STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/22/2007

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SPECIALTY HOSPITAL OF WASHINGTON-HADLEY SNF	4601 MLK KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted February 20 through 22, 2007. The following deficiencies were based on record review, observations, and interviews with the facility staff and residents. The sample included 15 residents based on a census of 61 residents on the first day of survey and three (3) supplemental residents.	F 000		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for one (1) supplemental resident, it was determined that facility staff failed to assess Resident S1 for the use of a restraint. The findings include: During the initial tour, Resident S1 was observed on February 20, 2007 at 9:30 AM, sitting in his/her room in a geri chair with his/her feet resting on a straight back chair. A face-to-face interview was conducted immediately with a Certified Nurse Aide (CNA) regarding the positioning of Resident S1. The CNA stated, "I usually work nights. When [Resident S1] gets restless, we put him/her in the geri chair and put his/her feet on the other [straight back] chair to keep him/her from getting up. It's the only thing that works." The surveyor asked how long staff has been using this method.	F 221	F221 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The straight back chair was removed immediately on 2/20/07 and the CNA was instructed by RCC to stop the deficient practice. An assessment of the resident was done. It was determined that restraint is not necessary. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Rounds on all residents' room and day rooms were conducted on 2/20/07 to ensure that no other resident is being prevented from getting up by using straight back chairs. No other resident's were found to be affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All nursing staff was in-serviced on 2/28/07, 3/5/07, and 3/7/07 on the facility's restraint policy, which includes the types of restraints recognized by the facility. (Emphasis was placed on the use a straight back chair as a form of restraint as not acceptable practice). See attachment #1.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kasi Mann Cullen | TITLE: Administrator | (X6) DATE: 3/15/07

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 221	Continued From page 1 The CNA stated, "At least since Christmas." A review of the resident's record revealed that there was no assessment for the use of the straight back chair as a restraint. There was no evidence in the record that the use of the straight back chair was recognized by facility staff as a restraint. The record was reviewed February 22, 2007.	F 221	F-221 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** RCC's will conduct daily rounds to monitor, and outcomes will be reported to DON and Administrator during daily Stand up meetings. Statistics will be reported to new monthly Quality Assurance meetings, using new QA tool. See attachment #2.	April 5, 2007
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by : During the environmental tour, it was determined that housekeeping and maintenance services were not adequate to maintain the facility in a safe and sanitary manner, as evidenced by: marred and scarred straight back chairs, damaged walls and doors and stained ceiling tiles . These observations were made in the presence of the Director of Maintenance, Housekeeping Supervisor and nursing staff. The findings include: 1. The arms and legs of straight back chairs in the 3 East dining room were marred and scarred in seven (7) of seven (7) chairs observed on February 21, 2007 at 2:00 PM. 2. Walls were observed to be damaged and scarred in the following areas: 3 East dayroom, rooms 301, 312, 316, 324 and 336 in six (6) of 18 walls observed from 2:00 PM until 3:30 PM on	F 253		

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F 221	Continued From page 1 The CNA stated, "At least since Christmas." A review of the resident's record revealed that there was no assessment for the use of the straight back chair as a restraint. There was no evidence in the record that the use of the straight back chair was recognized by facility staff as a restraint. The record was reviewed February 22, 2007.	F 221	F253 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The arms and legs of all 7 straight back chairs in 3East dining room were painted on 3/16/07. Damaged walls observed on 3East day room were all painted. Damaged doors observed in 3 east day room were painted on 3/6/07. 3 East shower stretchers and under mats were cleaned by housekeeping on 2/22/07. The stained ceiling tiles on 3East ding room were replaced on 3/5/07.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by : During the environmental tour, it was determined that housekeeping and maintenance services were not adequate to maintain the facility in a safe and sanitary manner, as evidenced by: marred and scarred straight back chairs, damaged walls and doors and stained ceiling tiles . These observations were made in the presence of the Director of Maintenance, Housekeeping Supervisor and nursing staff. The findings include: 1. The arms and legs of straight back chairs in the 3 East dining room were marred and scarred in seven (7) of seven (7) chairs observed on February 21, 2007 at 2:00 PM. 2. Walls were observed to be damaged and scarred in the following areas: 3 East dayroom, rooms 301, 312, 316, 324 and 336 in six (6) of 18 walls observed from 2:00 PM until 3:30 PM on	F 253	2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Engineering and Housekeeping Department did environmental rounds and all other stained ceiling tiles were replaced, all damaged, scarred and marred, soiled doors, chairs, and walls were cleaned and painted. No other stretchers or under mats were dirty. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** New environmental rounds to be conducted weekly have been instituted to include housekeeping and maintenance department. A rounds checklist will be utilized to identify any damages or concerns in rooms. All findings will be reported to the Administrator. All findings will be fixed immediately.	

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F 253	Continued From page 2 February 21, 2007. 3. Doors were observed damaged, marred, scarred or soiled in rooms 301, 318, 3 East dayroom and 3 East shower room in four (4) of 18 door observations from 2:00 PM through 3:30 PM on February 21, 2007. 4. Ceiling tiles were observed stained or damaged in rooms 301, 316, 343 and the 3 East dining room in four (4) of 18 ceiling tile observations from 2:00 PM through 3:30 PM on February 21, 2007.	F 253	F253 **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** The Maintenance and Housekeeping Supervisor will do weekly rounds to commence 4/3/07; any deficient findings will be reported in monthly Environment of Care Committee, Process Improvement, and QA meeting.	April 5, 2007
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.	F 278		

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F 278	Continued From page 3 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for one (1) of 15 sampled residents, it was determined that Resident #12 was inaccurately coded for behaviors on the quarterly Minimum Data Set (MDS) assessment. The findings include: A review of Resident #12's record revealed that according to the quarterly MDS completed February 5, 2007, the resident was coded in Section E4e, "Mood and Behaviors" as resisting care. The Assessment Reference Date (ARD) for the MDS was February 3, 2007. The ARD date is the last date of observations. The look back period for Section E4 is seven (7) days. According to the "Behavior Monitoring Sheet" for January and February 2007, and the nurses' notes for January and February 2007, there was no evidence that the resident resisted care. A face-to-face interview was conducted with the Certified Nurse Aide (CNA) on February 21, 2007 at 2:30 PM. He/she stated, "[Resident #12] used to fight us when were tried to give care. But for a couple of months, now, I haven't heard that [he/she] has given anybody any trouble." The record was reviewed February 21, 2007.	F 278	F-278 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** MDS Coordinator was notified of survey findings, and re-educated on 2/22/07. MDS modification was done and transmitted on 2/22/07. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of all resident MDS with behavior monitoring flow sheets were reviewed to ensure that behaviors coded were within the parameter of the 7 day look back from the ARD. See attachment #2. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** At weekly IDT care plan meeting, the team members will review the MDSs of resident's scheduled for care plan for compliance to the 7-day look back if behaviors are coded in the MDS. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Compliance monitoring outcomes will be reported to the Administrator by the IDT weekly and QA committee monthly using the MDS QA tool. See Attachment #3.	April 5, 2007
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 4 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and review of the clinical record for one (1) of 15 sampled residents, it was determined that facility staff failed to initiate a care plan for aspiration precautions during meal time for Resident #3. The findings include: A review of Resident #3's record revealed a physician's orders dated December 12, 2006 that directed, "4 Gram Na (sodium) pureed diet with nectar thick [nectar thickened liquids]. Aspiration precautions require close supervision and assistance at meal time; elevate HOB (head of bed) to 90 degrees at meal time and one (1) hour	F 279	F279 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The care plan for resident #3 was reviewed and additional approaches for aspiration precautions were added and shared with the surveyor during the surveyor on 2/20/07, See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Audits of all resident's care plan that are on a puree diet were reviewed to include aspiration precautions. A tool was done on 2/20/07. See attachment #2. No other residents were found to have this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The interdisciplinary team was re-educated (2/23/07) on all components of the care plan. All residents who will be placed on a puree diet will include Aspiration precautions in their comprehensive care plans as the order for a puree diet is carried out by the nursing staff.	

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F 279	Continued From page 5 after meals." The review of the resident's interdisciplinary care plan dated February 9, 2007 lacked a problem with goals and approaches for aspiration precautions during meal time. A face-to-face interview was conducted with the Resident Care Coordinator on February 20, 2007 at approximately 9:30 AM who acknowledged that the resident's care plan lacked goals and approaches for aspiration precautions during meal time. The record was reviewed on February 20, 2007.	F 279	F279 **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. (i.e., what Quality Assurance Program will be put into place?** Monitoring for compliance will be conducted by the IDT weekly during care plan meeting. The RCC's will report all deficient practices to the DON and Administrator weekly and the monthly QA meeting for monitoring. See new QA tool attachment #3	April 5, 2007
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 :	F 280		

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F 280	Continued From page 6 Based on staff interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to update Resident #12's fall care plan with goals and approaches after multiple falls with a subsequent injury. The findings include: A review of Resident #12's record revealed the following: March 11, 2006 - found on the floor in room August 10, 2006 - observed kneeling on floor September 17, 2006 - observed climbing out of bed October 15, 2006 - attempting to climb out of bed October 28, 2006 -attempting to climb out of bed November 23, 2006 - found on the floor November 28, 2006 - found crawling on the floor November 29, 2006 - attempted to get out of bed February 3, 2007 - sitting on the floor February 17, 2007 - found on the floor with swelling and complaint of pain to left wrist An x-ray of the left wrist and arm was taken on February 18, 2007 and revealed a fracture of the left wrist. A review of the care plan revealed that on March 12, 2006, facility staff initiated the approach of placing the resident across from the nurse's station when up in the geri chair. There was no evidence that facility staff implemented any additional approaches to prevent the resident from falling. On February 17, 2007, Resident #12 fell out of the geri chair, onto the floor in the day room and fractured his/her left wrist. A face-to-face interview was conducted with the	F 280	F280 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A care plan meeting was held on 2/23/07 for resident #12 by IDT team who reviewed additional approaches to prevent future falls such as utilization of a chair alarm, a new low bed and floor mat for this resident. See attachment #1. Chair alarms arrived 3/6/07, and in-service conducted for staff, attachment #2. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of the all the remaining residents with multiple falls was done on 2/23/07 per facility protocol by the RCCs to prevent any other resident from being affected by this practice. All residents at risk for falls were evaluated for chair alarms, low beds, and floor mats. See attachment #3. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The falls prevention protocol was re-visited on 3/5/07 to institute low beds, floor mats and chair alarms for all residents at risk for frequent falls. Ongoing education for staff and auditing of the charts of all residents per facility protocol will be done by the RCC to ensure that deficient practice does not recur.	

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F 280	Continued From page 7 Resident Care Coordinator on February 22, 2007 at 8:15 AM. He/she acknowledged that there were no new goals and approaches initiated after March 12, 2006 to prevent Resident #12 from falling. The record was reviewed February 22, 2007.	F 280	F280 **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** RCC will use the facility chart audit form and audit all charts of residents presently at risk for falls and any new admissions to ensure that a care plan is put in place after any resident falls. Any deficient practices will be reported to the DON and the monthly QA meeting.	April 5, 2007
F 309 SS=G	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 staff interview and record review for three (3) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to: follow up on a Dilantin level for one (1) resident who was subsequently diagnosed with Dilantin toxicity; ensure that a complete order was written for blood sugar monitoring and follow-up on the resident's request to decrease frequency of fingersticks and a report of feeling depressed for one (1) resident; re-weigh one (1) resident who lost 48 pounds in one month; and ensure that a PT/INR level was drawn as ordered by the physician. Residents #14, 1, 6 and H1. The findings include: 1. Facility staff failed to follow up on a Dilantin (Phenytoin) level result for Resident #14 who was subsequently admitted to the hospital with a	F 309		

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F 280	Continued From page 7 Resident Care Coordinator on February 22, 2007 at 8:15 AM. He/she acknowledged that there were no new goals and approaches initiated after March 12, 2006 to prevent Resident #12 from falling. The record was reviewed February 22, 2007.	F 280	F-309 (1) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively corrective action could not be done for this incident as the resident never returned to the nursing facility.	
F 309 SS=G	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 staff interview and record review for three (3) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to: follow up on a Dilantin level for one (1) resident who was subsequently diagnosed with Dilantin toxicity; ensure that a complete order was written for blood sugar monitoring and follow-up on the resident's request to decrease frequency of fingersticks and a report of feeling depressed for one (1) resident; re-weigh one (1) resident who lost 48 pounds in one month; and ensure that a PT/INR level was drawn as ordered by the physician. Residents #14, 1, 6 and H1. The findings include: 1. Facility staff failed to follow up on a Dilantin (Phenytoin) level result for Resident #14 who was subsequently admitted to the hospital with a	F 309	2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Records of all residents receiving Dilantin level orders were reviewed on 2/24/07 to check if; results were in the record and if not results were obtained; results were reported to physician and orders carried out accordingly; appropriate documentation are recorded in the medical records of interventions if any. See attachment # 1. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Medical records of future residents who will receive Dilantin with Dilantin level test order will be reviewed daily by licensed staff on the night shift. Review outcomes will be documented on the lab log sheet, see attachment #2. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Monitoring outcomes will be reported to the Administrator at daily standup meetings. Monthly compliance monitoring outcomes will b reported to QA committee by DON. See attachment #3.	April 5, 2007

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F 309	Continued From page 8 diagnosis of Dilantin toxicity. The physician's order sheet dated December 2006 directed, "Dilantin level every 3 months-March/June/Sept/Dec [original order dated September 8, 2006]." A review of the laboratory (lab) section of the record revealed that a Dilantin level was drawn on December 1, 2006. There was no evidence in the record that the results for the aforementioned Dilantin level were present at the time of this review. A face-to-face interview was conducted with the Resident Care Coordinator and the Director of Nursing on February 21, 2007 at 12:30 PM. After reviewing the record, they both acknowledged that there were no Dilantin level results. According to the following nurses' notes: February 7, 2007 at 2:00 PM "Physical therapist came up on the unit and stated that the resident was much weaker on the left side than yesterday in therapy. A call has been made to Doctor [name] to make [him/her] aware." February 7, 2007 at 8:00 PM, "Speech therapist expressed concern to writer about resident's weakness on the right side. This writer contacted Doctor [name] to convey concerns of weakness and decline in speech pattern. Doctor [name] ordered that resident be transferred to ER [emergency room] for evaluation of altered neurological status. Follow up call made to determine status... resident was taken to hospital [name] and admitted for Dilantin toxicity and dehydration."	F 309	F-309 (2A) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The physician was notified and new order for finger stick was received and carried out for resident #1. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Medical records of all residents receiving finger sticks were reviewed for completeness of the orders (completeness of parameters). No other residents were found to be affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Nursing staff on both units were in-serviced about receiving and carrying out complete physician orders. New monitoring tool created to track deficient practice. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Monitoring outcomes will be reported to Administrator at daily stand up meetings and monthly at QA committee meetings.	April 5, 2007

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F 309	Continued From page 9 On February 21, 2007 at 4:15 PM the facility staff obtained the Dilantin level results at the request of the surveyor. The lab report revealed a Dilantin result of 29.6 H [high], [normal range 10.0-20.0]. There was no evidence that facility staff followed up on the Dilantin level drawn on December 1, 2006. Subsequently, the resident was hospitalized with a diagnosis of Dilantin toxicity on February 7, 2007. The record was reviewed on February 21, 2007. 2. Facility staff failed to ensure that a complete order was written for blood sugar monitoring and follow-up on Resident #1's request to decrease the frequency of fingersticks and the resident's statement of feeling depressed timely. A. A review of Resident #1's record revealed a physician's order dated June 6, 2006 and subsequently renewed every 30 days, with the most recent order signed February 2, 2007. The order directed, "Glucose finger stick every day at 6:00 AM." There was no direction from the physician regarding the action facility staff should take for the results of the finger stick. A review of the glucose monitoring record and the nurses' notes from June 2006 through February 2007, revealed that finger sticks ranged from 90 to 252. On November 13, 2006, the resident's fingerstick was 252 (Normal range is 60-120). There was no evidence that facility staff notified the physician of the elevated finger stick results. A face-to-face interview was conducted with the charge nurse on February 20, 2007 at 11:00 AM.	F 309	F-309 (2B) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Physician was notified on 2/22/07 of resident #1s request. The physician did not change the order. The medical Director was notified and changed the order from daily to finger sticks every Monday and Friday. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on 3/5/07 of all nursing notes to ensure nursing staff follow-up of all residents request do occur. No other deficient practices were noted. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The RCC/designees will review resident's records in the respective units of evidence of documentation addressing follow up of resident's requests from the previous shifts daily. Identified deficient practices will be called to the attention of staff involved to correct immediately. Failure for staff compliance will result in progressive disciplinary action. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Outcomes will be reported to DON daily and DON will report to Administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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F 309	Continued From page 9 On February 21, 2007 at 4:15 PM the facility staff obtained the Dilantin level results at the request of the surveyor. The lab report revealed a Dilantin result of 29.6 H [high], [normal range 10.0-20.0]. There was no evidence that facility staff followed up on the Dilantin level drawn on December 1, 2006. Subsequently, the resident was hospitalized with a diagnosis of Dilantin toxicity on February 7, 2007. The record was reviewed on February 21, 2007. 2. Facility staff failed to ensure that a complete order was written for blood sugar monitoring and follow-up on Resident #1's request to decrease the frequency of fingersticks and the resident's statement of feeling depressed timely. A. A review of Resident #1's record revealed a physician's order dated June 6, 2006 and subsequently renewed every 30 days, with the most recent order signed February 2, 2007. The order directed, "Glucose finger stick every day at 6:00 AM." There was no direction from the physician regarding the action facility staff should take for the results of the finger stick. A review of the glucose monitoring record and the nurses' notes from June 2006 through February 2007, revealed that finger sticks ranged from 90 to 252. On November 13, 2006, the resident's fingerstick was 252 (Normal range is 60-120). There was no evidence that facility staff notified the physician of the elevated finger stick results. A face-to-face interview was conducted with the charge nurse on February 20, 2007 at 11:00 AM.	F 309	F-309 (2B) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Physician was notified of resident #1s request. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on 3/5/07 of all nursing notes to ensure nursing staff follow-up of all residents request do occur. No other deficient practices were noted. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The RCC/designees will review resident's records in the respective units of evidence of documentation addressing follow up of resident's requests from the previous shifts daily. Identified deficient practices will be called to the attention of staff involved to correct immediately. Failure for staff compliance will result in progressive disciplinary action. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Outcomes will be reported to DON daily and DON will report to Administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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F 309	Continued From page 10 The surveyor asked the nurse what action would be taken if the resident's fingerstick was below 60 or above 120. The nurse stated, "It is a nursing judgement to notify the physician." There was no evidence in the record that the resident experienced hypoglycemic or hyperglycemic reactions. The record was reviewed February 20, 2007. B. According to a nurse's note dated June 9, 2006 at 6:00 AM, "Resident stated, "I don't want my finger stick. I am not that bad a diabetic." Will have AM nurse call [physician] and see if daily BS [blood sugar] can be changed." There was no evidence that facility staff followed up on the resident's request. A review of the Medication Administration Record for June 2006 through February 2007 revealed that the resident had a finger stick done every morning at 6:00 AM A face-to-face interview with the RCC was conducted on February 20, 2007 at 11:30 AM. He/she stated, "I wasn't aware that the resident didn't want daily finger sticks. No one told me." C. According to a nurse's note dated June 19, 2006 at 3:45 PM, "Resident MD has been called to come and see resident because resident said [he/she] is depressed. MD promised to come and see resident tonight." There was no evidence that the physician saw the resident on June 19, 2006. There was no evidence that facility staff followed-up on the resident's statement of depression. The psychiatrist saw the resident on July 19, 2006	F 309	F-309 (2C) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Psychiatrist was notified of the resident's request. The Psychiatrist saw the resident on March 3, 2007. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted to ensure resident's request to see Psychiatrist were followed. No other residents were found to have this deficient practice. All residents with the diagnosis of depression and /or verbalize feelings of sadness, anger, or depression documented in record were referred to the clinical social worker for intervention and/or follow-up with Psychiatrist as deemed appropriate. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Nursing staff were in-serviced to report expressions of mood and behavior changes of their residents to team leaders for intervention/referral to social worker. A new QA tool was created see attachment #2. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Outcomes will be reported to DON daily and DON will report to Administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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F 309	Continued From page 11 . The resident was prescribed Zoloft for depression. A face-to-face interview was conducted with the RCC on February 20, 2007 at 11:35 AM. He/she stated, "The resident is on an antidepressant. The psychiatrist saw [him/her]" After reviewing the Resident's record, the RCC stated, "The psychiatrist didn't see the resident for about a month after [he/she] said [he/she] was depressed." The record was reviewed February 20, 2007. 3. Facility staff failed to re-weigh Resident #6 after significant weight loss. The annual Minimum Data Set assessment dated December 26, 2006 included the following diagnoses in Section I: Diabetes Mellitus, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, other Cardiovascular Disease, Arthritis, Allergies, Anemia and Renal Failure. According to the "Yearly Weight Chart" for Resident #6, the resident weighed: August 2, 2006 277# (pounds) September 1, 2006 229.2#. October 3, 2006 230# November 2, 2006 214#. There was an 18% weight change between August and September 2006 and 7% between October and November 2006. There was no evidence in the record that facility staff re-weighed the resident after the aforementioned weight loss.	F 309	F-309 (3) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The resident was weighed on 2/20/06. Employee was counseled on the importance of weighing residents. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on all remaining residents to ensure weights were being done and were correct. See attachment #1. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** A newly created Weight committee began 3/7/07 to include dietary and nursing to commence monthly, see attached #2. Education of staff was conducted on 3/7/07. Weight Policy was updated to reflect weights to be done 1st thru the 5th of each month. Re-weights will be done when there is a difference of 2-4 lbs from 2 successive weights and will be done no later than the 6th of every month. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Wight committee will monitor staff compliance. Outcomes will be reported to DON and administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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F 309	Continued From page 11 . The resident was prescribed Zoloft for depression. A face-to-face interview was conducted with the RCC on February 20, 2007 at 11:35 AM. He/she stated, "The resident is on an antidepressant. The psychiatrist saw [him/her]" After reviewing the Resident's record, the RCC stated, "The psychiatrist didn't see the resident for about a month after [he/she] said [he/she] was depressed." The record was reviewed February 20, 2007. 3. Facility staff failed to re-weigh Resident #6 after significant weight loss. The annual Minimum Data Set assessment dated December 26, 2006 included the following diagnoses in Section I: Diabetes Mellitus, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, other Cardiovascular Disease, Arthritis, Allergies, Anemia and Renal Failure. According to the "Yearly Weight Chart" for Resident #6, the resident weighed: August 2, 2006 277# (pounds) September 1, 2006 228.2#. October 3, 2006 230# November 2, 2006 214#. There was an 18% weight change between August and September 2006 and 7% between October and November 2006. There was no evidence in the record that facility staff re-weighed the resident after the aforementioned weight loss.	F 309	F-309 (3) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The resident was weighed on 2/20/06. Employee was counseled on the importance of weighing residents. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on all remaining residents to ensure weights were being done and were correct. See attachment #1. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** A newly created Weight committee began 3/7/07 to include dietary and nursing to commence monthly, see attached #2. Education of staff was conducted on 3/7/07. Weight Policy was updated to reflect weights to be done 1st thru the 5th of each month. Re-weights to be done no later than the 6th. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Outcomes will be reported to DON daily and DON will report to Administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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F 309	Continued From page 12 A face-to-face interview was conducted with the Resident Care Coordinator on February 20, 2007 at 4:00 PM. He/she stated, "When the weight loss is greater than five pounds we have to re-weight the resident. I don't know why the resident wasn't re-weighed at these times (September and November 2006). A face-to-face interview was conducted with the dietician on February 20, 2007 at 3:45 PM. He/ she stated, "I did a lot of counseling with [Resident] at least two or three times a week in August, September, October and November. We talked about the carry out Chinese food that [he/ she] ate and how important it was not to eat foods high in sodium because of [Resident's] edema. I informed the doctor of the resident's condition and that I was counseling the resident at least twice a week. I talked at great length with the resident to eat only the food we provided here, not to eat the carry out food. [His/her] on-going weight loss is desired because of the resident's medical condition. [Resident] doesn't have any more edema and the breathing is better." According to the facility's policy, SNS. 59 " Resident ' s Weight ": "If a variance of 2-4 lb exists between two successive weights a re-weight should be obtained and verified by the licensed nurse or designee and reported to the Charge Nurse and DON " and " Addressing Significant Weight Changes" states: "All residents with significant weight changes will be reweighed under the supervision of a licensed nurse within 48 hours." The above cited policy defines significant change as:	F 309	F-309 (4) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively corrective action could not be done. On 2/22/07 blood was redrawn and found to be hemalized. Blood was redrawn on 2/23/07 and results were shared with physician and placed on resident's record. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on all residents receiving Coumadin with a PT/INR ordered were reviewed for lab results and if they were in the record the MD was notified. No other residents were identified with this same deficient practice. See attachment #2. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The lab log was revised to include follow-up of results on tests ordered. This will be done by the licensed staff on the night shift on a daily basis. RCC will check logs on a daily basis. A dedicated fax line to receive lab reports from reference lab daily was installed.	

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F 309	Continued From page 13 5% in one month 7.5% in three months and 10% in six months There was no evidence in the record that facility staff re-weighed the resident after the weight loss. The record was reviewed February 20, 2007. 4. Facility staff failed to ensure that a PT/INR level was drawn as ordered by the physician for Resident H1. A review of Resident H1's record revealed a physician's order dated February 8, 2007 that directed, "Increase Coumadin to 6mg daily via G-tube (gastrostomy tube) for pulmonary embolism ... Do PT/INR in one week when 6 mg Coumadin has been given for one week." There was no evidence in the record that the PT/INR was drawn on February 15, 2007. A face-to-face interview was conducted with the RCC on February 23, 2007 at 1:45 PM. He/she acknowledged that the PT/INR should have been drawn on February 15, 2007. The record was reviewed February 22, 2007.	F 309	F-309 (4) **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** RCC will report to DON and Administrator at daily stand up meeting. Outcomes monitoring will be reported to the QA committee monthly.	April 5, 2007
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by : Based on observations during the environmental tour, it was determined that facility staff failed to ensure that the environment was free from	F 323		

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F 323	Continued From page 14 accident hazards as evidenced by one (1) resident's bed that prevented the door from closing and one (1) blanket observed on the floor in a resident's room. These observations were made in the presence of the Director of Maintenance, Housekeeping Supervisor and nursing staff. The findings include: 1. During the environmental tour, an isolated observation at 2:40 PM on February 21, 2007, revealed that the position of Resident S3's bed in room 333 prevented the resident's door from closing. A face-to-face interview with facility staff touring with the surveyor was conducted immediately. Staff members indicated that the position of the bed had been a concern for many years. The resident refused to move the position of the bed. Resident S3 was interviewed on February 21, 2007 at 3:00 PM. After explanation by the surveyor of the concerns regarding the door, the resident agreed to position the bed to allow the door to close. 2. During the initial tour, at 9:30 AM on February 20, 2007, an isolated observation revealed a blanket on the floor near the bed of Resident S4 in room 324. The blanket was not secured and easily moved when touched. A face-to-face interview was conducted with the Resident Care Coordinator (RCC) who was touring with the surveyor. He/she stated, "[Resident] has had that down on the floor since Christmas. [Resident] complains the floor is cold.	F 323	F323 (1) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The resident agreed to change the position of the bed to allow the door to be closed, and the wheels of the bed were locked in place. Maintenance will put a permanent mark on the floor for staff and resident to know correct positioning of bed. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All other rooms were evaluated for this deficient practice and no other resident was found to be affected. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All staff was educated as to the hazards of accident and the prevention on 3/7/07. Housekeeping and Maintenance Departments will be responsible for monitoring during weekly environmental rounds. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** The Maintenance and Housekeeping Supervisor will monitor the areas on a schedule and report any deficient practices to the Administrator weekly, and monthly to EOC Committee, Patient Safety, Process Improvement, and Quality Assurance meeting.	April 5, 2007

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F 323	Continued From page 14 accident hazards as evidenced by one (1) resident's bed that prevented the door from closing and one (1) blanket observed on the floor in a resident's room. These observations were made in the presence of the Director of Maintenance. Housekeeping Supervisor and nursing staff. The findings include: 1. During the environmental tour, an isolated observation at 2:40 PM on February 21, 2007, revealed that the position of Resident S3's bed in room 333 prevented the resident's door from closing. A face-to-face interview with facility staff touring with the surveyor was conducted immediately. Staff members indicated that the position of the bed had been a concern for many years. The resident refused to move the position of the bed. Resident S3 was interviewed on February 21, 2007 at 3:00 PM. After explanation by the surveyor of the concerns regarding the door, the resident agreed to position the bed to allow the door to close. 2. During the initial tour, at 9:30 AM on February 20, 2007, an isolated observation revealed a blanket on the floor near the bed of Resident S4 in room 324. The blanket was not secured and easily moved when touched. A face-to-face interview was conducted with the Resident Care Coordinator (RCC) who was touring with the surveyor. He/she stated, "[Resident] has had that down on the floor since Christmas. [Resident] complains the floor is cold.	F 323	F323 (2) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident agreed to replace blanket with red rug with a non skid backing that was completed on 2/21/07. After discussion with all residents it was agreed by all residents to remove all rugs from resident's rooms. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All other resident's with rugs on room floors were evaluated for this deficient practice and the residents were informed that the rugs had to be removed. All residents agreed. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All staff was educated as to the hazards of accident and the prevention of injury. Housekeeping and Maintenance Departments will be responsible for monitoring during weekly environmental rounds. A daily rounds check list was created for nursing staff also. See attachment #1. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Maintenance and Housekeeping Supervisor will monitor the areas on a schedule and report any deficient practices weekly to the Administrator, and monthly to EOC committee, Patient Safety Committee, Process Improvement Committee, and Quality Assurance meeting.	April 5, 2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/22/2007

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F 323	Continued From page 15 Housekeeping cleans the floor then put the blanket back down on it." The surveyor asked why the resident was using a blanket and not a rug with a non-skid backing. The RCC stated, " We'll replace that with a rug."	F 323	F324 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively no corrective action could be done as there was insufficient staff on the day the incident occurred. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice when the PPD falls below 3.5. The 24 hour nurse staffing rule was reviewed with staff to ensure that a minimum of PPD of 3.5 is achieved on a daily basis. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The DON is in the process of recruiting for PRN staff. A unit clerk position for weekends on both nursing units was approved to keep nurses from doing majority of administrative duties on weekends. On weekends /Holidays/ inclement weather days when there are call outs we have instituted an emergency bonus plan for nursing staff. See attached #1. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported to DON and Administrator daily by RCC for immediate action and correction.	
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to provide adequate supervision for Resident #12 who had multiple falls with a subsequent injury. The findings include: A review of Resident #12's record revealed the following: March 11, 2006 - found on the floor in room August 8, 2006 - observed climbing over the side rails October 15, 2006 - attempting to climb over side rails October 28, 2006 - attempting to climb out of bed November 12, 2006 - found on the floor November 28, 2006 - found crawling on the floor November 29, 2006 - attempted to get out of bed February 3, 2007 - sitting on the floor February 17, 2007 - found on the floor with swelling and complaint of pain to left wrist An x-ray of the left wrist and arm was taken on	F 324		April 5, 2007

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F 324	Continued From page 17 during the day of the incident was 3.0 nursing hours per resident per day, below the DC requirement of 3.5 nursing hours per resident per day. A face-to-face interview was conducted with the Resident Care Coordinator on February 22, 2007 at 8:15 AM. He/she acknowledged that after reviewing the record, there were no interventions initiated after March 12, 2006 to prevent the resident from falling. The record was reviewed February 22, 2007.	F 324	F-329 (1) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Psychiatrist of resident #1 was notified of the survey findings, and she re-assessed the resident and discontinued the Haldol, see attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** The charts of all other residents on Haldol were reviewed. No other residents are affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All residents receiving Haldol will be monitored for presence/absence of clinical indication for continued use. Monitoring and outcomes will be reported to the MD for dosage adjustments or discontinuation by Charge Nurses. See attachment #2. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Compliance monitoring outcomes will be reported to monthly Quality Assurance.	
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		April 5, 2007