STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	B. WING	01/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON NURSING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted on January 12 through 16, 2009. The following deficiencies were based on record review, observations, and interviews with residents and the facility staff. The sample included 30 residents based on a census of 349 residents on the first day of survey and 59 supplemental residents.	F 000	The filing of the Plan of Correction does not constitute an admission that the deficiencies actually did in fact exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the regulatory requirements of responding to these citations and to continue to provide quality resident care.	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	**483.10(b)(11) Notification of Changes Resident S5** 1. Physician was notified, reason for the order change documented, and the resident was notified of the change of order. The order includes differentiation as to which medication is to be given for mild, moderate and severe pain. 2. All medical records identified with a physician order change were audited, documentation of the reason why the order was changed, if the resident was notified of the change and that the resident notification was documented in the resident's medical record. 3. The Nursing Quality Improvement Program will monitor for notification of changes in medication orders. Data will be submitted to the Director of Nursing (DON) for evaluation and the Implementation of an action plan when Necessary. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/6/09 3/31/09 3/31/09 4/309

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/23/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS An annual recertification survey was conducted on January 12 through 16, 2009. The following deficiencies were based on record review, observations, and interviews with residents and the facility staff. The sample included 30 residents based on a census of 349 residents on the first day of survey and 59 supplemental residents.	F 000	The filing of the Plan of Correction does not constitute an admission that the deficiencies actually did in fact exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the regulatory requirements of responding to these citations and to continue to provide quality resident care.	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	**483.10(b)(11) Notification of Changes Resident S5** 1. Physician was notified, reason for the order change documented, and the resident was notified of the change of order. The order includes differentiation as to which medication is to be given for mild, moderate and severe pain. 2. All medical records identified with a physician order change were audited, documentation of the reason why the order was changed, if the resident was notified of the change and that the resident notification was documented in the resident's medical record. 3. The Nursing Quality Improvement Program will monitor for notification of changes in medication orders. Data will be submitted to the Director of Nursing (DON) for evaluation and the Implementation of an action plan when Necessary. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/6/09 3/31/09 3/31/09 4/309

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, it was determined for one (1) supplemental resident that facility staff failed to notify Resident S5 of a change in medications. The findings include: A face-to-face interview was conducted with Resident S5 on January 14, 2009 at 4:30 PM. Resident S5 stated, " My pain medicine was changed, I didn't see the doctor to talk about it, I didn't ask for a change in medication and no one told me about it." A review of Resident S5' s record revealed a telephone order dated January 11, 2009 at 10:00 PM, signed by the physician with no date or time that directed: " 1. D/C (discontinue) Percocet 5/325 mg 2 tabs q 6 hrs PRN (as needed). 2. Darvocet - N50 Give 2 tabs PO (orally) TID (three times daily) PRN for moderate pain. 3. Motrin 800 mg po q 8 hors prn for moderate pain. 4. Tylenol Extra Strength 500 mg Give 2 tabs (100 mg) po q 8 hrs PRN for moderate pain." There was no physician's or nurse's note documenting the reason the medication was changed. There was no evidence that the resident requested a change in medication. Additionally, there was no differentiation among	F 157		

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F 157	Continued From page 2 the use of Darvocet - N50, Motrin and Tylenol Extra Strength, all prescribed for moderate pain. A face-to-face interview was conducted with Employee #5 on January 16, 2009 at 8:45 AM. He/she acknowledged that the resident was not consulted or notified when his/her pain medication was changed. Further interview with Resident S5 on January 15, 2009 at 4:30 PM revealed that his/her pain was controlled with the use of Motrin. The record was reviewed January 15, 2009.	F 157		
F 161 SS=C	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: The facility Staff failed to provide surety bond coverage to assure the security of all personal funds of residents deposited with the facility. The findings include: A review of the Surety Bond on January 14, 2009 at 12:01 PM indicated the surety bond held by the facility was in the amount of $225,000.00. A review of three (3) months of bank statements revealed the balance in the resident fund account on: October 2, 2008 as $283, 939.08; October 31, 2008 as $284,540.00 and December 2, 2008 as $261,819.52.	F 161	**483.10(7) Assurance of Financial Security** 1. The facility initiated a new practice with the bank which receives the direct deposits of resident funds where the account is electronically swept every day at 2:00 pm and the resident payability portions of their checks are transferred to the operating account. At no time, will the Resident Fund Account have a final daily balance of over $225,000. 2. There are no other accounts which have the potential to be affected by the same deficient practice. 3. The Business Office Coordinator will monitor the ending daily balance of the Patient Fund Account on a routine basis to ensure that the balance of the fund never exceeds the surety bond. 4. The Business Office Coordinator will report her findings to the Administrator at the monthly Quality Improvement Committee.	3/12/09 3/12/09 3/12/09 4/309

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F 161	Continued From page 3 A face-to-face interview was conducted with Employee #1 on January 14, 2009 at 12:30 PM. Employee # 1 acknowledged the findings.	F 161		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations for two (2) of 30 sampled	F 164	**483.10(e), 483.75 (l)(4) Privacy and Confidentiality** Resident #11 1. Employees involved were counseled of the importance of providing privacy to by making sure that the privacy curtain is pulled completely around the resident during the performance of any assessment and/or any treatment. 2. Rounds were made by the Clinical Mgr./ designee to ensure that privacy curtains were completely pulled around all residents during wound treatments. 3. Inservice education was given to all members of the nursing staff to ensure compliance in providing privacy to all residents during wound treatments. The Nursing Quality Improvement Program will collect data on the the nurse's adherence to privacy and confidentiality while rendering wound and will present their findings to the DON. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/10/09 3/10/09 3/31/09 4/309

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F 164	Continued From page 4 residents and one (1) supplemental resident, it was determined that facility staff failed to provide privacy by completely pulling the privacy curtain for two (2) residents during a wound care treatment, and during a radiology procedure for one (1) resident. Residents #11, #27 and A1. The findings include: 1. Facility staff failed to provide privacy to Resident #11 during a wound care treatment. A wound care treatment observation to Resident #11's left lower leg ulcer was conducted on January 14, 2009 at approximately 11:30 AM. Employee #26 failed to completely pull the privacy curtain throughout the wound care treatment and assessment of the pressure ulcer. Resident #11's bed was located by the entry door to the room. The resident was within view of any visitor to the room. A face-to-face interview was conducted with Employee #26 on January 15, 2009 at approximately 3:00 PM. He/she acknowledged that the privacy curtain was not completely pulled around the resident while providing the wound care treatment and assessment. The record was reviewed January 15, 2009. 2. Facility staff failed to provide privacy to Resident #27 during a wound care treatment. A wound care treatment observation to Resident #27's sacral pressure ulcer was conducted on January 15, 2009 at approximately 1:15 PM. Employee #27 failed to completely pull the privacy curtain and close the door throughout the assessment and treatment of the pressure ulcer. The resident was located next to the window but within view of any visitor to the room. The resident was unclothed from the chest down while Employee #27 was providing wound care treatment to the resident's sacral pressure ulcer. A face-to-face interview was conducted with	F 164	**483.10(e), 483.75 (l)(4) Privacy and Confidentiality (continued)** Resident #27 1. Employees involved were counseled of the importance of providing privacy to by making sure that the privacy curtain is pulled completely around the resident during the performance of any assessment and/or any treatment. 2. Rounds were made by the Clinical Mgr or designee to ensure that privacy curtains were completely pulled around all residents during wound treatments. 3. Inservice education was given to all members of the nursing staff to ensure compliance in providing privacy to all residents during wound treatments. The Nursing Quality Improvement Program will collect data on the the nurse's adherence to privacy and confidentiality while rendering wound treatment and will present their findings to the DON. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/31/09 3/31/09 3/31/09 4/309

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F 164	Continued From page 5 Employee #27 on January 15, 2009 at approximately 2:45 PM. He/she acknowledged that the door was not closed and the privacy curtain was not completely pulled around the resident while providing the wound treatment and assessment. The record was reviewed January 15, 2009 3. Radiology technician failed to provide privacy to Resident A1 during a radiology procedure. Resident A1 was observed during a radiology procedure: Doppler ultra sound to the lower extremities on January 14, 2009 at approximately 11:30 AM. The resident was on the bed by the door. The resident was unclothed from the chest down. The radiologist failed to completely pull the privacy curtain around the resident and close the door. The resident was partially unclothed and was unnecessarily exposed. This observation was made in the company of Employee #9.	F 164	**483.10(e), 483.75 (l)(4) Privacy and Confidentiality (continued)** 3. Resident A1 1. The radiology tech was counseled on the importance of providing privacy by making sure that the privacy curtain is pulled completely around the resident and the door is closed during the performance of any radiology procedure. 2. Rounds were made by the Clinical Mgr designee to ensure that privacy curtains were completely pulled around all residents and doors were closed during radiology procedures. 3. Inservice education was given to members of the nursing staff and the radiology tech to ensure compliance in providing privacy to all residents during radiology procedures. The Nursing Quality Improvement Program will collect data on the adherence to privacy and confidentiality while rendering radiology procedures and will present their findings to the DON. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/10/09 3/10/09 331/09 4/3/09
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, for six (6) of six (6) nursing units, it was determined that facility staff failed to post the	F 167	**483.10(g)(1) Examination of Survey Results** 1. The most recent survey was posted on the 5 units immediately upon discovery.	1/13/09

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F 167	Continued From page 6 most recent survey results. The findings include: An observation of all nursing units was conducted on January 13, 2009 from 11:00 AM through 11:15 AM and revealed that survey results with the plan of correction were posted for the standard survey dated January 7 through 14, 2008 and the follow-up survey dated March 13 through 14, 2008. The word " met " was hand written on each deficiency tag for the plan of correction for March 13 through 14, 2008. A second follow-up survey was conducted on April 7, 2008 in which the facility was found in compliance for all deficiencies cited from the first follow-up survey completed March 13 through 14, 2008. Complaint surveys with deficiencies and plans of correction not posted included the following: May 19, June 6, June 18, and September 25, 2008. A face-to-face interview with Employee #1 was conducted on January 13, 2009 at 5:30 PM. He/she acknowledged that all survey information was not posted.	F 167	**483.10(g)(1) Examination of Survey Results (continued)** 2. Survey reports will be kept updated, available and accessible for the residents on all 6 units. 3. The Assistant Administrator or designee will be responsible for ensuring that the most recent survey is accessible and available to the residents. Reports of her efforts will be submitted monthly to the administrator. 4. The administrator will present her findings and action plans for improvement to the Quality Improvement Committee which meets monthly.	1/13/09 3/31/09 4/3/09
F 168 SS=B	483.10(g)(2) EXAMINATION OF SURVEY RESULTS A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. This REQUIREMENT is not met as evidenced by:	F 168	**483.10(g)(2) Examination of Survey Results** 1. The contact information was moved to the bulletin boards across from the nursing stations upon discovery. They had been relocated to other bulletin boards on the nursing units.	1/13/09

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F 168	Continued From page 7 Based on observations for four (4) of six (6) nursing units, it was determined that facility staff failed to post contact information for agencies acting as client advocates. The findings include: Observations of all nursing units were conducted on January 13, 2009 at 11:00 AM through 11:15 AM. Located on a bulletin board across from the nurse's station on two (2) nursing units was contact information for agencies acting as client advocates. Four (4) nursing units had no contact information posted. A face-to-face interview with Employee #1 was conducted on January 13, 2009 at 5:30 PM. He/she acknowledged that contact information for agencies acting as client advocates was not posted.	F 168	**483.10(g)(2) Examination of Survey Results (continued)** 2. All bulletin boards across from the nurse's station were reviewed and corrections made when necessary. 3. This posting will be placed in a frame and be permanently affixed to the wall, in an area accessible to the residents, so that it cannot be moved. This will ensure that residents will always have this posting available to them at all times 4. The Administrator will monitor the postings on an on-going bases as part of the Administrative Quality Improvement Program and report her findings to the Quality Improvement Committee monthly.	1/1309 3/31/09 4/3/09
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interview and record review for two (2) of 30 sampled residents, it was determined that facility staff failed to inform the responsible party of the use of side rails for one (1) resident and applied an incorrect restraint to one (1) resident. Residents #15 and 19. The findings include:	F 221	**483.13(a) Physical Restraints** 1. Resident #15 1. The resident's responsible party was notified and a consent obtained for the use of full side rails. 2. Medical records of all residents with full side rails were reviewed to ensure that a consent was obtained. Corrections were made if necessary 3. Inservice education was given to all nursing staff about the importance of following the facility protocol in applying Physical Restraints. Physical restraint consents will be Monitored through the Nursing Quality Improvement Program. Data collection results will be presented to the DON. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/14/09 3/31/09 3/31/09 4/3/09

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F 221	Continued From page 8 1. Facility staff failed to inform the responsible party for Resident #15 of the use of side rails on the resident's bed. On January 12, 2009 at approximately 4:00 PM, January 13 at 12:30 PM and January 14, 2009 at 4:10 PM, Resident #15 was observed lying in bed with full side rails up. In a face-to-face interview with the resident on January 13, 2009 at approximately 12:30 PM he/she was asked why the side rails were up and he/she responded, " They keep me from falling out of the bed. " The resident was then asked whether he/she could release the side rails. He/She responded, " No. " A review of the clinical record revealed a "Side Rail Assessment Form" dated December 5, 2008 which documented the following; " Recommendation: Full side rails indicated to serve as enabler to promote independence. " There was no evidence in the record that the bed rails were requested by the resident; or that consent for the use of the side rails was signed by the resident ' s responsible party. According to the information documented in the facility ' s Nursing Physical Restraint Policy #1404399A.000 Page 1 under the heading of "Procedure : Prior To The Use Of A Restraint # 6 A member of the IDC [Interdisciplinary Care] team will notify the Resident ' s Responsible Party of the restraint use and obtain signature on the Consent for Restraint Form (SM 152). " The facility staff failed to notify and obtain consent from the resident ' s responsible party prior to implementing the use of full side rails. According to the facility ' s aforementioned policy on Page 1 of 2 under the heading of "Definition " was "Physical restraints are any manual method	F 221	**483.13(a) Physical Restraints (continued)**	

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F 221	Continued From page 9 or physical or mechanical device, material, or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body." In addition, on Page 2 of 2 of the aforementioned policy under the heading of "Examples of Restraining Devices " the following examples are listed: " 1. Merry Walker 2. Velcro seat belt 3. Soft waist belt 4. Clip belt 5. Lap buddy 6. Lap Tray 7. Reverse Seat belt 8. Reclining Geri-chair without tray 9. Straight back Geri-chair with tray 10. Bed rails not requested by the resident 11. Bed against the wall. " A face-to-face interview was conducted with Employee # 6 on January 14, 2009 at approximately 3:00 PM. He/she acknowledged that the record lacked a consent for the use of full side rails and that he/she had failed to notify the resident's Responsible Party while the resident was in bed and stated, " I will call the Responsible Party to inform him/her of the use of the side rails and to obtain the consent." On January 15, 2009 Employee # 6 informed this investigator that he/she had obtained a telephone consent from the Responsible Party for the use of full side rails while the resident is in bed. The record was reviewed on January 13, 2009. 2. Facility staff applied a clamp seat belt to Resident #19, who was assessed for a Velcro seat belt. A review of Resident #19's record revealed a	F 221	**483.13(a) Physical Restraints (continued)** 2. Resident #19 1. The resident's responsible party was notified and a consent obtained for the use of a clamped seat belt. 2. Medical records of all residents with a eat belt were reviewed to ensure the order reflected the correct type of seat belt, the seat belt in use was correct and consent was obtained for the correct seat belt. 3. Inservice education was given to all nursing staff about the importance of following the facility protocol in applying Physical Restraints. Physical Restraint application and consents will be monitored through the Nursing Quality Improvement Program. Data collection results will be presented to the DON. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/14/09 3/31/09 3/31/09 4/3/09

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	095022	A. BUILDING _____ B. WING _____	01/16/2009

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F 221	Continued From page 10 telephone order dated December 18, 2008 at 4:00 PM, signed by the physician on the same date that directed, "Obtain consent for seat belt (self release) from guardian. Resident to have self release seat belt on while sitting up in w/c (wheelchair). " " Consent for the Use of a Physical Restraint " for a seat belt (Velcro) was signed by the responsible party on December 22, 2008. Care plan #7, " Restraint device ... " was updated on December 22, 2008 when the Velcro seat belt was applied to Resident #19. An observation of Resident #19 was conducted in the presence of Employee #13 on January 15, 2009 at 2:15 PM. Resident #19 was observed with a clamp type seat belt and was unable to open the belt. Employee # acknowledged that the resident was wearing a clamp type seat belt and was unable to open the belt. The record was reviewed January 15, 2009.	F 221	**483.13 © Staff Treatment of Residents** 1. The 2 identified employees had been terminated prior to the start of the survey 2. Records of all new hires from January were audited to ensure Abuse training was given.	1/12/09. 1/19/09
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 10 newly hired employees, it was determined that the facility failed to provide abuse training prior to the day services were provided to the residents.	F 226	3. Employees will be educated on Resident Abuse at the time of hire with a sign off Sheet in their employee file to acknowledge receipt of the training. This education will be reinforced during General Orientation. The Director of Human Resources will monitor this practice through her HR Quality Improvement Program. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/31/09 4/3/09

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F 226	Continued From page 11 The findings include: Review of Policy No.: 1401010A.DC Abuse, Neglect and Mistreatment states: " All employees and new hires will receive mandatory inservices on identifying, preventing and notifying administration of potential resident abuse, neglect, and mistreatment " A review of 10 personnel records on January 15, 2009 revealed the following: Employee # 57 was hired December 29, 2008 as a nursing assistant and was currently working in that position. His/Her personnel file lacked documentation of abuse training. Employee # 58 was hired December 31, 2008 in to the dietary department and was currently working in that position. His/Her personnel file lacked documentation of abuse training. During a face-to-face interview held on January 15, 2009 at 11:00 AM with Employee #2 and Employee #4, it was stated by both employees that, "Staff sometimes start to work before attending orientation because orientation is only held once a month. The last scheduled orientation had been rescheduled. " The facility's failure to train employees on the abuse policy prior to providing services to residents does not provide protection to all residents from potential abuse.	F 226		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241	**483.15(a) Dignity** 1. Resident #1	

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F 241	Continued From page 12 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations for two (2) of 30 sampled residents and nine (9) supplemental residents, it was determined that facility staff failed to enhance and maintain residents' self-esteem as evidenced by failure to: setup lunch tray for one (1) resident, provide incontinence care in a timely manner to one (1) resident, change one (1) resident's stained pants, maintain comfortable water temperatures for four (4) residents, knock on one (1) resident's door prior to entry, prevent one (1) resident being exposed in a mirror while unclothed, sit while assisting one (1) resident to eat, dress one (1) resident in appropriate sized pants, and position one (1) resident in bed. Residents #1, 5, F7, F12, F14, F19, JH2, S3, S4, S8 and S9. The findings include: 1. Facility staff failed to setup the lunch tray for Resident #1. On January 12, 2009 at approximately 12:25 PM, the resident was observed seated in a geri chair at the rear of the first floor dinning room with his/her lunch tray. The content of the lunch tray included: two (2) slices of bread, butter/spread and two (2) pieces of chicken. The resident was observed struggling to butter the bread. The resident said, "I would like some help." The resident had to call for help to assist in buttering the bread. Employee #25 responded and assisted in buttering the resident's bread.	F 241	**483.15(a) Dignity (continued)** Resident # 1 (continued) 1. Facility staff of the unit where resident resides was given an inservice regarding that resident's needs specific to tray set-up. 2. All residents who require assistance with tray set-up for meals were reviewed to ensure the same deficient practice does not occur. 3. Clinical Managers or their designee will make rounds during meal times to ensure that any resident identified to need setup help during meal times receive the needed setup help as soon as the tray is served An inservice training was given to nursing staff of all the units to ensure that assistance is provided to residents identified as needing help in setup of lunch tray in a timely manner. Clinical Managers or their designee will monitor this practice through the Nursing Quality Improvement Program and report their findings to the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/18/09 1/12/09 3/31/09 4/3/09

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F 241	Continued From page 13 The pieces of chicken were not cut up and the resident was unable to eat the chicken. At approximately 1:30 PM, after assisting other residents, Employee #24 came to assist the resident with his/her meal. Employee #24 cut the chicken in manageable bite sizes for the resident. According to the last quarterly Minimum Data Set (MDS) completed November 11, 2008, Section G1(h): eating, the resident was coded as "Independent setup help only". Section G4 "Functional Limitation in Range of Motion" the resident's hand including wrist or fingers presents with "Limitation on one side with partial loss of voluntary movement". Face-to-face interview was conducted with Employee #24 on January 12, 2009 at 2:45 PM approximately. He/she acknowledged that facility staff failed to setup the resident's lunch tray. The record was reviewed January 12, 2009. 2. Facility staff failed to assist Resident #5 to dress in unstained pants. An observation of Resident #5 was conducted on January 12, 2009 at 11:00 AM. He/she was wearing navy blue pants. The pants had a large light colored stain on the right knee and thigh area. The resident was asked if the stain happened during the day (January 12, 2009). He/she stated that the pants were returned from the laundry with the stain. According to the quarterly Minimums Data Set (MDS) assessment completed December 12, 2008, Resident #5 was coded in Section B (Cognitive Patterns) with no long or short term memory problems and in Section G (Physical	F 241	**483.15(a) Dignity (continued)** 2. Resident #5 1. A pair of pants without stains on the knees was provided to this resident. 2. All residents' clothing was inspected from the Laundry to ensure that stained clothing was not delivered back to the residents. 3 An inservice was done with the laundry staff to ensure that clothing with stains is pulled and not delivered back to the residents. The Interdisciplinary Team will identify those residents requiring clothing and ensure that the family is contacted for clothing which is both appropriate and clean. Social Workers will monitor the residents' clothing on an on-going basis and report their findings to the Director of Social Work. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/12/09 3/31/09 3/31/09 4/3/09

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F 241	Continued From page 14 Functioning and Structural Problems) as requiring extensive assistance with dressing. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM. He/she acknowledged that the resident's was wearing stained pants. The record was reviewed January 12, 2009. 3. Facility staff failed to maintain water temperatures at levels for residents to have personal care without having to use personal care wipes instead of warm water. Residents F7, F12, F14 and F19. During the testing of the resident room water temperatures on January 13 and 14, 2009 the water temperature readings were as follows: Room Water temperatures on January 13, 2009 between 9:25 AM to 10:30 AM 137 84.4 141 79.3 109 85.0 121 77.2 159 82.8 A face-to-face interview was conducted with Employee #29 on January 13, 2009 at 10:07 AM. He/she stated, " The main boiler for the floors [that services the resident rooms] is down. The kitchen and the laundry boilers are okay. We [the facility] have three (3) boilers. I spoke with the [name of boiler company] and they are on the way to repair the problem. " A face-to-face interview was conducted with Employee #2 on January 13, 2009 at 10:20 AM. He/she stated, " The maintenance department	F 241	**483.15(e) Dignity (continued)** 3. Water Temperatures 1. Water temperatures were attended to immediately upon discovery. Facility's contractor, Capital Boilers, was contacted and hot water temperatures were restored within a matter of hours on both days noted. Disaster Plan was implemented which included the use of personal care wipes and warming water in the microwave oven. 2. Water temperatures were checked continuously both as the water exited the boilers and as the hot water flowed out of the faucets in the residents' rooms until appropriate temperatures were returned. 3. The Maintenance Department monitors water temperatures through its Quality Improvement Program and monitors the functioning of the facility's boilers through its Preventative Maintenance Program and routine maintenance done by its contractor. Nothing either Maintenance or its contractor could have done would have prevented the boilers from going down on these two days. 4. The Department Head will present a report of the data collected on water temperatures and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/14/09 1/14/09 3/31/09 4/3/09

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F 241	Continued From page 15 made me aware of the water temperature problem. We will use the wipes. The CNA ' s on all floors are being notified to use the wipes. " Additional resident room temperatures were as follows: Room Water temperatures on January 13, 2009 between 10:43 AM to 11:54 AM 333 66.6 341 77.4 317 66.6 305 86.1 357 66.6 359 79.9 304 78.4 354 74.8 310 73.8 314 71.4 338 77.7 342 76.1 Room Water temperatures on January 14, 2009 between 8:15 AM to 9:15 AM 126 82.0 219 85.1 205 84.7 257 84.4 231 85.1 240 89.1 305 91.0 A face-to-face interview was conducted on January 14, 2009 at 8:15 AM with Employee #29. He/she stated, " The water temperatures are down. The boiler that provides water to the residents is down. I have the company coming back out today to repair the boiler. When the water temperature is down we [the facility]	F 241	**483.15(e) Dignity (continued)**	

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F 241	Continued From page 16 implement the wipes that can be warmed for the residents to use for personal care. " A face-to-face interview was conducted on January 14, 2009 at 8:37 AM with Resident F7. He/she stated, " The water is cold. The water was cold yesterday. I haven ' t seen any wipes in I don ' t know when. " A face-to-face interview was conducted on January 14, 2009 at 8:45 AM with Resident F19. He/she stated, " The water is cold. I had to wait to get dressed. The water is just cold. I don ' t like the wipes. People can ' t get their hair done because the water is cold. " A face-to-face interview was conducted on January 14, 2009 at 4:10 PM with Resident F12. He/she stated, " I couldn't ' t get my hair done yesterday. I had to reschedule my appointment for today at 10:00 AM. The water was still cold, so I didn't ' t get my hair done until today at 1:00 PM. " A face-to-face interview was conducted on January 14, 2009 at 4:25 PM with Resident F14. He/she stated, " The water is cold, it ' s cold now. I don ' t sweat a lot so I just wash my arms. " 4. Facility staff failed to knock on Resident JH2's door before entry. On January 12, 2009, at approximately 10:50 AM during the medication pass, Employee #50 did not knock prior to entering Resident JH2 room. A face-to-face interview was conducted on January 12, 2009, at approximately 11:00 AM	F 241	**483.15(e) Dignity (continued)** 4. Resident JH2 1.Facility staff of the unit where resident JH2 resides was given an inservice to remember always to knock on each resident's door before entering. 2.Facility staff of all the nursing units were given an inservice to remember always to knock on each resident's door before entering. 3. Rounds will be conducted by Clin.Mgr.or designee to ensure that the all facility's staff knock on resident's doors before entry. Identified deficient practice will be corrected on the spot. Repeat non-compliance will subject the employee to the facility disciplinary process. "Staff knocking on the Door Before Entering the Resident's Room" is a criteria that is studied through the Administration's Fresh Eyes Quality Improvement Program. Data on this criteria will be collected and action plans implemented if necessary. 4. The Administrator will present a report of the data collected on Staff Knocking on the Door Before Entering the Resident's Room and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee.	1/18/09 1/18/09 1/18/09 4/3/09

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F 241	Continued From page 17 with Employee #50. He/she acknowledged that they did not knock upon entering Resident JH2 ' s room. 5. Facility staff failed to draw the privacy curtain around Resident S2 and prevent his/her unclothed image from being viewed in a mirror from the hallway. An observation of Resident S3 was conducted on January 15, 2009 at 3:00 PM. The resident was unclothed from the waist down, sitting in a chair near the window in his/her room. The resident's unclothed reflection was visible in the mirror in the resident's room from the hallway. Employee #21 was in the hallway at the time of the observation and acknowledged seeing the resident's unclothed reflection in the mirror from the hallway and stated, "I just came out of that room. I just changed (Resident S3). [He/she] takes [his/her] clothes off all the time." An observation was conducted on the same day (January 15, 2009) at 4:05 PM. The resident was wearing a hospital gown and had pulled the gown up around his/her waist. The resident was unclothed from the waist down. His/her unclothed reflection was visible in the mirror in the resident's room from the hallway. Employee #21 failed to position the resident's privacy curtain to prevent the resident's reflection in the mirror to be seen from the hallway. According to a quarterly MDS assessment completed November 11, 2008, Resident S3 was coded in Section B (Cognitive Patterns)with long and short term memory problems and in Section G (Physical Functioning and Structural Problems) requiring extensive assistance for dressing.	F 241	**483.15(e) Dignity (continued)** 5. Resident S2 1. Facility staff where resident resides was given inservice training on pulling privacy curtain completely around the resident to provide privacy to the resident. 2. Rounds were made by the Clinical Mgr or designee to ensure that privacy curtains were completely pulled around all residents on all units while in the room. 3. Inservice education was given to all members of the nursing staff to ensure compliance in providing privacy to all residents. The Nursing Quality Improvement Program will collect data on the the nurse's adherence to privacy and confidentiality and will present their findings to the DON. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/31/09 3/31/09 3/31/09 4/3/09

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F 241	Continued From page 18 6. Employee #20 was observed standing over Resident S4 during the lunch meal while assisting him/her to eat. On January 14, 2009 from 12:50 PM through 12:58 PM, Employee #20 was assisting Resident S4 to eat the lunch meal. Employee #20 stood over the resident during the eight (8) minutes he/she was assisting the resident, did not speak to the resident and carried on a conversation with another employee. According to the annual MDS assessment completed January 8, 2009, Resident S4 was coded in Section B as having long and short term memory problems and in Section G requiring limited assistance with eating. 7. Resident S8 was observed wearing oversized pants. On January 15, 2009 at 2:30 PM, Resident S8 was observed sitting in the wheelchair and clutching his/her pants. The resident had gathered approximately eight (8) inches at the waist line and was holding it in his/her right hand. When asked about the pants at the time of the observation, Resident S8 stated, " These are not my pants. They are way too big. If I stood up, they would fall down. I need a belt. " A face-to-face interview was conducted with Employee #19 on January 15, 2009 at 4:30 PM. Employee #19 acknowledged that he/she saw Resident S8 with the oversized pants that morning but didn't do anything about it. The resident attended occupational therapy on	F 241	**483.15(e) Dignity (continued)** 6. Resident S4 1. Inservice was given to the employee to ensure her knowledge of Dignity in Dining 2. All staff on that resident's unit was inserviced on Dignity in Dining 3. The Charge Nurses and Clinical Managers will monitor staff performance during meal service. The Nutritional Services Quality Improvement Program collects data on Meal pass including the staff's positioning while feeding a resident. Such data will be analyzed and presented to the DON for review. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 7. Resident S8 1. Resident was given a pair of scrubs with drawstring waist from the facility's stock. His family was contacted to secure clothing for him. He had been recently admitted. 2. All residents were assessed to ensure their clothes were not too big. Corrections were made if necessary. 3. Social Work will assess the resident's need for proper fitting clothing during the first 14 days after admission. Contact will be made to the family if additional clothing or better fitting clothing is needed. Such data will be collected by the Social Workers and given to the Director of Social Work for evaluation with her Quality Improvement Team.	3/31/ 4/3/09 1/16/09 3/31/09 3/31/09

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F 241	Continued From page 19 January 15, 2009. A face-to-face interview was conducted with Employee #17 on January 16, 2009 at 10:30 AM. He/she stated, "I worked with (Resident S8) yesterday (January 15, 2009). Those pants were about a size 56 and (Resident S8) is probably a 32 or maybe even smaller. Usually [Resident S8] walks alone with a contact guard on the parallel bars. I had to get another therapist to help me hold up the pants so [Resident S8] could walk. " According to the admission MDS assessment completed January 5, 2009, Resident S8 was coded in Section B with short term memory problems and Section G requiring extensive assistance with dressing. 8. Resident S9 was observed during a wound treatment positioned so that his/her head was resting on the side rails. During a wound treatment observation, conducted on January 15, 2009 at 11:45 AM until 12:15 PM, it was observed that Resident S9 was positioned in bed on his/her left side. The head of the bed was elevated and Resident S9's shoulders were located at the fold of the upper part of the bed, with his/her head resting on the side rails. Employee #22 failed to reposition the resident before or after the wound treatment was completed. According to the quarterly MDS assessment completed January 12, 2009, the resident was coded in Section B (Cognitive Patterns) for long and short term memory problems and in Section G (Physical Functioning and Structural Problems) as being totally dependent for bed mobility with	F 241	**483.15(e) Dignity (continued)** Resident S8 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 8. Resident S9 1. Inservice training was given to this staff member which addressed proper positioning before and after each wound treatment. 2. Nursing staff from other units were given inservice training in proper positioning of residents before and after each wound treatment. 3. Wound treatments will be observed by ADONs, Clinical Mgrs, & Nursing supervisors to ensure that residents positioning is proper and comfortable during the treatment. Data collected through the Nursing Quality Improvement Program's Treatment Observation Tool Will be forwarded to the Director of Nurses and her QI team for evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	4/3/09 1/16/09 1/16/09 3/31/09 4/3/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	01/16/2009

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F 241	Continued From page 20 full loss of voluntary movement on both sides of his/her body.	F 241		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations of one (1) of 30 sampled residents and four (4) supplemental residents reviewed, it was determined that facility staff failed to ensure that the call bell was within reach to accommodate residents that may need reasonable assistance while in their rooms. Residents #27, JH6, F15, F16, and F18. The observations were made and acknowledged in the presence of Employees #11, 22, 27, 29, and 30. The findings include: 1. During a wound care treatment observation for Resident #27 on January 15, 2009 at approximately 1:30 PM, the resident's call bell was tied to the bed rail to the resident's left side. The bed rail was down and out of the resident's immediate reach. 2. Facility staff failed to place call bell in reach for Resident JH6. On January 13, 2009, at approximately 11:55 AM,	F 246	**483.15(e)(1) Accommodation of Needs** Residents #27, JH6, F15, F18 1. Call bells were appropriately placed for each resident upon discovery. 1/16/09 2. Rounds conducted throughout the facility to ensure proper placement of the call bells was done. 1/16/09 3. An inservice training session was done to make sure that call bells are within reach of residents to accommodate those who may need assistance while in their rooms. Rounds will be made by nursing supervisors to ensure that call bells are all within residents' reach. 3/31/09 The "Nursing Care Review" of the Nursing Quality Improvement Program specifically addresses the proper placement of the call bell. The Nursing Quality Improvement Team will collect data on this issue and Forward their findings to the DON. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 4/3/09	

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F 246	Continued From page 21 Resident JH6 was observed sitting in a gerichair in his/her room. The call bell was on the bed and out of reach of the resident. Employee #22 acknowledged that the call bell was out of the resident ' s reach. 3. During the environmental tour on January 12, 2009 at approximately 4:00 PM Residents F15 and F16 were observed in their rooms and the call bells were observed on the floor and not within reach of the residents. During the environmental tour on January 13, 2009 at approximately 10:20 AM, Resident F18 was observed in his/her room and the call bell was observed on the floor and not within reach.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled ceiling tiles, floors, walls, wheel chairs/chairs/gerichairs, faucets, roller carts, and hair dryer; damaged ceiling tiles, doors, wheelchair arms, baseboards and walls; excessive items in resident rooms; and items stored on the floor in storage areas. The environmental tour was conducted on	F 253	**483.15(h)(2) Housekeeping/Maintenance** Soiled Ceiling Tiles 1. Ceiling tiles were changed upon discovery. 2. Ceiling tiles throughout building were assessed and changed if needed. 3. All areas of the building are assessed my maintenance on a frequent basis for soiled or damaged ceiling tiles. Ceiling Tile is a criteria for review under "Resident Floor Maintenance" in the Maintenance Quality Improvement Program. The Maintenance QI team will collect data on this criteria and forward it to the Director of Maintenance for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/14/09 1/16/09 3/31/09 4/3/09

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F 253	Continued From page 22 January 12, 2009 from 3:06 PM to 4:10 PM, January 13, 2009 from 9:25 AM to 4:20 PM and January 14, 2009 8:15 AM to 4:25 PM in the presence of Employees #11, 29, and 30. The findings were acknowledged at the time of the observations. 1. The following areas were observed soiled: Ceiling Tiles Two (2) of six (6) soiled utility rooms, 1S and 2N; two (2) of six (6) clean linen rooms, 1N and 1S; 11 of 31 resident rooms, 137, 159, 110, 116, 122, 136, 231, 232,244, 206 and 333; one (1) of six (6) storage rooms, 1S; one (1) of six (6) nourishment rooms, 1S; one (1) of 12 resident hallway bathrooms, 1S; and one (1) of 12 resident lounge areas, 1N Floors- in the Rehabilitation Gym and practice stairs in the rehabilitation gym Walls- in two (2) of 31 resident rooms 135 and 136; and two (2) of three (3) in the resident dining rooms, 2nd and 3rd floors Chairs Wheel chair/gerichair- room 110 in one (1) of 39 observed Resident arm chairs three (3) of 12 soiled in the 3N resident lounge area Beauty Shop Two (2) of two (2) sink faucets; two (2) of two (2) hair roller carts; and one (1) of three (3) hair dryers were observed soiled 2. The following items/areas were observed damaged:	F 253	**483.15(h)(2) Housekeeping/Maintenance** Soiled Floors 1. The floor in the Rehab Gym was scrubbed and waxed upon discovery. 1/15/09 2. The floor in the Rehab Gym is scheduled for cleaning every afternoon. 1/15/09 3. The Director of Housekeeping and her Team of supervisors visually verifies the cleanliness of the Rehab Gym floor each morning and makes immediate corrections when needed. Cleanliness of the floor is found in the "Common Area" section of the Housekeeping Quality Improvement Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09 Soiled Walls 1. Both resident rooms and dining room walls were scrubbed upon discovery. 1/16/09 2. Other resident rooms and the 1st floor dining room were evaluated for cleanliness and corrections made when indicated. 3/31/09 3. Housekeeping Supervisors are monitoring the walls for on-going cleanliness each day with a daily report of their findings done each day. Wall cleanliness is part of the Housekeeping Quality Improvement Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping. 3/31/09	

483.15(h)(2) Housekeeping and Maintenance (continuation sheet)
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Soiled Walls (continued)
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator — 4/3/09

Soiled Chairs
1. The one geri-chair and 3 arm chairs, identified at the time of the survey as being soiled was cleaned immediately. — 1/16/09
2. All facility geri-chairs and wheel-chairs were checked for cleanliness and corrections were made if any were necessary. — 1/16/09
3. All geri-chairs and wheelchairs are on a routine monthly and PRN cleaning schedule. Chair cleanliness is part of the Housekeeping Quality Improvement Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping. — 3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator — 4/3/09

Soiled Items in the Beauty Shop
1. Items found soiled were cleaned upon discovery. — 1/16/09
2. All areas of the Beauty Shop were evaluated for cleanliness and corrections were made if necessary. — 1/16/09
3. Cleanliness of the Beauty Shop Is included in the "Common Areas" Section of the Housekeeping QI Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping. — 3/31/09
4. The Department Head will present

Soiled Items in the Beauty Shop (cont,)

a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09
A. Damaged Walls	
1. Noted wall damage was corrected Immediately upon discovery.	1/16/09
2. Other wall areas were reviewed in the resident rooms and janitor's closets and corrections were made if necessary.	1/16/09
3. Walls are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation.	3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09

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F 253	Continued From page 23 A. Walls- in two (2) of 31 rooms, 110 and 136; and one (1) of six (6) janitor ' s closet, 3S B. Ceiling tiles-1N resident hallway bathroom, room 109, C. The entry door to resident ' s room was observed to be split at the top in one (1) of 31 resident entry doors, room 257. D. Wheel chair - armrest was damaged in two (2) of 39 observed, wheel chairs observed in room areas 126 A and 102 B E. Baseboards- in one (1) of six (6) janitor ' s closet; in one (1) of six (6) nourishment rooms; in one (1) of 12 resident lounge areas; and in two (2) of 31 rooms 110 and 122 F. Walls - in one (1) of six (6) clean linen rooms, 1N; in one (1) of six (6) soiled utility room, 1S; and in one (1) of six (6) janitor ' s closet, 3N 3. The following items/areas were observed marred/scarred: The wall in the 1S- resident lounge area in one (1) of 12 resident lounge areas observed and one (1) of 31 resident rooms observed, room 232 4. Excessive items were observed in resident rooms in five (5) of 31 resident rooms observed: rooms 110, 233, 317, 305 and 357 5. The following items were observed stored on floor(s): 1N - supply room five (5) of five (5) boxes	F 253	**483.15(h)(2) Housekeeping/Maintenance** B. Ceiling Tiles 1. All damaged ceiling tiles noted at the time of the survey were replaced upon discovery. 2. Other ceiling tiles were reviewed in the and corrections were made if necessary. 3. Ceiling tiles are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator C. Room Door 1. The door was replaced immediately upon discovery. 2. Other doors were evaluated for damage and corrections were made if necessary. 3. Door are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which	1/16/09 1/16/09 3/31/09 4/3/09 1/16/09 1/16/09 3/31/09 4/3/09

483.15(h)(2) Housekeeping/Maintenance
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C. Room Door (continued)
is chaired by the Administrator

D. Wheelchair Armrest

1. The two armrests were replaced upon discovery. 1/16/09
2. Other wheelchair armrests were evaluated and replaced if necessary. 1/16/09
3. Wheelchair repairs are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation. 3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09

E. Damaged Baseboards

1. Damaged baseboards were replaced or repaired upon discovery. 1/16/09
2. Other baseboards were evaluated for the need for repair or replacement and action was taken when necessary. 3/31/09
3. Baseboards are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation. 3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09

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F. Damaged Walls	
1. Noted wall damage was corrected Immediately upon discovery.	1/16/09
2. Other wall areas were reviewed in Ancillary spaces and corrections were made if necessary.	1/16/09
3. Walls are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation.	3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09
3. Marred/Scarred Walls	
1. The two wall areas noted as being marred or scarred at the time of the survey were repaired upon discovery.	1/16/09
2. Other wall areas were reviewed in Ancillary spaces and corrections were made if necessary.	1/16/09
3. Walls are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation.	3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09

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4. Excessive Items in Resident Rooms	
1. Excessive items were removed upon discovery.	1/16/09
2. Resident rooms were evaluated for the storage of excess items. Family members were called and asked to remove the items whenever it was necessary to do so.	3/31/09
3 Resident Room Cleanliness/Clutter is part of the Housekeeping Quality Improvement Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping.	3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09
5. Items stored on the Floor	
1. All items were removed and properly Stored upon discovery.	1/16/09
2. Other areas of Rehab were evaluated for proper storage and corrections made if necessary.	1/16/09
3. The Director of Rehabilitation inserviced his staff regarding the proper storage of rehab equipment kept in their department.	3/31/09
4. The Rehab Director will ensure, through monthly inspection and evaluation, that sustained correction has been made in this area.	4/3/09

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F 253	Continued From page 24 3N-five (5) of five (5) boxes stored on the floor in the storage closet Multiple prosthetic items and boxes were store on the floor in the storage closet of the Rehabilitation gym.	F 253		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	**483.20(g)-(j) Resident Assessment**	

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F 278	Continued From page 25 Based on record review and staff interview, for three (3) of 30 sampled residents, it was determined that facility staff failed to accurately code: one (1) resident ' s wound, one (1) resident for weight gain and one (1) resident for being verbally abusive. Residents #4, 5 and 13. The findings include: 1. Facility staff failed to accurately code Resident #4's wound. The resident was admitted to the facility on February 21, 2007. The admission history and physical assessment completed December 21, 2007 described a "chronic right leg ulcer." The annual history and physical assessment completed December 22, 2008 described, "Chronic (right) leg ulcer at bottom of shin - non pressure area." According to the admission Minimum Data Set (MDS) assessment completed December 31, 2007 and the quarterly MDS assessments completed February 18 and May 15, 2008, the resident was coded in Section M2 (Type of Ulcer) as a stasis ulcer on the right lower leg. According to the quarterly MDS assessment completed on August 12, 2008 and the annual MDS assessment completed on November 12, 2008, the resident was coded for a pressure ulcer on the right lower leg. This was the same ulcer as previously described as a stasis ulcer. There was no evidence in the resident's record to verify that the previously identified stasis ulcer changed to a pressure ulcer.	F 278	**483.20(g)-(j) Resident Assessment** (continued) 1. Resident #4 1. MDS was corrected to accurately reflect Resident's wound. Error was reviewed with the MDS nurse in question. 2. MDSs of all residents with wounds were reviewed to ensure the wounds were coded accurately. If inaccurate codes were used, corrections were made. 3. Appropriate staging of wounds on the MDS is found under "Skin Section" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 2. Resident #5 1. MDS was corrected to accurately reflect resident's weight loss. Error was reviewed with the MDS nurse in question. 2. MDS of all residents with identified weight loss was reviewed to ensure that the loss was coded accurately. If identified, inaccurate codes were corrected by MDS coordinators.	3/6/09 3/6/09 3/31/09 4/3/09 3/6/09 3/6/09

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F 278	Continued From page 26 A face-to-face interview was conducted on January 13, 2009 at 4:15 PM with Employee #18. He/she acknowledged that the stasis ulcer was miscoded as a pressure ulcer. The record was reviewed January 13, 2009. 2. Facility staff failed to accurately code weight loss for Resident #5. According to the admission MDS assessment completed July 11, 2008, the resident was coded in Section K2 (Height and Weight) as weighing 178 pounds. According to the quarterly MDS completed October 6, 2008, the resident was coded in Section K2 as weighing 192 pounds and was coded for weight loss. A face-to-face interview was conducted on January 12, 2009 at 3:45 PM with Employee #18, who acknowledged that the MDS was miscoded for weight loss. The record was reviewed January 12, 2009. 3. Facility staff inaccurately coded Resident #13 for verbally abusive behavior. A review of the quarterly MDS revealed that Resident #13 was coded in Section E (Behavior Patterns) as being verbally abusive one (1) to three (3) time in the last seven (7) days prior to the Assessment Reference Date (last date for observations) of July 22, 2008. A review of the nurses' notes for July 2008 and the Behavior Monitoring Flow Sheet for July 2008 revealed no documented episodes of verbal abuse. A face-to-face interview with Employee #5 was	F 278	**483.20(g)-(j) Resident Assessment** 2. Resident #5(continued) 3. Appropriate recording of weigh loss is on the weight Change Review of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 3. Resident #13 1. MDS was corrected to accurately reflect resident's verbally abusive behavior. Error was reviewed with the MDS nurse in question. 2. MDSs of all residents with verbally abusive behavior were reviewed if the behavior was coded accurately in the resident's MDS. 3. MDS of residents with verbally abusive behavior and scheduled for weekly care conference will be audited if the verbally abusive behavior is accurately coded in the MDS 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	3/31/09 4/3/09 3/6/09 3/6/09 3/10/09 4/3/09

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	Continued From page 27 conducted on January 13, 2009 at 3:45 PM. He/she acknowledged that there were no documented episodes of verbal abuse for July 2008. The record was reviewed January 13, 2008.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for six (6) of 30 sampled residents, it was determined that facility staff failed to initiate care plans with appropriate goals and approaches for: one (1) resident with Anemia and Multiple Sclerosis, two (2) residents for anticoagulant therapy, two (2) residents for the potential	F 279	**483.20(d), 483.20(k)(1) Comprehensive Care Plans**	

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	095022	A. BUILDING _____ B. WING _____	01/16/2009

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F 279	Continued From page 28 adverse interaction for the use of nine (9) or more medications, three (3) resident for incontinence, one (1) resident for the use of side rails and one (1) resident for abusive/aggressive behaviors. Residents # 2, 5, 6, 7, 13 and 15. The findings include: 1. Facility staff failed to initiate care plans with goals and approaches for Anemia and Multiple Sclerosis for Resident #2. According to the admission Minimum Data Set (MDS) assessment completed November 24, 2008, the resident was coded in Section I (Disease Diagnoses) for Anemia and Multiple Sclerosis (MS). A review of the resident's care plans initiated November 24, 2008, revealed that no care plan with appropriate goals and approaches was initiated for Anemia or MS. A face-to-face interview was conducted with the resident at approximately 8:15 AM on January 13, 2009. He/she acknowledged being aware that he/she had a diagnosis of Multiple Sclerosis. The resident stated, " I was diagnosed with MS many years ago [not sure how many]. I used to receive Avonex injections once a week for MS but I have not had any [injections] since I have been here. I didn't ' t get any injections while I was in the other hospital either. I thought I told someone about the injections when I first got here but I am not sure who I told. " A face-to-face interview was conducted with the Employee #9 on January 15, 2009 at approximately 9:00 AM. He/she stated she was not aware of the diagnoses of Anemia and Multiple Sclerosis. He/she added, " I will look into that [the diagnoses]. " In another face-to-face interview conducted with Employee # 9 at approximately 9:30 AM on January 16, 2009 the employee stated, " I have	F 279	**483.20(d), 483.20(k)(1) Comprehensive Care Plans** (continued) 1. Resident #2 1. Resident #2's care plan was amended o include a care plan with goals and approaches for Anemia and Multiple Sclerosis. 2. Care Plans of all residents with the Diagnoses of Anemia and Multiple Sclerosis were reviewed for the same deficient practice and changes made as needed. 3. Appropriate care plans with goals and Approaches for Anemia and Multiple Sclerosis will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 2. Resident #5 1. Resident #5's care plan was amended to include goals and approaches for a resident receiving anticoagulant therapy. 2. Care Plans of all residents receiving anticoagulant therapy were reviewed for goals and approaches for anticoagulant therapy and amended as needed	3/13/09 3/13/09 3/31/09 4/3/09 3/6/09 3/10/09

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F 279	Continued From page 29 spoken to the physician and the resident will be evaluated for Anemia and MS. " The record was reviewed on January 12, 2009. 2. Facility staff failed to initiate a care plan for anticoagulant therapy for Resident #5. According to the preprinted "Physician's Orders" signed by the physician on December 23, 2008, the resident was prescribed Plavix 75 mg daily. A review of the resident's care plans revealed that there was no care plan initiated with appropriate goals and approaches for the use of anticoagulant therapy. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM. He/she acknowledged that there was no care plan for the use of Plavix. The record was reviewed January 3. Facility staff failed to initiate a care plans with appropriate goals and approaches for the potential adverse interactions for the use of nine (9) or more medications for Resident #6. A review of the clinical record for Resident #6 revealed a Physician ' s Order Sheet (POS) signed on January 6, 2009 with medications which included Colace, Folic Acid, Furosemide, Labetalol, Keppra, Procardia, Coumadin, Dilantin, Senokot, Dulcalox Suppository, Citrate of Magnesia and Tylenol tablets. Further review of the record revealed that no care plan was initiated for the potential adverse interactions for the use of nine or medications. A face-to-face interview was conducted with Employee #6 on January 14, 2009 at approximately 11:00 AM. He/she acknowledged that the care plan for the potential interaction of the use of nine or more medications was not on	F 279	**483.20(d), 483.20(k)(1) Comprehensive Care Plans** (continued) 3. Appropriate care plans with goals and Approaches for Anticoagulant Therapy will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 3. Resident #6. 1.Resident #6's care plan was amended to include appropriate goals and approaches for the potential adverse interactions for the use of 9 or more meds. 2. Medical records of all residents with 9 or more medications were reviewed if a corresponding care plan with appropriate goals and approaches for the potential adverse interactions. 3. Appropriate care plans with goals and Approaches for Adverse Interactions for the Use of 9 or More Meds will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/31/09 4/3/09 3/6/09 3/6/09 3/31/09 4/3/09

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F 279	Continued From page 30 the record. He/she added, " I will put one on right now. " The record was reviewed on January 13, 2009. 4. Facility staff failed to initiate a care plan for anticoagulant therapy and incontinence for Resident #7. A. Facility staff failed to initiate a care plan for anticoagulant therapy for Resident #7. Review of Resident #7's record revealed a physician's order initiated December 12, 2007 and renewed with each physician ' s visit most recently January 6, 2009, for " Plavix 75 mg q d (once daily) po (by mouth). " A review of the resident ' s care plans revealed that there was no care plan initiated with appropriate goals and approaches for the use of anticoagulant therapy. A face-to-face interview was conducted with Employee #6 on January 13, 2009 at 2:25 PM. He/she acknowledged that there was no care plan for the use of Plavix. The record was reviewed January 13, 2009. B. Facility staff failed to initiate a care plan for incontinence. A review of Resident #7's record revealed quarterly MDS assessments completed March 14 and June 9, 2008 and the annual MDS assessment completed September 2, 2008 coded the resident as frequently incontinent of bowel and bladder function in Section H (Continence in last 14 days). The quarterly MDS assessment completed	F 279	**483.20(d), 483.20(k)(1) Comprehensive Care Plans** (continued) 4. Resident #7 A. Anticoagulant Therapy 1. Resident # 7's care plan was amended to include goals and approaches for a resident receiving anticoagulant therapy. 2. Care Plans of all residents receiving anticoagulant therapy were reviewed for goals and approaches for anticoagulant therapy and amended as needed. 3. Appropriate care plans with goals and Approaches for Anticoagulant Therapy will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 4. Resident #7 B. Incontinence 1. Resident # 7s care plan was amended to include goals and approaches for a resident who has incontinence. 2. Care Plans of all residents who has incontinence were reviewed for goals and approaches for incontinence and amended as needed. 3. Appropriate care plans with goals and Approaches for Incontinence will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation.	3/6/09 3/10/09 3/31/09 4/3/09 3/6/09 3/31/09 3/31/09

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F 279	Continued From page 31 December 2, 2008 coded the resident as totally incontinent of bladder and frequently incontinent of stool in Section H. A review of the resident's care plans revealed that there was no care plan initiated with appropriate goals and approaches for bowel and bladder incontinence. A face-to-face interview was conducted with Employee #6 on January 13, 2009 at 2:25 PM. He/she acknowledged that there was no care plan for incontinence. The record was reviewed January 13, 2009. 5. Facility staff failed to initiate care plans for Resident #13 for incontinence and aggressive/ abusive behaviors. A. Facility staff failed to initiate a care plan for incontinence for Resident #13. Review of Resident #13's record revealed the admission MDS completed May 21, 2008 coded the resident as usually incontinent of bowel and totally incontinent of bladder. The quarterly MDS assessments completed July 24 and October 16, 2008 and January 21, 2009 coded the resident in Section H as usually incontinent of bowel and bladder. A review of the resident's care plans revealed that there was no care plan initiated with appropriate goals and approaches for bowel and bladder incontinence. A face-to-face interview was conducted with Employee #5 on January 13, 2009 at 11:00 AM. He/she acknowledged that there was no care	F 279	**483.20(d), 483.20(k)(1) Comprehensive Care Plans** (continued) 4. Resident #7 (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 5. Resident #13 A. Incontinence 1. Resident # 3s care plan was amended to include goals and approaches for a resident who has incontinence. 2. Care Plans of all residents who has incontinence were reviewed for goals and approaches for incontinence and amended as needed. 3. Appropriate care plans with goals and Approaches for Incontinence will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	4/3/09 3/6/09 3/31/09 3/31/09 4/3/09

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F 279	Continued From page 32 plan for incontinence. The record was reviewed January 13, 2009. B. Facility staff failed to initiate a care plan for aggressive/abusive behaviors for Resident #13. According to a review of Resident #13's of the "Initial Psychiatric Evaluation" dated October 9, 2008, " ...[Resident] admits to being verbally abusive to other patients at times and physically assaultive off and on ... " The resident was prescribed Seroquel 50 mg orally twice daily and Klonopin 1 gm orally daily for agitated behaviors. According to a quarterly MDS assessment completed July 24, 2008, the resident was coded in Section E (Mood and Behaviors) for verbal abuse. A review of the " Psychoactive Medication Monthly Flow Sheet " which monitored target behaviors and medication side effects were blank for October, November, December 2008 and January 2009. A review of the resident ' s care plans revealed that there was no care plan initiated with appropriate goals and approaches for abusive/aggressive behaviors. A face-to-face interview was conducted with Employee #5 on January 13, 2009 at 11:00 AM. He/she acknowledged that there was no care plan for incontinence and aggressive/abusive behaviors. The record was reviewed January 13, 2009. 5. Facility staff failed to initiate a care plans with	F 279	**483.20(d), 483.20(k)(1) Comprehensive Care Plans** (continued) 5. Resident #13 B. Aggressive/abusive behaviors 1. The care plan was amended to include goals and approaches for a resident exhibiting both aggressive/ abusive behaviors. 2. Medical records of all residents who exhibit aggressive/abusive behaviors were reviewed for corresponding goals and amended as needed. 3. Appropriate care plans with goals and Approaches for aggressive/abusive behaviors will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/6/09 3/6/09 3/31/09 4/3/09

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F 279	Continued From page 33 appropriate goals and approaches for the potential adverse interactions for the use of nine (9) or more medications and for the use of full side rails for Resident #15. A. Review of the clinical record for Resident #15 revealed a Physician ' s Order Sheet (POS) signed on January 6, 2009 with medications which included Aspirin, Coreg, Lasix, Glipizide, Keppra, Synthroid, Simvastatin, Prednisone, Zantac, Zaroxylin and Tylenol tablets. Further review of the record revealed that no care plan was initiated for the use of nine or more medications for Resident #15. A face-to-face interview was conducted with Employee #6 on January 14, 2009 at approximately 3:00PM. He/she acknowledged that the care plan for potential adverse interaction for the use of nine or more medications was not on the record. He/she added, " I will put one on right now. " The record was reviewed on January 13, 2009. B. Facility staff failed to initiate a care plan for the use of full side rails for Resident # 15. Resident #15 was observed lying in bed with full side rails up on January 13, 2009 at approximately 12:30PM and 4:10PM on January 14, 2009. The resident was asked why the side rails were up and she responded, " They keep me from falling out of the bed. " The resident was then asked whether she could release the side rails. She responded, " No. " According to the facility ' s policy entitled " Nursing Physical Restraints: Policy # 1404399A.000 " Page 1 of 2 under the heading of " Definition " it is stated "Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of	F 279	**483.20(d), 483.20(k)(1) Comprehensive Care Plans** (continued) 5. Resident #15 A. Adverse Interactions for 9+ medications 1.Resident #15's care plan was amended to include appropriate goals and approaches for the potential adverse interactions for the use of 9 or more meds. 2. Medical records of all residents with 9 or more medications were reviewed if a corresponding care plan with appropriate goals and approaches for the potential adverse interactions. 3. Appropriate care plans with goals and Approaches for Adverse Interactions for the Use of 9 or More Meds will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. B. Full Side Rails 1. Resident #15's care plan was amended to include a care plan for the use of full side rails. 2. Medical records of all residents using full side rails were reviewed for a corresponding care plan for the use of side rails and care plan amended as needed.	3/6/09 3/6/09 3/31/09 4/3/09 3/6/09 3/6/09

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F 279	Continued From page 34 movement or normal access to one ' s body. " In addition, on Page 2 of 2 of the aforementioned policy under the heading of " Examples of Restraining Devices " the following examples are listed: " 1. Merry Walker 2. Velcro seat belt 3. Soft waist belt 4. Clip belt 5. Lap buddy 6. Lap Tray 7. Reverse Seat belt 8. Reclining Geri-chair without tray 9. Straight back Geri-chair with tray 10. Bed rails not requested by the resident 11. Bed against the wall. " A review of the clinical record revealed a "Side Rail Assessment Form" dated December 5, 2008 which documented the following; " Recommendation: Full side rails indicated to serve as enabler to promote independence. " There was no evidence in the record that the side rails were requested by the resident. A face-to-face interview was conducted with Employee # 6 on January 14, 2009 at approximately 3:00 PM. He/she acknowledged that there was no care plan on the record for the use of side rails and stated, " I will add the care plan to the record. " The record was reviewed on January 13, 2009.	F 279	**483.20(d), 483.20(k)(1) Comprehensive Care Plans** (continued) 5. Resident #15 (continued) B. Full side Rails 3. Appropriate care plans with goals and Approaches the use of Full Side Rails will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/31/09 4/3/09
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	**483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans**	

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F 280	Continued From page 35 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and resident review for four (4) of 30 sampled residents, it was determined that facility staff failed to review and revise care plans for four (4) residents with multiple falls with no injury and for one (1) resident for smoking marijuana. Residents #5, 13, 19 and 25. The findings include: 1. Facility staff failed to review and revise Resident #5's "Falls" care plan after multiple falls. A review of Resident #5's record revealed the in the nurses' notes that the resident fell on August 8 and 25, 2008. A review of care plan #7 " Falls " initiated July 3, 2008 revealed that both falls were hand written on the care plan under "Problems." The "Risk	F 280	**483.20(d)(3), 483.10(k)(2)** **Comprehensive Care Plans** (continued) 1. Resident #5 1.Resident# 5's care plan may not be amended retrospectively. 2. Medical records of residents who had multiple falls were audited to ensure that the care plan was reviewed and revised after each fall with additional goals and approaches to prevent further falls. 3. Appropriate care plans with goals and Approaches for Falls will be evaluated using "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/16/09 3/31/09 3/31/09 4/3/09

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F 280	Continued From page 36 Management: Falls: Interdisciplinary Care Plan" was initiated September 26, 2008. The care plans were last reviewed October 14, 2008. There was no evidence that either care plan was revised and reviewed after either fall with additional goals and approaches initiated to prevent further falls. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM. He/she acknowledged that additional care plan goals were not initiated after either fall. The record was reviewed January 12, 2009. 2. Facility staff failed to review and revise Resident #13's care plan after multiple falls. According to Resident #13's nurses' notes, the resident was found on the floor in his/her room on November 29, December 6, December 8, 2008 and January 11, 2009. A review of the resident's fall care plan revealed an entry dated December 6, 2008, "Encourage resident to seek assistance during transfer ..." There was no evidence that the care plan was revised and reviewed after the other above cited falls with additional goals and approaches initiated to prevent further falls. A face-to-face interview was conducted with Employee #5 on January 13, 2009 at 11:00 AM. He/she acknowledged that the falls care plan was not revised and reviewed after each of the above cited falls. The record was reviewed January 13, 2009.	F 280	**483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans** (continued) 2. Resident #13 1.Resident# 13's care plan was amended with additional goals and approaches to prevent further falls 2. Medical records of residents who had multiple falls were audited to ensure that the care plan was reviewed and revised after each fall with additional goals and approaches to prevent further falls. 3. Inservice training was given to IDTeam/ staff on all units learning different goals and approaches to implement in an effort to prevent further falls.. Appropriate care plans with goals and Approaches for Falls will be evaluated using "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/18/09 3/31/09 4/3/09

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F 280	Continued From page 37 3. Facility staff failed to review and revise Resident #19 ' s falls care plan after multiple falls without injury. A review of Resident #19 ' s nurses ' notes revealed the following: November 22, 2008 at 11:00 PM: " Resident observed on the floor at 8 PM ...no injury " November 26, 2008 at 7:00 AM: " Resident observed on the floor ...no injury " November 28, 2008 at 2:00 PM: " Observed on the floor ...no injury " December 12, 2008 at 4:00 AM: " At 1:30 AM observed lying beside bed ...no injury. " A review of the two (2) care plans marked #7, " Interdisciplinary Care Plan for Falls " and " Potential for injury related to falls " , revealed that the date and time of each fall cited above was hand written onto the care plans. The care plan, " #7 Potential for injury related to Falls " was initiated November 21, 2008. Interventions initiated on November 21, 2008 included, " PT (Physical Therapy) referral PRN (as needed), Keep room clutter free and floor dry, Keep bed at lowest possible setting when in bed to prevent falling from position of bed, Use of safety devices as appropriate, Monitor behavior, Keep call light within reach at all times & encourage use of, Frequent reminders of safety issues, ex., refrain from sitting at the edge of the bed and chair, take a nap if you feel sleepy, hold on to something steady during ambulation or use walker at all times secondary to unsteady gait, Refer to PMD (Private Medical Doctor) and psychiatrist as needed. "	F 280	**483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans** (continued) 3. Resident #19 1.Resident#19's care plan was amended with additional goals and approaches to prevent further falls. 2. Medical records of residents who had multiple falls were audited to ensure that the care plan was reviewed and revised after each fall with additional goals and approaches to prevent further falls. 3. Inservice training was given to IDTeam/ staff on all units learning different goals and approaches to implement in an effort to prevent further falls.. Appropriate care plans with goals and Approaches for Falls will be evaluated using "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/18/09 3/6/09 3/31/09 4/3/09

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F 280	Continued From page 38 There were no interventions identified as initiated after the above cited falls. The care plan, " Interdisciplinary Care Plan for Falls " was initiated October 18, 2008. Interventions dated November 22, 2008 included, " Determine the predisposing conditions to falls: Previous seizure activity, Provide a safe environment. " Interventions dated November 26, 2008 included, " Keep call bell in reach. " Interventions dated December 11, 2008 included, " Place resident ' s belongings within reach, Encourage resident to utilize hand rails. " An intervention hand written on the bottom of page 2 dated December 12, 2008, included, " Res to be monitored at the nurse ' s station when OOB (out of bed). " Interventions documented on the " Interdisciplinary Car Plan for Falls " and " #7 Potential for injury related to Falls " although phrased differently, were essentially the same type of interventions. There was no evidence that interventions were initiated after the falls on November 22 and 26, 2008. A seat belt was added on December 12, 2008 with a separate care plan. A face-to-face interview was conducted with Employee #13 on January 15, 2009 at 2:15 PM. He/she acknowledged that the interventions in both care plans were the same and additional interventions were not initiated after the November 2008 falls. The record was reviewed	F 280	**483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans** (continued)	

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F 280	Continued From page 39 January 15, 2009. 4. Facility staff failed to review and revise Resident #25's "Substance Abuse" care plan after multiple incidents of "Found resident smoking marijuana." A review of Resident #5's record revealed the following nurses' notes: February 13, 2008 at 12AM, "...Resident was seen smoking marijuana ..." April 9, 2008 at 8:00 PM, "Resident was observed smoking a substance while on the patio(unknown) MD [Physician] notified, order given to obtain urine specimen to test for marijuana, specimen collected and tested, result was positive for mAmp (amphetamines) and THC (tetrahydrocannabinol)... " May 15, 2008 urine was tested and the result was positive for THC. When questioned, resident stated he/she was given weed by another resident ... " July 1, 2008 at 11:00 PM, "...Resident was observed smoking marijuana in the smoking patio ..." July 20, 2008 at 10:30 PM, "Resident was reported smoking weed...Urine drug test was done with negative result ..." November 2, 2008 at 3:00 PM, "...Resident was seen with a bag of weed ...a bag of marijuana was obtained from his/her pocket ..." November 5, 2008 at 11:00 PM "...was informed that patient was smoking marijuana on the patio ..." November 8, 2008 at 11:00 PM "...Resident was observed smoking marijuana on the patio ... " December 2, 2008 at 9:00 PM, " ...Patient was observed smoking marijuana in his/her room ... "	F 280	**483.20(d)(3), 483.10(k)(2)** **Comprehensive Care Plans** (continued) 4. Resident #25 1. Resident care plan was amended to include additional goals and approaches to prevent further incident of smoking marijuana while waiting for appropriate placement in a therapeutic setting. 2. Records of residents with "substance abuse" care plans were reviewed to determine if care plans in place include goals and approaches to alleviate/prevent incidents of further drug seeking behaviors. 3. IDTeam staff were given inserivce training to review and revise care plans of residents with " substance abuse " to include additional goals and approaches to alleviate/prevent incidents of further drug seeking behaviors. Appropriate care plans with goals and Approaches for Substance Abuse will be evaluated using "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/10/09 3/13/09 3/31/09 4/3/09

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F 280	Continued From page 40 December 8, 2008 at 9:45 PM, " ...Patient was observed smoking marijuana in the room ... " January 3, 2009 at 5:00 AM, " Resident was observed smoking marijuana in his/her bedroom ... " January 7, 2009 at 1:00 AM, " Resident observed smoking marijuana in his/her room ... " A review of the social work notes revealed the followings: March 13, 2008 "...Discharge if he/she violates the smoking policy ... " April 9, 2008 "IDT Invite Note ...[Resident] was caught with a little marijuana piece today, and he/she continues to present behavioral problems ..." May 14, 2008 " Interim Note: Resident was observed with a little piece of marijuana stick and smelled like he/she was smoking marijuana ..." July 2, 2008 "Interim Note: Resident caught smoking marijuana ...the nursing staff recommends that the resident receives talk therapy. Writer will forward this recommendation to the social service supervisor ..." July 11, 2008 "IDT Quarterly Note: ...[Resident] continue to be caught with contraband (cigarettes, matches, marijuana, and stolen nutritional drinks) Consequently there is no change in his behavior ...no plan to discharge the resident at this time..." July 21, 2008 "Interim Note: Resident was reported by security to be smoking marijuana ... " November 3, 2008 "Interim Note:Resident was seen with a bag of marijuana on 11-2-08 ... " November 7, 2008 " Interim Note: Resident was observed smoking marijuana on the patio on 11-5-08, and the resident said, I want to stop smoking marijuana, but I don't want to go to a drug program for help...This social worker will seek appropriate placement within a therapeutic	F 280	**483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans** (continued)	

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F 280	Continued From page 41 setting for this resident ..." November 10, 2008 " Interim Note: resident was observed smoking marijuana ...This SW (Social Worker) is seeking an appropriate therapeutic setting for this resident ..." December 2, 2008 Interim Note: Resident was observed smoking marijuana in bed on 12-2-08 ...This writer is currently seeking an appropriate therapeutic setting for this resident ..." December 11, 2008 " Interim Note: Writer spoke with [representative] from [program] on 12/8/08. Resident ' s name was placed on the waiting list and writer will be contacted in 2 weeks." December 15, 2008 "Interim Note:...Resident was scheduled to go to [program] drug treatment ...on 12-15-08 at 9:00 AM ...however, the resident refused to go..." January 8, 2009 "Interim Note: Late Entry for the date of 12-24-08, Resident allegedly dropped a piece of marijuana stick on the floor in front of the nursing station ..." January 9, 2009 "IDT Quarterly Note: ...[Resident] is on waiting list for [Program] ..." A review of the Interdisciplinary (IDT) Care Plan #9 "Substance abuse" initiated January 18, 2008 lacked evidence that the care plan was reviewed and revised between April 9, and November 3, 2008 with additional goals and approaches to prevent further marijuana use. A face-to-face interview was conducted with Employee #28 on January 16, 2009 at approximately 9:20 AM. He/she acknowledged that additional goals and approaches were not initiated before November 10, 2008. The record was reviewed January 16, 2009.	F 280	**483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans** (continued)	
F 309 SS=G	483.25 QUALITY OF CARE	F 309	**483.25 Quality of Care**	

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F 309	Continued From page 42 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for nine (9) of 30 sampled residents and five (5) supplemental residents, it was determined that facility staff failed to: stop wound care treatments to re-assess the residents for complaints of pain for three (3) residents, follow an order for administration of topical antifungal cream for three (3) residents, follow the physician's order to treat with skin cream for one (1) resident, follow up with a physician's order for a cardiology consult for one (1) resident, administer dilantin as per physician's order for one (1) resident, obtain a physician's order to discontinue a foley catheter for one (1) resident, obtain a physician's order for use of full side rails for one (1) resident, obtain an order for velcro seat belt for one (1) resident, follow a wound care order to fluff gauze for one (1) resident, failed to follow the physician's order for administration of medication for two (2) residents and obtain the physician's order prior to medication administration for three (3) residents. Residents #11, 20, 27, 1, 2, 8, 14, 15, 19, JH1, JH2, JH8, JH 9 and JH10. The findings include: 1. Facility staff failed to stop a wound care	F 309	**483.25 Quality of Care** (continued) 1. A. Resident #11 1. Staff where resident resides were given inservice on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment. 2. Facility staff on all units were given inservice training on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment. 3. Observation of wound treatments will be done by Nursing Supervisors to ensure compliance with the facility's pain management protocols.. Wound care will be evaluated using the "Treatment Observation" tool of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/18/09 1/18/09 3/31/09 4/3/09

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F 309	Continued From page 43 treatment to re-assess residents for complaints of pain. Residents #11, 20 and 27. A. Facility staff failed to stop and re-assess Resident #11 for a complaint of pain during a wound care treatment. A wound care treatment observation was conducted on January 14, 2009 at approximately 11:30 AM for Resident #11 who had left lower lateral leg wound. The resident was pre-medicated on January 14, 2009 with Tylenol 325 mg two (2) tablets at 11:00 AM, as per physician's orders dated December 15, 2008. A review of the resident's clinical record revealed a physician's order signed and dated December 15, 2008 that directed "...Cleanse left lower lateral leg with NS [normal sterile saline]. Apply thin layer of silvadene cream, cover with dry gauze and change daily." Employee #26 introduced self to the resident and explained what he/she intended to do. Resident #11 was positioned on his/her right side, pulled up the pant leg on the left lower leg to expose the wound to be dressed. As Employee #26 cleansed the left lower lateral leg wound, the resident grimaced and said, "That's sore" Employee #26 responded, "I am sorry." Employee #26 continued to wipe the area with 4x4 gauze pads moistened with normal sterile saline, applied Silvadene with 4x4 gauze pads, wrapped the dressing and secured the dressing with a tape. Employee #26 failed to stop the wound care treatment to re-assess the resident's pain. A	F 309	**483.25 Quality of Care** (continued) B. Resident #20 1. Staff where resident resides were given inservice on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment including fluffing the wound treatment gauze per MD order. 2. Facility staff on all units were given inservice training on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment including fluffing the wound treatment gauze per MD order. 3. Observation of wound treatments will be done by Nursing Supervisors to ensure compliance with the facility's pain management protocols including following the physician's wound treatment order. Wound care will be evaluated using the "Treatment Observation" tool of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/18/09 1/18/09 3/31/09 4/3/09

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F 309	Continued From page 44 face-to-face interview was conducted with Employee #26 on January 15, 2009 at approximately 2:45 PM. He/she acknowledged that he/she did not stop the wound care treatment to re-assess the resident's complaint of pain. The record was reviewed on January 15, 2009. B. Facility staff failed to reassess Resident #20 for pain during a wound treatment and failed to follow the physician's order to fluff the wound treatment gauze. A wound treatment observation was conducted on January 14, 2009 at 12:00 PM for Resident #20 who had sacral and ischial wounds. The resident was pre-medicated on January 14, 2009 with Percocet two (2) tablets at 11:00 AM, as per physician's orders dated November 8, 2008. According to the physician's telephone order dated December 22, 2008 and unsigned, "(1) Cleanse left ischium with normal sterile saline (NSS). Pat dry. Pack with fluffy gauze and Santyl ointment. Cover with 4 x 4 (gauze) and Coversite BID and PRN (twice daily and as needed ... (4) Cleanse sacral wound with NSS and pat dry. Pack with fluffy gauze and Santyl ointment. Cover with 4 x 4 (gauze pads) and ABD (abdominal pad) then tape until healed BID and PRN." The resident was positioned on his/her left side, exposing both wounds. The nurse cleaned the left ischial wound. Employee #23 cleansed the interior of the wound twice and the exterior of the wound twice. Each time Employee #23 cleansed the wound, the resident moaned loudly. Employee #23 applied the 4 x 4 gauze pads and	F 309	**483.25 Quality of Care** (continued)	

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F 309	Continued From page 45 Santyl ointment and failed to fluff the gauze to pack the wound as per the physician's order. Employee #23 failed to stop the wound treatment and reassess the resident's pain. After completing the treatment on the left ischial wound, Employee #23 began treatment on the sacral wound. Employee #23 cleansed the interior of the sacral wound twice and the exterior of the wound three times. Each time Employee #23 cleansed the wound, the resident moaned. After cleansing the sacral wound the first time Employee #23 stated to the resident, "I know it hurts. I'm sorry but we are almost done." Employee #23 applied the 4 x 4 gauze pads with Santyl ointment and failed to fluff the gauze to pack the wound as per physician's orders. Employee #23 then applied the Coversite. The resident moaned during the application of the dressing. The wound treatments were completed at 12:30 PM. Employee #23 failed to reassess the resident's pain during the wound treatment. Additionally, the nurse failed to fluff the 4 x 4 gauze pads to pack the wound as per physician's orders. C. Facility staff failed to stop and re-assess Resident #27 for complaint of pain during a wound care treatment. A wound care treatment observation was conducted on January 15, 2009 at approximately 1:15 PM for Resident #27 who had a sacral pressure ulcer. The resident was pre-medicated on January 15, 2009 with one (1) tablet of Tylenol #3 at 12:30	F 309	**483.25 Quality of Care** (continued) C. Resident #27 1. Staff where resident resides was given inservice on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment. 2. Facility staff on all units were given Inservice training on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment. 3. Observations of wound treatments Will be done by Nursing Supervisors To ensure compliance with the facility's pain management protocols. Wound Care will be evaluated using the "Treatment Observation" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/18/09 1/18/09 3/31/09 4/3/09

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F 309	Continued From page 46 AM, as per an unsigned physician ' s telephone orders of December 16, 2008. A review of the resident's clinical record dated December 16, 2008, revealed an unsigned physician's telephone order that directed "...Cleanse sacral area Stage III with NSS, pat dry, apply Santyl, pack with fluffy gauze daily, cover with 4 x 4, tape till healed ... " The resident was positioned on his/her left side, soiled with contents of the resident's ostomy bag, exposing the sacral pressure ulcer. Employee # 27 cleansed the sacral ulcer. As the Employee #27 cleansed the ulcer, the resident moaned and grimaced. Employee #27 continued with the wound care treatment. Employee #27 applied Santyl on fluffy 4 x 4 gauze pads, packed the wound and secured the dressing with pre-labeled tape. Employee #27 failed to stop the wound treatment to re-assess the resident's complaint of pain. 2. Facility staff failed to follow-up with and clarify the podiatrist's plan of care for use of over the counter (OTC) topical anti-fungal medication for Residents # 1 and 11. A. Facility staff failed to clarify an order for an anti-fungal medication for Resident #1. Resident #1 was seen by the podiatrist on November 25, 2008. The podiatrist's plan of care included the following: "All mycotic nails were debrided ...The patient is not a candidate for oral antifungal. OTC topical may be used. Tinactin anti-fungal medication was recommended." Use of a topical antifungal was included in the podiatrist's plan of care for Resident #1 on June	F 309	**483.25 Quality of Care** (continued) 2. A. Resident #1 1. Podiatrist order for antifungal medication was clarified . PMD notified. 3/6/09 2. Medical records of all residents seen by the podiatrist with an order for an anti-fungal medication were reviewed to ensure that the order was clarified if necessary. 3/13/09 3. Routine review of medical records of residents seen by the podiatrist will be reviewed if orders for antifungal medication and other orders were clarified whenever necessary. Clinical Mangers will report the results of this review and data collection to the Director of Nurses. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 4/3/09	

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F 309	Continued From page 47 30, 2008. There was no evidence in the record that facility staff clarified the podiatrist's recommendation for the use of anti-fungal medication with the resident's primary physician. A review of the resident's Medication Administration Record (MAR) for July 2008 through January 2009 lacked evidence that the resident was administered any topical antifungal medication for the feet. A face-to-face interview was conducted with Employee #6 on January 16, 2009, at approximately 11:30 AM. He/she acknowledged that facility staff failed to follow-up with and clarify the podiatrist's plan of care for the use of topical antifungal medication on the resident's feet. The record was reviewed January 16, 2009. B. Resident #11 was seen by the podiatrist on April 15, June 17, August 26, and November 11, 2008. The Podiatrist's plan of care included the following: "...All mycotic nails were debrided today ...Topical antifungals may be used as needed." There was no evidence in the record that facility staff clarified the podiatrist's recommendation for the use of anti-fungal medication with the resident's primary physician. A review of the resident's MAR for July 2008 through January 2009 lacked evidence that the resident was administered any topical antifungal medication. A face-to-face interview was conducted with	F 309	**483.25 Quality of Care** (continued) B. Resident #11 1. Podiatrist order for antifungal medication was clarified . PMD notified. 3/6/09 2. Medical records of all residents seen by the podiatrist with an order for an anti-fungal medication were reviewed to ensure that the order was clarified if necessary. 3/13/09 3. Routine review of medical records of residents seen by the podiatrist will be reviewed if orders for antifungal medication and other orders were clarified whenever necessary. Clinical Managers will report the results of this review and data collection to the Director of Nurses. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 4/3/09	

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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 309	Continued From page 48 Employee #8 on January 16, 2009, at approximately 11:30 AM. He/she acknowledged that facility staff failed to follow-up with and clarify the podiatrist's plan of care for the use of topical antifungal medication on the resident's feet. The record was reviewed January 16, 2009. 3. Facility staff failed to follow the physician's order to apply Kenalog Cream to Resident # 2's chest in a timely manner. A review of Resident # 2's clinical record revealed a telephone order dated January 12, 2009 which stated, "Kenalog Cream to incision site on chest tid [three times a day] for two (2) weeks for itching." Daily review of the MAR on January 12, 13 and 14, 2009, revealed that the medication was not administered. According to the January 2009 MAR, the medication was administered on January 15, 2009. A face-to-face interview was conducted with Employee #9 at approximately 3:00 PM on January 14, 2009. He/she stated, "I did not know [he/she] was not getting the cream. I will check on it." The record was reviewed on January 12, 2009. 4. Facility staff failed to follow up with a physician's order for a cardiology consult for Resident # 8. A review of the resident's clinical record revealed an "Interim Order Form" dated and signed November 27, 2008 that directed "Cardiology consult: confirm need of anticoagulation." A review of the resident's record lacked evidence that facility staff followed up with the physician's order for a cardiologist consult.	F 309	**483.25 Quality of Care** (continued) 3. Resident #2 1. Incident report completed. Pharmacy was notified. Discovered that the Kenalog Cream was placed in the treatment cart instead of the Medication cart. 2. MARs were audited to review that meds ordered were administered in a timely manner for all residents. 3. Facility staff were given an inservice training on Medication Administration placing special emphasis on calling pharmacy for meds. Telephone Orders will be evaluated using the "Telephone/Verbal Orders" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/15/09 3/31/09 3/31/09 4/3/09

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	095022	A. BUILDING _____ B. WING _____	01/16/2009

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F 309	Continued From page 49 A face-to-face interview was conducted with Employee #12 on January 16, 2009 at approximately 11:00 AM. He/she acknowledged that Resident #8's clinical record lacked evidence that facility staff followed up with the physician's order for a cardiologist consult. The record was reviewed January 16, 2009. 5. Facility staff failed to obtain a physician's order to discontinue Resident #14's foley catheter. According to an admission Minimum Data Set (MDS) completed September 22, 2008 Resident # 14 was admitted to the facility on September 17, 2008. Section H3 "Continence/Appliances and Program " coded the resident as having an indwelling catheter. A review of the resident's clinical record revealed a "Admission Order Sheet and Physician Plan of Care sheet " that "Foley Catheter ...16FR [French], until seen by MD [Medical Doctor] ... " routine care ...change cath. [Catheter] Q. month ... " The following order, on the October 2008 MAR, "Foley cath. [Catheter] care Q.S. [Every Shift] and Foley cath Fr. 16 change Q month" was discontinued on October 8, 2008. A review of the resident ' s clinical record lacked evidence that facility staff obtained a physician ' s order to discontinue the foley. A face-to-face interview was conducted with Employee #9 on January 15, 2009 at approximately 12:45 PM. He/she acknowledged that the resident's clinical record lacked evidence of that facility staff obtained a physician's order to	F 309	**483.25 Quality of Care** (continued) 5. Resident #14 1. MD notified and order carried out. 2. Medical records of all residents with discontinued foley catheters were audited to ensure the presence of a physician's order prior to discontinuing the catheter. 3. Facility staff were given an inservice on the facility protocol for Insertion and removal of a foley catheter. Discontinued catheter orders will be evaluated using the "urethral Catheter" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/16/09 3/31/09 3/31/09 4/3/09

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F 309	Continued From page 50 discontinue Resident #14's foley catheter. The record was reviewed January 15, 2009. 6. Facility staff failed to administered Dilantin as per the physician's order. Resident #11. A physician's order dated November 20, 2008 and signed by the physician on December 13, 2008, directed, "Phenytoin ...100mg ...Dilantin ...2 capsules (200mg) by mouth twice daily for seizures." A review of the resident's MAR for the month of August 2008 lacked evidence that the resident was administered Dilantin at 8:00 PM on August 26 and 29, 2008 as evidenced by absence of initials for Dilantin during the aforementioned dates indicating Dilantin was not administered. The resident's clinical record lacked documentation as to why Dilantin was not administered. There was no evidence in the record that the resident experienced untoward effects from the omitted Dilantin doses. A face-to-face interview was conducted with Employee #8 on January 14, 2009 at approximately 11:30 AM. He/She acknowledged that the resident's MAR lacked evidence that facility staff administered Resident #11 Dilantin as per the physician 's order. The record was reviewed January 14, 2009. 7. Facility staff failed to obtain a physician's order for the use of full side rails for Resident #15. On January 12, 2009 at approximately 4:00 PM, January 13 at 12:30 PM and 4:10 PM on January 14, 2009, Resident #15 was observed lying in bed with full side rails up. In a face-to-face interview with the resident on	F 309	**483.25 Quality of Care** (continued) 6. Resident #11 1. Involved nursing staff was counseled for not administering/not documenting Dilantin 100 mg (2capsules 200mg) by mouth twice daily for seizures. PMD was notified of the lack of evidence that the Dilantin was administered. 2. MARs were audited for similar over-sight of documentation. Non-compliance with the facility's policy for MAR documentation will result in the employee being subjected to the facility's disciplinary process. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 7. Resident #15 1. Physician's order obtained for use of full side rails for resident. 2. Medical records of all residents using full side rails were reviewed to ensure the presence of a physician's order. 3. Inservice training was given to facility staff on the facility protocol for use of full side rails	3/6/09 3/31/09 3/31/09 4/3/09 1/16/09 1/16/09 3/13/09

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F 309	Continued From page 51 January 13, 2009 at approximately 12:30 PM he/she was asked why the side rails were up and he/she responded, "They keep me from falling out of the bed." The resident was then asked whether he/she could release the side rails. The resident responded, "No."' A review of the clinical record revealed that there was no physician's order for the use of full side rails for Resident # 15. A face-to-face interview was conducted with Employee #6 at approximately 4:00 PM on January 14, 2009. He/she acknowledged that there was no order for the use of full side rails for Resident #15. The employee added, "I will call the physician for an order for the use of the side rails." The record was reviewed on January 13, 2009. 8. Facility staff failed to follow physician's orders to use a Velcro seat belt for Resident #19. A review of Resident #19's record revealed a telephone order dated December 18, 2008 at 4:00 PM, signed by the physician on the same date that directed, "Obtain consent for seat belt (self release) from guardian. Resident to have self release seat belt on while sitting up in w/c (wheelchair)." "Consent for the Use of a Physical Restraint" for a seat belt (Velcro) was signed by the responsible party on December 22, 2008. Care plan #7, "Restraint device ..." was updated on December 22, 2008 when the Velcro seat belt was applied to Resident #19. An observation of Resident #19 was conducted in the presence of Employee #13 on January 15, 2009 at 2:15 PM. Resident #19 was observed	F 309	**483.25 Quality of Care** (continued) 7. Resident #15 (continued) Restraint documentation will be evaluated using the "Physical Restraint" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 8. Resident #19 1. The clamp style seat belt was discontinued, and replaced with the Velcro seat belt per physician's order. RP was notified and consent obtained. 2. Medical records of all residents using a clamp style seat belt were audited to ensure a corresponding physician order. Changes were made whenever necessary. 3. Inservice was given to facility staff re' the difference between a Velcro self release seat belt that a resident can self release and a clamp style seat belt that a resident is unable to self release(Physical Restraint) Restraint documentation will be evaluated using the "Physical Restraint" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	3/31/09 4/3/09 1/15/09 3/13/09 3/13/09 3/31/09 4/3/09

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F 309	Continued From page 52 with a clamp type seat belt and was unable to open the belt when asked. Employee #13 acknowledged that the resident was wearing a clamp type seat belt and was unable to open the belt. The record was reviewed January 15, 2009. 9. Facility staff failed to follow the physician's order for administration of medication for Residents JH1 and JH2. A. Facility staff failed to administer medication as per physician's orders to Resident JH1. On January 13, 2009, at approximately 11:40 AM , during the medication pass, Employee #22 administered Multivitamin, Plavix 75mg, Glipizide 2.5mg, Ranitidine 150mg, Amlodipine 5mg, Geodon 80mg and Divalproex EC 500mg to Resident JH1. After reconciling the Physicians Orders Sheet (POS) signed and dated on January 10, 2009 with the Medication Administration Record (MAR) for January 2009, it was discovered that Simvastin 20 mg was omitted during the medication pass. A face-to-face interview was conducted on January 16, 2009, at approximately 1:05 PM, Employee #22 stated, "I gave the medication during the medication pass that morning." the medication was not observed as being administered during the morning medication pass. B. Facility staff failed to administer medication as per physician's orders to Resident JH2. On January 13, 2009, at approximately 9:50 AM, during the medication pass, Employee 40# administered Multivitamin, Amlodipine 10mg, Isoniazid 300mg, ASA 325 mg, Vitamin B-6 50	F 309	**483.25 Quality of Care** (continued) 9. A. Resident JH! 1. The involved staff member was counseled with inservice given. 2. Subsequent observations have been done on all nurses to ensure their ability to pass medications as ordered. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. B. Resident JH2 1. The involved staff member was counseled with inservice given. 2. Subsequent observations have been done on all nurses to ensure their ability to pass medications as ordered. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/16/09 3/31/09 3/31/09 4/3/09 1/16/09 3/31/09 3/31/09 4/3/09

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F 309	Continued From page 53 mg, Lisinopril 20 mg, and Haloperidol 1 mg to Resident JH2. After reconciling the Physicians Orders Sheet (POS) signed and dated on December 18 2008 and an Interim order signed and dated December 16, 2008 with the Medication Administration Record (MAR) for January 2009, it was discovered that Alphagan 0.15% ophthalmic drops, Cospt ophthalmic drops, Cardiazem ER180mg and Ranitidine 150 mg tablets were omitted during the medication pass. A face-to-face interview was conducted on January 16, 2009, at approximately 1:15 PM, Employee #40 stated, "I am not familiar with this floor. I looked and asked someone to help me find it. I administered the all medication before 12:00 PM." 10. Facility staff failed to obtain the physician's order prior to medication administration. Residents JH8, JH9, and JH10. A. Facility staff failed to obtain the physician's order prior to medication administration for Resident JH8. Review of the physician ' s order for Resident JH8, signed and dated June 23, 2008, directed, " D/C [Discontinue] Percocet ii [two] tabs 5/325 mg q [every] Monday before tx [treatment] and qd [daily] before tx [treatment]. " 30 tablets were dispensed. On January 15, 2009, at approximately 12:00 PM during the inspection of the medication carts for 1 South, a blister package containing 10 tables of Oxycodone/APAP 5/325mg (Percocet) tablets	F 309	**483.25 Quality of Care** (continued) 10. A. Resident JH8 1. Employee involved was counseled and received education regarding the facility's Pharmacy policies and procedures. 2. MARs and Controlled Substance sign-Out sheets for all residents were reviewed to ensure compliance. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/31/09 1/31/09 3/31/09 4/3/09

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F 309	Continued From page 54 were observed stored in the medication cart. A review of the Controlled Drug Record documented that medication was removed on July 7, 8, 19 and 20, 2008 and August 24, 2008. This medication was dispensed after the physician had discontinued the order. Oxycodone/APAP 5/325mg was not transcribed onto the MAR for July and August 2008 because it was discontinued. There was no evidence that the resident received the medication on the above cited days. A face-to-face interview was conducted on January 15, 2009 at approximately 12:15 PM with Employee #53. He/ she acknowledged the above stated findings. B1. Facility staff failed to obtain the physician's order prior to medication administration for JH9 A review of the physician ' s order signed for Resident JH9 and dated July 11, 2008, directed , " Tylenol #3, two tabs stat, *i* [one] q4h [every 4 hours] prn [as needed] pain for five days for dental extraction " 30 tablets were dispensed. On January 16, 2009, at approximately 10:00 AM during the inspection of the medication carts for 2 South, a blister package containing 22 tablets of APAP/Codeine 300 mg/ 15mg (Tylenol #3) tablets were observed stored in the medication cart. A review of the Controlled Drug Record documented that tablets of Oxycodone/APAP 5/325mg was removed on September 16, October 11 and 16, and November 13, 2008, for a total of eight (8) tablets removed after the	F 309	**483.25 Quality of Care** (continued) B1. Resident JH9 1. Employee involved was counseled and received education regarding the facility's Pharmacy policies and procedures. 2. MARs and Controlled Substance sign-Out sheets for all residents were reviewed to ensure compliance. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/31/09 1/31/09 3/31/09 4/3/09

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F 309	Continued From page 55 medication was discontinued. There was no evidence on the September, October and November 2008 MAR that the medication was administered to the resident. A face-to-face interview was conducted on January 15, 2009 at approximately 12:15 PM with Employees #8 and 54. They acknowledged the above stated findings. B2. Facility staff failed to obtain the physician's order prior to medication administration for JH9. A physician's order dated April 15, 2008 directed, "APAP W/codeine #3 (Tylenol #3) two (2) tablets po every 6 hours as needed for pain" for JH9. 30 tablets were dispensed. The physician did not renew the above cited order when orders were signed on August 21, September 22, and November 24, 2008. According to the Controlled Drug Record Tylenol #3, two (2) tablets were removed on August 24, September 1 (twice), October 17, October 22, November 22, November 24 and November 28, 2008. There was no evidence on the August, September, October and November 2008 MARs that the resident received the medication. A face-to-face interview was conducted on January 15, 2009 at approximately 12:15 PM with Employees #8 and 54. They acknowledged the above stated findings. C. Facility staff failed to obtain the physician's	F 309	**483.25 Quality of Care** (continued) B2. Resident JH9 1. Employee involved was counseled and received education regarding the facility's Pharmacy policies and procedures. 2. MARs and Controlled Substance sign-Out sheets for all residents were reviewed to ensure compliance. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. C. Resident JH10 1. Employee involved was counseled and received education regarding the facility's Pharmacy policies and procedures. 2. MARs and Controlled Substance sign-Out sheets for all residents were reviewed to ensure compliance.	1/31/09 1/31/09 3/31/09 4/3/09 1/31/09 1/31/09

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F 309	Continued From page 56 order prior to medication administration for JH10. Review of the physician ' s order for Resident JH10, signed and dated October 2, 2008, directed, " Tylenol #3 q6h [every 6 hours] prn [as needed] pain for 4 (four) days, dental extractions. " 16 tablets were dispensed. On January 14, 2009, at approximately 3: 30 PM during the inspection of the medication carts on the 3 North unit, a blister package containing seven (7) APAP/Codeine 300 mg/ 15mg (Tylenol #3) tablets was observed stored in the medication cart. According to the Controlled Drug Record, one (1) tablet was removed on October 7 and one (1) tablet was removed on October 8, 2008, after the mediation was discontinued by the physician. There was no evidence on the MAR for October 2008 that the medication was administered to the resident, as evidenced by no initials were recorded in the allotted area. A face-to-face interview was conducted on January 15, 2009 at approximately 3: 45 PM with Employee #52. He/ she acknowledged the above stated findings.	F 309	**483.25 Quality of Care** (continued) C. Resident JH10 (continued) 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	3/31/09 4/3/09
F 311 SS=E	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record	F 311	**483.25(a)(2) Activities of Daily Living**	

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F 311	Continued From page 57 review for 13 of 30 sampled residents and four (4) supplemental residents, it was determined that facility staff failed to: provide assistance with grooming for seven (7) residents and attempt to restore bladder function or initiate an incontinence management program for 11 residents. Residents # 1, 3, 5, 7, 10, 13, 14, 18, 19, 20, 23, 24, 27, F1, S5, S6 and S7. The findings include: 1. Facility staff failed to complete Resident #1's bladder continence assessment. A review of the resident ' s clinical record revealed a quarterly Minimum Data Set (MDS), completed November 11, 2008, that coded the resident in ' Section H1-Continence ' as occasionally bladder incontinent. An " Interdisciplinary Care-plan" dated December 12, 2008 revealed "incontinence" . [indicating that the resident was determined to be incontinent]. Upon further review, the record lacked evidence that additional assessments and/or screens were completed to further assess the resident's bladder status per the facility's policy. A face-to-face interview was conducted with Employee #6, on January 16, 2009 at approximately 11:30 AM. He/she acknowledged that there were no additional assessments completed to determine the Resident's #1 incontinent status. He/she added that the current assessment tool was not in use at the time of the resident ' s admission. The record was reviewed on January 12, 2009.	F 311	**483.25(a)(2) Activities of Daily Living** 1. Resident #1 1. Bladder continence assessment was done upon discovery. 2. Clinical records of all residents were reviewed for documentation of a bladder continence assessment. Corrections were made whenever necessary. 3. Facility staff were given inservice training on the facility protocol on Continence Assessment. Continence assessment and documentation will be evaluated using the "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/16/09 3/31/09 3/31/09 3/31/09 4/3/09

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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 311	Continued From page 58 2. Facility staff failed to complete Resident #3's bladder continence assessment. The "Resident Admission Evaluation Form" dated August 20, 2008 revealed that bladder incontinence was checked "yes" [indicating that the resident was determined to be incontinent]. The record revealed an admission MDS, completed August 8, 2008, included an assessment of the resident having bladder incontinence [Section H-Continence]. The " Nursing Care-Plan " evaluated November 11, 2008 revealed " Care for urinary incontinence " . [indicating that the resident was determined to be incontinent]. Upon further review, the record lacked evidence that additional assessments and/or screens were completed to further assess the resident's bladder status per the facility's policy. A face-to-face interview was conducted with Employee #5, on January 12, 2009 at 11:00 AM. He/she acknowledged that there were no additional assessments completed to determine the Resident #3's incontinent status. The record was reviewed on January 12, 2009. 3. Facility staff failed to initiate an incontinence management program for Resident #5. A review of Resident #5 ' s record revealed a "Resident Admission Evaluation Form" completed July 2, 2008. Under the section " Bowel and Bladder Assessment and Management " the resident was scored as " 6. " The legend on the form documented, " 0-6 Poor	F 311	**483.25(a)(2) Activities of Daily Living** 2. Resident #3 1. Bladder continence assessment was done upon discovery. 2. Clinical records of all residents were reviewed for documentation of a bladder continence assessment. Corrections were made whenever necessary. 3. Facility staff were given inservice training on the facility protocol on Continence Assessment. Continence assessment and documentation will be evaluated using the "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 3. Resident #5 1. An incontinence management program was developed. 2. Medical records of all residents identified to have bowel and bladder incontinence were reviewed for the presence of an incontinence management program 3. Facility staff were given an inservice training on the facility policy on how to develop an incontinence management program. Continence assessment and documentation will be evaluated using the "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation.	1/16/09 3/31/09 3/31/09 3/31/09 4/3/09 3/6/09 3/13/09 3/31/09

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	095022	A. BUILDING _____ B. WING _____	01/16/2009

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F 311	Continued From page 59 candidate for toileting programs/likely candidate for incontinence management program. " A care plan for " Incontinence of urine and stool " was initiated December 24, 2008. There was no evidence that an individualized incontinence management program was initiated. A face-to-face interview was conducted on January 12, 2009 at 3:45 PM with Employee #5, who acknowledged that no individualized incontinence management program was initiated for Resident #5. The record was reviewed January 12, 2009. 4. Facility staff failed to assist Resident #7 with cleaning and trimming fingernails and develop a toileting program. A. An observation of Resident #7 was conducted on January 13, 2009 at 9:00 AM. The resident ' s fingernails were long with accumulated debris under the nails. According to the Quarterly MDS assessment completed on December 2, 2008, the resident was coded in Section G as requiring extensive assistance for personal hygiene. B. Facility staff failed to develop a toileting program for Resident #7. A review of Resident #7 ' s record revealed a " Resident Admission Evaluation Form " completed December 11, 2007. There was no evidence that additional bowel and bladder assessment were completed after December 11, 2007. Under the section " Bowel and Bladder Assessment and Management " the resident was	F 311	**483.25(a)(2) Activities of Daily Living** 3. Resident #5 (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 4. Resident #7 A. 1. Facility staff cleaned and trimmed the resident's fingernails. 2. Facility residents identified to need extensive assistance for personal hygiene were inspected and needed assistance (i.e. cleaning and trimming fingernails) provided. 3. Inservice training was provided to facility staff responsible for providing assistance to residents requiring extensive assistance for personal hygiene. Fingemail cleanliness will be evaluated using the "Nursing Care Review" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator B. Resident #7 1. A prompted toileting/habit training program was developed for the resident. 2. Medical records of any resident who scored 7-14 from the bowel and bladder assessment were reviewed for documentation of prompted toileting/habit training.	4/3/09 1/13/09 1/13/09 3/13/09 3/31/09 4/3/09 3/6/09

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F 311	Continued From page 60 scored as " 10. " The legend on the form documented, " 7-14 Candidate for prompted toileting/habit training. " There was no evidence that a prompted toileting/habit training program was initiated for Resident #7. A face-to-face interview was conducted with Employee #6 on January 13, 2009 at 2:25 PM. He/she acknowledged that the resident's fingernails needed to be cleaned and trimmed and that a prompted toileting/habit training program was not initiated for Resident #7. The record was reviewed January 13, 2009. 5. Facility staff failed to assist Resident #10 with cleaning and trimming fingernails and develop a toileting program. A. An observation of Resident #10 was conducted on January 14, 2009 at 8:50 AM. The resident ' s fingernails were long with accumulated debris under the nails. According to the Quarterly MDS assessment completed on November 11, 2008, the resident was coded in Section G as being totally dependent for personal hygiene. B. Facility staff failed to develop an incontinence management program for Resident #10. A review of Resident #10 ' s record revealed a " Resident Admission Evaluation Form " completed	F 311	**483.25(a)(2) Activities of Daily Living** (continued) 3. Facility staff were given inservice training of the facility Incontinence Management Program. Toileting status will be evaluated using the "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 5. Resident #10 A. . Facility staff cleaned and trimmed the resident's fingernails. 2. Facility residents identified to need extensive assistance for personal hygiene were inspected and needed assistance (i.e. cleaning and trimming fingernails) provided. 3. Inservice training was provided to facility staff responsible for providing assistance to residents requiring extensive assistance for personal hygiene. Fingernail cleanliness will be evaluated using the "Nursing Care Review" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	3/13/09 3/31/09 4/3/09 1/13/09 1/13/09 3/31/09 3/31/09 4/3/09

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F 311	Continued From page 61 Assessment and Management " the resident was scored as " 2. " The legend on the form documented, " 0-6 Poor candidate for toileting programs/likely candidate for incontinence management program. " There was no evidence that an incontinence management program was initiated for Resident #10. A face-to-face interview was conducted with Employee #12 on January 14, 2009 at 3:30 PM. He/she acknowledged that the resident's fingernails required cleaning and trimming and that an incontinence management program was not initiated for Resident #7. The record was reviewed January 13, 2009. 6. Facility staff failed to assist Resident #13 with cleaning and trimming fingernails and develop a toileting program. A. An observation of Resident #13 was conducted on January 13, 2009 at 2:30 PM. The resident ' s fingernails were long with accumulated debris under the nails. According to the quarterly MDS assessment completed on October 16, 2008, the resident was coded in Section G as requiring extensive assistance for personal hygiene. B. Facility staff failed to develop a toileting program for Resident #13. A review of Resident #13 ' s record revealed a " Resident Admission Evaluation Form " completed March 13, 2008. Under the section " Bowel and Bladder Assessment and	F 311	B. 1.An Incontinence Management Program was developed for this resident. 2. Medical records of residents who scored 0-6 from the bowel and bladder assessment were reviewed for initiation of an incontinence management program.. 3.Toileting status will be evaluated using the "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 6. Resident #13 A. 1. Facility staff cleaned and trimmed Fingernails of this resident. 2. Facility residents identified as being totally dependent for personal hygiene were assessed and needs attended to. 3. Inservice training was provided to facility staff responsible for providing personal hygiene care for residents identified as being totally dependent for personal hygiene. Fingernail cleanliness will be evaluated using the "Nursing Care Review" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	1/31/09 1/31/09 3/31/09 4/3/09 1/13/09 1/13/09 3/13/09 3/31/09 4/3/09

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F 311	Continued From page 62 Management " the resident was scored as " 16. " The legend on the form documented, " 15-20 Possible candidate for retraining or individualized training. " There was no evidence that a retraining or individualize toilet training program was initiated for Resident #13. A face-to-face interview was conducted with Employee #5 on January 13, 2009 at 11:00 AM. He/she acknowledged that the resident's fingernails needed cleaning and trimming and that a retraining or individualized training program was not initiated for Resident #13. The record was reviewed January 13, 2009. 7. Facility staff failed to initiate a toileting program for Resident #14. A review of Resident #14 ' s record revealed a "Resident Admission Evaluation Form" completed September 17, 2008. Under section " Bowel and Bladder Evaluation " resident had an indwelling catheter. According to the October 2008 Medication Administration Record (MAR), the resident ' s indwelling catheter was discontinued on October 8, 2008. The resident was observed during physical therapy on January 15, 2009 at approximately 10:00 AM. He/she stated that that his/her goal was to return home soon and that he/she was glad the catheter was out. The resident stated that he/she calls for help when there was a need to urinate.	F 311	**483.25(a)(2) Activities of Daily Living** (continued) 6. Resident #13 B. 1. An Incontinence Management Program was developed for this resident. 2. Medical records of residents who scored 16 from the bowel and bladder assessment were reviewed for initiation of a retraining or individualized training program. 3.Toileting status will be evaluated using the "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	1/31/09 3/13/09 3/31/09 4/3/09

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F 311	Continued From page 63 A review of the resident ' s clinical record revealed a quarterly MDS, completed December 18, 2008 that coded the resident in ' Section H1-Continence ' as bladder incontinent. A review of a care plan for "Incontinence Bowel and Bladder" dated December 18, 2008, lacked evidence that a toileting program was develop for Resident #7. A face-to-face interview was conducted on January 15, 2009 at approximately 12:30 PM with Employee #9. He/she acknowledged that the resident ' s clinical record lacked evidence that an individualized toileting program was initiated for the resident after the resident ' s foley catheter was discontinued. The record was reviewed January 16, 2009. 8. Facility staff failed to complete Resident #18's bladder continence assessment. A review of Resident #18's record on January 13, 2009 at 10:00 AM revealed that the "Resident Admission Evaluation Form " was not in the resident's record. There was no evidence that additional bowel and bladder assessment were completed. The " Nursing Care-plan " evaluated January 10, 2008 revealed care for " Alteration in elimination: incontinence of urine and stool " . [indicating that the resident was determined to be incontinent]. The record revealed a quarterly MDS, completed December 18, 2008, included an assessment of the resident having bladder incontinence [Section H-Continence].	F 311	**483.25(a)(2) Activities of Daily Living** Resident #18 1. Bladder continence assessment was Completed. 1/16/09 2. Clinical records of all residents on the unit were reviewed for documentation of a completed bladder continence assessment. 3/6/09 3.Toileting status will be evaluated using the "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 4/3/09	

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F 311	Continued From page 64 Upon further review, the record lacked evidence that additional assessments and/or screens were completed to further assess the resident's bladder per the facility's policy. A face-to-face interview was conducted with Employee #8, on January 13, 2009 at 11:05 AM. He/she acknowledged that there were no additional assessments completed to determine the Resident #18's incontinent status. The record was reviewed on January 13, 2009. 9. Facility staff failed to initiate a toileting program for Resident #19. A review of Resident #19 ' s record revealed a " Resident Admission Evaluation Form " completed November 4, 2008. Under the section " Bowel and Bladder Assessment and Management " the resident was scored as " 8. " The legend on the form documented, " 7-14 Candidate for prompted toileting/habit training. " A care plan for " Alteration in Elimination function secondary to incontinence of both urine and stool " was reviewed by the Interdisciplinary care team on October 15, 2008. Under approaches, " Toilet resident before and after mealtime, before bedtime and upon waking up. " There was no evidence that this approach was based on an assessment of the resident's voiding pattern and evaluated for the resident ' s individual needs. The admission MDS assessment completed October 22, 2008, coded the resident in Section G (Physical Functioning and Structural Problems) as totally dependent for toileting and in Section H (Continence) as incontinent of bowel and bladder.	F 311	**483.25(a)(2) Activities of Daily Living** 9. Resident #9 1.An Incontinence Management Program was developed. 2. The medical records residents on the same unit were reviewed to ensure compliance. 3.Toileting status will be evaluated using the "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	3/6/09 3/31/09 3/31/09 4/3/09

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F 311	Continued From page 65 A face-to-face interview was conducted on January 15, 2009 at 2:15 PM with Employee #5, who acknowledged that an individualized toileting program was not initiated for Resident #19. The record was reviewed January 12, 2009. 10. Facility staff failed to assist Resident #20 with cleaning and trimming fingernails and develop an incontinence management program. A. An observation of Resident #20 was conducted on January 14, 2009 at 12:00 PM. The resident ' s fingernails were long with accumulated debris under the nails. According to the significant change MDS assessment completed on December 29, 2008, the resident was coded in Section G as being totally dependent for personal hygiene. B. Facility staff failed to develop an incontinence management program for Resident #20. A review of Resident #20 ' s record revealed a " Resident Admission Evaluation Form " completed December 19, 2008. Under the section " Bowel and Bladder Assessment and Management " the resident was scored as " 3. " The legend on the form documented, " 0-6 Poor candidate for toileting programs/likely candidate for incontinence management program. " There was no evidence that an incontinence management program was initiated for Resident #20. A face-to-face interview was conducted with Employee #12 on January 15, 2009 at 9:45 AM. He/she acknowledged that the resident's	F 311	**483.25(a)(2) Activities of Daily Living** 10. Resident #20 A. 1. Facility staff cleaned and trimmed Fingernails of this resident. 2. Facility residents identified as being totally dependent for personal hygiene were assessed and needs attended to. 3. Inservice training was provided to facility staff responsible for providing personal hygiene care for residents identified as being totally dependent for personal hygiene. Fingernail cleanliness will be evaluated using the "Nursing Care Review" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator B. 1.An Incontinence Management Program was developed. 2. Medical records of residents on the same unit were reviewed to ensure compliance. 3.Toileting status will be evaluated using the "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	1/13/09 1/13/09 3/13/09 3/31/09 4/3/09 3/6/09 3/31/09 3/31/09 4/3/09

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F 311	Continued From page 66 fingernails needed cleaning and trimming and that an incontinence management program was not initiated for Resident #20. The record was reviewed January 15, 2009. 11 Facility staff failed to complete Resident #23's bladder continence assessment. A review of Resident #23 ' s medical record on January 14, 2008 at 10:00 AM revealed that a " Resident Admission Evaluation Form " was not completed. There was no evidence that additional bowel and bladder assessment were completed after November 30, 2008. The record revealed a significant change in status MDS, completed October 3, 2008, included an assessment of the resident having bladder incontinence [Section H-Continence]. The " Nursing Care Plan " evaluated January 14, 2009 revealed care for " Incontinence of urine " . [indicating that the resident was determined to be incontinent]. The " Nursing Monthly Summary Note " dated November 30, 2008 documented that the resident was sometimes incontinent of bowel and bladder. The " Nursing Monthly Summary Note " dated December 22, 2008 documented that resident was incontinent of bowel and bladder. Upon further review, the record lacked evidence that additional assessments and/or screens were completed to further assess the resident's bladder. A face-to-face interview was conducted with Employee #5 on January 14, 2009 at 10:30 AM.	F 311	**483.25(a)(2) Activities of Daily Living** 11. Resident #23 1.An Incontinence Management Program was developed. 2. Medical records of residents on the same unit were reviewed to ensure compliance. 3.Toileting status will be evaluated using The "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	3/6/09 3/31/09 3/31/09 4/3/09

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F 311	Continued From page 67 He/she acknowledged that there were no additional assessments completed to determine the Resident #23's incontinent status. The record was reviewed January 14, 2009. 12. Facility staff failed to initiate an individualized toileting program for Resident # 24 or to indicate in the care plan/progress note that the resident could not be trained. Review of an annual MDS dated April 16, 2008, quarterly MDS assessments dated July 5 and October 13, 2008 coded the resident as being incontinent of bowel and bladder function under Section H (Continence). A review of the Incontinent Care Plan dated January 10, 2009 revealed the following documentation under approaches: " Briefs to manage incontinence; Good skin care; Check for wetness/BM [Bowel Movement] q 2 hrs and prn [every two hours and as needed]; Use skin barrier after every incontinent episode. " A face-to-face interview was conducted with Employee # 8 on January 16 at approximately 11:00 AM. He/she acknowledged that an individualized toilet training program was not initiated for this resident. The record was reviewed on January 16, 2008. 13. Facility staff failed to initiate toileting program for Resident #27. A review of Resident #27 ' s record revealed a "Bowel and Bladder Assessment and Management" completed September 11, 2008. The resident was scored as "11" The legend on the form documented, " 7-14 candidate for prompt toileting programs/habit training " A further review of the resident ' s clinical record	F 311	**483.25(a)(2) Activities of Daily Living** 12. Resident #24 1.An Incontinence Management Program was developed. 2. Medical records of residents on the same unit were reviewed to ensure compliance. 3.Toileting status will be evaluated using The "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 13. Resident #27 1.An Incontinence Management Program was developed 2. Medical records of residents on the same unit were reviewed to ensure compliance. 3.Toileting status will be evaluated using The "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	3/6/09 3/31/09 3/31/09 4/3/09 3/6/09 3/31/09 3/31/09 4/3/09

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F 311	Continued From page 68 revealed a quarterly MDS, completed December 18, 2008 that coded the resident in ' Section H1-Continence ' as bladder incontinent. A care plan for "Incontinence" dated December 24, 2008 lacked evidence that a prompted toileting/habit training program was initiated for Resident #27. A face-to-face interview was conducted on January 15, 2009 at 12:30 PM with Employee #9. He/she acknowledged that the resident ' s clinical record lacked evidence that an individualized toileting program was initiated for Resident #27. The record was reviewed January 16, 2009. 14. Facility staff failed to initiate toileting program for Resident F1. A review of Resident F1' s record revealed a "Resident Admission Evaluation Form" completed December 2, 2008. Under the section " Bowel and Bladder Assessment and Management " the resident was scored as "12". The legend on the form documented, "7-14 Candidate for prompted toileting/habit training." A care plan for " Incontinence of urine" was initiated December 24, 2008. There was no evidence that an individualized toileting program was initiated. A face-to-face interview was conducted on January 15, 2009 at 11:35 AM with Employee #13, who acknowledged that no individualized toileting program was initiated for Resident F1. The record was reviewed January 15, 2009.	F 311	**483.25(a)(2) Activities of Daily Living** 14. Resident# F1 1.An Incontinence Management Program was developed. 2. Medical records of residents on the same unit were reviewed to ensure compliance. 3.Toileting status will be evaluated using The "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	3/6/09 3/31/09 3/31/09 4/3/09

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	095022	A. BUILDING _____ B. WING _____	01/16/2009

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F 311	Continued From page 69 15. Facility staff failed to develop a toileting program for Resident S5. A review of Resident S5 ' s record revealed a " Resident Admission Evaluation Form " completed October 25, 2008. Under the section " Bowel and Bladder Assessment and Management " the resident was scored as " 19. " The legend on the form documented, " 15-20 Possible candidate for retraining or individualized training. " There was no evidence that a retraining or individualized training program was initiated for Resident S5. A face-to-face interview was conducted with Employee #7 on January 16, 2009 at 8:45 PM. He/she acknowledged that an incontinence training program was not initiated for Resident S5. The record was reviewed January 16, 2009. 16. Facility staff failed to assist Resident S6 with cleaning and trimming of fingernails. On January 13, 2009 at 10:10 AM, Resident S6 was observed outside the dining room on the 2nd floor. Resident S6 ' s finger nails were thick, long and had accumulated debris under the nails. When queried about his/her nails, Resident S6 stated, " I ' ve asked them to cut my fingernails many times. It hasn ' t happened yet. " According to a quarterly MDS assessment completed November 24, 2008, Resident S6 required extensive assistance with personal hygiene. 17. Facility staff failed to assist Resident S7 with	F 311	**483.25(a)(2) Activities of Daily Living** 15. Resident #S5 1.An Incontinence Management Program was developed. 2. Medical records of residents on the same unit were reviewed to ensure compliance. 3.Toileting status will be evaluated using The "Bowel and Bladder Status" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 16. Resident# S6 1. Facility staff cleaned and trimmed resident's fingernails. 2. Facility residents identified to be requiring extensive assistance w/ personal hygiene needs were assessed and needs attended to. 3. Inservice training was provided to facility staff responsible for providing personal hygiene care for residents identified as being totally dependent for personal hygiene. Fingernail cleanliness will be evaluated using the "Nursing Care Review" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee	3/6/09 3/31/09 3/31/09 4/3/09 1/14/09 1/13/09 3/13/09 3/31/09 4/3/09

which is chaired by the Administrator

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F 311	Continued From page 70 cleaning and trimming of fingernails. On January 15, 2009 at 2:30 PM, Resident S7 was observed outside the dining room on the 1st floor. Resident S7 ' s finger nails were jagged and had accumulated debris under the nails. When queried about his/her nails, Resident S7 stated, " They look pretty bad. " According to the annual MDS assessment completed December 8, 2008, Resident S7 was coded in Section G as requiring extensive assistance with personal hygiene.	F 311	**483.25(a)(2) Activities of Daily Living** 17. Resident#S7 1. Facility staff cleaned and trimmed Resident's fingernails. 2. Facility residents identified to be requiring extensive assistance were assessed and needs attended to. 3. Inservice training was provided to facility staff responsible for providing personal hygiene care for residents identified as being totally dependent for personal hygiene. Fingernail cleanliness will be evaluated using the "Nursing Care Review" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee	1/14/09 1/13/09 3/13/09 3/31/09 4/3/09
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations for three (3) of six (6) wound treatment observations, it was determined that facility staff failed to: accurately code a pressure sore for one (1) residents and follow clean technique during the wound treatment for two (2) residents. Residents # 20, 27 and S2. The findings include: 1. Facility staff failed to follow clean technique during a wound treatment for Resident #20.		**483.25(c.) Pressure Sores** 1. The staff member involved was counseled and given 1:1 inservice. 2. Nursing staff from other units were given inservice training in proper wound techniques before and after each wound treatment. 3. Wound treatments will be observed by ADONs, Clinical Mgrs, & Nursing supervisors to ensure that proper techniques were used during the treatment. Data collected through the Nursing Quality Improvement Program's Treatment Observation Tool Will be forwarded to the Director of Nurses and her QI team for evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	1/31/09 1/16/09 3/31/09 4/3/09

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F 314	Continued From page 71 A wound treatment observation was conducted on January 14, 2009 at 12:00 PM. The resident had an ischial and sacral wound. Employee #23 completed the ischial wound treatment and failed to wash hands and change gloves before beginning the treatment on the sacral wound. After completing the sacral wound treatment, Employee #23 failed to clean the resident ' s bedside table that was used to house wound treatment equipment. 2. Facility staff failed to accurately stage a pressure for Resident #27. A " Weekly Wound Progress Report " dated July 29, 2008 coded an initial observation of a Stage III sacral pressure sore 1.5 cm x 4 cm x 0.1cm. According to "Pressure Ulcers in Adults: Prediction and Prevention" by the U.S. Department of Health and Human Services, page 1, "Stage II: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater. Stage III: Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue." There was no evidence in the record that documented damage or necrosis of subcutaneous tissue. The resident was observed on January 15, 2009 at approximately 1:15 PM during a wound treatment to the sacral pressure ulcer by Employee #27.	F 314	**483.25(c.) Pressure Sores** (continued) 2. Resident #27 1. The staff member involved was counseled and given 1:1 inservice. 1/31/09 2. Nursing staff from other units were given inservice training in proper wound staging 3/31/09 3. Wound treatments will be observed by ADONs, Clinical Mgrs, & Nursing supervisors to ensure that proper techniques and proper staging was used. Data collected through the Nursing Quality Improvement Program's Treatment Observation Tool Will be forwarded to the Director of Nurses and her QI team for evaluation to ensure competencies. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09	

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F 314	Continued From page 72 A face-to-face interview was conducted with Employee #9 on January 15, 2009 at approximately 4:20 PM. He/she acknowledged that the pressure should have been identified as a Stage II. The record was reviewed January 15, 2009. 3. Facility staff failed to follow clean technique during a wound treatment for Resident S2. A wound treatment observation was conducted on January 15, 2009 at 11:45 AM. Employee #22 placed a package of 4 x 4 gauze pads, bottle of Isagel (hand cleanser) and bottle of normal sterile saline on a non-permeable barrier on top of the resident ' s bedside stand. After completion of the wound treatment, Employee #22 removed the soiled dressing and the non-permeable barrier, placing the package of 4 x 4 gauze, the bottle of normal sterile saline and the bottle of Isagel directly on the top of the bedside stand. Employee #22 disposed of the wound treatment waste, returned to the resident ' s room and placed the package of 4 x 4 gauze sponges, the bottle of Isagel and the bottle of normal sterile saline in the treatment cart. Additionally, Employee #22 failed to wash the beside table after all items were removed.	F 314	**483.25(c.) Pressure Sores** (continued) 3. Resident S2 1. The staff involved was counseled and given a 1:1 inservice. 1/31/09 2. Nursing staff from other units were given inservice training in proper wound techniques before and after each wound treatment. 3/31/09 3. Wound treatments will be observed by ADONs, Clinical Mgrs, & Nursing supervisors to ensure that proper techniques were used during the treatment. Data collected through the Nursing Quality Improvement Program's Treatment Observation Tool Will be forwarded to the Director of Nurses and her QI team for evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09	
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	**483.25(h) Accidents and Supervision**	

483.25(h) Accidents and Supervision
(continued)
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1. Extension Cords	
1. Extension cords were removed upon discovery and replaced with a surge protector.	1/16/09
2. All residents' rooms were searched for the use of extension cords. No other instances were found.	1/16/09
3. Extension cord use will be monitored by the Maintenance Quality Improvement Team. Any data collected on this issue will be forwarded to the Director of Maintenance for his review and evaluation.	
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09
2. Wall Outlet Cover	
1. Wall outlet cover were replaced upon discovery.	1/16/09
2. All residents' rooms were searched for the missing outlet covers. No other instances were found.	1/16/09
3. Missing outlet covers will be monitored by the Maintenance Quality Improvement Team. Any data collected on this issue will be forwarded to the Director of Maintenance for his review and evaluation.	
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09

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F 323	Continued From page 73 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that facility staff failed to maintain a hazard free environment as evidenced by: extension cords in residents' rooms, a missing electrical socket face plate, a non-skid backed rug in a resident's room, four (4) treatment carts left unlocked and unattended, Resident #19's foot stuck in a side rail and medication left unattended on one (1) medication cart. The findings include: 1. Extension cords were observed in the following residents' rooms: Room 233 plugged into a multiple plug device at approximately 2:25 PM on January 13, 2009. Room 205 plugged into a radio at approximately 2:50 PM on January 13, 2009. 2. A wall outlet cover was observed missing in the first floor dining room January 14, 2009 at 10:50 AM. 3. A rug with a non-skid backing was observed in room 357 on January 13, 2009 at 11:05 AM. These findings were acknowledged by Employees #11 and 29, 30 at the time of the observations. 4. Facility staff failed to lock four (4) treatment carts that were left unattended. A. During a wound treatment observation on January 14, 2009 at 12:00 PM on unit 3 South, Employee #23 removed wound treatment items from the treatment cart and placed them in the	F 323	**483.25(h) Accidents and Supervision** (continued) **3. Rug** 1. The throw rug was removed by the resident upon discovery. 2. All resident rooms were evaluated for the presence of a throw rug without a non-skid backing. No other issues were uncovered. 3. Housekeeping staff were inserviced on the need to report the presence of a throw rug without a non-skid backing to the nursing staff and the housekeeping supervisor. Monitoring of this issue will be done by the Housekeeping Quality Improvement Team as they collect data on the issues which may be present in the resident rooms. The data collected with be brought to the Director of housekeeping for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **4. Locking of treatment carts.** A. 1. Treatment carts found unlocked at the time of the survey were locked promptly upon discovery. 2. All treatment carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found	1/16/09 1/31/09 4/3/09 1/16/09 1/31/09

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F 323	Continued From page 74 resident ' s room. Employee #23 positioned the treatment cart against the wall in the hallway by the resident ' s room and closed the door. The treatment cart was left unlocked and unattended. When the wound treatment was completed, the resident ' s door was opened and two (2) residents were observed in the hallway in close proximity to the treatment cart. Items contained in the top drawer of the treatment cart included tubes of Santyl ointment, Bacitracin ointment, Urea 40% cream, Collagen hydrogel wound dressing ointment and Hydrocortisone Valerate 0.2% ointment. The treatment cart was observed unlocked in the presence of Employee #23 immediately after the wound treatment was completed. B. During a wound treatment observation on January 15, 2009 at 11:45 AM. Employee #22 removed wound treatment items from the treatment cart. Employee #22 turned the cart drawers towards the wall by the resident ' s room in the hallway on 1 North and closed the resident ' s door. The treatment cart was left unlocked and unattended. After the wound treatment was completed, the resident ' s door was opened. One (1) resident was sitting in a wheelchair next to the treatment cart. The top drawer of the treatment cart contained tubes of Collagen hydrogel wound dressing ointment. The treatment cart was observed in the presence of Employee #22 immediately after the wound treatment was completed.	F 323	**483.25(h) Accidents and Supervision** (continued) **4. Locking of treatment carts** (continued) 3. Inservice training was given to facility staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatment carts will be done through the Nursing Quality Improvement Team and their "Treatment Observation" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator B. 1. Treatment carts found unlocked at the time of the survey were locked promptly upon discovery. 2. All treatment carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found 3. Inservice training was given to facility staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatment carts will be done through the Nursing Quality Improvement Team and their "Treatment Observation" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation.	3/31/09 4/3/09 1/16/09 1/31/09 3/31/09

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F 323	Continued From page 75 C. During a wound treatment observation on January 15, 2009 at 1:15 PM, Employee #27 removed wound treatment items from the treatment cart. Employee # 27 turned the cart ' s drawers towards the door of the resident ' s room in the hallway on 3 North. The resident ' s door was left opened. Resident # 27 ' s bed was by the window away from the entry door and the privacy curtain was pulled. The treatment cart was left unlocked and unattended. Several residents were observed walking up and down the hallway returning from the dinning room. The contents of the top drawer included the following wound dressing ointments: Accuzyme, Bacitracin, Collagen hydrogel Santyl, and Urea 40% cream. The treatment cart was observed unlocked and unattended in the presence of Employee #27 immediately after the wound treatment was completed. Employee #27 eventually secured the treatment cart in the clean utility room. A-face-to-face interview was conducted with Employee# 27 on January 15, 2009 at approximately 2:45 PM. He/she acknowledged that the treatment cart was not locked. D. During a tour of the facility on January 16, 2009 at approximately 10:35 AM, in the presence of Employee #10, it was observed that Employee #30 left the treatment cart unlocked and unattended in front of room 310, in the hallway on 3 South. Several residents were observed walking up and down the hallway returning from the dinning room and other activities around the facility.	F 323	**483.25(h) Accidents and Supervision** (continued) B. (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator C. 1. Treatment carts found unlocked at the time of the survey were locked promptly upon discovery. 2. All treatment carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found 3. Inservice training was given to facility staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatment carts will be done through the Nursing Quality Improvement Team and their "Treatment Observation" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator D. 1. Treatment carts found unlocked at the time of the survey were locked promptly upon discovery. 2. All treatment carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found	4/3/09 1/16/09 1/31/09 3/31/09 4/3/09 1/16/09 1/31/09

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F 323	Continued From page 76 The contents of the top drawer included the following wound dressing ointments: Ammonium lactate, Ketoconazole shampoo, Hydrocortisone, Accuzyme, Bacitracin, Collagen hydrogel, Santyl, Urea 40% cream and plastic bags. A face-to-face interview was conducted with Employees #10 and 30. They both acknowledged that the treatment cart was unlocked and unattended with the aforementioned contents. 5. Facility staff failed to provide adequate supervision for Resident #19 who's foot was stuck in a side rail. A review of Resident #19's record revealed a nurse's note dated December 24, 2008 at 12:00 AM, "Resident's foot stocked [stuck] in the bedside rail..." The resident was hospitalized from December 25, 2008 through January 6, 2009 for a deep vein thrombosis. A telephone order dated January 14, 2009 at 6:50 PM, unsigned by the physician noted, "Needs order for 1/2 side rails to aid in bed mobility for resident." Resident #19 was observed on January 15, 2009 at 7:45 AM in bed with the top side rails in the up position. A face-to-face interview was conducted with the resident at the time of the observation. When asked if he/she remembered getting his/her leg stuck in the side rails, the resident replied, "I don't remember." The record was reviewed January 15, 2009. 6. Facility staff left medication unattended on the	F 323	**483.25(h) Accidents and Supervision** (continued) D. 3. Inservice training was given to facility staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatment carts will be done through the Nursing Quality Improvement Team and their "Treatment Observation" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 5. Resident #19 1. The resident is currently using a low bed with half rails. 2. Other residents who may have an order for half rails were evaluated. No other issues were found. 3. Inservice training will be given to the facility staff regarding making frequent rounds and checking all residents during their tour of duty paying close attention to resident's body parts during the rounds Monitoring of the side rail incidents will be done through the Nursing Quality Improvement Team. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	3/31/09 4/3/09 3/20/09 3/31/09 3/13/09 3/31/09 4/3/09

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F 323	Continued From page 77 medication cart . On January 12, 2009, at approximately 9:56 AM during the medication pass, Employee #23 left medication unattended on the medication cart in front of Resident JH7's room while he/she attended to the resident. The following medications remained on the medication cart Multivitamin/Iron, Lisinopril 20mg, Isosorbid Dinitrate 20mg, Hydrochlothiazide 25mg, Digoxin 0.25mg, Caredilol 25mg and Docusate 100mg when Employee #23 entered the resident's room. The medication cart was out of the sight of Employee #23. A face-to-face interview was conducted at the time of this observation with Employee #23. He/she acknowledged that the medications were left on the medication cart.	F 323	**483.25(h) Accidents and Supervision** (continued) 6. Unlocked Med Cart 1. Med carts found unlocked at the time of the survey were locked promptly upon discovery. 2. All med carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found 3. Inservice training was given to facility staff about the importance of making sure that med carts are locked when not in use for safety reasons. Monitoring of the locking of med carts will be done through the Nursing Quality Improvement Team and their "Med Pass" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	1/16/09 1/31/09 3/31/09 4/3/09
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents it was determined, that facility staff failed to address	F 325	**483.25(i) Nutrition** Resident #6 1. The resident has been reweighed and is being closely monitored by the dietician and the Risk Management team for Weight Loss. The resident will be evaluated soon at Johns Hopkins to rule out the possibility that he has Mysthenia Gravis. 2. All residents with significant weight loss are being presented to the Risk Management Committee for Weight Loss to ensure that a reweigh has taken place and that approaches are in	3/31/09 3/31/09

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F 325	Continued From page 78 Resident # 6 ' s significant weight loss. The findings include: A review of Resident # 6 ' s clinical record revealed a " Resident Weight and Height Record" which revealed the following documentation: 10/5/08 Weight = 190 pounds 12/2/08 Weight = 159 pounds No weight was recorded on the " Resident Weight and Height Record. " for November 2008. However a weight of 156 & 3/4lb (pounds) was noted in a nurse ' s note dated November 25, 2008 at 10:30 PM. There was no evidence on the record that the resident was ever reweighed to verify the weight of 156 and 3/4lb which represented a significant weight loss of 17% from October 5, 2008. There was no further documentation and or interventions on the record regarding the weight of 156 and 3/4lb. A review of the facility ' s policy " Nursing Weights and Heights " Policy #1403070A.000, Page two of nine, item " c " revealed the following statement: " Check the previous weight for changes. If there is a change of + or - 5% in 30 days, 7.5% in 90 days or 10% in 180 days, schedule resident to be reweighed within 24 hours. " The facility failed to follow its policy regarding a weight change. Resident # 6 ' s weight loss was greater than 10% but there was no evidence in the record that the resident was reweighed within 24 hours. A face-to-face interview was conducted with Employee #39 at approximately 2:30 PM on January 14, 2009. He/she acknowledged, that he/she was unaware of the resident ' s significant weight loss until he/she assessed the resident upon his/her readmission to the facility, from an area hospital on December 26, 2008. He/she	F 325	**483.25(i) Nutrition** Resident #6 place for any resident with such weight loss. 3. The facility Weight policy will be re-inserviced with staff to ensure that weights are taken and recorded properly and reweighs occur within the guidelines mandated. The Risk Management Committee for weight loss follows every resident with significant weight loss to ensure all appropriate approaches are carried out. 4. The Director of Nurses chairs the Risk Management Committee for Weight Loss and will report any significant findings to the Administrator monthly at the Quality Improvement Committee.	3/31/09 4/3/09

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F 325	Continued From page 79 added, " When I assessed him/her I recognized the weight loss. I also determined that he/she was experiencing difficulty chewing and swallowing due to dental problems. I changed his/her diet from regular to mechanical soft and added three cans of Supplena daily. " The record was reviewed on January 13, 2009.	F 325		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for five (5) of 30 sampled residents, it was determined	F 329	**483.25(l) Unnecessary Drugs**	

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F 329	Continued From page 80 that facility staff failed to: document evidence and monitor for the use of Ambien for insomnia for one (1) resident, monitor Dilantin levels for one (1) resident, and adequately monitor behaviors and medication side effects for three (3) residents receiving antipsychotic medications. Residents #1, 5, 10, 11 and 13. The findings include: According to the facility's policy, "Nursing Psychoactive Drug Review, Policy #1404423A.000, pages 1 and 2, "Psychoactive Medications - Atypical ...Seroquel ... " Under "Psychoactive Drug Monitoring Reference Sheet ... Antipsychotic - Must know diagnosis to determine if target behaviors will need monitoring. i.e. Dementia diagnosis - document side effects, non drug interventions, monitor, and count target behaviors and summarize monthly ... " 1. Facility staff failed to document evidence and monitor for the use of Ambien for insomnia for Resident #1. A physician's order signed and dated December 16, 2008 directed, "Ambien 10 mg 1 PO QHS [one (1) tablet by mouth at hour of sleep]. A review of the resident ' s clinical record revealed the following ' Doctor's Progress Notes': "December 16, 2008: Attending: Resident has been prescribed Ambien 10 mg po QHS because of insomnia. " According to the Medication Administration Record (MAR) for the months of December 2008 and January 2009, Resident #1 was administered "Ambien 10 mg P.O. QHS for insomnia", on	F 329	**483.25(l) Unnecessary Drugs** (continued) 1. Resident #1 1. Medical record will reflect monitoring for the indication for use, insomnia, with the administration of Ambien. This is a routine order for an over-the-counter medication. 2. All other residents who have orders for the routine use of Ambien 10mg for insomnia will be evaluated with monitoring added whenever necessary. 3. Facility staff were given inservice regarding documenting evidence and monitoring for the use of Ambien. The Consultant Pharmacist will assist in monitoring Ambien 10mg. Documentation of issues will be forwarded to the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	3/31/09 3/31/09 4/2/09 4/3/09

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F 329	Continued From page 81 December 17 through December 31, 2008 and January 1 through 15, 2009 as evidenced by the initials on the MAR on the aforementioned dates. A further review of the resident's 'Nurse's Notes', 'Doctor's Progress Notes' and a December 16, 2008 dated and signed 'Physician History and Physical' lacked documented evidence for monitoring for the use of Ambien. A face-to-face interview was conducted with Employee #6 on January 16, 2009 at approximately 11:30 AM. He/She acknowledged that the resident's clinical record lacked documented evidence for monitoring for the use of Ambien for insomnia. The record was reviewed January 16, 2009. 2. Facility staff failed to adequately monitor the use of Seroquel for Resident #5. A review of Resident #5's record revealed admission orders signed by the physician on July 4, 2008 directing, "Seroquel 25 mg twice daily and Seroquel 400 mg at bedtime" for Bipolar disease. According to the "Initial Psychiatric Evaluation" completed August 21, 2008, the psychiatrist directed, "Continue Seroquel ...as ordered." A review of the resident's record revealed that the "Behavior Monitor Flow Sheet" for December 2008 and January 2009 failed to identify the target behaviors and medication side effects to monitor for Resident #5. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM.	F 329	~~483.25(l) Unnecessary Drugs~~ (continued) (continued) 2. Resident #5 1. Psychiatrist consult will be ordered for this resident requesting to evaluate the resident for the continued use of Seroquel. With its continued use, the nursing staff will initiate Behavior Monitoring Flow Sheet to document any episodes of negative behaviors. 2. For any other resident on Seroquel who has not been evaluated continued use staff will request a consultation from the Psychiatrist. With its continued use, the nursing staff will initiate Behavior Monitoring Flow Sheet to document any episodes of negative behaviors 3. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Psychoactive Drug Review." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 3. Resident #10 1. Psychiatrist consult will be ordered for this resident requesting to evaluate the resident for the continued use of Seroquel. With its continued use, the nursing staff will initiate Behavior Monitoring Flow Sheet to document any episodes of negative behaviors.	3/31/09 3/31/09 3/31/09 4/3/09 3/31/09

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F 329	Continued From page 82 He/she acknowledged that the behavior monitoring sheets for December 2008 and January 2009 were blank. The record was reviewed January 12, 2009. 3. Facility staff failed to adequately monitor the use of Seroquel for Resident #10. A review of Resident #10's record revealed a physician's order dated November 22, 2008, "Seroquel 50 mg daily." The "Behavior Monitoring Flow Sheet" for November and December 2008 and January 2009 were blank. Target behaviors and medication side effects to be monitored were not documented on the sheets. A face-to-face interview was conducted with Employees #15 and 16. Both employees stated that Resident #10 removes his/her clothes daily and has to be re-dressed at least twice during the day shift. A face-to-face interview was conducted with Employee #12 on January 14, 2009 at 3:30 PM. He/she acknowledged that the behavior monitoring sheets were blank for November and December 2008 and January 2009 and that Resident #10 removes his/her clothes several times a day. The record was reviewed January 14, 2009. 4. The physician failed to followed up with his/her order to monitor monthly Dilantin levels for Resident #11. A physician's order dated March 19, 2008 and signed by the physician on May 1, 2008, directed:	F 329	**483.25(l) Unnecessary Drugs** (continued) 3. Resident #10 2. For any other resident on Seroquel who has not been evaluated continued use staff will request a consultation from the Psychiatrist. With its continued use, the nursing staff will initiate Behavior Monitoring Flow Sheet to document any episodes of negative behaviors 3. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Psychoactive Drug Review." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4. Resident #11 1. Physician reviewed the total plan of care on this resident to provide evidence of the resident's dilantin level. 2. All the medial records of this physician were reviewed to provide evidence of other residents who take dilantin. 3. Physician Services meeting was held to review the physicians' responsibility in addressing specific resident issues. Monitoring of inclusion of these issues in the physician progress notes will be done by the Clinical Managers who will forward any concerns to the Director of Nurses.	3/31/09 3/31/09 4/3/09 3/31/09 3/31/09 3/31/09 3/31/09

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F 329	Continued From page 83 "Phenytoin ...100mg...Dilantin ...2 capsules (200 mg) by mouth twice daily for seizures. Ori: (Origin) 12/05/07, ..." "Dilantin level every month ...orig 09/13/2007." According to the resident's MAR for the months of April and May 2008 the resident was administered Dilantin as evidenced by the initials for Dilantin during the aforementioned months. Monthly Dilantin levels were not available in the resident's record for the aforementioned months. A review of the physician's progress notes in Resident #11's clinical record dated May 2, June 3, and July 3, 2008 lacked evidence that the physician reviewed the resident ' s monthly Dilantin laboratory levels. There was no evidence that the physician followed up with his/her order to monitor the resident's Dilantin levels monthly for the aforementioned months. A face-to-face interview was conducted with Employee #10 on January 14, 2009 at approximately 11:30 AM. He/She acknowledged that the resident's clinical record lacked evidence that the physician followed up with his/her order to monitor the resident's monthly Dilantin levels for the months of April and May 2008. The record was reviewed January 14, 2009. 5. Facility staff failed to adequately monitor the use of Seroquel and Klonopin for Resident #13. A psychiatrist ' s order dated October 9, 2008 directed, "Seroquel 50 mg po (orally) twice daily	F 329	**483.25(l) Unnecessary Drugs** (continued) 4. Resident #11 (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 5. Resident #13 1. Psychiatrist consult will be ordered for this resident requesting to evaluate the resident for the continued use of Seroquel and Klonopin.. With its continued use, the nursing staff will initiate Behavior Monitoring Flow Sheet to document any episodes of negative behaviors 2. For any other resident on Seroquel and Klonopin who have not been evaluated for its continued use, staff will request a consultation from the Psychiatrist. 3. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Psychoactive Drug Review." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	4/3/09 3/31/09 3/31/09 3/31/09 4/3/09

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F 329	Continued From page 84 for agitated behaviors and Klonopin 1 mg po daily for agitation." The "Behavior Monitoring Flow Sheet" for November, 2008 and January 2009 were blank. Target behaviors and medication side effects to be monitored were not documented on the sheets. The "Behavior Monitoring Flow Sheets" for October and December 2008 could not be located at the time of this review by Employee #5. A face-to-face interview was conducted with Employee #5 on January 13, 2009 at 3:45 PM. He/she acknowledged that the behavior monitoring sheets were blank and some missing and that target behaviors and medication side effects were not monitored. The record was reviewed on January 13, 2009.	F 329		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the medication error rate was 5.43 % in 2 (two) of 13 medication passes. The findings include: On January 12, 13 and 14, 2008 medication pass was observed on five (5) of six (6) nursing units. 92 opportunities were observed with five (5) non-significant errors.	F 332	**483.25(m)(1) Medication Errors** A. Resident JH1 1. Employee involved in the errors of omission during medication pass were counseled and inserviced. The staff member was observed by the QA nurses from Remedi SeniorCare for the proper administration and documentation during Med Pass. 2. All nurses were observed by the QA nurses from Remedi SeniorCare for the proper administration and documentation during Med Pass. Baseline competencies were established. 3. Proper Medication administration will be monitored by the Nursing QI Team and the use of the "Med Pass" tool in the Nursing QI Program. Results of their monitoring will be given to the Director of Nurses for her review and evaluation.	3/31/09 3/31/09 3/31/09

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F 332	Continued From page 85 The non-significant errors were as follows: A. Resident JH1 was observed receiving medications on January 13, 2009 at 11:40 AM. After reconciling the Physicians Orders Sheet (POS) signed and dated on January 10, 2009 with the Medication Administration Record (MAR) for January 2009, it was discovered that Simvastin 20 mg was omitted during the medication pass. B. Resident JH2 was observed receiving medications on January 12, 2009 at 10:50 AM. After reconciling the Physicians Orders Sheet (POS) signed and dated on December 18, 2008 and an Interim order signed and dated December 16, 2008 with the MAR for January 2009, it was discovered that Alphagan 0.15% ophthalmic drops, Cospt ophthalmic drops, Cardiazem ER180mg and Ranitidine 150 mg tablets were omitted during the medication pass.	F 332	**483.25(m)(1) Medication Errors** (continued) A. **Resident JH!** (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **B. Resident JH2** 1. Employee involved in the errors of omission during medication pass were counseled and inserviced. The staff member was observed by the QA nurses from Remedi SeniorCare for the proper administration and documentation during Med Pass. 2. All nurses were observed by the QA nurses from Remedi SeniorCare for the proper administration and documentation during Med Pass. Baseline competencies were established. 3. Proper Medication administration will be monitored by the Nursing QI Team and the use of the "Med Pass" tool in the Nursing QI Program. Results of their monitoring will be given to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09 3/31/09 3/31/09 3/31/09 4/3/09
F 368 SS=E	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	F 368		

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F 368	Continued From page 86 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, for four (4) of six (6) nursing units, it was determined that facility staff failed to consistently offer bedtime snacks to all residents. The findings include: A resident group interview was conducted on January 14, 2009 from 3:00 PM until 4:30 PM. Residents stated that the staff did not consistently offer snacks after 8:00 PM. Observations were made on January 14, 2009 from 8:00 PM until 9:00 PM on all nursing units regarding the availability of snacks as follows: 1 North: 2 packages of potato chips, several packages of crackers, and 25 bagged snacks for specific residents. Unit census was 57 residents with 7 residents receiving tube feedings. 1 South: 4 packages of cookies, 2 packages of crackers, several packages of peanut butter crackers and graham crackers and 28 bagged snacks for specific residents. Unit census was 58 residents with 6 residents receiving tube feedings. 2 North: 2 pieces of cake, packages of potato chips, graham crackers with several bagged snacks for specific residents. 2 South: snacks provided included 4 packages of cookies, 10 packages of graham crackers, 2 packages of pretzels, 2 packages of potato chips, 2 containers of pudding, 28 bagged snacks for	F 368	**483.35(f) Frequency of Meals** 1. The amount of snacks provided to each unit has been increased to afford a snack for each non-tube fed resident. 2. The adequacy and provision of snacks will be added as a permanent agenda item on the Menu Planning Committee and the Residents' Council to ensure residents' satisfaction with the facility's snack program. 3. Inservice will be provided to the nursing staff on the importance of passing and offering nourishments and snacks to all residents. Monitoring of the snack program will be done by the Nutritional Services QI Team. Results of their monitoring efforts will be forwarded to the Directors of Nutritional Services and Nursing for their review and evaluation. 4. 4. The Department Heads will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/31/09 3/31/09 3/31/09 3/31/09 4/3/09

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specific residents. Unit census was 60 residents with 9 residents receiving tube feedings.

3 North: snacks provided included 2 packages of cookies, 10 packages of graham crackers, 12 packages of Ritz crackers, 2 containers of Jello, 2 packages of potato chips and 19 bagged snacks for specific residents. Unit census was 57 residents with 4 residents receiving tube feedings.

3 South: No snacks and 25 bagged snacks for specific residents. Unit census was 57 residents with 3 residents receiving tube feedings.

Staff interviews with Certified Nurse Aides were conducted on January 15, 2009 from 3:30 PM through 4:35 PM regarding procedure of providing snacks for the residents as follows:

1 North: Interview with Employee #31 was conducted at 4:15 PM. He/she stated, " We pass the bagged snacks first and then we know who usually wants a snack at night. I don't ask anyone, I know who wants. "

1 South: Interview with Employee #32 was conducted at 4:25 PM. He/she stated, " I don't have to offer snacks, I know who wants and doesn't want a snack. "

2 North: Interview with Employee #33 was conducted at 4:10 PM. He/she stated, " We put the snack and the bagged snacks with juice and water on the cart and go down the hall. Each CNA has there own area and everyone gets offered a snack. "

2 S: Interview with Employee #34 was conducted at 4:35 PM. He/she stated, " We pass the

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WASHINGTON NURSING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020

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F 368	Continued From page 88 bagged snacks first and then go and ask if anyone wants a snack. " 3 North: Interview with Employee #34 was conducted at 3:30 PM. He/she stated, " We use the cart and put all the snacks on the cart with water and juice, usually about 8:15 or 8:20 at night. We pass out the snacks and then give anyone else a snack if they ask for it. " 3S: Interview with Employee #35 was conducted at 3:30 PM. He/ she stated, " We always get bagged snacks but we don't always get the extra snacks. If someone doesn't want their bagged snack, we can use it for another resident. If we have snacks and residents ask, we give them what ever we have. " Facility acknowledged that bedtime snacks were not consistently offered to residents. Additionally, no non-bagged bedtime snacks were available on unit 3 South on January 14, 2009.	F 368		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not	F 371	**483.35 (i) Sanitary Conditions** A. Undated Food in the Refrigerators and Dry Storage Areas 1. Food found undated was taken out of storage and discarded. 2. All food in the walk-in and reach-in refrigerators and the dry storage areas were reviewed to ensure proper dating. 3. Nutritional Services staff was inserviced regarding the need to date all perishable and canned goods upon delivery to the facility. Monitoring of this practice will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation.	1/16/09 1/16/09 3/31/09

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F 371	Continued From page 89 adequate to ensure that foods were served in a safe and sanitary manner as evidenced by: foods observed undated in the walk-in refrigerator, reach-in refrigerator and the dry storage area; soiled dome covers, ice machine, ceiling tiles, spice rack and food carts; damaged ceiling tile in the dry storage area; and serving utensils were observed wet; foods were observed being plated with the incorrect ladle [scoop size] during the tray line service; and a pan of vegetables placed on the floor tray line service. These findings were acknowledged by Employees #14 and 41 at the time of the observations. The findings include: A. The following foods were observed undated in the walk-in refrigerator, reach-in refrigerator and the dry storage area: Two (2) bundles of withered lettuce One (1) box of withered kale One (1) case of strawberries with a green and white substance on the berries and side of the cartons One (1) pan of lemon pudding undated Two (2) of four (4) cartons of packed parmesan cheese undated Three (3) of three (3) cans of gelatin undated Two (2) of seven (7) containers of pudding were unclearly dated [January 2009], facility staff unable to determine if the date was January 9, 2009 or January 2009 B. The following were observed soiled and/or damaged in the main kitchen: One (1) of one (1) ice machine interior surface was observed soiled in the main kitchen	F 371	**483.35 (i) Sanitary Conditions** (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator B. Soiled Interior of the Ice Machine 1. The interior of the ice machine was cleaned upon discovery. 2. There are no other ice machines in the kitchen area. 3. Nutritional Services staff was inserviced regarding the need to routinely clean the interior of the ice machine. Monitoring of this practice will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09 1/16/09 1/16/09 3/31/09 4/3/09

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F 371	Continued From page 90 Ceiling tiles were soiled in the chemical room One (1) damaged ceiling tile in the dry storage area One (1) of one (1) spice rack was soiled 24 of 51 food carts were observed soiled One (1) full size pan of serving utensils were observed wet and was stored for reuse Seven (7) of 41 dome covers were observe soiled and were store for reuse C. During tray line observations on January 12, 2009 at 1:40 PM on the 1st floor dining room and during the tray line service on January 13, 2009 at 12:40 PM on the 3rd floor, dietary staff was observed plating the following foods for residents with the incorrect ladle [scoop size]: Season spinach, mechanical soft pork and rice The ladle sizes were verified with Employee #14 on January 14, 2009 at approximately 4:00 PM. D. During the tray line observation on January 12, 2009 at 1:44 PM on the 1st floor dining room, Employee #40 was observed removing a loaf pan of vegetables [covered with foil] from the warmer and placing it on the floor and then putting it back into the food warmer. At the time of the finding Employee #40 acknowledged what happened and stated that the pan was hot and he/she had to put it down. Approximately five minutes later the pan was removed from the warmer by Employee #41.	F 371	**483.35 (i) Sanitary Conditions** (continued) B. Continued Ceiling Tiles 1. Soiled and damaged ceiling tiles noted at the time of the survey were replaced upon discovery. need for replacement and no other changes were necessary. 3. . Monitoring of the ceiling tiles will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator Spice Rack 1. The Spice Rack was cleaned upon discovery. 2. There are no other spice racks in the kitchen. 3. . Monitoring of the spice rack will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	1/16/09 1/16/09 3/31/09 4/3/09 1/16/09 1/16/09 3/31/09 4/3/09
F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility	F 386		

483.35 (i) Sanitary Conditions
(continued)
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B. Continued
Food Carts
1. Food Carts were cleaned upon discovery. 1/16/09
2. All food carts were evaluated for cleanliness and no further action was needed. 1/16/09
3. . Monitoring of the food carts will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09
Wet Serving Utensils
1. Serving utensils were removed from service, re-washed and properly dried. 1/19/09
2. All serving utensils were evaluated for proper drying and no further action was needed. 1/16/09
3. . Monitoring of the utensils will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09

483.35 (i) Sanitary Conditions
(continued)
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B. Continued

1. Dome lid covers noted to be soiled at the time of the survey were removed from service and re-washed.	1/16/09
2. All dome lid covers were evaluated for the need for re-washing and no further action was needed.	1/16/09
3. . Monitoring of the dome lid covers will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation.	3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09

C. Ladle Size

1. The employee involved with the use of the wrong sized ladle was counseled and inserviced.	1/16/09
2. All servers were inserviced on the size of ladles.	3/31/09
3. . Monitoring of the ladles will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation.	3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09

483.35 (i) Sanitary Conditions
(continued)
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B. Continued
Loaf Pan of Vegetables

1. Employee involved in this incident was corrected, counseled and inserviced.	1/16/09
2. All servers were monitored to ensure that proper technique is used in handling food.	3/31/09
3. . Monitoring of food handling will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation.	3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09

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F 386	Continued From page 91 policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 30 sampled residents, it was determined that the physician failed to review the total plan of care. Residents #5, 6, 7, and 8. The findings include: 1. The physician failed to review the total plan of care for Resident #5. A review of Resident #5's record revealed the following nurses' notes: August 25, 2008 at 3:00 PM.: "Resident found sitting on the floor ... " October 19, 2008 at 3:00 PM: "Monthly summary - Patient had a verbal confrontation with roommate and threatened [him/her] ...also had a verbal confrontation with another patient on [another unit] and threatened to stab [him/her] and called 911 to report the confrontation ... " A review of Resident #5's record revealed that the physician wrote progress notes dated September 25 and November 20, 2008. There was no evidence in the progress notes of the above cited fall or episodes of agitated behaviors. A face-to-face interview was conducted wit Employee #5 on January 12, 2009 at 3:45 PM. He/she acknowledged that the physician did not address the above incidents in the physician's progress notes. The record was reviewed January 12, 2009.	F 386	**483.40(b) Physician Visits** 1. Resident #5 1. Physician reviewed the total plan of care on this resident to provide evidence of the resident's falls and episodes of agitated behaviors. 2. All the medial records of this physician were reviewed to provide evidence of other residents who have had falls and episodes of agitated behaviors. 3. Physician Services meeting was held to review the physicians' responsibility in addressing specific resident issues. Monitoring of inclusion of these issues in the physician progress notes will be done by the Clinical Managers who will forward any concerns to the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	3/31/09 3/31/09 3/31/09 3/31/09 4/3/09

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F 386	Continued From page 92 2. The physician failed to address the total plan of care for Resident #6 to maintain a therapeutic Dilantin level. A review of the clinical record for Resident #6 revealed that on August 20, 2008 the resident had a Dilantin level of 5.2 ug/ml (normal 10 ug/ml to 20 um/ml) and diagnoses which include Seizures. The lab report was signed by the physician on August 21, 2008. Further review of the clinical record revealed documentation in the "Doctor's Progress Notes " which revealed the following note dated August 21, 2008, "Labs Dilantin level 5:2. Will give him/her a loading dose of Dilantin 300mg extra each day for 5 [five] days and repeat Dilantin Level on 8/27/08." No lab report was noted on the record for August 27, 2008 but the record revealed a lab report dated September 19, 2009 with a Dilantin level of 4.5 ug/ml and another report dated October 8, 2008 with a Dilantin level of 9.2 ug/ml. The resident did not have any seizures despite the sub therapeutic Dilantin level. The record revealed documentation from the attending physician for October 4, October 14, November 25, December 23, and December 30, 2008. The attending physician failed to address to the resident's Dilantin levels and/or document that the treatment plan included sub-therapeutic Dilantin levels. A face-to-face interview was conducted with Employee # 6 at approximately 10:00 AM on January 14, 2009. The employee acknowledged that the attending physician failed to follow up on the resident' s sub-therapeutic Dilantin level. The record was reviewed on January 13, 2009. 3. The physician failed to address the total plan of care for Resident #7.	F 386	**483.40(b) Physician Visits** (continued) 2. Resident #6 1. Physician reviewed the total plan of care on this resident to provide evidence of the resident's dilantin level. 2. All the medial records of this physician were reviewed to provide evidence of other residents who take dilantin. 3. Physician Services meeting was held to review the physicians' responsibility in addressing specific resident issues. Monitoring of inclusion of these issues in the physician progress notes will be done by the Clinical Managers who will forward any concerns to the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	3/31/09 3/31/09 3/31/09 3/31/09 4/3/09

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F 386	Continued From page 93 A review of Resident #7's record revealed a dietary progress note dated October 31, 2008, "Weight 138 # (pounds) Down 9.8% in 30 days. Significant weight loss is unintended ... " A physician's progress note dated November 4 and December 16, 2008 failed to address the resident's weight loss. A laboratory report dated October 31, 2008 revealed the following: Hemoglobin 9.2 [normal 11.6-15.1 gm/dl] and Hematocrit 27.9 [normal 34.0 - 45.0 %]. A laboratory report date December 10, 2008 revealed the following: Hemoglobin 8.5 and Hematocrit 26.7. Each lab report was signed by the physician. However, there was no evidence that the physician indicated in the December 16, 2008 note what was his/her plan of care for the decreasing Hemoglobin and Hematocrit. A face-to-face interview with Employee #6 was conducted on January 13, 2009 at 2:25 PM. He/she acknowledged that the physician failed to address the above cited issues. The record was reviewed January 13, 2009. 4. The physician failed to review the total plan of care for Resident #8. A review of Resident #8's record revealed the following interim order form: November 27, 2008: " ...Cardiology consult: confirm need of anticoagulation."	F 386	**483.40(b) Physician Visits** (continued) 3. Resident #7 1. Physician reviewed the total plan of care on this resident to provide evidence of the resident's weight loss and lab values. 2. All the medial records of this physician were reviewed to provide evidence of other residents who have had falls and episodes of agitated behaviors. 3. Physician Services meeting was held to review the physicians' responsibility in addressing specific resident issues. Monitoring of inclusion of these issues in the physician progress notes will be done by the Clinical Managers who will forward any concerns to the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4. Resident #8 1. Physician reviewed the total plan of care on this resident to provide evidence of the resident's cardiology consult. 2. All the medial records of this physician were reviewed to provide evidence of other residents who have had orders for cardiology consults.	3/31/09 3/31/09 3/31/09 3/31/09 4/3/09 3/31/09 3/31/09

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F 386	Continued From page 94 A review of Resident #8's record revealed that the physician wrote progress notes on January 8 and 12, 2009. The aforementioned physician's progress notes lacked evidence that he/she followed up with the aforementioned order for a cardiologist consult. A face-to-face interview was conducted with Employee #12 on January 16, 2009 at 11:00 AM. He/she acknowledged that the resident's clinical record lacked evidence that the physician followed up with his/her order for a cardiologist consult. The record was reviewed January 16, 2009.	F 386	**483.40(b) Physician Visits** (continued) 3. Physician Services meeting was held to review the physicians' responsibility in addressing specific resident issues. Monitoring of inclusion of these issues in the physician progress notes will be done by the Clinical Managers who will forward any concerns to the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	3/31/09 3/31/09 4/3/09
F 412 SS=D	483.55(b) DENTAL SERVICES - NF The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must 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 30 sampled residents, it was determined that facility staff failed to obtain an annual routine screen for Resident #7. The findings include:	F 412	**483.55(b) Dental Services** Resident #7 1. This resident received her annual dental screen. 2. An audit was done for all residents of the facility to ensure that an annual dental screen was done. Correction were made whenever necessary. 3. The unit clerks will perform monthly quantitative audits noting the date of the last dental screening. Their findings will be communicated to the consultant dentist. The Clinical Managers will monitor the timeliness of annual dental screens and communicate their findings to the DON. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/31/09 3/31/09 3/31/09 4/3/09

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F 412	Continued From page 95 A review of Resident #7's record revealed a dental screen dated December 20, 2007. There was no evidence that an annual dental screen was completed for 2008. A face-to-face interview was conducted with Employee #6 on January 13, 2009 at 2:25 PM. He/she stated, "We must have missed this resident." The record was reviewed January 13, 2009.	F 412		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES 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 observation, record review and staff interview, it was determined that the facility staff failed to consistently document administration of	F 425	**483.60(a)(b) Pharmacy Services**	

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F 425	Continued From page 96 controlled substances on the Medication Administration Record (MAR), to date and initial multi-dose vials; to remove expired medication from the medication carts and refrigerator and failed to administer medications in a timely manner to two (2) residents. JH1, JH15, JH16 and JH20. The findings include: 1. The facility staff failed to consistently document the administration of controlled substances on the November and December 2008 MARs for Residents JH15 and JH16. A. On January 16, 2009, at approximately 9:30 AM, during a review of Resident JH15 ' s records revealed a physician ' s order dated November 24, 2008 that directed, "Oxycodone/APAP tab 5-325mg, Take two (2) tablets by mouth every 6 hours as needed for pain. " The November 2008 MAR was reviewed and indicated that Oxycodone 5-325 mg tablet was not administered in November, there were no initials entered in the allotted areas. The " Controlled Drug Record " indicated the Oxycodone 5-325 mg tablet was removed from the controlled substance drawer on November 12, 2008. There was no evidence on the November 2008 MAR that the Oxycodone 5-325 mg was administered on November 12, 2008 to the resident. B. On January 16, 2009, at approximately 9:30 AM, during a review of Resident JH16 ' s records revealed a physician ' s order dated November	F 425	**483.60(a)(b) Pharmacy Services** 1A. Resident # JH 15 1. Employees involved in the errors of documentation for the administration of Oxycodone were counseled and inserviced. Each was observed by QA nurses from Remedi SeniorCare for the proper administration and documentation during Med Pass. 2. All nurses were observed by the QA nurses from Remedi SeniorCare for the proper administration and documentation during Med Pass. Baseline competencies were established. 3. Controlled substance documentation will be monitored by the Clinical Manger throughout the month. The results of their monitoring will be given to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	3/31/09 3/31/09 3/31/09 4/3/09

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F 425	Continued From page 97 24, 2008 that directed , " Lorazepam 1mg tablet, take 1 tablet by mouth every 8 hours as needed for agitation, hold if blood pressure < 90/60 falls or sedation. " The November 2008 MAR were reviewed and indicated that Lorazepam 1mg tablet was not administered in November, there were no initials entered in the allotted areas. There was no evidence that the resident received the medication. The " Controlled Drug Record " indicated the Lorazepam 1mg tablet was removed from the controlled substance drawer on November 3 and 12, 2008. A face-to-face interview was conducted immediately after the review on the resident's records with Employees # 8 and 54. They acknowledged that the MARs did not indicate with signatures that the controlled substance was administered and the Controlled substance record did not indicate that to Residents JH15 and JH16. The record was review on January 16, 2009. 2. The facility staff failed to date and initial opened multi-dose vials. On January 14, 2008 between during the inspection of two (2) of six (6) the medication storage areas, it was determined that multi-dose vials were not dated and initialed when first opened. 1 North (2) Lantus 10 ml vial Novolog 10 ml vial	F 425	**483.60(a)(b) Pharmacy Services** (continued) 1B. Resident #JH 16 1 Employees involved in the errors of documentation for the administration of Lorazepam were counseled and inserviced. Each was observed by QA nurses from Remedi SeniorCare for the proper administration and documentation during Med Pass. 2. All nurses were observed by the QA nurses from Remedi SeniorCare for the proper administration and documentation during Med Pass. Baseline competencies were established. 3. Controlled substance documentation will be monitored by the Clinical Manger throughout the month. The results of their monitoring will be given to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 2. Multi-dose Vials 1. Opened Multi-dose vials found not to be dated or initialed at the time of the survey were destroyed upon discovery. 2. All multi-dose vials were inspected to insure proper documentation if opened. No other issues were found.	3/31/09 3/31/09 3/31/09 4/3/09 1/16/09 1/16/09

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	095022	A. BUILDING _____ B. WING _____	01/16/2009

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F 425	Continued From page 98 (2) Pneumococcal vaccine 1ml vials Heparin 10,000 unit, 10ml vial 3 North Lorazepam Injection mg/ ml 10 ml vial 3. The facility staff failed to remove expired medications from the medication cart. According to the manufacturer's specifications, "A vial of Tuberculin PPD which has been entered and in use for 30 days must be discarded." On January 14, 2008 at approximately 3:30 PM during the inspection of the medication area on 3 North the following medications were found expired in the medication cart and refrigerator. Buspirone 10 mg, 30 tablets, expiation date 5/28/2008 Risperdal 1 mg, 50 tablets, 2/15/2008 Multivitamin, 50 tablets, 2/15/2008 Loperamide 2 mg, 5 capsules, 9/13/2008 Alprazolam 0.25 mg, 25 tablets, 12/28/2008 Tylenol #3, 12 tablets, 8/6/2008 Clonazepam 0.5 mg, 9 tablets, 5/30/2008 Fluvirin 5 ml injection, 1 vial, 6/30/2008 Tubersol 5 TU vial - opened, 1 vial, 1/3/2009 2 South observed on January 16, 2009 at 9:00 AM Diphenhydramine 25 mg capsules, 10/08 Loperamide 2 mg capsules, 12/28/08 Tylenol 325 mg tablets, 10/07 A face-to-face interview was conduct with Employee #8 and 54 on January 14, 2008, after the carts were inspected. He/she acknowledge that the above findings at the time of the	F 425	**483.60(a)(b) Pharmacy Services** (continued) **2. Multi-dose Vials (continued)** 3. Multi-dose vial documentation will be monitored by the Clinical Manger throughout the month. The results of their monitoring will be given to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator **3. Expired Medication** 1. Expired medication found in the medication area of 3 North and 2 South at the time of the survey were disposed of per policy 2. All medication areas were inspected for the presence of expired meds and no further issues were found. 3. Expired medication disposition will be monitored by the Clinical Manger throughout the month. The results of their monitoring will be given to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	3/31/09 4/3/09 1/31/09 1/31/09 3/31/09 4/3/09

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F 425	Continued From page 99 inspection. 3. Facility staff failed to administer medications in a timely manner for Residents JH1 and JH20. On January 13, 2009 at approximately 10:30 AM during the morning medication pass the keys could not be located to unlock the medication cart on Unit 1 North. A face-to-face interview was conducted with Employee #55 on January 13, 2009 at 10:30 AM. He/she stated, " At about eight forty-five this morning, I realized that I didn't ' t have the keys. [Night shift Employee #56] was called and said [he/she] did not have the keys. I called the pharmacy at nine thirty. I ' m waiting for the master key to come from pharmacy. " A review of the January 2009 MAR revealed that two (2) residents did not receive the morning scheduled doses of medication. A. According to a physician ' s order for Resident JH5 dated November 21, 2008, " Tylenol Extra Strength, two capsules by mouth three times a day with meals for pain. " The facility had determined that the resident would receive the medication at 8:00 AM, 12:00 PM and 6:00 PM. The 8:00 AM dose was omitted because the medication cart keys were not available to unlock the medication cart and provide access to the medication. B. According to a physician ' s order for Resident JH20 dated December 18, 2008, " Novolog 3 units subcutaneously three times with meals. "	F 425	**483.60(a)(b) Pharmacy Services** (continued) 3. Resident JH1 and JH20 1 Employees involved in the errors of notification of the missing keys and the late administration of Tylenol Extra Strength and Novolog insulin was counseled and inserviced on the use of the interim box. A procedure to ensure the consistent provision of on-site replacement keys for all med carts was put in place by the Administrator. 2. All nurses were observed by the QA nurses from Remedi SeniorCare for the proper and timely administration and documentation during Med Pass. Baseline competencies were established. 3. the timeliness of medication passes will be monitored by the Clinical Mangers throughout the month. The results of their monitoring will be given to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	1/31/09 3/31/09 3/31/09 4/3/09

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F 425	Continued From page 100 The facility had determined that the resident would receive the medication at 8:30 AM, 1:30 PM and 5:30 PM. The 8:30 AM dose was omitted because the medication cart keys were not available to unlock the medication cart and provide access to the medication. A face-to-face interview was conducted with Employee #55 on January 13, 2009 at 10:30 AM. He/she stated, " I went to the interim box for the insulin and the Tylenol. " A review of the contents of the interim box revealed that the dosage of Tylenol required for Resident JH1 and the type of insulin required for Resident JH20 were not included in the interim box. A pharmacy representative delivered the medication cart keys at approximately 11:30 AM. The physicians for the additional 14 residents who were scheduled to receive medications at 10:00 AM, were contacted and telephone orders were received to adjust the administration of additional medications throughout the day and monitor the residents. No untoward effects were observed for any of the above cited residents as a result of the adjustment of their medications.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	**483.60(c.) Drug Regimen Review**	

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F 428	Continued From page 101 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents, it was determined that the pharmacist failed to: recommend attempting a dose reduction for antipsychotics for two (2) residents, and review one (1) resident's medication monthly. Residents #5 and 13. The findings include: 1. The pharmacist failed to recommend attempting a dose reduction for Resident #5 who was prescribed Seroquel for five (5) months and complete a review of the Drug Regimen for one (1) month. A. The pharmacist failed to review Resident #5's medications for November 2008. A review of Resident #5's record revealed that the pharmacist reviewed the resident's medications on July 29, August 28, September 29, October 27 and December 24, 2008. There was no evidence that the pharmacist reviewed the resident's medications for November 2008. A face-to-face interview with Employee #5 was conducted on January 12, 2009 at 3:45 PM. He/she acknowledged that the pharmacist did not review the resident's medications for November 2008. The record was reviewed January 12, 2009.	F 428	**483.60 (c.) Drug Regimen Review** (continued) 1A. Resident #5 1. Consultant Pharmacist was made of the oversight. 2. Other charts were checked to ensure the monthly Drug Regimen Review was completed. No further notification to the Consultant Pharmacist was necessary. 3. Monitoring of the Consultant Pharmacists notes will be added to the monthly audit tool completed by the Unit Clerks. Discrepancies will be brought to the attention of the Consultant Pharmacist immediately upon discovery. by the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 1B. Resident #5 1. Psychiatrist consult will be ordered for this resident requesting to evaluate the resident for a gradual dose reduction of her Seroquel. 2. For any other resident on Seroquel who has not been evaluated for a gradual dose reduction, staff will request a consultation from the Psychiatrist. 3. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Psychoactive Drug Review." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation.	3/6/09 3/9/09 4/1/09 4/3/09 3/31/09 3/31/09

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F 428	Continued From page 102 B. Review of Resident #5 ' s record revealed that admission orders, signed by the physician on July 4, 2008, directed, " Seroquel 25 mg twice daily; Seroquel 400 mg at bedtime. " A review of the " Chronological Record of Medication Regimen Review " revealed that the pharmacist reviewed the resident ' s medication on July 29, August 28, September 29, October 27 and December 24, 2008. The pharmacist did not review the resident ' s medication in November 2008. There was no evidence that the pharmacist recommended attempting a gradual dose reduction for Resident #5 ' s Seroquel. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM. He/she acknowledged that the pharmacist failed to recommend attempting a gradual dose reduction for Resident #5 ' s Seroquel. The record was reviewed January 12, 2009. 2. The pharmacist failed to recommend a gradual dose reduction for Resident #13 who was prescribed Seroquel for three (3) months. A review of Resident #13's record revealed the psychiatrist's order dated October 9, 2008, "Seroquel 50 mg po twice daily for agitated behaviors, Klonopin 1 mg po daily for agitation." There was no "Behavior Flow Sheet" located by Employee #5 at the time of this review for October and December 2008. The November 2008 "Behavior Flow Sheet" was blank. The pharmacist reviewed the resident's	F 428	**483.60 (c.) Drug Regimen Review** (continued) 1B. Resident #5 (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 2. Resident #13 1. Psychiatrist consult will be ordered for this resident requesting to evaluate the resident for a gradual dose reduction of her Seroquel. 2. For any other resident on Seroquel who has not been evaluated for a gradual dose reduction, staff will request a consultation from the Psychiatrist. 3. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Psychoactive Drug Review." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	4/3/09 3/31/09 3/31/09 4/3/09

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F 428	Continued From page 103 medications on October 19, November 19, and December 18, 2008. The pharmacist failed to recommend a gradual dose reduction for the use of Klonopin and Seroquel for Resident #13. A face-to-face interview with Employee #5 was conducted on January 13, 2009 at 3:45 PM. He/she acknowledged that the a gradual dose reduction was not recommended by the pharmacist. The record was reviewed January 13, 2009.	F 428		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES 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. 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	F 431	**483.60(b), (d), (e) Pharmacy Services**	

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F 431	Continued From page 104 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility staff failed to properly store medication under proper temperature controls and stored Xalatan unopened in the medication cart. The findings include: 1. 22 DCMR 3227.8, " Each refrigerator that is used for storage of medications shall operate at a temperature between thirty-six degrees (36) and forty-six degrees (46) Fahrenheit (F); each refrigerator shall be equipped with a thermometer that is easily readable, accurate and in proper working condition. " On January 15, 2009, at approximately 10:20 AM, during the inspection of the medication refrigerators, the 3 North medication refrigerator ' s temperature read 24 F. According to the monthly unit pharmacy inspection reports for 2008 , the temperature of the 3 North refrigerator in November was 28 F and December 35 F. A face-to-face interview was conducted at the time of the observation with Employee #29. He/she acknowledge that the refrigerator was out	F 431	**483.60(b), (d), (e) Pharmacy Services** 1. Noted refrigerator temperatures were retaken at the time of the survey and found to be in range. 2. All medication refrigerators were checked for the correct temperature and no corrections were needed. 3. Medication refrigerators are checked monthly by the Consultant Pharmacist, monthly by the Maintenance QI Team and routinely by the nursing staff. Fluctuations in temperature are brought to the attention of the Director of Maintenance for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 2. 1. Xalatan eye drops found improperly stored at the time of the survey were discarded upon discovery. 2. All medication carts were checked for the improper storage of Xalatan eye drops and no corrections were necessary. 3. Inservice training regarding proper storage of Xalatan eye drops was provided to the staff. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Med Pass." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation.	1/16/09 1/16/09 4/3/09 1/16/09 1/16/09 3/31/09

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F 431	Continued From page 105 of range and immediately adjusted the refrigerator to the correct temperature. 2. Xalatan was observed stored unopened in the medication cart on 2 South. Two (2) unopened vials of Xalatan were observed on January 16, 2009 at 9:00 AM stored in the medication cart on 2 North. According to the manufacturer's recommendation, "Store unopened bottle (s) under refrigeration at 36 F to 46 F." A face-to-face interview was conducted at the time of the observation with Employees #8 and 54. Both acknowledged that the unopened Xalatan should have been stored in the refrigerator.	F 431	**483.60(b), (d), (e) Pharmacy Services** (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	4/3/09
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and record review for two (2) of 30 sampled residents, it was determined that facility staff failed to: wash hands after	F 441	**483.65(a) Infection Control** 1. Resident #11 1. Employee involved was counseled and provided inservice with return demonstration to ensure competency. 2. Wound treatment observation was done with nursing staff to ensure their competency with infection control and wound care. 3. Inservice training regarding proper handwashing while in the process of doing wound care treatments was provided to the staff. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Infection Control." The Nursing QI Team will forward their findings to the Director of Nursing for her evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	3/6/09 3/31/09 3/31/09 4/3/09

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F 441	Continued From page 106 reaching into a pocket before proceeding with a wound care treatment for one (1) resident, and clean a soiled mattress for one (1) resident. Residents #11 and 27. The findings include: 1. Facility staff failed to wash his/her hands after reaching into his/her pocket and before proceeding with a wound care treatment for Resident #11. Employee #26 was observed during a wound care treatment to Resident #11 on January 14, 2009 at approximately 11:30 AM. He/she introduced self to the resident and explained what he/she was going to do. He/she washed hands, cleaned the table and covered with a barrier before putting the treatment supplies on the table. Employee #11 reached into his/her pant's pocket, took out keys and locked the treatment cart. He/she failed to wash his/her hands before proceeding with the wound care treatment procedure after locking the treatment cart. A-face-to-face interview was conducted with Employee# 26 on January 16, 2009 at approximately 10:30 AM. He/she acknowledged that he/she failed to wash his/her hands after taking the keys from his/her pocket to lock the treatment cart. 2. Facility staff failed to clean Resident # 27's soiled mattress after removing bed linen soiled and soaked with the contents of the resident's colostomy bag and before making the bed with clean linens.	F 441	**483.65(a) Infection Control** (continued) 2. Resident #27 1. Employee involved was counseled and provided inservice. 2. There are no other residents in the facility with both a colostomy and who require wound care. 3. Inservice training regarding proper Infection Control under the cited circumstances was provided to the staff. This practice will be monitored through the Nursing Services Quality Improvement Program's tool for "Infection Control." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	3/6/09 3/6/09. 3/31/09 4/3/09

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F 441	Continued From page 107 Resident # 27 was observed during a wound treatment on January 15, 2009 at 1:15 AM by Employee #27. The resident's body and bed linens were observed soiled and soaked with the contents of the resident's colostomy bag. After Employee #27 completed the resident's wound care treatment, Employee #29 took over from Employee #27 to clean the resident. Employee #29 stripped the bed of a fitted and flat sheets, picked up some crumbs on the mattress and applied clean linens (a fitted and flat sheets) to make the bed. Employee #29 failed to clean the stained mattress before applying clean bed linens to make the bed. A face-to-face interview was conducted with Employee #29 on January 15, 2009 at approximately 2:35 PM. He/she acknowledged that the stained mattress was not cleaned after stripping the soiled linens from the bed and before making the bed with clean linens.	F 441		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observations during the tray line service and medication pass, it was determined that facility staff failed to: use gloved hands to place noodles on resident plates when plating food; use gloves when checking ladles sizes; consistently use gloves when testing food temperature and to wash hands after administering medication to	F 444	**483.65(b)(3) Preventing Spread of Infection** 1. Tray Line Service A. The Noodle 1. The employee was corrected and the plate was discarded. 1/13/09 2. All servers were monitored to ensure proper serving and infection control technique. 1/16/09 3. Inservice was done on the proper use of gloves and serving utensils when handling food and taking temperatures. Compliance will be monitored through the Nutritional Services Quality Improvement Program's tool for "Infection Control." The QI team will forward their findings to the Director of Nutritional Services for his 3/31/09	

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	095022	A. BUILDING _____ B. WING _____	01/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON NURSING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020

(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 444	Continued From page 108 resident JH19 and before administering medications to Resident JH4. The observations were made in the presence of Employees #14, 41 and 51. The findings include: 1. During tray line observations on January 12, 2009 at 1:40 PM in the 1st floor dining room, the following was observed: A. Employee #42 was observed placing loose noodles on resident plates with gloved hand not a utensil. B. Dietary staff was observed checking the ladle sizes with ungloved hands. 2. During tray line observations on January 13, 2009 at 12:40 PM the 3rd floor dining services staff was observed using one (1) gloved hand when testing the temperatures for the mechanical soft Salisbury steak, mechanical soft chicken, gravy, carrots, mashed potatoes and baked potatoes. Employee #42 inserted the thermometer with the gloved hand and cleaned the thermometer with the ungloved hand. The above mentioned findings were acknowledged by Employee #14 and 41. 3. Facility staff failed to wash hands after administering medications to residents. On January 12, 2009, at approximately 11:30 AM during the morning medication pass, Employee #51 administered medications to Resident JH19. He/she failed to wash or sanitize his/her hands before preparing and administering medications	F 444	**483.65(b)(3) Preventing Spread of Infection** (continued) 1. Tray Line Service A. The Noodle (continued) review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator B. Ladle 1. The ladle was taken out of service upon discovery. 2. All servers were monitored to ensure proper serving and infection control technique. 3. Inservice was done on the proper use of gloves and serving utensils when handling food and taking temperatures. Compliance will be monitored through the Nutritional Services Quality Improvement Program's tool for "Infection Control." The QI team will forward their findings to the Director of Nutritional Services for his 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator 2. The thermometer 1. The thermometer in question was cleaned using an alcohol pad and a gloved hand. 2. All servers were monitored to ensure proper serving and infection control technique.	3/31/09 4/3/09 1/12/09 1/16/09 3/31/09 4/3/09 1/13/09

2. The Thermometer (continued)
3. Inservice was done on the proper use of gloves and serving utensils when handling food and taking temperatures. Compliance will be monitored through the Nutritional Services Quality Improvement Program's tool for "Infection Control." The QI team will forward their findings to the Director of Nutritional Services for his — 3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator — 4/3/09

3.Resident #JH!
1. The employee was counseled upon discovery. — 1/16/09
2. Med Pass observations were done on all the nurses by the QA nurses of the contract pharmacy. Staff who did not follow proper technique were corrected on the spot with follow-up observations done by the Inservice Coordinator of the facility. Competencies were established for all nurses in Med Pass techniques. — 3/31/09
3. The Nursing Quality Improvement Team will collect data on the Med Pass technique using the ""MAR Review" tool in the Nursing QI Program. They will report their findings to the Director of Nurses. — 3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator — 4/3/09

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F 444	Continued From page 109 to Resident JH4. A face-to-face interview was conducted immediately after the observation with Employee #51. He/she concurred that no hand-washing or sanitizing occurred after passing medication to Resident JH19 and before preparing and passing medications to Resident JH4.	F 444		
F 454 SS=D	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation of two (2) of 31 resident rooms during the environmental tour conducted on January 12 and 13, 2009, it was determined that facility staff failed to maintain fire safety as evidenced by propping open fire doors. The environmental tour was conducted on January 12, 2009 from 3:06 PM to 4:10 PM, January 13, 2009 from 9:25 AM to 4:20 PM and January 14, 2009 8:15 AM to 4:25 PM in the presence of Employees #11, 29, and 30. The findings were acknowledged at the time of the observations. The findings include: During the tour of 1 South and 2 South, it was observed that the entry door to the resident ' s rooms, 110 and 202 were propped open with a wooden wedge. These observations were made in the presence of Employee #11, 29 and 30 who acknowledged	F 454	**483.70 Physical Environment** Resident Room Doors 1. New door closures were installed on the doors of rooms 110 and 202. 2. All resident room doors were checked to ensure that they had a positive latch and none were held opened by any other means than the door closure. 3. The Maintenance Quality Improvement Team will collect data through their QI Program on the door closures. The findings will be reported to the Director of Maitenance for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator.	1/16/09 1/16/09 3/31/09 4/3/09

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F 454	Continued From page 110 the findings at the time of the observation.	F 454	**483.70 (c.)(2) Space and Equipment** **1. Garbage disposal**	
F 456 SS=F	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility did not maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by: a damaged garbage disposal, dishwashing machine sink, the dishwashing machine wash temperature, damaged Heating Ventilation and Air Conditioning (HVAC) units and pulley hook and water temperatures between 95 degrees Fahrenheit (F) to 110 F in resident rooms; and water temperatures between 130 - 155 degrees F needed for the laundry wash cycles. The environmental tour was conducted on January 12, 2009 from 3:06 PM to 4:10 PM, January 13, 2009 from 9:25 AM to 4:20 PM and January 14, 2009 8:15 AM to 4:25 PM in the presence of Employees #11, 29, and 30. The findings were acknowledged at the time of the observations. The findings include: 1. One (1) of two (2) garbage disposals was observed damaged in the main kitchen. 2. The sink to the dishwashing machine was leaking water and was observed to have a	F 456	1. The garbage disposal damaged at time of the survey has been replaced. 2. The second garbage disposals was evaluated for repair or replacement was determined to need replacement. 3. The Assistant Director of Nutritional Services will monitor the on-going kitchen equipment status through the use of the Environment section of the Nutritional Services Quality Improvement Program. She will report her findings to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **2. Sink at the dishwashing area** 1. The hairline crack at the top of the sink was repaired and stopped the leak. 2. All sinks in the kitchen were evaluated for any similar leaking areas and none were found. 3. The Assistant Director of Nutritional Services will monitor the on-going kitchen equipment status through the use of the Environment section of the Nutritional Services Quality Improvement Program. She will report her findings to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator.	4/3/09 4/3/09 3/31/09 4/3/09 1/31/09 2/28/09 3/31/09 4/3/09

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F 456	Continued From page 111 crack/gap. 3. The wash cycle temperature reached 148 F on January 12 and 14, 2009 during the dishwashing machine observation. 4. Damaged HVAC units were observed in rooms 136, 206, 304 and 1N resident lounge area. 5. The right pulley [resident rehabilitation gym equipment] located in the rehabilitation room was observed to have a broken hook. 6. Facility staff failed to maintain water temperatures between 95 degrees Fahrenheit (F) to 110 F in resident rooms for residents to have personal care without having to use personal care wipes instead of warm water. Residents F7, F12, F14 and F19. During the testing of the resident room water temperatures on January 13 and 14, 2009 the water temperature readings were as follows: Room Water temperatures on January 13, 2009 between 9:25 AM to 10:30 AM 109 85.0 F 121 77.2 F 137 84.4 F 141 79.3 F 159 82.8 F A face-to-face interview was conducted with Employee #29 on January 13, 2009 at 10:07 AM. He/she stated, " The main boiler for the floors [that services the resident rooms] is down. The kitchen and the laundry boilers are okay. We [the facility] have three (3) boilers. I spoke with the [name of boiler company] and they are on the way	F 456	**483.70 (c.)(2) Space and Equipment** **3. Wash Cycle** 1. Heating elements and booster heater were evaluated for proper operation. adjustments were made when necessary. 2. Temperatures of the wash cycle will be routinely monitored by the Nutritional Services Supervisors to ensure continued compliance. 3. The Assistant Director of Nutritional Services will monitor the on-going kitchen equipment status through the use of the Environment section of the Nutritional Services Quality Improvement Program. She will report her findings to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator. **4. Damaged HVAC Units** 1. HVAC units noted to be damaged at the time of the survey were corrected immediately upon discovery. 2. All HVAC units in resident bedrooms and lounge areas were evaluated to ensure that they were in good condition. 3. The Maintenance Quality Improvement Program monitors the functioning and repair of the HVAC units. The Maintenance QI Team will collect data on this issue and report their findings to the Director for his evaluation. 4. The Department Head will present a report of the data collected on water temperatures and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/31/09 3/31/09 3/31/09 4/3/09 1/16/09 1/31/09 3/31/09 4/3/09

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F 456	Continued From page 112 to repair the problem. " A face-to-face interview was conducted with Employee #2 on January 13, 2009 at 10:20 AM. He/she stated, " The maintenance department made me aware of the water temperature problem. We will use the wipes. The CNA [Certified Nurse Aide] ' s on all floors is being notified to use the wipes. " Additional resident room temperatures were as follows: Room Water temperatures on January 13, 2009 between 10:43 AM to 11:54 AM 304 78.4 F 305 86.1 F 310 73.8 F 313 62.3 F 314 71.4 F 317 66.6 F 324 59.0 F 333 66.6 F 338 77.7 F 341 77.4 F 342 76.1 F 347 65.2 F 354 74.8 F 357 66.6 F 359 79.9 F Room Water temperatures on January 14, 2009 between 8:15 AM to 9:15 AM 126 82.0 F 205 84.7 F 219 85.1 F 231 85.1 F 240 89.1 F 257 84.4 F	F 456	**483.70 (c.)(2) Space and Equipment** **5. Pulley in the Rehabilitation Gym** 1. The pulley was repaired upon discovery. 2. All the pulleys were evaluated for the need for repair . 3. The Maintenance Quality Improvement Program monitors the functioning and repair Rehab equipment. The Maintenance QI Team will collect data on this issue and report their findings to the Director for his evaluation. 4. The Department Head will present a report of the data collected on water temperatures and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. **6. Water Temperatures** 1. Water temperatures were attended to immediately upon discovery. Facility's contractor, Capital Boilers, was contacted and hot water temperatures were restored within a matter of hours on both days noted. Disaster Plan was implemented which included the use of personal care wipes and warming water in the microwave oven. 2. Water temperatures were checked continuously both as the water exited the boilers and as the hot water flowed out of the faucets in the residents' rooms until appropriate temperatures were returned.	1/16/09 1/16/09 3/31/09 4/3/09 1/14/09 1/14/09

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F 456	Continued From page 113 305 91.0 F Beauty shop - 85.6 F A face-to-face interview was conducted on January 14, 2009 at 8:15 AM with Employee #29. He/she stated, " The water temperatures are down. The boiler that provides water to the residents is down. I have the company coming back out today to repair the boiler. When the water temperature is down we [the facility] implement the wipes that can be warmed for the residents to use for personal care. " A review of the work order dated January 14, 2009 revealed, " ...Boiler #3 [services the resident areas] air leak in piping vent; these [this] is the second time recommended installing air vent ... " A face-to-face interview was conducted on January 14, 2009 at 8:37 AM with Resident F7. He/she stated, " The water is cold. The water was cold yesterday. I haven ' t seen any wipes in I don ' t know when. " A face-to-face interview was conducted on January 14, 2009 at 8:45 AM with Resident F19. He/she stated, " The water is cold. I had to wait to get dressed. The water is just cold. I don ' t like the wipes. People can't get their hair done because the water is cold. " A face-to-face interview was conducted on January 14, 2009 at 4:10 PM with Resident F12. He/she stated, " I couldn't ' t gets my hair done yesterday. I had to reschedule my appointment for today at 10:00 AM. The water was still cold, so I didn't ' t gets my hair done until today at 1:00 PM. "	F 456	**483.70 (c.)(2) Space and Equipment** (continued) **6. Water Temperatures (continued)** 3. The Maintenance Department monitors water temperatures through its Quality Improvement Program and monitors the functioning of the facility's boilers through its Preventative Maintenance Program and routine maintenance done by its contractor. Nothing either Maintenance or its contractor could have done would have prevented the boilers from going down on these two days. 4. The Department Head will present a report of the data collected on water temperatures and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/31/09 4/3/09

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F 456	Continued From page 114 A face-to-face interview was conducted on January 14, 2009 at 4:25 PM with Resident F14. He/she stated, " The water is cold, it's cold now. I don't sweat a lot so I just wash my arms. " 7. On January 14, 2009 at 12:06 PM during a tour of the laundry it was observed that the water temperature for three (3) of three (3) washing machines did not reach 130 degrees F in order to activate the enzymes needed to sanitize and/or remove soiled products from facility linen. The temperatures were as follows: 97.1 99.1 77.7 A review of the [vendor name] letter to the facility dated January 9, 2008 revealed, " ...Detergents: [name] These products are used during the wash-bath and their temperature range is 130-140 degrees. Destainer (bleach): This product is used during the ' bleach-bath ' . It ' s temperature range is from 140-155 degrees. " The observation were made and acknowledged in the presence of Employees #11 and 29.	F 456	**483.70(g) Dining and Resident Activities** 1. Residents are seated in the third floor dining room so that they are given sufficient space. 2. Residents in all dining rooms are are seated so that they are given sufficient space. 3. Restorative Nursing will be assigned the responsibility of ensuring that proper space is afforded to each resident in the dining rooms. The Nursing Supervisors will oversee this process to ensure that this correction is sustained. They will report their findings to the Director of Nurses. 4. The Department Head will present a report of the data collected on water temperatures and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/31/09 3/31/09 3/31/09 4/3/09
F 464 SS=D	483.70(g) DINING AND RESIDENT ACTIVITIES The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.	F 464		

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F 464	Continued From page 115 This REQUIREMENT is not met as evidenced by: Based on observation during the survey period, it was determined that the facility staff failed to provide sufficient space for 11 supplemental residents dining in the rear right section of the 3rd floor dining room. Residents F20, F21, F22, F23, F24, F25, F26, F27, F28, F29 and F30. The findings include: On January 13, 2009 at approximately 12:40 PM, the above cited residents were observed in the rear right section of the 3rd floor dining room [near the steam tables]. Table One residents seated two (2) residents: one (1) in an electric wheelchair which blocked the walk way and one (1) in a gerichair which was backed against the wall. Table Two seated three (3) residents in regular arm chairs. Table Three seated three (3) residents: one (1) in a geri chair, which was next to the resident in the electric wheel chair seated at Table One; and two (2) residents seated in wheel chairs. Table Four seated three (3) residents: one(1) in a merry walker, and two (2) in wheel chairs. The residents seated in the geri chairs, merry walker and the electric wheel chair were positioned side ways in order to eat at the table, which blocked the walk way and lacked sufficient space in this area.	F 464	**483.75(b) Administration** Resident #7 1. This resident received her annual H&P. 1/7/09 2. An audit was done for all residents of the facility to ensure that an annual dental screen was done. Correction were made whenever necessary. 3/31/09 3. The unit clerks will perform monthly quantitative audits noting the date of the last dental screening. Their findings will be communicated to the consultant dentist. The Clinical Managers will monitor the timeliness of annual dental screens and communicate their findings to the DON. 3/31/09	
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with	F 492	4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 4/3/09	

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F 492	Continued From page 116 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 30 sampled residents, it was determined that the physician failed to complete an annual history and physical for Resident #7. 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 every twelve (12) months, and documented in the resident ' s medical record. " A review of Resident #7 ' s record revealed that the last history and physical examination was December 12, 2007. A face-to-face interview was conducted with Employee #6 on January 13, 2009 at 2:25 PM. He/she acknowledged that an annual history and physical examination should have been completed in December 2008. The record was reviewed January 13, 2009.	F 492		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS 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.	F 514	**483.75(l)(1) Clinical Records**	

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F 514	Continued From page 117 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to ensure that the monthly weight record was readily accessible and systematically organized, and failed to include the discharge tracking form in the closed record for one (1) resident, and failed to correctly transcribe a medication for one (1) resident. Resident #1, 30, and JH18. The findings include: 1. A review of Resident #1's Minimum Data Set (MDS) completed November 11, 2008 reveled that the resident was coded in: " Section K2: Height and weight:...96 pounds, Section K3: Weight Change: weight loss of five (5) percent or more in the last 30 days or 10 percent in last 180 days. " A review of the July and August 2008 Physician's Order revealed an order that directed "Weigh every month" A review of the resident's Dietary Progress Notes revealed the following: "May 14, 2008 Annual assessment completed"	F 514	**483.75(l)(1) Clinical Records** (continued) Resident #1 1. The weights for this resident were found and made accessible upon discovery. 2. Unit clerks reviewed all the resident's charts to ensure that the monthly weight record was readily accessible and well organized. 3. The Nursing Quality Improvement Team will collect data on the routine documentation of weights using the "Weight Change Review" tool in the Nursing QI Program. They will report their findings to the Director of Nurses. 4. The Department Head will present a report of the data collected on water temperatures and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	1/16/09 3/31/09 3/31/09 4/3/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON NURSING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020

(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 514	Continued From page 118	F 514	**483.75(l)(1) Clinical Records** (continued)	

"August 19, 2008: MDS/Quarterly Reviewed Today: Current weight: 105 pounds [increase 7% x 1 month ..."
"October 31, 2008: weight check, current: 96 pounds decrease 8.1% x 1 month significant weight loss ..."

The resident's weight was not easily accessible from the dietary progress notes and the resident's clinical record lacked evidence that the resident's weight record was systematically organized.

According to the "Resident Weight and Height Record" form for 2008 documented the resident's weight as follows:

October 2008 96 pounds
November 2008 98 pounds
December 2008 97 pounds
January 2009 88 pounds.

The weights for April, May, June, July and September 2008 were not on the "Resident Weight and Height Record" form and were not easily accessible in the clinical record.

A face-to-face interview was conducted with Employee #6 on January 16, 2009 at approximately 11:30 AM. He /she acknowledged that the resident's weight for April to September were not listed on the "Resident Weight and Height Record." Employee #6 reviewed the resident's record and compiled the resident's weights from April through September 2008 from other multiple sources in the record.

A face-to-face interview was conducted with Employee # 29 on January 16, 2008 at

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F 514	Continued From page 119 approximately 11:30 AM. He/she acknowledged that the Dietary Progress Notes lacked evidence that the resident's weight was readily accessible and systematically organized. He/she reviewed the resident's clinical record and acknowledged that the resident's weight for the month of September 2008 was not readily accessible. Facility staff failed to ensure that the resident's monthly weight record was readily accessible and systematically organized in the resident's clinical record. The record was reviewed January 16, 2009. 2. Facility staff failed include the "Discharge Tracking "form for Resident #30. A review of Resident #30's record revealed that the resident was discharged to an assisted living facility on august 28, 2008. The "Discharge Tracking" form was not present in the record. A face-to-face interview was conducted with Employee #2 on January 15, 2009 at 2:30 PM. He/she acknowledged that the "Discharge Tracking " form should have been on the record. The record was reviewed January 15, 2009. 3. Facility staff failed to transcribe the order correctly on the Medication Administration Record for JH18. A review of the resident ' s record revealed a physician ' s order signed and dated on December 31, 2008, directed, " Nifedipine 90 mg, one tablet po [by mouth], qd [daily] for HTN [hypertension]. On January 16, 2009, at approximately 9:00 AM	F 514	**483.75(l)(1) Clinical Records** (continued) 2. Resident #30 1. The discharge tracking form was found and made part of the medical record. 2. The medical records of all residents who were recently discharged were reviewed to ensure the presence of the discharge Tracking form. Corrections were made whenever necessary. 3. The Nursing Quality Improvement Team will collect data on the Discharge Tracking form using the "MDS" tool in the Nursing QI Program. They will report their findings to the DON. 4. The Department Head will present a report of the data collected on water temperatures and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 3. Resident JH 18 1. The resident's MAR was reviewed and the corrections were made as indicated. The employee involved was counseled. 2. MARs were reviewed to ensure that there were no other errors of transcription. Corrections were made whenever necessary.	1/31/09 3/31/09 3/31/09 4/3/09

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F 514	Continued From page 120 during the review of Resident JH18 ' s record, it was determined that the order for Nifedipine was transcribed onto the MAR as Nifedipine 20 mg instead of Nifedipine 90 mg. The blister pack located in the cart was observed as Nifedipine 90 mg and according to the January 2008 MAR, the resident received the medication daily. A face-to-face interview was conducted at the time of this observation with Employee #54. He/she acknowledged that the above cited order was transcribed incorrectly on the MAR. The record was reviewed January 16, 2009.	F 514	**483.75(l)(1) Clinical Records** (continued) Resident #JH18 3. The Nursing Quality Improvement Team will collect data on the transcription of physician orders using the tools in the Nursing QI Program. They will report their findings to the DON. 4. The Department Head will present a report of the data collected on water temperatures and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	3/31/09 4/3/09