DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING _____ B. WING _____	05/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HILL NURSING CENTER	700 CONST. AVE. NE WASHINGTON, DC 20002

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F 000	INITIAL COMMENTS An annual recertification survey was conducted on May 27 through May 30, 2008. The following deficiencies were based on record review, observations, and staff interviews. The sample included 24 residents based on a census of 116 residents on the first day of survey and 12 supplemental residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mona J. Wajon	Administrator	6/26/08

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 157	Continued From page 1 legal representative or interested family member. 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 notify the physician of Resident #24's refusal to return to the facility against medical advice (AMA). The findings include: A nurses' note dated May 6, 2008 at 7:55 AM revealed, "Resident called the facility and he/she stated that I am doing well, I am with my [friend] and I will not be back. I am a grown man/woman and I can make my own decisions. Resident discharged from facility." A social services progress note dated May 7, 2008 revealed, "Interim note: ...Administrator made several attempts via telephone with resident, responsible party to encourage resident to return to the facility of which he/she adamantly refused. Thus resident's refusal to return to the facility resulted in him/her being discharged AMA." The record lacked evidence that the physician was notified of the resident's refusal to return to the facility against medical advice. A face-to-face interview was conducted with Employee #7 on May 29, 2008 at approximately 1:00 PM. He/she acknowledged that the record did not reflect that the physician was notified of the resident refusing to return to the facility. The record was reviewed on May 29, 2008.	F 157	**#1.** The attending physician was notified May 30, 2008, that the resident left AMA. **#2.** Charts have been reviewed to identify residents that may have left AMA. There were no other resident affected by this deficiency. **#3.** A weekly audit will be done by the Unit Manger to ensure that the attending physician is notified when a resident leaves AMA. An inservice will be done June 30, 2008 to reeducate the staff on the AMA policy and the importance of notification of physicians. This will be incorporated in the facility's Quality Improvement (Q.I.) report. **#4.** Monitoring tool has been developed to track compliance. The Q.I. Director and Director of Nursing will continue to monitor, monthly and quarterly thereafter.	June 3, 2008 June 26, 2008 & ongoing June 30, 2008 & ongoing

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F 160 SS=D	483.10(c) (6) CONVEYANCE UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on the review of the residents' "Trial Balance" as of April 1, 2008 through May 27, 2008, for two (2) of five (5) sampled residents, it was determined that the facility failed to convey within 30 days the resident's funds and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. Residents F2 and F3. The findings include: The review of the residents' trial balance revealed the following for residents who had expired: Resident Balance Date F2 0.06 Expired March 14, 2008 F3 1,420.15 Expired February 29, 2008 On May 27, 2008 at 12:20 PM, a face-to-face interview was conducted with Employee #13. He/she acknowledged that the accounts were not closed within 30 days and stated, "The accounts were closed on May 20, 2008 for Residents F2 and F3."	F 160	**#1.** The affected residents' funds (F2 and F3) are closed, as of May 20, 2008 and a letter has been sent to the family members to advise them on how to claim the funds. **#2.** The trial balance have been reviewed in its entirety to identify other residents who might have been affected by the same deficient practice. Nine other resident accounts were found to have been closed and notices will be sent out to the family members instructing them on how to claim the funds. The staff member responsible for managing the resident funds will be educated and trained on the standard procedures that must be followed when residents with personal funds are deceased or discharged. Monthly review of the balance will be conducted to ensure accounts are closed within 30 days. **#4.** The business office monthly Q.I. tool used by the Business Office Director will monitor compliance monthly. Findings will be reported to the Q. I. Committee quarterly.	June 23, 2008 June 30, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing
F 174 SS=C	483.10(k) TELEPHONE The resident has the right to have reasonable	F 174		

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F 174	Continued From page 3 access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period for one (1) supplement resident, it was determined that facility staff failed to provide residents with reasonable access to the use of a telephone where calls can be made without being overheard. The findings include: Resident S1 was observed on May 30, 2008 at 9:30 AM talking on the telephone at one end of the nurses' station while sitting in his/her wheelchair. Staff and residents passed the resident while he/she was on the telephone. A tour of the facility revealed that a public telephone was at the end of corridor C on the 6th floor. The phone was not in working order. Additionally there were no public telephones on the 4th or 5th floor available for resident use. A face-to-face interview was conducted with Employee #8 on May 30, 2008 at 10:00 AM. He/she stated, "Most residents have a telephone in their room. If a resident doesn't have a telephone, they can use the phone at the nurses' station. We have a phone for resident use in the dining room on the 6th floor. Residents can use that phone, too." Facility staff failed to provide reasonable access to the use of a telephone where calls could be made without being overheard.	F 174	**#1.** Resident S1 and other residents on 5th floor are now provided with a telephone in the resident's Day Room that allows him/her access to telephone for private conversation away from the nurse's station. In addition there is a pay phone with privacy area on the 1st Floor for residents' use. **#2.** To identify other residents that may be affected, telephones have also been installed in the Day Room of the 4th and 5th Floor. **#3.** To ensure that we maintain residents' privacy when they make personal telephone calls, we issued a memorandum to all staff to encourage residents to use the telephones in the Day Room where their conversations cannot be overheard. The memorandum will also ask staff to gently dissuade residents from using telephones at the nurses' station. Unit Secretaries will observe for 90 days. **#4.** Observation of residents making personal telephone calls will be part of daily "Grand Rounds" education. Results of the observation will be addressed in the Q.I. meetings. The Social Worker, Unit Managers and Director of Nursing will monitor for compliance.	May 30, 2008 June 3, 2008 June 26, 2008 & ongoing July 14, 2008 & ongoing

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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 and staff interview for one (1) of 24 sampled residents, it was determined that the social worker failed to implement appropriate social service interventions for Resident #11 who had suicidal ideation. The findings include: A nurse practitioner's progress note dated February 16, 2008 at 1:30 PM included: "...while on rehab therapy expressed ? suicidal idea "I want to die" ..." On April 8, 2008 at 3:00 PM, the nurse's note revealed, "..Physical Therapist informed writer, resident stated, " I want to die" while at therapy. Upon assessment, resident denied. Told writer "I don't want to go to therapy" . N/P notified. Psych consult ordered. Call placed to [psych doctor]. Awaiting response. Resident placed at nurses' station" A social service quarterly review note was dated April 24, 2008. This was the only social service note written since Resident #11 expressed suicidal ideation on February 16, 2008 and April 8, 2008. The note included the following, " Interventions 1. Recent intervention - yes was	F 250	**#1** Resident #11's need for Social Service intervention has been addressed by the Social Worker regarding resident's suicidal ideation. **#2** To identify other residents who may have the potential to be affected, the interdisciplinary team has addressed the need and importance for Social Service intervention. We continue to review the charts to identify residents who may have suicidal ideation. Currently, no other resident has suicidal ideation. **#3** Social Services, Nursing and Unit Managers in tandem, will audit the consultant book (i.e. psychiatry problem list) maintained on each unit. A policy has been developed to address Social Service interventions once a resident has been identified as needing psychiatric interventions. The Social Worker will maintain a close follow-up with nursing. All staff will be inservice by the Staff Development Coordinator on the steps to follow when a resident expresses suicidal ideation. Annual inservice education training will also be maintained. **#4** The Social Work Director will report monthly to the Q.I. Committee. The Director of Nursing and QI Director will also monitor for compliance.	May 30, 2008 June 23, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing

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F 250	Continued From page 5 checked. Care Plan Goal #9 (reported...Depressed Mood Disorder) has continued and been met this review period. Care Plan Goal and approach plans will continue ... During this review period resident has maintained favorable adjustment. Resident is totally dependent of ADL's and [he/she] is incontinent of B&B [bowel and bladder]. Resident participates in individual therapy and this worker maintains via weekly sessions to provide emotional support and level encouragement ... Resident has verbally acknowledged that he/she is satisfied with [resident]current placement and resident as well as responsible party are in agreement that resident remain in current placement to a long term care." The progress note did not include reference to suicidal ideation from February or April 2008. A face-to-face interview was conducted with Employee #1 on May 28, 2008 at 12:00 PM. He/She acknowledged that there were no documented social service interventions in the record. There was no evidence that the social worker was aware of or initiated interventions after the resident expressed suicidal ideation on February 16 and April 8, 2008. The record was reviewed on May 28, 2008.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by:	F 253		

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F 253	Continued From page 6 Based on observations during the environmental tour, it was determined that facility staff failed to maintain a safe, clean and sanitary environment as evidenced by: damaged/soiled/marred doors, walls, wallpaper, floors, baseboards, corners, and sinks; dusty beds and over bed lights; broken/damaged furniture; light in resident rooms and bathrooms not working; and non-functional bathroom exhaust vents. These observations were made in the presence of Employees #10, 11 and 12 during the environmental tour on May 27, 2008 from 10:40 AM through 3:30 PM. The findings include: 1. Damaged/soiled/marred doors were observed in the following areas: Rooms 4110, 4112, 4115, 4122, 4th floor shower/whirlpool room, and 4119 resident bathroom in six (6) of 14 doors observed. Rooms 5106, 5111, 5116, 5123, and 5th floor fires doors on Hallway B in five (5) of 13 doors observed. Rooms 6115, 6111, 6122, 6145 and 6147 in five (5) of 12 doors observed. 2. Damaged/soiled/marred walls were observed in the following areas: Rooms 4119, 4125, 4133, 4156 in four (4) of 12 rooms observed. Rooms 5106, 5118, 5123, 5129, 5143 and 5147 in six (6) of 12 rooms observed. Rooms 6110, 6111, 6132 and restroom in four (4)	F 253	**#1.** 1. Damaged/soiled/marred doors in: rooms # 4110, 4112, 4115, 4122, 4th floor shower whirlpool room, and 4119 resident bathroom will be repaired. Also rooms 5106, 5111, 5116, 5123, and 5th Floor fires doors on Hallway B will be repaired. Also rooms 6115, 6111, 6122, 6145, and 6147 will be repaired. 2. Damaged/soiled/marred walls in: rooms 4119, 4125, 4133, 4156 will be repaired. Also rooms 5106, 5118, 5123, 5129, 5143, and 5147 will be repaired. Also rooms 6110, 6111, 6132, and restroom will be repaired. 3. Damaged/soiled/marred wallpaper in the bathrooms in room 4110 will be repaired. Also in the bathrooms in rooms 5111, 5116 5129, 5145, 5147 will be repaired. 4. Damaged/soiled/marred floors in Rooms 4115, 4th floor mechanical room with 16 missing tiles, and 4119 will be repaired.	July 14, 2008 & ongoing for 1-12

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F 253	Continued From page 7 of 12 rooms observed. 3. Damaged/soiled/marred wallpaper was observed in the bathrooms in the following areas: Room 4110 bathroom in one (1) of 12 rooms observed. Rooms 5111, 5116, 5129, 5145 and 5147 in five (5) of 13 doors observed. 4. Damaged/soiled/marred floors were observed in the following areas: Rooms 4115, 4th floor mechanical room with 16 missing floor tiles and 4119 in three (3) of 14 rooms observed. Rooms 5106, 5145, 5147 and 5149 in four (4) of 12 rooms observed. Rooms 6110, 6119, 6132, 6th mechanical room, and 6139 in five (5) of 13 rooms observed. 5. Damaged/soiled/marred baseboards were observed in the following areas: Hallway A 4th floor in one (1) of three (3) hallways observed. Hallway A 5th floor in one (1) of three (3) hallways observed and rooms 5106, 5111, 5118, 5123, 5129, 5130, 5143, and solid utility room in eight (8) of 13 rooms observed. Hallway A 6th floor in one (1) of three (3) hallways observed and rooms 6110, 6122, 6th floor rest room, 6130, 6139, 6145, 6147 and 6156 in eight (8) of 13 rooms observed. 6. Damaged/soiled/marred corners were observed in the following areas:	F 253	Also rooms 5106, 5145, 5147, and 5149 will be repaired Also rooms 6110, 6119, 6132, 6th floor Mechanical room, and 6139 will be repaired. 5. Damaged/soiled/marred baseboard In: Hallway 4th floor will be replaced. Also Hallway A 5th floor, and in rooms 5106 5111, 5116, 5118, 5123, 5129, 5130, 5143, and soiled utility room will be replaced. Also Hallway A 6th floor, and rooms 6110, 6122, 6th floor rest room, 6110, 6139, 6145, 6147, 6156 will be replaced. 6. Damaged/soiled/marred corners in: Room 5106, 5111, 5116,5118, 5123, 5130, 5143, and 5149 will be repaired. Also room 6112, 6113, 6115, 6119, 6th Floor tub and shower room, 6th Floor restroom, 6122, 6130, 6132, 6145, and 6147 will be repaired. 7. Damaged/soiled/marred sinks in: 4th Floor clean utility room will be scrubbed and cleaned and the 4th floor soiled utility room hopper, will be repaired. Also 5th Floor hopper in soiled utility room will be scrubbed and cleaned. Sinks in 6th floor clean and soiled utility room will be scrubbed and cleaned.	July 14, 2008 & ongoing for 1-12

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F 253	Continued From page 8 Rooms 5106, 5111, 5116, 5118, 5123, 5130, 5143 and 5149 in eight (8) of 12 rooms observed. Rooms 6112, 6113, 6115, 6119, 6th floor tub and shower room, 6th floor restroom, 6122, 6130, 6132, 6145 and 6147 in 11 of 13 rooms observed. 7. Damaged/soiled/marred sinks were observed in the following areas: 4th floor clean utility room sink and 4th floor soiled utility room hopper in two (2) of two (2) utility rooms observed. 5th floor hopper in the soiled utility room in one (1) of one (1) soiled utility room observed. 6th floor clean and soiled utility room sinks in two (2) of two (2) utility rooms observed. 8. Dusty bed frames were observed in the following areas: Room 4119 in one (1) of 12 rooms observed. Room 5116 in one (1) of 12 rooms observed. Rooms 6110, 6122, 6139, 6147 and 6156 in five (5) of 12 rooms observed. 9. Dusty over bed lights were observed in rooms 5111, 5116, 5123, 5129 and 5147 in five (5) of 12 rooms observed. 10. Broken/damaged furniture was observed in the following areas: 4th Floor: 4119 - dresser drawer off track 4115 - torn arms to geri chair 4120 - no handle on closet 4122 - torn geri chair arms	F 253	8. Bed frames in rooms 4119, 5116, 6110, 6122, 6139, 6147, and 6156 will be dusted and cleaned. 9. Bed lights in rooms 5111, 5116, 5123, 5129, and 5147 will be dusted and cleaned. 10. For broken furniture in rooms 4119, 4115, 4120, 4122, 4129, 4157, 5111, 5116, 5118, 5129, 5145, 5147, 6110, 6111, 6115, 6122, 6139, 6147, and 6146 will be repaired and/or replaced. 11. The light bulbs in rooms 5106, 5111, 5119, 5129 and 6104 will be replaced and are working. 12. Exhaust vents in bathroom 4110, 4119, 5106, 5111, 6104, 6110, 6119, 6156, and 6th floor restroom will be repaired.	July 14, 2008 & ongoing for 1-12

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F 253	Continued From page 9 4129 - broken side of nightstand 4157 - missing closet door In six (6) of 12 resident rooms observed. 5th Floor: 5111 - broken side of bedside stand, sink door off hinges, bedside stand drawer off track 5116 - broken side of night stand 5118 - broken side of night stand 5129 - broken side of night stand 5145 - night stand drawer missing 5147 - broken side of bed side stand In six (6) of 12 resident rooms observed. 6th Floor: 6110 - broken side of back of dresser 6111 - sink door off hinges 6115 -foot board missing off bed 6122- broken side of bed side stand 6139 - broken side of bed side stand 6147- broken side of bed side stand 6156 - broken side of bed side stand In seven (7) of 12 resident rooms observed. 11. Light bulbs were observed not working in the following areas: Rooms 5106, 5111, 5119 and 5129 in four (4) of 12 rooms observed Room 6104 in one (1) of 12 rooms observed. 12. Non-functional bathroom exhaust vent were observed in the following areas: Rooms 4110 and 4119 in two (2) of 12 rooms observed. Rooms 5106 and 5111 in two (2) of 12 rooms observed. Rooms 6104, 6110, 6119, 6156 and 6th floor restroom in five (5) of 13 rooms observed.	F 253	**#2** To identify other resident's rooms and common area that may be affected, we have done a walk through of the units and resident's rooms, hallways, shower rooms, and observe furniture. Those areas found to be damaged, soiled or marred will be repaired. **#3** We have put a system in place to provide more frequent and collaborative Environment of Care (EOC) rounds on the units. The Unit Managers, Engineer Supervisor, and Manager of Environmental Service, will do weekly rounds to ensure repairs are carried out. Findings of these rounds will be communicated to the QI Director, Administrator, and Facility Director using standardized tools for all units. We will also observe all furniture during EOC rounds, by the Engineering Supervisor, Unit Managers, and the Housekeeping Supervisor. **#4** EOC rounds will be done weekly by the Unit Managers, the Engineering supervisor, Housekeeping supervisor and Administrator. To sustain compliance the Q.I. Director, the Facility Director, and Administrator will continue to monitor and review the results of the EOC rounds at the monthly Q.I. meetings.	July 14, 2008 & ongoing for all July 14, 2008 & ongoing July 14, 2008 & ongoing

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F 253	Continued From page 10 Employees #10, 11 and 12 acknowledged the findings at the time of the observations	F 253		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 24 sampled residents, it was determined that the facility staff failed to	F 278		

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F 278	Continued From page 11 accurately code the Minimum Data Set (MDS) as evidenced by: one (1) resident with bilateral amputation coded for lower extremity range of motion, one (1) resident with inaccurate diagnoses, one (1) resident not coded for Hospice, and one (1) resident not coded for diagnoses and allergy. Residents #1, 9, 17,and 22. The findings include: 1. Facility staff failed to accurately code Resident #1 for functional limitation in range of motion on the quarterly MDS. The attending progress note dated April 6, 2008 revealed, "...2. s/p [status post] bil [bilateral] AKA [above the knee amputation]..." A review of the quarterly MDS completed April 8, 2008, Section G (Functional Limitation in Range of Motion) coded range of motion to the foot-including ankle or toes as limitation on both sides-partial loss. The quarterly MDS lacked evidence that Resident #1's range of motion was accurately coded. The record was reviewed on May 27, 2008. 2. Facility staff failed to accurately code a diagnosis on the MDS for Resident #9. A review of the annual MDS dated January 29, 2008, Section I (Disease Diagnoses) included a diagnosis of Osteoporosis. The most recent History and Physical dated August 30, 2007 included a diagnosis of Osteopenia.	F 278	**#1** 1. Resident #1 range of motion has been corrected and accurately coded on the quarterly MDS. 2. After reviewing MDS for Resident #9 with osteopenia, the physician has updated diagnosis to osteopenia. This diagnosis has been corrected on the MDS to read osteopenia. 3. MDS for Resident #17 receiving hospice has been corrected. Most recent The MDS has been corrected for the most recent quarterly MDS reflect hospice care. 4. Resident #22 has been discharged. **#2** To identify other residents that may have the potential to be affected, we have reviewed and continue to review charts and MDS for accurate coding. **#3** We have put a system in place to monitor, on a monthly basis, coding of MDS. A monitoring tool has been developed to aid in this process. We have reeducated the person coding MDS. We will also train all Unit Managers on the MDS system and coding. **#4** The MDS Coordinator, the Director of Nursing, and Q.I. Director will monitor for compliance by analyzing results of the monitoring tool.	June 24, 2008 June 24, 2008 June 24, 2008 Feb. 25, 2008 June 13, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing

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F 278	Continued From page 12 A nurse practitioner's progress note dated March 29, 2008 at 12:30 PM included, " ...Osteopenia - Tx (treatment refused) ... " A face-to-face interview was conducted with Employee #4 on May 27, 2008 at 11:15 AM. He/she acknowledged the inaccurate diagnosis. The record was reviewed on May 27, 2008. 3. Facility staff failed to accurately code Resident # 17's annual MDS for hospice care. A review of the resident's record revealed that an annual MDS, completed April 22, 2008, was not coded for hospice care in Section P (Special Treatments and Procedures). A review of the physician's orders revealed that hospice care was ordered on February 22, 2008 and began the same day. A face-to-face interview was conducted with Employee #6 at approximately 11:00 AM on May 29, 2008. He/she acknowledged that the MDS was not coded for hospice care. The record was reviewed on May 29, 2008. 4. Facility staff failed to accurately code a diagnosis of Hypertension and allergy to Bactrim on the admission MDS for Resident #22. The most recent History and Physical assessment dated February 17, 2008 included a diagnosis of Hypertension and an allergy to Bactrim. A review of the admission MDS completed February 25, 2008, in Section I (Disease	F 278		

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F 278	Continued From page 13 Diagnoses) was not coded for a diagnosis of Hypertension and allergies. A face-to-face interview was conducted with Employee #6 on May 28, 2008 at approximately 2:15 PM. He/she acknowledged that the diagnosis of Hypertension and allergy was not coded on the admission MDS. The record was reviewed on May 27, 2008.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 24 sampled residents, it was determined that facility staff failed to develop a	F 279		

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F 279	Continued From page 14 care plan for potential adverse drug interactions for nine (9) or more medications for Resident #2. The findings include: A review of the clinical record for Resident #2 revealed a physician's order dated and signed April 10, 2008 that included the following medications; Acetaminophen, Amiodarone, Ascorbic Acid, Fentanyl, Hydralazine HCL, Keppra, Multivitamin, Oyster-Cal, Prevacid, Senokot, Tegretol Transderm and Zinc Sulfate. A review of the care plan that was last updated on May 1, 2008, revealed there was no problem identified, with appropriate goals and approaches, for potential adverse drug interactions involving nine (9) or more medications. A face-to-face interview was conducted with Employee #5 at approximately 2:30 PM on May 27, 2008. He/she acknowledged that the record lacked a care plan for nine (9) or more medications and should have been updated. The record was reviewed on May 27, 2008.	F 279	**#1** A care plan for nine (9) or more medications were added on May 27, 2008 to the clinical record of Resident #2. **#2** Resident charts has been reviewed and we continue to review all charts to identify residents on nine (9) or more medication. This review revealed no other resident were affected by this deficient practice. **#3** A system will be put in place for randomly sampled, biweekly audits by the Unit Managers to identify any potential omissions within the care plans. Also, all licensed nurses and interdisciplinary team members will be reeducated on ensuring a care plan is in place for residents taking nine or more medications. An audit will be performed, ensuring the appropriate care plans are in place in the clinical record. **#4** We will ensure that compliance is maintained and monitored monthly by the Director of Nursing and Q.I. Director.	June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		

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F 280	Continued From page 15 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for two (2) of 24 sampled residents, it was determined that facility staff failed to ensure that two (2) residents receiving hospice care had integrated care plans. Residents #7 and 17. The findings include: 1. Facility staff failed to ensure that Resident #7, who was receiving hospice care, had an integrated care plan for coordination of care between the facility and the hospice service. A review of Resident #7's record revealed a physician's telephone order dated May 9, 2008 at 10:00 AM which directed, "Resident is on Hospice care." The record revealed two (2) separate care plans. The facility's care plans were last reviewed and/or updated on March 21, 22, April 23 and May 13, 2008. The hospice care plan was dated May 20, 2008 and was signed by the hospice nurse. The record lacked evidence of an integrated plan of care for Resident #7 between the facility and	F 280	**#1** 1 & 2. Care plans for residents #7 & #17 receiving hospice have been corrected. These residents now have integrated care plans. **#2** We have reviewed all charts to identify residents receiving hospice care and the need for integrated care plans. All other residents receiving hospice care has a corrected and integrated care plan. **#3** A system of biweekly audits, performed by the Unit Managers, MDS Coordinator, and Q.I. Director, has been put in place. The audits will check the clinical records of hospice residents, ensuring an integrated care plan is present. The interdisciplinary team members will be inservice on maintaining an integrated care plan for residents receiving hospice care. **#4** To ensure that compliance is sustained, the Director of Nursing, and the Q.I. Director will analyze the results of the audits. These results will be presented at the monthly Quality Improvement meetings to assess effectiveness of the plan.	June 26, 2008 June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing

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F 280	Continued From page 16 the hospice service. A face-to-face interview was conducted with Employee #1 on May 28, 2008 at 10:35 AM. He/she acknowledged that the resident had two (2) separate care plans and no coordination of care. The record was reviewed on May 28, 2008. 2. Facility staff failed to ensure that Resident #17, who was receiving hospice care, had an integrated care plan for coordination of care between the facility and the hospice service. A review of Resident #17's record revealed a physician's order dated February 22, 2008 which directed, "Admit into (Hospice company)." The record revealed two (2) separate care plans. The facility's care plans were last reviewed and/or updated on February 23, 29 and April 23, 2008. The hospice care plans were dated February 28 and April 10, 2008. The hospice care plans were signed by the hospice nurse. The record lacked evidence of an integrated care plan for the care of Resident #17 between the facility and the hospice service. A face-to-face interview was conducted with Employee #19 on May 29, 2008 at approximately 10:30 AM. He/she acknowledged that the resident had two (2) separate care plans and no coordination of care. The record was reviewed on May 29, 2008.	F 280		
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

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F 309	Continued From page 17 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 an observation, record review and staff interview for six (6) of 24 sampled residents, it was determined that the facility staff failed to ensure that: tube feeding orders for one (1) resident were transcribed accurately; clarify a tube feeding order for one (1) resident; differentiate between the usage of pain medications for two (2) residents; a PSA (Prostatic Specific Antigen) level was drawn as per physician's orders for one (1) resident; adequately monitor and implement preventive measures for one (1) resident who had suicidal ideation and obtain a psychiatric consult timely; and obtain a psychiatric consult was as ordered by physician for one (1) resident. Residents #3, 7, 9, 10, 11 and 18. The findings include: 1. Facility staff failed to ensure that tube feeding orders for Resident #3 were transcribed accurately. A review of Resident #3's record revealed a telephone order dated March 24, 2008 at 1:00 PM that directed, " 1) D/C (discontinue) old tube feeding order. 2) Diabetic Resource 85cc 18 hrs = 1530cc ..." The April 2008 Physician's Order Form signed by	F 309		

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F 309	Continued From page 18 the physician on April 8, 2008 included, " ...Tube feed Diabetic Source via G-tube via pump 80 ml time 18 hours ..." The origination date for this order was January 15, 2008. The May 2008 Physician's Order Form signed by the physician on May 26, 2008 included, " ...Tube feed Diabetic Source via G-tube via pump 80 ml [the zero was written in ink on top of a pre-printed number 5] time 18 hours ..." The origination date for this order was March 24, 2008. The TARs (Treatment Administration Records) for March and April 2008, beginning on March 24, 2008, included a rate of 85 cc/hr for the Diabetic Resource. However, the May 2008 TAR included a rate of 80ml/hr [the zero was written in ink on top of a pre-printed number 5] for the Diabetic Resource. On May 28, 2008 at 8:05 AM, it was observed that Resident #3's tube feeding bottle was labeled to infuse at a rate of 85cc per hour and the pump was set at a rate of 85cc per hour. A face-to-face interview was conducted with Employee #5 on May 28, 2008 at 9:25 AM. He/she acknowledged the inconsistency with the physician's orders and the observed infusion rate of the tube feeding. The record was reviewed on May 28, 2008. 2. Facility staff failed to clarify a tube feeding order for Resident #7. A review of Resident #7's record revealed a physician's telephone order dated May 27, 2008 which directed, "TF order D/C (discontinue) Iso 1.5 @ 70 x 18 and use Novasource, pulmonary	F 309	**#1** 1 & 2. The physician orders and the TAR now have been corrected and reflect the accurate infusion rate and time for the tube feeding for resident #3 and #7. **#2** We have reviewed the charts for all residents on tube feedings who may have the potential to be affected. **#3** We will be put in place a system of biweekly audits, conducted by Unit Manager and Dietician to ensure that all tube feeding orders infusion rates and times are accurately transcribed and that there are no inconsistencies with physician orders. The audit tool will enable the dietician to monitor physician orders against tube feeding infusing rate. Licensed staff will be reeducated on how to transcribe physician orders for tube feedings. **#4** To sustain compliance, the results of the audit will be presented at our monthly Quality Improvement meeting. The Director of Nursing, the Q.I. Director and Medical Director will monitor for compliance monthly.	May 30, 2008 June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing

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F 309	Continued From page 19 until Iso 1.5 is available" . The order for Novasource lacked the infusion rate and time. A face-to-face interview was conducted with Employee #1. He/she stated, "We need to clarify that (the order for the rate and time for Novasosurce)." The record was reviewed on May 28, 2008. 3. Facility staff failed to differentiate between the usage of pain medications for Resident #9. A review of Resident #9's record revealed pain medication orders on the May 2008 Physician's Order Form as follows: "Tylenol 325 mg 2 tabs by mouth every four hours as needed for pain and Motrin 400 mg 1 tab by mouth every six hours as needed for pain." A face-to-face interview was conducted with Employee #4 on May 27, 2008 at 2:45 PM. He/she acknowledged that there was no differentiation between the use of the two (2) pain medications. A review of the Medication Administration Records from November 2007 through May 2008 revealed that the resident had not received either medication. The record was reviewed on May 27, 2008. 4. Facility staff failed to ensure that a PSA (Prostatic Specific Antigen) level was drawn as per physician's orders for Resident #10. A review of Resident #10's record revealed a urology consult dated December 6, 2007 which included the following: " PSA - 4.52 mg/ml (previous PSA 2.6, 2.92 ... Plan: ... (2) F/U	F 309	**#1** 3. The order pertaining to the usage of pain medication, Tylenol & Motrin, for Resident #9 was clarified on May 27, 2008 **#2** An audit was conducted on all residents with multiple analgesic orders to ensure that there are instructions on usage. All orders are now clarified. **#3** Physician and all licensed nurses will be reeducated on residents receiving multiple pain medication, and the differential use of these drugs. A system of biweekly chart audits will be put in place. **#4** The results of the chart audit will be presented for review to the Q.I. Committee. Unit Manager, Q.I. Director, and Director of Nursing will monitor and report to the Q.I. Committee on a monthly basis. **#1** 4. The PSA was drawn on March 13, 2008 at the Physician office. The results are now placed in Resident #10 clinical record. **#2** To identify other residents that may have the potential to be affected an audit was performed of all other residents to see if labs ordered were drawn as ordered.	June 26, 2008 July 14, 2008 & ongoing July 14, 2008 May 30, 2008 June 26, 2008

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F 309	Continued From page 20 (follow up) PSA in 2-3 mos (months)" . A physician's order dated December 6, 2007 directed, " F/U PSA in 2-3 months" . The record lacked evidence of a PSA level for February or March 2008. A urology consult dated March 13, 2008 included, " ...No recent PSA available ... Plan Repeat PSA, done at Dr's (doctor's) office" . A face-to-face interview was conducted with Employee #1 on May 28, 2008 at 9:35 AM. He/she acknowledged that the PSA level was not drawn as ordered. The record was reviewed on May 28, 2008. 5. Facility staff failed to adequately monitor and implement preventive measures for Resident #11 who had suicidal ideation and obtain a psychiatric consult timely. A nurse practitioner's progress note dated February 16, 2008 at 1:30 PM included: "...while on rehab therapy expressed ? suicidal idea "I want to die" ..." The nurses' notes revealed the following: February 16, 2008 at 11:00PM, "...Resident was seen today by NP (nurse practitioner) due to c/o (complaint of) pain and suicidal ideation ... also order for psychiatric consultation was given ... call made to psych MD [name], message left on [his/her] voice mail, return call pending ..." February 17, 2008 at 2:45 PM, "...Call placed to psych MD [name] for psychiatric consultation,	F 309	Continued From page 20 **#3** A system has been put in place whereby labs due dates and results are maintained in a log-book. A follow-up of the lab log-book is done by the Unit Managers. All licensed nurses will be reeducated on the facility's lab process, including the lab follow-up form, to track and monitor completion of all labs **#4** The Unit Manager, licensed nurses, Q.I. Director and Director of Nursing will conduct audits for the next three months, to ensure labs are drawn and placed in the clinical record. All results will be reported to the Q.I. Committee. The Director of Nursing and Q.I. Director will continue to monitor. **#1** 5. Resident #11's need for Social Service intervention has been addressed by the Social Worker regarding resident's suicidal ideation. The Director of Nursing has followed-up with the psychiatrist consultation. **#2** To identify other residents who may have the potential to be affected, the interdisciplinary team has addressed the need and importance for Social Service and Nursing intervention. We continue to review the charts to identify residents who may have suicidal ideation. Currently, no other resident has suicidal ideation.	June 23, 2008 & ongoing July 14, 2008 & ongoing June 23, 2008 June 23, 2008 & ongoing

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F 309	Continued From page 21 message left on voice mail, return call pending, resident being monitored for suicidal ideation ..." A nurse practitioner's order dated February 16, 2008 at 1:30 PM included, "...Psychiatry consultation for eval of R/O Depression ..." There was no reference to the resident's suicidal ideation in this order. A nurse practitioner's order dated February 19, 2008 at 3:00 PM directed, "...Psychiatry F/U for eval of dose reduction of Lexapro received by pharmacist consultant " . The first psychiatric consultation was completed on March 19, 2008, 32 days after the original order. The consult included, "...Reason for consult/Follow-Up regarding Med Review - Patient has been on Lexapro & Aricept for Depression & Dementia to which [he/she] continues to respond fine - No recurrent depressive or agitated behaviors reported. [He/she] eats & sleeps fine. No MSE (mental status examination) changes ... Next visit in 3 months ..." The aforementioned psychiatric consultation did not include reference to suicidal ideation. The record lacked evidence of a care plan for the initiation of increased monitoring and preventive measures for the above complaint of suicidal ideation. On April 8, 2008 at 3:00 PM, the nurse's note revealed, "...Physical Therapist informed writer, resident stated, " I want to die" while at therapy. Upon assessment, resident denied. Told writer " I don' t want to go to therapy" . N/P notified. Psych consult ordered. Call placed to [psych doctor].	F 309	Continued From page 21 **#3** Social Services, Nursing and Unit Managers in tandem, will audit the consultant book (i.e. psychiatry problem list) maintained on each unit. A policy has been developed to address Social Service interventions for residents who have suicidal ideation. Once a resident has been identified as needing psychiatric interventions as stated in the policy. The Social Worker will maintain a close follow-up with nursing, to ensure appropriate protocols are maintained. All staff will be inservice by the Staff Development Coordinator on the steps to follow when a resident expresses suicidal ideation. Annual inservice education training will also be maintained. **#4** The Social Worker Director will report monthly to the Quality Improvement Committee. The Director of Nursing and QI Director will also monitor for compliance on monthly basis.	June 26, 2008 & ongoing July 14, 2008 & ongoing

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F 309	Continued From page 22 Awaiting response. Resident placed at nurses' station." A physician's telephone order dated April 8, 2008 directed, "Psych consult secondary suicidal thought ..." Review of the nurses' notes revealed the following: April 8, 2008 at 10:00 PM, "...No suicidal ideation noted on this shift ..." April 9, 2008 at 6:40 AM, "...No suicidal ideation verbalized, denied having plan of taking own life ..." April 9, 2008 at 2:40 PM, "...No suicidal ideation verbalized ..." A psychiatric consultation dated April 9, 2008 revealed, "...Follow-up- Patient seems to be exhibiting depressive symptoms, recurrent, at the time Lexapro is being weaned off - he/she is not actively suicidal ... No suicidal or homicidal tendency as we speak ... Should suicidal ideations recur, send patient to [hospital] ER for further investigation. Next visit PRN." The facility's policy entitled " Suicide Ideation" with an effective date of January 31, 2008, included the following: " Purpose: To provide immediate intervention to address residents with suicidal ideation. Policy: A. In the event that a resident displays any signs of mental disorder or the likelihood of causing harm to self or other, the nurse assigned to the resident shall take the following steps. B. Physician and Psychiatrist will be notified of resident's suicidal ideation. C. Family will be notified of resident's suicidal ideation. D. Nursing Documentation will reflect monitoring of residents suicidal ideation and	F 309		

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F 309	Continued From page 23 preventive measures that have been implemented. E. Based on outcome of psychiatric consult facility will follow through accordingly, ..." On May 28, 2008 at 11:45 AM, Resident #11 was observed in the dayroom/dining room seated at a table in his/her wheelchair. There was a CNA (Certified Nurse Aide) in the room and two (2) other residents. Resident #11 stated that he/she was waiting for lunch. A face-to-face interview was conducted with Employee #1 on May 28, 2008 at 12:00 PM. He/She stated, " We were monitoring [him/her] hourly after the fall. At that time we had two (2) psych doctors, we now have one (1). [Resident] is up everyday and [he/she] comes out and sits at the nurse's station until time for [him/her] to eat. We usually bring [him/her] close by where we can see [resident]. He/She goes to activities" . The record was reviewed on May 28, 2008. 6. Facility staff failed to obtain a psychiatric consult as ordered for Resident #18 on admission and differentiate between the usage of pain medications. A. Facility staff failed to obtain a psychiatric consult as ordered for Resident #18 on admission. Resident #18 was admitted on May 16, 2008 to the facility and admission orders included, "Psych consult, reason Depression/Anxiety" . A face-to-face interview was conducted with Employee #5 on May 29, 2008 at 11:20 AM. He/She stated, " I didn't see it (the psyc consult)" .	F 309	**#1** 6(A). The psychiatric consult has been completed by the Psychiatrist for Resident #18. The report has been placed in the resident's medical record. **#2** We have reviewed charts for residents admitted to ascertain if psychiatric consults are outstanding. We will continue to review the charts. **#3** To ensure that psychiatric consults are carried out timely, we will secured additional psychiatric coverage for the residents of the facility. In addition, the Unit Managers and Unit Secretaries will maintain the consult log-book on each unit, and review the log weekly. **#4** In order to ensure that our action plan is sustained, the Unit Managers will present the results of the audit at the monthly Q.I. meetings. The Medical Director, Q.I. Director and Director of Nursing will continue to monitor monthly for compliance.	June 11, 2008 June 23, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing

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F 309	Continued From page 24 Employee #5 acknowledged that the record lacked evidence that a psychiatric consultation was done. B. Facility staff failed to differentiate between the usage of pain medications. Resident #18's admission orders dated May 16, 2008 included the following medications to be administered for pain: Motrin 400 mg 1 tab po Q6 hly PRN (by mouth every 6 hours when needed) pain; Percocet 5/325 mg 2 tabs po Q4 hly PRN pain; and Tylenol 325 2 tabs po Q4 hly PRN pain/headache. There was no evidence in the record that the orders for Motrin and Percocet were clarified with the physician to determine when to use either medication. From May 17 through 29, 2008, Resident #18 was administered Percocet 22 times. Documentation on the Medication Administration Record (MAR) for the reason for the use of the Percocet was for "complaint of pain, complaint of general pain or complaint of pain at back." Motrin was not administered during May 2008. A face-to-face interview was conducted with Employee #5 on May 28, 2008 at 11:20 AM. He/she acknowledged that there was no differentiation between the use of Motrin and Percocet. The record was reviewed on May 28, 2008.	F 309	**#1** 6(B). The order pertaining to the usage of pain medication, Percocet & Motrin, for Resident #18 was clarified. The Motrin was discontinued on May 27, 2008 and the Percocet discontinued on May 29, 2008. **#2** An audit was conducted on all residents with multiple analgesic orders to ensure that there are instructions on usage for these medication. All orders are now clarified. **#3** Physician and all licensed nurses were reeducated on residents receiving multiple pain medication, and the differential use of these drugs. A system of biweekly chart audits has been put in place. **#4** The results of the chart audit will be presented for review to the Q.I. Committee. Unit Manager, Q.I. Director, and Director of Nursing will monitor monthly and report to the Q.I. Committee on a monthly basis.	June 30, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing
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	F 329		

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F 329	Continued From page 25 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews for one (1) of 24 sampled residents, it was determined that the physician failed to review the resident's behavior history prior to increasing the dosage of an antipsychotic medication. Resident #14. The findings include: A review of Resident #14's record revealed the psychiatrist's order dated October 10, 2007 that directed, "Increase Seroquel to 75mg po bid (orally twice daily) for agitated behaviors." On May 21, 2008 the psychiatrist directed, " Increase Seroquel 100 mg po bid for agitated	F 329		

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F 329	Continued From page 26 behaviors." The nurses' notes were reviewed from January 31, 2008 through May 21, 2008. The following entry described the only documented episode of agitated behaviors: May 6, 2008 at 3:30 PM, " Resident was observed to be agitated this afternoon. Trying to stand up stating, " I' m going to see my mother. I don't want to be here." Trying to take off [his/her] clothes..." The January, February, March, April and May 2008 "Behavior Monitoring Flow Sheet(s)" were reviewed. Behaviors of false beliefs and nervousness were documented for May 9 and 13, 2008 . There was no documentation on the "Behavior Monitoring Flow Sheet (s)" that any additional behaviors of false beliefs and/or nervousness occurred for January, February, March, April and May (other than the aforementioned days) 2008. A face-to-face interview with Resident #14 was conducted on May 28, 2008 at 2:30 PM. He/she appeared calm, voiced no complaints and stated, " I' m really sleepy." A face-to-face interview with Employee #1 was conducted on May 28, 2008 at 3:15 PM. He/she reviewed the resident's record and acknowledged that there was no documentation that the resident had demonstrated agitated behaviors (exception May 9 and 13, 2008) from January through May 2008. The record was reviewed May 28, 2008.	F 329	**#1** The Psychiatrist has reviewed Resident #14 chart. **#2** We continue to review charts of residents in collaboration with the Pharmacist consultant to identify residents that may have increased dosage of their antipsychotic medication without physician review of resident's behavior history. The Medical Director has put a system in place of regular written communication to attending and consulting Physicians. The Medical Director has also issued a memorandum to the Psychiatrist, addressing the need to review resident's behavior history prior to increasing the dosage of an antipsychotic medication. In addition, licensed nurses will be re-inservice on documentation of abnormal behaviors exhibited by residents, to ensure that these behaviors are clearly documented in the Nurses Notes and/or the Behavioral Monitoring Flow sheet. **#4** To ensure that our plan is sustained, we will monitor for compliance. The Medical Director, Pharmacist, Q.I. Director, Director of Nursing and Unit Managers will continue to monitor for compliance monthly and ongoing.	June 25, 2008 June 25, 2008 & ongoing June 26, 2008 July 14, 2008 & ongoing
F 371 SS=C	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		July 14, 2008 & ongoing

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F 371	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on the tour of the main kitchen and unit pantries, it was determined that facility staff failed to: separate stored expired and non-expired nutritional supplements and date and label foods in pantry refrigerators. These observations were made in the presence of Employees #5, 6, 21 and 22 on May 27, 2008 between 8:40 AM and 10:45 AM and on May 28 between 9:00 AM and 10:05 AM. The findings include: 1. Facility staff failed to separate expired and non-expired nutritional supplements. 12 cases of renal nutritional supplement were observed with the following expiration dates: October 16, 2006 - One (1) case October 1, 2007 - One (1) case November 21, 2007 - Three (3) cases May 3, 2008 - One (1) case May 11, 2008 - Five (5) cases May 28, 2008 - One (1) case The above expired nutritional supplements were stored on shelves that contained approximately 20 cases of non-expired nutritional supplement. Employees #21 and 22 acknowledged the findings at the time of the observation. 2. Two (2) of three (3) unit pantry refrigerators contained unlabeled and undated food.	F 371	**#1** 1. Although expired and non-expired nutritional supplements were observed, no residents were identified as being affected by this deficient practice. The expired nutritional supplement were discarded. **#2** To identify other residents that may be affected, nutritional supplements are delivered 3 times a week to nursing center floors, dates of supplements will be checked prior to being taken to the floors **#3** We have put a system in place to perform daily checks for expired supplements. Staff was inservice on the First In First Out (FIFO) method. When new deliveries are brought in the FIFO method will be practiced. **#4** Food Service Manager, supervisors, clinical dietitians, and diet aide will monitor nutritional supplements daily as part of daily checklist and will report findings monthly to the Q.I. Committee.	May 30, 2008 June 9, 2008 & ongoing June 23, 2008 & ongoing July 14, 2008 & ongoing

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F 371	Continued From page 28 An undated and unlabeled container with a strong odor of fish was observed in the 5th floor unit pantry refrigerator. Employee #6 acknowledged the findings at the time of the observations. An undated and unlabeled container of pineapple slices and a bag containing a sandwich and banana were observed in the 6th floor pantry refrigerator. Employee #5 acknowledged the findings at the time of the observations.	F 371	**#1** 2. The unlabeled and undated food have been discarded. **#2** To identify other residents or equipments that may be affected, we have checked all pantry refrigerators in 4th, 5th, 6th floors, discarding any unlabeled or undated food observed. **#3** The Director of Nursing will issued a memorandum to the nursing staff, informing them that resident's food must be labeled and dated before placed in pantry refrigerators. This system will be monitored by both Food Services and nursing staff. This information will be reinforced monthly at Resident Council meetings.	May 30, 2008 May 30, 2008 July 14, 2008
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 interviews for four (4) of 24 sampled residents, it was determined that the physician failed to review the total program of care as evidenced by: signing orders for one (1) resident with an inaccurate tube feeding order; failure to follow up on an ordered psychiatric consultation for two (2) residents; and increasing an antipsychotic medication without evidence of increased agitated behaviors for one (1) resident. Residents #3, 11,14 and 18. The findings include:	F 386	**#4** In order to sustained our corrective action plan, the Q.I. Director, Director of Nursing, and Unit Managers will monitor for compliance.	July 14, 2008 & ongoing

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F 386	Continued From page 29 1. The physician failed to ensure that tube feeding orders for Resident #3 were accurate prior to signing Physician's Order Forms. A review of Resident #3's record revealed a telephone order dated March 24, 2008 at 1:00 PM that directed, " 1) D/C (discontinue) old tube feeding order. 2) Diabetic Resource 85cc 18 hrs = 1530cc ..." The April 2008 Physician's Order Form signed by the physician on April 8, 2008 included, " ...Tube feed Diabetic Source via G-tube via pump 80 ml time 18 hours ..." The origination date for this order was January 15, 2008. The May 2008 Physician's Order Form signed by the physician on May 26, 2008 included, " ...Tube feed Diabetic Source via G-tube via pump 80 ml [the zero was written in ink on top of a pre-printed number 5] time 18 hours ..." The origination date for this order was March 24, 2008. The TARs (Treatment Administration Record) for March and April 2008, beginning on March 24, 2008, included a rate of 85 cc/hr for the Diabetic Resource. However, the May 2008 TAR included a rate of 80ml/hr [the zero was written in ink on top of a pre-printed number 5] for the Diabetic Resource. On May 28, 2008 at 8:05 AM it was observed that Resident #3's tube feeding bottle was labeled to infuse at a rate of 85cc per hour and the pump was set at a rate of 85cc per hour. A face-to-face interview was conducted with Employee #5 on May 28, 2008 at 9:25 AM.	F 386	**#1** 1. The attending physician has clarified his/her order for tube feedings for Resident #3. **#2** To identify other residents that may be affected, residents will be reviewed continuously to clarify orders that may be unclear. **#3** To ensure that we are in compliance, we have a system in place of regular written communication by the Medical Director to Attending Physicians. The Medical Director has issued a memorandum to the attending physicians that: A. the resident's total program of care including medications and treatments, are reviewed carefully at each visit. B. All orders, progress notes, labs, and other statements, are reviewed, signed and dated on time. In addition, the Unit Secretaries will conduct regular monthly audits on Physician services documentation and present the results to the Medical Director. **#4** The Administrator, Medical Director, Director of Nursing, and Q.I. Director will monitor for compliance monthly.	May 28, 2008 June 23, 2008 & ongoing June 26, 2008 & ongoing July 14, 2008 & ongoing

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F 386	Continued From page 30 He/she acknowledged the inconsistency with the physician's orders and the observed infusion rate of the tube feeding. The record was reviewed on May 28, 2008. 2. The physician failed to follow up on an ordered psychiatric consultation for Resident #11 who had suicidal ideation. A nurse practitioner's progress note dated February 16, 2008 at 1:30 PM included: " ...while on rehab therapy and expressed ? suicidal idea " I want to die" ..." A nurse practitioner's order dated February 16, 2008 at 1:30 PM included, " ...Psychiatry consultation for eval of R/O Depression ..." The order did not reference the resident's of suicidal ideation. A nurse practitioner's order dated February 19, 2008 at 3:00 PM written by the nurse practitioner directed, " ...Psychiatry F/U for eval of dose reduction of Lexapro received by pharmacist consultant " . There were physician and/or nurse practitioner progress notes in the record dated February 19 and 26, 2008. There was no mention of suicidal ideation or the absence of a psychiatric consultation in either progress note. The psychiatric consultation was not completed until March 19, 2008, 32 days after the original order. The consult included, "...Reason for consult/Follow-Up regarding Med Review - Patient has been on Lexapro & Aricept for Depression & Dementia to which he/she continues to respond fine - No recurrent	F 386		

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F 386	Continued From page 31 depressive or agitated behaviors reported. He/she eats & sleeps fine. No MSE (mental status examination) changes ... Next visit in 3 months ..." The aforementioned psychiatric consultation did not include reference to the resident's suicidal ideation. The record was reviewed on May 28, 2008. 3. The psychiatrist failed to review Resident #14's behavioral history before increasing an antipsychotic medication. A review of Resident #14's record revealed the psychiatrist's order dated October 10, 2007 that directed, "Increase Seroquel to 75mg po bid (orally twice daily) for agitated behaviors." On May 21, 2008 the psychiatrist directed, " Increase Seroquel 100 mg po bid for agitated behaviors." The nurses' notes were reviewed from January 31, 2008 through May 21, 2008. The following entry described the only documented episode of agitated behaviors: May 6, 2008 at 3:30 PM, " Resident was observed to be agitated this afternoon. Trying to stand up stating," I' m going to see my mother. I don't want to be here." Trying to take off [his/her] clothes..." The January, February, March, April and May 2008 "Behavior Monitoring Flow Sheet(s)" were reviewed. Behaviors of false beliefs and nervousness were documented for May 9 and 13, 2008 . There was no documentation on the "Behavior Monitoring Flow Sheet (s)" that any additional behaviors of false beliefs and/or	F 386	**#1** 2 & 3. The psychiatrist has reviewed Resident #14 and #11 antipsychotic medication and behavioral history. **#2** The Psychiatrist and Pharmacy consultant, will review resident's charts to identify resident's that the physician may have failed to review the behavior history. **#3** To ensure that we have a system in place to maintain compliance, the Medical Director has issued a memorandum to Attending Physicians and Psychiatric Consultants, to notify that: The resident's total program of care including medication and treatments are reviewed carefully at each visit. In addition, the Unit Secretaries will conduct regular monthly audits on Physician services documentation and present the results to the Medical Director. **#4** The Administrator, Medical Director, Director of Nursing, and Q.I. Director will monitor for compliance monthly.	June 25, 2008 July 14, 2008 & ongoing June 26, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing

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F 386	Continued From page 32 nervousness occurred for January, February, March, April and May (other than the aforementioned days) 2008. A face-to-face interview with Resident #14 was conducted on May 28, 2008 at 2:30 PM. He/she appeared calm, voiced no complaints and stated," I' m really sleepy." A face-to-face interview with Employee #1 was conducted on May 28, 2008 at 3:15 PM. He/she reviewed the resident's record and acknowledged that there was no documentation that the resident had demonstrated agitated behaviors (exception May 9 and 13, 2008) from January through May 2008. The record was reviewed May 28, 2008. 4. The physician failed to follow up on an ordered psychiatric consultation for Resident #18. Resident #18 was admitted on May 16, 2008 to the facility and admission orders included, "Psych consult, reason Depression/Anxiety" . A physician's progress note dated May 26, 2008 at 2:00 PM did not include reference to a psychiatric consultation. A face-to-face interview was conducted with Employee #5 on May 29, 2008 at 11:20 AM. He/She stated, " I didn't see it (psyc consult)" . Employee #5 acknowledged that the record lacked evidence that a psychiatric consultation was done. The physician failed to follow up on the psychiatric consultation that was ordered for Resident #18. The record was reviewed on May 29, 2008.	F 386	**#1** 4. The Psychiatrist has reviewed Resident #14 chart. **#2** We continue to review charts of residents in collaboration with the Pharmacist consultant to identify residents that may have psychiatric consultation that need follow-up by physician. **#3** The Medical Director has put a system in place of regular written communication to attending and consulting Physicians. The Medical Director has also issued a memorandum to the Psychiatrist, addressing the need to review resident's behavior history prior to increasing the dosage of an antipsychotic medication. In addition, licensed nurses will be re-inservice on documentation of abnormal behaviors exhibited by residents, to ensure that these behaviors are clearly documented in the Nurses Notes and/or the Behavioral Monitoring Flow sheet. **#4** To ensure that our plan is sustained, we will monitor for compliance. The Medical Director, Pharmacist, Q.I. Director, Director of Nursing and Unit Managers will continue to monitor monthly for compliance.	June 25, 2008 July 14, 2008 & ongoing June 26, 2008 July 14, 2008 July 14, 2008 & ongoing

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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 observations and staff interview, it was determined that facility staff failed to date and initial 12 of 14 multi-dose medication vials and/or bottles when first opened and ensure the administration of a controlled substance for Resident JH4. The findings include: 1. On May 29, 2008, between 11:30 AM and 2:30 PM, during the inspection of the medication carts the following multi-dose medication vials and/or bottles were not initialed or dated when first opened:	F 425		

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F 425	Continued From page 34 4th floor Unit Xalatan Ophthalmic drops vial Lidocaine 1% vial 20 ml Heparin 5,000 unit vial 10 ml Heparin 5, 000 unit vial 20 ml x 3 Miacalcin 30 dose vial 3.7 ml x 2 5th Floor Unit Heparin 5,000 unit vial 10 ml Morphine Sulfate Concentrate 20mg/ml Solution (30 ml) x 2. Written on the outside of the package was "Discard after 90 days after opening." 6th Floor Unit Amoxicillin suspension 250mg/ml 150 ml. Written on the outside of the package was "Discard 14 days after opening." During a face-to-face interview conducted at the time of the observations, Employees #1, 4 and 5 acknowledged that the vials and/or bottles listed above were not dated and initialed at the time of the observation. 2. Facility staff failed to document the administration of a controlled substance on the May 2008 Medication Administration Record (MAR) for Resident JH4. A review of Resident JH4's record revealed a physician's order dated May 24, 2008 that directed, "Oxycodone w/APAP 5-325mg tablet, 1 tab by mouth every 6 hours as needed for breakthrough pain." The May 2008 Medication Administration Record was reviewed and indicated that Oxycodone	F 425	**#1** 1. All undated multi medication vials and/or bottles have been discarded. A completed audit of all multi-dose vials on all units revealed no other deficiencies. **#2** Daily, the licensed nurses and night supervisor will check all medication carts and medication refrigerators to ensure that vials/bottles are dated and initialed. **#3** An audit tool has been implemented to track and monitor compliance. Staff will be reeducated on the policy relating to labeling and initialing multi dose vials. **#4** An analysis of the audits will be presented on a monthly basis to the QI Committee. The Unit Manager and Director of Nursing will monitor monthly. **#1** 2. Concerning MAR for Resident JH4, the licensed nurses have been reeducated. **#2** In the future, all licensed nurses will sign the MAR when controlled substances are administered.	May 29, 2008 June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing June 26, 2008 June 26, 2008 & ongoing

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F 425	Continued From page 35 w/APAP was administered on May 10,11,16, 24 and 25 as evidenced by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated that the Oxycodone w/APAP was administered on May 10,11,12,14,16, 24, 25 and 26, 2008. There was no evidence on the May 2008 MAR that the Oxycodone w/APAP 5-325mg was administered on May 12, 14 and 26, 2008. A face-to-face interview was conducted with Employee #5 on May 30, 2008 at approximately 3:45 PM. He/she acknowledged that the MAR did not indicate that the Oxycodone w/APAP was administered to Resident JH4 on May 12, 14 and 26. The record was reviewed on May 30, 2008.	F 425	Continued From page 35 **#3** An audit toll has been developed and implemented to verify staff is correctly documenting the administration of a controlled substance. All staff have been reeducated on medication administration which includes, signing the MAR when medications are administered. **#4** The Unit Managers, Q.I. Director and Director of Nursing will monitor weekly and report to the Q.I. Committee.	July 14, 2008 & ongoing July 14, 2008 & ongoing
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 by: Based on record review and staff interview for two (2) of 24 sampled residents, it was determined that facility staff failed to follow up on the pharmacist's recommendations in a timely manner for one (1) resident and recommend a	F 428		

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F 428	Continued From page 36 dose reduction for one (1) resident on Seroquel for six (6) months. Residents #11 and 14. The findings include: 1. Facility staff failed to follow up on the pharmacist's recommendations in a timely manner for Resident #11. A review of Resident #11's record revealed two (2) pharmacist's consultation reports signed by the pharmacist on January 28 and February 8, 2008 which included, "[Resident] has taken an antidepressant, Lexapro since 7/06 ... Recommend: Please consider clarifying [Resident #11] antidepressant history including the specific indication for starting therapy, the outcome(s) of previous attempts at close reduction or withdrawal and the potential duration of current therapy." Both of the aforementioned pharmacist consultation reports were signed by the nurse practitioner on February 19, 2008,19 days after the initial consult report, and included "Psychiatry F/U (follow up) ..." There were nurse practitioner progress notes in the record dated February 2 and 16, 2008. A nurse practitioner's order dated February 19, 2008 at 3:00 PM directed, "...Psychiatry F/U for eval of dose reduction of Lexapro received by pharmacist consultant" . A psychiatrist consultation dated March 19, 2008, 29 days after the order. The consult included, "...Reason for consult/Follow-Up regarding Med Review - Patient has been on Lexapro & Aricept for Depression & Dementia to which he/she	F 428	**#1** The Nurse Practitioner and Unit Manager were reeducated on the need to follow-up on pharmacist's recommendation in a timely manner. **#2** An audit will be conducted on pharmacy recommendations to follow-up any outstanding recommendations. **#3** Licensed staff were reeducated on following-up on pharmacist's recommendations in a timely manner. In addition, a new Psychiatrist is in the process of being credentialed and will be added to the medical staff. The Director of Nursing will conduct monthly audits to verify that pharmacy recommendations are not only addressed by the Attending Physician, but that any consultations required are done expeditiously. **#4** The Director of Nursing will report findings from the audit to Q.I. Committee monthly for 90 days.	July 12, 2008 July 15, 2008 July 14, 2008 July 14, 2008 & ongoing

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F 428	Continued From page 37 continues to respond fine ... Recommendation/Tx Plan (1) Decrease Lexapro to 10 mg PO (by mouth) daily for depression x 12 weeks then 10 mg PO every other day x 2 weeks then 10 mg PO twice weekly x 2 weeks then STOP ..." A face-to-face interview was conducted with Employee #1 on May 28, 2008 at 12:00 PM. He/she acknowledged that the pharmacist's recommendations were not followed up timely. The record was reviewed on May 28, 2008. 2. The pharmacist failed to recommend a dose reduction for Seroquel for Resident #14. A review or Resident #14's record revealed the following psychiatrist' s orders: October 10, 2007: " Increase Seroquel 75 mg po bid (orally twice a day) for agitated behavior." May 21, 2008: " Increase Seroquel 100 mg po bid for agitated behavior." The pharmacist reviewed the drug regimen on the following dates: November 8, 2007 December 4, 2007 January 5, 2008 February 7, 2008 March 10, 2008 April 26, 2008 May 23, 2008 There was no evidence that the pharmacist recommended an attempted dose reduction of Seroquel on the aforementioned dates. A face-to-face interview with Employee #5 was conducted on May 29, 2008 at 1:00 PM. He/she acknowledged that there was no evidence that	F 428	**#1** 2. The Medical Director has reeducated the pharmacist consultant on the need to recommend gradual drug reduction on residents receiving antipsychotic medication. **#2** Drug regimen review will be performed on all patients on antipsychotic medications to assess for appropriate gradual dose reduction using the GDR tracker in the Omnicare system. **#3** All residents on antipsychotic medication will be monitored monthly during drug regimen review and GDR will be recommended when clinically stable. All residents on antipsychotics will receive a Gradual dose reduction if not clinically contraindicated. **#4** Medical Director will do a monthly audit on residents receiving antipsychotic medication. The results from the monthly monitoring tool will be presented at the quarterly Pharmacy meeting and presented to the Q.I. Committee.	June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing

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F 428	Continued From page 38 the pharmacist recommended an attempted dose reduction for Seroquel. The record was reviewed May 29, 2008.	F 428		
F 431 SS=E	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.	F 431		

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F 431	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for three (3) of four (4) medication refrigerator, it was determined that facility staff failed to store drugs and biologicals under proper temperature controls. The findings include: The facility's policy 5.3 "Storage and Expiration Dating of Drugs, Biological Syringes and Needles " stipulates, (8.) " Drugs and biological are stored at their appropriate temperatures. (8.2) Refrigeration: 36 - 46° Fahrenheit (F) or 2 - 8° Celsius." On May 29, 2008, between 4:00 PM and 5:00 PM, the medication refrigerators were inspected. . The thermometer in the medication refrigerator on the 5th floor measured 47 F. The thermometer used by the surveyor measured 57° F. The thermometer in the medication refrigerator on the 6th floor measured 32° F, and the thermometer used by the surveyor measured 59.4° F. A face-to-face interview was conducted after each observation with Employees #17 and 18 on the 5th floor and Employees #5 and 17 on the 6th floor. They acknowledged that the refrigerator temperatures were out of range.	F 431	**#1** The refrigerators on the 4th, 5th & 6th floors will be replaced for proper and required temperature. **#2** The Unit Secretaries/Unit Managers will check temperatures in the refrigerators on a daily basis, to verify temperatures are in compliance. **#3** Licensed staff will be reeducated on the normal temperatures for refrigerators storing drugs and biologicals. They will also be educated on the protocol in the event that the refrigerator is out of range to contact Maintenance immediately. **#4** Daily findings will be reported to the Q.I. Committee monthly and the Director of Nursing will monitor.	July 14, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing
F 456 SS=E	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care	F 456		

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F 456	Continued From page 40 equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour conducted on May 27, 2008 from 10:40 AM through 3:30 PM and random observations conducted throughout the survey period, it was determined that facility staff failed to maintain valves that effected water temperatures as evidenced by fluctuating water temperatures in residents' rooms. These observations were made in the presence of Employees #10, 11 and 12. The findings include: Temperatures were measured at the sinks [in resident rooms] in degrees Fahrenheit (F) as follows: Room 4110 May 27, 2008 at 11:00 AM -118 F May 27, 2008 at 2:00 PM - 95 F May 28, 2008 at 9:00 AM - 69.7 F May 29, 2008 at 9:45 AM -105 F Room 4115 May 27, 2008 at 11:00 AM - 71.6 F May 27, 2008 at 2:00 PM - 105 F May 28, 2008 at 9:00 AM - 68.4 F May 29, 2008 at 9:45 AM - 70.4F Room 4129 May 27, 2008 at 11:00 AM - 74.2 F May 27, 2008 at 2:00 PM - 102 F May 28, 2008 at 9:00 AM - 69.1 F May 29, 2008 at 9:45 AM - 95.3 F	F 456	**#1** The fluctuating water temperature in rooms 4110, 4115, 4129, 4138, 4149, 6130, 6139, 6145, and 6147 has been corrected. The system was repaired on June 6th 2008 with a new check valve and ball valve. The repair immediately improved the water temperature for all resident rooms. With the improvement to the water temperatures some faucets in several rooms require three to five minutes before obtaining 95 degrees or better. **#2** The hot water will continue to be worked on to sustain a threshold of 95 degrees. To identify residents that may have fluctuating hot water, we will do daily checks of the hot water for two months, followed by weekly checks thereafter. The hot water system will be re-evaluated and repaired to eliminate cold water in the hot water system. Weekly temperatures will be monitored on a continuing basis. **#3** The engineering supervisor will conduct (commenced on June 3, 2008) weekly rounds and the out come will be reported at the Q.I. Committee Meetings, using Q.I. tool.	June 6, 2008 June 6, 2008 & ongoing June 3, 2008 & ongoing

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F 456	Continued From page 41 Room 4138 May 27, 2008 at 11:00 AM - 67.7 F May 27, 2008 at 2:00 PM - 95 F May 28, 2008 at 9:00 AM - 81.8 F May 29, 2008 at 9:45 AM - 70.3 F Room 4149 May 27, 2008 at 11:00 AM - 112.2 F May 27, 2008 at 2:00 PM - 108 F May 28, 2008 at 9:00 AM - 77.5 F May 29, 2008 at 9:45 AM - 69.2 F The 5th floor had no fluctuating water temperatures at the time of survey. Room 6130: May 27, 2008 at 10:00 AM -107.3 F May 27, 2008 at 2:00 PM - 111 F May 28, 2008 at 9:30 AM - 70.1 F May 29, 2008 at 11:30 Am - 88.2 F Room 6139 May 27, 2008 at 10:00 AM -66.7 F May 27, 2008 at 2:00 PM - 97.0 F May 28, 2008 at 9:30 AM - 105.6 F May 29, 2008 at 11:30 AM - 69.6 F Room 6145 May 27, 2008 at 10:00 AM -67.4 F May 27, 2008 at 2:00 PM - 104 F May 28, 2008 at 9:30 AM - 112.1 F May 29, 2008 at 11:30 AM - 87.3 F Room 6147 May 27, 2008 at 10:00 AM - 68.0F May 27, 2008 at 2:00 PM - 109 F May 28, 2008 at 9:30 AM - 112.2 F May 29, 2008 at 11:30 AM - 82.0 F	F 456	**#4** To ensure that our action plan is effective, we will monitor the daily checks for two months ongoing and monitor weekly thereafter. If the Facility Director and Administrator determines that there is a need for further corrective actions based on the analysis of our monitoring, we will modify our plan with notification to the Department of Health. The Engineering Supervisor, the Administrator and the Facility Director will continue to monitor daily for two months and weekly thereafter.	July 14, 2008 & ongoing

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F 456	Continued From page 42 A review of maintenance water temperature logs revealed that hot water temperatures were recorded on the following dates on the 4th, 5th, and 6th floors: 4th Floor January 14, 2008 - 10 rooms had water temperatures between 56 F and 90 F. February 22, 2008 - 25 rooms had temperatures between 50.3 F and 77.3 F. May 13, 2008 - 14 rooms had temperatures between 66.3 F and 93.2 F. 5th Floor January 14, 2008 - Six (6) rooms had temperatures between 55 F and 70 F. February 1, 2008 - 12 rooms had temperatures between 68 F and 94 F. February 22, 2008 - 19 rooms had temperatures between 57.2 F and 91.2 F. March 7, 2008 - Three (3) rooms had temperatures between 51 F and 66 F. March 21, 2008 - All rooms were between 95 F and 110 F. May 15, 2008 - 10 rooms had temperatures between 69.3 F and 94.6 F. 6th floor January 14, 2008 - Five (5) rooms had temperatures between 60 F and 89 F. February 1, 2008 - All rooms were between 95 F and 110 F. February 22, 2008 - Seven (7) rooms had temperatures between 49 F and 65 F. March 7, 2008 - Two (2) rooms had temperatures of 62 F and 78 F. March 14, 2008 - All rooms were between 95 F and 110 F. March 21, 2008 - Nine (9) rooms had temperatures between 87 F and 94 F.	F 456		

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F 456	Continued From page 43 March 28, 2008 -10 rooms had temperatures between 58 F and 94 F. May 15, 2008 - 12 rooms had temperatures between 64.3 F and 93.6 F. A face-to-face interview was conducted with Employee #10 on May 28, 2008 at 5:00 PM. Employee #10 stated, "This is an old building and we have had problems with hot water temperatures for years. The hot water temperature is not predictable. From day-to-day, even hour-to-hour, the temperature of the hot water in any one room fluctuates. At first, the plumber thought that the shower valves needed to be replaced because the valve interfered with hot water temperatures. We replaced several shower valves (10) from January (2008) right up through last month (April 2008) based on the evaluation of the plumber from November (2007). That did not solve the problem. We called the plumber again and he will be here tomorrow (May 29, 2008)." A follow-up interview was conducted with Employee #10 on May 29, 2008 at 4:45 PM. He/she stated, "The plumber suggested replacing the check valve, gate valve and gasket. Then he will test the hot water circulating pump. That may or may not work. Since we have to shut off the water for about 2 hours, we will schedule the work for early Tuesday (June 3, 2008) morning. If that doesn't work, then the plumber will have to trace the water lines throughout the whole building."	F 456		
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with	F 492		

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F 492	Continued From page 44 accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined that facility staff failed to maintain hot foods above 140 degrees Fahrenheit (F) and cold food below 45 F at the point of service to residents. The findings include: According to 22DCMR 3220.2, "The temperature for cold foods shall not exceed forty-five degrees Fahrenheit and for hot foods shall be above one hundred and forty degrees Fahrenheit at the point of delivery to the resident." A test tray left the kitchen at 1:10 PM and arrived on the unit at 1:12 PM. All residents were served and eating or being assisted with their meal at 1:30 PM. The following food temperatures were measured at 1:30 PM in the presence of Employee #20: Chicken breast - 127 F Pureed liver - 143 F Chopped liver - 126.6 F Liver - 119.3 F 2% Milk - 46.9 F Chocolate pudding - 49.8 F Employee #20 acknowledged the findings at the time of the observations.	F 492	**#1** Food temperatures will be checked and food trays will be distributed to residents as soon as food carts are delivered to the units. **#2** To identify residents that may be affected, test trays will continue to be done on a weekly basis. **#3** The process of tray set up from tray-line to delivery truck to resident floors will be monitored daily. Staff was in serviced on proper procedures to get meals out in a timely manner #4 Food Service Manager, supervisors, clinical dietitians will conduct daily test trays for one month to monitor temperatures. Findings will be reported in monthly QI meetings. The Food Service Manager and Director, Q.I. Director, and Administrator will monitor for compliance.	June 26 2008 & ongoing June 26, 2008 & ongoing July 14, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS	F 514		

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	095027	A. BUILDING _____ B. WING _____	05/30/2008

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F 514	Continued From page 45 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 observation, record review and staff interview for two (2) of 24 sampled residents, it was determined that nursing staff failed to sign the Medication Administration Record [MAR] after administering medication to one (1) resident and failed to document that the physician was notified regarding a stool specimen that was not collected for one (1) resident in isolation. Residents #5 and 21. The findings include: 1. On May 28, 2008, at approximately 9:00 AM, during the observation of the medication pass, Employee #14 administered medications to Resident #5. After he/she administered medications, the nurse prepared medications for the next resident. At that time, the surveyor approached the nurse regarding the signing of the MAR for the previous resident. A face-to-face interview was conducted at that time. He/she acknowledged that the MAR was	F 514	**#1** The staff was reeducated on the protocol for proper medication administration and documentation. **#2** An MAR audit was conducted by each Unit Manager to identify any unsigned MAR and we will continue daily audits. **#3** We have put a system in place for the Unit Managers and Director of Nursing to conduct random audits during Med Pass, to ensure staff are signing the MARs after administrating medication. All licensed staff were reeducated on the protocol for proper medication administration and documentation. **#4** The results of the audits will be reported to the Q.I. Committee. The Director of Nursing and Q.I. Director will continue to monitor.	June 26, 2008 June 26, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing

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F 514	Continued From page 46 not signed after the administration of medications for Resident #5. 2. Facility staff failed to document that the physician was notified regarding a stool sample that was not obtained from Resident #21 for five (5) days. Resident #21 was admitted on May 15, 2008 with a diagnosis of Clostridium Difficile (C-diff). The resident was in contact isolation. A review of Resident #21's record revealed a physician's order dated May 20, 2008 at 9:00 AM and signed by the physician on May 21, 2008 that directed, "Stool for c-diff (x1). Diagnosis: history of positive stool for c-diff." According to the nurses' notes: May 21, 2008 at 11:30 PM: "...Stool for c-diff continues not obtained due to resident's lack of bowel movement ..." May 23, 2008 at 11:15 PM: " ...No bowel movement noted today ..." May 24, 2008 at 3:00 PM: "Unable to collect stool at this time as resident did not pass any stool..." May 24, 2008 at 10:00 PM: "No stool collected as resident did not pass any stool ..." May 25, 2008 at (no time noted): "Specimen of stool obtained and submitted to lab for testing ..." According to the physician' s orders: May 22, 2008 at 1:00 PM: " Senokot - S two (2) tabs via G-tube (gastrostomy tube) daily for constipation." May 24, 2008 at 8:30 AM, " Lactulose 60 ml via G-tube daily x 2 days then 45 ml via GT daily for constipation ..."	F 514	**#1** 2. The Physician has been notified of inability to collect stool culture and notification has been documented. **#2** Residents charts have been reviewed, to identify residents whose charts may lack documentation for notification of physician, if stool sample cannot be obtained. **#3** We will put a system in place for chart audits to be done by Unit Managers, Director of Nursing, and Q.I. Director, to ensure that physician notifications are documented. **#4** The Unit Managers, Q.I. Director and Director of Nursing will conduct random audits and report findings to Q.I. Committee on a monthly basis. The Director of Nursing and the Medical Director will monitor monthly.	May 30, 2008 July 14, 2008 July 14, 2008 July 14, 2008 & ongoing

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F 514	Continued From page 47 There was no documented evidence that facility staff notified the physician of the stool sample not being collected. A face-to-face interview was conducted on May 29, 2008 at 1:00 PM with Employee #1. He/she acknowledged that there was no documented evidence that facility staff notified the physician that a stool sample had not been collected. The record was reviewed on May 29, 2008.	F 514		
F 520 SS=C	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		

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F 520	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, it was determined that the facility failed to develop and implement an plan of action to correct fluctuating water temperatures. The findings include: Temperatures were measured in degrees Fahrenheit (F) as follows: Room 4110 May 27, 2008 at 11:00 AM -118 F May 27, 2008 at 2:00 PM - 95 F May 28, 2008 at 9:00 AM - 69.7 F May 29, 2008 at 9:45 AM -105 F Room 4115 May 27, 2008 at 11:00 AM - 71.6 F May 27, 2008 at 2:00 PM - 105 F May 28, 2008 at 9:00 AM - 68.4 F May 29, 2008 at 9:45 AM - 70.4F Room 4129 May 27, 2008 at 11:00 AM - 74.2 F May 27, 2008 at 2:00 PM - 102 F May 28, 2008 at 9:00 AM - 69.1 F May 29, 2008 at 9:45 AM - 95.3 F Room 4138 May 27, 2008 at 11:00 AM - 67.7 F May 27, 2008 at 2:00 PM - 95 F May 28, 2008 at 9:00 AM - 81.8 F May 29, 2008 at 9:45 AM - 70.3 F Room 4149 May 27, 2008 at 11:00 AM - 112.2 F May 27, 2008 at 2:00 PM - 108 F May 28, 2008 at 9:00 AM - 77.5 F	F 520	**#1** The fluctuating water temperature in rooms 4110, 4115, 4129, 4138, 4149, 6130, 6139, 6145, and 6147 has been corrected. The system was repaired on June 6th 2008 with a new check valve and ball valve. The repair immediately improved the water temperature for all resident rooms. With the improvement to the water temperatures some faucets in several rooms require three to five minutes before obtaining 95 degrees or better. **#2** The hot water will continue to be worked on to sustain a threshold of 95 degrees. To identify residents that may have fluctuating hot water, we will do daily checks of the hot water for two months, followed by weekly checks thereafter. The hot water system will be re-evaluated and repaired to eliminate cold water in the hot water system. Weekly temperatures will be monitored on a continuing basis. **#3** The engineering supervisor will conduct (commenced on June 3, 2008) weekly rounds and the out come will be reported at the Q.I. Committee Meetings, using Q.I. tool.	June 6, 2008 June 16, 2008 & ongoing June 3, 2008 & ongoing

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F 520	Continued From page 49 May 29, 2008 at 9:45 AM - 69.2 F The 5th floor had no fluctuating water temperatures at the time of survey. Room 6130: May 27, 2008 at 10:00 AM -107.3 F May 27, 2008 at 2:00 PM - 111 F May 28, 2008 at 9:30 AM - 70.1 F May 29, 2008 at 11:30 Am - 88.2 F Room 6139 May 27, 2008 at 10:00 AM -66.7 F May 27, 2008 at 2:00 PM - 97.0 F May 28, 2008 at 9:30 AM - 105.6 F May 29, 2008 at 11:30 AM - 69.6 F Room 6145 May 27, 2008 at 10:00 AM -67.4 F May 27, 2008 at 2:00 PM - 104 F May 28, 2008 at 9:30 AM - 112.1 F May 29, 2008 at 11:30 AM - 87.3 F Room 6147 May 27, 2008 at 10:00 AM - 68.0F May 27, 2008 at 2:00 PM - 109 F May 28, 2008 at 9:30 AM - 112.2 F May 29, 2008 at 11:30 AM - 82.0 F A review of maintenance water temperature logs revealed that hot water temperatures were recorded on the following dates on the 4th, 5th, and 6th floors: 4th Floor January 14, 2008 - 10 rooms had water temperatures between 56 F and 90 F. February 22, 2008 - 25 rooms had temperatures between 50.3 F and 77.3 F. May 13, 2008 - 14 rooms had temperatures	F 520	**#4** To ensure that our action plan is effective, we will monitor the daily checks for two months ongoing and monitor weekly thereafter. If the Facility Diretor and Administrator determines that there is a need for further corrective actions based on the analysis of our monitoring, we will modify our plan with notification to the Department of Health. The Engineering Supervisor, the Administrator and the Facility Director will continue to monitor daily for two months and weekly thereafter.	July 14, 2008 & ongoing

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F 520	Continued From page 50 between 66.3 F and 93.2 F. 5th Floor January 14, 2008 - Six (6) rooms had temperatures between 55 F and 70 F. February 1, 2008 - 12 rooms had temperatures between 68 F and 94 F. February 22, 2008 - 19 rooms had temperatures between 57.2 F and 91.2 F. March 7, 2008 - Three (3) rooms had temperatures between 51 F and 66 F. March 21, 2008 - All rooms were between 95 F and 110 F. May 15, 2008 - 10 rooms had temperatures between 69.3 F and 94.6 F. 6th floor January 14, 2008 - Five (5) rooms had temperatures between 60 F and 89 F. February 1, 2008 - All rooms were between 95 F and 110 F. February 22, 2008 - Seven (7) rooms had temperatures between 49 F and 65 F. March 7, 2008 - Two (2) rooms had temperatures of 62 F and 78 F. March 14, 2008 - All rooms were between 95 F and 110 F. March 21, 2008 - Nine (9) rooms had temperatures between 87 F and 94 F. March 28, 2008 -10 rooms had temperatures between 58 F and 94 F. May 15, 2008 - 12 rooms had temperatures between 64.3 F and 93.6 F. A face-to-face interview was conducted on May 28, 2008 at 5:00 PM with Employee #10. He/she #10 stated, "This is an old building and we have had problems with hot water temperatures for years. The hot water temperature is not	F 520		

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F 520	Continued From page 51 predictable. From day-to-day, even hour-to-hour, the temperature of the hot water in any one room fluctuates. At first, the plumber thought that the shower valves in the rooms needed to be replaced because the valve interfered with hot water temperatures. We replaced several shower valves (10) from January (2008) right up through last month (April 2008) based on the evaluation of the plumber from November (2007). That did not solve the problem. We called the plumber again and he will be here tomorrow (May 29, 2008)." A follow-up interview was conducted with Employee #10 on May 29, 2008 at 4:45 PM. He/she stated, "The plumber suggested replacing the check valve, gate valve and gasket. Then he will test the hot water circulating pump. That may or may not work. Since we have to shut off the water for about 2 hours, we will schedule the work for early Tuesday (June 3, 2008) morning. If that doesn't work, then the plumber will have to trace the water lines throughout the whole building." A face-to-face interview was conducted with Employee #7 on May 29, 2008 at 4:00 PM. He/she was asked if there was a plan of action developed to correct the fluctuating water temperatures. Employee #7 stated, " We discuss the issue of fluctuating water temperatures daily in our morning stand-up meeting. We have implemented the use of wipes warmed with the conventional warmer back in January (2008). We have continued with that same plan. We met with the governing board in March (2008) to discuss the water temperatures. We haven't heard from the board since." Although the facility replaced valves in eight (8)	F 520		

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F 520	Continued From page 52 rooms on floors 4, 5 and 6, water temperatures continued to fluctuate. There was no evidence that facility staff initiated additional approaches to correct the fluctuating water temperatures throughout the building after January 2008.	F 520		