STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/22/2007

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SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF	4601 MLK KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted February 20 through 22, 2007. The following deficiencies were based on record review, observations, and interviews with the facility staff and residents. The sample included 15 residents based on a census of 61 residents on the first day of survey and three (3) supplemental residents.	F 000	F221 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The straight back chair was removed immediately on 2/20/07 and the CNA was instructed by RCC to stop the deficient practice. An assessment of the resident was done. It was determined that restraint is not necessary. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Rounds on all residents' room and day rooms were conducted on 2/20/07 to ensure that no other resident is being prevented from getting up by using straight back chairs. No other resident's were found to be affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All nursing staff was in-serviced on 2/28/07, 3/5/07, and 3/7/07 on the facility's restraint policy, which includes the types of restraints recognized by the facility. (Emphasis was placed on the use a straight back chair as a form of restraint as not acceptable practice). See attachment #1.	
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 observation, staff interview and record review for one (1) supplemental resident, it was determined that facility staff failed to assess Resident S1 for the use of a restraint. The findings include: During the initial tour, Resident S1 was observed on February 20, 2007 at 9:30 AM, sitting in his/her room in a geri chair with his/her feet resting on a straight back chair. A face-to-face interview was conducted immediately with a Certified Nurse Aide (CNA) regarding the positioning of Resident S1. The CNA stated, "I usually work nights. When [Resident S1] gets restless, we put him/her in the geri chair and put his/her feet on the other [straight back] chair to keep him/her from getting up. It's the only thing that works." The surveyor asked how long staff has been using this method.	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kasi Mann Cullen — TITLE: Administrator — (X6) DATE: 3/15/07

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 221	Continued From page 1 The CNA stated, "At least since Christmas." A review of the resident's record revealed that there was no assessment for the use of the straight back chair as a restraint. There was no evidence in the record that the use of the straight back chair was recognized by facility staff as a restraint. The record was reviewed February 22, 2007.	F 221	F-221 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** RCC's will conduct daily rounds to monitor, and outcomes will be reported to DON and Administrator during daily Stand up meetings. Statistics will be reported to new monthly Quality Assurance meetings, using new QA tool. See attachment #2.	April 5, 2007
F 253 SS=D	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 : During the environmental tour, it was determined that housekeeping and maintenance services were not adequate to maintain the facility in a safe and sanitary manner, as evidenced by: marred and scarred straight back chairs, damaged walls and doors and stained ceiling tiles . These observations were made in the presence of the Director of Maintenance, Housekeeping Supervisor and nursing staff. The findings include: 1. The arms and legs of straight back chairs in the 3 East dining room were marred and scarred in seven (7) of seven (7) chairs observed on February 21, 2007 at 2:00 PM. 2. Walls were observed to be damaged and scarred in the following areas: 3 East dayroom, rooms 301, 312, 316, 324 and 336 in six (6) of 18 walls observed from 2:00 PM until 3:30 PM on	F 253		

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F 221	Continued From page 1 The CNA stated, "At least since Christmas." A review of the resident's record revealed that there was no assessment for the use of the straight back chair as a restraint. There was no evidence in the record that the use of the straight back chair was recognized by facility staff as a restraint. The record was reviewed February 22, 2007.	F 221	F253 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The arms and legs of all 7 straight back chairs in 3East dining room were painted on 3/16/07. Damaged walls observed on 3East day room were all painted. Damaged doors observed in 3 east day room were painted on 3/6/07. 3 East shower stretchers and under mats were cleaned by housekeeping on 2/22/07. The stained ceiling tiles on 3East ding room were replaced on 3/5/07. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Engineering and Housekeeping Department did environmental rounds and all other stained ceiling tiles were replaced, all damaged, scarred and marred, soiled doors, chairs, and walls were cleaned and painted. No other stretchers or under mats were dirty. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** New environmental rounds to be conducted weekly have been instituted to include housekeeping and maintenance department. A rounds checklist will be utilized to identify any damages or concerns in rooms. All findings will be reported to the Administrator. All findings will be fixed immediately.	
F 253 SS=D	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 : During the environmental tour, it was determined that housekeeping and maintenance services were not adequate to maintain the facility in a safe and sanitary manner, as evidenced by: marred and scarred straight back chairs, damaged walls and doors and stained ceiling tiles . These observations were made in the presence of the Director of Maintenance, Housekeeping Supervisor and nursing staff. The findings include: 1. The arms and legs of straight back chairs in the 3 East dining room were marred and scarred in seven (7) of seven (7) chairs observed on February 21, 2007 at 2:00 PM. 2. Walls were observed to be damaged and scarred in the following areas: 3 East dayroom, rooms 301, 312, 316, 324 and 336 in six (6) of 18 walls observed from 2:00 PM until 3:30 PM on	F 253		

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F 253	Continued From page 2 February 21, 2007. 3. Doors were observed damaged, marred, scarred or soiled in rooms 301, 318, 3 East dayroom and 3 East shower room in four (4) of 18 door observations from 2:00 PM through 3:30 PM on February 21, 2007. 4. Ceiling tiles were observed stained or damaged in rooms 301, 316, 343 and the 3 East dining room in four (4) of 18 ceiling tile observations from 2:00 PM through 3:30 PM on February 21, 2007.	F 253	F253 **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** The Maintenance and Housekeeping Supervisor will do weekly rounds to commence 4/3/07; any deficient findings will be reported in monthly Environment of Care Committee, Process Improvement, and QA meeting.	April 5, 2007
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.	F 278		

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F 278	Continued From page 3 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for one (1) of 15 sampled residents, it was determined that Resident #12 was inaccurately coded for behaviors on the quarterly Minimum Data Set (MDS) assessment. The findings include: A review of Resident #12's record revealed that according to the quarterly MDS completed February 5, 2007, the resident was coded in Section E4e, "Mood and Behaviors" as resisting care. The Assessment Reference Date (ARD) for the MDS was February 3, 2007. The ARD date is the last date of observations. The look back period for Section E4 is seven (7) days. According to the "Behavior Monitoring Sheet" for January and February 2007, and the nurses' notes for January and February 2007, there was no evidence that the resident resisted care. A face-to-face interview was conducted with the Certified Nurse Aide (CNA) on February 21, 2007 at 2:30 PM. He/she stated, "[Resident #12] used to fight us when were tried to give care. But for a couple of months, now, I haven't heard that [he/she] has given anybody any trouble." The record was reviewed February 21, 2007.	F 278	F-278 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** MDS Coordinator was notified of survey findings, and re-educated on 2/22/07. MDS modification was done and transmitted on 2/22/07. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of all resident MDS with behavior monitoring flow sheets were reviewed to ensure that behaviors coded were within the parameter of the 7 day look back from the ARD. See attachment #2. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** At weekly IDT care plan meeting, the team members will review the MDSs of resident's scheduled for care plan for compliance to the 7-day look back if behaviors are coded in the MDS. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Compliance monitoring outcomes will be reported to the Administrator by the IDT weekly and QA committee monthly using the MDS QA tool. See Attachment #3.	April 5, 2007
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 4 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, staff interview and review of the clinical record for one (1) of 15 sampled residents, it was determined that facility staff failed to initiate a care plan for aspiration precautions during meal time for Resident #3. The findings include: A review of Resident #3's record revealed a physician's orders dated December 12, 2006 that directed, "4 Gram Na (sodium) pureed diet with nectar thick [nectar thickened liquids]. Aspiration precautions require close supervision and assistance at meal time; elevate HOB (head of bed) to 90 degrees at meal time and one (1) hour	F 279	F279 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The care plan for resident #3 was reviewed and additional approaches for aspiration precautions were added and shared with the surveyor during the surveyor on 2/20/07, See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Audits of all resident's care plan that are on a puree diet were reviewed to include aspiration precautions. A tool was done on 2/20/07. See attachment #2. No other residents were found to have this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The interdisciplinary team was re-educated (2/23/07) on all components of the care plan. All residents who will be placed on a puree diet will include Aspiration precautions in their comprehensive care plans as the order for a puree diet is carried out by the nursing staff.	

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F 279	Continued From page 5 after meals." The review of the resident's interdisciplinary care plan dated February 9, 2007 lacked a problem with goals and approaches for aspiration precautions during meal time. A face-to-face interview was conducted with the Resident Care Coordinator on February 20, 2007 at approximately 9:30 AM who acknowledged that the resident's care plan lacked goals and approaches for aspiration precautions during meal time. The record was reviewed on February 20, 2007.	F 279	F279 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur. (i.e., what Quality Assurance Program will be put into place?** Monitoring for compliance will be conducted by the IDT weekly during care plan meeting. The RCC's will report all deficient practices to the DON and Administrator weekly and the monthly QA meeting for monitoring. See new QA tool attachment #3	April 5, 2007
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. 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 :	F 280		

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F 280	Continued From page 6 Based on staff interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to update Resident #12's fall care plan with goals and approaches after multiple falls with a subsequent injury. The findings include: A review of Resident #12's record revealed the following: March 11, 2006 - found on the floor in room August 10, 2006 - observed kneeling on floor September 17, 2006 - observed climbing out of bed October 15, 2006 - attempting to climb out of bed October 28, 2006 -attempting to climb out of bed November 23, 2006 - found on the floor November 28, 2006 - found crawling on the floor November 29, 2006 - attempted to get out of bed February 3, 2007 - sitting on the floor February 17, 2007 - found on the floor with swelling and complaint of pain to left wrist An x-ray of the left wrist and arm was taken on February 18, 2007 and revealed a fracture of the left wrist. A review of the care plan revealed that on March 12, 2006, facility staff initiated the approach of placing the resident across from the nurse's station when up in the geri chair. There was no evidence that facility staff implemented any additional approaches to prevent the resident from falling. On February 17, 2007, Resident #12 fell out of the geri chair, onto the floor in the day room and fractured his/her left wrist. A face-to-face interview was conducted with the	F 280	F280 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A care plan meeting was held on 2/23/07 for resident #12 by IDT team who reviewed additional approaches to prevent future falls such as utilization of a chair alarm, a new low bed and floor mat for this resident. See attachment #1. Chair alarms arrived 3/6/07, and in-service conducted for staff, attachment #2. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of the all the remaining residents with multiple falls was done on 2/23/07 per facility protocol by the RCCs to prevent any other resident from being affected by this practice. All residents at risk for falls were evaluated for chair alarms, low beds, and floor mats. See attachment #3. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The falls prevention protocol was re-visited on 3/5/07 to institute low beds, floor mats and chair alarms for all residents at risk for frequent falls. Ongoing education for staff and auditing of the charts of all residents per facility protocol will be done by the RCC to ensure that deficient practice does not recur.	

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F 280	Continued From page 7 Resident Care Coordinator on February 22, 2007 at 8:15 AM. He/she acknowledged that there were no new goals and approaches initiated after March 12, 2006 to prevent Resident #12 from falling. The record was reviewed February 22, 2007.	F 280	F280 **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** RCC will use the facility chart audit form and audit all charts of residents presently at risk for falls and any new admissions to ensure that a care plan is put in place after any resident falls. Any deficient practices will be reported to the DON and the monthly QA meeting.	April 5, 2007
F 309 SS=G	483.25 QUALITY OF CARE 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 staff interview and record review for three (3) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to: follow up on a Dilantin level for one (1) resident who was subsequently diagnosed with Dilantin toxicity; ensure that a complete order was written for blood sugar monitoring and follow-up on the resident's request to decrease frequency of fingersticks and a report of feeling depressed for one (1) resident; re-weigh one (1) resident who lost 48 pounds in one month; and ensure that a PT/INR level was drawn as ordered by the physician. Residents #14, 1, 6 and H1. The findings include: 1. Facility staff failed to follow up on a Dilantin (Phenytoin) level result for Resident #14 who was subsequently admitted to the hospital with a	F 309		

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F 309	Continued From page 8 diagnosis of Dilantin toxicity. The physician's order sheet dated December 2006 directed, "Dilantin level every 3 months-March/June/Sept/Dec [original order dated September 8, 2006]." A review of the laboratory (lab) section of the record revealed that a Dilantin level was drawn on December 1, 2006. There was no evidence in the record that the results for the aforementioned Dilantin level were present at the time of this review. A face-to-face interview was conducted with the Resident Care Coordinator and the Director of Nursing on February 21, 2007 at 12:30 PM. After reviewing the record, they both acknowledged that there were no Dilantin level results. According to the following nurses' notes: February 7, 2007 at 2:00 PM "Physical therapist came up on the unit and stated that the resident was much weaker on the left side than yesterday in therapy. A call has been made to Doctor [name] to make [him/her] aware." February 7, 2007 at 8:00 PM, "Speech therapist expressed concern to writer about resident's weakness on the right side. This writer contacted Doctor [name] to convey concerns of weakness and decline in speech pattern. Doctor [name] ordered that resident be transferred to ER [emergency room] for evaluation of altered neurological status. Follow up call made to determine status... resident was taken to hospital [name] and admitted for Dilantin toxicity and dehydration."	F 309	F-309 (2A) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The physician was notified and new order for finger stick was received and carried out for resident #1. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Medical records of all residents receiving finger sticks were reviewed for completeness of the orders (completeness of parameters). No other residents were found to be affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Nursing staff on both units were in-serviced about receiving and carrying out complete physician orders. New monitoring tool created to track deficient practice. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Monitoring outcomes will be reported to Administrator at daily stand up meetings and monthly at QA committee meetings.	April 5, 2007

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F 309	Continued From page 9 On February 21, 2007 at 4:15 PM the facility staff obtained the Dilantin level results at the request of the surveyor. The lab report revealed a Dilantin result of 29.6 H [high], [normal range 10.0-20.0]. There was no evidence that facility staff followed up on the Dilantin level drawn on December 1, 2006. Subsequently, the resident was hospitalized with a diagnosis of Dilantin toxicity on February 7, 2007. The record was reviewed on February 21, 2007. 2. Facility staff failed to ensure that a complete order was written for blood sugar monitoring and follow-up on Resident #1's request to decrease the frequency of fingersticks and the resident's statement of feeling depressed timely. A. A review of Resident #1's record revealed a physician's order dated June 6, 2006 and subsequently renewed every 30 days, with the most recent order signed February 2, 2007. The order directed, "Glucose finger stick every day at 6:00 AM." There was no direction from the physician regarding the action facility staff should take for the results of the finger stick. A review of the glucose monitoring record and the nurses' notes from June 2006 through February 2007, revealed that finger sticks ranged from 90 to 252. On November 13, 2006, the resident's fingerstick was 252 (Normal range is 60-120). There was no evidence that facility staff notified the physician of the elevated finger stick results. A face-to-face interview was conducted with the charge nurse on February 20, 2007 at 11:00 AM.	F 309	P-309 (2B) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Physician was notified on 2/22/07 of resident #1s request. The physician did not change the order. The medical Director was notified and changed the order from daily to finger sticks every Monday and Friday. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on 3/5/07 of all nursing notes to ensure nursing staff follow-up of all residents request do occur. No other deficient practices were noted. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The RCC/designees will review resident's records in the respective units of evidence of documentation addressing follow up of resident's requests from the previous shifts daily. Identified deficient practices will be called to the attention of staff involved to correct immediately. Failure for staff compliance will result in progressive disciplinary action. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Outcomes will be reported to DON daily and DON will report to Administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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F 309	Continued From page 10 The surveyor asked the nurse what action would be taken if the resident's fingerstick was below 60 or above 120. The nurse stated, "It is a nursing judgement to notify the physician." There was no evidence in the record that the resident experienced hypoglycemic or hyperglycemic reactions. The record was reviewed February 20, 2007. B. According to a nurse's note dated June 9, 2006 at 6:00 AM, "Resident stated, "I don't want my finger stick. I am not that bad a diabetic." Will have AM nurse call [physician] and see if daily BS [blood sugar] can be changed." There was no evidence that facility staff followed up on the resident's request. A review of the Medication Administration Record for June 2006 through February 2007 revealed that the resident had a finger stick done every morning at 6:00 AM A face-to-face interview with the RCC was conducted on February 20, 2007 at 11:30 AM. He/she stated, "I wasn't aware that the resident didn't want daily finger sticks. No one told me." C. According to a nurse's note dated June 19, 2006 at 3:45 PM, "Resident MD has been called to come and see resident because resident said [he/she] is depressed. MD promised to come and see resident tonight." There was no evidence that the physician saw the resident on June 19, 2006. There was no evidence that facility staff followed-up on the resident's statement of depression. The psychiatrist saw the resident on July 19, 2006	F 309	F-309 (2C) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Psychiatrist was notified of the resident's request. The Psychiatrist saw the resident on March 3, 2007. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted to ensure resident's request to see Psychiatrist were followed. No other residents were found to have this deficient practice. All residents with the diagnosis of depression and /or verbalize feelings of sadness, anger, or depression documented in record were referred to the clinical social worker for intervention and/or follow-up with Psychiatrist as deemed appropriate. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Nursing staff were in-serviced to report expressions of mood and behavior changes of their residents to team leaders for intervention/referral to social worker. A new QA tool was created see attachment #2. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not reeur (i.e., what Quality Assurance Program will be put into place?** Outcomes will be reported to DON daily and DON will report to Administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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F 309	Continued From page 11 . The resident was prescribed Zoloft for depression. A face-to-face interview was conducted with the RCC on February 20, 2007 at 11:35 AM. He/she stated, "The resident is on an antidepressant. The psychiatrist saw [him/her]" After reviewing the Resident's record, the RCC stated, "The psychiatrist didn't see the resident for about a month after [he/she] said [he/she] was depressed." The record was reviewed February 20, 2007. 3. Facility staff failed to re-weigh Resident #6 after significant weight loss. The annual Minimum Data Set assessment dated December 26, 2006 included the following diagnoses in Section I: Diabetes Mellitus, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, other Cardiovascular Disease, Arthritis, Allergies, Anemia and Renal Failure. According to the "Yearly Weight Chart" for Resident #6, the resident weighed: August 2, 2006 277# (pounds) September 1, 2006 229.2#. October 3, 2006 230# November 2, 2006 214#. There was an 18% weight change between August and September 2006 and 7% between October and November 2006. There was no evidence in the record that facility staff re-weighed the resident after the aforementioned weight loss.	F 309	F-309 (3) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The resident was weighed on 2/20/06. Employee was counseled on the importance of weighing residents. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on all remaining residents to ensure weights were being done and were correct. See attachment #1. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** A newly created Weight committee began 3/7/07 to include dietary and nursing to commence monthly, see attached #2. Education of staff was conducted on 3/7/07. Weight Policy was updated to reflect weights to be done 1st thru the 5th of each month. Re-weights will be done when there is a difference of 2-4 lbs from 2 successive weights and will be done no later than the 6th of every month. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Wight committee will monitor staff compliance. Outcomes will be reported to DON and administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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F 309	Continued From page 12 A face-to-face interview was conducted with the Resident Care Coordinator on February 20, 2007 at 4:00 PM. He/she stated, "When the weight loss is greater than five pounds we have to re-weight the resident. I don't know why the resident wasn't re-weighed at these times (September and November 2006). A face-to-face interview was conducted with the dietician on February 20, 2007 at 3:45 PM. He/she stated, "I did a lot of counseling with [Resident] at least two or three times a week in August, September, October and November. We talked about the carry out Chinese food that [he/she] ate and how important it was not to eat foods high in sodium because of [Resident's] edema. I informed the doctor of the resident's condition and that I was counseling the resident at least twice a week. I talked at great length with the resident to eat only the food we provided here, not to eat the carry out food. [His/her] on-going weight loss is desired because of the resident's medical condition. [Resident] doesn't have any more edema and the breathing is better." According to the facility's policy, SNS. 59 " Resident ' s Weight ": "If a variance of 2-4 lb exists between two successive weights a re-weight should be obtained and verified by the licensed nurse or designee and reported to the Charge Nurse and DON " and " Addressing Significant Weight Changes" states: "All residents with significant weight changes will be reweighed under the supervision of a licensed nurse within 48 hours." The above cited policy defines significant change as:	F 309	F-309 (4) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively corrective action could not be done. On 2/22/07 blood was redrawn and found to be hemalized. Blood was redrawn on 2/23/07 and results were shared with physician and placed on resident's record. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on all residents receiving Coumadin with a PT/INR ordered were reviewed for lab results and if they were in the record the MD was notified. No other residents were identified with this same deficient practice. See attachment #2. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The lab log was revised to include follow-up of results on tests ordered. This will be done by the licensed staff on the night shift on a daily basis. RCC will check logs on a daily basis. A dedicated fax line to receive lab reports from reference lab daily was installed.	

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F 309	Continued From page 13 5% in one month 7.5% in three months and 10% in six months There was no evidence in the record that facility staff re-weighed the resident after the weight loss. The record was reviewed February 20, 2007. 4. Facility staff failed to ensure that a PT/INR level was drawn as ordered by the physician for Resident H1. A review of Resident H1's record revealed a physician's order dated February 8, 2007 that directed, "Increase Coumadin to 6mg daily via G-tube (gastrostomy tube) for pulmonary embolism ... Do PT/INR in one week when 6 mg Coumadin has been given for one week." There was no evidence in the record that the PT/ INR was drawn on February 15, 2007. A face-to-face interview was conducted with the RCC on February 23, 2007 at 1:45 PM. He/she acknowledged that the PT/INR should have been drawn on February 15, 2007. The record was reviewed February 22, 2007.	F 309	F-309 (4) **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** RCC will report to DON and Administrator at daily stand up meeting. Outcomes monitoring will be reported to the QA committee monthly.	April 5, 2007
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by : Based on observations during the environmental tour, it was determined that facility staff failed to ensure that the environment was free from	F 323		

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F 323	Continued From page 14 accident hazards as evidenced by one (1) resident's bed that prevented the door from closing and one (1) blanket observed on the floor in a resident's room. These observations were made in the presence of the Director of Maintenance, Housekeeping Supervisor and nursing staff. The findings include: 1. During the environmental tour, an isolated observation at 2:40 PM on February 21, 2007, revealed that the position of Resident S3's bed in room 333 prevented the resident's door from closing. A face-to-face interview with facility staff touring with the surveyor was conducted immediately. Staff members indicated that the position of the bed had been a concern for many years. The resident refused to move the position of the bed. Resident S3 was interviewed on February 21, 2007 at 3:00 PM. After explanation by the surveyor of the concerns regarding the door, the resident agreed to position the bed to allow the door to close. 2. During the initial tour, at 9:30 AM on February 20, 2007, an isolated observation revealed a blanket on the floor near the bed of Resident S4 in room 324. The blanket was not secured and easily moved when touched. A face-to-face interview was conducted with the Resident Care Coordinator (RCC) who was touring with the surveyor. He/she stated, "[Resident] has had that down on the floor since Christmas. [Resident] complains the floor is cold.	F 323	F323 (1) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The resident agreed to change the position of the bed to allow the door to be closed, and the wheels of the bed were locked in place. Maintenance will put a permanent mark on the floor for staff and resident to know correct positioning of bed. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All other rooms were evaluated for this deficient practice and no other resident was found to be affected. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All staff was educated as to the hazards of accident and the prevention on 3/7/07. Housekeeping and Maintenance Departments will be responsible for monitoring during weekly environmental rounds. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** The Maintenance and Housekeeping Supervisor will monitor the areas on a schedule and report any deficient practices to the Administrator weekly, and monthly to EOC Committee, Patient Safety, Process Improvement, and Quality Assurance meeting.	April 5, 2007

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F 323	Continued From page 15 Housekeeping cleans the floor then put the blanket back down on it." The surveyor asked why the resident was using a blanket and not a rug with a non-skid backing. The RCC stated, " We'll replace that with a rug."	F 323	F324 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively no corrective action could be done as there was insufficient staff on the day the incident occurred. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice when the PPD falls below 3.5. The 24 hour nurse staffing rule was reviewed with staff to ensure that a minimum of PPD of 3.5 is achieved on a daily basis. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The DON is in the process of recruiting for PRN staff. A unit clerk position for weekends on both nursing units was approved to keep nurses from doing majority of administrative duties on weekends. On weekends /Holidays/ inclement weather days when there are call outs we have instituted an emergency bonus plan for nursing staff. See attached #1. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported to DON and Administrator daily by RCC for immediate action and correction.	April 5, 2007
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to provide adequate supervision for Resident #12 who had multiple falls with a subsequent injury. The findings include: A review of Resident #12's record revealed the following: March 11, 2006 - found on the floor in room August 8, 2006 - observed climbing over the side rails October 15, 2006 - attempting to climb over side rails October 28, 2006 - attempting to climb out of bed November 12, 2006 - found on the floor November 28, 2006 - found crawling on the floor November 29, 2006 - attempted to get out of bed February 3, 2007 - sitting on the floor February 17, 2007 - found on the floor with swelling and complaint of pain to left wrist An x-ray of the left wrist and arm was taken on	F 324		

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F 324	Continued From page 17 during the day of the incident was 3.0 nursing hours per resident per day, below the DC requirement of 3.5 nursing hours per resident per day. A face-to-face interview was conducted with the Resident Care Coordinator on February 22, 2007 at 8:15 AM. He/she acknowledged that after reviewing the record, there were no interventions initiated after March 12, 2006 to prevent the resident from falling. The record was reviewed February 22, 2007.	F 324	F-329 (1) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Psychiatrist of resident #1 was notified of the survey findings, and she re-assessed the resident and discontinued the Haldol, see attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** The charts of all other residents on Haldol were reviewed. No other residents are affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All residents receiving Haldol will be monitored for presence/absence of clinical indication for continued use. Monitoring and outcomes will be reported to the MD for dosage adjustments or discontinuation by Charge Nurses. See attachment #2. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Compliance monitoring outcomes will be reported to monthly Quality Assurance.	April 5, 2007
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.	F 329		

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F 329	Continued From page 18 This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for two (2) of 15 sampled residents, it was determined that facility staff failed to ensure that one (1) resident was adequately monitored and assessed for the continued use of Haldol and one (1) resident was assessed for the continued use of multiple pain medications and that the drug regimen was free from unnecessary drugs. Residents #1 and 9. The findings include: 1. Facility staff failed to adequately monitor and assess Resident #1 who had received Haldol for seven (7) months. According to the admission Minimum Data Set assessment completed June 8, 2006, Resident # 1 was coded in Section B, "Cognitive Patterns" with no short or long-term memory loss. The resident was coded as having no mood or behavior issues in Section E, "Mood and Behavior Patterns." According to an nurse's note dated July 15, 2006 at 11:00 PM, "Resident in room in wheel chair visited by family. C/O room mate yelling and frightening [him/her]. Resident was calmed down ..." A nurse's note dated July 16, 2006 at 11:00 PM documented, "Resident alert and verbally responsive. Verbalized that [he/she] is scared because of [his/her] room mate moaning, yelling and saying strange things out loudly..." A physician's telephone order dated July 17, 2006	F 329	F-329 (2) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #9's Attending Physician was notified of survey findings on and the medication dosages were reduced by physician after assessment on 3/3/07. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** The charts of all other residents on pain medications were audited. No other residents were found to be affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** RCC's and Charge Nurses were re-educated as to when pain medications were changed per facility protocol and policies. See attachment #2 in-service list. In the event the attending physicians does not address pharmacy consultants recommendation with no documented explanations the medical director will be notified by designee. Cases referred to Medical Director will be reviewed at monthly QA meetings. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Compliance monitoring will be conducted monthly by RCC/designee, any deficient practices will be reported to monthly Quality Assurance.	April 5, 2007

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F 329	Continued From page 19 at 3:120 PM directed, "Psychiatry consult with [Psychiatrist]." The psychiatrist's progress note dated July 17, 2006 documented, "...R/O [rule out] major depressive disorder, Schizophrenic Disorder..." In the margin of the above cited note was the word "Dictated." There was no evidence of a dictated note on the record at the time of this review. Additionally, there was no evidence the psychiatrist had seen the resident since the initial visit of July 17, 2006. A psychiatrist's order dated July 17, 2006, directed, "Haldol 2 mg po q (by mouth every) bedtime for [unable to read]." A face-to-face interview was conducted with the psychiatrist on February 21, 2007 at 11:20 AM. After reviewing the record, he/she stated, "I would have to review the dictated note. I will get back to you." There was no further contact with the psychiatrist during the survey period. The physician and/or nurse practitioner saw the resident August 21, September 4, October 2, October 5, October 9, October 11, November 4 and December 4, 2006 and January 6, February 2 and February 12, 2007. The progress notes did not include discussion of the resident's behaviors, the on-going use of Haldol or a dose reduction of the Haldol. The resident was being monitored for agitation, outbursts and restlessness. A review was conducted of the behavior monitoring records from July 2006 through February 2007. There was no evidence of the above cited behaviors occurring during this time period.	F 329		

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F 329	Continued From page 20 There was no evidence of an indication for the on -going use or a dose reduction of Haldol from July 2006 through February 2007. The record was reviewed February 20, 2007. 2. Facility staff failed to ensure that Resident #9 was assessed for the continued use of multiple pain medications and that the drug regimen was free from unnecessary drugs. Resident #9 was admitted to the facility on July 6, 2005. The annual Minimum Data Set assessment dated October 18, 2006, revealed the following diagnoses in Section I: Quadriplegia, Manic Depression, Anemia, Urinary Tract Infection, Gastritis, Drug Abuse, Joint Effusion and Endocarditis. Admission orders dated July 6, 2005, directed, " Methadone 5 mg twice daily for withdrawal. Dilaudid 2mg every 4 hours PRN (as needed) for pain." On November 12, 2005, a physician's order directed, "Methadone 5 mg twice daily for pain." There was no evidence a pain assessment was conducted by the nursing staff or the physician. On December 30, 2005, a physician's order directed, "Dilaudid 4 mg every 4 hours for pain." There was no evidence a pain assessment was conducted by the nursing staff or the physician. A review of Resident #9's record revealed physician orders dated December 28, 2006 for the following medications and indications for use: Benadryl 50 mg every night for anxiety and sleep, Dilaudid 4 mg every 4 hours for pain, Methadone	F 329		

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F 329	Continued From page 21 5 mg twice daily for pain, Acetaminophen with Codeine #3, 2 tabs every 6 hours as needed for dental pain, Ambien 5 mg at bedtime as needed for sleep and Flexeril 5 mg three times daily as needed for muscle spasms. The Benadryl was discontinued January 11, 2007. The other above cited medications were renewed January 30, 2007. Dilaudid and Methadone were administered daily as routine pain medication for December 2006 and January and February 2007. The specific type of pain that the aforementioned medications were ordered for was not indicated. The "Pharmacist/Physician Communication" form dated July 22, 2005 included, "A supportive diagnosis could not be retrieved from the resident ' s chart for the following medication(s): Methadone ... Recommendation - Please add diagnosis on physician's order sheet to support administration of the medication listed below. Medication: Methadone DX: Narcotic withdrawal [diagnosis was written in]..." The "Pharmacist/Physician Communication" form dated September 19, 2005 included, "This resident is on Methadone for narcotic withdrawal. However, he is also prescribed Dilaudid, a narcotic, on a PRN basis for pain management and has received at his request periodically over the past month. This represents a contraindication in therapy. Recommendation: Please reevaluate the usage of Dilaudid as it makes Methadone treatment ineffective. Physician Response: I have read the above suggestions and do not wish to implement any changes for the following reasons: The Methadone allows us to use lower doses of the	F 329		

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F 329	Continued From page 22 narcotics ... " A review of the care plan dated 7/15/06 revealed the following problems and approaches: Problem #11 - " Resident is using more than 9 medications every day. Potential for adverse reaction from medications. " One approach listed was to " Review medication for duplication of indication and call the attention of MD " . Problem #5 - " Resident is on pain management due to DJD, toothache. On Dilaudid for pain, on Methadone for pain ... on Flexeril for muscle spasm, on Tylenol for pain " . Approaches listed, " Encourage to verbalize pain and Analgesics as ordered prn (when needed) " . The care plan reviews revealed the following, " 7/28/06, Demands for his medications given as per MD ' s order " and " 1/19/06, Pain medications given (subjective) but it ' s given with immediate result. MD aware. " The care plan was last reviewed on 1/19/07. Review of the December 2006 MAR (Medication Administration Record) revealed the following: The resident received two (2) medications for sleep, Benadryl and Ambien. Both Benadryl 50 mg and Ambien 5 mg were given on December 1, 9 through 24, 27 and 29 through 31, 2006. The resident received Dilaudid 4 mg every four (4) hours daily, Methadone 5 mg two times every day and Acetaminophen with Codeine #3, 49 times in December 2006. The resident received Dilaudid 4mg and Methadone 5 mg everyday at 10AM and 6PM. Acetaminophen with Codeine #3 was administered within one (1) hour of the aforementioned medications 19 times and administered at the same time four (4) times.	F 329		

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F 329	Continued From page 23 The Pain Management Log for December 2006 revealed that the resident was assessed by nursing staff for pain 69 times prior to the administration of pain medication as having mild pain. There were 10 entries without pain assessments prior to administration of medication . The resident was assessed as having no pain one (1) hour after pain medication was administered. Review of the January 2007 MAR revealed the following: Benadryl 50 mg every night for anxiety and sleep was discontinued on January 11, 2007. Both Benadryl 50 mg and Ambien 5 mg were given on January 1 through 4 and 6 through 11, 2007. Ambien was also given January 13 and 15 through 31, 2007. The resident received Dilaudid 4 mg every four (4) hours daily, Methadone 5 mg two times every day and Acetaminophen with Codeine #3, 60 times in January 2007. The resident received Dilaudid 4 mg and Methadone 5 mg everyday at 10AM and 6PM. Acetaminophen with Codeine #3 was administered within one (1) hour of the aforementioned medications 10 times and was administered at the same time nine (9) times. The Pain Management Log for January 2007 revealed that the resident was assessed by nursing staff for pain 155 times prior to the administration of pain medication as having mild pain; and once as having moderate pain. The resident was assessed as having no pain one (1) hour after pain medication was administered.	F 329		

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F 329	Continued From page 24 Review of the February 2007 MAR revealed the following: The resident received Ambien 5 mg for sleep February 1 through 17 and 19, 2007. The resident received Dilaudid 4 mg every four (4) hours daily, Methadone 5 mg two times every day and Acetaminophen with Codeine #3, 32 times in January 2007. The resident received Dilaudid 4 mg and Methadone 5 mg everyday at 10AM and 6PM. Acetaminophen with Codeine #3 was administered within one (1) hour of the aforementioned medications 13 times. The Pain Management Log for February 2007 revealed that the resident was assessed by nursing staff for pain 64 times prior to the administration of pain medication as having mild pain; and two (2) times as having moderate pain. There was one entry without a pain assessment prior to administration of pain medication. The resident was assessed as having no pain 63 times and moderate pain two (2) times, one (1) hour after pain medication was administered. On February 1 at 11:00 AM, there was no entry for an assessment one (1) hour after administration of pain medication. The record was reviewed on February 20, 2007.	F 329	F371 (1,2,3,& 4) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All Chinaware, spoons, scoops, serving ladles, and hotel pans were thoroughly rewashed and checked by the supervisor prior to drying. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All other chinaware, spoons, scoops, serving ladles and hotel pans were checked for cleanliness. No other residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** New pots and pans, spoons, chinaware, scoops, serving ladels and hotel pans have been placed in the capital budget for purchase. Daily spot checks will be conducted by the Production Manager/Dietary Supervisor and a log book was created to track the daily monitoring on 3/27/07.	
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by	F 371	4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported to monthly Process Improvement and Quality Assurance.	April 5, 2007

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F 371	Continued From page 25 : Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: soiled chinaware, spoons, ladles, hotel pans and cooking hood filters and an opening in the ceiling around the Ansul supply lines. These findings were observed in the presence of the Food Service Director. The findings include: 1. Leftover food particles were observed on the top and bottom surfaces of plates (chinaware) in 16 of 50 plate observations at 9:40 AM on February 20, 2007. 2. Spoons were not thoroughly cleaned of food residue after washing in 12 of 43 spoons observed at 9:45 AM on February 20, 2007. 3. Serving scoops and ladles in a rack near the tray line were soiled with food and debris on the inner and bottom surfaces in 5 of 14 scoops and ladles observed at approximately 12:15 PM on February 20, 2007. 4. Hotel pans (12x14x6 inches) were not thoroughly cleaned after washing. Food particles were observed on the inner and outer surfaces and pans were not allowed to dry before storing on racks in the dish room in five (5) of five (5) hotel pans observed at 3:30 PM on February 20, 2007. 5. The inner surfaces of cooking hood filters were soiled with accumulated grease and dust over cooking areas in 20 of 20 hood filter observations	F 371	F371 (5) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The inner surfaces of cooking hoods and filters soiled with accumulated grease and dust over cooking areas were cleaned immediately 2/23/07. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** 20/20 areas were checked and cleaned. No other residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All hoods and filters will be checked bi-weekly for cleanliness by the Production Manager. Replacements and/or cleaning will be conducted at this time. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Dietary Production Manager will report any deficient practices to monthly Quality Assurance.	April 5, 2007

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F 371	Continued From page 26 at 9:00 AM on February 20, 2007. 6. An opening (14x8 inches) was observed in the ceiling adjacent to the cook's preparation around the Ansul supply lines in one (1) of one (1) ceiling observation at 9:30 AM on February 20, 2007.	F 371	F371 (6) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The opening around the ansul supply lines observed in the ceiling adjacent to the cooks preparation area was fixed immediately 2/22/07. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Rounds were conducted throughout the kitchen to ensure no other openings were present. No residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All staff was educated on 2/26/07 as to reporting any and all items needing fixing or replacing. Environmental rounds will be done to include maintenance and housekeeping department weekly. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Outcome of rounds will be reported to Administration weekly, and monthly to EOC committee, Patient Safety Committee, Process Improvement and QA meetings.	
F 385 SS=D	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for two (2) of 15 sampled residents, it was determined that the physician failed to: complete the annual history and physical assessment for two (2) residents. Residents #3 and 6. The findings include: 1. The physician failed to complete an annual history and physical examination for Resident #3. During the review of the resident's record the physician's orders signed and dated December 1, 2006 included, "H&P (History and Physical) every year November."	F 385		April 5, 2007

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F 385	Continued From page 27 The last history and physical examination form in the record was dated November 22, 2005. On February 22, 2006 at approximately 9:30 AM, a face-to-face interview was conducted with the RCC (Resident Care Coordinator) who acknowledged that a H&P was not in the record for November 2006. The record was reviewed on February 20, 2007. 2. The attending physician failed to complete an annual history and physical assessment for Resident #6. A review of the facility's policy "Medical Staff Attending Physician," Section K, documented, " Each resident shall have a medical examination and evaluation of his/her heath status at least every twelve months which shall be documented both in the appropriate History and Physical Form and the progress notes.. " A review of the clinical record for Resident #6 revealed a H&P examination dated January 26, 2006. There was no evidence of an annual history and physical (H&P) examination. for January 2007. A face-to-face interview was conducted with the Resident Care Coordinator on February 22, 2007 at 10:00 AM. He/she acknowledged that the H&P was not completed for January 2007. The record was reviewed on February 22, 2007.	F 385	F385 (1 2) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Primary Physician and Medical Director were notified of the deficient practice. The primary care physician completed the H&P for resident #3 and #6. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of all remaining residents charts were done to determine the presence of H&P's. No other residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Medical Records will be reviewing monthly physician documentation for required H&P. Deficiency will be reported to Medical Director and Administrator. Physicians failing to comply within a timely manner will have privileges suspended immediately. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported by Medical Records staff at monthly QA meetings.	April 5, 2007
F 386 SS=G	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	F 386		

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F 386	Continued From page 28 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 policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for one (1) of 15 sampled residents, it was determined that the physician failed to follow-up on Dilantin level results for Residents #14, who was subsequently hospitalized for Dilantin toxicity. The findings include: The physician's order sheet dated December 2006 directed, "Dilantin level every 3 months-March/June/Sept/Dec [original order dated September 8, 2006]." A review of the laboratory (lab) section of the record revealed that a Dilantin level was drawn on December 1, 2006. There was no evidence in the record that the results for the aforementioned Dilantin level were present at the time of this review. A face-to-face interview was conducted with the Resident Care Coordinator and the Director of Nursing on February 21, 2007 at 12:30 PM. After reviewing the record, they both acknowledged that there were no Dilantin level results. According to the following nurses ' notes: February 7, 2007 at 2:00 PM "Physical therapist came up on the unit and stated that the resident was much weaker on the left side than yesterday	F 386	F386 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The physician was notified regarding his failure to follow-up on the Dilantin level results for resident #14. No retrospective corrective action can be accomplished at this time as the resident is no longer at the facility. Medical Director was also notified of deficient practice. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** The medical records of all other residents on Dilantin levels were reviewed. No other residents were found to have the same deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Medical records of future residents who will receive Dilantin with Dilantin level test order will be reviewed daily by licensed staff on the night shift. Review outcomes will be documented on the lab log sheet. See attachment #2 for F-Tag 309(1). 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Monitoring outcomes will be reported to the Administrator at daily standup meetings. Monthly compliance monitoring outcomes will b reported to QA committee by DON.	April 5, 2007

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F 386	Continued From page 29 in therapy. A call has been made to Doctor [name] to make [him/her] aware." February 7, 2007 at 8:00 PM "Speech therapist expressed concern to writer about resident ' s weakness on the right side. This writer contacted Doctor [name] to convey concerns of weakness and decline in speech pattern. Doctor [name] ordered that resident be transferred to ER [emergency room] for evaluation of altered neurological status. Follow up call made to determine status... resident was taken to hospital [name] and admitted for Dilantin toxicity and dehydration." Physician notes were present in the record dated December 11, 2006, January 10, 2007 and February 5, 2007. The progress note dated February 5, 2007 included a review of the resident's laboratory reports. However, there was no evidence that the Dilantin level of December 1, 2006 was reviewed. On February 21, 2007 at 4:15 PM the facility staff obtained the Dilantin results, drawn on December 1, 2006, at the request of the surveyor. The lab report revealed a Dilantin result of 29.6 H [high], [normal range 10.0-20.0]. There was no evidence that the physician followed up on the Dilantin level drawn on December 1, 2006. Subsequently, the resident was hospitalized with a diagnosis of Dilantin toxicity on February 7, 2007. The record was reviewed on February 21, 2007.	F 386	F428 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Medical Director and the Attending Physician were both notified of the deficient practice. Both the fasting lipid and the hepatic function panels were ordered on 3/6/07. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Consultation reports from the consultant pharmacist was reviewed for further evidence of physician deficient practice. No similar occurrences were observed. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** RCCs will notify physicians of consultant pharmacist's recommendations until physician responds. Outcomes will be shared with Medical Director also. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Review outcomes will be reported by RCCs to the monthly QA Meetings where Medical Director is present.	April 5, 2007
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	F 428		

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F 428	Continued From page 30 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by : Based on record review for one (1) of 15 sampled residents, the physician failed to respond to the consultant pharmacist's report. Resident #1. The findings include: According to review of Resident #1's record, a pharmacist's "Consultation Report" dated December 5, 2006, noted, "[Resident] takes simvastatin (statin) It is recommended to monitor a fasting lipid panel and hepatic function panel 12 weeks after initiation of therapy or following any dosage increase and periodically (e.g., semiannually) there after to monitor efficacy and toxicity of this therapy. Recommendation: Please consider monitoring a fasting lipid panel and hepatic function panel on the next convenient lab day and every six months there after." The physician signed the consultation report on February 7, 2007. However, there was no evidence on the consultation report or in the physician's progress notes of the physician's response to the pharmacist's recommendation. The record was reviewed February 20, 2007.	F 428	F441 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Both shower stretchers and the underside of the mat were cleaned immediately 2/22/07. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All other shower stretchers and the underside of all other mat were checked and were found to be clean. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Nursing staff were in-serviced and instructed to clean off stretchers between each resident's uses and to check the undersurfaces of mats to ensure they are clean. Housekeeping staff will clean and disinfect these items on a weekly basis. See attachment #1. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Team leader CNAs will monitor and report deficient practices to Charge nurses. RCC will notify DON and Administrator daily. Deficient findings will be reported to monthly QA Meetings.	April 5, 2007
F 441 SS=D	483.65(a) INFECTION CONTROL	F 441		

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F 441	Continued From page 31 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 observations during the environmental tour, facility staff failed to maintain equipment in a sanitary manner as evidenced by a soiled shower stretcher. This observation was made in the presence of the Director of Maintenance, Housekeeping Supervisor and nursing staff. The findings include: The shower stretcher on unit 3 East was observed with residual soap on the underside of the bath mat and a grey substance on the flat plastic surface of the stretcher frame and underside of the mat in one (1) of two (2) stretchers observed on February 22, 2007 at 2:10 PM.	F 441	F-492 (1) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** One of the in-services required were not conducted within the year although 2 in-services were done by the consultant pharmacist. No retrospective corrective action can be done. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** The Pharmacy was contacted in reference to the in-service not being conducted by the consultant pharmacist. No residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** A new consultant pharmacist was requested by the Administrator to attend pharmacy meetings effective the next meeting April 5, 2007. The DON and the Administrator will track on an annual basis to ensure the required in-services are being given by the consultant pharmacists. Administrative QA tool was updated to reflect monitoring, see attachment #1.	
F 492 SS=E	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 accepted professional standards and principles that apply to professionals providing services in such a facility.	F 492	4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** The Administrative QA tool will be utilized to track all findings, and will be reported to monthly QA Meetings.	April 5, 2007

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F 492	Continued From page 32 This REQUIREMENT is not met as evidenced by : Based on staff interviews and record review, it was determined that the contract pharmacist failed to conduct an in-service as required by the District of Columbia regulations and facility staff failed to remove expired medications from the interim box, obtain a criminal background check for two (2) employees before the date of hire and maintain nurse staffing at 3.5 nursing hours per resident per day. The findings include: 1. The pharmacist failed to conduct an in-service that included indications, contraindications and possible side effects of commonly used medications. According to 22 DCMR (District of Columbia Municipal Regulations) 3224.3(c), " The supervising pharmacist shall do the following: (c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications. " On February 22, 2007, during a review of the consultant pharmacist in-service programs, it was determined that (2) two in-services were conducted in 2006: May 17, 2006, "Tuberculosis in The Elderly " and August 23, 2006, "Bacterial Pneumonia and the Elderly Nursing Home Resident ". Although (2) two in-service sessions were	F 492	F-492 (2) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Expired drugs were immediately removed and destroyed according to regulatory requirements 2/20/07. The documentation was submitted to the contracted Pharmacy services who were informed of the deficient practice. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** In the presence of the surveyor the rest of the narcotics were inspected and no other expired narcotics were found. No other residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The administrator requested a meeting to be conducted with the contracted pharmacy services on 3/16/07 to review consultant pharmacist responsibilities and pharmacy policy and procedure manual. A new consultant pharmacist was requested by the Administrator to attend pharmacy meetings effective the April 5, 2007. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported by RCC's to the DON and Administrator at monthly QA Meetings.	April 5, 2007

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F 492	Continued From page 33 conducted, neither of these sessions included the required indications, contraindications and possible side effects of commonly used medications. 2. Facility staff failed to remove expired medications from the narcotic interim box. 22 DCMR, 3227.12 stipulates, "Each expired medication shall be removed from usage." On February 20, 2007, at approximately 1:00 PM, the Narcotic Interim Box on 3 West was found to contain the following expired medications: 1. Roxicet 5mg / 325 mg tablet, Lot#557151A, Exp. January 20, 2007. 2. Morphine Sulfate 15 mg tablet, Lot# 8315051987, Exp. August 8, 2006. During a face-to-face interview with the Resident Care Coordinator (RCC) at approximately 1:15 PM on February 20, 2007, the expired medications were brought to his/her attention. The RCC stated, "I did not know that the medications were expired and will remove the medication from the box and destroy them". 3. Facility staff failed to obtain a criminal background check prior to hire for two (2) employees. The review of personnel records for two (2) employees revealed that the employees were hired and allowed to work in the facility before a criminal background check was completed. A review of employee #1's personnel record [that was hired to work in administration] revealed a hire date of November 20, 2006.	F 492	F-492 (3) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Criminal background checks were obtained for both employees in question on 2/21/07. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All new hires for the past six months were reviewed to ensure that criminal background checks were completed prior to hire on 2/22/07. There were no other deficient practices noted. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** A concurrent audit tool utilized to ensure that all pre-employment requirements are met prior to hire date. All HR employees were educated as the regulatory requirements on 2/21/07. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** HR director will report any deficient practices noted after monthly audit to Process Improvement and QA meetings.	April 5, 2007

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F 492	Continued From page 34 A review of employee #2's personnel record [that was hired as a Certified Nursing Assistant] revealed a hire date of December 15, 2006. According to the 22 DCMR 4701.2 "Each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Registry before employing or using the contract services of an unlicensed person." On February 23 at approximately 11:00 AM, a face-to-face interview was conducted with the Human Resource representative who acknowledged the lack of the criminal background check prior to hire for employees'#1 and 2. He/she indicated that it was discovered during an audit that the employees were hired prior to the completion of the criminal background checks. The criminal background checks did not reveal any criminal convictions. The personnel records were reviewed on February 21, 2007. 4. Facility staff failed to maintain nurse staffing at 3.5 nursing hours per resident per day. According to 22 DCMR 3211.3, Beginning no later that January 1, 2005, "Each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per resident per day." The Nursing Daily Staffing Sheets were requested for February 17 through 20, 2007. The actual staffing schedules were reviewed with the Director of Nursing [DON] for February 17, 18, 19, and 20, 2007. Two (2) of the four (4) days reviewed, revealed that the actual staffing was	F 492	F-492 (4) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively no corrective action could be done as there was insufficient staff on the day the incident occurred. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice when the PPD falls below 3.5. The 24 hour nurse staffing rule was reviewed with staff to ensure that a minimum of PPD of 3.5 is achieved on a daily basis. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The DON is in the process of recruiting, and interviewing for PRN staff. A unit clerk position for weekends on both nursing units was approved to keep nurses from doing majority of administrative duties on weekends. On weekends /Holidays/ inclement weather days when there are call outs we have instituted an emergency bonus plan for nursing staff. See attachment #1 from F-Tag 324. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported to administration daily for on-going intervention, and immediate response.	April 5, 2007

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F 492	Continued From page 35 less than 3.5 nursing hours per resident per day. The same days were reviewed again by the DON and the result of the staffing schedule indicated: February 17, 2007 3.0 February 18, 2007 3.25 Two (2) of the four (4) days revealed staffing below the required 3.5 nursing hours per resident per day. The staffing sheets/schedules were reviewed on February 22, 2007.	F 492	F505 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively corrective action could not be done for this incident as the resident never returned to the nursing facility. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Records of all residents receiving Dilantin level orders were reviewed to check if; results were in the record and if not results were obtained; results were reported to physician and orders carried out accordingly; appropriate documentation are recorded in the medical records of interventions if any. See attachment # 1 for F-tag 309 (1). 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Medical records of future residents who will receive Dilantin with Dilantin level test order will be reviewed daily by licensed staff on the night shift. Review outcomes will be documented on the lab log sheet, see attachment #2 F-tag 309 (1). 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Monitoring outcomes will be reported to the Administrator at daily standup meetings. Monthly compliance monitoring outcomes will b reported to QA committee by DON.	April 5, 2007
F 505 SS=D	483.75(j)(2)(ii) LABORATORY SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for one (1) supplemental resident, it was determined that facility staff failed to notify the attending physician of an abnormal Dilantin level for Resident S2. The findings include: A review of Resident S2's record revealed a laboratory report dated January 2, 2007 of a Dilantin level of 6.8 (normal 10-20.0 ug/ml). There was no evidence that facility staff notified the physician of the Dilantin level. A review of the nurses' notes revealed that the resident did not experience seizure activity from January 2 through February 22, 2007. A face-to-face interview was conducted with the RCC (Resident Care Coordinator) on February 22	F 505		

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F 505	Continued From page 36 , 2007 at 2:00 PM. He/she reviewed the record and acknowledged that the physician should have been notified of the Dilantin value. The record was reviewed February 22, 2007.	F 505	F514 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** This weights loss was desirable with diuretic agent and weight loss was a plan of her care. No retrospective action could be accomplished with resident #6. Resident will be weighed weekly for 8 weeks (3/7/07 to 4/25/07) to establish base line weight goals with the administration of diuretic agents. The care plan was revised. Resident's current weight (3/1/07) is 216.9lbs. See revised care plan attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All charts have been audit for all residents on weight loss goals. Charts were audited to ensure weights and reweighs were completed and interventions were documented as applicable. No other residents were found to be deficient in this practice.	
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. 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 staff and resident interviews and record review for one (1) of 15 sampled residents, it was determined that the dietician failed to document interventions initiated for Resident #6's weight loss. The findings include: According to the "Yearly Weight Chart" for Resident #6, the resident weighed: August 2, 2006 277# (pounds) September 1, 2006 229.2#. October 3, 2006 230# November 2, 2006 214#. Monthly dietary notes were present in the record from August through November 2006. The	F 514		

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F 514	Continued From page 37 dietician reviewed the weight history, appetite and general status of the resident monthly. There was no evidence in the dietician's notes of interventions initiated during this time. A face-to-face interview was conducted with the dietician on February 20, 2007 at 3:45 PM. He/she stated, "I did a lot of counseling with [Resident] at least two or three times a week in August, September, October and November. We talked about the carry out Chinese food that [he/she] ate and how important it was not to eat foods high in sodium because of [Resident's] edema. I informed the doctor of the resident's condition and that I was counseling the resident at least twice a week. I talked at great length with the resident to eat only the food we provided here, not to eat the carry out food. [His/her] on-going weight loss is desired because of the resident's medical condition. [Resident] doesn't have any more edema and the breathing is better. " A face-to-face interview was conducted with Resident #6 on February 21, 2007 at 10:00 AM. He/she stated, "The dietician was on my case a couple times a week about eating Chinese food and other carry out foods. [Dietician] would come and see me when I was eating dinner and we would talk about the good foods and bad foods I was eating. [Dietician] finally convinced me that I should stop eating carry out and just eat what was on my tray. The first month I stopped eating carry out at the end of the summer (August) I lost a lot of weight. I have been loosing weight ever since and I feel really good." The dietician failed to document the interventions initiated for Resident #6 that led to a desired weight loss. There were no untoward effects	F 514	F514 **3. What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** In-service education on protocol for recoding significant weights changes (Wight loss chart placed on units (3/12/07). New QA audit tools for nursing/dietary for monthly audited see attachment #2. Physicians will be notified with appropriate documentation. Dietician will follow-up with RCC when reweighs are not done. Weight committee have begun meeting monthly to address interventions for residents identified with significant weight loss. During the committee meetings residents identified with significant weight loss will have related documentation placed immediately in chart which will detail the appropriate interventions per committee members. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what Quality Assurance Program will be put into place?** The new QA tool (attachment #3) will be utilized to report any deficient practices to monthly QA meeting monthly.	April 5, 2007

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F 514	Continued From page 38 from the resident's weight loss. The record was reviewed February 20, 2007.	F 514		