6:00 PM Klonopin 0.25mg awaiting supply, not given; July 26th 6:00 AM Klonopin 0.25 mg C-2 form to be complete and faxed; July 26th 6:00 PM Klonopin 0.25mg awaiting Pharm (Pharmacy) not given; July 27th 8:00 PM Klonopin anxiety c/o (complained of) shaking - effective. According to the nurses Progress Note dated and signed July 22, 2010 at 4:00 PM, Resident #2 was " readmitted to the facility. " According to the Nurses Progress Note dated and signed July 23, 2010 11:00 PM, " Klonopin order faxed to MD (Medical Doctor) for Authorization. " According to the Nurses Progress Note dated and signed July 25, 2010 at 10:00 PM, " The resident ' s Klonopin, still awaiting delivery. " According to the Nurses Progress Note dated and signed July 26, 2010 at 7:00 AM Pharmacy called for Klonopin 0.25 mg (milli gram) tab. " Has not received since ordered on July 22, 2010. "	F 425	Continued From page 125 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 1Resident #2 medication was received and behaviors were noted. 2. A review of new physician orders for the past 30 days has been completed by the unit managers to assure medications have been received in a timely manner. Corrections made as needed. 3. A review of the process of the receipt of medications has been completed with the pharmacy consultant and the attending physician. Supervisors have been educated by the Director of Nursing, to check physician orders each shift, with each nurse team leader to ensure medications have been received and to implement corrective actions as needed. 4. An audit of this process will be conducted monthly by the Director of Nursing/designee. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and the frequency of further audits.	 8/11/10 10/19/10 10/19/10 10/19/10

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F 425	Continued From page 126 According to a Nurses Progress Note dated and signed July 27, 2010 Physician started new meds [medications] for Seroquel today. " According to the Nurses Progress Note dated and signed July 30, 2010 9:30 PM " resident received all evening meds (medications). " A face-to-face interview was conducted with Employee #6 on August 2, 2010 at approximately 3:40 PM. He/she acknowledged the above findings and indicated that the " Klonopin C-2 form was faxed to the MD (Medical Doctor) from the facility and that the MD faxed to pharmacy. Pharmacy did not give a cause for the delay. The medications were sent on July 27, 2010 at night. Pharmacy suggested if the MD would fax to the facility and let the facility fax to pharmacy this may be better. " The record was reviewed on August 2, 2010	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of 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.	F 431		

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F 431	Continued From page 127 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.	F 431	**483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** **Ftag 431** **#1 and #2 Response**	
			1. The nurse remediated the time of survey. The treatment cart was secured.	8/5/10
			2. All residents have the potential to be affected by the practice. An audit was completed of facility treatment carts by the wound nurse and temperature logs.	10/19/10
	This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to store drugs and biologics in locked compartments under proper temperature controls and include the appropriate accessory and cautionary instructions, and the expiration date when applicable as evidence by one (1) unlocked treatment cart, unattended drugs on top of medication cart, two (2) of three (3) inconsistent temperature control logs, and remove expired drugs from three (3) of three (3) medication carts.		3. Staff has been education on the HIPPA requirements, resident rights, on securing and storing drugs and biological. Random audits of medication and treatment carts will be completed monthly by the pharmacist and pharmacy nurse consultant. A report of these audits will be submitted to the director of nursing.	10/19/10
	The findings include: 1. On August 5, 2010 at 6:35 PM during dining observation, Employee #25 left 6 [six] vials of Insulin on the top of the medication cart. The employee left the cart unattended by the nurse ' s		4.The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly by the DON/ designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10

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F 431	Continued From page 128 station in front of the elevator with the unattended medications on top of the cart. During this time, residents were observed ambulating in the hallway and staff was observed sitting in the nursing station. A face-to-face interview was conducted with Employee #25 on August 5, 2010 at approximately 6:45 PM. He/she stated, " that the medication should have been locked in the medication cart when it was unattended. He/she then placed the medications in the medication cart and locked it. " 2. The treatment cart on 1st floor was observed unlocked on August 4, 2010 at 2: 20 PM and August 10, 2010 at 10:55 AM. Employees #2 and Employee #18 removed the wound care carts from the locked medication room. While transporting the wound cart to Resident # 12 and Resident #19 room prior to doing wound treatments, the drawers kept opening. A face-to-face interview was conducted with Employee #2 on August 4, 2010 and August 10, 2010 at approximately 3:30 PM and 12:30 PM. He/she stated, " We do not lock the wound carts. They are locked in the medication room. " 3. Facility staff failed to remove the expired medications from the medication carts as follows: Expired Medications 1st floor Team 2 medication cart 11 Pentoxifillin (Trental) 400mg tabs expired 6/15/2010 2nd floor Team 1 medication cart	F 431	**#3**	
			1. The expired medications were removed from the medication cart.	8/10/10
			2. All residents have the potential to be affected by the practice. An audit was completed of facility medication carts by the charge nurse.	10/19/10
			3. The staff was in-service on the removal of expired medications from the medication carts by the educator. Random audits for expired medications on the medication and treatment carts will be completed monthly by the pharmacist and pharmacy nurse consultant. A report of these audits will be submitted to the director of nursing.	10/19/10
			4. The results of the above audit will be reported to the CQI committee quarterly by the Pharmacist/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	Feb, May Aug, Nov

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F 431	Continued From page 129 14 Glipizide 10 mg tab expired 7/31/2010 Team 2 medication cart 1 bottle antidiarrehal Caplets (Loperimide HCL) 2mg expired 6/10 16 Acetaminophen 3225mg tab expired 10/12/2009 23 Promethazine HCL 25mg tab expired 1/29/2010 Team 3 medication cart 1 Hydralazine 25mg tabs expired 7/31/2010 17 Senna Plus expired 4/30/2010 3rd floor Team 2 medication cart 3 Glipizide 5mg tabs expired 6/15/2010 Team 3 medication cart 61 Oyster shell calcium tabs expired 7/15/2010 Discontinued Medication Guaifenesin 100mg/ 5ml cough formula, discontinued on 5/24/2009 Diabetic Tussin Ex 100mg/ 5ml Liquid, two (2) bottles discontinue on 4/29/2009, 5/1/2009 Guaifenesin -DM 100mg/ 5ml cough formula, three (3) bottles discontinued on 4/7/2009, 12/09/2008 and 4/18/2009 Unlabelled Medication (no patient name on medication) (1) Lovenox 30 mg/ 0.3 ml (1) Ranitidine 150 mg tablet (2) Calcium Carbonate 10gr tablets (1) Lisinopril 20 mg tablet (1) Ibuprofen 600 mg tablet (1) Zyprexia 2.5 mg tablet	F 431		
F 441 SS=H	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	F 441		

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F 441	Continued From page 130 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. (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: A. Based on observations, record reviews, staff and residents interviews for four (4) of 26 sampled residents and four (4) Supplemental residents and two (2) observations it was	F 441		

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F 441	Continued From page 131 determined that facility staff failed to: provide an infection control program that identified control and prevention procedures to prevent the spread of infections, failed to develop and implement an effective TB Infection Control Program to prevent the spread communicable disease, wash hands between residents' care, wash hands after disposing of a red bag, post transmission based precautions signage, handle soiled linen appropriately and maintain clean technique during wound treatments. Residents # 5, 6, 12, 19, CBL5, CBL8, CBL13 and CBL14. The findings include: 1. The facility's "Infection Control Policy", Policy and Procedure No. 1018; Revised August 3, 2007 stipulated, " Purpose: The primary purpose of infection control monitoring procedure is to establish guidelines to follow in reporting nosocomial infections and communicable diseases in the facility." Included in the "Infection Control Policy" on pages 1 and 2 were specific directions on reporting an infection to the infection control practitioner, documenting action taken in the resident's record and monthly reporting of information contained in the "Infection Control Workbook." On page 2, "Tabulation of the Facility's Nosocomial Rate" discussed the tabulation and calculation of the nosocomial rate of infections in the facility. On page 3, "Resident Infection Surveillance and Monitoring" discussed analysis and trends of nosocomial rates greater than 5% and the reporting of communicable disease breakouts.	F 441	1. Infection Control Plan has been reviewed and revised to reflect CDC Standards for Long Term Care. 2. No resident was identified. The current data collected has been used to initiate interventions and to prevent the spread of infection. 3. The infection control policy and program has been reviewed, re-evaluated, and revised. Policies have been developed that address the control and prevention of infection throughout the facility. The review of the program has been completed and signed off by the medical director. The current program will be used to identify, prevent, and control the spread of infection throughout the facility. Staff has received education on policies. 4. Data collected will be analyzed and corrections have been implemented into staff practices presented to the CQI committee monthly by the ADON/IC Coordinator. The CQI committee will determine the need for other interventions and need and frequency of further audits. Report results to scheduled Board meetings.	10/19/10 10/19/10 10/19/10 10/28/10

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F 441	Continued From page 132	F 441		
	Although the facility investigated causes of infections and the treatment of residents, there was no evidence that the facility had developed policies that addressed the control or prevention of infections throughout the facility. Data was collected by the facility on a monthly basis regarding nosocomial and community acquired infections and was reviewed to include January through July 2010. There was no evidence at the time of this review that facility staff utilized the collected data to initiate interventions for control and prevention of infections. There was no evidence that on-going in-services regarding infection disease prevention had been conducted. A face-to-face interview was conducted with Employee #3 on August 4, 2010 at 11:30 AM. At this time the Infection Control Program was reviewed and he/she acknowledged the program did not utilize the collected data to develop a control or prevention component. 2. Facility staff failed to minimize exposure to a potential source of infection for Resident #5 during a wound treatment. A wound care treatment observation was conducted on August 3, 2010 at approximately 11:10 AM with Resident #5 who had bilateral lower extremity venous stasis ulcers.		1. Staff was re-educated at the time of survey on proper technique dressing/ wound treatment.	10/19/10
			2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the educator. Remediation has been made as needed. Infection control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by educator and unit managers.	10/19/10
			3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the infection control coordinator and the environmental team. Dining and meal service education has been completed by the dining services director. Meal pass observations will be conducted by the Infection Control Coordinator monthly.	10/19/10

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F 441	Continued From page 133 potential source of infection as evidenced by failing to ensure that saline soaked gauze remained free of potential contaminants and failed to create a barrier between the wound site and bed linens. The resident ' s bedside table was used as the treatment work surface area. Employee #16 placed disposable washcloths atop the bedside table prior to the treatment observation. The employee opened packages containing sterile 4X4 gauze sponges and dropped them onto the covered bedside table. The employee saturated the gauze sponges with normal saline. The saline soaked sponges penetrated through the washcloths atop the table and made contact with the table surface. The employee proceeded with the wound treatment and utilized the saline sponges to cleanse the wound sites. The resident ' s legs rested atop the bed linens and there was no barrier placed between the resident ' s legs and the bed linens. The cleansing of the wounds, in the absence of a barrier, afforded an opportunity for the saline solution to drain onto the bed linen. Employee #16 failed to ensure the integrity of the gauze sponges; as they were exposed to potential contaminants atop the bedside table. Additionally, a barrier was not placed between the wound site and the bed linen, potentially exposing the wounds and/or linens to potential contaminants. A face-to-face interview was conducted with Employee #16 subsequent to the wound observation. He/she stated that the washcloths	F 441	4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov.	10/28/10

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F 441	Continued From page 134 utilized to line the work surface area were disposable cloths stored on linen carts. A face-to-face interview with Employee #6 on August 6, at approximately 2:00 PM revealed that it was customary to utilize a barrier beneath the wound site during treatment. 3. Facility staff failed to maintain appropriate infection control practices during wound care treatment. Resident #6 A review Resident ' s 6 ' s record revealed a physician ' s order dated and signed July 2, 2010 directed " right leg - cleanse W/NS (with/normal saline) apply Neosporin every shift and leave open to air until healed. " A wound treatment observation was conducted on August 4, 2010 at approximately 9:15 AM with Employee #32. Employee #32 failed to maintain clean technique during the wound treatment process: The resident was sitting in an upright position on his/her bed. The following was not maintained during the wound treatment observation. Employee #32 failed to wash hands greater than 15 seconds (upon entering the room, after placing supplies on table, after cleaning the wound and removing the dirty gloves, after leaving and reentering the room to address a second wound, and after completing the process), failed to place a barrier under the resident ' s right leg prior to cleaning the wound. Placed a small size red bag marked biohazard directly on the table with the clean supplies. Removed an ink pen from his/her pocket to label the dressing with same gloved	F 441	1. Staff was re-educated at the time of survey on proper technique dressing/wound treatment. Resident #6 2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the educator. Remediation has been made as needed. Infection control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by Educator and unit managers. 3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the director of nursing. Environmental rounds will be completed bi-weekly by the infection control coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the Infection Control Coordinator monthly. 4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov.	8/4/10 10/19/10 10/19/10 10/28/10

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F 441	Continued From page 135 hand after cleaning the second wound, and failed to clean over bed table after removing used supplies and completion of the process. A face-to-face interview was conducted with Employee #5 at 8:50 AM after review of the above, he/she acknowledged the findings. The observation was made August 4, 2010 4. Facility staff failed to maintain clean technique during wound care for Resident #12. On August 4, 2010 at approximately 2:20 PM, Employee # 32 was observed during wound care treatment for Resident #12. The employee used a pair of scissors to remove the soiled bandage from the resident ' s right heel. The bandage was placed in a red bag. The employee placed the scissors on the field which she/he had set up on the resident ' s over the bed table. She/he completed the dressing change and discarded the field and proceeded to wash the scissors with soap and water. The employee did not clean the over bed table after the wound treatment. A face-to-face interview was conducted with Employee #5 on August 4, 2010 at approximately 3:15 PM. He/she stated that the over bed table should have been cleaned after the wound treatment and the scissors should have been cleaned with a germicide. The chart was reviewed August 4, 2010. 5. A. On August 10, 2010 at approximately 10:55 AM, Employee #18 was observed during wound care to umbilicus abdomen treatment for Resident #19. Employee failed to apply barrier prior to wound care. Also, during wound care,	F 441	1. Staff was re-educated at the time of survey on proper technique dressing/wound treatment. Resident #12. 2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by educator and unit managers. 3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the director of nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the Infection Control Coordinator monthly. 4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov.	8/4/10 10/19/10 10/19/10 10/28/10

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1. Staff was re-educated at the time of survey on proper technique dressing/wound treatment. The hamper in Resident #19's room was replaced.	8/10/10
2. All residents have the potential to be affected by this practice. Wound competency has been completed for the licensed staff by the educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by Educator and unit managers.	10/19/10
3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the infection control coordinator monthly.	10/19/10
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 136 observed hamper in resident ' s room was full with soiled clothing with no cover. A face-to-face interview was conducted on August 10, 2010 at 12:30 PM with Employee #5. He/she stated that a barrier should have been placed prior to wound care. The chart was reviewed on August 10, 2010. B. Employee # 18 was observed on August 5, 2010 at approximately 1:50 PM provide wound treatment to Resident CBL5. After the completion of the treatment, Employee #18 failed to wash his/her hands after discarding the red trash bag in the soiled utility room. A face-to-face interview was conducted with Employee #18 on August 5, 20010 at approximately 2:00 PM. He/she acknowledged the observation. 6. Facility staff failed to post transmission based precaution signage for Resident CBL8 who was on contact precautions. On August 3, 2010 at 9:30AM the nurse walked in to the resident's room and immediately put her face mask on. When queried about her wearing a mask she replied that resident was on isolation for positive MRSA in nacres and VRE in urine A review of admission physician order sheet and Plan of care notes dated July 26, 2010 in the section mark treatments reads, " monitor isolation precaution every shift " . A face-to-face interview was conducted on August 3, 2010 at 9:40 AM with Employee # 16. He/she "stated I was so busy she did not check or looked up to see if isolation sign was on the door." The record was reviewed on August 3, 2010.	F 441	1. Staff was re-educated at the time of survey on proper technique dressing/wound treatment. Resident #CBL5. 2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the Educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by Educator and unit managers. 3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the infection control coordinator monthly. 4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov.	8/5/10 10/19/10 10/19/10 10/28/10

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1. Staff was re-educated at the time of survey on proper technique dressing/wound treatment. Resident #CBL8	8/3/10
2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the Educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by Educator and unit managers.	10/19/10
3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the Infection Control Coordinator monthly.	10/19/10
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F 441	Continued From page 137 7. Facility staff failed to develop and implement an effective TB Infection Control Program to prevent the spread Communicable disease and subsequently one resident was not identified with TB [Resident 13], one resident was exposed and converted to a positive PPD [Resident 14] and three (3) staff members converted. Resident CBL 13. A review of the resident's clinical record revealed the followings: Facility Policy #200 titled " Admissions Policy ", Effective: 09/19/00[September 19, 2000], revised: 08/03/2007, 07/29/2010 indicates: an individual meeting any of the following conditions may be refused admission: 1. Those with communicable diseases. 2. Those currently addicted to alcohol, narcotics, or other controlled drugs or whose condition presents a probability of causing significant risk to themselves or others Facility Policy # 1018 " Infection Control Policy " Effective 09/19/00 [September 19, 2000], Revised 08/07/07 [August 3, 2007], indicates; ...The primary purpose of infection control monitoring procedure is to establish guidelines to follow in reporting nosocomial infections and communicable disease in the facility. ...Communicable disease: a disease capable of being transmitted from one person to another ...The infection control Practioner is notified of any resident admitted with a communicable disease and or any resident admitted with and infection requiring isolation precautions ... A review of the resident's clinical record revealed the following:	F 441	1. Preventive measures were put in place at the time of discovery. For the residents CBL14. 2. All residents have the potential to be affected by this practice. Review of residents requiring isolation has been conducted by the ADON corrective actions implemented and physician notified as needed. 3. The facility has reviewed and revised its policies. A TB Exposure Control Plan has been reviewed and approved by the medical director. The DC Bureau of TB Control Clinical nurse supervisor has provided staff education in recognizing the signs and symptoms of TB, administering the PPD, reading the PPD, and documenting results. The ADON has completed staff education on isolation implementation and discontinuation. A review of the facility policy on isolation has been completed and corrections made as needed. An audit of residents on isolation will be completed monthly and a report provided to the DON. 4. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits Feb., May, Aug., Nov	 10/19/10 10/19/10 10/28/10

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A report from the discharging community based residence dated 6/19/2009 [June 19, 2009] provided the following information:
Diagnoses included Dementia, Anemia, HepA+/HepC+ and Chronic Diarrhea.
Multiple reports of lab test.
A chest X-ray dated June 2, 2009 was included in this packet.
The findings included: " Chest PA and Lateral 06/02/2009 at 12:19 hours: No Priors. There is deformity of the right distal clavicle, which is displaced superiorly, consistent with old trauma, and ossification of the coracoclavicular ligament. Nodule at the left posterior lung base, probably calcified granuloma. CT scan would be necessary to be certain. Lungs otherwise clear. Vascularity normal. There is mild ectasia and unfolding of the thoracic aorta consistent with but not diagnostic of hypertension. No pleural fluid or pneumothorax. IMPRESSION: Probable calcified granuloma at the left posterior lung base. CT scan could be performed to be certain. "

The report from the discharging community based residence dated 6/19/2009 [June 19, 2009] lacked information regarding a Tuberculin skin test with a positive result.

The a discharge summary that accompanied the resident on June 22, 2009 indicated that his/her active problems included dementia, anemia, Hepatitis A +, Hepatitis C+, positive PPD on June 14, 2009 with a 20mm indurations for PPD screen on June 14, 2009. The discharge summary further stated that the resident's chest X-ray showed no infectious process but recommended a chest CT to further evaluate a granuloma found on the chest X-ray. Also, the

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discharge summary indicated that the discharging facility was unable to initiate treatment for latent TB infection because of the inability to follow through the full course of treatment and is leaving the decision to initiate treatment at the discretion of the admitting facility.

The Resident was admitted to the Long Term Care facility on June 22, 2009.

His/her admission Minimum Data Set MDS completed on June 30, 2009 coded him/her for: depression, anemia, organic brain syndrome, and hepatitis C carrier.
On the date of Admission a consent form was obtained for Tuberculin Skin Test and the test was administered on June 22, 2009. The results were documented as negative on June 24, 2009.

An "Interim Order Form" date June 23, 2009 contained orders including CT chest scan without contrast: Dx abnormal CXR "

Documentation in the record indicates this CT scan of the chest was obtained on July 6, 2009 but no results for this CT scan were available in the clinical record. Facility staff could not provide results when requested.

The clinical record lacked documentation that the resident was placed on any type of isolation upon admission until his/her communicable disease status could be determined.

Nursing notes dated March 17, 2010 at 3:00PM and 6:00PM indicated the following: resident presented with coughing, an order for a chest X-ray that revealed ' Rt. Upper Lung field pneumonia infiltrate ', a physician's order to

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transfer the resident to the nearest emergency room and the resident was subsequently admitted to the hospital .

A chest x-ray report with an exam date of 3.17.2010 indicated the following:
" Impression: Right Upper Lobe Parenchymal Changes which Could Be Secondary to TB, Correlate Clinically. "

A CT of the Chest report, exam date 3/17/2010 with an indication of Respiratory distress, rule out TB indicated: " Impression: Nodular infiltrates in the right upper lobe. Changes of previous granulomatous infection. This could represent tuberculosis however; activity of disease must be established clinically. "

On 3/26/2010 [March 26, 2010] a Flexible fiberoptic bronschoscopy with bronchoalveolar lavage was performed by a surgeon at the acute care hospital. Samples were obtained and sent for AFB smears, culture and sensitivity, fungal stains and cytology.

A physician progress note dated March 30, 2010 by the pulmonary physician during the above procedure indicates; " AFB smear negative, C&S no growth after 29 hours; RUL infiltrate- TB ruled out; Discontinue respiratory isolation ...

A hospital ' Transfer summary ' dictated by the primary physician on March 28, 2010 indicated that the " patient had had blood culture, urine culture, sputum colure, but was reported negative. The sputum for acid-fast bacillus will take a long time to get report back. It was noted

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by the time of this dictation they have got sputum acid -fast bacillus smear which was negative, and the bronchial lavage done by [physician name], though still pending and was reported from day of admission. Finally from the small PPD-positive which was reported reactive to 5mm perimeter."

A nursing note dated March 30, 2010 at 3:30 PM that indicated that the resident was re-admitted to the facility post hospitalization with a diagnosis of " Right pneumonia"

A nursing note dated May 17, 2010 at 4:00 PM that indicated that the resident was transferred out of the facility and admitted to a hospital.

Another CT scan was done on May 17, 2010 a the admitting hospital reveals " ...a calcified granuloma measuring approximately 8mm, remains within the left lower lobe posterior segment without change with an adjacent area of scarring versus subsegmental atelectasis.

The state agency was notified on June 14, 2010, of the resident ' s positive test for TB , that the Resident's roommate Resident CBL 14 was exposed to tuberculosis and is currently on prophylaxis treatment for tuberculosis and that three (3) staff members converted post exposure.

A memorandum from DC Department of Health Bureau of TB Control dated May 27, 2010 indicated that the facility failed to comply with recommended infection control guidelines by failing to appropriately isolate the resident with undiagnosed pulmonary tuberculosis.

A face-to-face interview was conducted with Employee #2 on August 10, 2010 at

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F 441	Continued From page 142 approximately 10:00 AM. After reviewing the resident's clinical record, he/she acknowledged the above findings. The record was reviewed August 9, 2010. 8. Facility staff failed to implement appropriate interventions to prevent the spread of infection of a communicable disease subsequently resulted in resident having a Positive PPD and hospitalized for treatment of tuberculosis exposure. Resident CBL #14. According to a history and physical dated June 2, 2010 revealed, " Past medical history: Chronic Obstructive Pulmonary Disease, Parkinson ' s disease, Debility, Peripheral Vascular Disease, Hypertension, and Degenerative Joint Disease. " According to the Quarterly MDS [Minimum Data Set] completed March 3, 2010, Section I (Infections) revealed, " Antibiotic resistant infection. " There was no June 2010 Quarterly MDS on the clinical record. A review of Resident CBL #14 ' s record revealed a PPD [Positive Purified Protein Derivative] tuberculin screening resident log sheet report that was conducted on October 27, 2008. " Results negative on October 30, 2008. According to nurses ' progress notes dated: May 28, 2010 at 7:00 PM revealed, " PPD placed on right forearm " . May 29, 2010 at 2:00 PM ... " [status post] PPD right are. No reaction noted. " May 30, 2010 at 3:00 PM ... " Post PPD on 5/29/10, no reaction noted. " June 1, 2010 at 6:00 AM ... " Resident alert and verbally responsive. 2cm X 2cm reddish area	F 441	1. Preventive measures were put in place at the time of discovery. For the residents identified. 2. All residents have the potential to be affected by this practice. Review of residents requiring isolation has been conducted by the ADON corrective actions implemented and physician notified as needed. 3. The facility has reviewed and revised its policies. A TB Exposure Control Plan has been reviewed and approved by the medical director. The DC Bureau of TB Control Clinical nurse supervisor has provided staff education in recognizing the signs and symptoms of TB, administering the PPD, reading the PPD, and documenting results. The ADON has completed staff education on isolation implementation and discontinuation. A review of the facility policy on isolation has been completed and corrections made as needed. An audit of residents on isolation will be completed monthly and a report provided to the DON. 4. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits	 10/19/10 10/19/10 10/28/10

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	095015	A. BUILDING ______ B. WING ______	08/11/2010

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noted on [right] arm PPD site. "
June 2, 2010 at 7:00 AM ... " Resident remains stable. PPD site right arm remain reddish. "
June 1, 2010 at 5:30 PM ... " [Medical Doctor] called and requests the following test for resident [as soon as possible] ... Cat Scan of chest with contrast to [rule out mass], to evaluate pleural effusion. "

According to an attending note dated June 2, 2010 at 11:00 AM revealed, " This is an alert oriented X3 [times three] [male/female] with multiple medical conditions. Social history negative for tobacco or [alcohol] abuse. Resident is noncompliant with treatment and medications. [His/her] roommate was recently diagnosed with pulmonary tuberculosis. Resident is currently asymptomatic but has [chest x-ray] of last week positive for pleural effusion. Plan: After long conversation with resident at bedside; resident has agreed to admission at [hospital] for further investigation for tuberculosis and Cat Scan of Chest. "

According to a History and Physical dated June 3, 2010 revealed, " Plan: Admission to the negative-pressure room. Pulmonary workup, pulmonologist consultation, [Infectious disease] consultation. "

According to a CT [computerized] Scan of the chest dated June 2, 2010 revealed, " Impression: There are few scattered noncalcified subcentimeter nodules abutting the pleural surface of the middle lobe which may reflect early airway infection. A follow-up study is recommended, a correlation with previous exam, if available, is suggested. "

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Infectious Disease hospital consultation report dated June 4, 2010 revealed, " Reason for Consultation: The patient with TB exposure, positive PPD; evaluation and anti-TB recommendation. " " The patient stated, [he/she] had a roommate for a couple of months, and the roommate too was just diagnosed with pulmonary tuberculosis. The patient underwent bronchoscopy with bronchoalvelolar lavage today, results are pending. The patient is on respiratory isolation. "

According to a nephrologist hospital consultation dated June 28, 2010 revealed, " Infectious disease recommended full treatment for tuberculosis with 4 [four] agents based on high risk for prolonged exposure. [He/She] was admitted on June 2, 2010, and after an initial workup, has been treated with isoniazid, pyrazinamide, ethambutol, and rifampin. Considering recent history of starting multiple antituberculosis medications, must also consider interstitial nephritis or rapidly progressive glomerulonephritis due to anti-TB medications, which have been associated with ethambutol, pyrazinamide, and rifampin; and rapidly progressive glomerulonephritis has been rarely reported with rifampin. Plan: Change ethambutol and pyrazinamide to every other dosing based on reduced glomerular filtration rate. "

According to a hospital transfer summary form dated July 7, 2010 revealed, " Hospital Course: At this point, the patient has adequately been treated with antituberculous medication for about a month, and [he/she] is considered not to be infectious. [He/She] has been removed from isolation, and he/she has been deemed stable for return back to the nursing home by the infectious

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disease doctor and pulmonologist doctor. [His/her] TB medications are ethambutol 400mg 4 tablets po [by mouth] every other day, isoniazid 300 mg po daily, pyrazinamide 500mg 3 [three] tablets po every other day, rifampin 300mg 2 [two] tablets daily. "

A face-to-face interview was conducted with Resident CBL #14 on August 10, 2010 at approximately 12:30 PM. Resident stated, " I had a roommate, when he first came in, it was something wrong with [him/her] and I was exposed to it ... I was exposed to.... I can ' t think of the name of it. "

A face-to- face interview was conducted on August 10, 2010 at approximately 12:45 PM with Employees #2 and Employee #3. Both acknowledged appropriate interventions were not implemented to ensure resident was not exposed to a communicable disease. The record was reviewed on August 10, 2010.

Facility staff failed to implement appropriate interventions to prevent the spread of infection of a communicable disease to Resident CBL #14. The resident sustained a Positive PPD; subsequently resident was hospitalized for treatment of tuberculosis exposure.

9. On August 4, 2010 at approximately 10:30 AM, observed linen hamper in hallway corridor uncovered with red bag inside linen hamper. This observation was in the presence of Employee #5. He/she stated the linen hamper should have been covered. Also the red bag should have not been in the linen hamper.

10. Facility staff failed to maintain appropriate

Provider's Plan of Correction:

1. Uncovered hampers in the hallway were replaced at the time of the survey. — 8/4/10

2. All residents have the potential to be affected by this practice. Wound competency has been completed on the licensed staff by the Educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by educator and unit managers. — 10/19/10

3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the Infection Control Coordinator monthly. — 10/19/10

4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov. — 10/28/10

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F 441	Continued From page 146 practices to prevent the spread of infection during a dinning observation by not washing hands in between feeding more than one resident at a time. A dinning observation was conducted on August 3, 2010 at approximately 1:30 PM. Employee #27 entered the dining hall began to assist residents with opening their sugar packets and assisting with placing butter on several residents food items without washing his/her hands. After assisting other residents Employee #27 sat down and immediately began feeding a resident without washing his/her hands. Hand sanitizer was not observed in the dining hall at this time. A dinning observation was conducted on August 4, 2010 at approximately 1:10 PM. Employee #27 entered the dining hall, sat down and began immediately feeding a resident without washing his/her hands. Hand sanitizer was not observed in the room at this time. A face-to-face interview was conducted with Employee #7 on August 5, 2010 at approximately 9:00 AM. He/she acknowledged the above findings that hand washing should have taken place between feeding and assisting residents with their food. A face-to-face interview was conducted with Employee #7 on August 5, 2010 at approximately 9:00 AM. He/she acknowledged the above findings that hand washing should have taken place between feeding and assisting residents with their food. The observations were made on August 3, 2010 and August 4, 2010.	F 441	1. Hand sanitizer dispensers have been placed in the dining room. 2. All residents have the potential to be affected by this ractice. Wound competency has been completed on the licensed staff by the Educator. Remediation has been made as needed. Infection Control in the environment has also been addressed by the Infection Control Coordinator. Handwashing observations have been completed by Educator and unit managers. 3 Wound education, staging, isolation techniques, clean dressing technique Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the Director of Nursing. Environmental rounds will be completed bi-weekly by the Infection Control Coordinator and the environmental team. Dining and meal service education has been completed by the Dining Services Director. Meal pass observations will be conducted by the Infection Control Coordinator monthly. 4. The results of the above audit will be reported to the CQI committee monthly by the ADON/Infection Control Coordinator . A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Feb., May, Aug., Nov.	10/25/10 10/19/10 10/19/10 10/28/10

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F 441	Continued From page 147 11. On August 4, 2010 at approximately 10:30 AM, observed linen hamper in hallway corridor uncovered with red bag inside linen hamper. This observation was in the presence of Employee #5. He/she stated the linen hamper should have been covered. Also the red bag should have not been in the linen hamper. B. Based on observations during the survey period it was determined that proper procedures were not followed to prevent the spread of infectious as evidenced by: diapers improperly stored on floors in residents rooms in three (3) of 20 observations, strong urine odors observed in a residents room In one (1) of one (1) observation, soiled covers on clean linen carts in one (1) of four observations, improper storage of a soiled toilet plunger in a residents room in none (1) of one (1) observation, ice scoops were improperly stored inside ice bins in water one (1) of three (3) observations, residents soiled linen holder lacked lids in four (4) of 20observations and a large electric fan was operating in the laundry room adjacent to clean linen in one (1) of one (1) observation. These findings were observed in the presence of employees # 13 and 31. The findings included: 1. Diapers and pads were improperly stored on closet floor surfaces outside of wrappers in residents ' rooms 135, 218, 308 in three (3) of 20 observations between 3:15 PM on August 2, 2010 and august 3, 2010. 2. A strong urine odor was observed in room 140, the resident placed a towel on the floor in the bathroom to avoid making contact with the urine in front of the toilet In one (1) of one (1) observation at 10:15 AM on August 2, 2010. 3. The top surfaces of clean linen cart stored in	F 441	#11 1. Infection Control Plan has been reviewed and revised to reflect CDC Standards for Long Term Care. 2. No resident was identified. The current data collected has been used to initiate interventions and to prevent the spread of infection. 3. The infection control policy and program has been reviewed, re-evaluated, and revised. Policies have been developed that address the control and prevention of infection throughout the facility. The review of the program has been completed and signed off by the Medical Director. The current program will be used to identify, prevent, and control the spread of infection throughout the facility. Staff has received education on policies. 4. Data collected will be analyzed and corrections have been implemented into staff practices presented to the CQI committee monthly by the ADON/IC Coordinator. The CQI committee will determine the need for other interventions and need and frequency of further audits. Report results to scheduled Board meetings.	 10/19/10 10/19/10 10/19/10 10/28/10

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F 441	Continued From page 148 the hallway outside of room 109 and 146 was observed to be soiled with debris in one (1) of four observations at 10:45 AM on August 3, 2010. 4 A toilet soiled toilet plunger was observed on floor surfaces in room 225 in none (1) of one (1) observation at approximately 12:30 PM on August 3, 2010. 5. A ice scoop was observe stored on the interior of the of the ice chest in the Third floor Nourishment Room and the bin was ¼ full of water and the scoop was submerged in water one (1) of three (3) observations at 4:30 PM on August 3, 2010. 6. A large electric floor fan was observed operating on the clean side adjacent to clean linen potentially contaminating clean linen in one (1) of one (1) observation at 12:40 PM on August 4, 2010. 7. Residents soiled linen hampers lacked covers in rooms 214, 245, 321, and 324 in four (4) of 20 observations.	F 441		
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: Based on observations during the survey period, it was determined that an effective pest control program was not in place to control flies and gnats in the facility in four (4) of eight (8) observations. These observations were observed in the presence of employees # 13 and 31. The findings include:	F 469	1. On August 6, 2010 and August 20, 2010 the pest control company was onsite to address the gnats and flies in the facility. Areas identified in the first floor dining room, first floor day room, were assessed and treated by 8/20/10. The conference, training room and 340 will be scheduled no later than 10/19/10 for treatment and at the time of the assessment if warranted treatment will be conducted for these areas .	10/19/10

Continued page 149

2. A facility-wide pest control inspection was conducted by the pest control vendor on August 6 and 20, 2010; September 3, 9 and 12, 2010. This inspection included common areas, resident rooms, nurse's stations, pantries, offices and bathroom areas, which entailed all drains, sinks and toilets. Areas identified in need of corrective action will be corrected no later than October 19, 2010. Other basis practices recommended include the timely emptying of hampers, cleaning of air vents and timely removal of meal trays in attempt to eliminate the pest control issues. 10/19/10

3. A thorough pest control treatment schedule combined with a room cleaning schedule will be scheduled no later than October 19, 2010 to be implemented on a monthly basis to entail the removal of items from residents' drawers and closets for treatment. This process will entail in-servicing by the pest control company, which will be scheduled with both environmental and nursing staff to ensure that an interdisciplinary approach is coordinated to ensure that the facility is free of pests and rodents. 10/19/10

Effective October 19, 2010, a quality assurance program was implemented under the supervision of the Director of Environmental Services to monitor the pest control program. The Director of Environmental Services will report on the monthly pest control findings, which will be documented and submitted at the monthly CQI committee meeting for further review and corrective action. If at the end of six months, the committee is confident that the deficiency is resolved the monitoring activities will be conducted and presented to the CQI quarterly. 10/28/10

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F 469	Continued From page 149 Flying insects such as gnats and flies were observed in the First Floor Dining Room, First Floor Day Room, Conference and Training Room and room 340 in four (4) of eight (8) observations between 8:00 AM on August 2, 2010 and 4:00 Pm on August 5, 2010.	F 469		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the Administrative staff failed to integrate, coordinate and monitor the facility's practices related to residents' care and safety. The findings include: 1. Cross reference CFR 483.13, Abuse F221 (Actual harm that is not immediate jeopardy) 2. Cross reference CFR 483.13, Abuse F223 (Actual harm that is not immediate jeopardy) 3. Cross reference CFR 483.13, Abuse F226 (Substandard Quality of Care) 4. Cross reference CFR 483.25, Quality of Care	F 490	**483.75 EFFECTIVE ADMINISTRATION/ RESIDENT WELL-BEING** **Ftag 490 #1-8** 1. It is the Administrative Staff and the governing body-facility's mission to provide the highest quality of care services to its residents and safety. 1. Cross reference CFR 483.13, Abuse F221 2. Cross reference CFR 483.13, Abuse F223 3. Cross reference CFR 483.13, Abuse F226 4. Cross reference CFR 483.25, Quality of Care F309 5. Cross reference CFR 483.25, F323 6. Cross reference CFR 483.35, F371 7. Cross reference CFR 483.65, F441 8. Cross reference CFR 483.75, F497 2. All residents are potentially affected by the cited deficiency 1. Cross reference CFR 483.13, Abuse F221 2. Cross reference CFR 483.13, Abuse F223 3. Cross reference CFR 483.13, Abuse F226 4. Cross reference CFR 483.25, Quality of Care F309 5. Cross reference CFR 483.25, F323 6. Cross reference CFR 483.35, F371 7. Cross reference CFR 483.65, F441 8. Cross reference CFR 483.75, F497 3. Competency Training has been conducted with all team members requiring a return demonstration. Facility staff received in-service training regarding their role and responsibility for being competent on the types of resident abuse, the preventing and the timely reporting of all allegations of abuse.	10/19/10 10/19/10 10/19/10

Continued From Page 150
1. Cross reference CFR 483.13, Abuse F221
2. Cross reference CFR 483.13, Abuse F223
3. Cross reference CFR 483.13, Abuse F226
4. Cross reference CFR 483.25, Quality of Care F309
5. Cross reference CFR 483.25, F323
6. Cross reference CFR 483.35, F371
7. Cross reference CFR 483.65, F441
8. Cross reference CFR 483.75, F497

4. Effective 10/19/10, a quality assurance program was implemented to address and ensure that the facility has integrated and coordinated the revised Abuse policy, which will be monitored via by the governing body on a monthly basis via a monthly written board report that will be submitted by the facility's Administrator. **10/28/10**

1. Cross reference CFR 483.13, Abuse F221
2. Cross reference CFR 483.13, Abuse F223
3. Cross reference CFR 483.13, Abuse F226
4. Cross reference CFR 483.25, Quality of Care F309
5. Cross reference CFR 483.25, F323
6. Cross reference CFR 483.35, F371
7. Cross reference CFR 483.65, F441
8. Cross reference CFR 483.75, F497

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F 490	Continued From page 150 Care) 5. Cross reference CFR 483.25, F323 (Actual harm that is not immediate jeopardy) 6. Cross reference CFR 483.35, F371 (No actual harm with the potential for more than minimal harm that is widespread) 7. Cross reference CFR 483.65, F441 (Substandard Quality of Care) 8. Cross reference CFR 483.75, F497 (No actual harm with the potential for more than minimal harm that is widespread)	F 490		
F 492 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 26 sampled residents and one (1) of 30 supplemental residents, it was determined that the physician failed to complete an annual history and physical for Residents #4, and #CBL 5. The findings include: According to 22DCMR 3207.11, "Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least	F 492	**483.75(b) COMPLY WITH FEDERAL/ STATE/LOCAL LAWS/PROF STD** **Ftag 492** 1. Resident#4 had a H&P completed and Resident#25 had a H&P completed. 2. All residents have the potential to be affected by this practice. 3. Physicians were educated by the medical director regarding the requirements of physician visits and documentation. Unit secretaries were re-educated regarding the documentation requirements by physicians on new and long term care residents. Unit secretaries will complete monthly audits of physician documentation and provide a report to the director of nursing and medical director of finding.	08/21/10 10/19/10 10/19/10

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F 492	Continued From page 151 every twelve (12) months, and documented in the resident's medical record." 1.A review of Resident #4's record revealed that the last history and physical examination was January 3, 2009. A face-to-face interview was conducted with Employee #5 on August 2, 2010 at approximately 4:00 PM. He/she acknowledged that an annual history and physical examination should have been completed in January 2010. The record was reviewed August 2, 2010. 2. A review of Resident CBL 5's record revealed that the last history and physical examination on his/her clinical record was August 28, 2008. A face-to-face interview was conducted with Employee #5 on August 9, 2010 at approximately 11:30 PM. After a review of the resident's clinical record, he/she acknowledged the above findings. He/she said that an annual history and physical examination should have been completed June 2010. The record was reviewed August 9, 2010.	F 492	Continued From page 151 4. The results of the above audit will be reported to the CQI committee quarterly by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10
F 493 SS=D	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility	F 493		

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(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 493	Continued From page 152 This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, it was determined that the Governing Body failed to integrate, coordinate and monitor the facility's practices related to residents' care and safety. The findings include: 1. Cross reference CFR 483.13, Abuse F221 (Actual harm that is not immediate jeopardy) 2. Cross reference CFR 483.13, Abuse F223 (Actual harm that is not immediate jeopardy) 3. Cross reference CFR 483.13, Abuse F226 (Substandard Quality of Care) 4. Cross reference CFR 483.25, Quality of Care F309 (Actual harm that is Substandard Quality of Care) 5. Cross reference CFR 483.25, F323 (Actual harm that is not immediate jeopardy) 6. Cross reference CFR 483.35, F371 (No actual harm with the potential for more than minimal harm that is widespread) 7. Cross reference CFR 483.65, F441 (Substandard Quality of Care) 8. Cross reference CFR 483.75, F497 (No actual harm with the potential for more than minimal harm	F 493	Continued From page 152 **483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN** **Ftag 493 #1-8** 1. It is the governing body-facility's mission to provide the highest quality of care services to its residents and to ensure their safety. 1. CFR 483.13 Abuse F221 2. CFR 483.13, Abuse F223 3. CFR 483.25, Quality of Care 4. CFR 483.13, Abuse F226 5. CFR 483.25, F323 6. Cross reference CFR 483.35, 7. Cross reference CFR 483.65, F441 8. Cross reference CFR 483.75, F497 2. All residents are potentially affected by the cited deficiency 1. CFR 483.13 Abuse F221 2. CFR 483.13, Abuse F223 3. CFR 483.25, Quality of Care 4. CFR 483.13, Abuse F226 5. CFR 483.25, F323 6. Cross reference CFR 483.35, 7. Cross reference CFR 483.65, F441 8. Cross reference CFR 483.75, F497 3. Competency Training has been conducted with all team members requiring a return demonstration via a written test. All facility staff received in-service training regarding their role and responsibility for being competent on the types of resident abuse, the preventing and the timely reporting of all allegations of abuse. Competency training has been established as an annual requirement, but will be provided more frequently if needed.	10/19/10 10/19/10 10/19/10
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	F 497		

Continued From page 150
1. CFR 483.13 Abuse F221
2. CFR 483.13, Abuse F223
3. CFR 483.25, Quality of Care
4. CFR 483.13, Abuse F226
5. CFR 483.25, F323
6. Cross reference CFR 483.35,
7. Cross reference CFR 483.65, F441
8. Cross reference CFR 483.75, F497

4. Effective 10/19/10, a quality assurance program was implemented to address and ensure that the facility has integrated and coordinated the revised Abuse policy (CFR 483.13 Abuse F221), which will be monitored via by the governing body on a monthly basis via a monthly written board report that will be submitted by the facility's Administrator.

10/28/10

1. CFR 483.13 Abuse F221
2. CFR 483.13, Abuse F223
3. CFR 483.25, Quality of Care
4. CFR 483.13, Abuse F226
5. CFR 483.25, F323
6. Cross reference CFR 483.35,
7. Cross reference CFR 483.65, F441
8. Cross reference CFR 483.75, F497

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F 497	Continued From page 153 The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on a review of the employee records and staff interview for certified nurse aides, it was determined that facility staff failed to complete a performance review of every nurse aide at least once every 12 months. The findings include: A review of employee records was conducted for Employees # 30, 35, 36, 37, 38, 39, 40, 41, 42, 43, and 44. Through interview it was determined that all Certified Nurse Aides employed with the facility had not had performance evaluations. A face-to-face interview was conducted with Employee # 10 on August 4, 2010 at 11:20 AM. He/she acknowledged that performance evaluations had not been conducted for the aforementioned Certified Nurse Aides. He/she additionally added that none of the staff working	F 497	Continued From page 153 483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE **Ftag 497** 1. The identified Certified Nurse Aide employee, who are currently employed by the facility will receive an annual performance evaluation no later than October 19, 2010. 2. The facility's employees potentially affected by this cited practice of 10/1/10 have an annual performance evaluation scheduled for completion through the end of 2010 year in an anniversary performance review roster. An annual and probationary period performance evaluation schedule will be developed by the Human Resources Manager on a monthly basis. This entails managers being informed 30 days in advance of the evaluation due date. 3. Facility directors and employees have received training on the performance evaluation tool during the months of May and June 2010. On a monthly basis notifications are submitted to the appropriate Department Director. The Human Resources Manager is verifying weekly to determine that the performance reviews have been completed. A two week notice will be distributed to the appropriate Departmental Director and the Administrator for overdue performance evaluations, if not completed within 30 days of due date a notice which will be distributed to senior management. Non-compliance will result in a poor performance score on the Department Director's performance evaluation.	10/19/10 10/19/10 10/19/10

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F 497	Continued From page 154 at the facility have had recent performance evaluations but they were implementing a process to begin evaluating employees. There was no documented evidence that performance evaluations were completed for the facilities Certified Nurse Aides.	F 497	Continued From page 154 4. The performance evaluation report will be reported to the CQI committee on a monthly basis for further corrective action if deemed necessary. If at the end of a six month period the CQI committee is confident that the deficiency is resolved, the monitoring activities will be presented to the CQI committee quarterly.	10/28/10
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for one (1) of 26 records reviewed, it was determined facility staff failed to obtain laboratory tests in accordance with physician ' s orders. Resident #5. The findings include: Facility staff failed to obtain diagnostic laboratory tests for Resident #5 as per physician ' s orders. Physician ' s orders dated July 7, 2010 directed: check Chemistry 7 with albumin level every 3 months [Mar/Jun/Sep//Dec]. A review of the clinical record lacked evidence of the Chemistry 7 and albumin levels for June 2010. The most recent chem. 7 and albumin levels were dated March 2010. A face-to-face interview was conducted with Employee #6 on August 2, 2010 at approximately	F 504	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN **F tag 504** 1. The physician was notified of the delay in carrying out the orders for the identified resident. The labs were obtained and were placed on the resident's record. 2. All residents will have the potential to be affected by this practice. A review of residents with laboratory tests ordered will be completed by the unit secretaries. Physician notification and corrections will be made as needed by the unit managers. 3. A Laboratory Log system has been implemented. Staff has been educated on the use of the laboratory Log and policy. The Unit managers and supervisors will review the lab log daily to assure labs ordered have been received and compliance with this process. A report on the results of these daily reviews will be provided to the ADON by the supervisors and the Unit Managers.	6/10/10 10/19/10 10/19/10

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F 504	Continued From page 155 4:30 PM. He/she stated that further review of the medical record failed to reveal the laboratory tests had been obtained. Facility staff failed to obtain diagnostic laboratory tests in accordance with physician ' s orders. The record was reviewed August 2, 2010.	F 504	Continued From page 155 4. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10.
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for one (1) of 26 records reviewed, it was determined facility staff failed to promptly notify the physician of abnormal laboratory test results. Resident #9. The findings include: Facility staff failed to promptly notify the attending physician of diagnostic findings for Resident #9. Facility policy number 903, Laboratory and Radiological Services, stipulated, " ...these [laboratory] services are provided only on the orders of the attending physician who is notified promptly of the findings by the Charge Nurse, Nurse Manger or Clinical Coordinator. DON/ADON must be notified of significant abnormal diagnostic results that require immediate investigation and follow-up. " A review of Resident #9 ' s record revealed a	F 505	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS **F tag 505** 1. Resident # 2 had a chemistry7 and albumin levels drawn and aded on her chart on.	6/10/10
			2. All residents with laboratory tests ordered will have the potential for this practice.	10/19/10
			3. Each resident ordered to have a laboratory test will be documented on the Laboratory Log. When laboratory test results are returned to the facility it will be checked on the Log. These results will be called to the physician and date and time will be noted on the log. New orders will be checked for new interventions after the results are given to the physician. These results will be checked and noted by the Nurse Practitioner/Physician. These lab results will be noted on the log when it is placed in the resident's medical record. The Unit Manager will review the Laboratory log on daily basis and compare with 24 hour report documentation to ensure the lab results are on the chart.	10/19/10

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F 505	Continued From page 156 nurse ' s progress note dated June 13, 2010 at 3:00 PM, " patient with yellow cloudy urine...new order for U/A [urinalysis] with C&S [culture and sensitivity] in AM. " The record revealed the U/A with C&S was collected on June 14, 2010 and the results were reported on June 16, 2010. The abnormal U/A with C&S was acted on by the nurse practitioner approximately seven (7) days after the report was available. The resident was diagnosed with a urinary tract infection and prescribed antibiotic therapy on June 23, 2010. The record lacked evidence that facility staff promptly notified the attending physician or his/her designee of the abnormal laboratory values. Additionally, facility staff failed to follow their policy for prompt notification of diagnostic findings. The findings were reviewed and confirmed during a face-to-face interview with Employee #5 on August 9, 2010 at approximately 4:30 PM. The record was reviewed August 4, 2010.	F 505	Continued From page 156 4. The Laboratory Log completion and lab results not documented in charts will be reported to ADON. These findings will be reported to the Quality Improvement meeting. Further recommendations will be given by the Committee and other interventions will be developed to ensure adequate lab services.	Jan., Apr. Jul., Oct.
F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews for one (1) of 26 sampled residents, it was determined that facility staff failed to file in the	F 513		

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F 513	Continued From page 157 resident ' s clinical record, signed and dated reports of ordered CT chest scan. Resident CBL 13. Facility staff failed to file in the resident ' s clinical record, signed and dated reports of ordered CT chest scan for Resident #CBL13. A review of the resident ' s clinical record reveals a physician ' s order signed and dated June 23, 2009 that included " ...CT chest scan [without contrast] ... " A further review of the resident ' s clinical record lacked a documented evidence of a signed and dated report of the aforementioned order. A face-to-face interview was conducted with Employee # 5 on August 10, 2010 at approximately 11:45 AM. After reviewing the resident ' s clinical record, He/she acknowledged the above findings and added " It was done. I do not know why it is not on the record. " Employee #2 later produce another report un signed and undated CT scan report but not for the date in question. The record was reviewed August 10, 2010.	F 513	Continued From page 157 1. The report was obtained for the resident identified on survey. 2. All residents will have the potential to be affected by this practice. A review of residents with laboratory tests ordered will be completed by the unit secretaries. Missing reports will be filed on the charts as needed. 3. Staff education has been completed regarding filing laboratory reports. The unit secretaries will audit charts monthly for the presence of ordered laboratory reports. A report on the results of these audits will be provided to the ADON. 4. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	8/10/10 10/19/10 10/19/10 10/28/10
F 514 SS=E	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 158 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 observations, record review and interview for nine (9) of 26 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to complete fall assessments for two (2) residents, identify the affected eye for one (1) resident, document food preferences for one (1) resident who sustained weight loss, document the accurate bed assignment for one (1) resident, sign the treatment administration record after treatment was rendered for one (1) resident, document the status of altered skin integrity for two (2) residents, document fluid intake for one (1) resident on fluid restriction, document activity notes for one (1) resident and document the reason for medication omission for one (1) resident. Residents #2, 4, 5, 6, 9, 12, 14, 16, 22, 24, 25, and CBL30. The findings include: 1. Facility staff failed to consistently document multiple falls in the "Fall Assessment Record" and failed to consistently document the right eye redness in the "Progress Notes" for Resident #2 a. According to the " Nursing Progress Notes dated and signed April 25, 2010 at 11:00 AM resident slid to the floor from wheelchair, no injury; June 28, 2010 at 4:00 PM observed sitting	F 514	Continued From page 158 **#1a** 1. The Fall Assessments Record been amended for resident #2. 2. All residents with falls have the potential to be affected by this practice. A review of fall records will be completed for residents who have sustained falls and corrective actions will be completed as needed. 3. The Fall Assessment policy was reviewed and updated. The staff was educated on the policy. An audit of Falls documentation will be completed monthly by the ADON. A report of this audit will be provided to the DON. 4. The results of the above audit will be reported to the CQI committee monthly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. **#1b** 1. Resident #2. was seen by the ophthalmologist on 8/26/10. 2. All residents have the potential to be affected by the practice. A review has been completed of residents identified on the 24 hour report with concerns.	10/19/10 10/19/10 10/19/10 10/28/10 8/26/10 10/19/10

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F 514	Continued From page 159 on the floor near bed/wc (wheelchair), no injury; and July 3rd, 2010 at 1:00 PM resident noted on floor beside her bed in her room with bed in low position on the floor. July 3, 2010 2:30 PM resident lying on her right side on the floor near big elevator area from shower room " . Review of the " Fall Assessment Record " revealed that facility staff failed to document falls that occurred on June 28, 2010 at 4:00 PM and July 3, 2010 at 2:30 PM. According to the " Facilities Fall Assessment Policy ... Residents will be assessed after each fall using the Fall Assessment Record. " According to " Protocol #2 - Procedure after a fall; number 8. Document fall in nurses ' notes, complete an incident report and complete the " Fall Assessment Record " . A face-to-face interview was conducted with Employee #6 on August 5, 2010 at approximately 3:50 PM. After review of the clinical record, he/she acknowledged that each fall should be documented on the " Fall Assessment Record " . Facility staff failed to consistently document multiple falls on the " Fall Assessment Record " The record was reviewed on August 5, 2010 b. Facility staff failed to consistently document the assessment of the eye redness in the progress notes for Resident #2 According to a Nursing Progress Note dated and time April 10, 2010 at 2:00 PM Resident #2 " Right eye redness noted in lower inner corner of the eye. No drainage, discomfort or itching in eye." At 11:15 AM. Physician notified, order given	F 514	Continued From page 159 3. Staff education has been completed by the educator on generalized assessment and documentation. A monthly audit of services and documentation of assessment post injury will be completed by the unit manager/designee monthly and a report provided to the DON.	10/19/10
			4. The results of the above audit will be reported to the CQI committee quarterly by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10
			#2 1. Staff was remediated at the time of the survey. The physician was notified at the time of omission.	8/2/10
			2. All residents have the potential to be affected by the practice. A review has been completed of the MARS/TARS and corrective actions implemented as needed.	10/19/10
			3. Staff has been educated by the educator on the documentation on the MAR/TAR to include omissions. A review of MARs/TARs will be completed monthly by the unit managers and report provided to the ADON.	10/19/10

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F 514	Continued From page 160 read "to just monitor eye and have NP (Nurse Practitioner see on Monday ... " April 11, 2010 at 11:00 PM " Right eye sclera redness clearing ... " April 12, 2010 at 4:00 PM " no redness noted to right eye ... " April 12, 2010 at 10:20 PM " ...s/p (status/post) right eye red around sclera. Res (resident) denies any pain or discomfort. " April 13, 2010 at 8:30 AM " ...ABT (Antibiotic) Gentamycin to both eyes in progress ... " April 13, 2010 at 10:00 PM " ...Redness in Left eye decreasing. Denies pain or discomfort. " A face-to-face interview was conducted with Employee #6 at 3:40 PM. After review of the Progress Notes he/she acknowledged the inconsistent assessment of the eyes for Resident #2. The record was reviewed on August 5, 2010 2. Facility staff failed to document reason for Ativan omission on Medication Administration Record for Resident #4. A review of the May " Physician ' s Order Form " signed May 5, 2010 directed, " Lorazepam (Ativan) 0.5mg, 1 (one) tablet by mouth twice daily for agitation, Hold if blood pressure less than 90/60. A review of the May 2010 MAR [medication administration record] revealed that on May 22nd for 9:00 AM and May 23, for 9:00 AM and 5:00	F 514	Continued From page 160 4.The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. **#3a** 1. The wound was assessed by the wound team and corrections were made as needed. The staff was remediated in regards to legalities of documentation. 2. All residents have the potential to be affected by the practice. The wound nurse has audited the assessments of residents with wounds and corrective actions have been implemented as needed. 3. The staff has been in-serviced on wound assessment. Wound competencies have been completed on current staff. Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the director of nursing.	10/28/10 8/3/10 10/19/10 10/19/10

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F 514	Continued From page 161 PM there was no documentation that Resident #4 received Ativan on those days. There were no signatures in the boxes indicating medication was given. A face-to-face interview was conducted on August 2, 2010 at approximately 11:30 AM. He /she acknowledged that there was no follow up documentation indicating the omission of the Ativan. The record was reviewed on August 2, 2010. 3. A review of the clinical record for Resident #5 revealed facility staff failed to fully assess the status of an alteration in skin integrity. Additionally, licensed staff signed the Treatment/Medication Administration Record [T/MAR] before treatment was administered. a.) Facility staff failed to fully assess the status of Resident #5 ' s pressure sore. Facility staff identified a newly acquired right heel pressure sore on July 21, 2010 according to the facility ' s Pressure Area Documentation Form. The document lacked evidence of the stage of the pressure sore. A face-to-face interview was conducted with Employee #26 on August 3, 2010 at approximately 11:30 AM. He/she acknowledged the assessment lacked documented evidence of the stage of the right heel pressure sore. b.) A review of Resident #5 ' s T/MAR for August 3, 2010 revealed licensed staff signed the T/MAR prior to performing the wound treatment.	F 514	Continued From page 161 4. The results of the above competencies reports will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. **#3b** 1. The staff was remediated in regards to legalities of documentation. 2. All residents have the potential to be affected by the practice. A review of documentation has been completed and Corrective actions have been implemented as needed. 3. Staff education has been completed on the legal aspects of documentation. Random audits of MARs/TARs will be completed by educator quarterly. A report will be provided to the director of nursing.	10/28/10 8/3/10 10/19/10 10/19/10

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	095015	A. BUILDING ______ B. WING ______	08/11/2010

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F 514	Continued From page 162 A face-to-face interview with Employee #16 was conducted on August 3, 2010 at 11:05 AM. He/she stated that that s/he signed the T/MAR on "yesterday" [August 2, 2010] because he/she knew he/she would be performing the wound treatment today. Licensed staff signed the T/MAR indicating that a treatment had been performed, 24 hours prior to performing a wound treatment. The record was reviewed August 2nd and 3rd, 2010. 4. Facility staff failed to identify a right leg shin wound type; document the indication for use of Pentoxifylline and Plavix and for multiple falls on the "Fall Assessment Record" of Resident #6. a) The " Non-Pressure Area Documentation Form " Identified a right leg shin as the area of location of a non- pressure area that was acquired on June 19, 2010. The stage of the wound was not identified. The form further identified July 30 as the most recent date that the wound was assessed. The wound assessment included: wound measurement, wound color, wound base, wound drainage amount, surrounding skin, tunneling, tx (treatment) pressure relief, pain, comments, and initials. A face to-face interview was conducted with Employee # 5 on August 5, 2010 at approximately 8:50 AM, after review of the " Non-Pressure Area Documentation Form " he/she acknowledged that the form lacked documentation to identify the wound type on the right leg shin area. The record was reviewed on August 5, 2010. b) Facility staff failed to document the indication for use for Pentoxifylline and Plavix for Resident	F 514	Continued From page 162 4. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. **#4a & #6** 1. The documentation on the non-pressure area form was corrected for Resident #5. The staging for Resident #12 was corrected by the Wound Care Nurse. 2. All residents have the potential to be affected by the practice. The wound nurse has audited the assessments of residents with wounds and corrective actions have been implemented as needed. 3. The staff has been in-serviced on wound assessment. Wound competencies have been completed on current staff. Wound competencies will be completed on licensed staff during orientation and quarterly by the educator. A report of these competency results will be provided to the director of nursing. 4.The results of the above competencies reports will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10 8/5/10 10/19/10 10/19/10 10/28/10

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F 514	Continued From page 163 #6. Review of the July Physician ' s Order Form revealed that the medications Pentoxifylline and Plavix lacked documentation for the indication for use. Further review of the July Medication Administration Record (MAR) lacked documentation for the indication for use of Pentoxifylline and Plavix. According to the Interim Order Form dated and signed by the Physician on January 27, 2010 directed Plavix 75 mg po (by mouth) daily Dx (diagnosis) Bilat (bilateral) Feet Edema, and Trental 400mg po TID (three times a day) with food Dx Bilat Feet Edema. A face-to-face interview was conducted with Employee #5 on August 5, 2010 at approximately 8:50 AM. After review of the clinical record he/she acknowledged the findings. Facility staff failed to document the indication for use for Pentoxifylline and Plavix. The record was reviewed on August 5, 2010 c) The facility staff failed to document multiple falls using the " Fall Assessment Record. " Resident #6 Nursing Progress Notes dated and signed July 16, 2010 at 9:00 PM revealed " resident was observed sitting on the floor in her room, stated " I did not fall, like to sit on the floor. " Nursing Progress Notes dated and signed March 23, 2010 3:00 PM revealed the following: "	F 514	Continued From page 163 **#4b & #7** 1. The indication for use of medication in Resident #6 and Resident #14 was completed at the time of survey. 2. All residents have the potential to affected by the practice. MARs and TARs have been audited by the unit managers and corrective actions implemented as needed. 3. Staff has been in-serviced on the legalities of documentation to include the transcription of physician orders to include indication for use. A review of MARs/TARs will completed monthly by the turnover team to assure that documentation is complete. A report will be provided to the ADON. 4. The results of the above review will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further reports and audits.	8/5/10 10/19/10 10/19/10 10/28/10

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F 514	Continued From page 164 Resident alert and verbal. s/p (status/post) fall, no changes in mental status noted ... " According to the Nursing Progress Notes dated and signed March 3, 2010 at 8:00 AM, " Resident was observed sitting on floor in dayroom and stated, I just fell ... " Review of the clinical record revealed that the " Fall Assessment Form " was not in the clinical record. A face-to-face interview was conducted on August 5, 2010 with Employee #5 at approximately 8:50 AM. After review of the clinical record he/she acknowledged that the " Fall Assessment Form " should have been completed for Resident #6 with multiple falls and kept in the clinical record. The record was reviewed on August 5, 2010. 5. A review of the clinical record for Resident #9 revealed facility staff failed to carryover physician orders for the administration of a protein supplement. A nutrition consult progress note dated April 20, 2010 revealed the following, " ...visceral protein stores show depletion (albumin 2.5) ...increase Prosource to 30ml tid [three times daily] via tube feeding for adequate protein. Physician ' s orders dated April 20, 2010 directed, " Increase Prosource to 30ml via GT [gastrostomy tube] three times daily [formerly administered twice daily]. " A review of the Medication Administration Record [MAR] revealed Prosource was administered	F 514	Continued From page 164 **#4c** 1. The fall assessment record for Resident #6 was updated at the time of survey. 2. All residents with falls have the potential to be affected by this practice. A eview of fall records has been completed for residents who have sustained falls and corrective actions will be completed as needed. 3. The Fall Assessment policy was reviewed and updated. The staff was educated on the policy. An audit of Falls documentation will be completed monthly by the ADON. A report of this audit will be provided to the DON. 4. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	8/5/10 10/19/10 10/19/10 10/28/10

Continued from page 165

#5.

1 The physician was notified of medication error for Resident #9. **8/9/10**

2. All residents have the potential to be affected by this practice. An audit of the medication orders was completed via turnover of monthly orders for October. **10/19/10**

3. Staff has been in-serviced on the realities of documentation. A review of MARs/TARs will be completed monthly by the turnover team. A report will be provided to the ADON. **10/19/10**

4. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits **10/28/10**

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F 514	Continued From page 165	F 514	Continued From page 165	

three times daily for the period of April 21 - 30, 2010. The MAR ' s for the period of May through August 2010 revealed Prosource was administered twice daily as formerly prescribed.

A face-to-face interview was conducted with Employee #5 on August 9, 2010 at approximately 4:30 PM. He/she stated that it appeared that the protein supplement order was not carried over after the frequency was increased.

6. Facility staff failed to document stage of right heel ulcer for Resident #12.

According to the " Physician ' s Order Form " dated July 2, 2010 directed, " Scrub [right] heel with mild soap and water daily and apply a small dab of silvadene daily and cover with dry gauze and kling. "

Physician Order Sheet and Plan of Care dated July 14, 2010 directed, " Cleanse [right] heel wound with wound cleanser. Apply Santyl ointment - Cover with 4 X 4, ABD Pad and wrap with kerlix [[every day].

According to the weekly " Pressure Area Documentation Form, Stage 1: Inflammation or redness of the skin, Stage 2: Superficial skin break with redness of surrounding area, Stage 3: Skin break with deep tissue involvement, Stage 4: Skin break with deep tissue involvement with necrotic tissue present.

According to the " Pressure Area Documentation Form " for July 2010, there is no documentation regarding stage of right heel ulcer.

A face-to-face interview was conducted on

#8

1. On August 4, 2010 Resident #16's medical record revealed documented notes under the activity section. On August 5, 2010 the Therapeutic Recreational Director and two members of the DOH survey team discussed the concern of the missing records. The missing therapeutic recreational notes for Resident #16 were unable to be located. Resident #16 was reassessed by August 25, 2010 by the interdisciplinary team (IDT) and a quarterly progress note was completed and placed on Resident #16's medical record. — 8/25/10

2. For other residents having the potential to be affected by the same practice a Random audit has been performed by the Therapeutic Recreational department for compliance of quarterly and annually progress notes. — 10/19/10

3. The Therapeutic Recreational staff will be in-serviced on quarterly and annual documentation regarding resident's quality of life. Copies of each resident's progress notes will be made and placed in a binder retained in the Therapeutic Recreational Department. — 10/19/10

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F 514	Continued From page 166 August 3, 2010 at approximately 2:00 PM. He/she acknowledged the " Pressure Area Documentation Form " lacked documentation of stage of right heel ulcer. The chart was reviewed August 3, 2010. 7. Facility staff failed to document the indication for use for Clotrimazole for Resident #14. Review of the June Physician ' s Order Form revealed that the medications Clotrimazole (Lotrimin) lacked documentation for the indication for use. Further review of the June Medication Administration Record (MAR) lacked documentation for the indication for use of Clotrimazole (Lotrimin). According to the Interim Order Form dated and signed by the Physician on May 18, 2010 directed Lotrimin cream sig (not clear on abbreviation): apply to both feet daily x (times) 4 (four) weeks. A face-to-face interview was conducted with Employee #6 on August 5, 2010 at approximately 3:50 PM. After review of the clinical record he/she acknowledged the findings. Facility staff failed to document the indication for use for Clotrimazole (Lotrimin). The record was reviewed on August 5, 2010 8. Facility staff failed to maintain activity notes on current record for Resident #16. According to the Admission MDS [Minimum Data Set] completed June 8, 2010, under Section N4,	F 514	Continued From page 166 4. The Therapeutic Recreational Director will conduct quarterly audits for six months to monitor adherence to documentation requirements for care plan development and completion; for readmission progress notes. The findings from the auditing and monitoring processes will be documented and submitted at the quarterly CQI committee meeting for further review and corrective action. If, at the end of six months, the committee is confident that the deficiency is resolved, the monitoring activities will be conducted and presented to the CQI committee semi-annually. **#9** 1. Staff was remediated at the time of survey and the behavior monitoring sheet updated at the time. 2. An audit of residents receiving psychotropic medications has been completed by the unit managers. corrective actions have been implemented as needed.	 8/5/10 10/19/10

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F 514	Continued From page 167 indicated that resident activities preferences were: crafts/arts, spiritual/religious activities, watching TV, and talking or conversing. According to the care plan " adjustment care plan " initiated April 26, 2010 and updated June 9, 2010 revealed, " Encourage socialization/participation in activities. Assess and document resident ' s preferences in routines and activities. " A review of the medical record on August 4, 2010 revealed documented notes under the activity section. August 5, 2010 revealed no documented notes under the activity section. A face-to-face interview was conducted with Employees #5 and Employee #22 on August 5, 2010 at approximately 10:00 AM. He/she acknowledged that the " activity notes were there. " He/she stated, " I do not know what happened to them. I think they may have gotten mixed up and placed in another resident ' s chart. I will have the secretary look in other charts. " The record was reviewed August 5, 2010. 9. A review of the clinical record for Resident #22 revealed facility staff failed to accurately document the behavior monitoring record. According to physician ' s orders dated July 2, 2010, the resident ' s psychotropic drug regimen included Seroquel 50mg twice daily and Ativan 1mg twice daily for agitation. According to the August 2010 behavior monitoring record, the targeted behaviors identified for Resident #22 included agitated	F 514	Continued From page 167 3. Staff education has been completed by the educator on the use of psychotropic medications in the elderly, documentation of monitoring side effects and resident specific behaviors and the importance of following up with the PMD and psychiatrist in reference to documentation of dose reductions. Audits of psychotropic medications and dose reductions will be completed by the social worker monthly. The results of these audits will be reported to the Administrator. Audit of behaviors and side effect monitoring will be completed by the unit managers monthly. The results of these audits will be reported to the director of nursing, 4. The results of the above audit will be reported to the CQI committee quarterly by the Director of Social Services/Designee and the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10 10/28/10

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F 514	Continued From page 168 behaviors and stating he wants to go home. A review of the behavior monitoring record for August 1, 2010 revealed the resident exhibited none of the targeted behaviors; however, a review of the facility ' s incident report for August 1, 2010 revealed the resident was engaged in a resident to resident altercation. Facility staff failed to accurately document the behavior monitoring record for Resident #22. The record was reviewed August 5, 2010. 10. Facility staff failed to maintain nursing progress notes on the current/active clinical record for Resident #24. Resident #24 ' s active/current record and the overflow [resident information that has been thinned off of the active/current record] were reviewed. Upon reviewing the nursing notes it was observed that there were no nursing progress notes from January 2010 through April 11, 2010. A face-to-face interview was conducted with Employee #20 at approximately August 9, 2010 at approximately 3:00 PM. He/she acknowledged that the nursing notes could not be located. The record was reviewed on August 9, 2010. The record lacked documented evidence that nursing progress notes were maintained on the active/clinical record. 11. Facility staff failed to transcribe the diet order to the Medication and Treatment Administration Records for Resident #25.	F 514	Continued From page 168 **#10** 1. The records for the resident identified were found and placed on the closed record. 2. All residents have the potential to be affected by the practice. Resident records in the overflow were assessed for misfiling of information and correctives actions taken as needed. 3. The unit clerks have been in-serviced on confidentiality and the proper filing of information that is thinned off the medical record. The Medical Records clerks will conduct monthly audits of the overflow records and provide a report to the Director of Nursing/designee of problems identified and corrective actions implemented. 4. The results of the above audit will be reported to the CQI committee quarterly by the Medical Records Clerk. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10 10/19/10 10/19/10 10/12810

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F 514	Continued From page 169 The Physician Order Sheet and Plan of Care dated June 18, 2010 directed, " Diet: mechanical soft and 2-3 GM [gram] NA+ [sodium] ... " The July 2010 " Physician ' s Order " form signed by the physician on July 2, 2010 lacked a diet order for Resident #25. The record lacked documented evidence that the diet for mechanical soft and 2-3 GM NA+ to the July 2010 physician order sheet. A face-to-face interview was conducted with Employee #5 at approximately August 9, 2010 at approximately 4:17 PM. He/she acknowledged that there was no diet order transcribed to the July 2010 Physician ' s order and there was no untoward effect to the resident. The record was reviewed on August 9, 2010. 12. Facility staff failed to document on the Medication Administration Record (MAR) and Treatment Administration Record (TAR) the appropriate bed assigned to (1)one resident. Resident # CBL 30 The findings include: Facility staff failed to document resident assigned bed on MAR and TAR. During medication pass on August 3, 2010 at 10:35AM it was observed that resident MAR and TAR showed resident # CBL 30 being assigned to bed 108A instead of 108B. A face-to-face interviewed was conducted on August 3, 2010 at 10:40AM with Employee # 48. He/she acknowledge that that he/she was familiar with the resident and was aware that the resident was in bed 108B and not bed 108A. The record was review on August 3, 2010. B. Based on observation and record review it was	F 514	Continued From page 169 **#12a** 1. The documentation of that assignment for Residents #CBL30 was corrected on MAR/TAR at the time of survey. 2.All residents have the potential to be affected by the practice. A review of MARs/TARs for resident room #s has been completed and corrections made as necessary. 3. Staff has been in-serviced on the legalities of documentation and the accuracy of medical record information to include resident room #s. A review of MARs/TARs will be completed monthly by the turnover team to assure that documentation is complete. A report will be provided to the ADON. 4. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	8/3/10 10/19/10 10/19/10 10/28/10

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F 514	Continued From page 170 determined that facility staff failed to consistently document the refrigerator temperature on two (2) of three (3) refrigerator temperature log sheet as per facility refrigerator log sheet guidelines. The Findings include: Facility staff failed to consistently document the refrigerator temperature on two (2) of three (3) refrigerator temperature log sheet A review of the facility refrigerator temperature log guidelines reads " Temperatures must be recorded a minimum of three (3) times during each 24 hour period. On August 5, 2010 during the survey the facility three (3) medication refrigerator temperatures log was reviewed, it was revealed that facility staff failed to follow the temperatures log guidelines on two (2) of three refrigerators.. The refrigerator logs ' documentation on August 5, 2010 at 9:35Am was as follows: First floor refrigerator log documentation August 1, 2010 night, days and evening shift no documentation August 2, 2010 night, 60 degree; days and evening shift no documentation August 3, 2010 night, 42 degree; days and evening shift no documentation August 4, 2010 night, 60 degree; days and evening shift no documentation August 5, 2010 night, 42 degree; days and evening shift no documentation Second floor refrigerator log documentation August 1, 2010 night no documentation, days 40 degree and evening shift no documentation August 2, 2010 night, no documentation, days 40 degree and evening shift no documentation August 3,, 2010 night, 40 degree; days and evening shift no documentation August 4, 2010 night, days and evening shift no documentation	F 514	Continued From page 170 **#12b** 1. The temperature log sheets were updated to reflect the current temperatures at the time of survey. The staff was remediated at the time of survey.	8/5/10
			2. The results of the above audit will be reported to the CQI committee quarterly by the ADON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10
			3. Staff has been educated on the facility policy for refrigerator temperature documentation. Refrigerator temperatures will be audited by the infection control practitioner monthly. A report will be provided to the director of nursing.	10/19/10
			4. The results of the above audit will be reported to the CQI committee quarterly by the ICP/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10

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F 514	Continued From page 171 August 5, 2010 night, days and evening shift no documentation	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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: A. Based on a review of the Quality Assurance Committee Sign in sheet and staff interview, it was determined that the " designated physician " failed to attend meetings of the Quality Assurance Committee at least quarterly.	F 520		

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F 520	Continued From page 172 The findings include: The Quality Assurance Committee minutes from July 2009 through July 2010 were reviewed with Employee #3 on August 11, 2010 at approximately 11:00 AM. The facility ' s Quality Assurance meetings were held quarterly. The review revealed that the designated physician was in attendance at the meetings held January 28, 2010, April 29, 2010, and July 29, 2010. There was no evidence that the designated physician attended the Quality Assurance meeting for October 29, 2009. A face-to-face interview was conducted at the time of the review with Employees #3 and #1. They acknowledged that the designated physician did not attend all of the quarterly meetings. B. Based on observations, record review and staff interview, it was determined that the facility's Quality Assurance Committee failed to adequately implement plans of action to correct identified deficient practices. The findings include: 1. The Quality Assurance Committee failed to monitor and implement components of the abuse policy in its program, as Prevention of abuse was not included as a component of Abuse. A face-to-face interview was conducted with Employee #3 on August 11, 2010 at approximately 11:00 AM. He/she stated, "We [the facility] discussed abuse in safety but not in CQI."	F 520	Continued From page 172 **520** 1. The Physician has been given a schedule of the Quality Improvement meeting for the next year 2010-2011. 2. This does not affect the residents. 3. The Medical Director/designee will be given a written reminder prior to each Quality Improvement meeting to ensure his attendance. If an unusual emergency situation develops the On call physician will attend the meeting. 4. The system will be monitored by the Vice President of Performance Improvement and the Administrator.	10/19/10 10/19/10 10/19/10 10/19/10

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F 520	Continued From page 173 Cross reference CFR 483.13, Abuse F226. Based on a review of the facility ' s abuse policy, it was determined that facility staff failed to develop and operationalize procedures for " Prevention " . The findings include: The census on the first day of survey (August 2, 2010) was 167 residents. A review of the Policy "Resident Abuse, Neglect and Misappropriation of Property: Policy and Procedure No: 117, Revised Date: 08/11/08, stipulated, " Practice Guidelines: Component I: Screening, Component II: Training, Component III: Identification, Component IV: Investigation, Component V: Protection, Component VI: Reporting/Response " . The policy lacked documented evidence that the facility developed and operationalize procedures for "Prevention". A face-to-face interview was conducted with Employees #1 and 3 on July 29, 2010 at approximately 10:50 PM. The employees reviewed all aspects of the " Resident Abuse, Neglect and Misappropriation of Property " policy and acknowledged that procedures for " Prevention " were not included in the policy. 2. The Quality Assurance Committee failed to ensure that residents received 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.	F 520	**520-1** 1. The Abuse policy was updated and revised to include Prevention. 2. All residents have the potential to be affected by this deficient practice. 3. All resident's alleged to have been abused ill be discussed in the Safety committee meeting monthly and the CQI meeting quarterly. 4. The Quality Improvement program was revised and upgraded to include new audit tools with a focus on improving resident care to be determined. 1. Correction Actions has been implemented for specific deficiencies identified in this report. New policies and monitoring systems has been developed. 2. All resident care and administrative processes were evaluated and revised. Staff have been educated and evaluated to determine level of competency and knowledge necessary to function	09/09/10 10/19/10 10/28/10 10/19/10 10/19/10

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F 520	Continued From page 174 CFR 483.25, Quality of Care F309. Based on observations, record reviews and interviews for eight (8) of 26 sampled residents and six (6) supplemental residents, it was determined that facility staff failed to: manage a graft site per physician orders for one (1) resident, obtain specialty consultations for two (2) residents, administer oxygen therapy as prescribed for three (3) residents, discontinue eye drops and obtain an order for adaptive equipment for one (1) resident, clarify orders for type of isolation for one (1) resident, fully assess an eye injury sustained by one (1) resident, administer pain medications as prescribed for two (2) residents and for one (1) resident that sustained undue pain, failed to assess a sudden change in one (1) resident's respiratory condition, failed to have medication available for one (1) resident for 3 days, failed to administer psychotropic medications for one (1) resident whose behaviors escalated in the absence of the medication, assess blood pressure per physician ' s orders for three (3) residents and consistently monitor a venous access device for one (1) resident. Residents #2, 4, 5, 10, 13, 16, 18, 25, CBL3, CBL8, CBL10, CBL11, and CBL14. The findings include: 1. Facility staff failed to acquire medication according to physician ' s order in a timely manner resulting in escalation of the resident's behaviors. Resident #2. A review of the MAR (Medication Administration Record) for Resident #2 indicated an order for Klonopin 0.25 1 tablet po (by mouth) q (every) 12 hours for agitated behavior, original order date July 22, 2010. Further review of the MAR	F 520	3. The Quality Improvement Committee met to develop a revised system of quality indicators to monitor resident care and administrative systems. The assigning of audits on a monthly schedule has been developed to research and identify problem areas as well as develop corrective actions necessary to maintain the a quality standard of care for residents. 4. The system will be monitored by the Vice President of Performance Improvement and the Administrator will report findings monthly to the Board. **F tag 520** **#1 - Resident#2** 1. A review of Resident #2's current medication regimen has been completed. All medications are being administered as ordered and the resident's behaviors are under control. 2. A review of new physician orders for the past 30 days has been completed by the unit managers to assure medications have been received in a timely manner. Corrections made as needed.	10/19/10 10/19/10 10/19/10

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revealed that the medication was not given on July 24th, 25th, 26th, as evidenced by the 6:00 AM and 6:00 PM doses being circled and that July 27th 6:00 AM dose was also circled.

A review of the MAR's " medication not administered reason " section identified the following:
July 24, 2010 6:00AM, not yet received by pharmacy;
July 24, 6:00 PM Klonopin 0.25 mg awaiting supply not given;
July 25, 2010 6:00 [no AM or PM time identified], Pharmacy called awaiting del.
July 25th 6:00 PM Klonopin 0.25mg awaiting supply (delivery); not given;
July 26th 6:00 AM Klonopin 0.25 mg C-2 form to be complete and faxed;
July 26th 6:00 PM Klonopin 0.25mg awaiting Pharm (Pharmacy) not given;
July 27th 8:00 PM Klonopin 0.25 mg [documented as given] anxiety c/o (complained of) shaking - effective.

According to the Nurses Progress Note:

Dated and signed July 22, 2010 at 4:00 PM, Resident #2 was " readmitted to the facility. "

Dated and signed July 23, 2010 11:00 PM, " Klonopin order faxed to MD (Medical Doctor) for Authorization. "

Nurses Progress Note dated and signed July 25, 2010 at 10:00 PM, " The resident ' s Klonopin, still awaiting delivery. "

Nurses Progress Note dated and signed July 26, 2010 at 7:00 AM Pharmacy called for Klonopin

3. A review of the process of the receipt of medications has been completed with the pharmacy consultant and the attending physician. Supervisors have been educated by the Director of Nursing, to check physician orders each shift, with each nurse team leader to ensure medications have been received and to implement corrective actions as needed. — 10/19/10

4. An audit of this process will be conducted monthly by the Director of Nursing/designee. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and the frequency of further audits. — 10/19/10

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F 520	Continued From page 176 0.25 mg (milli gram) tab. " Has not received since ordered on July 22, 2010. " Nurses Progress Note dated and signed July 27, 2010 at 8:00 AM " ...[Resident #2] OOB (out of bed) in w/c (wheel chair) throughout the night he/she was pulling items out of the carts and infection control cart. He/She was going through trash ... " Nurses Note dated and signed July 27, 2010 at 4:00 PM "[Resident #2] ...riding [wheelchair] up and down the hallway yelling ... " Nurses Progress Note dated and signed July 27, 2010 Physician started new meds for Seroquel today. " Nurses Progress Note dated and signed July 30, 2010 9:30 PM " resident received all evening meds (medications). " A face-to-face interview was conducted with Employee #6 on August 2, 2010 at approximately 3:40 PM. He/she acknowledged the above findings of the escalating behaviors and indicated that the " Klonopin C-2 form was faxed to the MD (Medical Doctor) from the facility and that the MD faxed to pharmacy. Pharmacy did not give a cause for the delay. The medications were sent on July 27, 2010 at night. The record was reviewed on August 5, 2010.	F 520		
	2. Facility staff failed to follow physician ' s order for discontinuation of eye drops and obtain an order for adaptive equipment for Resident #4. a.) The physician ' s orders dated and signed July 2, 2010 directed, " Isopto Homatropine 5% drops		F tag 520 #2 1. The eye drops were discontinued for Resident #4 on 7/2/10. 2. An audit was completed on physician orders over the past 30 days. Corrections were implemented as needed.	10/19/10 10/19/10

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F 520	Continued From page 177 ...instill one (1) drop in each eye every day for glaucoma. An interim telephone order dated July 21, 2010 directed, " [discontinue] isopto homatropine 5% drop. A review of the July 2010 Medication Administration Record (MAR) revealed that Isopto Homatropine 5% was initialed as being given daily at 9:00 AM on July 22-30, 2010. There was no evidence that facility staff discontinued the Isopto Homatropine eye drops on July 21, 2010. A face-to-face interview was conducted on August 4, 2010 approximately 1:00 PM with Employee #5. He/she acknowledged that the Isopto Homatropine eye drops was not discontinued as directed by the physician on July 21, 2010. The record was reviewed on August 3, 2010. Resident #4 was observed on August 3, 2010 at approximately 12 Noon wearing a splint on left arm. A review of the resident ' s record lacked evidence that the facility staff obtained a physician ' s order to administer an arm splint to the resident. A face-to-face interview was conducted with Employee #45 and Employee #46 on August 4, 2010 at approximately 11:10 AM. After a review of the resident ' s record and an observation of the resident, he/she acknowledged that the resident ' s clinical record lacked evidence that	F 520	Continued From page 177 3. New orders will be reviewed daily by the unit managers/supervisors to assure that they have been transcribed correctly. All medical records will have a 24-hour chart review of all orders written for the day by the night shift team leader. All new orders will be reviewed for accuracy, start/stop dates, transcription on MAR/TAR. The night shift supervisor will check with each team leader on each unit to ensure that the process is completed and orders are sent to pharmacy. 4. Problems identified in the above process will be reported to the CQI committee monthly for three months, then quarterly by the DON or designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need for frequency of further audits	10/19/10 10/28/10

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the facility staff obtained a physician ' s order to administer an arm splint to the resident. The record was reviewed on August 4, 2010.

Facility staff failed to properly manage Resident #4 ' s gastrostomy tube in accordance to facility policy as it related to patency, subsequently resident had gastrostomy tube replaced.

According to physician ' s orders signed July 2, 2010 directed, " Enteral Protocol ... Check tube for proper placement prior to each feeding, flush or medication administration... Flush tube with 250ml [millimeters] of water every 4 [four] hours .... Flush tube with 30ml water before and after medication as needed and 5ml water between each medication

Nurse ' s note dated July 3, 2020 at 8:00 AM revealed, " GT [Gastrostomy Tube] is very short due to breakage while milking it. It is a PEG [Percutaneous Endoscopic Gastrostomy] GT and need to go out to be replaced. "

According to " Taber ' s Cyclopedic Medical Dictionary " , 20th edition, copyright 2005, page 1367 defined " milking as ... removal of the contents of a tubular structure by compressing the tube with the fingers and moving them along the course of the tube and away from the origin .... This maneuver forces material out of the tube that might not otherwise be seen. "

According to your " Policy & Procedure No. 1012, Tube Feeding, " Effective: 02/2005, Revised: 08/03/07 " , directed the following: " Procedures, Gravity Feeding Tube ... #7 [seven] ... Insert 30cc of air into the feeding tube while holding the stethoscope over the epigastrium to listen for

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F 520	Continued From page 179 gurgling sound. (If none is heard, do not start feeding and report to supervisor or charge nurse), Pump Feeding... Flush feeding tube with prescribed bolus flush by using an eccentric or catheter tip syringe as often as prescribed. " A review of the " EGD [Esophagogastroduoenoscopy] Report " completed on July 20, 2010 revealed, " Indications: Malfunctioning GT]. Other findings: S/P [Status Post} PEG placement. GT was replaced with a #20 [number 20] replacement tube. A face-to-face interview was conducted with Employees #4 and Employee #5 on August 5, 2010 at 5:59 PM. Both stated " we do not milk the tubing. " The record was reviewed on August 5, 2010. 3. Upon review of the clinical record for Resident #5, it was determined that facility staff failed to assess a venous access device [VAD], blood pressure, obtain an Ear, Nose and Throat [ENT] specialty consultation and administer medications that were labeled and dispensed for the resident. According to the History and Physical Examination dated August 23, 2009, Resident #5 ' s diagnoses included hypertension, anemia, peripheral vascular disease, degenerative joint disease, chronic venous stasis wounds and angioedema. a.) Facility staff failed to assess Resident #5 ' s Porta-cath [VAD] per physician orders. Physician ' s orders dated July 7, 2010 directed " assess Porta-cath insertion site every 3 days for	F 520	**F tag 520 #3** **Resident #5a** 1. Resident #5 venous access device was assessed and flushed at the time of survey. There were no redness and/or drainage observed.. 2. All residents with Venous Access Devices have the potential to be affected by this with Venous Access Devices. 3. Systematic changes/measures implemented to correct this practice include staff education, which has been provided on assessment and documentation of venous access devices. 4. Unit Managers will complete audits monthly, which will be provided to the DON/designee of problems identified and corrective actions implemented	8/2/10 10/19/10 10/19/10 10/28/10

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F 520	Continued From page 180 redness, warmth, swelling and drainage. " A review of the monthly Treatment and Medication Administration Records [TAR/MAR] revealed that the Porta-cath assessment schedule was annotated on the TAR by a darkened box. Licensed staff initialed inside the box when an assessment was performed. The boxes remained blank on the following dates, reflecting that the assessments were not performed: May 2nd, June 10th, July 1st and 25th 2010. Licensed staff failed to consistently assess the resident ' s Porta-cath every three (3) days in accordance with physician ' s orders. The record was reviewed August 2, 2010.	F 520		
	b.) Facility staff failed to assess Resident #5 ' s blood pressure in accordance with physician ' s orders.		**Resident #5b** 1. The corrective action achieved for **Resident #5** includes the review of Resident#5's blood pressure monitoring revealed that no others were missed.	10/19/10
	Resident #5 ' s medication regimen included Norvasc 5mg daily and Hydralazine 50mg three times daily by mouth for hypertension.		2. All residents have the potential to be affected by this practice. Residents receiving hypertensive medications had a review of their MAR.	10/19/10
	Physician ' s orders dated July 7, 2010 [originated July 28, 2009] directed blood pressure assessments every week at 6AM, 2PM and 10PM for hypertension.		3. The systematic change/measures taken to correct this practice entails: staff education on the importance of documentation on the MAR/TAR and revised shift report, which includes the review of MARs/TARs.	10/19/10
	A review of the monthly Treatment and Medication Administration Records [TAR/MAR] revealed that the blood pressure assessment schedule was annotated on the TAR by a darkened box. Licensed staff documented the blood pressure reading inside the box when an assessment was performed. The boxes remained blank on the following dates, reflecting that blood		4. Unit Managers will complete audits monthly and a report will be provided to the DON. The results of this audit will be reported to the CQI committee monthly for three months then quarterly by the DON/ designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need for frequency of further audits.	10/28/10

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F 520	Continued From page 181 pressure assessments were missing: April 1st, May 6th, 20th, 27th, June 2nd, 9th, 16th, 23rd, 30th, July 7th, 14th, 21st, and 28th, 2010. Facility staff failed to consistently assess Resident #5 ' s blood pressure on three (3) occasions weekly in accordance with physician ' s orders. The record was reviewed August 2, 2010. c.) Facility staff failed to obtain an ENT specialty consultation per physician orders. Physician ' s order dated February 16, 2010 directed " ENT appt in 3 months " A review of the May 2010 TAR revealed that an ENT appointment scheduled for May 11, 2010 was cancelled. The clinical record lacked evidence of a reason for the cancellation and there was no evidence that the appointment had been rescheduled. The findings were reviewed and confirmed during a face-to-face interview with Employee #6 on August 2, 2010 at approximately 4:30 PM. d.) Facility staff failed to administer medications that were labeled and dispensed for Resident #5. During a wound treatment observation for Resident #5 on August 3, 2010 at 11:10 AM, it was determined that Employee #16 administered medications that were not labeled for Resident #5. Physician ' s orders dated July 7, 2010 prescribed the administration of Ammonium Lactate 12% to both legs and feet daily and cleanse the wound on the resident ' s left lateral leg with normal	F 520	**F tag 520** **Resident #5c** 1. The corrective action achieved for Resident #5, is that an ENT consultation was completed on 8/24/10.	8/24/10
			2. All residents with consultation orders have the potential to be affected by this practice. An audit has been completed by the unit secretary of appointments for the past 30 days to assure completion of problems identified have been corrected.	10/19/10
			3. Systematic changes/measures to prevent this practice from reoccurring entails: staff education has been completed by the DON regarding the process for appointment scheduling and follow-up. The unit secretaries will complete weekly audits of appointments and provide a report to the DON.	10/19/10
			4. The results of the above audit will be reported to the CQI committee monthly for three months then quarterly by DON/ designee for three months then quarterly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further interventions and need and frequency of further audits.	10/28/10
			Resident #5d 1. Medications were ordered for Resident #5 and received.	8/11/10
			2. Review of MARs has been completed to assure that medications have been received as ordered.	10/19/10

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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 520	Continued From page 182 saline, apply Polysporin powder and Medihoney and cover. Employee #16 administered the medications during the wound treatment; however, a review of the medication containers post treatment revealed that the Polysporin powder and Ammonium lactate were labeled for residents other than Resident #5. A face-to-face interview was conducted with Employee # 16 following the wound treatment on August 3, 2010. He/she stated that Resident #5 ' s prescriptions had run out and were on order. The medications that were assigned to the other resident ' s were the same and were utilized until Resident #5 ' s prescriptions arrived. Facility staff failed to administer medications that were labeled and dispensed for Resident #5. 4. Facility staff failed to follow physician ' s orders to remove pressure tape from AV (Arterial Venous) site at 11:00 PM on dialysis days of Resident #10. According to the Physician ' s Orders dated and signed by the physician July 2, 2010 that directed staff to " remove pressure tape from AV site at 11:00 PM on dialysis days. An observation was made on August 3rd 2010 at approximately 1:50 PM. Resident #10 was observed sitting in his/her wheelchair, a white taped dressing covering the left arm AV site was noted in place. Review of the dialysis communication record revealed that dialysis was last performed on	F 520	Continued From page 182 3. Staff has been educated by the pharmacist on the ordering and receiving of medications.	10/19/10
			4. An audit of this process will be conducted monthly by the Director of Nursing/designee. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and the frequency of further audits.	10/28/10
			Resident #10 1. The tape was removed at the time of the survey for Resident #10 and the staff was remediated.	8/3/10
			2. A review has been completed of residents receiving dialysis by the unit manager to assure orders are being implemented as ordered by the physician.	10/19/10
			3. The educator has provided in-service training to the staff on care of dialysis access sites.	10/19/10
			4. Random audits of dialysis shunts will be completed weekly by the supervisor and corrective actions made as needed.	10/28/10