STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	07/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

(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 A recertification Quality Indicator Survey was conducted on July 9 through July 16, 2012. The deficiencies are based on observation, record review, resident and staff interviews for 33 sampled residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D. Elise Miller — TITLE: Administrator — (X6) DATE: 8/17/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview for two (2) of 33 sampled residents, it was determined that facility staff failed to immediately notify the physician of a significant change in status for one (1) resident who sustained frequent episodes of loose bowels and one (1) resident that sustained an alteration in skin integrity manifested as a rash. Residents #9 and 316. The findings include: 1. Facility staff failed to notify the physician of Resident #9 ' s altered skin integrity. A review of the clinical record for Resident #9 revealed the following nurse ' s entry on May 24 2012 at 4:01 AM, " Skin not WNL [within normal limits], pertinent findings are as follows: Upper back rash is disseminated pink; Precipitating factors: linen. " The record lacked any other documentation or notification of the physician regarding the "rash" assessed on the resident ' s back on May 24, 2012. An observation of the resident on July 13, 2012 at approximately 10:00 AM lacked evidence of an alteration in the integrity of his/her skin on the back [" rash "]. A face-to-face interview was conducted with "	F 157	**F 157#1 483.10(b)(11) Nursing Response:** 1. There are no further corrective actions for resident # 316 as she was discharged from the facility on 7/13/12. Resident # 9 remains on the unit free of any identified rash. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission through initial admission and through physician orders, nursing assessments and shift to shift/hand off reports. 3. The following systemic changes will be put into place to ensure that the same deficient practice will not recur: • The physician will be notified immediately when the nurse observes a change in the resident's condition (i.e., rash/ loose bowels) to obtain medical interventions as indicated. • Nursing staff will verbalize to each oncoming nurse the status of any noted change to ensure resident treatments are being performed per physician order. • The Unit Educator/Quality Nurse will re-in-service the nursing staff on the importance of physician notification and the documentation of changes in a resident's condition into the electronic health record. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings, starting 9/30/12. 5. This corrective action will be completed by 8/30/12	07/13/12 08/30/12 08/30/12 08/30/12

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F 157	Continued From page 2 Employee #9 on July 13, 2012 at approximately 10:00 AM. She/he stated that the resident likely sustained an adverse reaction to the linen. The laundry detergent used to clean linen is " harsh " and " on occasion patients have a reaction to it ...when that happens, we separate their linen into a separate receptacle and request the " non-detergent " laundry. " Employee #9 acknowledged that the record lacked evidence of an assessment of the [" rash "] alteration in skin integrity of the resident ' s back subsequent to the initial identification and lack of physician notification. Facility staff failed notify the physician when it was determined the resident sustained an alteration in the integrity of his/her skin. The nurse assessed the alteration as a " rash " and there was no evidence that the alteration resolved or that the physician was notified. The record was reviewed July 13, 2012. 2. Facility staff failed to notify the physician with timeliness, when it was determined Resident #316 sustained multiple episodes of loose bowels. According to an interview with the resident and a review of the clinical record, Resident #316 began to encounter episodes of loose bowels during the evening of July 7, 2012 at approximately 11:00 PM. She/he sustained approximately seven (7) episodes during the night, however; the physician was not notified until July 8, 2012 at approximately 10:30 AM.	F 157	**Nursing Response F 157#2 483.10(b)(11):** 1. There are no further corrections for resident # 316. Resident #316 was discharged from the facility. 2. Other residents having the potential to be affected by the same deficient practice will be identified per shift to shift reporting between off going and on coming nurses and continued reporting from the CNA throughout the day of the status of the residents' bowel movements. 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: • Nursing staff will be re-educated on the importance of consistently monitoring and documenting accurate change in status (i.e., sustained episodes of loose bowels) into the Electronic Health Records • Nursing staff will be reeducated on how to identify the signs and symptoms of dehydration in their residents and to document into the Electronic Health Records if indicated • During the change of shift report, nurses will report any status changes of their assigned residents. The nurse will instruct the nursing assistant to provide ongoing report of the resident's bowel movements, to enable the nurse to determine if other medical intervention may be needed. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings starting 9/30/12. 5. This corrective action will be completed by 8/30/12.	7/13/12 8/30/12 8/30/12 8/30/12

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F 157	Continued From page 3 July 7, 2012]. According to the interview conducted with Resident #316 on July 10, 2012 at approximately 9:15 AM, episodes of loose bowels began shortly after receiving the evening dosage of Peri-Colace and Senokot. The resident described the episodes as " frequent " and accompanied with abdominal cramps. The physician was notified on July 8, 2012 at approximately 10:30 Am, greater than eight (8) hours after the start of symptoms. A review of the Medication Administration Record [MAR] for July 2012 revealed the resident ' s medication regimen included Peri-Colace 1 tablet by mouth twice daily and Senokot 2 tablets twice daily for constipation. Each medication was administered in accordance with physician ' s orders on Saturday, July 7, 2012 as scheduled at 9 AM and 9 PM respectively. A review of Resident #316 ' s ADL (activities of daily living) record for July 7, 2012 revealed the resident had seven (7) bowel movements during the evening/night shift [7PM - 7AM]. Nurse ' s progress notes dated July 8, 2012 at 4:56 PM read: " GI not WNL (within normal limits) had multiple bowel movements today, soft, no foul odor noted ...MD made aware and started on Lactinex three times daily (a probiotic supplement used to treat loose bowels). " The physician ' s telephone order for Lactinex was dated July 8, 2012 at 10:30 AM [the resident ' s symptoms began at approximately 11:00 PM on	F 157	**F253#1 483.15(h)(2) Housekeeping Response::** 1. No direct impact to patients from the deficient practice of dusty vents. 2. No direct impact to other patients from dusty vents. 3. To ensure this deficiency does not recur semi-annual environmental rounds performed by the Environment of Care Committee (EOC) will pay attention to high dusting and the Environmental Services management team will ensure the 7 step cleaning method is used. 4. Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Environmental Services monitors and inspects for cleanliness on an ongoing basis and environmental rounds data are reported and reviewed by the EOC Committee for quality assurances. 5. Summary Item 1D F253-1 (South Rooms 317,320,321,324,325 and 326) were inspected and cleaned as needed on 8/10/12. **F253#2 483.15(h)(2) Laundry Response:** 1. No direct impact identified to patients from this deficient practice. 2. Curtains were reattached or replaced in the cited areas to identify other patients having the potential to be affected by this same deficient practice. 3. Staff is to place work orders for defective curtains in a timely manner. 4. Curtains will be monitored during scheduled quarterly curtain inspections and incidental inspection during routine curtain changes. The plan of correction will be integrated into the quality assurance system through quarterly scheduled environmental rounds. In the interim staff are to place work orders for defective curtains. 5. Curtains were reattached or replaced in the following areas on the following dates: 304north and 321south reattached on 8/9/12. 308 north curtains replaced on 8/10/12. 301 north curtain, 306north curtain and 311north curtain reattached on 8/10/12. 328south was replaced on 8/10/12. Corrective action completed by 8/10/12.	8/10/12 8/10/12

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F 157	Continued From page 4 July 7, 2012]. A face-to-face interview was conducted with Employee #16 on July 12, 2012 at 10:00 AM. S/he stated that Peri-Colace and Senokot were administered to Resident #9 at approximately 10:00 PM on July 7, 2012 and the resident experienced multiple episodes of loose bowels and abdominal cramping approximately an hour after receiving the medications. There was no foul odor and the amount of stool expelled was small, stating that " there was mostly stimulation but not much passed in the toilet. " The resident was alert and oriented x3 (time, person and place) and very involved in his/her care management. Employee #16 stated he/she was aware of approximately four (4) episodes of loose bowels sustained by the resident and that between the hours of 4-6 AM she/he was doing rounds and was not aware of episodes that may have occurred during those hours. The doctor was not notified because the resident did not present symptoms that would warrant physician notification. The information was passed to the oncoming shift. Facility staff failed to notify the physician with timeliness when the resident sustained a change in condition. The resident experienced multiple episodes of loose bowels with cramping and the physician was notified by staff from the next shift, greater than eight (8) hours after the onset of symptoms. The record was reviewed July 12, 2012	F 157		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253	Continued From page 5 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 made during an environmental tour of the facility on July 9, 2012 at approximately 3:30 PM and July 10, 2012 at approximately 10:00 AM, it was determined that the facility failed to provide housekeeping services necessary to maintain an orderly and comfortable interior as evidenced by dusty bathroom vents in six (6) of ten (10) residents' rooms on 3 South, unattached and/or torn privacy curtains in seven (7) of 21 residents' rooms, low water temperatures in three (3) of 11 residents' rooms on 3 North, call bell cords that were wrapped around the grab bar in six (6) of 11 residents' bathrooms, and soiled window ledges in fifteen (15) of twenty-one residents' rooms on 3 North and 3 South. The findings include: 1. Bathroom vents were dusty in six (6) of ten (10) residents room on 3 South specifically rooms #317, #320, #321, #324, #325 and #326. 2. Privacy curtains were not fully attached and/or were torn in seven (7) of 21 residents rooms on 3 North and 3 South including rooms #301, #304, #306, #308, #311, #321 and #328. 3. Water temperatures in rooms #310, #311 and #314 were less than 95 degrees Fahrenheit (F) in three (3) of eleven residents rooms surveyed on 3 North. 4. Bathroom call bell cords were observed wrapped around the grab bar in six (6) of eleven residents bathrooms surveyed on 3 South	F 253	**F253#3 483.15(h)(2) Plant Operations and Maintenance Response:** 1. Water temperature is monitored at the source located in the boiler room. Temperature of the water was adjusted to 95-110 degrees Fahrenheit for the building per 2010 edition of the "Guidelines for Design and Construction of Health Care Facilities" Table 7.4; Hot Water Use- General Hospital. On the day of the inspection, 7/9/12, low water temp was encountered; it was immediately turned up a few degrees at the source in Rooms 310, 311 and 314 North. 2. Water temperatures are maintained between 95-110 degrees Fahrenheit for the entire building, thus assuring that all of the patient rooms' water temperatures fall within the desired range. 3. The boiler room is staffed 24-7. Readings are taken during each of the three shifts. Domestic hot water temperatures are being logged during each shift; specified degree ranges from 95-110 degrees. When temperatures are logged by the engineer on duty and the value does not fall within the parameters, immediate action will be taken to adjust the temperature into the proper range. Engineers will note their actions on the daily log sheet. 4. For quality assurance, the Chief Engineer's Monthly Report reviews log sheets and notes problems and actions taken. 5. The corrective action, adjusting out of range water temperature was immediately corrected on the day of the finding, 7/9/12. Ongoing surveillance is maintained as outlined above.	7/9/12

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F 253	Continued From page 6 including rooms # 319, #320, #322, #324, #325 and #329. 5. Window ledges in fifteen (15) of 21 rooms surveyed on units 3 north and south were soiled with various debris and needed to be cleaned. (Rooms #301, #302, #303, #304, #306, #307, #308, #310, #311, #313, #314, #317, #319, #320 and #329). These observations were made in the presence of employee #4 who confirmed the findings.	F 253	**F253#4 483.15(h)(2) Housekeeping Response:** 1. No direct impact to patients from the deficient practice of call bells cords being wrapped around the grab bar. 2. No direct impact to other patients from call bell cords being wrapped around the grab bar. 3. To ensure this deficiency does not recur semi-annual environmental rounds performed by the Environment of Care (EOC) Committee will pay attention to untying the call bells in the bathrooms and the Environmental Services management team will ensure that call bells in the bathrooms are not tied to grab bars. 4. Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Environmental Services monitors and inspects for tied cords on the grab bars an ongoing daily basis. The environmental rounds performed by the Environment of Care (EOC) Committee are done on a 6 month rotation. Environmental Services managers or team leaders perform daily rounds and environmental rounds data are reported and reviewed by the EOC Committee for quality assurances. 5. The following areas will be inspected on 8/17/12 and call bells will be untied as needed: South Rooms 319, 320, 322, 324, 325 and 329.	8/17/12
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review and	F 279	**F253#4 483.15(h)(2) Nursing Response:** 1. The corrective action that has been taken is bathroom call bell cords in rooms #319, #320, #322, #324, #325 and #329 which were wrapped around the grab bar were removed. All SNF bathrooms have been checked and call bell cords were removed from grab bars. 2. Other residents having the potential to be affected by the same deficient practice will be identified through daily nursing rounds starting 8/30/12 3. The following systemic changes have been implemented: • Random audits will be conducted by the Director of Nursing/Quality Nurse during unit rounding to monitor compliance. • Staff were instructed not to wrap the call bell cords on the grab bars in the bathrooms. • Nursing staff will check the bathrooms daily during rounds to ensure that the call bell cords are not wrapped around the grab bars in the bathrooms 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings, starting 9/30/12. 5. This corrective action will be completed by 8/30/12.	07/09/12 08/30/12 08/30/12 07/10/12 08/30/12

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F 279	Continued From page 7 interview for three (3) of 33 sampled residents, it was determined that facility staff failed to develop care plans to manage one (1) resident with a diagnosis of dehydration and one (1) resident receiving psychotropic medications. Residents #161 and 309. The findings include: 1. Facility staff failed to initiate a care plan with goals and interventions to manage dehydration for Resident #161. A review of the admission documentation in the clinical record revealed that the resident was admitted to the facility with a diagnosis of Dehydration on February 4, 2012. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of February 11, 2012 revealed that the MDS was coded for dehydration. Further review of the clinical record revealed a problem list initiated on February 4, 2012 which failed to include dehydration as a problem. Review of the care plans in the record also failed to reveal a care plan for the management of dehydration. A face-to-face interview was conducted with Employee #8 at approximately 11:00 AM on July 16, 2012. The employee reviewed the care plans and acknowledged the finding. The record was reviewed on February 13, 2012. 2. Facility staff failed to initiate a care plan for a psychotropic medication for Resident #309.	F 279	**F253#5 483.15(h)(2) Housekeeping Response:** 1. No direct impact to patients from the deficient practice of window ledges and screens being soiled with debris. 2. No direct impact to other patients from window ledges and screens being soiled with debris. 3. To ensure this deficiency does not recur semi-annual environmental rounds performed by the Environment of Care (EOC) Committee will pay attention to high dusting and the Environmental Services management team will ensure the 7 step cleaning method is used. 4. Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Environmental Services monitors and inspects for cleanliness on an ongoing basis and environmental rounds data are reported and reviewed by the EOC Committee for quality assurances. 5. The following areas were inspected and cleaned on 8/10/12 as needed: Summary Item ID F235-Rooms 301, 302, 303, 306, 307, 308, 311, 313 and 314. The following areas will be inspected and cleaned on 8/17/12 as needed: Summary Item ID F235-Rooms 304, 310, 317, 319, 320 and 329. **F279 #1 & #2 483.20(d), 483.20(k)(1) Nursing Response:** 1. Facility staff failed to initiate a satisfactory plan of care with objectives, goals, and approaches to address residents with dehydration and use of psychotropic medication. Although we recognize this failure, no further corrections are needed as resident #309 was discharged on 8/3/12 and resident #161 was discharged on 8/2/12. 2. All other resident care plans will be reviewed and updated as indicated to reflect the usage of psychotropic medications and residents with a diagnosis of dehydration. 3. The following systemic changes will be implemented to ensure that the same deficient practice will not recur: The interdisciplinary Care Team will review the care plans/problem lists at meetings to monitor compliance and update as needed. • The Quality Nurse will review an article on dehydration and the psychotropic medication list/audit tool with the nursing staff to enhance staff knowledge. • The Quality Nurse will re-educate the nursing staff on the quality monitoring tool which was developed to enhance the awareness of what needs to be care planned on their individual resident. • MDS Coordinator will do care plan inservicing on overall care plan process, which includes using the results of the assessment to develop, review and revise comprehensive care plans. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings starting 9/30/12	8/10/12 8/3/12 08/30/2012

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F 279	Continued From page 8 A review of the clinical record for Resident # 309 revealed that the resident was admitted to the facility on June 25, 2012 with diagnoses of Status Post Incision and Drainage of Right Elbow; Status Post Right Elbow/Left Hand/Left Ankle ORIF (Open Reduction and Internal Fixation). An interim physician' s order written July 5, 2012 directed: Valium 2mg po (by mouth) daily; 20 minutes before PT (Physical Therapy) for spasms. " Review of the care plans on the record failed to reveal a care plan with goals and objectives for the use of a psychotropic medication. A face-to-face interview was conducted with Employee #9 at approximately 4:00 PM on July 11, 2012. He/she acknowledged that the resident's record lacked a care plan for a psychotropic medication. The record was reviewed on July11, 2012.	F 279	**Continued Nursing Response for F279 #1 & #2 483.20(d), 483.20(k)(1) :** 5. This corrective action will be completed by 8/30/12 **F281 483.20(k)(3)(i) Nursing Response:** 1. The resident was not affected by the deficient practice. The nurse was inserviced 1:1 by the senior charge nurse on how to properly administer eye medications 2. Other residents on the unit receiving eye medication will be observed to ensure eye medication is administered per protocol. Admission orders will be monitored for eye medications. 3. The following systemic changes will be implemented to ensure the deficient practice does not recur: • The Quality Nurse/Nursing Educator will provide inservice education to nursing staff with return demonstrations/competencies. • Re-educate staff to utilize the Sibley Intranet for detailed information resources and nursing protocols for administering eye medications. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings, starting 9/30/12. 5. This corrective action will be completed by 8/30/12.	08/30/12 7/11/12 8/30/12 8/30/12 8/30/12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 281		

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F 281	Continued From page 9 interview for one (1) of 33 sampled residents, it was determined that facility staff failed to administer ophthalmic solution according to professional standards of care. Resident #310. The findings include: During a medication administration observation on July 12, 2012 at approximately 11:15 AM, it was determined that facility staff failed to administer prescribed ophthalmic solution in accordance with professional standards of practice. Physician ' s orders dated July 8, 2012 directed the administration of Alphagan ophthalmic solution, one (1) drop in right eye tid [three times daily] for Glaucoma. Employee #11 was observed administering eye drops to Resident #310 on July 11, 2012 at approximately 11: 15 AM. The employee instructed the resident to look up with eyes open and turn his/her head to the right. Employee #11 proceeded to open the container of ophthalmic solution; removed the dropper; held the dropper above the resident's right eye and instilled one drop into the resident ' s eye. The resident was instructed immediately to close his/her eyes. A face-to-face interview was conducted on July 11, 2012 with Employees #2 and #11 regarding the aforementioned observations. Employee #2	F 281		

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	095030	A. BUILDING _____ B. WING _____	07/16/2012

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F 281	Continued From page 10 acknowledged that Employee #11 did not instill the eye drop into Resident #310's right eye according to facility's policy and professional standards of care. The facility ' s policy: Medical/Surgical- Instillation of Ophthalmic Medications into the Conjunctival Sac " (no date indicated); stipulated: "With your forefinger, gently pull down on the skin below the lower lid until the internal conjunctiva forms a pocket. " According to the " 2006 Lippincott ' s Nursing Procedure Manual, page 283 under " Medication Administration, to instill eye drops...pull the lower lid down to expose the conjunctival sac, have the patient look up and away, then squeeze the prescribed number of drops into the sac. " Facility staff failed to administer eye drops in accordance with accepted professional standards. Cross over to §483.25	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 309		

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F 309	Continued From page 11 interview for three (3) of 33 sampled residents, it was determined that facility staff failed to consistently monitor and document the status of: one (1) resident that sustained episodes of frequent loose bowels; one (1) resident with altered skin integrity and failed to clarify physician ' s orders and administer eye drops in accordance with professional standards for one (1) resident. Residents #9, 310 and 316 The findings include: 1. Facility staff failed to monitor and document the status of Resident #9 ' s altered skin integrity. A review of the clinical record for Resident #9 revealed the following nurse ' s entry on May 24 2012 at 4:01 AM, " Skin not WNL [within normal limits], pertinent findings are as follows: Upper back rash is disseminated pink; Precipitating factors: linen. " The record lacked any other documentation regarding the " rash " assessed on the resident ' s back on May 24, 2012. There was no documentation to indicate the " rash " resolved. An observation of the resident on July 13, 2012 at approximately 10:00 AM lacked evidence of an alteration in the integrity of his/her skin on the back [" rash "]. A face-to-face interview was conducted with " Employee #9 on July 13, 2012 at approximately 10:00 AM. She/he stated that the resident likely sustained an adverse reaction to the linen. The laundry detergent used to clean linen is " harsh " and " on occasion patients have a reaction to it	F 309	**F309 #1 483.25 Nursing Response:** 1. Resident #9, remains on the unit and there is no further evidence of a rash/altered skin integrity at this time. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon initial admission, nursing assessment, shift assessment or resident self reporting. 3. The following systemic changes will be implemented: • Re-educate the nursing staff on the importance of monitoring and documenting the status of the resident in the Electronic Health Record and Care Plan. • Re-inservice nursing staff that when resident has an alteration in skin integrity to offer/change linens to non-detergent linens or obtain other medical interventions for alleviation of symptoms. • Staff will be instructed to document the resident's response to the new intervention in the Electronic Health Record. • Nursing staff will notify the physician as to whether the interventions are effective or to obtain a new treatment. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings, starting 9/30/12. 5. This corrective action will be completed by 8/30/12. **F309 #2a 483.25 Nursing Response:** 1. There are no further corrections for resident # 310. Resident #310 was discharged from the facility. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission by nursing staff reviewing eye drop orders from the physician order sheet to the E-MAR.	08/30/2012 08/30/2012 08/30/2012 7/14/12 8/30/12

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F 309	Continued From page 12 ...when that happens, we separate their linen into a separate receptacle and request the " non-detergent " laundry. " Employee #9 acknowledged that the record lacked evidence of an assessment of the [" rash "] alteration in skin integrity of the resident ' s back subsequent to the initial identification and lack of physician notification. Facility staff failed to monitor and document the status of an alteration in the integrity of the skin on Resident #9 ' s back. The nurse assessed the alteration as a " rash " and there was no evidence that the alteration resolved or that the physician was notified. The record was reviewed July 13, 2012. 2. Facility staff failed to clarify physician ' s orders for the administration of eye drops (ophthalmic solution) and failed to administer eye drops in accordance with professional standards of care for Resident #310. a.) During a medication administration observation on July 12, 2012 at approximately 11:15 AM, Employee #11 administered one (1) drop of Alphagan eye drop into the right eye of Resident #310. Prior to the administration of the eye drop, at approximately 10:00 AM, Employee #11 reviewed the physician ' s orders and Medication Administration Record [MAR] and identified that the transcribed order observed on the MAR did not correlate with the physician ' s order. There was a variance in the eye to which the drop was to be instilled.	F 309	**Continued Nursing Response to F309 #2a 483.25:** 3. The following systemic changes will be implemented to ensure this deficient practice does not recur: • Staff will be re-educated on the appropriate method to review the E-MAR and to verify all orders with physicians. • Staff will be re-educated on following the process for the 24 hr chart check and the two nurse verification process. • Quality nurse will re-educate nursing staff to contact the pharmacist related to any question or clarification they have regarding physician orders and to utilize the fax to pharmacy clarification form. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings, starting 9/30/12. 5. This corrective action will be completed by 8/30/12. **F309 #2a 483.25 Pharmacy Response:** 1. The original order written for Alphagan on 7/1/12 was for one drop daily to the left eye for glaucoma. There was a modification order taken as a verbal order by a nurse on 7/8/12 changing the frequency to TID. During this investigation it was determined that below the frequency change, the nurse wrote RT and circled it. That piece was missed by the pharmacist when they updated the order, as they only saw the change in frequency and the RT was difficult to read. The order should have been clarified with the physician prior to processing. As soon as the pharmacy was notified of this error on 7/12/12, the order was corrected in the computer system to indicate it should be administered TID to the right eye. 2. Audits will be conducted by the Assistant Director of Pharmacy as outlined below in Item number 4 to assess if other orders that should have been clarified were not. 3. The pharmacist who did not clarify the Alphagan order from 7/8/12 will be counseled by 8/30/12. All pharmacists will be re-educated on the departmental policy requiring order clarification by 8/30/12. Additionally, an article will be included in the Pharmacy Newsletter to be published by 8/30/12 reiterating the importance and the requirement that unclear orders be clarified by the pharmacist before being processed.	08/30/2012 08/30/2012 08/30/2012

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F 309	Continued From page 13 The records were documented as follows: Physician ' s interim order dated July 8, 2012: " Alphagan Eye Drop- 1 [one] drop right eye tid [three times a day] for Glaucoma. " MAR July 2012: A transcription entry dated July 8, 2012: Alphagan Eye Drop -1 drop left eye tid for Glaucoma. " Employee #11 queried Resident #310 at approximately 10:10 AM on July 12, 2012 regarding the indication for the eye drops and which eye the drop was to be instilled into; he/she responded, " It is for my glaucoma and it goes in my right eye. " At approximately 10: 15 AM on July 12, 2012 Employee #11 called the physician and pharmacy for clarification of the physician ' s order . The physician and pharmacist stated that the Alphagan was to be given in the right eye three times a day. The July 2012 Medication Administration Record (MAR) revealed that licensed nurse ' s signed that one (1) drop of Alphagan ophthalmic solution was administered in the resident ' s left eye (3) three times a day at 10:00 AM, 2:00 PM and 6:00 PM from July 9 through 11, 2012. There was no evidence that facility staff attempted to clarify the discrepancy in the orders for the Alphagan ophthalmic solution prior to the Medication Pass observation conducted on July 12, 2012. Licensed staff that signed the MAR indicating that they administered Alphagan ophthalmic solution to Resident #310 during the period July	F 309	**F309 #2a 483.25 Continued Pharmacy Response:** 4. The Assistant Director of Pharmacy will randomly audit 30 charts per quarter beginning September 1, 2012, following the reeducation of all pharmacists, and continuing until June, 2013. A compliance rate of 90% will be expected. Any identified non-compliance will precipitate the counseling of the involved pharmacist(s) by the Assistant Director of Pharmacy. This plan will be incorporated into the Pharmacy Quality Assurance Program and results will be reported to the Hospital's Quality Council on a quarterly basis through June, 2013. 5. This corrective action will be completed by 8/30/12. **F309 #2b 483.25 Nursing Response:** 1. The resident was not affected by the deficient practice. The nurse was inserviced 1:1 by the senior charge nurse on how to properly administer eye medications. 2. Other residents on the unit receiving eye medication will be observed to ensure eye medication is administered per protocol. Admission orders will be monitored for eye medications. 3. The following systemic changes will be implemented to ensure the deficient practice does not recur: • The Quality Nurse/Nursing Educator will provide inservice education to nursing staff with return demonstrations/competencies. • Re-educate staff to utilize the Sibley Intranet for detailed information resources and nursing protocols for administering eye medications. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings, starting 9/30/12. 5. This corrective action will be completed by 8/30/12.	8/30/12 7/11/12 8/30/12 8/30/12

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F 309	Continued From page 14 9-12, 2012 were identified and interviewed as follows: Face-to-face and telephonic interviews were conducted with Employees #9, #11, #12, #13, and #14 on July 12, 2012 at approximately 12 Noon and July 13, 2012 between the hours of 10 AM to 11 AM. The employees were queried; " To which eye was the Alphagan eye drop administered?" All of the employees acknowledged that the Medication Administration Record indicated to administer the eye drop in the left eye. However, " we knew that the resident was competent and [he/she] knew which eye the drop was to be instilled and also was aware of the reason for its use. The eye drop was administered in the right eye; however, we failed to call the physician and pharmacy for clarification. " The clinical record was reviewed on July 12, 2012. Facility staff failed to clarify physician ' s orders for administration of eye drops. b.) During a medication administration observation on July 12, 2012 at approximately 11:15 AM, it was determined that facility staff failed to administer prescribed ophthalmic solution in accordance with professional standards of practice. Physician ' s orders dated July 8, 2012 directed the administration of Alphagan ophthalmic solution, one (1) drop in right eye tid [three times daily] for Glaucoma.	F 309	**F309 #3 483.25 Nursing Response:** 1. There are no further corrections for resident # 316. Resident #316 was discharged from the facility. 2. Other residents having the potential to be affected by the same deficient practice will be identified per shift to shift reporting between off going and on coming nurses and continued reporting from the CNA throughout the day of the status of the residents' bowel movements. 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: • Nursing staff will be re-educated on the importance of consistently monitoring and documenting accurate change in status (i.e., sustained episodes of loose bowels) into the Electronic Health Records • Nursing staff will be reeducated on how to identify the signs and symptoms of dehydration in their residents and to document into the Electronic Health Records if indicated • During the change of shift report, nurses will report any status changes of their assigned residents. • The nurse will instruct the nursing assistant to provide ongoing report of the resident's bowel movements, to enable the nurse to determine if other medical intervention may be needed. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings starting 9/30/12. 5. This corrective action will be completed by 8/30/12.	7/13/12 8/30/12 8/30/12

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F 309	Continued From page 15 Employee #11 was observed administering eye drops to Resident #310 on July 11, 2012 at approximately 11: 15 AM. The employee instructed the resident to look up with eyes open and turn his/her head to the right. Employee #11 proceeded to open the container of ophthalmic solution; removed the dropper; held the dropper above the resident's right eye and instilled one drop into the resident ' s eye. The resident was instructed immediately to close his/her eyes. A face-to-face interview was conducted on July 11, 2012 with Employees #2 and #11 regarding the aforementioned observations. Employee #2 acknowledged that Employee #11 did not instill the eye drop into Resident #310's right eye according to facility's policy and professional standards of care. The facility ' s policy: Medical/Surgical- Instillation of Ophthalmic Medications into the Conjunctival Sac " (no date indicated); stipulated: "With your forefinger, gently pull down on the skin below the lower lid until the internal conjunctiva forms a pocket. " According to the " 2006 Lippincott ' s Nursing Procedure Manual, page 283 under " Medication Administration, to instill eye drops...pull the lower lid down to expose the conjunctival sac, have the patient look up and away, then squeeze the prescribed number of drops into the sac. " Facility staff failed to administer eye drops in accordance with accepted professional standards.	F 309		

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F 309	Continued From page 16 3. Facility staff failed to consistently monitor and document the status of Resident #316 who sustained episodes of frequent loose bowels. A review of Resident #316 ' s clinical record revealed the resident was admitted on July 6, 2012, status post Left Total Knee Arthroplasty (TKR). A face-to-face interview was conducted with Resident #9 on July 10, 2012 at approximately 9:15 AM. She/he verbalized that s/he was " so sick " on the weekend following his/her Friday admission. The " sickness " was identified as " diarrhea " and " stomach cramps " after receiving a laxative. A review of the Medication Administration Record [MAR] for July 2012 revealed the resident ' s medication regimen included Peri-Colace 1 tablet by mouth twice daily and Senokot 2 tablets twice daily for constipation. Each medication was administered in accordance with physician ' s orders on Saturday, July 7, 2012 at the scheduled administration times of 9 AM and 9 PM respectively. According to the interview conducted with Resident #316, episodes of loose bowels began shortly after receiving the evening dosage of Peri-Colace and Senokot. The resident described the episodes as " frequent " and accompanied with abdominal cramps. The physician was notified greater than eight (8) hours after the start of symptoms. The nursing documentation lacked	F 309		

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F 309	Continued From page 17 evidence of assessment and consistent monitoring of the resident ' s GI (gastrointestinal) status. A review of Resident #316 ' s ADL (activities of daily living) record for July 7, 2012 revealed the resident had seven (7) bowel movements during the evening/night shift [7PM - 7AM]. The ADL records for the number of bowel movements for the day/evening shift on July 8, 2012 were blank. Nurse ' s progress notes dated July 8, 2012 at 2:13 AM [evening/night shift for July 7, 2012] read " GI WNL " (gastrointestinal system within normal limits) GI normal included: abdomen flat or rounded, symmetrical, soft and nontender; bowel sounds present in all quadrants and normoactive. Continent of bowel and no anal or rectal problems reported. Last bowel movement " July 7, 2012. " Nurse ' s progress notes dated July 8, 2012 at 4:56 PM read: " GI not WNL (within normal limits) had multiple bowel movements today, soft, no foul odor noted ...MD made aware and started on Lactinex three times daily (a probiotic supplement used to treat loose bowels). " The physician ' s telephone order for Lactinex was dated July 8, 2012 at 10:30 AM [the resident ' s symptoms began at approximately 11:00 PM on July 7, 2012]. Physician ' s telephone orders dated July 8, 2012 at 8:12 PM revealed the physician modified the resident ' s medication regimen after being contacted by the nurse, to include Zofran 4mg by mouth every 4 hours as needed for nausea and Immodium 4mg by mouth every 4 hours as	F 309		

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F 309	Continued From page 18 needed for diarrhea. The nurse ' s note dated July 9, 2012 at 3:22 AM documented by Employee #19 read: " GI WNL. " The MAR revealed Zofran and Immodium were administered to the resident on the evening of July 8, 2012. However, there was no documented evidence that the resident exhibited symptoms of nausea and/or loose bowels to warrant the administration of the prescribed medication. A face-to-face interview was conducted with Employee #15 on July 12, 2012 at 9:00 AM. She/he was assigned to Resident #9 during the night shift on July 7, 2012. She/he stated that the resident required assistance to ambulate to the bathroom (post-op TKR) and a bed alarm was in place to alert staff if the resident attempted to ambulate without assistance. S/he stated that the resident repeatedly required assistance to go to the bathroom to expel loose bowels. She/he offered the resident cool towels and lowered the thermostat in the room to provide comfort because the resident complained that it was " too hot. " The nurse was informed regarding the frequent bowel movements. A face-to-face interview was conducted with Employee #16 on July 12, 2012 at 10:00 AM. S/he stated that Peri-Colace and Senokot were administered to Resident #9 at approximately 10:00 PM on July 7, 2012 and the resident experienced multiple episodes of loose bowels and abdominal cramping approximately an hour after receiving the medications. Warm towels were offered to the resident to manage the abdominal cramps. There was no foul odor and	F 309		

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F 309	Continued From page 19 the amount of stool expelled was small, stating that " there was mostly stimulation but not much passed in the toilet. " The resident was alert and oriented x3 (time, person and place) and very involved in his/her care management. Employee #16 stated he/she was aware of approximately four (4) episodes of loose bowels sustained by the resident and that between the hours of 4-6 AM she/he was doing rounds and was not aware of episodes that may have occurred during those hours. The doctor was not notified because the resident did not present symptoms that would warrant physician notification. The information was passed to the oncoming shift. Employee #16 acknowledged that the nursing assessment documented in the nurse ' s progress notes was not consistent with the symptoms that the resident exhibited [GI WNL]. A face-to-face interview was conducted with Employee #19 on July 13, 2012 at 9:00 AM. S/he stated that the physician was called because the resident verbalized that he/she experienced nausea and the previous shift reported that the resident had loose bowels. He/she acknowledged that the nursing shift summary lacked evidence of an accurate assessment the resident ' s GI status. The record lacked evidence that the resident sustained an untoward effect. There was no evidence of signs and symptoms related to dehydration or infection. Facility staff failed to accurately assess and consistently monitor Resident #316 ' s GI status once the resident experienced multiple episodes of loose bowels. The record was reviewed July	F 309		

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F 309	Continued From page 20 12, 2012	F 309		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made during a tour of dietary services on day one of the survey at approximately 11:00 AM, it was determined that the facility failed to serve food under sanitary conditions as evidenced by cold food such as milk that tested at 47 degrees F (Fahrenheit) from the test tray. The findings include: A half-pint of milk from the test tray was measured at 47 degrees F, well above the maximum temperature of 41 degrees F for cold food. This observation was made in the presence of Employee #3 who acknowledged the findings.	F 371	**F371 483.35(i) Nutrition Services Response:** 1. No direct impact identified to patients from the deficient practice of milk being at 47 degrees. 2. Daily monitoring by management will identify other patients having the potential to be affected by the same deficient practice. 3. The internal temperature of the walk-in cooler will be turned down to 38 degrees to ensure the milk is cold before going on the assembly line. In addition the internal temperature of the reach-in cooler where the milk is stored during meal service will be reduced to 38 degrees to ensure milk stays at the proper temperature. If the milk reaches 40 degrees or higher at anytime, the milk will be placed on ice during the meal service. 4. This practice will be monitored daily by checking the walk-in cooler and reach-in cooler temperatures daily. The temperatures will be recorded on a monthly log with the time the temperature that was taken. In addition, test trays will be completed weekly and recorded to ensure the milk temperatures are 41 degrees or lower. The test trays and temperature logs will become part of the quality assurance system for the Food & Nutrition department and be monitored weekly and compiled in a monthly report. 5. Corrective action completed by August 15, 2012	8/15/12
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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	F 425	**F425 483.60 (a),(b)Nursing Response:** 1. There are no further corrections for resident # 310. Resident #310 was discharged from the facility. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission by nursing staff reviewing eye drop orders from the physician order sheet to the E-MAR	7/14/12

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	095030	A. BUILDING _____ B. WING _____	07/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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F 425	Continued From page 21 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 for one (1) of 33 sampled residents, it was determined that pharmacy staff failed to accurately interpret a physician's order as evidenced by an inaccurate transcription of a prescribed ophthalmic solution onto the Medication Administration Record [MAR]. Resident #310 The findings include: According to the facility's policy; " Medication Order Processing " , Policy Number 3.6, Date Effective: 05/2008; V- Procedures stipulates: " Pharmacists review all medication orders received for completeness, appropriateness and	F 425	**F425 483.60 (a),(b Continued Nursing Response:** 3. The following systemic changes will be implemented to ensure this deficient practice does not recur: • Staff will be re-educated on the appropriate method to review the E-MAR and to verify all orders with physicians. • Staff will be re-educated on following the process for the 24 hr chart check and the two nurse verification process. • Quality nurse will re-educate nursing staff to contact the pharmacist related to any question or clarification they have regarding physician orders and to utilize the fax to pharmacy clarification form. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings, starting 9/30/12. 5. This corrective action will be completed by 8/30/12. **F425 483.60 (a),(b Pharmacy Response:** 1. The original order written for Alphagan on 7/1/12 was for one drop daily to the left eye for glaucoma. There was a modification order taken as a verbal order by a nurse on 7/8/12 changing the frequency to TID. During this investigation it was determined that below the frequency change, the nurse wrote RT and circled it. That piece was missed by the pharmacist when they updated the order, as they only saw the change in frequency and the RT was difficult to read. The order should have been clarified with the physician prior to processing. As soon as the pharmacy was notified of this error on 7/12/12, the order was corrected in the computer system to indicate it should be administered TID to the right eye. 2. Audits will be conducted by the Assistant Director of Pharmacy as outlined below in Item number 4 to assess if other orders that should have been clarified were not. 3. The pharmacist who did not clarify the Alphagan order from 7/8/12 will be counseled by 8/30/12. All pharmacists will be re-educated on the departmental policy requiring order clarification by 8/30/12. Additionally, an article will be included in the Pharmacy Newsletter to be published by 8/30/12 reiterating the importance and the requirement that unclear orders be clarified by the pharmacist before being processed.	8/30/12 8/30/12 8/30/12

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F 425	Continued From page 22 safety (patient, indication, dose, route of administration and frequency). Patient ' s medication profiles are reviewed to check for therapeutic duplication, drug interactions, incompatibilities and drug allergies. " A physician ' s interim order dated July 8, 2012 at 19:50 (7:40 PM) directed: " Alphagan Eye Drop- 1 (one) drop to right eye tid (three times a day) for Glaucoma. " A review of the pre-printed MAR dated July 8, 2012 read: Alphagan- 1 (one) drop [of ophthalmic] solution left eye (3) three times per day at 10:00 AM; 1400 [2:00 PM] and 1800 [6:00 PM]. A face-to-face interview was conducted with Employee #10 on July 13, 2012 at approximately 4:30 PM. He/she acknowledged that the eye which the drop was to be instilled as recorded on the MAR was inconsistent with the physician ' s order. She/he identified the inconsistency as an error. The clinical record was reviewed on July 13, 2012.	F 425	**F425 483.60 (a),(b Continued Pharmacy Response** 4. The Assistant Director of Pharmacy will randomly audit 30 charts per quarter beginning September 1, 2012, following the reeducation of all pharmacists, and continuing until June, 2013. A compliance rate of 90% will be expected. Any identified non-compliance will precipitate the counseling of the involved pharmacist(s) by the Assistant Director of Pharmacy. This plan will be incorporated into the Pharmacy Quality Assurance Program and results will be reported to the Hospital's Quality Council on a quarterly basis through June, 2013. 5. This corrective action will be completed by 8/30/12. **F469 483.70(h)(4) Nutrition Services Response:** 1. No direct impact identified to patients from flying insects observed in the kitchen 2. Daily monitoring conducted by management, will identify other patients having the potential to be affected by the same deficient practice 3. Nutrition Services now has a new pest control company called Western Pest. They will come and complete an assessment as to what the department can do to ensure there are no flying insects in the kitchen. Corrective action will be taken according to their written recommendations. The protective flaps in the entrance way of the loading dock will be replaced to ensure insects cannot enter. All windows in the kitchen will be sealed so that they cannot open and allow insects to enter into the kitchen.	
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469	4. Weekly treatments will be performed by Western Pest for the kitchen and reported in the log book. If a flying insect is seen in the kitchen it will be logged in the Western Pest log book and Western Pest will be called to report the event. Western Pest will report to Sibley within 24 hours to do treatment. This process will become part of the quality assurance system for the Food & Nutrition department through daily monitoring by management to ensure there are no flying insects in the kitchen. 5. Corrective action completed by August 30, 2012	8/30/12

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F 469	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations during a tour of dietary services on day one of the survey at approximately 11:00 AM, it was it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects seen in dietary services. The findings include: Flying insects were observed during a tour of the kitchen on July 9, 2012. The observation was made in the presence of Employee # 3 who acknowledged the findings.	F 469		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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 record review and interview for one (1) of 33 sampled residents, it was determined that	F 514		

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F 514	Continued From page 24 facility staff failed to document the bowel elimination component of the Activities of Daily Living [ADL] record for one (1) resident that sustained episodes of loose bowels. Resident #316 The findings include: A review of the clinical record for Resident #316 revealed the resident sustained episodes of loose bowels on July 7 and 8th, 2012. A review of the Activities of Daily Living [ADL] records for July 8, 2012, in the section labeled " BM (number of times), " indicative of the number times the resident moved his/her bowels during a shift had no information recorded (remained blank) during day and evening shift. The prior shift on July 7, 2012 - night shift; revealed the resident sustained seven (7) episodes of loose bowels. A nurse ' s note dated July 8, 2012 at 4:56 PM (day shift) read: " had multiple bowel movements today, soft, no foul odor noted. " A face-to-face interview was conducted with Employee #18 on July 12, 2012 at approximately 2:30 PM. She/he acknowledged that the ADL records were blank and recalled that the resident sustained loosed bowels during his/her shift on July 8, 2012. She/he stated that the record was mistakenly omitted. The record was reviewed July 12, 2012.	F 514	**F514 483.75(l)(1) Nursing Response:** 1. It has been reinforced with the nursing staff that for any resident who sustains episodes of loose stool, it will be documented in the bowel elimination component of the Activities of Daily Living (ADL) record. 2. Other residents having the potential to be affected by the same deficient practice will be identified through daily ADL record reviews and shift to shift reports 3, The following systemic changes will be put into place to ensure the deficient practice will not recur: ▪ Facility staff will be re-educated on the importance of accurate documentation of findings onto the ADL records. ▪ The Quality Nurse will continue to perform random audits of the ADL record to promote compliance. ▪ Findings of ADL records will be presented to the facility staff in routine staff meetings to identify problem areas (i.e.) missing documentation along with steps to prevent further occurrences. ▪ MDS Coordinator will continue to provide inservices on ADL documentation on an ongoing basis. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the Quarterly Quality Assurance Committee meetings, starting 9/30/12. 5. This corrective action will be completed by 8/30/12	7/12/12 8/30/12