PRINTED: 10/15/2007
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING ______ B. WING ______	R 10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HILL NURSING CENTER	700 CONST. AVE. NE WASHINGTON, DC 20002

(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 follow-up survey (to the re-certification survey on July 31 through August 13, 2007) was conducted on October 5, 2007. The following deficiencies were based on record review, observations and staff interviews. The sample size was 14 residents based on 60% of the standard survey sample for 117 residents.	F159 {F 000}	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Resident provided a written consent on 9/13/07 for the facility to continue to act as his representative payee. The Business Office Director immediately began formulating policies and procedures for the business office in reference to the facility becoming representative pay for all residents.	
{F 159} SS=F	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds	{F 159}	**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other resident financial folders were audited and no others found to have the same deficient practice. As the policy and procedures were not yet written at the time the surveyor spoke to the Business Office Director all residents have the potential to be affected by this deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** New polices and procedures were written and completed for the business office at SHW-Capitol Hill on 10/15/07. See attached #1. All business office staff were educated on new policies and procedures and trained on the proper paperwork to be completed and retained in the resident's financial file. **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 residents who have selected the facility to act as rep payee will be audited and reviewed quarterly. All deficient practices will be reported and an action plan done when deficient practices are noted to QA monthly committee.	10/25/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/19/07

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.

The Specialty Hospital of Washington

Title:	APPLYING FOR REPRESENTATIVE PAYEE	Policy #:	
Effective Date:	OCTOBER 15, 2007	Date Reviewed:	
Department:	BUSINESS OFFICE	Reference:	

I. Purpose: To ensure that resident's or his/her legal representative's rights and funds are protected.

II. Policy: The facility will apply to be selected as a "Representative Payee" only upon receiving a written consent from the resident or his/her legal representative.

III. Procedure:

A. A copy of a letter from the resident/representative requesting the facility to the appointed the Representative Payee must be on file.

B. The Social Security Administration Form SSA-11 (REQUEST TO BE SELECTED AS PAYEE) will be completed and signed by the facility representative.

C. A physician statement certifying that the resident is unable to manage his/her own financial affairs will be completed, signed, and dated by the attending physician.

D. All the above documents will be mailed to Social Security Administration for processing and a copy will be retained in the resident's financial file.

APPROVALS:

Dept Manager	**Date**	**CEO**	**Date**
Administrator, LNHA	**Date**	**Governing Board**	**Date**

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{F 159}	Continued From page 1 of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that facility staff failed to develop a system, policy or procedure for obtaining written authorization from residents and/or responsible parties prior to the facility acting as representative payee for residents. The findings include: A review of the business office's policies revealed that there was no policy or procedure for the facility to become the representative payee for the resident. A face-to-face interview was conducted with Employee #5 on October 5, 2007 at 2:30 PM. He/she was asked if the facility had a system to ensure that the resident and/or responsible party would be contacted prior to identifying the facility as the representative payee. He/she stated, "	{F 159}		

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{F 159}	Continued From page 2 We have a new system [system name] that covers our handling of residents ' money and meets all the regulations. But there isn't anything in [new system] that discusses the process for the facility to become a representative payee for a resident ' s funds. I will have to develop that policy. "	{F 159}		
{F 253} SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour of the facility, it was determined that housekeeping and maintenance services were not provided to maintain a sanitary, orderly and comfortable interior as evidenced by: marred and/or damaged walls, baseboards, nightstands, a five drawer chest and cabinets and missing blinds. These observations were made in the presence of Employee #1 and Employee #3 on October 5, 2007 between 8:45 AM and 11:00 AM. The findings include: 1. 13 of 39 walls with marred and/or damaged surfaces were observed in the following rooms: 6103, 6104, 6112, 6118, 6123, 6127, 6130, 5142, 5111, 5104, 4139, 4110, 4104 and the 5th floor hallway wall near the shower room. 2. Four (4) of 39 baseboards with marred and/or damaged surfaces were observed in the following areas: 6103, 6105, 6118, and the 6th floor shower room tile baseboard.	F253-1,2 {F 253}	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 13 of 39 walls with marred and/or damaged surfaces observed in rooms 6103, 6104, 6112, 6118, 6123, 6127, 6130, 5142, 5111, 5104, 4139, 4110, 4104, and the 5th floor hallways near the shower room are all in the process of being painted. Painting began on 8/27/07. The baseboards will be replaced in rooms 6103, 6105, 6118, and shower room by 10/25/07. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other areas in the nursing center were inspected for marred and damaged surfaces and baseboards. All residents have the potential to be affected by this deficiency. There were other areas found that were placed on the painters schedule for repair. No other base boards were found needing repair. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff have been instructed to report damaged, marred and scarred areas to maintenance immediately. The painter will continue to add areas identified on his schedule for painting. Maintenance and Housekeeping Supervisors will monitor during weekly 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?** Maintenance and Housekeeping Supervisors will make routine rounds weekly of the environment and check all rooms. The results will be reported to the QA monthly committee.	10/25/07

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{F 159}	Continued From page 2 We have a new system [system name] that covers our handling of residents ' money and meets all the regulations. But there isn't anything in [new system] that discusses the process for the facility to become a representative payee for a resident ' s funds. I will have to develop that policy. "	{F 159} F253 - 3,4,5	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 5/39 nightstands, 1 of 39 five drawer chest will be replaced the order was placed on 10/5/07. The 2 of 39 damaged cabinet doors were removed in both rooms.	
{F 253} SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour of the facility, it was determined that housekeeping and maintenance services were not provided to maintain a sanitary, orderly and comfortable interior as evidenced by: marred and/or damaged walls, baseboards, nightstands, a five drawer chest and cabinets and missing blinds. These observations were made in the presence of Employee #1 and Employee #3 on October 5, 2007 between 8:45 AM and 11:00 AM. The findings include: 1. 13 of 39 walls with marred and/or damaged surfaces were observed in the following rooms: 6103, 6104, 6112, 6118, 6123, 6127, 6130, 5142, 5111, 5104, 4139, 4110, 4104 and the 5th floor hallway wall near the shower room. 2. Four (4) of 39 baseboards with marred and/or damaged surfaces were observed in the following areas: 6103, 6105, 6118, and the 6th floor shower room tile baseboard.	{F 253}	**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A complete audit of the nursing center rooms was done by the Administrator to include the nightstands, five drawer chests and cabinet doors and the listing was given to the CEO, Materials Manager, and Facilities Plant Director for repair, replacements and or fixing on 10/15/07. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The audited listing will be a phase in process for replacement and repair of all items in the nursing center and placed on the 2008 capital request. 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?** Items not repaired, replaced or fixed immediately will continue to be monitored and reported to monthly Quality Assurance meetings by maintenance and housekeeping departments until all items are completed.	10/25/07

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{F 159}	Continued From page 2 We have a new system [system name] that covers our handling of residents ' money and meets all the regulations. But there isn't anything in [new system] that discusses the process for the facility to become a representative payee for a resident ' s funds. I will have to develop that policy. "	{F 159} F253 -6	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 9 of 39 missing blind slots noted in 6123, 6116, 6112, 5154, 5104, 4154, 4147, 4139, and 4102 were replaced immediately on Friday, October 5, 2007.	
{F 253} SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour of the facility, it was determined that housekeeping and maintenance services were not provided to maintain a sanitary, orderly and comfortable interior as evidenced by: marred and/or damaged walls, baseboards, nightstands, a five drawer chest and cabinets and missing blinds. These observations were made in the presence of Employee #1 and Employee #3 on October 5, 2007 between 8:45 AM and 11:00 AM. The findings include: 1. 13 of 39 walls with marred and/or damaged surfaces were observed in the following rooms: 6103, 6104, 6112, 6118, 6123, 6127, 6130, 5142, 5111, 5104, 4139, 4110, 4104 and the 5th floor hallway wall near the shower room. 2. Four (4) of 39 baseboards with marred and/or damaged surfaces were observed in the following areas: 6103, 6105, 6118, and the 6th floor shower room tile baseboard.	{F 253}	**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other resident rooms on the 4th, 5th, and 6th floors were checked for missing blind slots. No others were found. No other resident affected by this deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** During weekly environmental rounds all rooms will be inspected by Housekeeping and Maintenance Supervisors to ensure blinds are not missing in residents rooms. **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 Supervisors will report all deficient practices to the monthly quality assurance meetings.	10/25/07

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{F 253}	Continued From page 3 3. Five (5) of 39 damaged nightstands were observed in the following rooms: 6105, 6116, 5123, 5154, and 5146. 4. One (1) of 39 damaged five drawer chest was observed in room 4106. 5. Two (2) of 39 damaged cabinet doors in rooms 6130 and 5113. 6. Nine (9) of 39 missing blind slats were observed in the following rooms: 6123, 6116, 6112, 5154, 5104, 4154, 4147, 4139 and 4102.	{F 253} F309 -1	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The employee was counseled on proper hand hygiene and infection control techniques. Medication nebulizers will be placed in labeled resident bags for delivery of respiratory medication and stored on oxygen flow meter when not in use or in resident bedside table. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other employees were given competency testing on hand hygiene. All other areas in nursing center were checked to ensure no other resident had nebulizer treatment and mask stored improperly. No other deficiencies found.	
{F 309} SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 14 sampled residents, it was determined that facility staff failed to: wash his/her hands prior to a nebulizer treatment and store the nebulizer and mask properly for one (1) resident and conduct a dietary consult and rehabilitation screening for one (1) resident according to facility policy. Residents W1 and W6. The findings include:	{F 309}	**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All respiratory employees were re-educated in proper hand hygiene and infection control practice, as well as proper storage of medication nebulizers. Respiratory Direction will monitor during daily rounds and conduct monthly random audits to ensure that all medication nebulizers are stored properly. Director will also conduct random quarterly skills competency to ensure respiratory therapists are adhering to proper procedure. **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?** Respiratory Director will continue to monitor and report all deficient practices to monthly QA meetings.	10/25/07

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{F 309}	Continued From page 4 1. Facility staff failed to wash his/her hands prior to a nebulizer treatment and store the nebulizer and mask properly for Resident W1. The facility's Infection Control Program for 2007/2008 included, "Hand Hygiene Procedures:... C. Perform Hand Hygiene... 2. Before direct contact with a resident..." On October 5, 2007 at 9:18 AM, the respiratory therapist entered Resident W1's room, donned gloves, listened to Resident W1's breath sounds with a stethoscope and obtained a pulse oximetry. He/She did not wash his/her hands prior to putting on the gloves. He/She removed the nebulizer unit with mask from the oxygen wall unit. The nebulizer unit and mask were not covered. A face-to-face interview was conducted with the respiratory therapist at the time of the observation. He/She stated, "It [nebulizer unit and mask] is supposed to be in the bag". There was a facility inservice entitled "Hand Hygiene" conducted August 9, 10, 11, 12 and 13, 2007. The respiratory therapist's name was included on the sign in sheet. However, he/she did not sign to indicate that he/she attended the inservice on any of the aforementioned dates. 2. Facility staff failed to conduct a dietary consult and a rehabilitation screen as per facility policy for Resident W6. A. The dietician failed to conduct a dietary consult as per facility policy. The Nutrition Assessment and Documentation	{F 309} F309 -2A	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Dietician immediately found the dietary consult for resident W1 which was done on 9/26/07, and placed it in the resident's record. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other resident records were reviewed to ensure dietary consults were present. No other deficient practices found. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Dietician was educated on the importance of timely completion of consults and placing them within 5 business days in the resident's record. The Dietician will do weekly reviews of all resident records to ensure that all consults are done and present on each residents chart utilizing a newly developed QA tool. **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 Dietician will continue to monitor and report all deficient practices to monthly Quality Assurance meetings.	Revision requested 10/23/07 10/25/07

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{F 309}	Continued From page 4	{F 309}		

{F 309}

1. Facility staff failed to wash his/her hands prior to a nebulizer treatment and store the nebulizer and mask properly for Resident W1.

The facility's Infection Control Program for 2007/2008 included, "Hand Hygiene Procedures:... C. Perform Hand Hygiene... 2. Before direct contact with a resident..."

On October 5, 2007 at 9:18 AM, the respiratory therapist entered Resident W1's room, donned gloves, listened to Resident W1's breath sounds with a stethoscope and obtained a pulse oximetry. He/She did not wash his/her hands prior to putting on the gloves. He/She removed the nebulizer unit with mask from the oxygen wall unit. The nebulizer unit and mask were not covered.

A face-to-face interview was conducted with the respiratory therapist at the time of the observation. He/She stated, "It [nebulizer unit and mask] is supposed to be in the bag".

There was a facility inservice entitled "Hand Hygiene" conducted August 9, 10, 11, 12 and 13, 2007. The respiratory therapist's name was included on the sign in sheet. However, he/she did not sign to indicate that he/she attended the inservice on any of the aforementioned dates.

2. Facility staff failed to conduct a dietary consult and a rehabilitation screen as per facility policy for Resident W6.

A. The dietician failed to conduct a dietary consult as per facility policy.

The Nutrition Assessment and Documentation

F309 -2A

1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?
The Dietician was counseled by the Dietary Director as the dietary consult for resident W1 which was done on 9/26/07 was found in the chart completed, but not in a timely manner.

2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?
All other resident records were reviewed to ensure dietary consults were present and completed in a timely manner. No other deficient practices found.

3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?
The Dietician was educated on the importance of timely completion of consults and placing them within 5 business days in the resident's record. The Dietician will do weekly reviews of all resident records to ensure that all consults are done and present on each residents chart utilizing a newly developed QA tool.

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 Dietician will continue to monitor and report all deficient practices to monthly Quality Assurance meetings.

Completion date: 10/25/07

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{F 309}	Continued From page 5 Standards dated March 16, 2006 included, "Dietary consults within 5 business days of physician order". Resident W6 was admitted to the facility on September 14, 2007 with the following diagnoses: Anoxic brain injury following CPR secondary to Respiratory Failure, CHF (Congestive Heart Failure, HTN (Hypertension, S/P (Status Post tracheostomy, S/P Peg Placement, S/P Substance Abuse, Encephalopathy, Asthma, Seizure Disorder, Cardiomyopathy, Pneumonia and UTI (Urinary Tract Infection). The Admission orders dated September 14, 2007 included an order for "Dietician Consult". The record revealed an initial dietary consult dated September 26, 2007, 12 days after Resident W6 was admitted. B. The rehabilitation staff failed to conduct screenings as per facility policy. Policy number 1303 "Resident Screening", dated June 1996 and reviewed July 2003 included, "Policy, 1. The screening procedure will be performed and documented within 48 working hours of admission ... " A review of the record revealed physical therapy and occupational therapy screens dated September 25, 2007, 11 days after admission. A speech therapy screen was dated September 14, 2007, 10 days after admission. A face-to-face interview was conducted with the RCC (Resident Care Coordinator) on October 5, 2007 at approximately 11:30 AM. He/She acknowledged that the consult and screens were	{F 309} F309 -2B	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All missing resident screens were placed on the residents charts immediately as they were already done. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other residents' charts were reviewed for missing screens. No others found, no other resident affected by this deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Rehab staff educated on the importance of doing screens timely. Weekly chart audits for new admissions and residents with falls will be maintained as a QA measure to ensure that resident admission and fall screens are on residents charts in accordance with facility policy and procedure. The Director of Rehab will monitor. **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 Rehab Director will report all deficient practices to the monthly QA meetings.	revision request 10/30/07 [handwritten] 10/25/07

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

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	095027	A. BUILDING ______ B. WING ______	R 10/05/2007

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{F 309}	Continued From page 5 Standards dated March 16, 2006 included, "Dietary consults within 5 business days of physician order". Resident W6 was admitted to the facility on September 14, 2007 with the following diagnoses: Anoxic brain injury following CPR secondary to Respiratory Failure, CHF (Congestive Heart Failure, HTN (Hypertension, S/P (Status Post tracheostomy, S/P Peg Placement, S/P Substance Abuse, Encephalopathy, Asthma, Seizure Disorder, Cardiomyopathy, Pneumonia and UTI (Urinary Tract Infection). The Admission orders dated September 14, 2007 included an order for "Dietician Consult". The record revealed an initial dietary consult dated September 26, 2007, 12 days after Resident W6 was admitted. B. The rehabilitation staff failed to conduct screenings as per facility policy. Policy number 1303 "Resident Screening", dated June 1996 and reviewed July 2003 included, "Policy, 1. The screening procedure will be performed and documented within 48 working hours of admission ... " A review of the record revealed physical therapy and occupational therapy screens dated September 25, 2007, 11 days after admission. A speech therapy screen was dated September 14, 2007, 10 days after admission. A face-to-face interview was conducted with the RCC (Resident Care Coordinator) on October 5, 2007 at approximately 11:30 AM. He/She acknowledged that the consult and screens were	{F 309} F309 -2B	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Rehab Director was informed on the importance of all resident screens being done in a timely manner and being placed in each resident's record. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other residents' charts were reviewed for missing screens or screens not done in a timely manner. No others found, no other resident affected by this deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Rehab staff educated on the importance of doing screens timely. Weekly chart audits for new admissions and residents with falls will be maintained as a QA measure to ensure that resident admission and fall screens are on residents charts in accordance with facility policy and procedure. The Director of Rehab will monitor. **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 Rehab Director will report all deficient practices to the monthly QA meetings.	[handwritten: reviewed 10/23/07] 10/25/07

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{F 309}	Continued From page 6 not conducted timely. The record was reviewed on October 5, 2007.	{F 309}		
{F 323} SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 14 sampled residents, it was determined that facility staff failed to provide adequate supervision for one (1) resident who fell and maintain a hazard free environment as evidenced by: unsecured skid strips and broken electrical outlet covers. Resident S1. The findings include: 1. A review of Resident S1's record revealed a nurse's note dated September 28 (29), 2007 at 5:30 AM, "Resident called at approximately 5 AM and was observed sitting on the floor. Resident notified writer that (he/she) was trying to retrieve (his/her) call bell which was dropped... no apparent injuries..." A "Physical Therapy Functional Needs Screening" was conducted on September 30, 2007 by the physical therapist. According to "Therapy Recommendations: Patient fell out of (his/her) bed. Physical Therapy not indicated at this time secondary to: Patient at maximal level of	F323-1 {F 323}	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Charge Nurse and the CNA were both counseled on the importance of responding to residents needs in an appropriate amount of time. Resident S1 was screened by OT on 10/18/07 for possible interventions to assist the resident in reaching. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other resident charts were reviewed in the last 30 days to determine if rehab screens were needed and to ensure appropriate interventions are in place. No other residents found. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Unit Managers will ensure that all residents sustaining a fall be referred to PT, and OT for screening within 48 hours. Residents that have sustained an injury due to fall, will be reviewed by the falls committee for further appropriate interventions. If a resident refuses the interventions offered the refusal will be brought to the attention of the Fall committee by the Unit Manger and optional interventions will be implemented and discussed. **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?** Unit Managers will continue to monitor and will report at the monthly Quality Assurance meetings any deficient practices.	Revisions requested 10/23/07 10/25/07

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{F 309}	Continued From page 6 not conducted timely. The record was reviewed on October 5, 2007.	{F 309} F323 -1	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Charge Nurse and the CNA were both counseled on the importance of responding to residents needs in an appropriate amount of time. Resident S1 was screened by OT on 10/18/07 for possible interventions to assist the resident in reaching. Resident care plan was updated with new interventions to include more staff monitoring and supervision and a long handled reacher to assists resident in grabbing items far away.	
{F 323} SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 14 sampled residents, it was determined that facility staff failed to provide adequate supervision for one (1) resident who fell and maintain a hazard free environment as evidenced by: unsecured skid strips and broken electrical outlet covers. Resident S1. The findings include: 1. A review of Resident S1's record revealed a nurse's note dated September 28 (29), 2007 at 5:30 AM, "Resident called at approximately 5 AM and was observed sitting on the floor. Resident notified writer that (he/she) was trying to retrieve (his/her) call bell which was dropped... no apparent injuries..." A "Physical Therapy Functional Needs Screening" was conducted on September 30, 2007 by the physical therapist. According to "Therapy Recommendations: Patient fell out of (his/her) bed. Physical Therapy not indicated at this time secondary to: Patient at maximal level of	{F 323}	**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other resident charts were reviewed in the last 30 days to determine if rehab screens were needed and to ensure appropriate nursing interventions are in place. No other residents found. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Unit Managers educated by DON to ensure that all residents sustaining a fall be referred to PT, and OT for screening within 48 hours. Residents that have sustained an injury due to fall will be reviewed by the falls' committee for further appropriate interventions. If a resident refuses the interventions offered the refusal will be brought to the attention of the fall committee by the Unit Manger and optional interventions will be implemented and discussed. **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?** Unit Managers will continue to monitor and will report at the monthly Quality Assurance meetings any deficient practices.	Revised received 10/23/07 10/25/07

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{F 323}	Continued From page 7 functioning." According to the resident's care plan, last reviewed September 26, 2007, "At risk for falls due to right hemiparesis and bilateral upper level contractures" under "Approaches: low bed was offered and a bed alarm was also offered." A face-to-face interview was conducted with Employee #9 on October 5, 2007 at 10:30 AM. He/she stated, "The resident refused the low bed and the bed alarm. The resident was screened by the physical therapist. [Resident S1] was not a candidate for therapy." Employee #9 acknowledged that no interventions were initiated after the resident refused the low bed and bed alarm. The record was reviewed October 5, 2007. 2. The 6th floor shower room skid strips [both shower stalls] were observed to be lifting and did not adhere to the shower floors. 3. The plastic covering of an electrical outlet was missing or damaged in the following areas: 5th floor shower room; room 5128 and room 5135. 4. A front cover to an HVAC (Heating Ventilation and Air Conditioning) unit was observed unsecured in room 6103. The aforementioned environmental deficient practices were acknowledged by Employee #1 and Employee #3 at the time of the observations on October 5, 2007 between 8:15 AM and 10:45 AM.	{F 323} F323-2	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The skid strips in both shower stalls on the 6th floor were replaced again on October 17, 2007. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Skid strips in shower stalls of all other units were inspected for damage. None other found. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** During weekly environmental rounds the floor skid strips will be inspected by housekeeping and maintenance supervisors to ensure skid strips are in good repair. **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 and report all deficient practices to monthly QA committee meetings.	10/25/07
{F 371} SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE	{F 371}		

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{F 371} SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE	{F 371}		

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{F 371} SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE	{F 371}		

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{F 371}	Continued From page 8 The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on a tour of the main kitchen, it was determined that facility staff failed to: dispose of moldy foods and cover, label and/or date food in the walk-in refrigerator. The tour of the main kitchen was conducted on October 5, 2007 from 8:10 AM to 9:30 PM in the presence of Employee #10. The findings include: 1. Moldy foods in the walk-in refrigerators were observed as follows: Eight (8) of 14 honeydew melons One-half flat of grapes Four (4) of four (4) cartons of tomatoes 14 of 14 sweet potatoes Seven (7) of Seven (7) cantaloupes 2. Items were observed uncovered, unlabeled and/or undated in the walk-in refrigerator as follows: Uncovered: Two (2) dishes of jello Two (2) dishes of chocolate puddings 13 dishes of pears Unlabeled and undated: 21 dishes of lettuce One (1) large salad One (1) small salad Two (2) dishes of cookies	{F 371} F371 -1	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The moldy items consisting of 8/14 honeydew melons, one half flat of grapes; 4/4 cartons of tomatoes; 14/14 sweat potatoes and 7/7 cantaloupes were removed from the walk in refrigerator immediately. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other areas in the kitchen were inspected immediately to ensure that no other food items were found to have this deficient practice. No other resident affected by this deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** During the week of 10/8/07 all dietary staff was in-serviced on proper storage practices, mostly stressing the importance of rotation of food by understanding the first in first out rule. Quarterly staff education will be done for reinforcement of standard policy and practice. Dietary supervisor and Director will continue to monitor on a daily basis. Food service supervisor will monitor walk in boxes 3 times daily, and meet with Director weekly to review audit findings for next three months to monitor process. **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 monthly at QA committee meetings.	10/25/07

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{F 371}	Continued From page 8 The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on a tour of the main kitchen, it was determined that facility staff failed to: dispose of moldy foods and cover, label and/or date food in the walk-in refrigerator. The tour of the main kitchen was conducted on October 5, 2007 from 8:10 AM to 9:30 PM in the presence of Employee #10. The findings include: 1. Moldy foods in the walk-in refrigerators were observed as follows: Eight (8) of 14 honeydew melons One-half flat of grapes Four (4) of four (4) cartons of tomatoes 14 of 14 sweet potatoes Seven (7) of Seven (7) cantaloupes 2. Items were observed uncovered, unlabeled and/or undated in the walk-in refrigerator as follows: Uncovered: Two (2) dishes of jello Two (2) dishes of chocolate puddings 13 dishes of pears Unlabeled and undated: 21 dishes of lettuce One (1) large salad One (1) small salad Two (2) dishes of cookies	{F 371} F371 -1	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The moldy items consisting of 8/14 honeydew melons; one half flat of grapes; 4/4 cartons of tomatoes; 14/14 sweat potatoes and 7/7 cantaloupes were removed from the walk in refrigerator immediately. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other areas in the kitchen were inspected immediately to ensure that no other food items were found to have this deficient practice. No other resident affected by this deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** During the week of 10/8/07 all dietary staff was in-serviced on proper storage practices, mostly stressing the importance of rotation of food by understanding the first in first out rule. Quarterly staff education will be done for reinforcement of standard policy and practice. Dietary supervisor and Director will continue to monitor on a daily basis. Food service supervisor will monitor walk in boxes 3 times daily, and meet with Director weekly to review audit findings for next three months to monitor process. **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 monthly at QA committee meetings. By the Director of Dietary. RMG [illegible]	10/25/07

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{F 371}	Continued From page 8 The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on a tour of the main kitchen, it was determined that facility staff failed to: dispose of moldy foods and cover, label and/or date food in the walk-in refrigerator. The tour of the main kitchen was conducted on October 5, 2007 from 8:10 AM to 9:30 PM in the presence of Employee #10. The findings include: 1. Moldy foods in the walk-in refrigerators were observed as follows: Eight (8) of 14 honeydew melons One-half flat of grapes Four (4) of four (4) cartons of tomatoes 14 of 14 sweet potatoes Seven (7) of Seven (7) cantaloupes 2. Items were observed uncovered, unlabeled and/or undated in the walk-in refrigerator as follows: Uncovered: Two (2) dishes of jello Two (2) dishes of chocolate puddings 13 dishes of pears Unlabeled and undated: 21 dishes of lettuce One (1) large salad One (1) small salad Two (2) dishes of cookies	{F 371} F371-2	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The unlabelled, uncovered, and undated jello, chocolate pudding, salads, cookies, and 1 sandwich were immediately removed from the walk in refrigerator. All items are covered and individually wrapped. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other food items were inspected to ensure no others were unlabelled, uncovered, and or undated. No others found. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** During the week on 10/08/07 dietary staff was all in-served on proper storage practices, and focused on the importance of label and dating food in storage. Quarterly staff in-services will be conducted to educate new staff and reinforce standard policy and practices. Dietary Director and Supervisor will meet weekly, and will monitor, track, and review audit findings. **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 monthly at QA committee meetings.	10/25/07 revision requested 10/18/07 TT

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095027	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED R 10/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 371}	Continued From page 9 One (1) sandwich Employee #10 acknowledged the above findings at the time of the observations.	{F 371} F385		
F 385 SS=D	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 14 sampled residents, it was determined that the physician failed to perform a History and Physical examination as per facility policy. Resident W6. The findings include: Policy number 14, "Medical Staff Documentation" dated September 15, 2005 included, " ... 5. The following documentation shall be completed as required: A. Admission History and Physical shall be performed five (5) days prior to admission or within 48 hours of admission ..." Resident W6 was admitted to the facility on September 14, 2007 with the following diagnoses: Anoxic brain injury following CPR secondary to Respiratory Failure, CHF (Congestive Heart	F 385	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The attending physician was notified to come and complete the H&P for resident W6 immediately. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other Nursing center resident charts were checked for missing H&Ps no other resident affected by this deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Medical Records Coordinator will place all physician delinquencies on monthly QA form. Weekly notices to indicate 5 days prior to due date will be given to all physicians as reminder. Medical Director and Administrator will be advised on all physicians failing to comply 5 business days after due date. Physicians that are non-compliant will be suspended privileges to nursing center. **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?** Medical Records Coordinator will report all delinquent practices monthly to the QA committee.	per [illegible] requested 10/23/07 10/25/07

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F 385	Continued From page 10 Failure, HTN (Hypertension, S/P (Status Post tracheostomy, S/P Peg Placement, S/P Substance Abuse, Encephalopathy, Asthma, Seizure Disorder, Cardiomyopathy, Pneumonia and UTI (Urinary Tract Infection). A nurse practitioner's progress note was dated September 29, 2007. The resident's admission orders were signed by the nurse practitioner; however, there was no date. There was no evidence of a History and Physical in the record. A face-to-face interview was conducted with Employee #7 on October 5, 2007 at approximately 11:30 AM. He/She acknowledged that there was no History and Physical examination in the record. The record was reviewed on October 5, 2007.	F 385 F454- 1&2	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The wedge and the paper towel propping the hallways fire doors on the 4th and 6th floors were removed immediately. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other fire doors were checked for propping in the nursing center. Doors found propped were closed and fire alarm was reset so doors could open without propping.	
F 454 SS=D	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour of the facility, it was determined that facility staff failed to ensure that there was no impediment to the closing of hallway fire doors. These observations were made in the presence of Employee #2 on October 5, 2007 between 8:15 AM and 10:45 AM. The findings include: 1. The 6th floor hallway fire door was propped open with a wooden wedge in one (1) of four (4)	F 454	**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Security was informed that doors could not remain open as battery failed for these two doors and the security company was notified and doors will be fixed by 10/21/07. **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 Security staff was monitor during rounds and report all deficient practices to monthly Quality Assurance meetings.	10/25/07

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F 385	Continued From page 10 Failure, HTN (Hypertension, S/P (Status Post tracheostomy, S/P Peg Placement, S/P Substance Abuse, Encephalopathy, Asthma, Seizure Disorder, Cardiomyopathy, Pneumonia and UTI (Urinary Tract Infection). A nurse practitioner's progress note was dated September 29, 2007. The resident's admission orders were signed by the nurse practitioner; however, there was no date. There was no evidence of a History and Physical in the record. A face-to-face interview was conducted with Employee #7 on October 5, 2007 at approximately 11:30 AM. He/She acknowledged that there was no History and Physical examination in the record. The record was reviewed on October 5, 2007.	F 385 F454- 1&2	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The wedge and the paper towel propping the hallways fire doors on the 4th and 6th floors were removed immediately. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other fire doors were checked for propping in the nursing center. Doors found propped were closed and fire alarm was reset so doors could open without propping.	
F 454 SS=D	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour of the facility, it was determined that facility staff failed to ensure that there was no impediment to the closing of hallway fire doors. These observations were made in the presence of Employee #2 on October 5, 2007 between 8:15 AM and 10:45 AM. The findings include: 1. The 6th floor hallway fire door was propped open with a wooden wedge in one (1) of four (4)	F 454	**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Security was informed that doors could not remain open as battery failed for these two doors and the security company was notified and doors will be fixed by 10/21/07. Nursing Center staff education began on 10/23/07 on not propping any fire door open. **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 Security staff was monitor during rounds and report all deficient practices to monthly Quality Assurance meetings.	10/25/07

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F 454	Continued From page 11 observations of fire doors on the 6th floor. 2. The 4th floor hallway fire door was propped open with a paper towel in one (1) of four (4) observations of fire doors on the 4th floor.	F 454 F463	**1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The resident affected by this deficient practice was given a hand bell to ring immediately. A work order was completed for the non functioning call bell for maintenance to fix. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other resident call bells were inspected immediately to ensure they were operational. No other bells were non-functional. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Staff was educated on being proactive and bringing incidents pertaining to resident rights and resident quality of care to charge nurses or nursing supervisors immediate. Nursing was educated also on the importance of responding to call bells immediately. Maintenance will add call lights to PM maintenance schedule. **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 department will monitor during weekly rounds and report all deficient incidents to monthly Quality Assurance meetings.	10/25/07
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review for one (1) of 14 sampled residents, it was determined that facility staff failed to provide a means of directly contacting staff. Resident S1. The findings include: During the environmental tour on October 5, 2007 at 9:45 AM, the call light in Resident S1's room did not function when activated. There was no alternate method provided to the resident to call for nursing assistance. A face-to face interview was conducted on October 5, 2007 at 10:00 AM with Resident S1. He/she stated, "They have been checking on me hourly, mostly. Sometimes they miss here and there, but mostly they check on me." A face-to-face interview was conducted with Employee #9 on October 5, 2007 at 10:15 AM. He/she stated, "The call light was broken on October 3 (2007) when I was getting ready to go	F 463		

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F 463	Continued From page 12 home. I called Employee #2 and told [him/her] the call light didn't work. I told the evening charge nurse before I left that we need to check on [resident] every hour. They started a log. When I came back the next morning, the call light still wasn't working. I called Employee #2 again. I called PT and Activities for a bell for the resident and they didn't have one. We did hourly checks. The resident has been fine." An observation was conducted at 2:15 PM on October 5, 2007. Resident S1's call bell was functional.	F 463		