STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	05/05/2008

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F 000	INITIAL COMMENTS An annual recertification survey was conducted on April 28 through May 5, 2008. The following deficiencies were based on record review, observations, and staff interviews. The sample included 30 residents based on a census of 244 residents on the first day of survey and 33 supplemental residents.	F 000	Washington Center for Aging Services 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 truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. This POC is prepared and/or executed solely because it is required by Federal and State Law.	
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	1. The pacemaker company was contacted regarding the procedures for checking pacemakers. The facility was advised that the technician was new and he was re-educated. Resident #26's pacemaker check will no longer be done at the nursing station. Unable to retrospectively correct. 2. A review of residents with pacemakers was completed. No other resident was found to be affected by this practice. 3. Re-educate the nursing staff regarding monitoring privacy and dignity during pacemaker checks. Radiation Physics was advised immediately that privacy must be maintained during pacemaker checks. Additional private phone lines have been identified for pacemaker checks. 4. Residents Rights is a part of the Social Services Quality Assurance tool. It is completed monthly and shared with the QA Committee.	6/6/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Williane D. Page | TITLE: Administrator | (X6) DATE: 5/28/08

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 and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to provide privacy for Resident #26 during a pacemaker check. The findings include: On May 1, 2008 at approximately 3:20 PM, Resident #26 was observed seated in his/her wheelchair at the nurses' station on Unit one (1) Blue. A technician from [pacemaker company] approached the resident, introduced him/herself and explained to the resident that he/she was going to check his/her pacemaker. The technician added, "I need to lift your shirt and place something on your chest and hook you up to the telephone. Is that okay?" The resident nodded "Yes". The technician lifted the resident's shirt to reveal his/her chest, wiped the upper chest and applied two (2) electrodes to the upper chest. The technician proceeded to check the pacemaker with the telephone. The technician stated to the resident, "It did not work. I am afraid I have to do it again. May I?" The resident nodded, "Yes". The technician then lifted the resident's shirt and exposed his/her chest for the second time, placed a square object in the center of the resident's chest and completed the test. A face-to-face interview was conducted with Employees #16 and 21 at approximately 4:00 PM	F 164		

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F 164	Continued From page 2 on May 1, 2008. Both employees acknowledged that the procedure was done without privacy at the nurses' station. Employee #16 stated, "I thought you were going to say something about that." Employee #21 said, "This is the only telephone we have on the unit."	F 164		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 30 sampled residents and 12 supplemental residents, it was determined that facility staff failed to promote dignity as evidence by: pulling three (3) residents backwards in a wheel chair; and during the breakfast and lunch meals. Residents # 7, 26, P1, A3, A4, A5, A6, A7, A8, S1, S3, W3, W4, and W5. The findings include: 1. Facility staff failed to promote dignity to Resident #7. Employee #20 was observed pulling Resident #7 backward in the Geri chair through the hallway from the resident's room. On May 2, 2008 at approximately 8:30 PM, it was observed that Employee #9 was pulling Resident #7 through the hallway from the resident resident's room. The resident was sitting in a Geri chair in the hallway in front of his/her room.	F 241	1. The employees who were transporting residents #7, 26, and P1 were advised of the correct procedure for transporting residents and the transporting of residents was corrected immediately. Residents #7, 26 and P1 were assessed and not found to be affected by this practice and staff will continue to monitor these residents. Staff have been re-educated regarding residents receiving their meals at the same time when dining together. Unable to retrospectively correct the meal service to residents number A3, A6, S1 and W3. 2. The nurse managers observed the process for transporting residents and no other residents were found to be transported inappropriately. The nursing management team also completed an audit of all wheelchairs and Geri-chairs to determine appropriate sitting and reposition of residents. Nursing Management, physical therapy and engineering will work collaboratively to ensure that leg rest are on the wheelchairs. A review of the meal service was conducted and it was determined that residents are being served at the same time. 3. Nursing staff were re-educated on the proper procedure for transporting residents . Additionally, the facility has a very successful dining with dignity program; staff has been re-in serviced on this program. 4. Nurse Managers/Charge nurses monitor transporting of residents in Geri-chairs and wheelchairs. The nursing management team will report to the QA committee. Dining room tray service reviews are conducted monthly and reported to the QA committee.	6/10/08

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F 241	Continued From page 3 The surveyor within full view of the resident was standing by Employee #21. Employee #9 had pulled the resident backward half-way through the hallway before Employee #21 interrupted him/her transporting the resident inappropriately. The surveyor told Employee #21 that Employee #9 and other facility staff had been observed at various times during the survey period pulling residents seated in Geri chair backward around the unit. 2. Facility staff failed to promote dignity to Resident #26 as evidenced by pulling him/her backwards while in the wheelchair. On April 30, 2008 at 11:00 AM it was observed that Employee #32, was pulling Resident #26 through the first floor living room backward in his/her wheelchair without wheelchair legs. Employee #32 told Resident #26, "Pick up your feet." The resident did not pick up his/her feet. Employee #32 was asked, "Where are the wheelchair legs?" He/she stated, "It [the wheelchair] doesn't have any legs." Employee #32 continued to tell Resident #26 to pick up his/her feet. Employee #32 continued attempting to pull the wheelchair backward, but Resident #26 did not lift his/her feet. Employee #31 and 15 acknowledged that Employee #32 was transporting Resident #26 backwards and the wheelchair did not have any wheelchair legs. 3. Facility staff failed to promote dignity to Resident P1 as evidenced by being pulled backwards while in a Geri chair.	F 241		

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F 241	Continued From page 4 On April 30, 2008 Employee #35, at approximately 12:15 PM, was observed pulling Resident P1 backwards from the Solarium past the nurse's station on Unit 2 Blue. 4. Facility staff failed to promote four (4) residents' dignity during the breakfast and lunch meals. A. The lunch meal was observed on May 2, 2008 at approximately 12:55 PM. Table 1 included Residents #26, A3, and A9. Resident #26's lunch was set up first, and he/she started eating immediately. Resident A7 also started eating as soon as he/she was served. Resident A3 received his/her lunch at approximately 1:08 PM. Table 2 included Residents A4, A5, and A6. Resident A5's plate was set up first. He/she started eating immediately. Resident A4 also started eating as soon as he/she was set up too. Resident A6 waited for his/her lunch while the table mates were eating. A6 received his/her lunch at approximately 1:10PM. B. The breakfast meal was observed on the 2nd floor Blue unit on April 28, 2008 at 9:05 AM. Table A included two (2) residents, Residents S1 and S3. Resident S3 was served his/her breakfast at 9:06 AM and was eating. Resident S1 was positioned at the same table at 9:08 AM but had not been served breakfast. At approximately 9:15 AM, S1 received his/her breakfast tray. Table B included two (2) residents, Residents W3	F 241		

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F 241	Continued From page 5 and W4. Resident W4 was eating his/her breakfast. Resident W3 had not been served breakfast. At 9:07 AM, facility staff brought a tray to the table and began to set it up. Resident W5 was brought to the table in a geri chair and began to eat the breakfast that was set up. Resident W3 received his/her breakfast tray at 9:15 AM. Employee #24 was present during this observation.	F 241		
F 253 SS=B	483.15(h) (2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenances services were not adequate to ensure that the facility was maintained sanitary manner as evidenced by: marred/scarred furniture and items stored underneath sinks. These observations were made in the presence of Employees #2, 3, 15, 21, 25, 28 and 20. The findings include: 1. Marred/scarred chair legs were observed in the following areas: 1 Orange: 13 of 13 chairs in the dining room. 2 Orange: 13 of 13 chairs in the dining room. 3 Blue: Four (4) of four (4) chairs in the family room. 2. Items stored underneath sinks were observed	F 253	1. The marred/scarred chair legs identified on the "newly purchased" furniture on 1 Orange, 2 Orange, and 3 Blue were repaired. The items stored under the sinks on 1 Blue, 2 Blue, 3 Blue, and 3 Green have been removed. 2. The chairs in the dining rooms and family rooms were reviewed and those identified to be marred/scarred were sanded and re-stained. The sinks located in other areas of the facility were checked and no others areas were noted to have items under them. 3. The vendors who supplied the new chairs was contacted regarding the finish on the chairs and it was determined that new chairs of that make will no longer be purchased. The preventive maintenance program is now in place to monitor and inspect all marred/scarred legs of the chairs. The nursing department has identified an alternative storage area for supplies, the environmental services manager in-serviced environmental staff on storage of supplies. 4. The Director of Engineering and the maintenance team will monitor and conduct audits of the furniture and report to the quality assurance committee. The Environmental management staff will inspect the areas under the sinks and report to the quality assurance committee.	6/13/08

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F 253	Continued From page 6 in the following areas: 1 Blue medication room: multiple packages of Styrofoam cups and soufflé cups. 2 Blue soiled utility room: Christmas wreath, red biohazard bags, five (5) rolls of clear tape, scrub pad, two (2) bottles of cleaning solution, and assorted mop heads. 2 Blue medication room: Sharp container and ambu-bag. 3 Blue pantry: box of bibs. 3 Green soiled utility room: red biohazard bags. Employees #2, 3, 15, 21, 25, 28 and 20 acknowledged these 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	F 278	1. Resident's #11 and 12 were re-assessed and significant corrections and/or MDS have been completed to address weight and urinary tract infection. 2. A review of the charts has been conducted including the MDS to ensure its accuracy. No other residents have been affected by this practice. 3. The MDS Coordinator, RCCs and Dietitians have been re-educated on the resident assessment instrument particularly as it pertains to weights and diagnosis. 4. The MDS audit is a part of the Quality Improvement Program and is completed monthly and presented at the Quality Assurance Meeting.	6/6/08

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F 278	Continued From page 7 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 interviews for two (2) of 30 sampled residents, it was determined that the facility staff failed to accurately code MDS (Minimum Data Set) for one (1) resident's weight and one (1) resident for UTI (Urinary Tract Infection). Residents #11 and 12. The findings include: 1. The facility staff failed to accurately code Resident #11's weight on the quarterly MDS of March 8, 2008. A review of the resident's record revealed a weight of 97 pounds under Section K (Oral/Nutritional Status) of the quarterly MDS completed on March 8, 2008. A review of the "Monthly Weight Record" revealed the following: December 2007 97 lbs (pounds) January 2008 101 lbs February 2008 105 lbs March 2008 107.5 lbs	F 278		

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F 278	Continued From page 8 A face-to-face interview was conducted on May 2, 2008 at approximately 10:20 AM with Employee #25. He/she acknowledged that the weight recorded on the March 2008, quarterly MDS was not accurate. The record was reviewed on May 1, 2008. 2. The facility staff failed to accurately code Resident #12 for infection on the quarterly MDS assessments dated January 25, 2008 and April 23, 2008. The resident's medical record revealed that Section I2 (j) was checked for Urinary Tract Infection (UTI) on the quarterly MDS assessments dated January 25, 2008 and April 23, 2008. Documentation in the medical record indicates the resident was treated for a UTI October 31, 2007 through November 11, 2007. No other documentation regarding treatment for a UTI could be found in the Medical Record. A face-to-face interview was conducted with Employee #23 on April 29, 2008 at approximately 4:00 PM. He/she acknowledged that January 25, 2008 and April 28, 2008 quarterly MDS assessments were not accurately coded for UTI. The record was reviewed on April 29, 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	F 279		

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F 279	Continued From page 9 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) for 30 sampled residents, it was determined that facility staff failed to develop a care plan with potential for adverse drug interactions involving nine (9) or more medications for Resident #21. The findings include: A review of Resident #21's record revealed a physician's order form signed and dated February 8, 2008 which listed 13 medications. The following medications were ordered for administration: Docusate Sodium 100mg capsule, Guaifenesin Oral Syrup 100mg/5ml, Heparin Sodium 10,000 u/ml, Hydralazine 10 mg tablet, Nephrocaps capsules, Novolin R 100u.ml, Oxycodone w/APAP 5-325mg tablet, Phoslo 667mg gelcap, Renagel 800mg tablet, Sensipar 60mg tablet, Sertraline 100mg tablet, Simvastin	F 279	1. Resident #21's medication regime was reviewed and it was determined that she did need the medications that were ordered. A care plan was developed to address the use of 9 or more medications. 2. A list of residents on 9 or more medications was obtained from the pharmacy. The care plans for those residents were reviewed. No other residents were affected by this practice. 3. The MDS Coordinator and RCCs were re-educated on the importance of care planning of nine or more medications. 4. Review of care plan and its accuracy is a part of the nursing comprehension medical record audit that is completed monthly and is presented at the Quality Assurance Committee meetings.	6/2/08

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F 279	Continued From page 10 20mg tablet and Xalatan eye drops. According to the quarterly "Minimum Data Set", completed February 7, 2008 revealed, Section O1, "Number of Medications" documents that the resident takes 13 medications. A review of the care plan section of the record lacked evidence that a care plan was developed 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 #25 on April 28, 2008 at 3:15 PM. He/she acknowledged a care plan for nine (9) or more medications for Resident #21 was not initiated. The record was reviewed on April 28, 2008.	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	F 280	1. Residents #6, 18 and 21 were receiving appropriate care to areas identified on the skin as ordered by the physician's plan of care. The nursing staff reassessed residents #6 and 18 and the care plans were updated to reflect the appropriate changes. Unable to retrospectively correct care plans for residents #21 and 28 as they were not in facility upon receipt of survey report. 2. The care plans for residents with alteration in skin integrity and with allergies was reviewed. No other residents were found to be affected by this practice. 3. The nursing management team and Dieticians were re-educated on care planning for alteration in skin integrity and food allergies. 4. The nursing management team monitors the care plan monthly. This information is reported at the QA/QI meetings.	6/9/08

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F 280	Continued From page 11 each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 30 sampled residents, it was determined that facility staff failed to: continue a care plan for skin integrity for one (1) resident, accurately reflect the current skin status on the care plan for two (2) residents and update a nutritional care plan for allergies for one (1) resident. Residents #6, 18, 21, and 28. The findings include: 1. Facility staff failed to continue the skin integrity care plan for Resident #6. Care plan #16 "Resident has surgical wound(s) R/T PVD (related to Peripheral Vascular Disease). Measurements: 2x3x0 cm Location: Left bka (below knee amputation) and small 1x1x0 cm front side of left stump. Start date 1-2-08 [January 2, 2008]." This care plan was discontinued on February 2, 2008 [with the comment] "Resident's surgical wound has healed without complication." This was the only care plan in the resident's record related to skin integrity. "Altered Skin Integrity Assessment Forms" in chart for Left stump below knee amputation(BKA) wound type surgical origin date 01/02/08 [January 02, 2008] included weekly documentation of surgical wound from January 11, 2008 through	F 280		

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F 280	Continued From page 12 April 21, 2008. The treatment sheet indicated that the last time the dressing change was done was April 30, 2008. "Altered Skin Integrity Assessment Forms" in the chart for a Left " BK Ulcer " Stage II Origin date 1/11/08 [January 11, 2008] included weekly documentation from January 11, 2008 through April 14, 2008. The documentation indicated "closed" on April 14, 2008. A face-to-face interview was conducted with Employees #17 and 20 on April 30, 2008 at approximately 12:01 PM. He/She acknowledged that the care plan had been discontinued on February 8, 2008. The record was reviewed on April 30, 2008. 2. Facility staff failed to revise Resident #18's care plan to include the right ischium pressure sore. A nurse's note dated April 23, 2008 included, "7 A Resident readmitted on 4/21/08 ... Resident has (R) ischium ulcer 4 x 3 x 0 x 0 cm, a Stage III pressure ulcer ... (L) Ischium 1 x 1 x 0 x 0 cm, a Stage III pressure ulcer ..." The care plan entitled "Alteration in Skin Integrity" included, "Area on right ischium will show signs of healing within the next month." The care plan did not include the left ischium pressure sore. A face-to-face interview was conducted with Employee #17 on April 30, 2008 at 10:40 AM. He/She acknowledged that the left ischium pressure sore had not been added to the care plan. The record was reviewed on April 30, 2008.	F 280		

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F 280	Continued From page 13 3. Facility staff failed to accurately reflect the current status of Resident #21's skin on the "decubiti" care plan. A review of the care plan entitled "decubiti" included revisions as follows: "2/13/08 skin continues to be free of open areas ..." A review of the "Altered Skin Integrity Assessment" forms revealed the following: "Location of Wound: Sacral. Date of Origin: 12/14/07. The forms included weekly assessments of the sacral pressure sore from December 14, 2007 through April 25, 2008." A face-to-face interview was conducted with Employee #25 on May 1, 2008 at 3:15 PM. He/She acknowledged that the entry on the care plan was inaccurate. The record was reviewed on May 1, 2008. 4. Facility staff failed to include an allergy to nuts on the "Nutritional Status" care plan for Resident #28 who was allergic to nuts. A review of the "Physician Order Sheet and Plan on Care" dated February 21, 2008 and signed by the physician on February 29, 2008 revealed, "Allergy history: Latex and nuts...". A review of the "Nutritional Status" care plan last updated on February 27, 2008 revealed, "Allergies: NKFA [no known food allergy]". The care plan lacked evidence that it was updated or amended to include the allergy to nuts. A face-to-face interview was conducted on April 30, 2008 at 9:30 AM with Employee #4. He/she acknowledged that Resident #28's allergy to nuts	F 280		

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F 280	Continued From page 14 was not included on the care plan. The record was reviewed on April 30, 2008.	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 observation, staff interview and record review for four (4) of 30 sampled residents, and two (2) supplemental residents, it was determined that facility staff failed to: follow up on a psychiatric consultation for one (1) resident, clarify an order for an appetite stimulant for one (1) resident with a GT (gastrostomy tube), follow up on a urology appointment for one (1) resident, discontinue isolation practices for two (2) residents, ensure that pain medication was available for administration for one (1) resident, notify the physician of a drug-to-drug interaction for one (1) resident, and apply cradle boots for one (1) resident. Residents #7, 8, 18, 21, JH3 and S2. The findings include: 1. Facility staff failed to reschedule a psychiatric consultation for Resident #7. A review of the resident's record revealed the following doctor's orders: A telephone order dated December 28, 2007 directed,"...Psychiatry consult due to patient	F 309	1. Resident #7 was seen immediately by the psychiatrist and it was determined that the plan of care was appropriate. Resident ##8s physician was contacted and he indicated that as the primary he interpreted that the resident was to be seen by the urologist prn (as necessary); however, an appointment has been scheduled. Additionally, the nursing staff had discontinued the isolation as ordered and ; however, the dietary department was re-notified regarding the discontinuance of the isolation. The physician was contacted regarding resident #18 and the mirtazapine was discontinued. As indicated in report resident #21 had no complaints of pain; however, Unable to retrospectively correct medication administration for resident #21. The dietary department was immediately notified regarding the resident not being on isolation. Resident #JH3 had been seen by the physician and lab work to evaluate the use of Coumadin had already been ordered and was within normal limits. The pharmacy recommendations regarding the use of Coumadin and Cipro was sent to the physician. The cradle boots were applied to resident #S2 immediately. 2. A review of the residents requiring psychiatric evaluations and outside urology appointments was conducted; a review of residents on GT feedings was conducted to ensure that they were not on appetite stimulants, a review of residents on isolation, and those residents receiving pain medication was conducted. An audit of resident's drug to drug interaction medications was done and a review of resident s with orders for cradle boots was done. No other residents were found to be affected by these isolated incidents.	

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F 309	Continued From page 15 agitation ..." A telephone order dated February 16, 2008 directed,"...Psychiatry consult due to patient status." The physician's progress note dated March 1, 2008 revealed the following "Psych. [Psychiatry] consult: attempt to see Resident. Resident currently at the hospital. Will follow after discharge from hospital." Documentation in the Nursing notes indicate the resident was sent to the emergency room on March 1, 2008 and returned to the facility within twenty-four (24) hours, Facility staff failed to reschedule Resident #7 for psychiatry evaluation after March 1, 2008. A face-to-face interview was conducted with Employee #21 on May 2, 2008 at approximately 3:30 PM. He/she acknowledged that the facility staff failed to reschedule the resident for the psychiatry consultation after March 1, 2008. The record was reviewed on May 2, 2008. 2. Facility staff failed to follow-up on a urology consult and discontinue isolation practices for Resident #8. A. Facility staff failed to follow up on a urology consult for Resident #8. According to the urologist's consult dated February 27, 2008, "Patient has had the catheter changed monthly per recommendation. ... Continue with catheter change ... See q (every) 4-6 weeks or PRN." Further review of the record revealed that no appointment was scheduled for the resident between February 27 and April 29, 2008.	F 309	3. The licensed nursing staff will be re-educated on follow up of psychiatric and urology appointments, medication administration including GT medication administration and use of appetite stimulant, drug to drug interactions, use of isolation, and cradle boots. An interim narcotic box has been put in place to ensure the resident receives pain medications in a timely manner. 4. The nursing management team completes a detailed nursing comprehensive medical records audit. This information is presented at the QA/QI meeting.	6/19/08

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F 309	Continued From page 16 A face-to-face interview conducted with Employee #17 at approximately 9:05 AM on April 30, 2008. He/she acknowledged that the appointment was not scheduled. He/she stated, "We did not think he/she needed to return because the order said prn and [the resident] did not have any problems." The record was reviewed on April 29, 2008. B. The facility staff failed to discontinue isolation practices for Resident #8. On May 1, 2008 at approximately 9:30AM Resident # 8 was observed eating with plastic utensils from a paper food container on a paper tray. A face-to-face interview was conducted with Employee #20 at approximately 10:00 AM on May 1, 2008. He/she was asked if the resident was on isolation, and if not why was he/she being served with paper ware. Employee #20 stated that the resident had been on isolation but it has been discontinued. The employee added, "I don't understand. I discontinued the isolation myself last week. Anyhow, I will do it again." Approximately five (5) minutes later Employee #20 displayed a form addressed to the Dietary Department regarding the discontinuation of isolation for the resident. The employee stated, "I am taking this downstairs myself this time." A review of the record revealed a physician's telephone order dated April 23, 2008 and signed on April 25, 2008 which directed, "Discontinue Isolation." The record was reviewed on April 29, 2008. 3. Facility staff failed to clarify an order for the	F 309		

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F 309	Continued From page 17 necessity of an appetite stimulant for Resident #18 who had a GT prior to withholding the medication. The resident was transferred to the hospital on April 15, 2008 and was readmitted on April 21, 2008. A review of the readmission orders dated April 21, 2008 revealed an order for Mirtazapine 15 mg via GT QD (everyday) for appetite stimulant. The resident was administered Mirtazapine prior to transfer to the hospital. The resident was readmitted after insertion of a GT with orders for enteral feedings of Nutrient 1.5 at 60 ml per hour for 18 hours per day. A review of the April 2008 Medication Administration Record (MAR) revealed that Mirtazapine 15 mg was administered to Resident #18 April 22 through 27, 2008. There were initials circled for April 28 through 30, 2008 indicating that Mirtazapine was not administered. There was no documentation on the back of the MAR to indicate why the medication was not administered. A face-to-face interview was conducted with Employee #12 on April 30, 2008 at approximately 10:30 AM. Employee #12 was shown the April 2008 MAR with the transcribed order for Mirtazapine. He/She stated, "[Resident #18] has a GT. I didn't get a chance to call the doctor, I wasn't here yesterday". Employee #12 acknowledged that the Mirtazapine was administered to the resident April 22 through 27, 2008 and not administered April 28 through 30, 2008. The record was reviewed on April 30, 2008.	F 309		

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F 309	Continued From page 18 4. Facility staff failed to ensure that pain medication was available for administration for Resident #21 and discontinue isolation practices as per physician's orders. A. Facility staff failed to ensure that Oxycodone was ordered and received in a timely manner. A physician's order dated January 29, 2008, signed by the physician on February 7, 2008, directed, "Oxycodone w/APAP 5-325 mg PO (by mouth) every evening at 6 PM for pain." The February 2008 Medication Administration Record (MAR) revealed that Oxycodone was not administered for 10 days from February 8 through 18, 2008. There were nurses' initials circled for February 8 through 17, 2008 and there was no entry on the MAR for February 18, 2008. Written on the back of the MAR for February 8 through 17, 2008 was "On Order" and "Not Given." There was no explanation for the omission for February 18, 2008. Oxycodone was administered on February 19, 2008. The March 2008 MAR revealed that Oxycodone was not administered for 10 days from March 4 through 12, 2008 and March 22, 2008. The resident was hospitalized from March 13 through 21, 2008. The nurses' initials were circled for March 4 through 12, 2008 and March 22, 2008. Written on the back of the MAR was "On Order" and "Not Given" for the aforementioned dates. A face-to-face interview was conducted with the Employee #25 on May 1, 2008 at 3:15 PM. He/She stated, "[Resident] has not complained of pain that I know of." Employee #25 was not aware of the reason for the delay in receiving	F 309		

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F 309	Continued From page 19 Oxycodone. A telephone interview was conducted with Employee #14 on May 2, 2008 at approximately 2:00 PM. He/She stated, "We [pharmacy] received three (3) orders for Percocet (Oxycodone) for [Resident #21] on January 22, February 18 and March 22, 2008. Each order was for a quantity of 15. There is no verification that any other orders for Percocet came in." The nursing monthly assessments for pain and nurses' notes were reviewed for February and March 2008. There was no documentation or indication that the resident complained of pain. Facility staff failed to ensure that Resident #21 had sufficient medication for administration as ordered. B. Facility staff failed to discontinue isolation practices for Resident #21 as per physician's orders. On April 28, 2008 at 9:30 AM, the door to Resident #21's room had a sign which instructed visitors to report to the nurses' station. There were paper products from the breakfast meal in the resident's room. A face-to-face interview was conducted with Employee #25 on May 5, 2008 at approximately 9:45 AM. He/She stated, "[Resident] is not on it [isolation] anymore." A physician's order dated April 14, 2008 at 11:45 AM read, "D/C (discontinue) MRSA (Methicillin Resistant Staphylococcus Aureus) isolation."	F 309		

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F 309	Continued From page 20 Facility staff continued isolation practices although a physician's order directed to discontinue isolation. The record was reviewed on May 1, 2008. 5. The facility failed to notify the physician of a drug-to-drug interaction for Resident JH3. The POS [physician's order sheet] dated April 11, 2008 directed, "Warfarin 5 mg tab, 1 (one) tab po [by mouth] every day for clot prevention " A review of Resident JH3's record revealed a physician's order dated April 14, 2008 that directed, "Cipro 500 mg 1 tab po bid [twice daily] x [times] 10 days for Urinary Tract Infection " . A review of the nurse's notes lacked evidence that document the Warfarin and Cipro causes a drug interaction. A telephone interview was conducted with Employee #14 on May 2, 2008 at approximately 3:00 PM. He/she stated, "The pharmacy telephoned the facility to inform them of the drug interaction. Employee #19 took the message." While the resident was receiving Warfarin and Cipro the resident's INR increased from 2.5 to 4.52. A face-to-face interview was conducted on May 2, 2008 at approximately 3:45 PM with Employee #19. He/she could not remember being informed by the pharmacy staff of the drug interaction. The record was reviewed on May 2, 2008. 6. Facility staff failed to apply cradle boots to Resident S2 as per physician orders.	F 309		

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F 309	Continued From page 21 Resident S2 was observed in bed on May 1, 2008 at 8:15 AM in the presence of Employee #25. The resident did not have cradle boots on his/her feet. A physician's order initiated March 15, 2008 and renewed April 1, 2008, directed, "Cradle boots to LE (lower extremities) while in bed for protection." A review of the April 2008 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed that the order had not been transcribed onto April MAR/TAR. A review of the May 2008 MAR/TAR revealed that the order for the use of cradle boots was present. Employee #25 stated at the time of the observation that he/she had just received a new pair of cradle boots the prior day and did not know why the boots had not been applied. The record was reviewed May 1, 2008.	F 309		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff	F 314	1. Resident's #16,18 and A1's community acquired pressure sores were re-assessed by the nursing management team in consultation with the physicians. All residents are currently receiving treatment of the areas as ordered by the physician. 2. The wound care nurse and nursing management team reviewed all residents with alteration in skin integrity to ensure that all residents had appropriate orders with independent supplies. No other residents were affected by this practice. 3. All nursing staff will be re-educated on proper infection control procedures and on physicians' orders for residents upon admission	

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F 314	Continued From page 22 interviews for two (2) of 30 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to follow proper infection control procedures during pressure ulcer treatment for two (2)residents, and accurately assess the skin to ensure that one (1) resident had treatment orders for pressure sores on readmission. Residents #16, 18 and A1. The findings include: 1. Facility staff failed to follow proper infection control procedures during pressure ulcer treatments for Residents #16 and A1. On April 29, 2008 at approximately 10:35 AM a pressure ulcer treatment was observed for Resident #16 and at approximately 11:00 AM a pressure ulcer treatment was observed for Resident A1. Employee #20 rolled the treatment cart to the entry of Resident #16's room. He/she entered the room with wound care supplies that included: a bottle of Septicare wound cleanser, Polysporin powder, and a pack of 4x4 gauze sponges. The supplies were placed on the resident's over bed table. The table was covered with a protective barrier prior to placing the supplies on the table. Employee #20 failed to cleanse the outside of the bottle of Septicare wound cleanser and Polysporin powder after completion of Resident 16's Stage IV buttock pressure ulcer treatment and before placing the bottle in the treatment cart. Employee #20 rolled the treatment cart to the entry of Resident A1's room. He/she provided wound care treatment to Resident A1 right	F 314	and re-admission. 4. A review of the alteration in skin integrity including treatments, infection control and physician orders are conducted monthly and present at the QA/QI meetings.	6/19/08

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F 314	Continued From page 23 buttock and left ankle pressure ulcers with the same wound care supplies used on Resident #16 including: Septicare, Polysporin powder, and the unused pack of 4x4 gauze sponges. A tube of Santyl cream used on Resident A1 was not labeled for the resident' s use. Employee #20 failed to cleanse the outside of the bottles of Septicare wound cleanser and Polysporin powder after completion of Resident A1's Stage IV pressure ulcers treatment and before placing the bottles in the treatment cart. A face-to-face interview was conducted on May 5, 2007 at approximately 3:00 PM with Employee #20. The nurse acknowledged that he/she failed to cleanse the outside of the bottles of Septicare wound cleanser and Polysporin powder before and after completion of treatments to Resident #16's Stage IV pressure ulcer and A1's Stage IV pressure ulcers and before placing the items in the treatment cart . 2. Facility staff failed to accurately assess the skin and ensure that Resident #18 had orders for the treatment of bilateral ischium pressure sores on readmission to the facility. A nurse's note dated April 14, 2008 at 10:00 PM revealed, "Head to toe skin assessment done TX (treatment) to open area RT (right) Ischium continues .." The resident was transferred to the hospital on April 15, 2008. Resident #18 was readmitted to the facility on April 21, 2008. The readmission nurse's note dated April 21, 2008 at 9:00 PM included the following, "...healed scar on both sides of buttocks (95%) ..."	F 314		

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F 314	Continued From page 24 A nurse's note dated April 23, 2008 at 7:00 AM included, "Resident readmitted on 4/21/08 ... Resident has (R) ischium ulcer 4 x 3 x 0 x 0 cm, a stage III pressure ulcer ... (L) Ischium 1 x 1 x 0 x 0 cm, a stage III pressure ulcer ..." A face-to-face interview was conducted with Employee #20 on April 30, 2008. He/She stated that the right ischium pressure sore was not healed when the resident was readmitted and that the left ischium pressure sore was first observed on readmission to the facility. Employee #20 acknowledged that the readmission assessment of the skin was wrong. The readmission orders dated April 21, 2008 were reviewed and did not include treatment orders for the right and left ischium pressure sores. The Interim Order Form included orders dated April 23, 2008 at 8:00 AM which directed, "Apply Santyl ointment and Polysporin powder to (R) Ischium daily after cleansing with wound cleanser and patting dry. Cover with Alleryn adhesive. Apply Santyl ointment and Polysporin powder to (L) Ischium daily after cleansing with wound cleanser and patting dry. Cover with Alleryn adhesive." The record was reviewed on April 30, 2008.	F 314		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities,	F 322		

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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 322	Continued From page 25 and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 30 sampled residents, and one (1) supplemental resident, it was determined that facility staff failed to label a bag of Nutren 1.5 with one (1) resident's name, the date, time and flow rate and failed to follow appropriate procedures to monitor patency of a G tube [gastrostomy tube] for one (1) resident. Resident's #11 and JH2. The findings include: 1. On May 1, 2008 at approximately 11:55PM Resident #11 was observed seated in a geri chair in the Solarium. A bag of Nutren 1.5 (Approximately ¾ filled) was infusing via pump via G tube (Gastrostomy tube) at a rate of 50 cc/hr (cubic centimeters an hour). At approximately 12:30PM on May 1, 2008 Employee #26 was observed standing next to the bag of Nutren with an open pen in his/her hand. At approximately 12:35PM on May 1, 2008 the bag of Nutren was observed hanging with Resident #11's name. The date on the bag was 5/1/08 and the time the feeding was hung was written in as 6:00AM. The rate of the feeding was written as 50cc and the initials of the person who documented the information were "Employee #26". A face-to-face interview was conducted with Employee #26 at approximately 12:35 PM.	F 322	1 Resident #11 and #JH2 were receiving the tube feeding as ordered by the physician. The bag of Nutren 1.5 for resident #11 was labeled immediately and the GT for JH2 was checked for patency using the appropriate procedure and was found to be in place and completely patent. 2. The nurse managers checked all residents on feeding tubes to ensure that tube feedings were labeled and that the G tubes were patent. No other resident was found to be affected by this practice. 3. All nursing staff will be re-educated for checking G-Tube patency and labeling the feeding bag before administration of feeding. 4. The nursing management team will utilize the nutrition/hydration resident care audit to ensure that all G-Tubes are properly labeled and that feedings are being administered as ordered.	6/9/08

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F 322	Continued From page 26 on May 1, 2008. He/she acknowledged that there was no information on the bag at 11:55 AM. The " Night Charge Nurse " had indicated by his/her signature on the MAR (Medication Administration Record) that the bag was hung at 6:00 AM; and that he/she had written the information on the bag. A review of the record revealed an order for " Nutren 1.5 at 50cc/hr via G tube via pump. Change feeding (spike cap set/bag) q 6AM (every day at AM)." The order was signed by the physician on April 1, 2008. The record was reviewed on May 1, 2008. 2. Facility staff failed to properly check for patency of the gastric tube for Resident JH2. On April 29, 2008 at approximately 10:40 AM, during medication pass, Employee #11 was observed unclogging the g-tube by squeezing and pulling on the tube to remove the coagulated liquid feed before administering medications. A face-to-face interview was conducted with Employee #11on May 1, 2008 at approximately 3:00 PM. He/she stated that the facility in-services the staff on how to maintain patency of a g-tube. He/she acknowledged that he/she knew the proper procedure.	F 322		
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	F 386	1. Residents #3,7,9,18 and W1 were re-assessed by the physicians. Progress notes and/or History and Physicals were updated or an addendum to the H&P was done to reflect condition of skin, psychiatric consultation, illnesses, GT placement, and discontinuance of appetite stimulant.	

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F 386	Continued From page 27 administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for four (4) of 30 sampled residents and one (1) supplemental resident+, it was determined that the physician failed to: include the presence of a pressure sore in the progress notes for one (1) resident; follow up on a psychiatry consultation for one (1) resident; include all illnesses on the History and Physical assessment (H&P) for two (2) residents; include an accurate skin assessment and the placement of a GT (gastrostomy tube) in the physician progress notes and evaluate the necessity for an appetite stimulant for one (1) resident. Residents #3, 7, 9, 18, and W1. The findings include: 1. The physician failed to include the presence of the right elbow pressure sore in the physician progress notes for Resident #3. The physician's progress note dated March 18, 2008 included, "...Skin intact small sacral decubitus doing well ..." An entry in the nurses' notes dated March 12, 2008 at 2:00 PM revealed, "Pressure ulcer assessment (R) elbow 4 x 4 x 0 x 0, a stage IV pressure ulcer ..." The record was reviewed on April 28, 2008. 2. The physician failed to follow-up on a psychiatry consultation order for Resident #7.	F 386	2. A review of the physician's Documentation was conducted by the physicians, nursing management and medical records staff. Areas of concern were addressed as indicated. 3. The Medical Director met with and/or contacted all members of the medical staff and reviewed regulatory compliance and facility requirements as it pertains to the care of the residents. 4. The Medical Director and/or member of the medical team conducts audits of the physician requirements. Additionally, nursing and medical records audits the clinical record. This information is presented in the QA/QI meetings.	6/19/08

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F 386	Continued From page 28 A review of the resident's record revealed the following nursing notes: December 28, 2007 at 10:00 PM, "Resident went to the patient in [another room] and hold [The patient' s] neck with two hands almost [choking] ...RP [Responsible Party] made aware, MD paged ..." December 28, 2007 at 11:50 PM, "...Increase Haldol from 0.5mg to 1mg 1tab P.O. BID (orally, twice per day) for psychosis will continue to monitor ..." A review of the resident' s record revealed the following doctor's telephone orders: December 28, 2007 that directed, "...Psychiatry consult due to patient agitation ..." February 16, 2008 directed, "...Psychiatry consult due to patient status." A review of the physician's progress notes revealed the following: January 15, 2008, "...Patient evaluated and examined ... Continue with present care." March 1, 2008, "[Psychiatry] consult: attempt to see Resident. Resident currently at the hospital. Will follow after discharge from hospital." March 4, 2008 Attending Note (Urgent Unit), "...Assessment Fall/ injury [no fracture] ..." The Physician's progress notes lacked evidence that the physician followed up with his/her order for a psychiatry consultation for Resident #7. A face-to-face interview was conducted with Employee #21 on May 2, 2008 at approximately	F 386		

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F 386	Continued From page 29 3:30 PM. He/she acknowledged that the physician failed to follow up with his/her orders of December 28, 2007 and February 16, 2008 for psychiatry consultation for Resident #7. The record was reviewed on May 2, 2008. 3. The physician failed to include all illnesses for Resident #9 on the H&P. The significant changed MDS (Minimum Data Set) dated November 5, 2007 and February 21, 2008 included the following diagnoses: Hypertension, Dementia other than Alzheimer disease and Depression. The H&P dated January 25, 2008 included the diagnoses Dementia and HTN (Hypertension). The area on the H&P " Has the resident had any of the following illnesses? (Circle and describe below if not previously described) did not have any illnesses circled." Depression was listed in this area, however Depression was not circled. A face-to-face interview was conducted with Employee #12 on April 30, 2008 at 10:00 AM. He/She acknowledged that illnesses for Resident #9 were not circled on the H&P. The record was reviewed on April 30, 2008. 4. The physician failed to include an accurate skin assessment and the placement of a GT in the physician progress notes for Resident #18 and evaluate the necessity for an appetite stimulant after insertion of the GT. A. A nurse's note dated April 14, 2008 at 10:00 PM included, "Head to toe skin assessment done. TX (treatment) to open area Rt (right) ischium	F 386		

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F 386	Continued From page 30 continues ..." The physician progress note dated April 15, 2008 included the following, "Attending Note, very poor PO (by mouth) intake/lethargic. Not drinking as well ... GI needs consent for GT - tube placement ... Skin - dry with poor turgor ...Plan Transfer to the hospital for evaluation." There was no reference to the open area to the right ischium in the progress note. The resident was transferred to the hospital on April 15, 2008 and was readmitted on April 21, 2008. The nurses' readmission note dated April 21, 2008 at 9:00 PM included, "...On G tube placement site clean patent and intact..." April 25, 2008, "MD Note - Called by the RN to evaluate resident with temp of 100.3 ...close observation". This was the first physician's progress note since Resident #18 was readmitted to the facility, but there was no reference in the physician's note to the GT. B. The physician failed to evaluate the necessity for an appetite stimulant after insertion of the GT for resident #18. A review of the readmission orders dated April 21, 2008 revealed an order for Mirtazapine 15 mg via GT QD (everyday) for appetite stimulant. The resident was readmitted after insertion of a GT with orders for enteral feedings of Nutrient 1.5 at 60 ml per hour for 18 hours per day. A review of the April 2008 Medication Administration Record (MAR) revealed that Mirtazapine 15 mg was administered to Resident	F 386		

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F 386	Continued From page 31 #18 April 22 through 27, 2008. There were initials circled for April 28 through 20, 2008 indicating that Mirtazapine was not administered. There was no documentation on the back of the MAR to indicate why the medication was not administered. A face-to-face interview was conducted with Employee #12 on April 30, 2008 at approximately 10:30 AM. Employee #12 was showed the April 2008 MAR with the transcribed order for Mirtazapine. He/She stated, "[Resident #18] has a GT. I didn't get a chance to call the doctor, I wasn't here yesterday". Employee #12 acknowledged that the Mirtazapine was administered to the resident April 22 through 27, 2008. The record was reviewed on April 30, 2008. 5. The physician failed to include all diagnoses and illnesses for Resident W1 on the H&P (History and Physical). A physician' s progress note dated August 31, 2007 included, "71 year old male with Prostatic Cancer, ETOH abuse, Seizure and multi infarcts ..." The H&P dated August 31, 2007 did not include any diagnoses for Resident W1. The area on the H&P "Has the resident had any of the following illnesses? (Circle and describe below if not previously described)" included Cancer and alcohol over use, but were not circled by the physician. A face-to-face interview was conducted with Employee #17 on May 1, 2008 at 10:20 AM.	F 386		

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F 386	Continued From page 32 He/She acknowledged that the physician failed to include Resident W1's diagnoses and illnesses on the H&P. The record was reviewed on April 30, 2008.	F 386		
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 observation, record review and staff interview, it was determined that four (4) of five (5) records reviewed for controlled substances, that facility staff failed to document the administration of controlled substances on the MAR (Medication Administration Record). Residents JH4, JH5, and JH6. The findings include:	F 425	1. Residents #JH4, JH5 and JH6 were re-assessed by the nursing team subjectively and objectively. All residents verbalized that they were free of pain and when requested that they receive their pain medication and it has been effective. Unable to retrospectively correct MAR. Staff currently signing MAR when administering pain medication. 2. A review of the MAR (medication administration record) was completed by the nursing management team. No other residents were found to be affected by this practice. 3. All nursing staff were re-educated on medication administration including routine medications and controlled substance. 4. The nursing management team monitors the MAR to ensure compliance. This information is presented in the QA/QI meeting.	6/9/08

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F 425	Continued From page 33 1. Facility staff failed to document the administration of controlled substances on the February and March 2008 MAR for Resident JH4. A review of Resident JH4's record revealed a physician's order dated February 8, 2008 that directed, "Oxycodone w/APAP 5-325mg tablet, 1 tab via g-tube every 6 hours as needed for pain." The February 2008 MAR was reviewed and indicated with signatures that Oxycodone w/APAP was administered six (6) times in February [February 5, 18, 25, 27 and 29, 2008] as evidence by the nurses' initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Oxycodone w/APAP was taken from Resident JH4's blister card on the following dates in February 5,16,18,19, 20, 22 25, 27 and 29, 2008. There was no evidence on the February 2008 MAR that the Oxycodone w/APAP 5-325mg was administered on February 16, 19, and 22, 2008. The March 2008 MAR was reviewed and indicated with signatures that Oxycodone w/APAP was administered two (2) times in March [March 21 and 28, 2008] as evidence by the nurses' initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Oxycodone w/APAP was taken from Resident JH4's blister card on the following dates in March 3,5,7,19,12,17,19,22, 26 and 31, 2008. There was no evidence on the March 2008 MAR that the Oxycodone w/ APAP 5-325 mg was	F 425		

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F 425	Continued From page 34 administered on the aforementioned dates. A face-to-face interview was conducted on Employee #15 on May 1, 2008 at approximately 3:45 PM. He/she acknowledged that the MAR did not indicate with signatures that the controlled substance was administered to Resident JH4. The record was reviewed on May 1, 2008. 2. Facility staff failed to document the administration of controlled substances on the January 2008 MAR for Resident JH5. A review of Resident JH5 's record revealed a physician's order dated December 7, 2008 that directed, " APAP/Codeine #3 tab, 1 tab po [by mouth] every four hours as needed for toothache." The January 2008 MAR was reviewed and indicated with signatures that APAP/Codeine was administered four (4) times in January 2008 [January 1 (11 AM), 4 (2:45 PM), 6 (2:45 PM) and 12 (5 PM)] as evidence by initials enter in the allotted areas for the dates mentioned. The "Individual Resident's Controlled Substance Record" indicated the APAP/Codeine #3 was taken from Resident JH5's blister card on the following dates and time: January Time 1 6 PM 2 6 PM 3 10:10 AM, 2 PM, 5 PM 4 1 AM 6 6 PM 8 3 PM, 8 PM 9 8 PM 10 1 AM, 6 PM	F 425		

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11 1:30 PM, 5:30 PM
14 6 PM
15 5:30 PM
17 1:30 PM
17 8 PM
18 6 PM
19 1:15 PM
19 5:30 PM
20 6 PM

There was no evidence on the January 2008 MAR that the APAP/Codeine #3 was administered on the above dates.

A face-to-face interview was conducted on Employee #15 on May 1, 2008 at approximately 3:30 PM. He/she acknowledged that the MAR did not indicate with signatures that the controlled substance was administered to Resident JH5. The record was reviewed May 1, 2008.

3. Facility staff failed to document the administration of controlled substances on the April 2008 MAR for Resident JH6.

Review of Resident JH6's record revealed a physician's order dated April 2, 2008 that directed, "Oxycodone w/APAP 5-325mg tab, 2 tablets (10-650mg) po [by mouth] 2 times a day as needed for pain."

The April 2008 MAR was reviewed. There was no indication of signatures that Oxycodone w/APAP was administered.

The "Controlled Drug Record" indicated the Oxycodone w/APAP was taken from Resident JH6's blister card on the following dates and time:

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F 425	Continued From page 36 April Time 11 5 PM 14 5 PM 15 5 PM 16 5 PM 17 5 PM 19 5 PM --- 5 PM 21 5 PM 22 5 PM There was no evidence on the April 2008 MAR that the Oxycodone w/APAP 5-325mg was administered on the above dates. A face-to-face interview was conducted with Employee #18 on May 1, 2008 at approximately 3:15 PM. He/she acknowledged that the April 2008 MAR did not indicate with signatures that the controlled substance was administered to Resident JH6. The record was reviewed May 1, 2008.	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	F 431	1. The medications requiring refrigeration were placed in the refrigerator immediately. The engineering staff checked the refrigerators adjusted the thermostat on 3 Blue and changed the refrigerator on 2 Blue. 2. The medication carts were checked to ensure that medications that required refrigeration were stored according to manufacture's recommendations. No other drug was found to be affected by this practice. All medication refrigerators were checked, and no other refrigerator was found to be affected by this practice.	

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F 431	Continued From page 37 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 observation, review of records and staff interview, it was determined that facility staff failed to store all drugs and biological under proper temperature controls. The findings include: 1.The facility staff failed to store medications at the proper temperatures. The facility's policy 4.1 "General Guidelines for Medication Storage" stipulates (9) "Medications requiring refrigeration or temperatures between 36° F and 46° F are kept in a refrigerator with a thermometer to allow temperature monitoring."	F 431	3. The licensed nursing staff were re-educated regarding storage of drugs and biologicals. Additionally, the licensed staff were re-educated on procedures for checking refrigerator temperatures. 4. Checking the storage of medications and the medication refrigerator temperatures is a part of the daily nursing rounds and monthly pharmacy inspections. Monitoring refrigerator temperatures is also part of the engineering inspections. This information will be presented in the QA/QI meetings.	6/16/08

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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 38 On April 29, 2008, between 1:00 PM and 3:00 PM, during the inspection of the facility's medication storage areas, nine (9)sealed containers were observed stored in the medication carts on 1 Green, 2 Green and 3 Orange units. These drugs required refrigeration, but were stored at room temperature. According to the manufacturer's recommendation, Xalatan must be stored under refrigeration until opened for use. According to the manufacturer's recommendations, Lactinex and Aranesp are to be refrigerated at all times. The medications included: Six (6) sealed container of Lactinex packages One (1) sealed container of Aranesp Injection Two (2) sealed containers of Xalatan ophthalmic drops 2. The facility staff failed to store refrigerated medication at the proper temperature in two (2) of nine (9) medication refrigerators . On April 30, 2008, between 3:00 PM and 4:00 PM, during the inspection of the facility's medication storage area, the medication refrigerators were out of range. The temperature should range between 36° Fahrenheit (F) - 46° F. On unit 2 Blue, the unit inspection reports showed the refrigerator temperatures were as follows: April 30, 2008 - 65° F, February 2008 - 20° F, January 2008 - 25 F , December 2007 - 20° F November 2007- 30° F, September 2007- 34° F and August 2007- 34° F. On three Blue, the unit inspection reports showed the refrigerator temperatures were as follows:	F 431		

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	095014	A. BUILDING _____ B. WING _____	05/05/2008

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F 431	Continued From page 39 April 30, 2008 - 65° F, February 2008 - 20° F, January 2008 - 25° F , December 2007 - 20° F November 2007- 30° F, September 2007- 34° F and August 2007- 34° F. A face-to-face interview was conducted on May 2, 2008 at 2:00 PM with Employees #25, 22, and 34. He/she acknowledged that the refrigerators were fluctuating and corrected the problem.	F 431		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews for four (4) of 30 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to: accurately document the status of one (1) resident's skin on readmission, document one (1) resident's behaviors on the monthly behavior monitoring flow record, document allergy and treatment on the discharge summary for one (1) resident, document the disposition of the body after pronouncement for one (1) resident and failed to discontinue a wound treatment before initiating	F 514	1. Resident' #18's community acquired pressure sore was assessed and accurate documentation is reflected in the record. Resident #22's record revealed accurate documentation in the nursing notes. Staff have been re-educated regarding documenting on the behavior monitoring record as well. Residents #28 and 29 were closed records. Resident #S2 was reassessed by the nursing management team in consultations with the physicians. Treatment order was obtained and record was modified to reflect the treatment as ordered. Unable to retrospectively correct documentation of record. 2. The nursing management team reviewed all residents with alteration in skin integrity and residents on behavior monitoring. A review of closed records including discharge summaries and/or residents who expired was completed. No other residents were found to be affected by this practice. 3. Nursing staff will be re-educated regarding documentation requirements. 4. Monthly audits are conducted by the nursing management team on open records and the medical records coordinator audits the closed records. This information is presented at the QA/QI committee meetings.	6/19/08

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F 514	Continued From page 40 another wound treatment for one (1) resident. Residents #18, 22, 28, 29 and S2. The findings include: 1. Facility staff failed to accurately document the status of Resident #18's skin on readmission to the facility. A nurse' s note dated April 14, 2008 at 10:00 PM revealed," Head to toe skin assessment done TX (treatment) to open area RT (right) Ischium continues ..." The resident was transferred to the hospital on April 15, 2008. Resident #18 was readmitted to the facility on April 21, 2008. The readmission nurses' note dated April 21, 2008 at 9:00 PM included the following, "...healed scar on both side of buttocks (95%) ..." A nurse's note dated April 23, 2008 at 7:00 AM included, " Resident readmitted on 4/21/08 ... Resident has (R) ischium ulcer 4 x 3 x 0 x 0 cm, a stage III pressure ulcer ... (L) Ischium 1 x 1 x 0 x 0 cm, a stage III pressure ulcer ..." A face-to-face interview was conducted with Employee #20 on April 30, 2008. He/She stated that the right ischium pressure sore was not healed when the resident was readmitted and that the left ischium pressure sore was first observed on readmission to the facility. Employee #20 acknowledged that the readmission assessment of the skin was wrong. The record was reviewed on April 30, 2008. 2. Facility staff failed to document all behaviors for Resident #22 on the "Monthly Behavior	F 514		

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F 514	Continued From page 41 Monitoring Flow Record." A review of the nurses' notes revealed the following: April 12, 2008 at 3:30 PM, " ...Eloped from the unit ..." April 17, 2008 at 8:20 PM, " From 6:30 PM [he/she] is very agitated and abusive and several times walking out of the unit, but caregivers have been following [him/her] ..." April 18, 2008 at 4:20 PM, " Resident left the unit unescorted ..." The "Monthly Behavior Flow Record" was reviewed for April 2008. The following behaviors were identified on the form: "Behavior #1 - Attempted elopement (leaving the unit unescorted) and Behavior #2 - Verbally abusive towards staff and residents." The aforementioned incidents on April 12, 17 and 18, 2008 were not entered on the Monthly Behavior Flow Record. A face-to-face interview was conducted with Employee #21 on May 1, 2008 at 3:45 PM. He/she acknowledged the absence of the behaviors on the "Monthly Behavior Flow Record." The record was reviewed on April 30, 2008. 3. Facility staff failed to document the resident's allergy to nuts and a wet-to-dry treatment to the abdomen on the "Discharge Summary" for Resident #28. A review of the " Interdisciplinary Discharge Summary" revealed, "...discharge date March 14, 2008 ..."	F 514		

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F 514	Continued From page 42 A telephone order dated March 13, 2008 at 12 Noon directed, "Discharge Orders ...Allergy- Latex and nuts, cephalosporin and erythromycin ... home health aide and home health PT [physical therapy] and OT [occupational therapy]" A. The " Physician's Order Sheet and Plan on Care" dated February 21, 2008 and signed by the physician on February 29, 2008 revealed," Allergy history: Latex and nuts..." The " Interdisciplinary Discharge Summary" lacked evidence that the allergy to nuts was transcribed to the final summary of the resident' s status. B. A physician's order dated and signed by the physician on February 29, 2008 directed, "Wet to dry dressing of surgical wound daily" . A review of the March 2008 Treatment Administration Record revealed that the wet to dry dressing was signed as being administered from March 1 through March 13, 2008. March 14, 2008 was not signed documenting that the treatment was not administered. Additionally, there was no discontinuation order in the record for the wet to dry dressing. The "Interdisciplinary Discharge Summary" and the discharge orders lacked evidence that the wet to dry dressing of the surgical wound was transcribed to the final summary of the resident's status. A face-to-face interview was conducted on April 30, 2008 at 9:30 AM with Employee #4. He/she acknowledged that Resident #28's allergy to nuts and the wet to dry dressing were not documented	F 514		

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F 514	Continued From page 43 on the " Interdisciplinary Discharge Summary" and the wet to dry dressing was not documented on the discharge orders. The record was reviewed on April 30, 2008. 4. Facility staff failed to document in the nurses notes the disposition of the Resident #29's body. A review of the "Discharge Summary" signed as completed by the physician on March 12, 2008 revealed,"...Expired, Date: February 11, 2008 at 11:00 PM, Released to: Funeral Home... Reason for Discharge: Expired..." A review of the nurse's notes dated February 11, 2008 at 11:15 PM documented, "...called stat and responded to room 172, assessment done skin very warm but no pulse, no respiration. O2 (oxygen) started and CPR (cardiopulmonary resuscitation) initiated... 911 was called and they responded and did EKG [electrocardiogram]. 11:30 PM they said they will not take him/her to hospital and we will call the police office. Which they did. Police officer arrived. Doctor [name] notified and RP [responsible party] number given to doctor [name] and he/she left a message on his/her answering machine at 11:50 PM..." The nurses notes lacked documented evidence as to what was done with Resident #29's body after the emergency respondents did not take him/her with them and failed to document in the record the date and time that the body was released to the funeral home. A face-to-face interview was conducted on April 29, 2008 at approximately 3:30 PM with Employee #15. He/She brought the surveyor a record book that documented the release of all expired bodies from the facility. According to this book Resident #29 was pronounced at 11:30 PM	F 514		

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F 514	Continued From page 44 on February 11, 2008 and was picked up by the funeral home at 1:30 PM on February 12, 2008. He/She further acknowledged that this record book was not a part of the resident's clinical record. The record was reviewed on April 29, 2008. 5. Facility staff failed to discontinue a wound treatment before initiating another wound treatment for the same area for Resident S2 According to re-admission orders dated March 14, 2008, signed by the physician May 1, 2008, directed, ""Wash LT (left) heel with soap and water, pat dry, apply A & D ointment and monitor daily." According to a physician's telephone order dated March 24, 2008 and signed by the physician on April 1, 2008, "Apply Acticoat to LT heel daily after cleansing with wound cleanser and patting dry. Cover with coversite" A review of the March 2008 MAR revealed the following orders: "Wash LT (left) heel with soap and water, pat dry, apply A & D ointment and monitor daily." The order was initiated on March 14, 2008. "Apply Acticoat to LT heel daily after cleansing with wound cleanser and patting dry. Cover with coversite" The order was initiated March 24, 2008. Both wound treatments were signed as administered concurrently from March 24 through March 31, 2008. A face-to-face interview was conducted on May 1, 2008 at 8:35 AM with Employee #26. He/she acknowledged that	F 514		

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F 514	Continued From page 45 he/she had incorrectly initialed that both wound treatments were administered. The record was reviewed May 1, 2008.	F 514		