STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	11/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK MANOR NURSING CTR	2131 O STREET NW WASHINGTON, DC 20037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual re-certification survey was conducted on November 12 through 14, 2008. The following deficiencies were cited based on observations, staff and resident interviews and record review. The sample size included 26 residents based on a census of 173 the first day of survey, with seven (7) supplemental residents.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	1a. No resident was harmed by the deficient practice. 1b. The incident report for resident #6 was faxed to the state survey agency on 10/24/08. 1c. Incident reports for resident #2 and #3 were faxed to the state survey agency on 10/6/08. 1d. Incident reports for residents #19, #22, #S1, #S4 and #S5 were given to the State survey agency on 11/13/08. 1e. Investigation results on incidents for residents #6, #S1, #S2 and #S3 were given to the state survey agency on 11/13/08. 2. All incident/accidents were reviewed and audited and no other deficient practices were noted. 3a. A weekly random audit will be conducted on incident/accident reports by the DON or designee to ensure that all reports of incidents/accidents are communicated by phone or faxed to the DOH within 8 hours and 48 hours respectively.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/15/08

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

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F 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on a review of incident/unusual occurrence reports from August through November 2008 and staff interview, it was determined that facility staff failed to report to the State Agency one (1) of one (1) injury of unknown origin, four (4) of four (4) falls with injury, and the results of two (2) of two (2) alleged abuse investigations. Residents #6, 19, 22, S1, S2, S3, S4 and S5. The findings include: 35 incident/unusual occurrence reports were reviewed from August through November 2008 and included the following:19 falls with no injuries, six (6) newly opened skin areas, three (3) behavior incidents, four (4) falls with injury and three (3) investigations of alleged abuse. A face-to-face interview was conducted with Employees #1 and 2 on November 13, 2008 at approximately 11:30 AM. Both employees acknowledged that the incidents and/or follow-up reports for the following incidents had not been sent to the State Agency. A. On September 5, 2008, Resident #6 was observed with a swollen left hand, origin unknown. The resident subsequently was diagnosed with a fractured wrist. An investigation	F 225	3b. The facility's policy was updated on 12/11/08 to emphasize incidents/accidents investigation and reporting to state survey agency. 3c. An in-service was given to nursing supervisors on 11/25/08 on the policy and procedure of reporting incidents/accidents to related state survey agency. 4. Problems relating to resident incidents/ accidents, investigation and reporting will be discussed during the Daily QA meeting, Monthly, Fall Incident Prevention meeting, Risk Management/QA and Quarterly QA meetings for further remedial action.	12/18/08

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F 225	Continued From page 2 was conducted by facility staff. There was no evidence that the incident was reported to the State Agency. B. On October 25, 2008, Resident #19 was observed by staff sitting on the floor by the side of the bed. On assessment, the resident was observed with a 9 cm (centimeter) x 1.8 cm red area on his/her right side. There was no evidence that this incident was reported to the State Agency. C. On September 23, 2008, Resident #22 was observed on the floor and sustained a laceration on his/her nose and forehead. There was no evidence that this incident was reported to the State Agency. D. Resident S4 was observed on the floor in front of a wheelchair on October 9, 2008. On assessment, there was a bump noted on the right side of his/her head. There was no evidence that the incident was reported to the State Agency. E. Resident S5 was eased to the floor during incontinent care on October 31, 2008. The resident complained of soreness of the mid back area. X-rays of the thoracic spine were negative for fracture. There was no evidence that the incident was reported to the State Agency. F. On October 16, 2008, Resident S1 complained that a CNA (certified nursing aide) handled him/her roughly. An investigation was conducted, which included copies of statements by the resident and staff that were on duty on the date of the incident. According to the " Incident Report/Unusual Occurrence Report - Future Preventative/Corrective Action: Per resident and	F 225		

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F 225	Continued From page 3 family request, no male caregivers are to provide care for [Resident S1] ... " There was no evidence that this incident and the result of the facility's investigative report were reported to the State Agency. The resident was discharged from the facility on November 6, 2008. G. On October 4, 2008, Resident S2 (female) alleged that Resident S3 (male) inappropriately touched her breasts and buttock. The incident was investigated by facility staff. There was no evidence that the result of the facility's investigation was sent to the State Agency. A face-to-face interview was conducted with Resident S2 on November 15, 2008 at 1:45 PM. Resident S2 stated that he/she did not remember the incident and that he/she had never had any trouble with any other resident.	F 225		
F 253 SS=C	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 the environmental tour conducted on November 11, 2008 from 11:30 AM through 4:00 PM, it was determined that facility staff failed to maintain the shower rooms on all resident units in a clean and sanitary manner. These observations were made in the presence of Employees #8 and 9. The findings include:	F 253	1. Cracked, soiled caulking and damaged ceilings in all shower rooms were repaired on 11/13/08. 2. All shower rooms were checked by the director of Maintenance on 11/10/08 and were found to be in good repairs. 3a. Maintenance aides were re-in-serviced on 11/28/08 on surveillance rounds to detect cracked, soiled caulking and damaged ceilings in shower rooms for immediate repairs. 3b. Shower rooms will be checked daily by CNAs for cracked, soiled caulking and damaged ceiling for recording in the maintenance log.	

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F 253	Continued From page 4 Five (5) of five (5) shower rooms were observed with cracked and soiled caulking, and/or damaged ceilings. Employees #8 and 9 acknowledged these findings at the time of the observations.	F 253	3c. The facility will continue with the weekly environmental QA rounds to detect and repair any damaged areas of the facility. 4. Deficient practices relating to shower rooms or any areas of the environment will be reported immediately to the Administrator for remedial action and discussed at Monthly Risk Management/ QA and Quarterly QA meetings.	12/18/08
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		

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F 278	Continued From page 5 Based on record review and staff interview for two (2) of 26 sampled records, it was determined that facility staff failed to code one (1) resident for significant weight gain and one (1) resident for diagnosis of Schizophrenia on the Minimum Data Set (MDS). Residents #2 and 3. The findings include: 1. The facility staff failed to code Resident #2's MDS for a significant weight gain. A review of the "Monthly Weight and Vital Sign Sheet" in the clinical record revealed a weight of 119.0 lb (pounds) on August 4, 2008 and a weight of 135.2 lb on September 9, 2008 (A gain of 16.2lb/19% in one month). A review of the significant change MDS with an Assessment Reference Date (ARD) of August 11, 2008 revealed, "Section K2 (Height and Weight), a height of 66 inches and a weight of 119 lb." A review of the quarterly MDS with an ARD of September 29, 2008 revealed, "Section K2 (Height and Weight), a height of 66 inches and a weight of 135 lb; and a "0" was coded under Section K3b (Weight Change) indicating that there was no weight gain. A face-to-face interview was conducted with Employee #3 at approximately 11:30 AM on November 13, 2008. He/she acknowledged that the quarterly MDS was not coded for weight gain. The record was reviewed on November 12, 2008. 2. The facility staff failed to code Resident #3's significant change MDS for diagnoses for Schizophrenia and Psychosis.	F 278	1. MDS assessments for resident #2 and #3 were corrected on 12/8/08 to reflect residents diagnoses of significant weight gain and schizophrenia respectively. 2. All MDS assessments relating to coding were reviewed on 12/9/08 for accuracy and were found to be in compliance. 3a. Inter-disciplinary team members were re-in-serviced on 11/25/08 by the MDS coordinator on how to accurately code on the MDSs. 3b. The MDS coordinator will monitor for coding compliance using the MDS/care plan audit tool. 4. Problems relating to MDS coding will be discussed in the Daily Risk management/QA meeting, monthly Risk management/QA and Quarterly QA meetings for remedial action.	12/18/08

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F 278	Continued From page 6 A review of "Psychiatric Evaluation" dated and signed July 10, 2008 revealed a diagnoses of Schizophrenia and Psychosis. A review of the significant change MDS completed August 28, 2008 revealed that Resident #3 was not coded for a diagnosis of schizophrenia in section I1 [Disease Diagnoses]. Section I3 [Other current or more detailed diagnoses and ICD -9-codes] was blank. A face-to-face interview was conducted with Employee #7 on November 13, 2008 at 11:00 AM. He/she acknowledged that diagnoses for Schizophrenia and Psychosis was not coded on significant change MDS. The record was reviewed on November 13, 2008.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	1a. No resident was harmed by the deficient practice. 1b. Care plan were immediately initiated for 9+ medication for residents #2 and #3. 2. All residents' charts for 9+ medications care plans were reviewed on 11/26/08 and found to be in compliance. 3a. Resident Care Coordinators (RCCs) were re-in-serviced on 11/25/08 by the MDS coordinator on initiating care plans for 9+ medications. 3b. MDS coordinator will monitor for coding and care plans compliance using care plan/MDS audit tool.	

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F 279	Continued From page 7 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 26 sampled residents it was determined that facility staff failed to develop a care plan with appropriate goals and approaches for two (2) residents for potential adverse interaction of the use of nine (9) or more medications. Residents #2 and 3. The findings include: 1. The facility staff failed to initiate a care plan for the potential adverse interaction of the use of nine (9) or more medications for Resident #2. A review of the Physician's Order Sheet (POS) for October 2008, signed by the physician on September 13, 2008, revealed the following medication orders: Avandia, Docusate Sodium, Ibuprofen, Lisinopril, Lorazepam, Megastrol, Multivitamins, Norvasc, Seroquel and Synthroid. A review of the care plans that were last updated on October 10, 2008, revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #3 at approximately 3:00 PM on November 12, 2008. He/she acknowledged that the record lacked a care plan for the potential adverse interaction of the use of nine (9) or more	F 279	4. Problems relating to care plans will be discussed in the Daily Risk Management/QA, Monthly Risk Management/QA and Quarterly QA Meetings for immediate remedial action.	**12/18/08**

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F 279	Continued From page 8 medications. The record was reviewed on November 12, 2008. 2. The facility staff failed to initiate a care plan for the potential adverse interaction of the use of nine (9) or more medications for Resident #3. A review of significant change MDS signed and dated August 28, 2008 coded resident to be on 10 medications under Section O1[Number of Medications]. A review of the August 2008 " Physician Order sheet" signed and dated August 8, 2008, revealed that Resident #3 received the following routine and PRN (as needed) medications: Abilify, Depakote, Lantus, Synthroid, Glucophage XR, Seroquel, Sorbitol Sol 70%, Thiamine HCL, Ativan, Acetaminophen, and Mobic. A review of August 2008 "Medication Administration Record (MAR)" revealed that Resident #3 receives 11 medications as follows: Abilify, Depakote, Synthroid, Glucophage XR, Seroquel, Thiamine HCL, Ativan, Acetaminophen, Sorbitol Sol 70%, Lantus and Mobic. A review of the care plans last updated on October 10, 2008, revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with the Employee #7 on November 13, 2008 at 10:30 AM. He/she acknowledged that there was no care plan for the potential adverse interaction for the use of nine (9) or more medication. The	F 279		

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F 279	Continued From page 9 record was reviewed on November 13, 2008.	F 279		
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 observation, record review and staff interview, for one (1) of seven (7) residents observed during medication pass, it was determined the facility staff failed to obtain a physician's order for Resident JH1 who had medications stored at the bedside. The findings include: Facility staff failed to obtain a physician's order for Resident JH1 who had medications stored at the bedside. The facility's policy and procedure 4.3, " Bedside Storage of Medication " , stipulates, " (5) A written doctor's order for the bedside storage of medication is placed in the resident's medical record. " On November 12, 2008, at approximately 10:00 AM, during the morning medication pass, the following over the counter drugs (OTC) were observed in Resident JH1's room: Fungoid tincture, Biofreeze roll-on, Clotrimazole 1% cream and Antacid liquid.	F 309	1a. Resident #JH1 was not harmed by the deficient practice. 1b. The resident was educated on 11/14/08 on the risk of having medication at the bedside and the use of unauthorized medication as documented in the resident's chart. 1c. The attending physician saw resident on 11/17/08, gave orders for self administration of over-the-counter medication, but resident declined the responsibility of self administration of medication. Hence the physician's order for the medication was discontinued. 2. All residents' charts were checked on 12/9/08 for medication administration and proper physicians orders and were found to be in compliance. 3a. All licensed nursing staff were re-in-serviced on 11/25/08 on self administration of medication and the importance of a physician order with regards to medication administration. 3b. The facility will educate all residents' during IDT, Resident Council Meeting and upon admissions that all medications must have physician order prior to administration.	**Ongoing**

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F 309	Continued From page 10 A review of the resident's October 2008 medication orders, signed by the physician on October 20, 2008, did not have these drugs listed on the medication orders. A face-to-face interview was conducted on November 12, 2008, at the time of the observation with Resident JH1. He/she stated that a family member brought the OTC medications to the facility. A face-to-face interview was conducted on November 12, 2008, at the time of the observation with Employee #12. He/she stated that he/she did not know the resident had medication in the room; he/she usually works on another floor. The record was reviewed on November 12, 2008.	F 309	3c. RCCs will spot check residents' rooms for improper storage of medication without physician orders during the AM rounds. 4. Problems related to medication administration and improper storage of medication will be discussed in the Daily Risk Management/QA, Monthly Risk Management/QA and Quarterly QA meetings for immediate remedial action.	**12/18/08**
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, staff interview and record review it was determined for one (1) of 26 residents, that facility staff failed to provide access to a call light for a blind resident who had sustained several falls. Resident #17 The findings include:	F 323	1. No resident was harmed by the deficient practice. 2. All resident call bells were checked for access and no deficient practices were noted 3a. Team leaders (CNAs) will conduct a periodic check of residents' rooms to ensure that all call bells are within the residents' reach. 3b. An in-service education was given to all levels of nursing staff on 12/11/08 relating to the importance and use of the call bells by all residents to include residents with blindness.	

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F 323	Continued From page 11 Three (3) observations of the resident's room and environment were made on November 14, 2008 at 8:25 AM, 9:35 AM and 9:50 AM. The resident's call light was wrapped around the arm of a chair at the resident's bed side during each observation. During the 9:35 AM observation, Resident #17 was asked whether [he/she] knew the location of [his/her] call bell. [He/she] responded by using [his/her] hand to feel for the call bell on the bed, and responded "I don't know." when the call bell could not be located. A review of the clinical record revealed a report of an Ophthalmology consult dated August 30, 2007 with a diagnosis of "Blindness". A review of the nurses' notes revealed the following: On May 6, 2008 the resident had a fall without injury. On June 12, 2008 the resident had a fall without injury. On October 23, 2008, "[Resident] complained of pain to right hip. Told nurse [he/she] fell while trying to get to the bathroom." An x-ray was taken on October 23, 2008 and revealed no injury. A review of the "Falls Prevention" care plan last updated November 6, 2008 revealed, "...Approaches/Interventions...5. ...Use call bell for assistance PRN..." Facility staff failed to ensure resident' s call light was accessible for the resident to call for assistance as needed. On November 14, 2008 at 9:50 AM [the third observation] Employee #4 was present and acknowledged that the call light was wrapped around the arm of the chair and out of the reach	F 323	4. Problems relating to call bells will be discussed during Daily/Monthly Risk Management/QA meeting and in the Quarterly QA meeting for further remedial action.	12/18/08

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	095031	A. BUILDING _____ B. WING _____	11/14/2008

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F 323	Continued From page 12 of the resident. The record was reviewed on November 14, 2008.	F 323		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and 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	F 431	1a. Resident #JH1 was not harmed by the deficient practice. 1b. The prescribed medication found at resident's bedside was immediately removed for appropriate storage. 1c. The resident was educated on 11/14/08 on the risk of having medication at the bedside and use of unauthorized medication as documented in the resident's chart. 1d. The attending physician saw resident on 11/17/08, gave orders for self administration of over-the-counter medication, but resident declined the responsibility of self administration of medication. Hence the physician order for the administration was discontinued. 1e. The resident room was checked on 11/12/08 for any citing of inappropriate medication and none was found as documented in the resident's chart. 2. All resident rooms were checked on 12/9/08 by nursing staff and found no inappropriate storage of medications. 3a. All licensed nursing staff were re-in-serviced 11/25/08 on self-administration of medication and proper storage of medication.	Ongoing

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F 431	Continued From page 13 by: Based on observation and staff interview, it was determined that in one (1) of seven (7) residents observed during medication pass, the facility staff failed to properly store Resident JH1's medication. The findings include: Facility's policy and procedure 4.3, "Bedside Storage of Medication", stipulates "(7) Bedside medications will be stored in a locked area, ..." On November 12, 2008, at approximately 10:00 AM, during the medication pass, drugs were observed stored in Resident JH1's room in a box on the bedside table. The following medications were found stored improperly: Antacid liquid, Deep Sea Spray, Clotrimazole 1% cream, Fluocinonide 0.05% cream, Fungoid tincture, Biofreeze roll-on for pain relief. A face-to-face interview was conducted at the time of the observation with Employee #12. He/she acknowledged that the medications in Resident JH1's room were not stored properly.	F 431	3b. LPNs, CNAs will report any medication found in residents' rooms during their daily rounds to RCC/Supervisor. 3c. RCCs will spot check residents' rooms for improper storage of medication during the AM rounds. 3d. The ground rounds team will report any medication found in residents' rooms to the RCC. 4. Problems related to medication administration and improper storage of medication will be discussed in the Daily Risk Management/QA, Monthly Risk Management/QA and Quarterly QA meetings for immediate remedial action	12/18/08
F 505 SS=D	483.75(j)(2)(ii) LABORATORY SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review for one (1) of 26 sampled residents, it was determined that facility staff failed to notify the	F 505	1a. The dilantin dosage for resident #18 was decreased during his hospitalization. 1b. The attending physician gave new orders on 11/20/08, to reflect a decrease in the dosage of the Dilantin. 2. Laboratory results of residents receiving Dilantin were reviewed by the ADON on 12/6/08 and all were in compliance with regards to physician notification.	

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F 505	Continued From page 14 physician of abnormal labs results for Resident #18. The findings include: The policy entitled, "Labs Results" [no policy number or date documented] stipulated, "Procedure: ...2. Charge Nurse should review all reports and immediately notify the physician of abnormal lab results..." A review of the labs results revealed the following: September 2, 2008- Phenytoin 22.0 [out of range], 10 - 20 [reference range] September 4, 2008- Phenytoin 25.0 [out of range], 10 - 20 [reference range] September 8, 2008- Phenytoin 21.7 [out of range], 10 - 20 [reference range] A review of the lab result forms and the nurses' notes lacked evidence that the physician was notified of abnormal labs immediately. A face-to-face interview was conducted on November 14, 2008 at 3:00 PM with Employees #1 and 2. They acknowledged that the physician was not notified of the abnormal labs immediately. The record was reviewed on November 14, 2008.	F 505	3a. Licensed nursing staff were in-serviced on 11/19/08 on physician notification of abnormal labs. 3b. RCCs including Nursing Supervisors will review all laboratory results to ensure that physicians are immediately notified of abnormal lab results. 4. Problems related to abnormal labs will be discussed in the Daily Risk Management/QA, Monthly Risk Management/QA and Quarterly QA Meetings.	12/18/08