STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING _____ B. WING _____	05/09/2007

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F 000	INITIAL COMMENTS An annual recertification survey was conducted on May 7 through 9, 2007. The following deficiencies were based on record review, observations,and interviews with facility staff and residents. The sample included 29 residents based on a census of 193 residents on the first day of survey and two (2) supplemental residents.	F 000	**JB Johnson Nursing Center makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/ or executed solely because it is required by Federal and State Law.**	
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	**F 278 483.20(g)-(j) Resident Assessment** 1. The MDS for resident #3 has been corrected to accurately code for the fall and the MDS for resident #18 corrected to reflect the diagnosis of Alzheimer's disease. Resident # 27 MDS was corrected to reflect a 14 day assessment. 2. All Minimum Data Sets (MDS)/Resident Assessment Instruments (RAI) for residents with falls, Alzheimer's disease and current residents on PPS were reviewed for accuracy. No other resident was affected by this practice. 3. The Nurse Managers and MDS Coordinator will be re educated on MDS coding and documentation as it pertains to diagnosis, falls, and assessment. 4. The MDS audit is a part of the Quality Improvement Program and is presented at the Quality Assurance Meeting.	6/22/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Annette Price	Administrator	5/29/07

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 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for three (3) of 29 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for: a fall for one (1) resident; a diagnosis of Alzheimer's disease for one (1) resident; and for an OBRA (Omnibus Budget Reconciliation Act) assessment for one (1) resident. Residents #3, 18 and 27. The findings include: 1. Facility staff failed to accurately code Resident # 3 for a fall on the quarterly Minimum Data Set (MDS). According to the MDS 2.0 User's Manual, page 3-29, "The Assessment Reference Date (ARD), is the specific end-point of the assessment process." A review of Resident # 3's record revealed a quarterly MDS completed on April 26, 2007 [ARD] . Section J 4 (Accidents) of this April 26, 2007 MDS was coded for "None of the above", indicating no falls. According to a nurse's note of March 4, 2007 at 3:00 PM, "...Resident was observed on the floor in the courtyard on (lt) [left] side lateral position. Upon assessment no injury noted at this time. Physician [ ] and RP [Responsible Party] made aware. Will continue to monitor ..." A face-to-face interview was conducted with Unit Manager #2 on May 7, 2007, at 1:00 PM. He / she acknowledged that Resident # 3's MDS of April 26, 2007 was not coded for the fall. The record	F 278		

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F 278	Continued From page 2 was reviewed May 7, 2007. 2. Facility staff failed to include the diagnosis of Alzheimer ' s disease on the admission MDS for Resident #18. A review of the physicians History and Physical report signed and dated January 12, 2007 revealed a list of diagnoses which included Alzheimer's disease. A review of the admission MDS completed January 18, 2007 revealed that the diagnosis of Alzheimer's disease was not coded in Section I [Disease Diagnoses]. A face-to-face interview with Unit Manager #3 was conducted on May 7, 2007 at approximately 3:50 PM. He/she acknowledged that the admission MDS did not code the resident for the diagnosis of Alzheimer's disease. The record was reviewed May 7, 2007. 4. Facility staff failed to code for an OBRA assessment for Resident #27. A review of Resident #27's closed record revealed that the resident was admitted to the facility on February 27, 2007 for skilled care. Three (3) MDS comprehensive assessments were completed as follows: March 3, 2007 was coded as a 5-day PPS (Prospective Payment Service) assessment; March 12, 2007 was coded as a 14-day PPS assessment; March 27, 2007 was coded as a 30-day PPS assessment. According to the MDS 2.0 User's Manual, page	F 278		

6/13/07

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FORM APPROVED
OMB NO. 0938-0391

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

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F 278	Continued From page 3 2-4, "The admission assessment is a comprehensive assessment for a new resident that must be completed within 14 calender days of admission..." On page 3-9 of the MDS 2.0 User's manual, "In Section AA8a enter the number corresponding to the primary reason for the assessment...if combining an OBRA assessment with a Medicare assessment, you would have to code in both Items AA8a and AA8b." Facility staff failed to code the comprehensive MDS assessment completed March 12, 2007 also as an OBRA assessment in AA8a. The record was reviewed May 7, 2007.	F 278		
F 279 SS=E	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).	F 279	**F 279 483.20(d), 483.20(k)(1)** **Comprehensive Care Plans** 1. The care plan for residents #3, 5, and 18 were initiated to reflect the goals and approaches for 9 or more medications. Resident #5's care plan was updated to reflect goals and approaches for wound care. Residents #14 and #20 care plan was updated to reflect goals and approaches for anticoagulant therapy. The care plan for resident #16 was updated to reflect goals for the pacemaker. Resident's # 18 and #19 care plan was initiated to reflect refusal of care. Resident #25 care plan was updated with new approaches for attempting to elope. Resident #26 care plan was updated to reflect goals and approaches for the diagnosis of seizure disorder. 2. Care plans for all residents with 9 or more medications, wounds, on anticoagulant therapy, having a pacemaker, refusing care, attempting to elope and diagnosis of seizure disorder were reviewed and updated as needed. 3. The Director of Nursing and Assistant Director of Nursing met with licensed nursing personnel. The personnel have been re educated regarding care plan and the importance of ensuring they are developed, implemented and followed. 4. The comprehensive care plan is audited monthly. Additionally the audit tool has been updated to reflect the care plan being developed and followed as written. This information is presented at the Quality Assurance Meeting.	6/22/07

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F 279	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review for nine (9) of 29 sampled residents, it was determined that facility staff failed to initiate a care plan with appropriate goals and approaches for: three (3) residents for potential adverse drug interactions from the use of nine (9) or more medications; one (1) resident with a pressure ulcer; two (2) residents for the use of an anticoagulant; one(1) resident with a pacemaker; two (2) residents who refused/resisted care; one (1) resident who attempted to elope from the facility; and one (1) resident with a diagnosis of Seizure disorder. Residents #3, 5, 14, 16, 18, 19, 20, 25 and 26. The findings include: 1. Facility staff failed to initiate a care plan with appropriate goals and approaches for potential adverse drug interactions from the use of nine (9) or more medications for Resident #3. A review of Resident #3's record revealed a physician's order dated and signed April 4, 2007 which prescribed the following : Ascriptin, Cogentin, Lasix, OS-Cal, Potassium Chloride, Risperdal, Trazodone, Vitamin E, Tylenol, Vitamin A and D. The IDT (Interdisciplinary) care plan last reviewed April 25, 2007 failed to include appropriate goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications. A face-to-face interview was conducted with Unit	F 279		

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F 279	Continued From page 5 Manager #2 on May 7, 2007, at 1:00 PM. He / She acknowledged that Resident #3's care plan did not include goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications . The record was reviewed May 7, 2007. 2. Facility staff failed to initiate a care plan with appropriate goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications and a pressure ulcer to the lower back for Resident #5. A. Facility staff failed to initiate a care plan with appropriate goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications Review of Resident #5's record revealed a physician's order sheet dated May 2007 that included the following medications: Carbamazepine, Keppra, Levothyroxine, Lipitor, Nexium, Warfarin, Ascorbic Acid, Folbee, OsCal, Vitamin B6, and Zinc Sulfate. A review of the IDT care plan, last updated April 11, 2007, failed to include a care plan with appropriate goals and approaches for the potential adverse drug interactions from the use of nine (9) or more medications. B. Facility staff failed to initiate a care plan with appropriate goals and approaches for a pressure ulcer to the lower back A review of Resident # 5's weekly pressure ulcer healing record revealed upon admission, March 13, 2007, an unstageable open area to the lower back measuring 1.9 x 2.5 x.0.5 cm.	F 279		

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F 279	Continued From page 6 On May 8, 2007 at 9:00 AM the pressure ulcer to lower back was observed in the presence of the Unit Manager. A review of the IDT care plan, last updated April 11, 2007, lacked evidence of goals and approaches for the pressure ulcer to the lower back. A face-to-face interview with Unit Manager #5 was conducted on May 8, 2007 at approximately 12:16 PM. He/she acknowledged the lack of a care plan for the potential adverse drug interactions for 9 (nine) or more medications and the pressure ulcer to the lower back. The record was reviewed May 8, 2007. 3. Facility staff failed to initiate a care plan with goals and approaches for Resident #14 who received anticoagulant therapy. The April 2007 Physician's Order Sheet signed by the physician on April 5, 2007 revealed " E C (enteric coated) Aspirin 325 mg 1 tab PO (by mouth) every day for prophylaxis " . The significant change MDS (Minimum Data Set) in Section I included diagnoses of PVD (Peripheral Vascular Disease) and other CVD (Cardiovascular Disease) A review of the IDT care plan failed to show evidence of appropriate goals and approaches for the daily use of EC Aspirin. A face-to-face interview was conducted with Unit Manager #5 on May 8, 2007 at 3:00 PM. He/she acknowledged that there was no care plan for EC	F 279		

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F 279	Continued From page 7 Aspirin use in the record. The record was reviewed on May 8, 2007. 4. Facility staff failed to initiate a care plan with appropriate goals and approaches for Resident #16's pacemaker. A review of Resident #16's record revealed that the resident was admitted on November 14, 2006. According to the admission Minimum Data Set assessment, in Section I, "Disease Diagnoses", the resident was coded for a pacemaker. An assessment of the function of the pacemaker was done on April 12, 2007 and present in the record at the time of this review. The resident's IDT care plan was last reviewed February 15, 2007. There was no evidence that facility staff initiated a care plan with appropriate goals and approaches for the pacemaker. A face-to-face interview with Unit Manager #2 was conducted on May 8, 2007 at 8:15 AM. He/she acknowledged that there was no care plan for the pacemaker. The record was reviewed May 8, 2007. 5. Facility staff failed to initiate care plans with appropriate goals and interventions for Resident #18's behavior of resisting ADL (Activities of Daily Living) care and the potential adverse drug interactions from the use of nine (9) medications. A. Facility staff failed to initiate a care plan with appropriate goals and interventions for Resident's #18's behavior of resisting ADL care. The resident was admitted to the facility on	F 279		

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F 279	Continued From page 8 January 9, 2007. A review of the quarterly Minimum Data Set (MDS) dated April 19, 2007 and the admission MDS dated January 18, 2007 revealed that the resident was coded in Section, E4, Behavioral Symptoms, as resisting care. The care plan, last reviewed April 11, 2007, did not include the resident's behavior of resisting care. A face-to-face interview was conducted with Unit Manager #1 on May 9, 2007 at 11:15 AM. He/She stated, "[Resident] gets agitated. They can't give [resident] a shower when [he/she] is agitated." He/she acknowledged the lack of a care plan for resisting ADL care. A face-to-face interview was conducted with CNA #1 on May 8, 2007 at 12:15 PM. CNA #1 is frequently assigned to care for the resident. He/she stated, "[Resident] fights me and I can't give [him/her] a shower ..." B. Facility staff failed to initiate a care plan with appropriate goals and interventions for the potential adverse drug interactions from the use of nine (9) or more medications. A review of the May 2007 Physician's Order Sheet, signed May 6, 2007, was inclusive of the following medications: Aricept, Lipitor, Lisinopril, Lorazepam, Metformin, Cogentin, Risperdal, Depakote and Haldol. The origination dates of the aforementioned medications were January 10 through May 3, 2007. The IDT care plan was last reviewed on April 11, 2007 and did not include problem identification for potential for adverse drug interactions from the	F 279		

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F 279	Continued From page 9 use of nine (9) or more medications. A face-to-face interview was conducted with Unit Manager #3 on May 9, 2007 at 11:15 AM. He/She acknowledged the lack of a care plan for nine (9) or more medications and the potential for adverse drug interactions. The record was reviewed on May 8, 2007. 6. Facility staff failed to initiate a care plan for Resident #19 who refused to wear a smoking apron while smoking in the courtyard. A review of the nurses' notes revealed the following: March 21, 2007 [no time indicated]: "Reported that resident has a wound on the right inner thigh ... Resident on assessment was asked what caused the wound, [he/she] said, while [he/she] was smoking some time last week that the cigarette fell in between [his/her] thighs. When asked if any one witnessed it and if [he/she] reported it to the courtyard monitor at that time when it happened, [he/she] said, 'No' ..." April 11, 2007 at 3:15 PM: "...Resident was observed putting [his/her] cigarette with flame in a plastic bag in the wheel chair and started bringing fire which the reporter said [he/she] put it off [out] immediately." A face-to-face interview was conducted on May 9, 2007 at approximately 1:00 PM with Resident #19. He/she stated, "No, I don't use anything over me when I smoke. I don't need anything." The resident denied that the above mentioned incidents occurred.	F 279		

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A face-to-face interview with Unit Manager #1, Director of Nursing and the Administrator was conducted on May 9, 2007 at approximately 3:00 PM. They stated, "The resident has a diagnosis of Schizophrenia and is delusional. We tired to put the apron on [him/her] but [he/she] didn't wear it. They acknowledged that there was no care plan in place to address the resident's refusal of wearing the smoking apron.

The record lacked evidence that a care plan was initiated to address the resident's refusal to wear a smoking apron while smoking. The record was reviewed May 9, 2007.

7. Facility staff failed to include goals and approaches for the use of Coumadin on the care plan initiated for anticoagulant therapy for Resident #20.

Resident #20 was prescribed three (3) anticoagulant medications, Aspirin, Plavix and Coumadin, on March 14, 2007. During the review of the care plan dated March 23, 2007 for anticoagulant therapy, it was observed.that goals and approaches for the use of Coumadin was not included.

On May 8, 2007 at approximately 11:00 AM, a face-to-face interview was conducted with Unit Manager #1 who acknowledged that Coumadin was not included in the care plan. The record was reviewed on May 8, 2007.

8. Facility staff failed to initiate a care plan with appropriate goals and approaches for Resident #25 who had multiple elopement attempts.

A review of the nurse's notes revealed the

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F 279	Continued From page 11 following: April 14, 2007 at 11:00 PM - "...aggressive behavior trying to leave the facility with a bag ..." April 15, 2007 at [no time indicated] - " Resident came out again. Ignored everybody and went to elevator. Writer called security and they stopped [him/her] and brought [him/her] back to the unit ... " April 17, 2007 at 10:00 PM - " ...[he/she] is at the lobby at this time with his/her belongings. Stated he/she wants to go home ... " A review of the IDT care plan last updated March 19, 2007, lacked problem identification of the resident's attempts to elope from the facility. A face-to-face interview with Unit Manager #5 was conducted on May 8, 2007 at approximately 12:16 PM. He/she acknowledged that a care plan for elopement should have been initiated after the three (3) attempts of elopement in April, 2007. The record was reviewed May 8, 2007. 9. Facility staff failed to initiate a care plan with appropriate goals and approaches to address Resident #26's diagnosis of Seizure disorder. During the review of the resident's record, the physician's orders signed and dated March 22, 2007 included, " Gabapentin 100mg 1 cap by mouth two (2) times a day for seizure" [origination date of March 8, 2007]. The IDT care plan dated March 19, 2007 lacked problem identification with approaches and goals for the diagnosis of Seizure disorder.	F 279		

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F 279	Continued From page 12 On May 9, 2007 at approximately 10:00 AM, a face-to-face interview was conducted with Unit Manager #5 who acknowledged that a care plan for Seizure disorder should have been initiated. The record was reviewed on May 9, 2007.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of 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 staff interview and record review for two (2) of 29 sampled residents, it was determined that facility staff failed to update the falls care plan with additional goals and approaches to prevent further falls. Residents #3 and 18. The findings include:	F 280	**F 280 483.20(d)(3), 483.10(k)(2)** **Comprehensive Care Plans** 1. Residents #3 and #18 care plans were updated to reflect appropriate interventions and goals. 2. The care plan for all residents with a fall in the last quarter was reviewed. No other resident was affected by this practice. 3. The Interdisciplinary Team (IDT) was re educated on proper documentation of goals and approaches for falls. 4. Fall care plans are reviewed during the monthly "Falls meeting" and is part of the Continuous Quality Improvement Program. Additionally, focus audits of care plans following a fall will be incorporated into the audit and reported at the Quality Assurance Meeting.	6/22/07

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F 280	Continued From page 13 1. Facility staff failed to update Resident #3's care plan for falls. A review of the nurses' note dated March 4, 2007 at 3:00 PM, revealed, "...Resident was observed on the floor in the courtyard on (lt) [left] side lateral position. Upon assessment no injury noted at this time. Physician [ ] and RP [ ] made aware. Will continue to monitor ..." Resident #3's record revealed an undated care plan for "Resident at risk for falling ..." There was no evidence that additional goals and approaches were developed in response to the resident's March 4, 2007 fall. A face-to-face interview was conducted with Unit Manager #2 on May 7, 2007 at 1:00 PM. He /she acknowledged that Resident #3's care plan was not updated to reflect additional goals and approaches in response to the above cited fall. The record was reviewed May 7, 2007. 2. Facility staff failed to update the care plan with appropriate goals and approaches for Resident #18 who had multiple falls. A review of Resident #18's nursing notes revealed the following: April 10, 2007 at 3:00 PM - "...Found [resident] on the floor in a sitting position in the hallway ..." April 17, 2007 at 6:00 AM - "...Resident in a sitting position inside the room ..." A review of the "Potential for Injury/fall " care plan last updated April 7, 2007 failed to address the above mentioned falls with new goals and	F 280		

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F 280	Continued From page 14 approaches to prevent further falls. A face-to-face interview with Unit Manager #3 was conducted on May 7, 2007 at approximately 3:50 PM. He/she acknowledged that the care plan did not address the aforementioned falls. The record was reviewed May 7, 2007.	F 280		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review for two (2) of 29 sampled residents and one (1) supplemental resident, it was determined that facility staff did not provide the necessary care and service as evidenced by failure to: follow-up on a consult for one (1) resident with a history of a subdural hematoma; obtain a psychiatric consult timely for one (1) resident and follow facility's policy prior to crushing medications for one (1) resident. Residents #2, 18 and JH2. The findings include: 1. Facility staff failed to ensure that a follow-up consult was scheduled for Resident #2. The March 26, 2007, "Report of Consultation" revealed a request by the attending physician "	F 309	**F 309 483.25 Quality of Care** Resident #2 follow up consult was scheduled on April 30th, the results were read on May 3rd and signed by the physician on May 7th. Resident # 18 the psychiatric consult was obtained March 28th, the facility cannot retrospectively correct for timeliness. A physician order was obtained for resident JH2 to crush medications. 2. Physician requested consults, psychiatric consults and residents taking crushed medications were reviewed for appropriate MD orders and follow through. There were no other residents found to be affected by this practice. 3. Nursing personnel was re educated on following up on consultation reports in a timely manner and obtaining a physician's order before crushing medications. 4. Consults have been added to the medical record audit tool and physician orders added to the nurse audit tool. The information will be presented at the Quality Assurance Meeting.	6/22/07

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F 309	Continued From page 15 F/U Subdural hematoma [hospital name] (April)" A review of the record failed to show evidence of a follow up consult for Subdural hematoma for April 2007. A face-to-face interview was conducted with Unit Manager #6 on May 7, 2007 at 4:00PM. He/she stated, "The follow-up was never scheduled." The record was reviewed on May 7, 2007 at 2:00 PM. 2. Facility staff failed to ensure that a psychiatric consult was conducted timely for Resident #18. A review of Resident #18's Physician Order Sheet dated January 9, 2007 and signed by the physician revealed, " ...Psychiatric Consult for Agitation ... " and a physicians order dated March 4, 2007 revealed, " ...Psychiatric Consult, indication: Depression and Dementia with Psychosis. " A review of the record failed to show evidence of a psychiatric consult conducted for January or February 2007. A consultation for "Evaluation for mental status and agitated behavior" signed by the consulting psychiatrist was dated March 28, 2007. The record lacked evidenced that a psychiatric consult was obtained as ordered by the physician on January 9, 2007. In addition, the second psychiatric consult that was ordered on March 4, 2007 was not obtained until March 28, 2007, 24 days after the order. A face-to-face interview with Unit Manager #3	F 309		

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F 309	Continued From page 16 was conducted on May 7, 2007 at approximately 3:50 PM. He/she acknowledged the psychiatric consults that were ordered on January 9 and March 4, 2007 were not completed until March 28, 2007. The record was reviewed May 7, 2007. 3. Facility staff failed to follow the facility's policy prior to crushing medications for Resident JH2. According to the facility's Policy 5.3.3, "Crushing of Medications" stipulates, "All medication which do not lose effectiveness, or produce side effects when crushed, may be crushed per physician's order for residents who have difficulty swallowing medications." On Tuesday, May 8, 2006, at approximately 10: 25 AM, the medication nurse (employee #7) was observed crushing a Hydralazine 50 mg tablet and a Multivitamin with Iron tablet for Resident JH2. The resident swallowed the enteric coated Aspirin with water that had a thickening agent added. A total of three (3) medications were administered to the resident. There were no untoward effects to the resident. The Physician Orders and the Medication Administration Record lacked evidence of an order to crush medication. A face-to-face interview was conducted with the Medication Nurse [Charge Nurse #1] on May 8, 2007, at 10:20 AM. He/she stated that the resident does not swallow properly and that it was a nursing judgment to crush the medicines.	F 309		
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance	F 324		

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F 324	Continued From page 17 devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interview for one (1) of 29 sampled residents, it was determined that facility staff failed to adequately supervise Resident #19, who was identified as requiring increased supervision in the courtyard while smoking. The findings include: A review of the nurses' notes revealed the following: March 21, 2007 [no time indicated]: " Reported that resident has a wound on the right inner thigh ... Resident on assessment was asked what caused the wound, [he/she] said, while [he/she] was smoking some time last week that the cigarette fell in between [his/her] thighs. When asked if any one witnessed it and if [he/she] reported it to the courtyard monitor at that time when it happened, [he/she] said, "No ..." April 11, 2007 at 3:15 PM: "...Resident was observed putting [his/her] cigarette with flame in a plastic bag in the wheel chair and started bringing fire which the reporter said [he/she] put it off immediately." The care plan, last reviewed April 11, 2007, included the approach of closely monitoring Resident #19 while in the courtyard and smoking. The record lacked evidence that increased monitoring of the resident occurred when the resident was in the courtyard.	F 324	**F 324 483.25(h)(2) Accidents** 1. Resident #19 was immediately added to the courtyard monitoring list of residents to closely monitor while smoking. 2. Residents needing additional assistance in the courtyard and all smokers were reassessed for smoking safety. 3. The interdisciplinary team and personnel on the residents' unit were in-serviced regarding the residents' need. The resident is included on the courtyard monitoring list as needing more supervision while smoking. 4. The quality assurance tool was updated and will be reported at the Quality Assurance Meeting.	6/22/07

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

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F 324	Continued From page 18 A face-to-face interview was conducted on May 9, 2007 at approximately 1:00 PM with Resident #19. He/she stated, "No, I don't use anything over me when I smoke. I don't need anything." The resident denied that the above mentioned incidents occurred. A face-to-face interview was conducted on May 9, 2007 at 3:00 PM with CNA #2. He/she was asked which residents required increased monitoring or supervision while in the courtyard. CNA #2 named five (5) residents that required increased monitoring. Resident #19's name was not included in the five (5) residents named by CNA #2. A face-to-face interview with Unit Manager #4, the Director of Nursing and the Administrator was conducted on May 9, 2007 at approximately 3:15 PM. They stated, "The resident has a diagnosis of Schizophrenia and is delusional. We don't know where [he/she] got the blister. We went through [his/her] clothes and we did not find any burn holes in the clothing. We tried to put the apron on [him/her] but [he/she] didn't wear it. We looked in the bag and there were no cigarettes or ashes in the bag. We could not substantiate the incidents." The record was reviewed May 9, 2007.	F 324		
F 371 SS=D	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

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F 371	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were served and prepared in a safe and sanitary manner as evidenced by soiled sheet pans, deep fryer and floor surfaces. These findings were observed in the presence of the Food Service Director. The findings include: 1. The inner and bottom surfaces of sheet pans were soiled with a greasy film after washing in the pot and pan wash sink in six (6) of 17 observations of sheet pans at approximately 4:00 PM on May 7, 2007. 2. Deep fryer exterior surfaces, inner panels, electrical wiring, gas lines and floor surfaces under the fryer were soiled with accumulated grease in one (1) of one (1) observation of the deep fryer and floor surfaces at 9:00 AM on May 7, 2007. The Food Service Director acknowledged the aforementioned findings at the time of the observations.	F 371	**F 371 483.35(i)(2) Sanitary Conditions- Food Prep & Service** 1. The inner and outer surfaces of sheet pans were cleaned and sanitized immediately. The deep fryer exterior surfaces, inner panels, electrical wiring, gas lines and floor surfaces under the fryer was cleaned and sanitized. 2. All sheet pans and other cooking equipment was inspected and determined that no other equipment or utensils were affected. No resident was affected by this practice. 3. The Director of Food Service met with the dietary personnel and they were re educated regarding this practice. 4. Monthly, a quality sanitation audit form will be completed. The Director of Food Services and/or designee will monitor the sanitation of the kitchen daily. The results will be presented at the Quality Assurance Meeting.	6/15/07
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.	F 386	**F 386 483.40 Physician Visits** 1. The attending physician for resident #17 has reassessed the resident. The physician's orders have been updated to address Dilantin dose. No adverse reaction was noted to the resident. 2. All pharmacy recommendations were reviewed to ensure physician orders were written. There were no other residents affected by this practice.	

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F 386	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 29 sampled residents, it was determined that the physician failed to write an order to decrease the Dilantin dosage for Resident #17 after acceptance of the pharmacist's recommendation. The findings include: A review of Resident #17's pharmacy consultant report dated February 27, 2007 revealed the following recommendation: "...Suggest decreasing dose of Dilantin and rechecking level in 7 days." Further review revealed that the physician signed the recommendation on March 2, 2007 and placed a check mark next to "Accept recommendation " in the section entitled "Doctor Response." Included in the section entitled, "Doctor Response" is the notation, "Please write any new orders on a physician's order sheet." A review of the record lacked evidence of an order to decrease the Dilantin dosage after March 2, 2007. A face-to-face interview with Unit Manager #7 was conducted on May 7, 2007 at approximately 2:40 PM. He/she acknowledged that the order to decrease the Dilantin dosage was not written by the physician and there was no further follow up. There was no evidence the resident experienced any untoward effects . The record was reviewed May 7, 2007.	F 386	**F 386 483.40 Physician Visits Continue** 3. All attending physicians were re educated on how to properly accept or deny pharmacy recommendations and follow through with a physician order based on the recommendation. 4. The consultant pharmacist reports the acceptance or denial of recommendations quarterly at the Quality Assurance meeting.	6/8/07
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES	F 425		

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F 425	Continued From page 21 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for three (3) of seven (7) nursing units, it was determined that facility staff failed to ensure that an emergency supply of Vitamin K was available for residents' use on one (1) nursing unit and emergency boxes were exchanged as per facility policy on two (2) nursing units. Units 1 North, 3 South and 4 North. The findings include: 1. Facility staff failed to ensure that an emergency supply of Vitamin K was available for residents' use on Unit 4 North.	F 425	**F 425 483.60(a) Pharmacy Services** 1. Emergency boxes on 4 North, 3 South, and 1 North were exchanged and new boxes were placed on the units. 2. All emergency boxes on all the units were inspected for missing or expired medications by the Woodhaven Pharmacist. No other boxes were found to be deficient of this practice. 3. Nursing personnel was re educated on the use of supplies from the emergency boxes. The pharmacy will check contents of the emergency boxes monthly. 4. The pharmacist checks the emergency boxes as part of the pharmacy inspections. This information will be presented at the Quality Assurance Meeting.	6/22/07

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F 425	Continued From page 22 On Monday, May 7, 2007, at approximately 9:30 AM, during the inspection of the facility's emergency boxes, emergency box #34A on Unit 4 North contained two (2) Vitamin K 10mg/ml ampules with an expiration date of May 1, 2007. There were no other ampules of Vitamin K in the emergency box. The emergency box's expiration date was documented as May 30, 2007. A face-to-face interview was conducted with Charge Nurse #3. He/she stated that the emergency box was never opened. The box was observed to be locked with a yellow plastic lock. Charge Nurse #3 stated that the pharmacy supplies the yellow locks and that the facility would put a red lock on the box if it was opened by facility staff. 2. Facility staff failed to ensure that emergency boxes on two (2) nursing units were exchanged as per facility policy. According to the facility's Policy and Procedure, # 3.5, "Emergency and Interim Drug supply" stipulates that, "Emergency Boxes will be exchanged only upon notification of use. During regular business hours, the nurse should call the Pharmacy to request exchange of the used Emergency Box. (Replacement should be requested after the first use to ensure availability of box contents.)" On Monday, May 7, 2007, between 10:30 AM and 3:00 PM, the nursing stations were inspected for the storage of medication. The emergency box #964A located on 3 South did not contain Glucagon Hypokit injection. The emergency box sign-out sheet for box #964A documented that on April 20, 2007, Glucagon was taken from the	F 425		

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F 425	Continued From page 23 emergency box and used for Resident JH1. The emergency box was opened and not replaced. A face-to-face interview was conducted with Charge Nurse #1 on May 7, 2007 at 10:55 AM. He/She stated that the facility should have telephoned the pharmacy to replace the emergency box. The emergency box #33 located on 1 North did not contain Glucose Insta-gel. The emergency box sign-out sheet for emergency box #33 was not available at the time of survey. A face-to-face interview was conducted with Charge Nurse #2 on May 7, 2007 at 2:50 PM, He/She stated that the pharmacy was telephoned to replace the drug.	F 425		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	**F 431 483.60(b), (d), (e)** **Pharmacy Services** 1. The medication refrigerator on 2 North was serviced to maintain a temperature within the required range of 36 to 46 degrees. 2. All medication refrigerators were inspected and no other refrigerators were out of range. 3. Maintenance personnel were re educated on how to service the refrigerator units and proper temperature ranges. 4. Checking the medication temperatures is a part of the daily nursing and monthly pharmacy inspections. This is also now included in the engineering inspections. This information will be presented at the Quality Assurance meeting.	6/8/07

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F 431	Continued From page 24 controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of Monthly Unit Inspection reports and staff interview, it was determined that facility staff failed to store all drugs and biologicals under proper temperature controls in one (1) of seven (7) medication refrigerators . The findings include: On May 7, 2007, at approximately 10:00 AM, during the inspection of the medication storage area on 2 North, the medication refrigerator's thermometer reading was 50 degrees Fahrenheit (F). According to 22 DCMR, Chapter 32, § 3227.8, "Each refrigerator that is used for storage of medications shall operate at a temperature between thirty-six degrees and forty-six degrees Fahrenheit..." On May 7, 2006, during the review of the Monthly	F 431		

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	095036	A. BUILDING _____ B. WING _____	05/09/2007

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F 431	Continued From page 25 Unit Inspection reports from the consultant pharmacist, it was noted that the medication refrigerator on 2 North fluctuated out of range in six (6) of the ten (10) monthly unit inspections from July 2006 through April 2007. The Monthly Unit Inspection reports had the following temperatures documented for the following months : April 2007 - 50° F, January 2007 - 50° F, December 2006 - 50° F, November 2006 - 50° F, October 2006 - 50° F and August 2006 - 50° F. A face-to-face interview was conducted with Charge Nurse #4. He/She stated that he/she was not aware that the medication refrigerator's temperatures were out of range.	F 431		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews for six (6) of seven (7) nursing units, it was determined that portions of the facility's call system failed to function. The findings include: During the initial tour conducted on May 7, 2007, at 8:45 AM, it was observed that, when activated, the call bell could not be heard when in resident rooms 119 through 123. This observation was made in the presence of Unit Manager #5.	F 463	**F 463 483.70(f)** **Resident Call System** 1. Amplified buzzers were installed to the enunciator panels to increase the alarm sound on 6 of the 7 nursing units. The sound of the call bell was retested and heard on May 22, 2007 by the environmental surveyor. 2. All 6 units alarm sound was amplified. When the remaining unit is upgraded the amplifier will be installed. No resident was affected. 3. Engineers will conduct random nurse call system tests to ensure that it is functioning properly. 4. The nurse call system is a part of the nursing audit and is presented at the Quality Assurance meeting.	5/22/07

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F 463	Continued From page 26 On May 9, 2007 from 6:40 AM through 7:00 AM and 9:30 AM through 10:10 AM, a tour of all the facility's units was conducted to determine if activated call lights were audible throughout the unit. The following findings were noted: On Unit 1 North, the call light system was set for "low tone" at 6:45 AM and 9:30 AM. The call bell system was activated in room 109 at 6:45 AM in the presence of Charge Nurse #1. The call bell was activated in room 110 at 9:30 AM in the presence of Unit Manager #1. The call bell was not audible in either room or the hallway from room 109 through room 111 either time tested. On Unit 1 South, the call light system was activated in room 119 at 6:40 AM and room 122 in the presence of Unit Manager #4 and CNAs #3 and 4. The call bell was activated at 9:40 AM in the presence of CNA #5. The call bell was not audible in either room or the hallway from room 119 through room 123 either time tested. On Unit 2 North, the call light system was activated in room 207 at 7:05 AM in the presence of Unit Manager #2, Charge Nurse #2 and CNAs #5 and 6. The call bell was activated in room 208 at 9:42 AM in the presence of Unit Manager #2. The call bell was not audible in either room or the hallway from room 207 through room 214 either time tested. On Unit 2 South, the call light system was activated in room 219 at 7:10 AM in the presence of CNAs #7 and 8. The call bell was activated in room 228 at 9:44 AM Charge Nurse #3. The call bell was not audible in either room or the hallway from room 219 through 234 either time tested.	F 463		

received 6/13/07

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

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F 463	Continued From page 27 On Unit 4 North, the call light system was activated in room 412 at 6:50 AM in the presence of CNAs #9 and 10. The call bell was activated in room 409 at 10:07 AM in the presence of Charge Nurse #4. The call bell was not audible in either room or the hallway from room 409 through 414 either time tested. On Unit 4 South, the call light system was activated in room 427 at 6:55 AM in the presence CNAs #11 and 12. The call bell was activated in room 429 at 10:01 AM in the presence of Charge Nurse #5. The call bell was not audible in either room or the hallway from room 427 through 429 either time tested. Facility staff present during the above observations acknowledged that the call bell was not audible in the rooms identified above or in the hallway identified above. On Unit 3 South the call light system was activated in room 327 at 7:00 AM and room 319 at 9:49 AM. The call bell was audible throughout the unit. The call light system was set on "high tone."	F 463		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	**F 514 483.75(l)(1) Clinical Records** 1. An addendum was made to the March monthly summary for resident #3 to reflect the fall incident and the April monthly summary bladder assessment checkbox was marked to reflect the resident's status. The behavioral flow record could not be retrospectively corrected for resident #4. 2. Review of all monthly summaries regarding falls, bladder assessments, and documentation of behavior monitoring was reviewed and adjusted as needed.	

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F 514	Continued From page 28 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review for two (2) of 29 sampled residents, it was determined that facility staff failed to document a fall and bladder assessment on the Nursing Monthly Summary for one (1) resident and document behaviors for one (1). Residents #3 and 4. The findings include: 1. Facility staff failed to document Resident #3's fall incident and bladder assessment on the Nursing Monthly Summary. A. Facility staff failed to document Resident #3's fall incident on the Nursing Monthly Summary. According to a nurse ' s note of March 4, 2007 at 3:00 PM, "...Resident was observed on the floor in the courtyard on (lt) [left] side lateral position. Upon assessment no injury noted at this time. Physician [ ] and RP [Responsible Party] made aware. Will continue to monitor ..." The Nursing Monthly Summary for March 2007 dated April 3, 2007 did not include the resident's March 4, 2007 fall. B. Facility staff failed to complete the Nursing Monthly Summary for bladder assessment for Resident #3. A review of Resident # 3's record revealed an	F 514	**F 514 483.75(l)(1) Clinical Records Continue** 3. Nursing personnel was re educated on accurately completing nursing monthly summaries including bladder assessments, falls, behaviors and correctly coding the behavior flow record. 4. Review of the nursing monthly summaries and behavior monitoring records is a part of the nursing audit and presented to Quality Assurance Committee.	6/22/07

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F 514	Continued From page 29 annual Minimum Data Set (MDS) completed on January 25, 2007 and a quarterly MDS completed on April 26, 2007. Section HI (b) (Bladder Continence) for both MDS assessments were coded "2" indicating "occasionally incontinent bladder." The Nursing Monthly Summary for April 2007 was blank for bladder assessment. A face-to-face interview was conducted with Unit Manager #2 on May 7, 2007 at 1:00 PM. He/she acknowledged that Resident #3's Nursing Monthly Summary for March 2007 failed to include the fall incident and the April 2007 Nursing Monthly Summary lacked a bladder assessment. The record was reviewed May 7, 2007. 2. Facility staff failed to document Resident #4's behavior on the behavior monitoring record and in the nurses' notes when the resident was administered medication for agitation. A review of Resident #4 ' s record revealed a physician ' s order dated January 9, 2007 and renewed on March 31, 2007, that directed " Lorazepam (Sub: Ativan) 0.5 milligram (mg) tab, one by mouth (po) every six (6) hours as needed for anxiety " . According to the April 2007 Medication Administration Record (MAR), Lorazepam was administered on April 9, 2007 at 12:00 PM. The back of the MAR indicated that Lorazepam was administered for agitation. The Behavioral Flow Record was coded "0" for the number of interventions for the day shift on April 9, 2007, which indicated no agitated	F 514		

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F 514	Continued From page 30 behavior occurred. A review of the resident's record revealed nurses' notes dated April 5 and 10, 2007. There was no nursing note written on April 9, 2007. A face-to-face interview was conducted with Unit Manager #4 on April 7, 2007 at 10:30 AM. He/she reviewed the record and acknowledged that the Behavioral Flow Record was coded incorrectly and that the agitated behavior was not documented in the nurses ' notes.	F 514		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 095036	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 5/9/2007

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 456	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on review of the review of emergency generator "Weekly Test Sheet", it was determined that facility staff failed to accurately document emergency generator odometer readings [total hours run]. The findings include: According to NFPA (National Fire Protection Association) 110 1999 Edition, Generators set in Level I shall be exercised at least once monthly for a minimum of thirty minutes. On May 8, 2007 at 9:30 AM, the Emergency Generator "Weekly Test Sheet" was reviewed. According to the "Weekly Test Sheet", the generator was exercised weekly for 30 minutes. The sheet had weekly entries dated January 29, 2006 through May 4, 2007 with odometer readings of 440.00 to 760.00 total hours of operation [facility staff added 20.00 total hours of operation each week]. An observation of the digital display on the generator revealed a odometer reading of 55 total hours of operation. The actual odometer reading of 55 was inconsistent with the last documented odometer reading dated May 4, 2007 of 760.00 total hours of operation. The aforementioned findings were acknowledged by the Maintenance Director at the time of the observation.

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

The above isolated deficiencies pose no actual harm to the residents