STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096026	A. BUILDING _____ B. WING _____	04/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted April 14 though April 15, 2008. The following deficiencies were based on record review, observations and interviews with staff and residents. The sample included 11 residents based on a census of 44 residents on the first day of survey and three (3) supplemental residents.	F 000	This plan of correction is prepared and/or executed solely because it is required by the Provisions of Federal and State law. The plan of correction is the facility's credible Allegation of Compliance.	
F 164 SS=D	483.10(e), 483.75(l) (4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e) (3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	It is this facility's policy to ensure that its staff provides privacy for the residents during care and treatment. (1) The RN #12 was counseled on pulling the privacy curtain all the way to provide the resident with privacy during treatments as well as draping the resident during wound care treatment on April 15, 2008 (2) Random rounds were conducted and no other privacy issues were detected (3) The Director of Nursing or Designee will inservice the Nursing staff on fully closing the privacy curtain during care and treatment and covering the resident from at least shoulders to knees, thereby only exposing the area being treated by May 7, 2008. The Director of Nursing or Designee will monitor care and treatment to ensure that privacy is maintained during care weekly X 4, then monthly X 3 and then quarterly. (4) The result of monitoring will be presented to Quality Assurance Committee for further recommendations	04/15/08 05/12/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara O'Gastino, LNHA — TITLE: Administrator — (X6) DATE: 5/7/08

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 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for one (1) of one (1) pressure sore treatment, it was determined that facility staff failed to provide privacy for Resident A1 during a wound care treatment.. The findings include: Resident A1 was observed in bed, during a wound care treatment to a Stage II pressure ulcer on the left buttocks on April 14, 2008, at approximately 3:15 PM. The resident's room mate was not in the room. The door was closed. The privacy curtain was not fully drawn to enclose the resident. The resident's gown was adjusted to drape only the shoulders and chest areas. The resident lay on the right shoulder during the treatment, facing the window- with back towards the entry door. At the end of the treatment, the resident's position was changed to the prone position further exposing her undraped abdomen and pelvic areas. The resident's abdomen, pelvic and lower extremities were exposed through out the treatment. A review of the resident's record revealed a physician's telephone order dated April 14, 2008 directing "Bacitracin ointment to Stage II ulcer." Facility staff failed to prevent unnecessary exposure of body parts during the provision of wound care treatment to Resident A1. A face-to-face interview was conducted with Employee #12 on April 15, 2008 at approximately 2:45 AM. He/she acknowledged that the privacy	F 164		

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F 164	Continued From page 2 curtain was not completely drawn to enclose the resident, and that the resident was not draped during the wound care treatment, to expose only the area receiving the treatment. The record was reviewed on April 15, 2008.	F 164	It is the facility's practice to ensure that Hospice and facility care plans are integrated and allergies are care planned.	
F 279 SS=D	483.20(d), 483.20(k) (1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b) (4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for two (2) of 11 sampled residents, it was determined that facility staff failed to initiate an integrated care plan for Hospice care for two (2) residents and allergies for one (1) resident. Residents #7 and 9.	F 279	(1) A. Integrated Care Plans on Hospice care were initiated on 4/17/09 for resident #7 and Resident #9 to address specific goals and appropriate approaches to coordinate care between Hospice and the facility staff. (1) B. A care plan was developed on 4/16/08 for resident #7 with goals and approaches to address allergies. (2) A. Integrated care plans have been developed for all residents on Hospice care on 4/17/08 with specific goals and approaches to coordinate care between Hospice and the facility staff. (2) B. Care plans with goals and approaches to address allergies will be developed for all residents with allergies by May 6, 2008. (3) A. Licensed Nurses will be inserviced on documentation of care plans, residents' needs, and coordination of service between Hospice and the facility by May 7, 2008. The MDS Coordinator will audit all Hospice charts on a monthly basis for the next six months and quarterly thereafter with the IDT team to ensure compliance. (3) B. Licensed Nurses will be inserviced by May 7, 2008 on how to develop and update care plans with goals and approaches to address residents' allergies. The MDS Coordinator will conduct a random chart audit on a monthly basis for the next four months and quarterly thereafter with the IDT team to ensure compliance.	04/17/08 04/16/08 04/17/08 05/06/08 05/12/08 05/12/08

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F 279	Continued From page 3 The findings include: 1. Facility staff failed to initiate an integrated care plan for Hospice care and allergies for Resident #7. A. Facility staff failed to initiate an integrated care plan for Hospice care for Resident #7. A physician's order dated April 2, 2008, directed, "Hospice care through [company] Hospice [original order dated January 25, 2008]." A review of the resident's care plan revealed a problem, "Resident has terminal condition" initiated January 31, 2008 revealed, "...Coordinate care with Hospice and keep family well informed of resident's condition..." There was no evidence in the record that the facility had developed a care plan, with specific goals and approaches that coordinated care between the Hospice agency and facility staff. A face-to-face interview was conducted on April 15, 2008 at 9:00 AM with Employee #8. He/she acknowledged that there was no integrated care plan for hospice care for Resident #7. The record was reviewed on April 15, 2008. B. Facility staff failed to develop a care plan with goals and approaches to address Resident #7's allergies. A review of April 2008 Physician's Order Form, signed by the physician on April 2, 2008 revealed, "Allergies: (Pen-Vee K/Veetids) Penicillin V Potassium, Bacitracin, Epinephrine, Laxative [and Cathartics]"	F 279	(4) The result of the audits will be presented to the Quality Assurance Committee for further recommendations.	

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F 279	Continued From page 4 The resident's care plan, last reviewed January 31, 2008, lacked evidence that a care plan with goals and approaches was developed to address the resident's allergies. A face-to-face interview was conducted on April 15, 2008 at 9:00 AM with Employee # 8. He/she acknowledged that there was no care plan for allergies for Resident #7. The record was reviewed on April 15, 2008. 2. Facility staff failed to initiate an integrated care plan Hospice care for Resident #9. A review of Resident #9's record revealed a physician's telephone order dated December 25, 2008 and signed by the physician on December 29, 2007, directed, "Begin routine Hospice care here at (facility name). Please notify (Hospice agency) of any changes. Hospice nurse may use/write Hospice standing orders." A review of the resident's care plan revealed a problem, "Resident has terminal care" which was initiated December 26, 2007 and updated March 13, 2008. An approach included, "Coordinate care with Hospice and keep family well informed of resident's condition." There was no evidence in the record that the facility had developed a care plan, with specific goals and approaches that coordinated care between the Hospice agency and facility staff. A face-to-face interview was conducted on April 15, 2008 at 11:00 AM with Employee #7. He/she stated, "The Hospice nurse comes about twice a month. We ask them if anything is going on with	F 279		

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F 279	Continued From page 5 the resident and the Hospice nurse asks us the same thing." A review of the nurses' notes from December 25, 2007 thorough April 15, 2008 revealed that there were no entries documenting that facility staff and the Hospice nurse discussed the resident's needs. The record was reviewed April 15, 2008.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of three (3) supplemental residents, it was determined that facility staff failed to ensure that an expired medication was discarded and not administered to Resident JH2. The findings include: On April 14, 2008, at approximately 2:00 PM, during the inspection of the controlled substances on medication cart #2, it was observed that Lorazepam 0.5 mg tablets for Resident JH2 had an expiration date of January 19, 2008. The "Controlled Drug Record" form dated February 7, 2007 documented that Resident JH2 received one (1) tablet of Lorazepam 0.5 mg on February 13 and 14, 2008.	F 309	It is the facility's practice to ensure that expired medications are not administered to residents and are properly discarded. (1) The Medication Nurse # 3 was counseled about the proper management of the medication cart, which includes frequent auditing and monitoring of the cart for expired drugs. The Lorazepam was immediately discarded. (2) All medication carts were audited on April 16, 2008 and no other expired medications were found. (3) Licensed staff will be inserviced by May 12, 2008 on proper management of medication carts to include auditing and monitoring for expired medications. The Assistant Director of Nursing or Designee will conduct a random audit of the medication carts for expired medications weekly X 4 then monthly thereafter. (4) The results of the audit will be presented to the Quality Assurance Committee for recommendations.	04/16/08 04/16/08 05/12/08

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F 309	Continued From page 6 On the March 2008 Physician Order Sheet dated February 2, 2007, the physician wrote "Lorazepam 0.5 mg one tablet po (by mouth) every 8 hours as needed for anxiety." A face-to-face interview was conducted at the time of the observation with Employee #3. He/she acknowledged that the Lorazepam was expired and administered after the expiration date. The record was reviewed April 14, 2008.	F 309		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour, it was determined that facility staff failed to maintain a hazard free environment as evidenced by: a damaged electrical and cable box and phone jack, missing night light cover, extension cord in one (1) resident's room and missing or loose over bed light covers. These observations were made in the presence of Employees #1, 2, 3, and 4 on April 14, 2008 from 1:00 PM through 3:45 PM. The findings include: 1. The cover to the electrical box by the resident's dresser was damaged and wires were exposed in room 7 in one (1) of 12 rooms observed.	F 323	It is the facility's practice to maintain a hazard free environment. (1) A. The cover to the electrical box by the resident's dresser has been replaced.	04/16/08

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F 323	Continued From page 7 2. The cable box was not securely attached to the wall in room 7 in one (1) of 12 rooms observed. 3. The phone jack was pulled out from the wall in room 21 in one (1) of 12 rooms observed. 4. An extension cord was observed in room 15 in one (1) of 12 rooms observed. 5. The night light cover was observed missing in room 26 in one (1) of 12 rooms observed. 6. The overbed upper light cover was missing in rooms 19 and 21 in two (2) of 12 rooms observed. 7. The overbed upper light cover was not secure in the frame in room 10 in one (1) of 12 rooms observed. Employees #1, 2, 3, and 4 acknowledged these findings at the time of the observations.	F 323	(1) B. The cable box has been securely attached to the wall in room 7. (1) C. The phone jack has been secured to the wall in room 21. (1) D. The extension cord in room 15 has been removed. (1) E. The night light cover in room 26 has been replaced. (1) F. The overbed upper light covers have been replaced in rooms 19 and 21. (1) G. The overbed upper light cover has been secured in the frame in room 10. (2) Rounds were conducted throughout the facility on May 8, 2008 and all above items were fixed. No further items of this type were found during the rounds. (3). The engineers will conduct weekly rounds X 4, then monthly thereafter and check all electrical boxes, cable boxes, phone jacks, night light covers and overbed upper light covers. They will also assure that there are not any extension cords in use. All engineer staff will be inserviced on the above items to observe and correct during rounds. The Chief Engineer or Designee will monitor the above on a monthly basis. (4). The results of the weekly and monthly rounds will be presented to the Quality Assurance Committee for recommendations.	04/16/08 04/16/08 04/16/08 04/16/08 04/16/08 04/16/08 05/08/08 05/12/08
F 371 SS=F	483.35(i) (2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review during the dietary tour, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by: soiled floors, baseboards, hand	F 371		

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F 371	Continued From page 8 washing sinks, appliances, and staff rest rooms. These observations were conducted in the presence of Employees #5 and 6 on April 14, 2008 from 8:40 AM through 11:45 AM. The findings include: The following items were observed soiled with accumulated grease and debris: 1. Floors throughout the main kitchen. 2. Baseboards throughout the main kitchen. 3. The exterior surfaces of three (3) of three (3) handwashing sinks. 4. The interior and exterior surfaces of one (1) of one (1) deep fryer and two (2) of four (4) deep fryer baskets. 5. Four (4) of 10 cooking hoods. 6. The exterior surface of one (1) of one (1) meat slicer. 7. The exterior surface of one (1) of one (1) blender. 8. The exterior surface of one (1) of one (1) mixer. 9. The interior surface of one (1) of one (1) drain by the salad preparation area. 10. The exterior surfaces of two (2) of two (2) convection ovens. 11. The exterior surface of one (1) of one (1)	F 371	It is the facility's practice to store, distribute and serve food under sanitary conditions. (1) A. Floors throughout the main kitchen were scrubbed end-to-end and mopped. (1) B. Baseboards throughout the main kitchen were cleaned. (1) C. The exterior surfaces of all handwashing sinks been cleaned. (1) D. The interior and exterior surfaces of the deep fryers and baskets have been cleaned. (1) E. All cooking hoods have been scheduled for cleaning with Industrial Cleaning Company. (1) F. The exterior surface of the meat slicer has been cleaned. (1) G. The exterior surface of the blender has been cleaned. (1) H. The exterior surface of the mixer has been cleaned. (1) I. The interior surface of the drain by the salad preparation area has been cleaned. (1) J. The exterior surface of the convection ovens has been cleaned. (1) K. The exterior surface of the knife holder has been cleaned. (2) Rounds were conducted throughout the kitchen and all above items have been addressed. No further items of this type were found during the rounds.	05/03/08 05/03/08 05/03/08 05/03/08 05/09/08 05/03/08 05/03/08 05/03/08 05/03/08 05/03/08 05/08/08

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F 371	Continued From page 9 knife holder. Employees #5 and 6 acknowledged these findings at the time of the observations.	F 371	(3) The Director of Dining Services or Designee will inservice the Dining staff on sanitation of equipment and flooring. The Director of Dining Services or Designee will monitor sanitation to ensure that all equipment and flooring is clean weekly X 4, then monthly. (4) The result of the monitoring will be presented to the Quality Assurance Committee for further recommendations.	05/08/08
F 425 SS=D	483.60(a), (b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to date and initial two (2) of two (2) multi-dose medication containers when first opened and remove expired medication from the carts. The findings include: 1. The facility staff failed to initial and date	F 425		

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F 425	Continued From page 10 multi-dose containers when first opened. On April 14, 2008, at approximately 2:30 PM, during the inspection of the medication carts, two (2) open containers of Morphine Sulfate Concentrate 20mg/ml Solution (30 ml) were observed undated and not initialed. On the outside of the container's packaging, was written, "Discard after 90 days after opening." During a face-to-face interview at the time of the observation, Employee #9 acknowledged that the containers listed above were not dated and/or initialed at the time of the observation. 2. Facility staff failed to remove expired medication from the medication cart. On April 14, 2008, at approximately 9:14 AM, during the inspection of the medication cart # 1, a blister pack of Benadryl 25 mg containing 15 capsules had an expiration date of November 1, 2007. On April 14, 2008 at approximately 2:00 PM, during the inspection of the controlled substances on medication cart # 2, a blister pack containing six (6) Lorazepam 0.5 mg had an expiration date of January 19, 2008. Employees #7 and 9 acknowledged that the medication was expired at the time of the observations.	F 425	It is this facility's practice to remove expired medications from the cart and to date and initial multi-dose medication containers when first opened. (1) A. The two (2) open containers of Morphine Sulfate Concentrate 20mg/ml Solution (30 ml) were discarded immediately. (1)B. The blister packs of Benadryl 25 mg and Lorazepam 0.5 mg were discarded immediately. (2) The medications nurses on cart #1 and cart # 2 on duty at the time of inspection were counseled about the proper management of medication carts, which includes audit of the cart for expired medications. The medication carts were audited on April 16, 2008. The audit revealed that there were no other expired medications. (3) The medication nurses will be inserviced on auditing the carts every month for expired medications and to initial and date multi-dose medication when first opened. The Assistant Director of Nursing or Designee will randomly audit the medication carts weekly X 4 then monthly thereafter for expired medications and to ensure that the multi-dose vials are initialed and dated. (4) The result of the audit will be presented to the Quality Assurance Committee for recommendations.	04/16/08 04/16/08 04/16/08 05/12/08
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 11 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for one (1) of 11 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to ensure that medications were labeled correctly for Resident #7 and medications were identified and labeled for	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. BUILDING _____ B. WING _____	04/15/2008

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F 431	Continued From page 12 Resident JH1. The findings include: 1. Facility staff failed to ensure that medications were labeled correctly for Resident #7. The facility's policy titled, " Order and Receipt of Drugs from Non-Contract Suppliers " , stipulated " ...The packaging and labeling of all medications must be in compliance with all state laws and regulations governing drug use in nursing homes. " On April 15, 2008, at approximately 9:00 AM during the medication pass, three (3) of 11 containers were observed improperly labeled. These containers were dispensed from non-contracted pharmacies. The medications were labeled as follows: 1. "Heart Nano Detox, 1.25 teaspoonful mixed with ¼ teaspoonful of Cottage Cheese." The frequency of administration and the route were not indicated. 2. "Liver Nano Detox, 1.25 teaspoonful mixed with ¼ teaspoonful of Cottage Cheese." The frequency of administration and route were not indicated. 3. "Memory Defense, two daily." The amount of medication to be administered and the route were not indicated. During the record review for Resident #7 the physician's orders dated April 2, 2008 directed: "Heart Nano-Detox ¼ teaspoonful po [by mouth]	F 431	It is the facility's practice to ensure that medications are labeled correctly and medications are identified and labeled. (1) A. On 4/16/08, the non-contracted pharmacy supplied labeled containers matching the physician's orders for the Heart Nano Detox, the Liver Nano Detox, and Memory Defense. (1) B. The Baclofen 20 mg for resident # JH1 was removed from the locked drawer and immediately discarded. Resident JH1 was given a labeled container with a top that she is able to flip open. The Assistant Director of Nursing observed her opening the container on April 30, 2008. The resident will be given a daily supply of the Baclofen as ordered by the physician. (2) A. An audit was conducted on April 16, 2008 to identify residents receiving medication from a source other than from the contracted pharmacy. The audit showed that there were no other residents with medication labels that did not match the Medication Administration Record. For the residents identified, their medication's labels were audited on April 16, 2008 to ensure that the label on the medication matches the Physician's order. (2) B. The facility will observe residents who have an order for self-administration of medications weekly to ensure that the residents are safe and compliant with the process. The observation will be documented in the Medication Administration Record.	04/16/08 04/16/08 04/16/08 04/16/08

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F 431	Continued From page 13 in cottage cheese every day for circulatory support, Liver Nano-Detox ¼ teaspoonful po in cottage cheese or apple sauce every day for Liver Detox, Memory Defense Caps 1 cap po 2 times a day for memory" A face-to-face interview was conduct on April 15, 2008, at approximately 11:00 AM with Employee #11. He/she acknowledged that the medications were not labeled according to the physician's orders. There record was reviewed on April 15, 2008. 2. Facility staff failed to label medications for Resident JH1 a self-medicator. On April 15, 2008, at approximately 1:00 PM, three (3) tablets were observed in a soufflé cup in a locked drawer of Resident JH1's bedside stand. The tablets were not labeled and subsequently identified by Employee #11 as Baclofen 20mg each. A face-to-face interview was conducted with Resident JH1 at the time of the observation. He/she stated, "Three tablets are given to me daily in this cup (soufflé cup) and I lock them in my drawer." A face-to-face interview was conducted with Employee #11 at 1:15 PM on April 15, 2008. He/she stated that the resident has always received Baclofen each morning for the day in a soufflé cup. This is the only medication that the resident administers to him/herself. A physician's order dated April 10, 2008, directed, "Baclofen 20mg, one tablet po three times a day at 8 AM, 4 PM and 12 Midnight, for muscle	F 431	(3) The medication nurses will be inserviced regarding the necessity to double check the label and the order on the Medication Administration Records during medication pass and the necessity to double check that medication handed to the residents for self administration are labeled. The Assistant Director of Nurses or Designee will randomly audit medication carts for residents who get their medication from a non-contracted pharmacy to ensure that the label on the container matches the information on the Medication Administration Record and the residents who are self medicating to ensure that medications kept in the locked drawer are properly labeled. This random audit will occur every week X 4, then monthly thereafter. (4) The result of the audit will be presented to the Quality Assurance Committee for further recommendations.	05/12/08

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F 431	Continued From page 14 spasm...Please observe resident self-administration of Baclofen weekly on Tuesdays at 4 PM." Employee #11 acknowledged that the medication was stored in a soufflé cup unlabeled. The record was reviewed April 15, 2008.	F 431		