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F 000	INITIAL COMMENTS An annual recertification survey was conducted on May 19 through 21, 2009. The following deficiencies were based on observations, staff and resident interviews and record review. The total sample was 15 residents based on a census of 58 on the first day of survey. There were 10 supplemental records.	F 000	This plan of correction is prepared and/or executed solely because it is required by the Provisions of Federal and State law. The plan of correction is ADF/Knollwood's credible Allegation of Compliance.	
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review for two (2) of 15 sampled residents, it was determined that the facility failed to engage in a systematic and on-going assessment for the use of the least restrictive restraints. Residents #3 and 12. The findings include: 1. Facility staff failed to perform on-going assessments for a least restrictive device for Resident #3's seat belt. The resident was observed on May 19, 2009 at approximately 10:00 AM through 12:00 PM in the day room across from the nursing station participating in various activities. The resident was observed with a fastened seat belt in place. Resident #3 was observed on May 19, 2009 at approximately 12:15 PM at lunch with three (3)	F 221	It is ADF/Knollwood's policy and practice to regularly perform ongoing assessments for the use of the least restrictive restraints for residents with a physical restraint. Resident # 3 was coded in the Minimum Data Set on October 7, 2008, and the quarterly MDS assessments for December 31, 2008 and March 26, 2009 for the use of ½ side rails and a trunk restraint in Section P4. The care plan entitled "History of Multiple Falls/ Seat Belt when out of bed to Wheelchair" was reviewed. 1(a) Resident #3's physical restraint elimination assessment was completed. 1(b) Resident #12's physical restraint elimination assessment was completed. 2. The interdisciplinary team has been re-educated to complete a Physical Restraint Elimination Assessment at least quarterly for all the residents who use a physical restraint to ensure that the least restrictive device is used for the resident.	7/21/09 7/21/09 7/21/09

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

Barbara O'Gaston, LNHA | Administrator | 6/25/09

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other feguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of rvey 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 cuments 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 other residents in a private room away from the dinning room to provide decreased distraction. The resident talked non-stop through out the dinning period. The seat belt was observed in place. The resident was coded on the annual Minimum Data Set assessment completed on October 7, 2008, and the quarterly MDS assessments completed December 31 2008 and March 26, 2009 for the use of side rails and a trunk restraint (seat belt) in Section P4 (Devices and Restraints). A review of the care plan entitled "Physical Restraint - Seat belt in the wheelchair and full side rails in bed " revealed that the care plan had been reviewed and revised on March 27, 2009. However, the resident's clinical record lacked evidence that an assessment was completed by facility staff to ensure that the seat belt and the side rails were the least restrictive devices for Resident #3. A face-to-face interview was conducted with Employees #7 and 8 on May 20, 2009 at approximately 2:45 PM. They both acknowledged that the resident ' s clinical record lacked evidence that an on-going assessment for the use of the least restrictive device was conducted. The record was reviewed May 20, 2009. 2. Facility staff failed to perform on-going assessments for Resident #12's seat belt and side rails. Resident #12 was observed on May 19, 2009 at 2:00 PM in his/her room, lying in bed with full side rails raised on both sides of the bed.	F 221	3. An audit of residents with restraints will be conducted by the Director of Nursing or designee to ensure that the residents with restraints are assessed for the use of the least restrictive device on a quarterly basis or with a change in status. The audit will be completed every month X 6. 4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	7/21/09 7/21/09

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Resident #12 was observed on May 20, 2009 at 11:00 AM participating in an activity with a fastened soft Velcro seat belt. When asked, the resident was unable to open the seat belt.

A review of the annual Minimum Data Set (MDS) completed May 14, 2009, coded the resident for long and short term memory problems in Section B (Cognitive Patterns). Resident #12 was coded as requiring extensive assistance for transfers and bed mobility and totally dependent for all other Activities of Daily Living with limited movement on both sides of the body in Section G (Physical Functioning and Structural Problems). The resident was coded in Section P4 (Devices and Restraints) for the use of side rails and a trunk restraint (seat belt) daily. Disease diagnoses listed in Section I included: Dementia, Arthritis, Parkinson' s Disease, and Behavioral Problems.

The resident was coded on the quarterly MDS assessments completed September 14 and November 26, 2008 for the use of side rails and a trunk restraint (seat belt) in Section P4.

A review of the care plan entitled "Physical Restraint - Seat belt in the wheelchair and full side rails in bed..." revealed that the care plan had been reviewed and revised on May 14, 2009.

There was no evidence in the record that an assessment had been completed by facility staff to ensure the seat belt and the full side rails were the least restrictive devices for Resident #12.

A face-to-face interview was conducted with Employee #7 on May 21, 2009 at 8:30 AM. He/she acknowledged that an on-going

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F 221	Continued From page 3 assessment for use of the least restrictive device had not been conducted. The record was reviewed May 21, 2009.	F 221		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, call bells were not within reach for residents in rooms 14A and 18. These observations were made in the presence of Employees #13 and 14. The findings include: During the environmental tour, the call bell was observed attached to the head board of the bed in room 18 on May 19, 2009 at 2:00 PM and out of reach of the resident. On May 19, 2009 at 2:10 PM, the resident was observed in room 14A sitting in a wheelchair next to the bed. The call light was located behind the back of the wheelchair and out of reach of the resident. The resident was asked how to call if he/she needed help. The resident reached down to his/her side of the wheelchair and stated, "The call button is usually right here. I don't know where it is." Employees #13 and 14 acknowledged the	F 246	It is ADF/Knollwood's policy and practice to keep call lights within reach of the residents. 1. The resident in Room 18 has a private duty aide. This aide was reminded to keep this residents call bell within reach of the resident at all times and HSC staff were instructed to check to ensure that call bells are always within reach. The resident in Room 14A also has a private duty aide. This aide was reminded to keep this residents call bell within reach of the resident at all times, and HSC staff were instructed to check to ensure that call bells are always within reach. 2. Staff as well as private duty aides were re-educated on the importance of keeping the call light within reach of the resident while they are in their rooms. 3. The Director of Nursing or designee will conduct an audit to monitor compliance of call bells within reach of the resident every week x 4, then every month x 3, then quarterly x 3. 4. The results of the audit will be submitted to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	5/22/09 5/22/09 7/21/09 7/21/09

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F 246	Continued From page 4 findings at the time of the observations.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour, it was determined that facility staff failed to maintain an orderly and comfortable environment as evidence by: dusty blinds in two (2) of 21 rooms observed, foot rests for wheelchairs on the floor in two (2) of 21 rooms observed and cracked/torn arm rests in six (6) of 20 wheel chairs observed. The environmental tour was conducted on May 19, 2009 from 1:30 PM until 4:00 PM in the presence of Employees #13 and 14 who acknowledged the findings at the time of the observations. The findings include: 1. Dusty blinds were observed in rooms 2 and 18 in two (2) of 21 resident rooms observed. 2. Foot rests were observed on the floor in rooms 6 and 45 in two (2) of 21 rooms observed. 3. Cracked, worn and/or torn arm rests were observed on wheel chairs in rooms 6, 9, 24 (two wheelchairs) 26, and 49 in six (6) of 20 wheelchairs observed. Employee #2 presented an order confirmation	F 253	It is ADF/Knollwood's policy and practice to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1(a) Blinds were dusted in rooms 2 and 18. 1(b) Footrests were removed from the floor in rooms 6 and 45. 1(c) Cracked, worn and/or torn armrests were replaced on wheelchairs in rooms 6, 9, 24A, 24B, 26 and 49. 2. Staff have been re-educated to keep wheelchair footrests off the floor. All resident rooms were checked for dusty blinds, foot rests on floors, and cracked, worn and/or torn arm rests. All are now in compliance. 3. The Director of Environmental Services or designee will conduct an audit for dusty blinds, foot rests on floors, and cracked, worn and/or torn arm rest and assess wheelchair armrests for repair or replacement every month x 4, then every quarter. 4. The results of the audits will be submitted to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	5/21/09 5/21/09 5/28/09 7/21/09 7/21/09

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F 253	Continued From page 5 from a supply company dated May 20, 2009 that included 20 padded arm rest replacements. An interview was conducted with Employee #2 on May 21, 2009 at 4:30 PM. When queried about the frequency that resident wheelchair arm rests were assessed for replacement, he/she stated, " Whenever necessary." There was no evidence that a system was in place to reassess the residents' wheelchair arm rests for repair or replacement on a consistent basis.	F 253		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

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F 278	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 15 sampled residents, it was determined that facility staff failed to accurately code one (1) resident with swallowing difficulties, two (2) residents for Ostomy care and one (1) resident for physical therapy. Residents #2, 6 and 7. The findings include: 1. A review of the clinical record for Resident #2 revealed facility staff failed to accurately code the MDS for a swallowing problem. According to the history and physical examination completed by the physician on April 14, 2009, Resident #2' s diagnoses included, Failure to Thrive; Percutaneous Endoscopic Gastrostomy (PEG); Cardiac Dysrhythmias; Dementia, Colitis and Hypothyroidism. According to the Speech-Language Pathologist (SLP) evaluation dated October 25, 2008, Resident #2 had Dysphagia. Skilled SLP services were recommended and implemented three (3) times weekly for four (4) weeks from October 25, 2008 through November 23, 2008. SLP intervention was implemented to"maximize swallow safety." Caregivers and the resident's family member were trained on feeding and safe swallowing strategies to maximize swallow safety. According to physician's orders dated May 7, 2009, Resident #2 received a mechanical soft, thin liquid diet and enteral bolus feedings twice	F 278	It is ADF/Knollwood's policy and practice to accurately code MDS assessments to reflect the residents' status. 1(a) Resident #2's MDS assessment was coded to include a swallowing problem. 1(b) Residents #2 and #6 MDS assessments were coded to include ostomy care. 1(c) Resident #7's MDS assessment was coded to include physical therapy. 2(a) An audit conducted by the MDS Coordinator revealed that all residents with swallowing problems were coded correctly on the MDS assessment. 2(b) An audit conducted by the MDS Coordinator revealed that all residents with ostomies were correctly coded on the MDS assessment. 2(c) An audit by the MDS Coordinator revealed that all residents who received physical therapy were correctly coded. 3. The licensed nurses and Dietitian will be re-educated on coding of MDS assessments to include residents with swallowing problems, ostomies and residents receiving physical therapy. The MDS Coordinator or designee will conduct an audit every month x 6 to assure compliance. 4. The results of the audits will be presented to the Quality Assurance Committee until the Committee determines compliance.	7/21/09 7/21/09 7/21/09 7/21/09 7/21/09 7/21/09

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F 278	Continued From page 7 daily. A review of the annual MDS completed April 16, 2009, revealed Section K1, Oral/Nutritional Status; oral problems, was coded as " none of above." According to the MDS 2.0 User's Manual 2003 edition, page 3 - 149," Swallowing problem" (b) is coded if Dysphagia has been identified and even when interventions have been successfully introduced. A face-to-face interview was conducted with Employee #8 on May 20, 2009 at 3:15 PM. He/she acknowledged the lack of coding related to the resident' s swallowing problem. Facility staff failed to accurately code the MDS to include the resident' s swallowing problem. The record was reviewed May 19, 2009. 2. Facility staff failed to accurately code Section P, Special Treatments and Procedures of the the Minimum Data Set (MDS) to include Ostomy Care for Residents #2 and 6. According to the MDS 2.0 User' s Manual, 2003 edition, page 3-183, " Ostomy Care" should be coded in Section P, for ostomies used for intake and excretion. A. Resident #2's MDS was not coded for Ostomy Care. According to Section K, Oral/Nutritional Status, of the annual MDS assessment completed and signed April 16, 2009, Resident #2 received 26-50% total daily calories and 1001-1500 cc/day	F 278		

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F 278	Continued From page 8	F 278	

of daily hydration enterally via PEG (feeding tube).

The significant change MDS dated July 22, 2008; the quarterly MDS' dated October 23, 2008 and January 24, 2009 and the annual MDS dated April 16, 2009 lacked evidence of Ostomy Care in Section P, Special Treatments and Procedures.

A face-to-face interview was conducted with Employee #8 on May 20, 2009 at 3:15 PM. He/she stated that interventions associated with the resident' s gastrostomy did not require coding in Section P. The record was reviewed on May 19, 2009.

B. According to the history and physical examination completed by the physician October 21, 2008, Resident #6's diagnoses included cerebral vascular accident (CVA) with hemiparesis, gastrostomy tube (G-tube), hypertension, hypercholesterolemia, spinal stenosis, chronic pain, hypothyroidism, gastroesophageal reflux disease, diabetes mellitus.

According to Section K of the quarterly MDS assessment completed and signed April 9, 2009, Resident #6 received 76-100% total daily calories and 2001 or more cc/day of daily hydration enterally via G-tube.

A review of the initial and quarterly OBRA (Omnibus Reconciliation Act) MDS assessments dated October 27, 2008, January 16, 2009 and April 9, 2009 respectively, were not coded for Ostomy Care in Section P, Special Treatments and Procedures. However, the record also revealed that the Medicare MDS assessments

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dated December 4, 2008 and December 15, 2008 revealed Ostomy Care was coded in Section P.

A face-to-face interview was conducted with Employee #8 on May 20, 2009 at 3:15 PM. He/she stated that interventions associated with the resident' s gastrostomy did not require coding in Section P.

Facility staff failed to code Ostomy Care on the OBRA MDS assessments for Resident #6 who received nutrition and hydration via G-tube. The record was reviewed on May 20, 2009.

3. Facility staff failed to accurately code the MDS for physical therapy for Resident # 7.

According to a "Report of Consultation" signed and dated November 13, 2008, the resident was recommended for skilled physical therapy. The physician signed and dated the consultation report on November 19, 2009.

The resident was seen for physical therapy from November 18 through December 17, 2008 as evidenced by a signed and physical therapy signed and dated progress notes on November 20, 2008, November 24, 2008, December 1, 8, 15 and 18, 2008.

A further review of the resident's clinical record revealed that the resident was not coded in Section P1 (b) (Special Treatments Procedures and Programs) / Therapies for receiving physical therapy on the quarterly Minimum Data Set (MDS) completed on December 4, 2008

A face-to-face interview was conducted with

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F 278	Continued From page 10 Employees #8 and 16 on May 20, 2009 at approximately 2:18 PM. After reviewing the resident's clinical record, they acknowledged that the resident's MDS assessment was not coded for physical therapy. The record was reviewed May 20, 2009.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review for three (3) of 15 sampled residents, it was determined that facility staff failed to initiate a care plan with appropriate goals and approaches for one (1) resident for skin tears, one (1) resident for self medication and one (1) resident for	F 279		

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F 279	Continued From page 11 incontinence. Residents #5, 8 and 12. The findings include: 1. Facility staff failed to develop a care plan for skin tears for Resident #5. A review of Resident #5's nurses' notes revealed the following: April 4, 2009 at 7:05 PM: " CNA brought resident to nurses station reporting small skin tear right elbow ... " April 13, 2009 at 12:00 AM, "...CNA observed and reported skin tear right elbow area ..." April 20, 2009 at 11:50 PM, "...skin tear below the right knee ..." A review of the resident's care plan last updated March 12, 2009, revealed that facility staff failed to initiate a care plan with appropriate goals and approaches for skin tears. A face-to-face interview with Employee #4 was conducted on May 21, 2009 at 2:30 PM. He/she acknowledged that a care plan for skin tears should have been initiated. The record was reviewed May 21, 2009. 2. Facility staff failed to initiate a care plan for self administration of Baclofen for Resident #8. A review of the resident ' s clinical record revealed " Physician ' s Order Form " sheets for May 2008 through May 2009 dated and signed by the physician that directed: "Baclofen Tab [Tablet] 20 mg, take 1 tablet by mouth three times daily at 8AM, 4PM, and 12 midnight for muscle spasms may self administer. Origin [original order]: 05/05/2008 "	F 279	It is ADF/Knollwood's policy and practice to initiate a care plan with appropriate goals and approaches for all residents. 1(a) Resident #5's current care plan addresses appropriate goals and approaches for skin tears. 1(b) Resident #8's current care plan addresses appropriate goals and approaches for self-medication of Baclofen three times daily. 1(c) Resident #12's current continence status was care planned with appropriate goals and approaches. 2(a) An audit was conducted to ensure that there were care plans developed for residents who sustained a skin tear. 2(b) An audit on physician orders was conducted by the MDS coordinator and the audit revealed that there are no other residents who self medicate. 2(c) Residents' continence status will be care planned using appropriate goals and approaches to manage the resident's incontinence. ADF/Knollwood has initiated the bladder and bowel program. 3(a) The licensed nurses will be re educated to care plan residents who sustained a skin tear using appropriate interventions. The MDS Coordinator or designee will conduct a random audit every month X 6 to ensure compliance.	5/25/09 5/25/09 7/21/09 7/21/09 7/21/09 7/21/09

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F 279	Continued From page 12 " Please observe resident self administration of Baclofen weekly on Tuesday at 4 PM Orig [original order]: 09/15/2006 " According to monthly Medication Administration Records [MAR] from May 2008 through May 2009, the resident self administered Baclofen weekly on Tuesdays. The resident's clinical record lacked evidence that facility staff initiated a care plan with appropriate goals and approaches for self administration of Baclofen. A face-to-face resident interview was conducted with Resident #7 on May 20, 2009 at approximately 11:30 AM. The resident said "I have MS [Multiple Sclerosis] I can only do so much and therefore try to do as much as possible for myself. I like to administer my own medication but right now I administer Baclofen once a week. I am very involved in my plan of care, make my own physician appointments. Tomorrow is my care plan day and I have this funeral at 12:00 PM that I must attend. " A face-to-face interview was conducted on May 20, 2009 at approximately 2:00 PM with Employees #7 and 8. After reviewing the resident's record, they both acknowledged that the resident's clinical record lacked evidence that a care plan was initiated for self administration of Baclofen for the resident. The record was reviewed May 21, 2009. 3. Facility staff failed to develop a care plan for incontinence for Resident #12.	F 279	3(b) Licensed nurses will be inserviced on care plans, to address goals and approaches for self-administration of Baclofen. The MDS coordinator will conduct a random chart audit on a monthly basis for the next 4 months and quarterly thereafter x 4 to ensure compliance. 3(c) The interdisciplinary team was instructed to put together an individualized care plan for each incontinent resident as well as documenting interventions. The MDS coordinator will conduct a random chart audit on a monthly basis for the next 4 months and thereafter quarterly to ensure compliance. 4. The care plans for skin tears, self-medication and incontinence care will randomly be audited every month and the results of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	7/21/09 7/21/09

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F 279	Continued From page 13 A review of the resident's annual Minimum Data Set assessment completed May 14, 2009, coded the resident in Section H (Continence in last 14 days) as being usually incontinent of bowel and bladder function. A review of the resident's care plan, last updated May 14, 2009, revealed a care plan entitled "Unable to perform self-care secondary to cognitive loss." Under approaches was an entry that directed to toilet the resident every two hours. There was no evidence in the record that a care plan with appropriate goals and approaches to restore or improve normal bowel and bladder function was initiated by the facility. A face-to-face interview was conducted with Employee #8 was conducted on May 21, 2009 at 10:30 AM. He/she acknowledged that there was no care plan for bowel and bladder incontinence. The record was reviewed May 21, 2009.	F 279		
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	F 280		

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F 280	Continued From page 14 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for one (1) of 15 sampled residents and one (1) of 10 supplemental residents reviewed, it was determined that facility staff failed to review and revise care plans for: one (1) resident for incontinence, anticoagulant therapy and long term memory loss and one (1) resident after a behavioral episode. Residents #9 and S1. The findings include: 1. Facility staff had developed two (2) care plans related to incontinence for Resident #9, who was assessed as continent, one (1) related to bleeding from anticoagulant therapy, who was not receiving anticoagulant therapy medication and one (1) for long term memory loss who was assessed with no long term memory problems. A. Review of Resident #9's record revealed an admission Minimum Data Set (MDS) assessment completed December 31, 2007 that coded the resident as frequently incontinent of bladder in Section H (Continence in the last 14 days). The quarterly MDS assessments completed March 27 and June 19, 2008 coded the resident as occasionally incontinent in Section H. The quarterly MDS assessments completed	F 280	It is ADF/Knollwood's policy and practice to review and revise care plans after a change in the resident's status occurs. 1(a) Resident # 9 care plan was reviewed and revised to mirror the residents' current condition and to reflect changes in medication. Resident #9 has only 1 care plan related to incontinence status. 1(b) Resident S1's care plan was updated to reflect the behavior documented in the social worker's notes and to plan approaches to change or avoid such behaviors. 2(a) The Interdisciplinary team was instructed to review and revise care plans when the residents' condition change and quarterly in preparation for the care plan meeting. 2(b) The interdisciplinary team was instructed to care plan unusual behaviors documented in the clinical records. 3. The Director of Nursing or designee will conduct an audit of the care plans every week X 4 then monthly thereafter to ensure that the care plans reflect the resident's current condition. 4. The results of the audit will be presented to the Quality Assurance Committee until it is determined that compliance has been achieved.	7/21/09 7/21/09 7/21/09 7/21/09 7/21/09

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F 280	Continued From page 15 September 11 and December 4, 2008 and March 10, 2009, and a significant change MDS completed April 30, 2009, coded the resident in Section H as continent of bowel and bladder function. A review of the resident's care plan last updated April 30, 2009, revealed the following: " Risk for UTI (urinary tract infection) related to incontinent bladder. Risk for skin breakdown related to incontinence of bladder and impaired mobility." The above cited care plans failed to reflect the resident's continent status. B. A review of the resident's care plans revealed the following:" Risk for bleeding related to Lovenox and ASA (aspirin)." The resident was hospitalized on April 14, 2009 and returned to the facility on April 24, 2009. Aspirin and Lovenox were prescribed by the physician prior to the hospitalization but not included in the list of medications after being discharged with from the hospital. According to the plan of care signed by the physician on April 28, 2008, the resident was not prescribed Aspirin or Lovenox post hospitalization. The care plan was not revised to reflect the change in the resident's medication. C. A review of the resident's care plans revealed the following: " Compromised long term and short term memory loss and impaired judgment." According to the admission MDS assessment completed December 31, 2007 and the quarterly MDS assessments completed March 27, June 9,	F 280		

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F 280	Continued From page 16 September 11 and December 4, 2008 and March 10, 2009 and the significant change MDS completed April 30, 2009, the resident was coded in Section B (Cognitive Patterns) for short term memory problems. However, the resident was not coded for long term memory problems. A face-to-face interview with Employee #4 was conducted on May 21, 2009 at 7:00 AM. He/she confirmed that the resident was continent of bowel and bladder function, was not currently receiving anticoagulant therapy and did not have long term memory problems. He/she acknowledged that the above cited care plans did not reflect the resident's current status. The record was reviewed May 20, 2009. 2. Facility staff failed to revised and review Resident S1's care plan after a behavioral episode. A review of Resident S1's record revealed the following social workers' note dated November 24, 2008, "Resident found in bed with male resident without top on but in depends, resident appeared to only be cuddling ..." There was no evidence that additional goals and approaches were initiated after the above cited episode. There was no evidence in the resident's record that any similar episodes had occurred after November 24, 2008. A face-to-face interview was conducted with Employee #4 on May 20, 2009 at 9:00 AM. He/she acknowledged that no approaches were initiated after the above cited episode. The record was reviewed May 20, 2009.	F 280		
F 282	483.20(k)(3)(ii) COMPREHENSIVE CARE	F 282		

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F 282 SS=D	Continued From page 17 PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for three (3) of 15 sampled residents and one (1) of 10 supplemental residents, it was determined that facility staff failed to provide care in accordance with each resident's plan of care: for two (2) residents observed in bed without a floor mat, one (1) resident observed unattended in his/her room, and one (1) resident whose wheelchair was not locked at the bedside. Residents #1, 3, 11 and JH3. The findings include: 1. Facility staff failed to implement place a mat at the resident's bedside for Resident #1. During the environment tour conducted on May 19, 2009 at 12:00 PM, Resident #1 was observed sleeping in a low bed with out a fall/floor mat adjacent to his/her bed. A review of the resident's record revealed a care plan entitled,"...History of falls" that was last reviewed May 6, 2009. Included in the approaches was,"Low bed with mat on the floor." The observation was made in the presence of Employees #13 and 14 at the time of the observation.	F 282	It is ADF/Knollwood's policy and practice to provide care in accordance with each resident's plan of care. 1(a) The floor mat was placed at resident #1's beside. 1(b) The wording in resident # 3's care plan was changed to:" Do not leave resident #3 in her room alone sitting in her wheelchair." 1(c) Resident #11 approaches for fall prevention are being followed and the wheelchair is locked at his bedside when he is in bed. 1(d) The floor mat was placed at resident JH3's bedside. 2. Interventions have been put in place for residents who are at risk for falls. These will be shared with the line staff during report. The nursing staff will be re- educated to follow the interventions put in place for the residents who are at risk for falls. 3. An audit will be conducted weekly X 4, then monthly X 4, then quarterly thereafter by the Director of Nursing or designee to ensure that the interventions for the residents at risk for falls are followed. 4. The results of the audit will be reported to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	5/21/09 7/21/09 7/21/09 7/21/09 7/21/09 7/21/09

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F 282	Continued From page 18 A face-to-face interview was conducted on May 20, 2009 at 2:00 PM with Employee #3. He/she acknowledged that the mat was not placed at the resident's bedside. The record was reviewed on May 20, 2009. 2. Facility staff failed to follow identified approaches for Resident #3 after a fall with injury. A review of the resident's clinical record revealed that the resident fell without injury on the following days: November 26, 2008, December 4, 3008, December 9, 2008, March 26, 2009, and March 27, 2009. On February 13, 2009, the resident fell and sustained a hematoma and laceration to the forehead. A review of the resident's clinical record revealed a " H/O [History of] fall with injury" care plan started on November 13, 2008 with several entries corresponding to the aforementioned fall dates. Under " Approach frequency" , for February 13, 2009 that corresponded to the date the resident fell with injury, the entry stated: " Do not leave resident in Rm [Room] unattended" The resident was observed on May 20, 2009 at approximately 3:30 PM asleep in a low bed with the side rails up and floor mats on both sides of the bed. He/ she was alone in the room, unattended. On May 21, 2009 at approximately 9: 30 AM, the resident was observed asleep in a low bed with the side rails up and floor mats on the floor on both sides of the bed. He/ she was alone in the room unattended. According to Employee # 9, the resident is very active when awake and staff	F 282		

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F 282	Continued From page 19 avoid interrupting his/her sleep. A face-to-face interview was conducted with Employees #7 and 8 on May 21, 2009 at approximately 8:30 AM. After reviewing the resident's clinical record including the aforementioned care plan, they both acknowledged the above cited care plan approach was not followed. The record was reviewed May 21, 2009 3. Facility staff failed to follow identified approaches for Resident #11 who had multiple falls. A review of Resident #11's nurses' notes revealed the following: January 12, 2009 at 2:45 PM: "Resident found on floor of room ..." February 18, 2009 at 9:00 AM: "Found on floor at bedside ...MD notified ..." March 14, 2009 at 5:00 PM: "On floor between the bathroom door in room ...MD notified ..." March 19, 2009 at 9:00 PM: "Tried to walk- couldn't ...fell getting back into the chair ... [Physician] notified ..." March 31, 2009 at 8:30 PM: "Slid off side of bed ...MD notified ..." April 3, 2009 at 3:30 PM: "Found sitting on floor by bedside ...MD notified ..." April 24, 2009 at 7:30 PM: "Got out of chair, alarm went off ...sitting on floor ...MD notified ..." May 5, 2009 at 7:00 PM: "Sitting at bedside with staff present. Slid off side of bed ...MD notified ..." Interventions had been put into place after each fall. The resident's care plan entitled, "Resident with history of multiple falls, gait unsteady, unassisted transfers, mobility	F 282		

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F 282	Continued From page 20	F 282		

impairment, disease process of Parkinson's and Dementia" was reviewed. The intervention put into place after the fall that occurred on March 31, 2009 was, "Keep wheelchair locked and close to the bed while the resident is in bed. Keep the bed raised slightly below the level of the wheelchair to facilitate transfer if resident needs to do so."

An observation of Resident #11 was conducted on May 21, 2009 at 6:40 AM. The resident was sleeping in bed which was slightly elevated, with the wheelchair stored in the resident's bathroom.

A face-to-face interview was conducted with Employees #23 and 24 on May 21, 2009 at 6:30 AM. Both employees acknowledged that Resident #11 always called for assistance and that the wheelchair was kept in the bathroom, not at the bedside.

A face-to-face interview was conducted with Employee #4 on May 21, 2009 at 7:00 AM. He/she acknowledged that the care plan approach was not implemented.. The record was reviewed May 21, 2009.

4. Facility staff failed to implement place a floor mat at the resident's bedside for Resident JH3.

During the environmental tour conducted on May 19, 2009 at 2:00 PM, Resident JH3 was observed awake and lying in a low bed. The bedside floor mat was observed stored in the closet.

A review of the resident's record revealed a care plan entitled, "History of falls" that was last reviewed March 26, 2009. Included in the approaches was, "Low bed with mat on the floor."

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F 282	Continued From page 21 A physician's order signed April 6 and May 6, 2009, directed, "Floor mat to left side of bed." A face-to-face interview was conducted with Employee #25 at the time of the observation. When queried about why the floor mat was in the closet, the employee stated that he/she had only left a few minutes to get the nurse to give the resident his/her medication.	F 282		
F 285 SS=D	483.20(m), 483.20(e) PREADMISSION SCREENING A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires	F 285		

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F 285	Continued From page 22 the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for eight (8) of 10 supplemental residents, it was determined that facility staff failed to ensure that a preadmission screening for mentally ill individuals and individuals with mental retardation (PASRR) was completed prior to admission to the facility. The findings include: A review of the resident records on the Special Care Unit revealed that there was no PASRR screen in the following residents' records: Resident JH2 was admitted on July 3, 2008. Resident S1 was admitted on October 22, 2008. Resident S2 was admitted on July 14, 2008. Resident S3 was admitted on May 15, 2008. Resident S4 was admitted on June 18, 2008. Resident S5 was admitted on October 14, 2008. Resident S6 was admitted on August 5, 2008. Resident S7 was admitted on July 17, 2008.	F 285	It is ADF/Knollwood's policy and practice to ensure that a preadmission screening for mentally ill individuals and individuals with mental retardation (PASRR) are completed and in the resident's record. 1. A PASRR screen was completed for Resident JH2, S1, S2, S3, S4, S5, S6 and S7 and put in the residents' records. 2. An audit was conducted on all residents' records and all records were brought into compliance. 3. A monthly audit will be conducted by the Director of Social Work or designee on all new admissions to assure that a PASRR screen was done prior to admission and is in the resident's record. 4. The results of the audit will be submitted to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	5/22/09 6/5/09 6/5/09

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F 285	Continued From page 23 A face-to-face interview with Employee #1 was conducted on May 20, 2009 at 2:45 PM. He/she acknowledged that a PASRR screen should have been completed for the above residents prior to admission. The records were reviewed May 20, 2009.	F 285		
F 309 SS=D	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 observations, staff interview and record review for four (4) of 15 sampled residents and two (2) of 10 supplemental residents, it was determined that facility staff failed to: follow the physician's orders for medication administration for three (3) residents, follow physician orders for placement of a floor mat and bed alarm for one (1) resident, crush medications identified as non-crushable for one (1) resident and clarify physician's orders for blood pressure parameters and blood pressure medications for one (1) resident. Residents #2, 3, 5, 8, JH1 and JH2. The findings include: 1. A review of the clinical record for Resident #2 revealed facility staff failed to administer cardiac medications in accordance with physician's orders.	F 309	It is ADF/Knollwood's policy and practice to provide each resident with 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. 1(a) Resident #2 is receiving her cardiac medication according to the physician's order. 1(b) Resident #3 is receiving her medications per physician's order. 1(c) Resident #5's floor mat and bed alarm are in place. The bed alarm is being checked for proper functioning and positioning on every shift. 1(d) The Solutab ordered for resident # 8 is being administered as directed per physician's order. 1(e) Resident JH1's patch is administered and replaced per physician's order. 1(f) Resident #JH2's order and parameter for blood pressure medications were clarified.	5/21/09 5/21/09 5/21/09 5/22/09 5/25/09 5/21/09

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	095026	A. BUILDING _____ B. WING _____	05/21/2009

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F 309	Continued From page 24 According to the history and physical examination completed by the physician on April 14, 2009, Resident #2's diagnoses included: Failure to Thrive; Percutaneous Endoscopic Gastrostomy (PEG); Cardiac Dysrhythmias; Dementia, Colitis and Hypothyroidism. Physician's orders signed May 7, 2009 directed: Amiodarone 200 mg 1 tablet daily via PEG for arrhythmia (original date 1/23/09) and Digoxin 0.125 mg 1 tablet daily via PEG for arrhythmia (original date 1/23/09) - hold for heart rate less than 60 beats per minute (bpm). The Medication Administration Record (MAR) for the month of March 2009 revealed Amiodarone and Digoxin were held on March 21, 2009 as evidenced by annotations on the reverse side of the MAR for each of the medications,"9 AM ...hold for low pulse." The MAR revealed the resident's 9AM pulse was assessed at 74 and 76 beats per minute. A face-to-face interview was conducted with Employee #3 on May 20, 2009 at approximately 3:15 PM. In response to a query regarding the omission of the cardiac medications, he/she agreed that the resident's heart rate on the morning of March 21, 2009 was within acceptable parameters for administration of the medication. He/she wasn't sure why the MAR revealed the medications were omitted. He/she stated that it would be investigated. No further evidence relative to the omission of the medications was provided. There was no evidence of any untoward affect sustained by the resident secondary to the	F 309	2. The licensed nurses were re-educated to follow physician's instructions when completing a medication administration, the importance of following the ordered dosage of medication, to keep the mats on the floor and the bed alarms on the beds as directed by the plan of care, the importance of administering resident's medication according to the instructions for medications that should not be crushed, to ensure that the resident's patch is applied per physician's order and checked to ensure that the patch is present on the resident's body after placement, and to clarify orders required to administer the medications that can affect the blood pressure when the blood pressure is low. 3. A random audit of the residents receiving cardiac medication, medication administration, floor mats and bed alarms, medications that should not be crushed, residents with a patch, and residents on blood pressure medications will be completed to ensure compliance. The audits will be completed by the Director of Nursing or designee every week X 4 then every month X 4, then every quarter x 3. 4. The result of these audits will be presented to the Quality Assurance Committee until the Committee determines compliance.	7/21/09 7/21/09

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F 309	Continued From page 25	F 309		

omission of the medications in the clinical record. The record was reviewed May 19, 2009.

2. Facility staff failed to ensure that the residents were free medication errors. Resident #3.

A review of the physician' s order signed and dated on May 6, 2009 directed " Tylenol (Acetaminophen) 500mg tab [1] tab [po] [tid] for back pain" and Artificial tears solution " Instill [2] drops both eyes three (3) times daily for dry eyes"

On May 19, 2009, at approximately 10:00 AM, during the medication pass, Employee #9 was observed administering two (2) tablets of Acetaminophen 500mg orally and instilling one (1) drop of Liqui Tears (Artificial tears) into each eye to Resident #3.

A face-to-face interview was conducted on May 20, 2009 at approximately 1:30 PM with Employee #9. He/she acknowledged that the resident received two (2) tablets of Acetaminophen instead of one (1) tablet. Additionally, Employee #9 acknowledged that he/she administered one (1) drop of Artificial Tears solution in each eye to the resident.

3. Facility staff failed to follow physician's orders for the placement of a floor mat and bed alarm for Resident #5.

A review of Resident #5's record revealed a physician's order initiated March 9, 2009 and most recently renewed May 1, 2009, that directed,"Bed alarm - check for proper functioning and positioning every shift."

A physician's order initiated March 19, 2009 and

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F 309	Continued From page 26 most recently renewed May 1, 2009 directed,"Floor mats to both sides of bed q shift." An observation of Resident #5's room was conducted on May 19, 2009 at 2:45 PM and May 20, 2009 at 7:30 AM. A floor mat and bed alarm were not observed on either date. A face-to-face interview view was conducted on May 20, 2009 at 7:40 AM with Employee #4. He/she checked the resident's room and acknowledged that a bed alarm and a floor mat were not present. The record was reviewed May 20, 2009. 4. Facility staff failed to follow "Nursing 2008 Handbook" , Lippincott, 28th Ed. pg 724, under Nursing Considerations for the administration of Prevacid SoluTab for Resident #8. The Facility' s "Nursing 2008 Handbook" , Lippincott, 28th Ed. pg 724, under Nursing Considerations for Prevacid, stipulated," ... dissolve a 15 mg tablet in 4 ml water and give with in 15 minutes ..." Medication label states " Do not crush or chew" On May 19, 2009, at approximately 10:00 AM, during the medication pass, Employee #9 was observed crushing Lisinopril 40 mg tablet, Levothyroxine 112mg tablet and the Prevacid 15 mg solutab together to administer to Resident #8. Employee #9 was interrupted by the surveyor before the medication was given to the resident. A face-to-face interview was conducted at that same time with Employee #9. He/she stated that she was unaware that the medication could not be crushed and that he/she would speak with	F 309		

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F 309	Continued From page 27 Employee #2 to find out how to give the medication. 5. Facility staff failed to follow physician order for administering the Exelon patch for Resident JH1. A review of the physician' s order signed and dated April 8, 2009 directed, " Exelon Patch 4.6 mg/24 hr, Apply [1] one patch to rotating sites daily." The manufacture' s package insert stipulates, " Bathing does not affect the patch. If the patch falls off, a new patch should be applied for the rest of the day, then replace the patch the next day at the same time as usual." On May 20, 2009 at approximately 9:40 AM during the medication pass Employee #19 was observed placing the Exelon patch on to Resident JH1's upper right chest. At this time, no Exelon patch was observed on the resident. A face-to-face interview was conducted on May 20, 2009 at 2:00 PM, Person #1 stated that he/she did not see the patch when they a wash-up the resident this morning at approximately 9:00 AM. A face-to-face interview was conduct at that same time with Employee #19. He/she stated that he/she did not see a patch on the resident before he/she placed the new patch on the resident. Additionally, the MAR revealed documented evidence that the patch was applied. On the May 20, 2009 the resident was observed without a patch. 6. Facility staff failed to clarify the physician' s	F 309		

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F 309	Continued From page 28 order and parameters for blood pressure (BP) for Resident JH2. A review of the physician' s order signed and dated April 15, 2009 directed," If BP < 100/60 hold BP Rx, If BP >180/100 call MD" On May 19, 2009 at approximately 10:15 AM during the medication pass, Employee #10 took Resident JH2' s blood pressure (BP). The BP measure was 95/47. Employee #10 did not administer the Lisinopril 10 mg tablet. Employee #10 administered the following oral medications: Carvedilol 6.25 mg tablet, Calcium w/D 600-400 tablet, Aricept 5 mg tablet, Citalopram 19 mg , Evista 60 mg, KCl 10 mEq tablet, Furosemide 40 mg tablet, Docusate 100 mg Capsule and one (1) Metamucil packet. The Carvedilol 6.25 mg tablet was not held as per physician order. A face-to-face interview was conducted on May 19, 2009 at approximately 2:00 PM with Employee #10. He/she stated that the physician wanted to hold the Lisinopril 10 mg tablet only. Employee #10 clarified the order for the Lisinopril 10 mg tablet with the physician that same day. The record was reviewed on May 19, 2009.	F 309		
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for two (2) of 15 sampled residents, it was determined that facility staff failed to	F 311		

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F 311	Continued From page 29 implement interventions to restore bladder function and or initiate an incontinence training program for Residents #3 and 13. The findings include: 1. Facility staff failed to implemented interventions to restore bladder function and initiate an incontinence training program for Resident #3. According to an annual Minimum Data Set (MDS) completed on July 17, 2008, Section I (Disease Diagnoses) the resident's coded diagnosis include: Dementia other than Alzheimer's disease, Depression, Urinary tract infection (last 30 days), Polymyalgia, and Behavioral Problems. A quarterly MDS, completed on March 26, 2009, in Section B2 [Memory] coded the resident as having short and long term memory loss. Section G1 [Physical Functioning and Structural Problems] coded the resident as requiring limited assistance with bed mobility and on unit locomotion, and total dependence with transfer and ambulation around the unit, locomotion off the unit, dressing, eating, personal hygiene, bathing, unable to maintain position for test of balance and some range of motion limitation. A review of the resident's clinical record revealed a care plan initiated March 30, 2009, that identified "Unable to perform self care" and approaches that included "Provide total assistance with dressing, grooming, personal hygiene and bathing activity. Provide incontinent care. Wash skin with soap and water during brief change ..." A further review of the resident's clinical record lacked evidence that a bowel and bladder	F 311	It is ADF/Knollwood's policy and practice to implement interventions that will help restore bladder function. ADF/Knollwood used a toileting program for its residents to ensure that they are frequently taken to the toilet. Implementation of a continence training program has begun. 1(a)(b) A bladder incontinence evaluation was completed for residents #3 and #13 to determine if the residents are good candidates for the continence training program. The related care plan was initiated with appropriate interventions for resident # 3 and #13. 2(a)(b) All residents will be assessed on admission, quarterly and with a change in condition for continence status. Incontinent residents will be assessed to determine if they could participate in a bowel and bladder retraining program. An individualized care plan will be put in place with interventions appropriate for each incontinent resident during the care planning process. 3(a)(b) Licensed nurses will be educated to complete an initial assessment of the resident's continence status on admission and initiate appropriate interventions according to the information generated from the assessment. The in service will also note the importance of care planning the continence status.	7/21/09 7/21/09 7/21/09

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F 311	Continued From page 30 assessment was completed for the resident. A face-to-face interview was conducted with Employee #8 on May 21, 2009 at approximately 10:30 AM. After reviewing the resident's clinical record, he/she acknowledged the aforementioned findings. He/she said,"We do not not have an incontinence bowel and bladder program." The record was reviewed May 21, 2009. 2. Facility staff failed to implement interventions to restore bladder function and initiate an incontinence training program for Resident #13. According to an annual Minimum Data Set (MDS) completed on October 7, 2008, Section I (Disease Diagnoses) the resident' s coded diagnosis include: Dementia other than Alzheimer's disease, Depression, Cerebrovascular accident, Hemiplegia / Hemiparesis, Macular Degeneration and Behavioral problems. A quarterly MDS, completed on April 2, 2009, in Section B2 [Memory] coded Resident #13 as having short term memory loss. Section G1 [Physical Functioning and Structural Problems] coded the resident as requiring extensive to total dependence with bed mobility, transfer and ambulation around the unit, extensive assistance with locomotion off the unit, dressing, eating, personal hygiene and bathing, unable to maintain position for test of balance and with some range of motion limitation. A review of the resident's clinical record revealed a "Resident Assessment -Data Collection Form" completed on October 30, 2008, that assessed the resident as incontinent of bladder. A care plan	F 311	A random audit will be completed weekly X 12 then monthly X 4 by the Director of Nursing to ensure that bladder continence assessments are completed, residents' individual needs are identified and care planned using a care plan for incontinence. 4(a)(b) The result of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	7/21/09

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F 311	Continued From page 31 was initiated October 9, 2009 that identified "Unable to perform self care" as a problem with approaches that included "Assist with dressing, grooming, personal hygiene and bathing activity, Provide incontinent care. Wash skin with soap and water during brief change ..." Further review of the resident's clinical record lacked evidence that the facility staff implemented interventions to restore bladder function and initiate an incontinence training program for the resident. A face-to-face interview was conducted with Employee #8 on May 21, 2009 at approximately 10:30 AM. After reviewing the resident's clinical record, he/she acknowledged the aforementioned findings. He/she said,"We do not not have an incontinence bowel and bladder program." The record was reviewed May 21, 2009.	F 311		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview during a tour of the main kitchen, it was determined that facility staff failed to ensure that all dietary staff were aware of the safe lightening of a gas stove burner.	F 323	It is ADF/Knollwood's policy and practice to ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. 1. The gas-stove burner has been repaired. 2. Dining staff will be educated on the safe lighting of a gas-stove burner, and what measures to take if a burner does not light.	5/22/09 5/30/09

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F 323	Continued From page 32 The tour of the main kitchen was conducted on May 19, 2009 from 8:30 AM until 12:00 PM in the presence of Employee #26. The findings include: During the tour of the main kitchen, Employee #27 was asked to ignite the four (4) burners on the gas stove. Three (3) burners lit immediately. The fourth burner did not light. Employee #27 was asked how he/she would light the burner that did not ignite. Employee #27 stated, "We use a paper towel or a piece of paper." Employee #26 acknowledged Employee #27's statement at the time of the observation and added, "We have a lighter, like the kind used on candles to light the burner if it doesn't ignite on its own. (Employee #27) knows better."	F 323	3. Spot checks will be conducted by the Director of Dining or designee and kitchen staff will demonstrate the proper lighting of a gas-stove burner weekly x 4 then quarterly x 3. 4. The result of the spot checks will be submitted to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	7/3/09
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	F 329		

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F 329	Continued From page 33 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff medicated Resident #12 with Ativan without adequate documented indications for its use. The findings include: A review of Resident #12's record revealed a physician's order dated November 5, 2008 and renewed February 19, March 5, April 13 and May 18, 2009, that directed: "Ativan 0.5 mg every 8 hours for agitation." The Medication Administration Records (MAR) were reviewed for December 2008, January, February, April and May 2009. There was no evidence that the resident received Ativan during the aforementioned months. According to the March 2009 MAR, the resident was administered Ativan March 19, 30 and 31, 2009. On the back of the March 2009 MAR was documented " Ativan 0.5 mg agitation, eff (effective)" for March 19, 20 and 31, 2009. There were no episodes of agitation recorded on the resident' s behavior monitoring sheet for March 2009. There were no nurses' notes describing episodes of agitation for March 19, 30	F 329	It is ADF/Knollwood's policy and practice to ensure that there is adequate documentation in the clinical record of all residents who are on anti-psychotropic drugs and to ensure that all residents' drug regimens are free from unnecessary drugs. 1. Resident #12 receives Ativan 0.5 mg every 8 hours as needed for agitation. The licensed staff have recorded the resident's behavior in the resident's behavior monitoring sheet, as well as the effectiveness of the medication in the Medication Administration Records (MAR) and nurses' notes. 2. The clinical record of all residents on anti-psychotic drugs will be reviewed by the ADON to ensure that the behavior monitoring sheets are completed and the effectiveness of the medications are documented on the MAR and nurses' notes. 3. Licensed staff will be in serviced on documentation of residents who are receiving anti-psychotic drugs to include the behavior monitoring sheets, effectiveness of the medication in the MAR. A random audit will be completed to ensure compliance. The audits will be completed by the ADON or designee every month week X 4 then every quarter x 3. 4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines compliance is achieved.	7/21/09 7/21/09 7/21/09

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F 329	Continued From page 34 and 31, 2009. A face-to-face interview was conducted with Employee #3 on May 21, 2009 at 10:00 AM. He/she acknowledged that the nurse failed to document the reason why the resident received the Ativan. The record was reviewed May 21, 2009.	F 329		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review for one (1) of nine (9) medication pass residents, it was determine that facility staff failed to follow the manufacturer's specification for the administration of Prevacid solutab for Resident #6. The findings include: The Facility's "Nursing 2008 Handbook", Lippincott, 28th Ed. pg 724, under Nursing Considerations for Prevacid, stipulated, "... dissolve a 15 mg tablet in 4 ml water and give with in 15 minutes...". The medication label stated "Do not crush or chew ". On May 19, 2009 at approximately 10:00 AM, during the medication pass, Employee #9 was observed crushing Lisinopril 40 mg tablet, Levothyroxine 112 mg tablet and the Prevacid 15 mg solutab together to administer to Resident #6. Employee #9 was interrupted by the surveyor before the medication was given to the Resident	F 333	It is ADF/Knollwood's policy and practice to ensure that residents are free of any significant medication errors. 1. Employee #9 was re-educated on following the manufacturer's specification for the administration of Prevacid solutab for Resident #6. 2. Medication Nurses will be inserviced by the Licensed Pharmacist Consultant on following the manufacturer's specification and on how to give medications that cannot be crushed to include Prevacid Solutab. 3. The ADON or designee will randomly observe medication pass weekly x 4, then monthly x 4, then quarterly x 3 to ensure that medications that cannot be crushed are administered correctly. 4. The results of the audit will be submitted to the Quality Assurance Committee until the Committee determines compliance.	5/21/09 7/21/09 7/21/09

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	095026	A. BUILDING _____ B. WING _____	05/21/2009

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KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

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F 333	Continued From page 35 #6. A face-to-face interview was conducted at the time of the observation with Employee #9. He/she stated that he/she was unaware that the medication could not be crushed and that he/she would speak with Employee #2 to find out how to give the medication. The record was review on May 19, 2009.	F 333		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations during the tour of the main kitchen, it was determined that facility staff failed to maintain a clean and sanitary kitchen as evidenced by soiled: two (2) of three (3) deep fryers and electrical equipment under the fryers, one (1) of one (1) tilt grill, one (1) of one (1) set of pipes behind the appliances, the lip of two (2) of two (2) convection ovens and their exterior surfaces, two (2) of two (2) standing racks, one (1) of one (1) vent above the clean pot and pan storage area, three (3) of six (6) back flow drains, two (2) of six (6) floor drains and two (2) of four (4) drain pipes from the ice machine. Additional findings included: chicken stored above	F 371	It is ADF/Knollwood's policy and practice to maintain a clean and sanitary kitchen. 1. The two (2) deep fryers and electrical equipment under the fryers, one (1) tilt grill, one (1) set of pipes behind the appliances, the lip of two (2) convection ovens and their exterior surfaces, two (2) standing racks, one (1) vent above the clean pot and pan storage area, three (3) back flow drains, two (2) floor drains and two (2) drain pipes from the ice machine have been cleaned. The crabmeat was immediately discarded. A thermometer was placed in the ice cream freezer, three (3) perforated pans were rewashed and stacked separately to dry, three (3) back flow pipes were repaired, and two (2) buckets filled with sanitizer solution in the food preparation area were removed. In the Special Care Center serving kitchen, eight (8) dish racks were removed from the floor, three (3) light covers were cleaned, one (1) marred wall was repaired, one (1) ice scoop was removed from the top of the ice machine	5/22/09 5/22/09 5/25/09

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F 371	Continued From page 36 crab meat in the walk-in refrigerator; no thermometer in the ice cream freezer, three (3) of three (3) perforated pans stored wet and ready for re-use, three (3) of six (6) back flow pipes with insufficient air gaps, and two (2) of two (2) buckets filled with sanitizer solution in the food preparation area. In the Special Care Center serving kitchen the following was observed: eight (8) of eight (8) dish racks stored on the floor, three (3) of three (3) dusty light covers, one (1) of one (1) marred wall, one (1) of two (2) ice scoops stored on top of the ice machine, two (2) of two (2) containers undated when opened of pink lemonade, and one (1) of one (1) bottle of chocolate syrup undated when opened in the refrigerator. The following was observed in the freezer in the kitchen located on the Special Care Center unit: one (1) of one (1) five-gallon container of vanilla ice cream undated when opened; 11 individual servings of ice cream undated and unlabeled and one (1) dish of tapioca pudding, uncovered, undated and unlabeled. These observations were made in the presence of Employees #13 and 26, who acknowledged the findings at the time of the observations. The tour of the main kitchen was conducted from 8:30 AM through 12:30 PM on May 19, 2009. The findings include: 1. The following items were observed soiled with grease and accumulated debris in the main kitchen: The interior and exterior surfaces of two (2) of	F 371	and inserted in the ice scoop holder, two (2) containers of pink lemonade was dated, and one (1) bottle of chocolate syrup was dated. In the Special Care Center freezer, one (1) five-gallon container of vanilla ice cream was discarded, eleven (11) individual servings of ice cream were discarded and one (1) dish of tapioca pudding was discarded. The interior and exterior surfaces of two (2) deep fryers were cleaned. The gas and electrical wiring located below two (2) deep fryers were cleaned. The interior and exterior hinges of one (1) tilt grill were cleaned. One (1) set of pipes located between the appliances were cleaned. The lip and exterior surfaces of two (2) convection ovens were cleaned. The shelf surfaces of two (2) standing racks were cleaned. One (1) exhaust vent located above the clean storage rack for pots and pans was cleaned. Three (3) back flow drains located throughout the main kitchen were cleaned. Two (2) floor drains located throughout the main kitchen were cleaned. Two (2) ice machine drainpipes were cleaned. The crabmeat in the walk-in refrigerator was immediately discarded. Three (3) perforated pans were rewashed and stacked separately to dry.	5/21/09 5/25/09 5/21/09 5/21/09

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F 371	Continued From page 37 three (3) deep fryers. The gas and electrical wiring located below two (2) of three (3) deep fryers. The interior and exterior hinges of one (1) of one (1) tilt grill. One (1) of one (1) set of pipes located between the appliances. The lip and exterior surfaces of two (2) of two (2) convection ovens. The shelf surfaces of two (2) of two (2) standing racks. One (1) of one (1) exhaust vent located above the clean storage rack for pots and pans. Three (3) of six (6) back flow drains located throughout the main kitchen. Two (2) of six (6) floor drains located throughout the main kitchen. Two (2) of four (4) ice machine drain pipes with approximately ½ inch of a white substance on the end of each pipe. 2. Chicken pieces were observed stored on the middle shelf of a storage rack above crab meat in the walk-in refrigerator. 3. Three (3) of three (3) perforated pans were observed stored wet and ready for re-use in the pot and pan wash area. 4. Three (3) of six (6) back flow pipes were observed with insufficient air gaps to prevent the back flow of contaminated water into the potable water system. 5. Two (2) of two (2) buckets of sanitizer were observed near cantaloupe, celery and onions being chopped in the food preparation area. The following was observed in the Special Care	F 371	Three (3) back flow pipes were repaired. Two (2) buckets filled with sanitizer solution in the food preparation area were removed. In the Special Care Center serving kitchen, eight (8) dish racks were removed from the floor, three (3) light covers were cleaned, one (1) marred wall was repaired, one (1) ice scoop was removed from the top of the ice machine two (2) containers of pink lemonade was dated, and one (1) bottle of chocolate syrup was dated. In the Special Care Center freezer, one (1) five-gallon container of vanilla ice cream was discarded, eleven (11) individual servings of ice cream were discarded and one (1) dish of tapioca pudding was discarded. 2. Each piece of equipment has been thoroughly cleaned by kitchen staff. In addition, kitchen staff have been re-educated on sanitation, specifically addressing every issue cited. 3. The Director of Dining or designee will make weekly sanitation inspections x4, then every month x 3, then quarterly x 3. 4. The results of the monitoring will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	7/3/09 5/21/09 5/25/09 5/21/09 6/1/09 6/1/09

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F 371	Continued From page 38 Center kitchen: 1. Eight (8) of eight (8) dish racks stored on the floor. 2. Three (3) of three (3) dusty light covers near the ice machine. 3. One (1) of one (1) marred and scarred wall. 4. One (1) of two (2) ice scoops stored uncovered on top of the ice machine. 5. Two (2) of two (2) containers of concentrated pink lemonade undated when opened. 6. One (1) of one (1) 32 ounce container of chocolate syrup undated when opened. The following was observed in the freezer in the kitchen located on the Special Care Center: 1. One (1) of one (1) five-gallon container undated when opened. 2. 11 of 11 individual dishes of ice cream undated when prepared. 3. One (1) of one (1) container of tapioca uncovered, undated and unlabeled.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the physician failed to review the	F 386		

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F 386	Continued From page 39 total plan of care for Resident #11. The findings include: A review of Resident #11's nurses' notes revealed the following: January 12, 2009 at 2:45 PM..."Resident found on floor of room ..." February 18, 2009 at 9:00 AM..."Found on floor at bedside ...MD [medical doctor] notified ..." March 14, 2009 at 5:00 PM..."On floor between the bathroom door in room ...MD notified ..." March 19, 2009 at 9:00 PM..."Tried to walk- couldn't ...fell getting back into the chair ... [Physician] notified ..." March 31, 2009 at 8:30 PM..."Slid off side of bed ...MD notified ..." April 3, 2009 at 3:30 PM..."Found sitting on floor by bedside ...MD notified ..." April 24, 2009 at 7:30 PM..."Got out of chair, alarm went off ...sitting on floor ...MD notified ..." May 5, 2009 at 7:00 PM..."Sitting at bedside with staff present. Slid off side of bed ...MD notified ..." A review of the Physician's progress notes written and dated January 21, February 11, and April 11, 2009. There was no evidence in the physician's progress notes that the resident's falls were addressed. A face-to-face interview was conducted with Employee #4 on May 21, 2009 at 8:20 AM. After reviewing the record, he/she acknowledged that	F 386	It is ADF/Knollwood's policy and practice for our physicians to review and address the resident's falls in the physician's progress note. 1. The physician entered a note in Resident #11's medical record regarding the plan of care as it relates to falls. 2. A letter will be sent to our physicians reminding them to review the residents' plan of care after a resident's fall and to write a progress note. 3 An audit will be completed by the Director of Nursing or designee to ensure that the physicians are reviewing the plan of care of residents who have sustain a falls and entering a note in the medical record. The audit will be completed weekly X 4 then monthly X 3. The results of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance had been achieved.	7/21/09 7/21/09 7/21/09

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F 386	Continued From page 40 the physician did not address the resident' s falls. The record was reviewed May 21, 2009.	F 386		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that the facility staff failed in an isolated incident to ensure the medications in the interim box were available for residents, to date and initial two (2) of two (2) multi-dose containers when first opened and to discard six (6) of 10 discontinued medications from the facility treatment carts. The findings include:	F 425		

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F 425	Continued From page 41 1. Facility staff failed to ensure that medication was available to the residents. On May 20, 2009 at approximately 3: 00 PM during the inspection of the medication storage areas, the Interim box was observed. Stock located in the medication refrigerator, contained in the Interim box, was listed as the following: Phenergan 25 mg suppositories Compazine 10 mg suppositories Lorazepam 2mg/ml injection, 10ml Acetaminophen 650 mg suppositories Aspirin 600mg suppositories Bisacodyl 10mg suppositories Novolin 70/30 insulin Novolin R insulin At the time of the observation Employee #19 acknowledged that he/she only observed Phenergan and Compazine suppositories and Lorazepam injection in the medication refrigerator. The pharmacy needs to replace the other medications. 2. The facility staff failed to initial and date multi-dose vials when first opened. On May 20, 2009 at approximately 3:30 PM during the inspection of the treatment cart, two (2) bottles of Sodium Chloride Solution 250 ml multi-dose containers were observed with no nurse ' s initials or date of opening. At the time of the inspection, Employee #19 acknowledged that the Sodium Chloride Solution bottles were not dated or initialed when first opened. 3. On May 20, 2009 at approximately 4:00 PM during the inspection of the facility ' s treatment cart on HSC and SCC units, medication was	F 425	It is ADF/Knollwood's policy and practice to ensure that medications in the interim box are available for residents, multi-dose containers are dated and initialed when first opened and discontinued medications from the treatment cart are discarded. 1(a) The missing medications for the interim box and medication refrigerators were replaced on 5/21/09. 1(b) The opened multi-dose vials without dates and initials were immediately discarded. 1(c) The discontinued medications were immediately discarded. 2. The medication nurses were counseled on the proper management of the interim box, medication refrigerators, medication carts, which include an audit of the carts for discontinued medications and to initial and date all multi-dose medication containers when first opened. 3. The medication nurses will be inserviced on auditing of the interim box and medication refrigerators, dating and initialing multi-dose containers, and auditing the medication carts for discontinued medications. The ADON or designee will randomly audit these areas every week x 4, then every month x 4, then quarterly x 3 thereafter to ensure compliance.	5/21/09 5/20/09 5/20/09 5/30/09 7/21/09 7/21/09

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F 425	Continued From page 42 observed with a dispensing label that stated " Stop Order " . A review of the physician's order for each medication revealed that the medication was to be used for a specified amount of time. The following medications were observed in the treatment cart: Nystatin 30gm ointment, discontinued April 16, 2009 Nystatin 30 gm ointment, discontinued April 24, 2009 Proctacart 30 gm cream, discontinued December 18, 2008 Mupirocin ointment 2%, discontinued March 3, 2009 Ketoclonazole 2% cream 30 gm, discontinued August 20, 2008 Nystatin 100,000 units/gm ointment, discontinued November 21, 2009 A face-to-face interview was conducted with Employee #22 at the same time of the observation. He/she acknowledged that the medications should have been discarded.	F 425	4. The results of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance is achieved.	
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

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F 431	Continued From page 43 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain proper temperature control for one (1) of two (2) medication refrigerators, to ensure that the medication bottle for one (1) of nine (9) medication pass residents was labeled correctly and to keep bedside medication for one (1) of one (1) resident who self-medicates stored in a locked drawer. Resident #7. The findings include: 1. The facility staff failed to maintain proper temperature control of the medication refrigerator	F 431	It is ADF/Knollwood's policy and practice to maintain proper temperature control for medication refrigerators, to ensure that medication bottles are labeled correctly and to keep bedside medication for residents who self-medicate stored in a locked drawer. 1(a) The medication refrigerator in the Health Services Center was adjusted to maintain proper temperature control on 5/20/09 and 5/21/09. 1(b) Resident #7 medication for Baclofen was discarded and replaced on 5/21/09 with a properly labeled container with the resident's name, name of the medication, and dosage. 1(c) Lamisil ointment for Resident #7 was immediately secured in a locked drawer on 5/21/09. Lamisil ointment was subsequently discontinued on 6/19/09. 2(a) The other refrigerators in the Health Services Center and Special Care Center were audited for proper temperature control on 5/20/09 and 5/21/09 and were observed to be functioning within acceptable range. 2(b) An audit was conducted on 5/23/09 to ensure that all medications were properly labeled. The audit revealed that all medications were properly labeled.	5/21/09 5/21/09 5/21/09 5/21/09 5/23/09

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F 431	Continued From page 44 on the HSC unit. The U.S. Pharmacopeia National Formulary, stipulates, "A refrigerator is a cold place in which the temperature is maintained thermostatically between 2 degrees (°) Fahrenheit (F) and 8 °F (36 ° F and 46 ° F). On May 20, 2009, at approximately 12:00 PM during the inspection of the medication refrigerators, the HSC unit ' s medication refrigerator's thermometer registered 50 ° F. A face-to-face interview was conducted at the time of the observation. Employees #3 and 20 acknowledged that the refrigerator was out of the temperature range and adjusted the refrigerator's thermostat. The medication refrigerator was re-inspected on May 21, 2009 at approximately 10:00 AM; the HSC unit's medication refrigerator's thermometer registered 30 ° F. A face-to-face interview was conducted at the time of the observations. Employee #2 acknowledged that the refrigerator was out of temperature range. 2. Facility staff failed to ensure proper labeling was on Resident#7's medication container. On May, 21, 2009 during the inspection of medication storage areas, Resident #7 medication for Baclofen was observed stored in a locked bedside drawer. The medication container was not labeled with a dispensing label that denoted the resident's name and the name of the medication.	F 431	2(c) An audit was conducted on 5/23/09 to ensure that all medications kept at the bedside were secured in locked drawers. The audit revealed that there was no other resident with orders to leave medication at the bedside. 3. The medication nurses will be inserviced on the proper maintenance of refrigerator temperature between 36 degrees F and 46 degrees F, the proper labeling of medications kept at the bedside and assuring the drawers are locked. The ADON or designee will randomly audit weekly x 4, then monthly x 4 then quarterly x 3 to ensure compliance. 4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	5/23/09 7/21/09 7/21/09

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F 431	Continued From page 45 A face-to-face interview was conducted with Employee #19 at the same time of the inspection. He/she stated that he/she did not know that the dispensing label had come off of the medication bottle. 3. Facility staff failed to keep bedside medication stored in a locked drawer for Resident #7. On May 21, 2009 during the inspection of the medication storage areas Lamisil ointment was observed on Resident #7 bedside tray. A review of the resident's clinical record revealed the following physician's orders dated May 6, 2009: "Please observe resident self administration of Baclofen weekly on Tuesday at 4:00 PM ...Baclofen 20 mg 1 tab (Tablet) PO 3 times a day ...for muscle spasms ...Lamisil AT Cream 1% apply to temporal area on scalp for fungus 2 times a day as needed (May keep at bedside)." The facility staff failed to keep the Lamisil ointment in a locked drawer. A face-to-face interview was conducted with Employee #19 at the same time of the inspection. He/she stated that they were unaware of the ointment on the bedside tray. it is suppose to be stored in the resident ' s locked bedside drawer.	F 431		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish	F 441		

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F 441	Continued From page 46 an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to maintain appropriate practices to prevent spread of infection during a wound care treatment and failed to ensure that the filter was clean for one (1) of three (3) oxygen concentrators. The findings include: 1. Facility staff failed to maintain appropriate practices to prevent the spread of infection during a wound care treatment. Employee #9 was observed during a wound care treatment to Resident # 3's left heel on May 19, 2009 at approximately 1:30 PM. Employee #9 failed to maintain appropriate practices to prevent spread of infection. when he/she failed to wash his/her hands immediately after discarding dirty linens in the dirty utility room. A face-to-face interview was conducted with Employee #9 on May 21, 2009 at approximately 11:20 AM. He/she acknowledged the aforementioned findings. He/she said, "I thought I washed my hands in the medication room. May	F 441	It is ADF/Knollwood's policy and practice to maintain an infection control program to include the prevention of infection during wound treatments and to ensure that oxygen concentrator filters are clean. 1(a) Employee #9 was re-educated on the importance of infection control to include handwashing immediately after discarding dirty linen. 1(b) The oxygen concentrator filter for Room# 15 (typo #25) was immediately removed, cleaned and replaced. 2. Staff will be inserviced on Infection Control to include handwashing after discarding dirty linen and the cleaning of oxygen concentrator filters. In addition, all oxygen concentrator filters were checked for cleanliness and observed to be in compliance. Licensed staff will initial the resident TAR (Treatment Administration Record) weekly after cleaning the filters. 3. The ADON or designee will conduct an audit of handwashing by staff and the cleanliness of oxygen concentrator filters to assure that they are cleaned on a weekly basis, weekly x 4, then monthly x 4, then quarterly x 3 to ensure compliance by staff. 4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines compliance.	5/30/09 5/21/09 7/21/09 7/21/09

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F 441	Continued From page 47 be I did not." The record was reviewed May 21, 2009. 2. Facility staff failed to ensure that one (1) of three (3) oxygen filters was clean. The environmental tour was conducted on May 19, 2009 from 1:30 PM until 4:00 PM in the presence of Employees #13 and 14 who acknowledged the findings at the time of the observations. During the environmental tour of the facility, the oxygen concentrator in room 25 was observed soiled with dust. The filter was immediately removed, cleaned and replaced by Employee #3. He/she stated at the time of the observation that the oxygen concentrator filters should be cleaned weekly and as needed.	F 441		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to maintain appropriate infection control practices during a wound care treatment. The findings include: Employee #9 was observed during a wound care	F 444		

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F 444	Continued From page 48 treatment to Resident #3's left heel on May 19, 2009 at approximately 1:30 PM. Employee #9 loosened the resident's old dressing and discarded it in the wastebasket. He/she placed a towel between the resident's left heel and the bed, cleansed the wound, applied cream on a 4x4 gauze, and secured the wound with tape. Employee #9 gathered the towel used as a wound barrier and the towel used as a barrier on the table and carried them unbagged against his/her chest to the soiled utility room and disposed of the linen in the appropriate container. Employee #9 went into the medication room, after discarding the dirty linens, left the medication room and walked towards the hallway across from the medication room, and went in and out of four (4) residents' rooms. Employee #9 did not wash his/her hands during any of the above cited activities. A face-to-face interview was conducted with Employee #9 on May 21, 2009 at approximately 11:20 AM. He/she acknowledged the aforementioned findings. He/she said, "I thought I washed my hands."	F 444	It is ADF/Knollwood's policy and practice to maintain an infection control program to include the prevention of infection during wound treatments. 1. Employee #9 was re-educated on the importance of infection control to include handwashing immediately after discarding dirty linen and bagging soiled linen and holding linen away from their clothing. 2. Staff will be inserviced on Infection Control to include handwashing after discarding dirty linen. 3. The ADON or designee will conduct an audit of handwashing by staff, appropriate handling of soiled linen and the cleanliness of oxygen concentrator filters weekly x 4, then monthly x 4, then quarterly x 3 to ensure compliance by staff. 4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines compliance.	7/21/09 7/21/09 7/21/09
F 456 SS=E	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview during a tour of the main kitchen, it was determined that facility staff failed to maintain the following	F 456		

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F 456	Continued From page 49 equipment: one (1) of one (1) hose with damaged insulation, one (1) of four (4) burners on the gas stove that failed to light, and one (1) of one (1) sanitizer system for the three (3) compartment sink that failed to dispense the appropriate amount of sanitizer. The tour of the main kitchen was conducted on May 19, 2009 from 8:30 AM until 12:30 PM in the presence of Employee #26 who acknowledged the findings at the time of the observations. The findings include: 1. One (1) of one (1) hose attached to the wall was observed with insulation protruding from the insulation wrapping. 2. One (1) of four (4) burners failed to light when tested on the gas oven. 3. The three (3) compartment sink, used to wash, rinse and sanitize cooking and baking utensils, was observed. The observation revealed that the ph test strip failed to change color when the water in the sanitizer sink was tested. This indicated that sanitizer was not added to the water. Employee #28 emptied the water from the sink, re-filled the sanitizer sink and adjusted the amount of sanitizer to be added to the water. When tested, the ph test strip failed to change color revealing that sanitizer had not been added to the water. Employee #26 notified the maintenance department that the sanitizer system was not functioning properly and a maintenance employee was promptly dispatched to the kitchen.	F 456	It is ADF/Knollwood's policy and practice to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. 1. One (1) hose with damaged insulation was repaired, one (1) burner on the gas stove was repaired, and one (1) sanitizer system for the three (3) compartment sink was repaired at time of survey. 2. Rounds were conducted throughout the kitchen and all above items have been addressed. Training has been conducted on the procedures for using the sanitizer system and for testing for the proper amount of sanitizer in the water. No further items of this type were found during the rounds. 3. The Director of Dining or designee will make weekly inspections x4, then every month x 3, then quarterly x 3. 4. The results of the monitoring will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	7/2/09 7/2/09 7/21/09

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F 456	Continued From page 50 After approximately 15 minutes, it was observed that the sanitizer sink was filled with water and sanitizer which resulted in soapy type bubbles in the water. The test strip turned very dark green, indicating too much sanitizer had been added. The water was emptied out of the sink. The sanitizer system was again adjusted by the maintenance employee and the sanitizer sink re-filled. There were no bubbles in the sanitizer sink and the test strip turned olive green indicating that the appropriate amount of sanitizer was present in the water.	F 456		
F 468 SS=D	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. 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 handrails were securely attached. The environmental tour was conducted on May 19, 2009 from 1:30 PM to 4:30 PM. These observations were made in the presence of Employees #13 and 14 who acknowledged these findings at the time of the observations. The findings include: Loose handrails were observed in the corridors on the Health Service Center near room 2 at 1:40 PM and room 18 at 1:50 PM. Employee #20 repaired the hand rails at the time of the	F 468	It is ADF/Knollwood's policy and practice to ensure that handrails are securely attached. 1.The handrails in the corridors in the Health Service Center near room 2 at and room 18 were repaired. Employee #20 repaired the handrails at the time of the observation. 2. Rounds were conducted throughout the Health Services Center and Special Care Center and no further items of this type were found. 3. The Chief Engineer or designee will make monthly rounds/inspections of all handrails x 4, then quarterly x 3. 4. The results of the monitoring will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	5/19/09 5/20/09 7/21/09

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F 468	Continued From page 51 observation. Employees #13 and 14 acknowledged the findings at the time of the observation.	F 468		
F 490 SS=C	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on review of facility documents and staff interviews, it was determined that facility staff failed to code the 672 [Resident Census and Conditions of Residents] and 802 [Roster Sample Matrix] forms to represent the current condition of residents. The findings include: On May 20, 2009 at 8:50 AM, Employee #2 presented the surveyor with the 672 and the 802 forms. A review of the 672 revealed that information contained was not consistent with the information provided by the facility on the 802 form(s). A face-to-face interview was conducted with Employee #2 at the time of the review. He/she acknowledged the differences. Additionally, a review of the " General Instructions and Definitions " form was conducted with Employee #2. The forms were returned to the facility to make the necessary modifications/changes.	F 490	It is ADF/Knollwood's policy and practice to accurately code the Resident Census And Condition of Residents and the Rooster Sample Matrix forms to represent the current condition of residents. 1. The Resident Census And Condition and the Rooster Matrix were corrected during the survey process to reflect the residents' current condition. 2. Instructions used to complete the Resident Census and Condition and the Rooster Matrix forms were reviewed with the nursing leadership. 3. An audit of the Resident Census And Condition and the Rooster Matrix will be conducted weekly X 4 then monthly by the DON or designee. 4. The result of the audit will be presented to the Quality Assurance Committee until the Committee determines that compliance was achieved.	5/20/09 7/21/09 7/21/09

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F 490	Continued From page 52 On May 20, 2009 at approximately 1:45 PM, Employee #2 resubmitted the 672 and the 802 forms to the surveyor. Upon review of the 802 form(s) it was found that while changes had been made to correct the previously identified areas of concern, other discrepancies were identified. The forms were return to Employee #2 to make the additional modifications and/or changes to the forms. On May 20, 2009 at 2:50 PM the third revision of the 672 and 802 forms were accepted.	F 490		
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 record review and staff interview for one (1) of 15 resident records reviewed and one (1) of one (1) supplemental resident records, it was determined that facility staff failed to consistently document behaviors for one (1) resident and incontinence approaches for one (1) resident. Residents #3 and S1. The findings include:	F 514	It is ADF/Knollwood's policy and practice to consistently document resident's behaviors and incontinence approaches. 1(a) Resident #3 behaviors are consistently being documented in the clinical record. 1(b) An incontinence care plan was developed for resident S1 with specific approaches to maintain or improve the continence status. 2(a) The licensed nurses will be re-educated to consistently enter documentation in the Medication Administration Records for residents who have medication prescribed for agitation. In the event that a resident has exhibited a behavior and non-pharmacological interventions are not effective, the resident will be given the prescribed medication and the licensed nurse will document the behavior on the behavior monitoring form.	7/21/09 7/21/09 7/21/09

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F 514	Continued From page 53 1. Facility staff failed to consistently document behaviors for Resident #3. Facility staff failed to consistently document behavior for Resident #3 while on Clonazepam for agitation. According to Section I (Diseases Diagnosis) of an annual Minimum Data Set (MDS) completed on July 17, 2008, the resident's diagnoses included Dementia and Behavior Problems. The resident's medications according to "Physician's order" sheets for May 2009 signed and dated April 21, 2009 included "Clonazepam 0.25 mg 1 tablet by mouth three times a day for agitation ..." According to dated and signed "Physician's Order" sheets for January through May 2009 the physician directed Clonazepam for agitation. According to the Medication Administration Records for January through May 2009, the resident received Clonazepam three times daily while in the facility. Further review of the resident's clinical record lacked consistent documented evidence that the resident's behavior was monitored for agitation. The "Behavior Monitoring Record" for January 2009 was completed for only January 30 and 31, 2009. The rest of the month was blank. Two (2) other behavior monitoring records were completed but lacked the actual months that the monitoring occurred. A face-to-face interview was conducted with	F 514	2(b) The interdisciplinary team was instructed to care plan resident's incontinence status with individualized approaches according to the resident's status. 3(a) An audit will be conducted by Social Services of residents exhibiting behaviors weekly X 4 then monthly X 4 to ensure compliance. 3(b) An audit will be completed by the Director of Nursing or designee monthly X 6 to ensure that the residents' incontinence status is care planned. 4. The results of these audits will be presented to the Quality Assurance Committee until the Committee determines that compliance has been achieved.	7/21/09 7/21/09 7/21/09

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F 514	Continued From page 54	F 514		

Employee #3 on May 21, 2009 at approximately 8:00 AM. After reviewing the resident's clinical record, Employee # 3 acknowledged the above findings. The record was recorded May 21, 2009.

2. Facility staff failed to consistently document incontinence approaches for Resident S1.

A review of Resident S1's care plan revealed that goals and approaches for incontinence was included on two (2) care plans: "Risk for skin breakdown related to incontinence of bladder and bowel related to cognitive loss" and "Unable to perform self-care related to cognitive loss."

The care plan entitled, "Risk for skin breakdown related to incontinence of bladder and bowel related to cognitive loss" included approaches including the resident's toileting schedule.

A physician's telephone order dated February 9, 2009 at 2:00 PM and signed by the physician the same day, directed, "Discontinue toilet resident before and after meals. Toilet resident every 3 hours while awake and as needed."

The care plan entitled for "Unable to perform self-care related to cognitive loss" was updated to include the above cited physician's order.

The care plan entitled, "Risk for skin breakdown related to incontinence of bladder and bowel related to cognitive loss" failed to include the above cited physician's order.

A face-to-face interview was conducted with Employee #8 on May 21, 2009 at 9:30 AM. He/she acknowledged that the physician's order should have been included on both care plans.

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F 514	Continued From page 55 The record was reviewed May 20, 2009.	F 514		