STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING _____ B. WING _____	12/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

(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 A re-certification survey was conducted on December 15 through 18, 2008. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size was 24 residents based on a census of 158 the first day of survey and 27 supplemental residents.	F 000	Preparation and/or execution of this Plan of Correction do not constitute admission or agreement by the provider of the truth of the facts alleged or concluded in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of Federal and State laws require it. The responses to the deficiencies in the Plan of Correction will be answered in the following numerical sequence: 1. How will the corrective actions be accomplished for those residents found to have been affected by the deficient practice? 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 3. What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not occur. 4. How do you plan to monitor your performance to make sure that solutions are sustained? 5. When will corrective action be completed?	
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		

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

RN/WHA Administrator 2/6/09

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

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on random observations for three (3) of three (3) residents, it was determined that facility staff failed to provide privacy as evidenced by failure to: completely pull the privacy curtain for one (1) resident during a wound treatment, and for two (2) residents while providing personal care. Residents #8 and 16 and A1. The findings include: 1. Facility staff failed to provide privacy to Resident #8 during a wound treatment. A wound treatment observation to Resident #8 right's bunion and an assessment of an upper back pressure ulcer was conducted on December 17, 2008 at approximately 12:00 PM. Employee #3 failed to completely pull the privacy curtain and close the door throughout the wound treatment and assessment of the pressure ulcer. A face-to-face interview was conducted with Employee #3 on December 18, 2008 at approximately 12:00 PM. He/she acknowledged that the door to the resident's room was not closed and the privacy curtain was not completely pulled around the resident while providing the wound treatment and assessment. 2. Facility staff failed to provide privacy to Resident #8 while providing personal care. Resident #8 was observed on December 18, 2008 at approximately 9:00 AM receiving morning care. The resident's lower body was exposed from the waist down. The resident's door was not closed and the privacy curtain was not pulled completely around the resident's bed. A face-to-face interview was conducted with Employee #19 on December 18, 2008 at approximately 12:00 PM. He/she acknowledged	F 164	Resident #8, 16 and A1 1. There were no negative outcomes to residents as a result of this care. 2. All other residents receiving wound and personal care were checked and corrected if required. 3. The Nursing Leadership team provided In-service to the nursing staff on 1/31, 2/1 and 2/3/09. 4. Residents' privacy will be monitored quarterly through CQI. 5. Completion date 2/5/09.	

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F 164	Continued From page 2 that the door to the resident's room was not closed and the privacy curtain was not completely pulled around the resident while he/she was providing personal care. 3. Facility staff failed to provide privacy to Resident A1 while providing personal care. Employee #20 was observed entering Resident A1's room at approximately 9:00 AM on December 18, 2008. The door to the room was open. Employee #20 opened the bathroom door. Resident A1 was in the bathroom receiving morning care and was unclothed. Employee #20 carried on a conversation with Employee #18, while Employee #18 was giving personal care to Resident A1. The bathroom door and the room door were open during the time of the conversation. A face-to-face interview was conducted with Employee #18 on December 18, 2008 at approximately 12:00 PM. He/she acknowledged unnecessarily exposing the resident's unclothed body.	F 164		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview for two (2) of 24 sampled residents and 15 supplemental residents, it was determined that facility staff failed to promote dignity during the breakfast and lunch meals. Residents #12, 18, A2, A3, A5, A7, A8, A9, A10, A11, A13, F1, JH3, P2, P3, P4 and P5.	F 241		

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F 241	Continued From page 3 The findings include: 1. The lunch meal was observed on the 1st floor unit on December 16, 2008 at approximately 12:00 PM. Residents sitting at the same table in the dining room were not served at the same time. Residents #18, A2, A3, A4, A5, A6, A7, A8, A9, A10, A11, and A13. Table A included three (3) residents, Residents A2, A3 and A4. Residents A2 and A3 were served their lunch at approximately 12:00 PM and were eating. Resident A4 was positioned at the same table at approximately 12:00 PM but received his/her lunch tray at approximately 12:30 PM. Table B included four (4) residents, Residents A5, A6, A7 and A8. Resident A6 and A7 were served their lunch at approximately 12:10 PM and were eating. Resident A8 was positioned at the same table at approximately 12:00 PM and received his/her lunch tray at 12:15 PM. Resident A5 was positioned at the same table at approximately 12:00 PM and received his/her lunch tray at approximately 12:40 PM. Resident A5 required feeding assistance. Table C included two (2) residents, Residents A9 and A10. Resident A9 was served his/her lunch at approximately 12:18 PM and was eating. Resident A10 was positioned at the same table at approximately 12:00 PM and received his/her lunch tray at approximately 12:32 PM. Table D included three (3) residents, Residents #18, A11 and A13. Resident A11 was served his/her lunch at 12:10 PM and was eating.	F 241	Resident #s as, 18, A2, A3, A5, A7, A9, A10, A11, A13, F1, JH3, P2, P3, P4, P5, A 4 and A6 1. There were negative outcome to the residents that did not receive their meals at the same time of the other residents. 2. Residents on other nursing units receiving breakfast and lunch meals were checked and the serving practice was corrected. 3. Nursing leadership and dietary service Provided in-services on Change in Serving Resident Meals on 1/31, 2/1 and 2/3/09. 4. Serving of Residents' meals will be monitored quarterly through CQI. 5. Completion date 2/5/09.	

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F 241	Continued From page 4 Resident #18 was served his/her lunch at approximately 12:20 PM and was eating. Resident A13 was positioned at the same table at approximately 12:00 PM and received his/her lunch tray at approximately 12:45 PM. Employee #19 confirmed the varied times residents A4, A10, and A13 received their meal trays in a face-to-face interview conducted at 12:45 PM on December 16, 2008. 2. The lunch meal was observed on the third floor on December 17, 2008 at 1:40 PM. Residents sitting at the same table were not served at the same time. Residents #12, P4, P5 and JH3. On December 17, 2008 at approximately 1:00 PM to 1:40 PM, lunch was observed being served to six (6) residents seated at two (2) tables on the third floor. Residents P2 and P3 were seated at Table E and Residents P4, P5, JH3 and #12 were seated at Table F. A. At 1:05 PM Residents P2 and P3 were observed seated at Table E. However, only Resident P2 was observed eating. Resident P3 had not been served. At 1:30 PM the second cart arrived on the unit and Resident P3 was served his/her lunch at 1:33 PM. At this time Resident P2, who had finished eating his/her lunch, got up from the table, walked over to another table and socialized with other residents. Resident P3 sat alone and ate until Resident P2 returned to the table approximately 10 minutes later. A face-to-face interview was conducted with	F 241		

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F 241	Continued From page 5 Employee #10 at approximately 1:35 PM on December 17, 2008. He/she acknowledged that Resident P2 and Resident P3 were served lunch at different times. The employee offered the following explanation, "[Resident P2's] lunch tray comes up on the first cart and [Resident P3's] tray comes up on the second cart. That is the routine for those residents." B. Residents P4, P5, JH3 and #12 were observed seated at Table F at approximately 1:05 PM. However, only Residents P4 and P5 were observed eating. Residents JH3 and #12 had not been served. Residents JH3 and #12 were served lunch from the second cart. Both residents received their trays simultaneously at 1:32 PM. A face-to-face interview was conducted with Employee #10 at approximately 1:35 PM on December 17, 2008. He/she acknowledged that Resident P4 and P5 were served lunch at a different time from Resident JH3 and Resident #12. The employee offered the following explanation, "[Residents P4's and P5's] lunch trays come up on the first cart and [Residents #12's and JH3's] trays come up on the second cart. That is the routine for those residents." 3. Facility staff failed to provide dignity to Resident F1 while being assisted with his/her meal. On December 15, 2008 between 1:30 PM and 1:40 PM, Resident F1 was observed being fed by Employee #17. Employee #17 was standing over the resident while feeding the resident with plastic cutlery and the food was served on a black	F 241		

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F 241	Continued From page 6 Styrofoam plate. A face-to-face interview was conducted on December 18, 2008 at 11:00 AM with Employee #4. He/she acknowledged that the employee should have been seated while feeding Resident F1. The record was reviewed on December 18, 2008.	F 241	F250 1. There was no documentation on the discharge summary re: home health agency name and telephone number but, resident received home health services on the day after discharge. 2. All resident discharges to home were reviewed for completeness of documentation in the discharge summary form. All discharges needing home health services had the name of the home health agency identified. 3. The Social Services Director provided an in-service on the importance of complete documentation on the discharge summary and progress notes on to the Social Worker on 2/4/09. 4. Documentation on discharge summary will be monitored through quarterly CQI. 5. Completion date: 2/5/09	
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services 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 record review of a closed record and staff interview for one (1) of 24 sampled resident records, it was determined that the social worker failed to follow-up with the home health agency for Resident #24 who was discharged home. The findings include: A review of Resident #24's record revealed that the resident was admitted to the facility on October 24, 2008 and discharged home on December 1, 2008. A review of the social worker' s note dated November 12, 2008, no time indicated, "This social worker completed a face to face discussion with resident regarding discharge and projected date ...Resident reported that [he/she] had home health aide prior to [facility] admission and expressed a desire to continue the services from	F 250		

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F 250	Continued From page 7 that agency. However, [he/she] could not recall name of agency or phone. Resident agreed to try to locate name and telephone number of agency and forward this information to this social worker. Resident expressed a willingness to switch to another agency if contact information could not be located." There was no further entry of the social worker's progress notes in the record. A review of the facility's discharge summary revealed that the home health agency name and telephone number were not documented on the form. A face-to-face interview with Employee #5 was conducted on December 16, 2008 at 11:10 AM. Employee #5 acknowledged that the name of the home health agency was not included on the discharge summary form. The record was reviewed December 16, 2008.	F 250	F 253 1. The damaged tile in the second and third floor shower rooms were replaced. 2. All shower rooms were checked for evidence of cracked or damaged tiles. There were no other damaged tiles found. 3. Protective wall covers were installed as a means of protecting damage to walls. 4. Environmental rounds will include observation for evidence of cracked tiles. Findings will be reported to CQI quarterly. 5. Completion date: 2/05/09 Bed frames were observed with accumulated dust in four (4)of 25 resident rooms observed rooms:311,315,318,and 322.	12/19/08
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour, it was determined that facility staff failed to maintain a clean and sanitary environment as evidenced by: damaged tile in the shower rooms, soiled/dusty bed frames, and privacy curtains and over the bed trapeze bars. The environmental tour was conducted on	F 253	1. Bed frames observed to be dusty were immediately cleaned. No residents were affected by this observation. 2. Housekeeping staff will perform routine cleaning. Daily inspection will be done by EMS supervisor to ensure compliance. 3. In-service on Environmental Infection Control: high and low dusting bed cleaning steps. 4. CQI process will be put in place to monitor compliance quarterly. 5. Continuous monitoring procedure.	on going.

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F 253	Continued From page 8 December 17, 2008 from 9:10 AM through 11:35 AM in the presence of Employees #11 and 13. The findings include: 1. Tile was observed damaged in two (2) of six (6) resident shower rooms observed; 2nd and 3rd floor shower rooms. 2. Bed frames were observed with accumulated dust in four (4) of 25 resident rooms observed; rooms: 311, 315, 318, and 322. 3. Privacy curtains were observed soiled in four (4) of 25 resident rooms observed; rooms: 311, 315, 318, and 322. 4. Trapeze bars were observed with accumulated dust in two (2) of 25 resident rooms observed; rooms: 315 and 322. Employees #11 and 13 acknowledged these findings at the time of these observations.	F 253	Privacy curtains were observed soiled in (4) of 25 rooms resident rooms observed rooms:311,315,318 and 322. 1. Privacy curtain observed to be soiled were changed immediately. No residents were affected by this observation. 2. All other rooms were inspected for soiled curtains and changed as needed. 3. Daily inspection will be done by EMS supervisor will ensure compliance. In-service on Cubicle Curtain Changing Procedure given to staff by EMS supervisor. 4. CQI process will be put in place to monitor compliance 5. Continuous inspection in effect procedure is going on a daily basis. Trapeze bars were observed with accumulated dust in two (2) rooms 315 and 322.	12/17/08 on-going
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.	F 278	1. No residents were affected by this observation. Housekeeping services corrected it immediately. 2. All other trapeze bars were checked for dust accumulation and cleaned as needed. 3. Daily inspection will be done by EMS supervisor will ensure compliance. In-service on environmental services, high and low dusting procedure. 4. CQI process will be put in place to monitor compliance quarterly. 5. Continuous monitoring procedure is going on a daily basis.	12/17/08

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F 278	Continued From page 9 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: Based on record review and staff interview for one (1) of 24 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for one (1) resident with an allergy. Resident #3. The findings include: A review of Resident #3's record revealed an "Interim Order" dated June 11, 2008 "...Allergies-Sulfa". A review of Resident #3's significant change MDS assessment completed June 18, 2008 revealed that the resident was not coded for allergies in Section I (Disease Diagnoses). A face-to-face interview was conducted on December 18, 2008 at 11:00 AM with Employee #4. He/she acknowledged that the MDS was not coded for allergies. The record was reviewed on December 18, 2008.	F 278	Resident #3 1. Modification coding for resident #3 allergies was corrected on 12/18/08. 2. All other residents with allergies, MDS coding were checked and corrected if required. 3. The Director of Nursing provided in-service on MDS Coding/ Assessment for the MDS Coordinator on 2/3/09. 4. MDS Coding/Assessment will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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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 staff interview and record review for three (3) of 24 sampled residents, it was determined that facility staff failed to initiate care plans with appropriate goals and approaches for two (2) residents with allergies and one (1) resident with inappropriate social behaviors. Residents #3, 21 and 22. The findings include: 1. Facility staff failed to develop a care plan for Resident #3 with allergies.	F 279	Resident 3, 21 and 22 1. Residents #3 and 21 care plans were updated regarding allergies on 12/18/08 and resident #22 expired, therefore, the care plan was not updated. 2. All other residents with allergies and inappropriate behavior care plans were checked and updated if required. 3. The Director of Nursing provided in-service on Care Plan Updates to include allergies and inappropriate behavior for the Resident Care Coordinators on 2/2/09. 4. Care plans will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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F 279	Continued From page 11 A review of the "Physician Interim Order " sheet, signed by the physician on June 11, 2008, revealed " ...Allergies- Sulfa". A review of the care plans last updated on September 4, 2008 lacked evidence that a care plan for allergies was developed with goals and approaches to address the resident's allergy to "Sulfa " . A face-to-face interview was conducted on December 18, 2008 at 11:00 AM with Employee #4. He/she acknowledged that a care plan for Resident #3's allergy was not developed. The record was reviewed on December 18, 2008. 2. The facility failed to initiate a careplan for Resident #21 for "Allergy to penicillin (PCN)". A review of Resident #21's clinical records on December 17, 2008 revealed an "Alert Sticker" for "Allergy to PCN" on the front of the chart. A review of the "Physician Order Sheet" signed September 9, 2008 revealed that the resident had an allergy to PCN. A review of care plans, last updated October 29, 2008, revealed that the facility staff failed to implement a care plan his/her allergy to PCN. A face-to-face interview was conducted on December 17, 2008 at 10:55 AM with the Employee #4. He/she acknowledged that a care plan was not in place for an allergy to PCN. The record was reviewed on December 17, 2008. 3. Facility staff failed to initiate care plans for Resident #22 for socially inappropriate behaviors	F 279		

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F 279	Continued From page 12 Face-to-face interviews were conducted with Employees #5 and 6 on December 15, 2008 at 3:15 PM. Both employees stated that Resident #22 frequently spit on the walls and curtains, masturbated daily, removed the feeding tube dressing and would place [his/her] feeding tube into her vagina several times per week, and two (2) to three (3) times per week would disrobed, suggestively dance in front of male residents and staff, rub the "private areas" of male residents and staff and once grabbed the "private area" of a male staff member. A review of the care plans for Resident #22 failed to reveal a care plan with appropriate goals and approaches for the above cited behaviors. Included on the care plan for "[Resident #22] has a potential for injury related to physiologic deterioration of cognitive functions ..." was, "[Resident #22] also has inappropriate behaviors that include touching staff in the perineal areas." In reviewing the care plan, there were no interventions that were specifically developed to address inappropriate touching staff in the perineal areas. A face-to-face interview with Employee #5 was conducted on December 16, 2008 at 11:30 AM. He/she acknowledged that there were no care plans with the appropriate goals and approaches developed for the aforementioned identified behaviors. The record was reviewed December 15, 2008.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must	F 309		

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F 309	Continued From page 13 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, staff interview and record review for 4 (four) of 24 sampled residents and two (2) supplemental residents, it was determined that facility staff failed to: clarify the code status for one (1) resident, change a suprapubic catheter as per physician's orders for one (1) resident, inform the physician of a delay in obtaining a Gastrointestinal (GI) consultation for one (1) resident, follow physician's orders for the use of a scoop plate for one (1) resident and to administer medication without errors for two (2) residents. Residents #3, 9,15, 22 , F1 and JH1. The findings include: 1. Facility staff failed to clarify Resident #3's code status. A review of the November 2008 "Physician' s Order" form signed by the physician on November 16, 2008 directed, "...Advance Directives: Yes-CPR. Resident is DNR [Do Not Resuscitate], DNI [Do Not Intubate], RN [Registered Nurse Pronouncement, may hospitalize ..." A review of the plan of care "...Advance Directives DNR/DNI, RN Pronouncement, may hospitalize" last updated December 17, 2008 revealed, "...Goals- Resident's wishes for advance	F 309	Resident #3, 9, 15, 22 F1 and JH1 1. Clarification of resident #3 code status was corrected on 12/18/08. Resident #9's suprapubic catheter was changed on 12/18/08. Resident #22 expired, therefore; G.I. consult was not obtained. The attending physician discontinued scoop plate for resident #F1 on 12/17/08. The above residents did not have any negative outcomes. Resident #15 was monitored and had no negative outcomes after receiving incorrect dose of acetaminophen. Resident #JH1 was monitored and had no negative outcome after receiving AZOPT ophthalmic solution 1 eye drop in left eye. 2. All residents with physician orders for code status, suprapubic catheter, GI consults, and eye drops were checked and corrected if required. 3. The Nursing Leadership team provided in-services on Update of Resident Code Orders, GI Consults, Residents with Orders for Scoop Plates, Safe Practice of PO Medications and Eye Drops were given on 1/31, 2/1 and 2/3/09.	

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F 309	Continued From page 14 directives will be honored ..." There was no evidence that facility staff clarified the code status for Resident #3. A face-to-face interview was conducted on December 18, 2008 at 11:00 AM with Employee #4. He/she acknowledged that Resident #3's code status needed to be clarified on the physician order form. The record was reviewed on December 18, 2008. 2. Facility staff failed to change Resident #9's suprapubic catheter as per physician's order. A review of Resident #9's clinical record revealed a physician's order, by the physician on October 5, 2008, which directed: "Suprapubic catheter: 22 Fr. [French] / 30ML Balloon. Change Suprapubic Tube once monthly on the 11th." A review of a nurse's note dated December 11, 2008 at 6:00 AM revealed the following documentation, "Suprapubic cath [catheter] tube & [and] Foley bag not changed because no Foley Bag and cath in the house." A face-to-face interview was conducted with Employee #5 on December 17, 2008 at approximately 3:00 PM. He/she acknowledged that the suprapubic catheter was not changed on December 11, 2008 as ordered by the physician. The record was reviewed on December 17, 2008. 3. Facility staff failed to inform the physician of a two (2) week delay in obtaining a GI (Gastroenterology) consult for Resident #22. A review of Resident #22's record revealed a	F 309	F 309 Continued 4. Residents' Code Status, GI Consults, Residents with Scoop Plates and Accuracy of PO Medications and Eye Drops will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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F 309	Continued From page 15 physician's telephone order dated August 19, 2008 and signed by the physician on August 20, 2008, directing, "Consult with [Physician #1] G-tube (Gastrostomy tube) replacement." A review of the appointment book kept by the unit secretary, who was responsible for making resident appointments, revealed the following notation for August 18, 2008: "An appointment was requested for [Resident #22] for a GI consult at [Physician #1's] office ...the office will give us a call because the doctor is on leave until the end of the month." A review of the nurses' notes revealed the following: September 1, 2008 at 3:00 PM: "Resident alert ...G-tube intact and patent. G-tube site noted without drainage or redness ...Call placed to [Physician #1's] office to schedule appoint for G-tube replacement. [Physician #1's] receptionist stated that they will call the unit tomorrow (September 2, 2008) with appointment date ..." September 2, 2008 at 3:30 PM: "Attempts to schedule appoint with [Physician #1] was unsuccessful. [Primary medical doctor] notified ...gave order to schedule appointment with [Physician #2] ...appointment for G-tube replacement scheduled for September 18, 2008 ..." There was no evidence in the record that facility staff notified the attending physician that Physician #1 was not available for approximately two (2) weeks after the primary medical doctor ordered the GI consult. A face-to-face interview was conducted with	F 309		

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F 309	Continued From page 16 Employee #9 on December 16, 2008 at 1:00 PM. He/she acknowledged that the primary medical doctor was not notified of the delay in scheduling the GI consult. The record was reviewed December 16, 2008. 4. Facility staff failed follow the physician's order for use a scoop plate at meal time for Resident F1. On December 15, 2008 between 1:30 PM and 1:40 PM, Resident F1 was observed being fed by Employee #17. The resident was being fed with plastic cutlery and the food was served on a black Styrofoam plate. A review of the tray ticket for Resident F1 revealed,"...Styrofoam Only and Hard Plastic Only". A review of the December 2008 " Physician' s Order" form signed by the physician on December 9, 2008 directed, " Diet: ...Scoop Plate at all meals- No glass or ceramic dishes..." A review of the plan of care " ...Nutrition/hydration due to need for a mechanically altered diet... Resident throws dishes off meal tray..." last updated December 4, 2008 revealed, " ...Interventions- ...nothing glass or ceramic, scoop plate 2nd [to] throws plate..." A face-to-face interview was conducted on December 18, 2008 at 11:00 AM with Employee # 4. He/she acknowledged that Resident F1 was not being served on a scoop plate as ordered by the physician. The record was reviewed on December 18, 2008.	F 309		

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F 309	Continued From page 17 5. Facility staff failed to administer medication without errors for Residents #15 and JH1. A. Facility staff failed to administer medication to Resident #15 as per physician's orders. A Physician's order was signed and dated on December 7, 2008 that directed, "Acetaminophen 325 mg tablet, Give 2 tabs (650mg) by mouth 3 times a day for back pain *Not to exceed 4 grams in 24 hours* " for Resident #15. On December 15, 2008, at approximately 9:00 AM, during the medication pass for Resident #15, Employee #1 administered one (1) tablet of Acetaminophen 325 mg to the resident instead of two (2) tablets. A face-to-face interview was conduct on December 15, 2008, at approximately 2:00 PM with Employee #1. He/she acknowledged that one (1) tablet of Acetaminophen 325 mg was administered to the resident instead of two (2) tablets. B. Facility staff failed to administer medication to Resident JH1 as per physician's orders. A physician's order was signed and not dated by the physician in December 2008 that directed, "Azopt ophthalmic solution, Instill 1 drop in left eye 2 times a day for glaucoma." On December 15, 2008, at approximately 10:00 AM, during the medication pass for Resident JH1. Employee #2 instilled Azopt ophthalmic drops into the right eye instead of the left eye.	F 309		

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F 309	Continued From page 18 A face-to-face interview was conduct on December 15, 2008, at approximately 3:00 PM with Employee #1. He/she acknowledged that the Azopt ophthalmic drops were instilled into the right eye instead of the left eye.	F 309	Resident #22	
F 319 SS=D	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 24 sampled residents, it was determined that the psychiatrist failed to monitor and initiate interventions for Resident #22's socially inappropriate behaviors. The findings include: A review of the resident's record revealed a psychiatrist's note dated February 22, 2008, no time noted, "[Resident] seen on follow-up visit for Organic Senility Syndrome with some disruptive behaviors. Klonopin was effective in management of symptoms in the past 2 months without side effects. Plan: Will continue Klonopin and follow-up in 30-60 days." There was no evidence in the record that the psychiatrist saw the resident after February 22, 2008 until his/her discharge on November 11, 2008.	F 319	1. There was no documentation of a follow-up visit to evaluate the resident by the psychiatrist from the note written on 1/22/08. The resident expired on November 11, 2008 2. All residents receiving Klonopin were reviewed and no reduction was required at this time. 3. The Medical Director provided an in-service on Physician Visits/ Documentation for the Psychiatrist on 2/4/09. 4. Physician follow-up visits will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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F 319	Continued From page 19 Face-to-face interviews were conducted with Employees #5 and 6 on December 15, 2008 at 3:15 PM. Both employees stated that Resident #22 frequently spit on the walls and curtains, masturbated daily, removed the feeding tube dressing and would place [his/her] feeding tube into her vagina several times per week, and two to three times per week would disrobed, suggestively dance in front of male residents and staff, rub the "private areas" of male residents and staff and once grabbed the "private area" of a male staff member. A further face-to-face interview was conducted with Employee #5 on December 15, 2008 at 4:00 PM. He/she stated, " I talked to the psychiatrist and the physician several times about [Resident #22's] behavior. Neither [Physicians] wanted to change the medication. They didn't write anything and neither did I. " A review of the resident's record revealed that there was no on-going monitoring of the above identified behaviors. Employees #5 and 6 acknowledged during the above cited interview, that there was no documentation of monitoring for the above cited behaviors. The record was reviewed December 15, 2008.	F 319		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for two (2) of 24 sampled residents, it was determined that facility staff failed to provide adequate supervision for: one (1) resident using the bathroom with temporarily stored equipment; and for the environment as evidenced by hydrogen peroxide stored at one (1) resident's bedside. Residents F2 and F3. The findings include: 1. Facility staff failed to provide adequate supervision for Resident F2 who was observed using the bathroom with temporarily stored equipment. On December 17, 2008 at 10:17 AM, the tub room/bathroom was observed during the environmental rounds. The tub/bathroom was observed to have approximately two (2) battery chargers for equipment, one (1) standing/ upright fan, one (1) geri chair recliner stationed in front on the hand wash sink, one (1) [name brand] lift in front of the paper towel dispenser, one (1) electric wheel chair, two (2) wheel chairs, and one (1) tub which was currently out of order. On December 17, 2008 at 10:23 AM, Resident F2 was observed entering the above observed tub/bathroom without assistance and he/she closed the door to the room. The surveyor summoned Employee #23 and queried as to Resident F2 using this particular tub/bathroom alone. He/she replied, "He/she is alert and comes in here [the tub/bathroom] or his/her room to use the bathroom."	F 323	Resident # F2 and F3 1. Resident #F2 had no negative outcome from using the bathroom in a room with stored equipment. The equipment was removed from the tub room on 12/17/08 and the resident continues to be monitored Resident #F3 had no negative outcome from the hydrogen peroxide being left at the bedside. The hydrogen peroxide was removed from the resident's room on 12/17/08. 2. All other nursing units were checked to ensure that residents were not using the bathrooms in the tub room without supervision. There was no stored equipment in the tub rooms on the other nursing units. All residents rooms were checked and no hydrogen peroxide was found at the residents bedside. 3. Nursing Leadership provided an in-service on Supervision of Residents' Safety and Prevention of Chemical Liquids at Bedside to Avoid Accidents to the nursing staff on 1/31 and 2/1/09. 4. Supervision of Resident Safety and Prevention of Residents Accidents will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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F 323	Continued From page 21 The quarterly Minimum Data Set completed December 10, 2008, revealed, "Section B2 [Memory] coded resident F2 and having short and long term memory loss; Section G1. [Physical Functioning and Structural Problems] coded resident as requiring supervision and setup help only when toileting. A face-to-face interview was conducted on December 17, 2008 at 10:33 AM with Employee #4. He/she stated, "The room [tub/bathroom] is occasionally used. We put the Geri chairs here. The tub is not working. We temporarily store things here. Occasionally, alert residents use the bathroom in here. If residents are not alert they are taken to the bathrooms in their rooms." The record was reviewed on December 18, 2008. 2. On December 17, 2008 at 10:03 AM, an unsecured bottle of hydrogen peroxide was observed on the night stand in Resident F3's room. A review of Resident F3's clinical record lacked orders and/or directives for use of hydrogen peroxide. The finding was observed in the presence of Employees #11 and 13; and on December 18, 2008 at 11:07 AM, Employee #4 observed and acknowledged the bottle of hydrogen peroxide on the night stand in the resident's room. The record was reviewed on December 18, 2008.	F 323		
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	F 329		

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F 329	Continued From page 22 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for three (3) of 24 sampled residents and two (2) supplemental residents, it was determined that facility staff failed to: attempt a gradual dose reduction for antipsychotic medications for two (2) residents and obtain a physician's order to administer Ativan and/or Ambien after the medication was discontinued for three (3) residents. Residents #3, 17, 22, JH2 and JH6. The findings include: 1. The physician failed to attempt a gradual dose reduction or document if clinically contraindicated for Sertraline (Zoloft) for Resident #17. A review of Resident #17's record revealed a	F 329	Resident #3, 17, 22, JH2 and JH6 1. The Psychiatrist reviewed resident #17 for Zoloft, but did not reduce the medication. The resident was monitored and had no negative outcome. Resident #22 expired, therefore; orders could not be obtained to discontinue or reduce the anti-psychotic medication. Residents' #3, JH2 and JH6 anti-psychotic medications were dis-continued on 12/17/08. All three residents were monitored and had no negative outcome. 2. All residents with physician orders for antipsychotic were checked and corrected if indicated. 3. The Nursing Leadership team provided in-services to the licensed staff on Administration of Accurate Antipsychotic and Reduction of Anti-psychotic Medications on 1/31 and 2/1/09. 4. Reduction of Anti-Psychotic Medications and Accuracy in Administering Anti-Psychotic Medications will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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F 329	Continued From page 23 physician's order initiated September 18, 2006 which directed, "Sertraline 50mg tab (AKA: Zoloft) Give 1 tab by mouth every day for Depression." The above order was renewed March 16, 2008, April 29, 2008, June 28, 2008, August 27, 2008, October 27, 2008 and December 8, 2008. A review of the Medication Administration Record (MAR) for March through December 2008 revealed that the resident received Zoloft 50 mg daily while in the facility. There was no evidence in the record that the physician or psychiatrist attempted a dose reduction of Zoloft. A face-to-face interview was conducted with Employees #8 and 21 at approximately 10:00 AM on December 18, 2008. Both employees acknowledged that there was no attempted dose reduction for Zoloft on the record. The record was reviewed on December 18, 2008. 2. The physician failed to attempt a gradual dose reduction or document if clinically contraindicated, for Klonopin for Resident #22. A review of Resident #22's record revealed a physician's order initiated November 11, 2007 directing, "Klonopin 0.5 mg daily at bedtime for psychotic features." The above cited order was renewed by the physician on March 23, April 28, May 27, June 6, July 29, August 28, September 18, and October 27, 2008. Face-to-face interviews were conducted with	F 329		

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F 329	Continued From page 24 Employees #5 and 6 on December 15, 2008 at 3:15 PM. Both employees stated that Resident #22 frequently spit on the walls and curtains, masturbated daily, removed the feeding tube dressing and would place [his/her] feeding tube into her vagina several times per week, and two (2) to three (3) times per week would disrobed, suggestively dance in front of male residents and staff, rub the "private areas" of male residents and staff and once grabbed the "private area" of a male staff member. According to the MAR for March through November 2008, the resident received Klonopin 0.5 mg daily while in the facility. Further discussion with Employee #5 was conducted on December 15, 2008 at 4:00 PM. He/she stated, "I talked to the psychiatrist and the physician several times about [Resident #22's] behavior. [The psychiatrist] didn't want to change the medication. But [he/she] never wrote anything and neither did I." There was no evidence in the record that the physician or psychiatrist attempted a dose reduction of Klonopin since the medication was prescribed on November 11, 2007. A face-to-face interview with Employee #9 was conducted on December 15, 2008 at 3:15 PM. He/she acknowledged that the physician or psychiatrist should have attempted a gradual dose reduction for Klonopin or documented why the drug should continue to be given. The record was reviewed December 15, 2008. 3. Facility staff failed to follow physician's medication orders, staff administered medication	F 329		

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F 329	Continued From page 25 after it was discontinued for three (3) of 12 residents observed Residents #3, JH2 and JH6. A. Facility staff administered four (4) doses of Lorazepam 0.25 mg to Resident #3 after it was discontinued. A physician's order was signed and dated on November 12, 2008 that directed, "Decrease Ativan to 0.25 mg po [by mouth] qhs [at bedtime] x [times] 7 (seven) days, then Ativan 0.25mg po [by mouth] qhs [at bedtime] every other day x [times] 7 days and stop. " On December 17, 2008, between 9:00 AM and 3:00 PM, during the inspection of the medication carts, the facility staff was requested to identify all "as needed" medications. Resident #3's "Controlled Substance Record" was reviewed for Lorazepam 0.25mg. The medication had a physician's stop order as above. The staff administered four (4) doses of the medication after the stop date. The "Controlled Substance Record" dated November 11, 2008, indicated that the Lorazepam 0.25mg was removed from the controlled substance drawer to administer on November 29, and 30, 2008 and December 11 and December 12, 2008. There was no documentation that the physician had written orders to restart the Lorazepam 0.25mg dose. B. Facility staff administered Ativan 0.5 mg to Resident JH2 after the order was discontinued. A physician's order was signed and dated on July 16. 2008 that directed. " D/C [Discontinue] Ativan	F 329		

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F 329	Continued From page 26 0.5mg po [by mouth] q6h every 6 hours prn [as needed] agitation/combativeness ... " On December 17, 2008, between 9:00 AM and 3:00 PM, during the inspection of the medication carts, the facility staff was requested to identify all "as needed" medication. Resident JH2's "Controlled Substance Record" was reviewed for Lorazepam 0.5 mg. The medications had a physician's order that discontinued the medication on July 16, 2008, however, the staff continued to administer the medications to the resident. The "Controlled Substance Record" dated December 27, 2008, indicated that the Lorazepam 0.25 mg was removed from the controlled substance drawer to administer on December 2, 2008. There was no documentation that the physician had written orders to restart the Lorazepam 0.5 mg dose. C. Facility staff administered Ativan 0.5 mg to Resident JH6 after the order was discontinued. A physician's order was signed and dated on June 19, 2008 that directed, " Disc. [Discontinue Ativan 0.25 mg po [by mouth] bid [twice daily] x [times] 14 days for organic syndrome." There were no additional orders to administer Ativan 0.25 mg after the above cited order. On December 17, 2008, between 9:00 AM and 3:00 PM, during the inspection of the medication carts, the facility staff was requested to identify all "as needed" medication. Resident JH6's "Controlled Substance Record" was reviewed for Lorazepam 0.25 mg. The medications had a	F 329		

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F 329	Continued From page 27 physician's order that discontinued the medication on June 19, 2008, however, the staff continued to administer the medications to the resident. The "Controlled Substance Record" indicated that Ativan 0.5 mg was removed from the controlled substance drawer on July 7, 8, 19, 21 and 27, 2008 and August 14 and 22, 2008 and November 7, 2008 and December 13, 2008. There was no documentation that the resident was administered the above cited medications. A face-to face interview was conduct on December 17, 2008 with Employees #2, 4 and 16 after each medical record review. They acknowledged that the medications were removed from the controlled substance drawer and administered without a physician's order.	F 329		
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 24 sampled residents, it was determined that the physician failed to review the total plan of care for Resident #22. The findings include:	F 386	F386 Resident #22 1. There was minimal documentation by the attending physician to validate review of the resident's total plan of care. The resident expired on November 11, 2008. 2. The attending physician's progress notes were reviewed for other residents and corrections were made if required. 3. The Medical Director provided an in-service to the attending physician regarding Physician Visits/Total Plan of Care. 4. Physician visits will be monitored through quarterly CQI. 5. Completion date 2/5/09	

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F 386	Continued From page 28 A review of Resident #22's record revealed that the physician visited the resident on March 14, April 22, June 2, August 17, September 19, and October 22, 2008. A review of Resident #22's record revealed a physician's order initiated November 11, 2007 directing, "Klonopin 0.5 mg daily at bedtime for psychotic features." The above cited order was renewed March 23, April 28, May 27, June 6, July 29, August 28, September 18, and October 27, 2008. Face-to-face interviews were conducted with Employees #5 and 6 on December 15, 2008 at 3:15 PM. Both employees stated that Resident #22 frequently spit on the walls and curtains, masturbated daily, removed the feeding tube dressing and would place [his/her] feeding tube into her vagina several times per week, and two (2) to three (3) times per week would disrobed, suggestively dance in front of male residents and staff, rub the "private areas" of male residents and staff and once grabbed the "private area" of a male staff member. A further face-to-face interview was conducted with Employee #5 on December 15, 2008 at 4:00 PM. He/she stated, " I talked to the psychiatrist and the physician several times about [Resident #22's] behavior. Neither [Physicians] wanted to change the medication. They didn't write anything and neither did I. " There was no evidence in the record that the physician addressed the resident's use of Klonopin for socially inappropriate behaviors.	F 386		

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F 386	Continued From page 29 After reviewing the resident's record on December 15, 2008 at 3:45 PM, Employee #5 acknowledged that the physician did not address the resident's use of Klonopin for socially inappropriate behaviors. The record was reviewed December 15, 2008.	F 386	**F425** JH2, JH3, JH4, JH6, JH8, and 3	
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that for six (6) of 13 resident observed in the medication pass, that facility staff failed to consistently document the administration of controlled substances on the Medication Administration Records (MARs),	F 425	1. There were no negative outcome to residents as a result of the staff not consistently documenting controlled substance medication given to the residents. 2. All other residents with orders for PRN controlled substance medications medical records were checked and corrected if required. 3. All appropriate licensed nurses were counseled regarding requirements of documentation for all controlled substance medications. Nursing Leadership provide in-service to the licensed nurses regarding Required Documentation of Control Substance Medications on 1/31, 2/1 and 2/2/09. 4. Documentation of Controlled Substance Medications will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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F 425	Continued From page 30 remove discontinued medication from the medication carts and reconcile the dispensation for four (4) of four (4) residents reviewed receiving antibiotics. The findings include: 1. The facility staff failed to consistently document the administration of controlled substance on the May, June, September, October and November 2008 MAR for Residents JH2, JH3, JH4, JH6, JH8 and #3. A. On December 16, 2008, at approximately 2:00 PM, a review of Resident JH2's record revealed a physician's order dated April 10, 2008 that directed, "Lorazepam 0.5 mg, Give one (1) tablet by mouth every 6 hours as needed for agitation/combativeness." The May and June 2008 MARs were reviewed and indicated that Lorazepam 0.5 mg was administered on May 4, 2008, as evidenced by nurse's initials entered in the allotted areas for May 4, 2008. There was no evidence the resident received the medication in June 2008 as evidenced by a lack of nurse's initials entered in the allotted area. The "Controlled Drug Record " indicated the Lorazepam 0.5 mg was removed from the controlled substance drawer on May 19 and 29 and June 8, 2008. There was no evidence on the May or June 2008 MAR that the Lorazepam 0.5 mg was administered on May 19 and 29, and June 8, 2008. The record was review on December 16, 2008.	F 425	Resident #JH5, 9 and 16. 1. The residents were monitored for signs and symptoms of infection. The residents vital signs including temperature remained within normal limits. There we no negative outcomes to residents that did not receive the complete doses of the antibiotics as ordered No new orders were received for above residents. 2. All other residents with orders for antibiotics were checked and corrections were made if required. 3. All appropriate licensed nurses were counseled regarding administration of all medications as ordered by the attending physician. Nursing Leadership provided in-services on Medication Administration on 1/31, 2/1 and 2/2/09. 4. Accurate Medication Administration will be monitored through quarterly CQI. 5. Completion date 2/5/09	

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F 425	Continued From page 31 B. On December 16, 2008, at approximately 12:20 PM, a review of Resident JH3's record revealed a physician's order dated November 24, 2008 that directed, "Ativan 0.25 mg [po] by mouth [q12h] every 12 hours [prn] as needed for agitation." The November and December 2008 MARs were reviewed and indicated that Ativan 0.25 mg was administered on November 24 and 25, 2008 and December 12 and 15, 2008, as evidence by nurse's initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Ativan 0.25 mg was removed from the controlled substance drawer on November 26, 27, 29 and 30, 2008 and in December 1, 2, 11 and 15, 2008. There was no evidence on the November or December 2008 MARs that the Ativan 0.25 mg was administered on November 26, 27, 29 and 30, 2008 and in December 1 and 2, 2008 to the resident. The record was review on December 16, 2008. C. On December 16, 2008, at approximately 11:30 AM, a review of Resident JH4's record revealed a physician's order signed, but not dated for November 2008, that directed, "Oxycodone/APAP (Roxicet) 5 mg-325 mg tablet, Give 2 tabs (via peg-tube) every 4-6 hours as needed for pain *Not to exceed 4 grams in 24 hours*. " The November and December 2008 MARs were reviewed and indicated that Oxycodone/APAP (Roxicet) 5 mg-325 mg was administered November 12, 20 and 25 and December 16,	F 425		

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2008, as evidence by nurse's initials entered in the allotted areas for the dates mentioned.

The "Controlled Drug Record " indicated the Oxycodone/APAP (Roxicet) 5 mg-325 mg was removed from the controlled substance drawer on November 12, 14, 17, 20 and 25 and December 1, 5 and 16, 2008.

There was no evidence on the November or on the December 2008 MAR that the Oxycodone/APAP (Roxicet) 5 mg-325 mg was administered on November 14 and 17, 2008 and December 1 and 5, 2008. The record was review on December 16, 2008.

D. On December 17, 2008, at approximately 1:30 PM, a review of Resident JH6's record revealed a physician's order dated August 5, 2008 that directed, "Ativan 0.5 mg, po [by mouth] bid [twice daily] prn [as needed] for agitation."

The August and September 2008 MARs were reviewed and indicated that Ativan 0.5mg was administered August 14, 2008, as indicated by the nurse's initials entered in the allotted areas. There were no nurse's initials recorded for September 2008.

The "Controlled Drug Record " indicated the Ativan 0.5mg was removed from the controlled substance drawer on August 5, 6 and 14, 2008. There was no evidence on the MARs that Ativan 0.5 mg was administered on August 5 and 6, 2008. The record was review on December 17, 2008.

E. On December 17, 2008, at approximately 2:30 PM, during a review of Resident JH8's record

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F 425	Continued From page 33 revealed a physician's order dated November 8, 2008 that directed, "Oxycodone w/APAP 5mg/325mg tablet, one[1] tablet by mouth every four hours as needed for pain.* Not to exceed 4 grams in 24 hours." The November 2008 MAR was reviewed and indicated that Oxycodone w/APAP 5 mg/325 mg tablets were administered on November 9 (twice), 12, 13 (twice), 18 and 20, 2008, as evidence by the nurse's initials entered in the allotted areas. The "Controlled Drug Record" indicated the Oxycodone w/APAP 5 mg/325 mg tablet was removed from the controlled substance drawer on November 8, 9(once), 10, 12, 13 (twice), 15, 19, 20, 22 and 26. There was no evidence on the November 2008 MAR that the Oxycodone w/APAP 5 mg/325 mg tablet was administered on November 8, 10, 15, 19, 22 and 26, 2008. The November 2008 MAR indicated that the Oxycodone w/APAP 5 mg/325 mg tablet was administered on November 9(once) and 18, 2008. There was no indication on the "Controlled Drug Record" that the medications were removed from the controlled substance drawer. The record was review on December 17, 2008 F. On December 18, 2008, at approximately 2:10 PM, a review of Resident #3's record revealed a physician's order dated March 19, 2008 that directed, "Lorazepam 0.5 mg po [by mouth] q8h [every 8 hours] prn [as needed] for agitation times 2 weeks."	F 425		

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F 425	Continued From page 34 The March 2008 MAR was reviewed and indicated that Lorazepam 0.5 mg was administered on March 19, 20, 21 and 25, 2008 as evidence by nurse's initials entered in the allotted areas. The "Controlled Drug Record" indicated that Lorazepam 0.5 mg was removed from the controlled substance drawer on March 19, 21 and 25. There was no evidence that the Lorazepam 0.5 mg was removed from controlled substance drawer on March 20, 2008. A face- to- face interview was conducted immediately after each resident's record was reviewed with Employees #2, 3, 4, 10, 15 and 16. They acknowledged that the documentation between the above cited MARs and the "Controlled Substance Records" was inconsistent for all the above cited residents. The records were review on December 18, 2008. 2. Facility staff failed to remove discontinued medications that were discontinued as per physician order from the medication carts for Residents JH7, JH6, JH5, JH2 and #3. On December 16 and 17, 2008, between 9:00 AM and 3:00 PM, during the inspection of the medication carts, the following medications were observed stored in the medication carts after the physician discontinued the medication. 1st Floor Diphenoxylate/ Atropine [Lomotil] 2.5-0.25 mg, 15 tablets, physician's order dated September 16, 2008 at 1:00 PM, "D/C Lomotil" for Resident JH7. Lorazepam 0.25mg, 17 tablets, physician's	F 425	F425 #2 JH7, JH6, JH5, #3 1. All discontinued medications were removed from the medication carts for above residents. The residents were monitored and had no negative outcome. 2. All medication carts were checked for evidence of discontinued medications and were removed if required. 3. Nursing Leadership Team provided in-service on Removing Expired Medication from Medication Cart on 2/1 and 2/3/09. 4. Discontinued Medications in Medication Cart will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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F 425	Continued From page 35 telephone order dated June 19, 2008, no time, continue Ativan 0.25 mg po bid x 14 days for organic syndrome" for Resident JH6. Nitrofurantoin 100mg, 8 capsules, physician's order dated December 11, 2008 at 6:00 PM, "Nitrofurantoin...100 mg caps, qid (four times daily) for UTI (Urinary Tract Infection) x 2 days" for Resident JH5. 2nd Floor Lorazepam 0.5mg, 24 tablets, physician's order dated July 15, 2008 at 4:00 PM, "D/C Ativan 0.5 mg po [by mouth] q [every] 6 hrs prn [as needed] for agitation/combativeness secondary to non-use..." for Resident JH2. Lorazepam 0.25mg, 20 tablets, physician's order dated November 12, 2008, no time, "Decrease Ativan to 0.25 mg po [by mouth] qhs [at bedtime] x 7 days then Ativan 0.25 mg po [by mouth] qhs [at bedtime] every other day x 7 days and stop" for Resident #3. Lorazepam 0.5 mg, 11 tablets, physician's order dated March 19, 2008 no time, "Ativan 0.5 mg po [by mouth] q [every] 8 hrs [hours] prn [as needed] agitation x 2 weeks" for Resident #3. A face- to- face interview was conducted immediately after each resident's record review with Employees #4 and 5. They acknowledged that the medication should have been removed when the physician discontinued the medication. 3. Facility failed to reconcile the dispensation of antibiotics for four (4) of four (4) residents reviewed. Residents: JH5, #5, 9 and 16.	F 425		

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	095020	A. BUILDING _____ B. WING _____	12/18/2008

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F 425	Continued From page 36 On December 17, between 9:00 AM and 3:00 PM, during the inspection of the medication carts, a list of residents on antibiotics was requested; randomly chosen resident records of antibiotic medications were requested to be reviewed. Residents: JH5, #5, 9 and 16. A. A physician's order signed and dated December 11, 2008 directed, "Nitrofurantoin 100 mg capsule po [by mouth] one caps qid [four times a day] for UTI [Urinary Tract Infection] x [times] 2 [two] days " for Resident JH 5. On December 17, 2008, the Nitrofurantoin blister package sent from the Pharmacy on December 12, 2008 was observed to contain eight (8) doses of the antibiotic. During the review of the December 2008 MAR for Resident JH5, nurse's initials in the allotted area indicated that eight (8) doses were administered. At the time on the observation, five (5) of the eight (8) doses remained in the blister package. A face-to-face interview was conducted with Employee #5 on December 17, 2008 at 9:50 AM. He/she stated that the additional required doses of Nitrofurantoin were administered from medication that the resident brought to the facility with him/her. There was no evidence on the December 2008 MAR that the additional five (5) doses were given from the medication that the resident brought into the facility. B. A physician's order signed and dated December 10, 2008 that directed, "Bactrim DS 1 [one] po [by mouth] bid [twice a day] x [times] 10 days for UTI." for Resident #9.	F 425		

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F 425	Continued From page 37 The Bactrim DS blister package sent from the Pharmacy contained 20 doses of antibiotic. During the review of the December 2008 MAR for Resident #9, nurse's initials in the allotted area indicated that 16 doses were administered. At the time on the observation, eight (8) of the 16 doses remained in the blister package. C. A physician's order signed and dated December 10, 2008 that directed, "Bactrim DS 1 [one] po [by mouth] bid [twice a day] x [times] 7 [seven] days for UTI. " for Resident #16. The Bactrim DS blister package sent from the Pharmacy contained 14 doses of antibiotic. During the review of the December 2008 MAR for Resident #16, nurse's initials in the allotted area indicated that nine (9) doses were administered. At the time on the observation, five (5) of the 16 doses remained in the blister package. D. A physician's order signed and dated December 12, 2008 that directed, "Nitrofurantoin 25mg / 5ml; 20 mls (100 mg) via g-tube every 12 hours for 4 [four] days" for Resident JH4. The Pharmacy dispensed a bottle of 160 ml of Nitrofurantoin suspension to the facility. During the review of the December 2008 MAR for Resident JH4, nurse's initials in the allotted area indicated that 160 mls were administered. At the time on the observation, 60 mls of the 160 mls remained in the container. A face-to-face interview was conducted immediately after the review of the residents'	F 425		

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F 425	Continued From page 38 records with Employees #5 and 10. They acknowledged that the number of doses of antibiotics remaining did not match the number of doses that were initialed as administered to the resident, without additional explanation.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced bv: Based on a closed record review and staff interview for one (1) of 24 sampled residents, it was determined that the pharmacist failed to report that there was no attempted dose reduction for Resident #22 who was prescribed Klonopin for nine (9) months. The findings include: A review of Resident #22's record revealed a physician's order initiated November 11, 2007, directing, "Klonopin 0.5 mg at bedtime for psychotic features." The above cited order was renewed December 31, 2007, January 28, February 11, March 23, April 28, May 27, June 6, July 29, August 28, September 18, and October 27, 2008.	F 428	F428 1. There was no noted negative outcomes of resident #22 as a result of no attempted dosage reductions of Klonopin for nine months. Resident expired on November 11, 2008. 2. A thorough audit of all residents on Klonopin was conducted and no reductions were required at this time. 3. An in-service to consultant pharmacist was conducted by Pharmacy Director on importance of psychotropic dosage reductions. 4. Dosage reduction will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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F 428	Continued From page 39 According to the "Chronological Record of Drug Regimen Review," the pharmacist conducted a review of the resident's medication on December 3, 2007, January 20, February 5, March 5, April 1, May 6, June 30, July 31, August 30, September 25, and October 21, 2008. There was no evidence that the pharmacist reported to the physician and Director of Nursing that a gradual dose reduction for Klonopin was not attempted since the medication was ordered on November 11, 2007. A face-to-face interview was conducted with Employee #9 on December 16, 2008 at 11:30 AM. He/she acknowledged that there were no irregularities reported by the pharmacist regarding the use of Resident #22's Klonopin. The record was reviewed December 15, 2008.	F 428		
F 456 SS=D	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 observations in the main kitchen on December 15, 2008 between 9:00 AM and 12:40 PM, it was determined that the facility failed to maintain the stove and steam table in good operating condition. The findings include: 1. The stove was observed to have three (3) of six (6) knobs missing	F 456	F456 1. The missing knobs on the stove and steam tables were all replaced. 2. All equipment were checked for missing knobs. There were no other equipment in need of knob replacement. 3. Knob check was included as part of the preventive maintenance procedure and replacement knobs maintained in the department. 4. Environmental rounds will include observation of missing knobs. Findings will be reported to CQI quarterly. 5. Completion date: 2/5/09	12/19/08

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F 456	Continued From page 40 2. The steam tables were observed to have four (4) of six (6) knobs missing Employee #12 acknowledged these findings at the time of these observations.	F 456		
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 two (2) of 24 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to consistently document: one (1) resident for socially inappropriate behaviors, wandering behaviors for one (1) resident and the administration of controlled substances on the Medication Administration Record, Controlled Substance Record, Behavior Monitoring Flow Record and the nurses' notes for one (1) resident. Residents #18, 22 and JH6. The findings include: 1. Facility staff failed to document wandering behaviors for Resident #18.	F 514	F514 Resident #18, 22 and JH6 1. There were no negative outcomes as a result of insufficient documentation of resident #18 wandering behavior and resident #22 inappropriate behavior. There were no negative outcome to resident #JH6 as a result of staff not consistently documenting control substance medications given to the residents. 2. All other residents with history of wandering/inappropriate behavior and orders for controlled substance medications were checked and corrected if required. 3. The Nursing Leadership team provided the nursing staff an in-service on Medicated Administration of Controlled Substance Medications and Appropriate Documentation for residents with history of Wandering Behavior Concerns on1/31, 2/1 and 2/2/09. 4. Residents with orders for Controlled Substance Medications and History of Inappropriate Behavior/Wandering will be monitored through quarterly CQI. 5. Completed date 2/5/09	

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F 514	Continued From page 41 A review of the Interim Order Form for Resident #18 revealed: "Resident transferred from Rm (Room) 120 to 131B. " According to a nurse's note dated December 8, 2008 at 6:00 PM, "Resident transferred to room 131B all personal belongings moved ...to new room ... " The resident's clinical record and facility's 24 hour report record lacked evidence of the resident's alleged wandering behavior. On December 18, 2008 the resident was observed several times throughout the day, sitting quietly with other residents in the dayroom . A face-to-face interview was conducted with Employee #5 on December 18, 2008 at approximately 12:45 PM. He/she stated, "The resident attempted to leave the unit three (3) times via the stairs close to room 120. The door alarm did not deter the resident on each occasion. I know the staff failed to document the resident's wandering behavior. They failed to document in the resident's chart. I cannot find any documentation in the 24 hour report log either. The resident has since calmed down with less wandering." A face-to-face interview was conducted with Employee #14 on December 18, 2008 at approximately 1:00 PM. He/she acknowledged that the resident was transferred to room 130 for increased supervision because of three (3) attempts to leave the unit via the stairs and was undeterred by the door alarm. The record was reviewed December 18, 2008.	F 514		

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F 514	Continued From page 42 2. Facility staff failed to document socially inappropriate behaviors for Resident #22. Face-to-face interviews were conducted with Employees #5 and 6 on December 15, 2008 at 3:15 PM. Both employees stated that Resident #22 frequently spit on the walls and curtains, masturbated daily, removed the feeding tube dressing and would place [his/her] feeding tube into her vagina several times per week, and two (2) to three (3) times per week would disrobed, suggestively dance in front of male residents and staff, rub the "private areas" of male residents and staff and once grabbed the "private area" of a male staff member. The "Behavior Monitoring Flow Records" for Resident #22 were reviewed from March through November 2008. The behaviors cited above were not included on the monitoring sheets for the months reviewed. "Inappropriate touching" was monitored for August, September and October, 2008. According to the "Behavior Monitoring Flow Record" episodes for inappropriate touching occurred on August 11 and 21, 2008 and October 25, 29 and 30, 2008. There were no nurses' notes explaining the episodes of inappropriate touching for the above cited dates. A face-to-face interview with Employee #9 was conducted on December 16, 2008 at 9:30 AM. He/she acknowledged that the aforementioned behaviors were not monitored and that the incidents that occurred on the above cited dates should have been explained in the nurses' notes. The record was reviewed December 15, 2008.	F 514		

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F 514	Continued From page 43 3. The facility failed to consistently document the administration of controlled substances on the Medication Administration Records (MARs), the Controlled Substance Record, Behavior Monitoring Flow Record and the nursing notes reviewed for JH6. On December 17, 2008, at approximately 1:30 PM, a review of Resident JH6's record revealed a physician's order dated August 5, 2008 that directed, "Ativan 0.5mg, po [by mouth] bid [twice daily] prn [as needed] for agitation." The August and September 2008 MARs were reviewed and indicated that Ativan 0.5mg was administered August 14, 2008 as indicated by the initials entered in the allotted areas and there were no initials recorded for September 2008. The "Controlled Drug Record" indicated the Ativan 0.5mg was removed from the controlled substance drawer on August 5, 6 and 14 and on September 11, 2008. There was no evidence on the MARs, the Behavior Monitoring Flow Record or the nursing notes that Ativan 0.5mg was administered on August 5 and 6, and September 11, 2008. The record was review on December 17, 2008.	F 514		