| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 095034 | A. BUILDING _____ B. WING _____ | 09/17/2010 |

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| CARROLL MANOR NURSING & REHAB | 726 BUCHANAN ST., NE WASHINGTON, DC 20017 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>An annual re-certification survey was conducted on September 13-17, 2010. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size included 30 residents based on a census of 243 the first day of survey, with two (2) supplemental residents. | F 000 | **Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of deficiencies. This Plan of Correction (POC) is prepared and/or executed because it is required by the state and federal laws.** | |
| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>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).<br><br>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.<br><br>The facility must record and periodically update | F 157 | **F 157 483.10(b) (11) NOTIFY OF CHANGES(INJURY/DECLINE/ROOM, ETC)**<br><br>1. Resident # 7 was assessed for regular bowel elimination pattern. He/She is having regular bowel movements. Physician notified, Resident # 7 is currently getting colace BID and fleet enema every 3 days as needed for constipation. 9/15/10<br><br>2. All residents will be assessed for regular bowel elimination pattern and physician will be notified when applicable. 11/26/10<br><br>3. All staff will be in-serviced on facility bowel elimination protocol. 11/26/10<br><br>4. Monthly audits will be conducted on bowel elimination pattern by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. On-going | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tina Landon | TITLE: VP/Administrator | (X8) DATE: 11/26/10

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<br>the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to notify the physician that one (1) resident did not have a bowel movement for more than 3 days / 72 hours prior to Resident #7's complaint that he/she did not have a bowel movement for one week .<br><br>The findings include:<br>According to the facility's policy: Bowel Management/Constipation Number:1242.2 effective December 1999, revised August 2004 and last reviewed August 1, 2009<br><br>I. Policy: "It is the policy of this facility to prevent fecal impaction secondary to inadequate elimination of feces."<br><br>II. Purpose: "To provide guidelines that ensure proper monitoring of residents regarding adequate elimination of feces. To prevent complications of constipation, fecal impaction, and bowel obstruction which have the potential for occasional hospital admission.<br><br>III. Supportive Data: "Constipation is a decrease in the number of bowel movements along with prolonged or difficult passage of stools. Constipation ...May progress to fecal impaction, which predisposes individuals to urinary tract infection and urinary incontinence.<br><br>VII. Intervention: If the resident complains of | F 157 | | |

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| F 157 | Continued From page 2<br>being constipated and / or has not had a bowel movement within 72 hours after admission...Obtain a physician's order for bulk laxative...If MOM [Milk of Magnesia] is unsuccessful after 6 hours, obtain a physician's order for a fleets enema.<br><br>V. Assessment: ...Validate complaints with further history ...stool frequency is less often than every three days unless the resident has been NPO [No oral intake] or if there is an acute change in the resident's bowel pattern.<br><br>V111. Documentation: ...Document the presence / absence of constipation, stool consistency, and frequency in the 'Nurses Progress Notes' section of the resident's clinical record.<br><br>A review of the resident's clinical record revealed the followings:<br>The "Resident Bowel and Bladder by shift Chart" revealed that the resident did not have a bowel movement from: April 8 to12, 2010, May 3 to 7, 2010, and f June 21 to 24, 2010.<br>A nursing note of May 8, 2010 at 1420 that noted "Resident C/O [Complained of] feeling constipated, stated [he/she] has not had a bowel movement in a week. Resident abd. [Abdomen] is distended soft and obese...Resident assisted to bed, checked for impaction. Large amount of stool palpated. Resident unable to pass stool. Call placed to the PMD [Primary Care Provide] Order obtained for enema. Enema administered, moderate amt. [Amount] of soft, formed...brown stool passed. However, moderate amt. of stool palpated in rectum. Resident states [he/she] feels better after administration of enema and [he/she] will stay in bed because [he/she] continues to feel | F 157 | | |

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| F 157 | Continued From page 3<br>some stool coming out. Order also obtained for Lactulose 30ml po [by mouth]. QHS [at hour of sleep]. Will continue to monitor resident for safety/comfort."<br><br>A nursing note of May 8, 2010 at 1500 that noted: "Resident c/o not having BM [Bowel movement] x 1wk [one week], found to be impacted. MD [Medical doctor] notified. Order for enema given and carried out. Had med. [Medium] BM. Continue to monitor. "<br><br>A nursing note of May 8, 2010 at 2240 that noted: "...Multiple bms [bowel movements] after receiving enema for C/O constipation. Encouraged PO H2O [Water] intake BS (+) [Positive bowel sound] in quadrants x 4. Abd. soft, non-tender/non-distended. Resident reports 'it's a whole lot better' initiated Lactulose for bowel regularity at HS [At time of sleep]."<br><br>Facility staff failed to notify the physician that Resident #7 did not have a bowel movement for more than 3 days / 72 hours prior to the resident's complaint that he/she did not have a bowel movement for one week.<br><br>A face-to-face interview was conducted with Employee #5 on September 15, 2010 at approximately 10:45 AM. After a review of the resident's clinical record, he/she acknowledged that the resident's clinical record lacked documented evidence that facility staff notified the physician that Resident #7 did not have a bowel movement for several days prior to the resident's complaint that he/she did not have bowel movement for one week. The record was reviewed September 15, 2010. | F 157 | | |
| F 253 | 483.15(h)(2) HOUSEKEEPING & | F 253 | | |

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| F 253 SS=E | Continued From page 4<br>MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made during environmental tours of the facility on September 15, and 16, 2010, it was determined that the facility failed to provide effective maintenance services in residents rooms: Bathroom vents were dusty in seven (7) of 70 resident rooms, Bathroom vents were not functioning in nine (9) of 70 resident rooms, walls were marred in seven (7) of 70 rooms, and call bell buttons (used at bedside by the residents) were stuck in the inward position once pressed in six (6) of 70 resident rooms and call bells were missing the reset button in four (4) of 70 resident rooms.<br><br>The findings include:<br><br>1. Bathroom air vents were dusty in rooms # 509, 511, 516, 545, 547, 431 and 429.<br><br>2. Bathroom vents were not functioning in rooms #155, 255, 409, 411, 451, 535, 545, 547 and 553.<br><br>3. Walls were marred or soiled in rooms # 125, 149, 301, 303, 315, 436 and 454.<br><br>4. Call bell buttons (used at bedside by the residents) were stuck in the inward position once pressed in rooms #214, 309, 333, 346, 404 and | F 253 | **F 253- 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES**<br>**1.**<br>1. Dusty bathroom vents identified were removed and power washed.<br><br>2. Housekeeping Manager inspected all vents throughout the facility.<br><br>3. Outer portion of bathroom vents will be cleaned weekly by housekeeping. Vents will be inspected by the Housekeeping Manager during daily rounds.<br><br>4. Bathroom vents will be inspected monthly by the Housekeeping supervisor/designee to ensure compliance. Findings will be reported to the QA/QI Committee quarterly.<br><br>**2.**<br>1. The main exhaust fan was not working, causing the bathroom vents to not operate. The electrical panel was checked and a trip breaker had tripped. The breaker was reset.<br><br>2. All exhaust fans and bathroom vents will be checked and repaired where applicable.<br><br>3. All exhaust fans will be checked and receive preventative maintenance 3 times per year.<br><br>4. Exhaust fans will be inspected by the CM Maintenance Supervisor/designee three times per year to ensure compliance. The results will be submitted at the quarterly QA/QI meeting. | 9/16/10<br><br>9/17/10<br><br>9/17/10<br><br>On-going<br><br>9/17/10<br><br>12/10/10<br><br>12/15/10<br><br>On-going |

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| F 253 | Continued From page 5<br>455.<br><br>5. Call bells were missing the reset buttons in rooms #214, 309, 323, and 333.<br><br>These observations were made in the presence of Employees # 14 and # 15 who acknowledged these findings during the survey. | F 253 | **3.**<br>1. All cited rooms will be painted.<br>2. All resident rooms will be inspected and painted where applicable.<br>3. All resident rooms will be inspected quarterly as part of the preventative maintenance plan.<br>4. Preventative maintenance will be done monthly to ensure compliance by the CM Maintenance Supervisor/designee. Findings will be reported to the quarterly QA/QI meeting. | 12/10/10<br>12/15/10<br>12/15/10<br>On-going |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>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.<br><br>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).<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview of five (5) of 30 sampled residents it was determined that facility staff failed to develop care plans for | F 279 | **4.**<br>1. The call bell reset buttons that stuck inward were functional, however, they were immediately replaced in all the cited rooms.<br>2. All call bell buttons were inspected and corrected where applicable.<br>3. The Nursing staff will check call bells daily and will report all issues to call center for repair<br>All resident rooms will be inspected quarterly as part of the preventative maintenance plan<br>4. Preventative maintenance will be done quarterly to ensure compliance by the CM Maintenance Supervisor/designee. Findings will be reported to the quarterly QA/QI meeting.<br><br>**5.**<br>1. The call bells' missing reset buttons were replaced.<br>2 All call bell buttons were inspected and corrected where applicable.<br>3. The Nursing staff will check call bells daily and will report all issues to call center for repair<br>All resident rooms will be inspected quarterly as part of the preventative maintenance plan<br>4. Preventative maintenance will be done quarterly to ensure compliance by the CM Maintenance Supervisor/designee. Findings will be reported to the quarterly QA/QI meeting. | 9/17/10<br>9/17/10<br>12/15/10<br>On-going<br><br>9/17/10<br>9/17/10<br>12/15/10<br>On-going |

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| F 279 | Continued From page 6<br>the potential adverse interaction of the use of nine (9) or more medication for three (3) residents, failed to develop a care plan for pressure ulcer for one (1) resident, and failed to develop a care plan for the use of a diuretic for one (1) resident. Residents, #5, 7, 15, 17, and 28.<br><br>The findings include:<br><br>1. Facility staff failed to develop a care plan for the potential for adverse interaction of nine (9) or more medications for Resident #5.<br><br>A review of the POS (Physician's Order Sheet) dated and signed by the physician on July 30, 2010 revealed the following medications that were prescribed for Resident #5, Galantamine, Namenda, Simvastatin, Galantamine, Asprin, Sertraline, Carvedilol, Vitron-C, Vitamin D, Lisinopril, Docusate Sodium, Colace, Calcium, Seroquel, Seroquel, Protein Plus pack, Cyanocobalamin, Zolof, Sorbitol, Fortical Nasal spray.<br><br>The care plan last reviewed on July 29, 2010 lacked documented evidence of a care plan for the potential adverse interaction of nine (9) or medications.<br><br>A face-to-face interview was conducted with Employee #6 on September 14, 2010 at approximately 11:30 AM. After review of the clinical record he/she acknowledged that the record lacked evidence of a care plan for the potential adverse interaction of nine (9) or more medications. The record was reviewed on September 14, 2010. | F 279 | **1. F279- 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS**<br><br>1. Resident #5's care plan was updated to include potential adverse interaction of the use of nine (9) or more medications.<br><br>2. All residents were reviewed for receiving nine (9) or more meds; care plans were generated for potential adverse interaction of the use of nine (9) or more medications when applicable.<br><br>3. All licensed staff will be in-serviced on initiating care plans for potential adverse interaction of the use of nine (9) or more medications for residents receiving nine (9) or more meds.<br><br>4. Monthly care plan audits will be conducted by Nurse Managers/designee to ensure compliance, and the results will be submitted to the DON for presentation at the QA/QI meeting. | 9/14/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 279 | Continued From page 7<br><br>2. Facility staff failed to develop a care plan for the potential for adverse drug interactions for 9 or more medications for Resident #7.<br>A review of the resident's clinical record revealed a 'Physician's Order Sheet' (POS) dated and signed by the physician on August 7, 2010 for the months of August and September 2010 that directed medications including:<br>"Amlodipine Besylate 10mg tab. 1 tablet by mouth daily for hypertension."<br>"Lasix 80mg daily P.O. [By mouth] for CHF [Congestive Heart Failure]."<br>"Sertraline HCL 100mg tablet. 1 tablet by mouth daily for depression."<br>"Multivitamins tablet. 1 tablet by mouth daily for supplement."<br>"Pentoxifyllinne ER 400mg tab. 1 tablet by mouth three times daily for peripheral vascular diseases."<br>"Gabapentin 300mg capsule.1capsule by mouth three times daily for lower extremity pain."<br>"Acetaminophen ER650mg.1 tablet by mouth three times daily for pain."<br>"Famotidine 40mg tablet. 1 tablet by mouth twice daily for GERD [Gastro esophageal reflux]."<br>"Bethanechol 10mg. 1 tablet by mouth twice daily for heartburn."<br>"Colchicine 0.6mg tablet. 1 tablet by mouth twice daily for gout."<br>"Docusate sodium 100mg capsule.1 capsule by mouth twice daily for bowel motility."<br>"Zolpidem tartrate 10mg tablet. 1 tablet by mouth every night at bedtime."<br>"Fleet enema. Give 1 enema per rectum every 3 days PRN/ as needed: DX: Constipation prevention"<br>According to an annual Minimum Data Set (MDS) | F 279 | **2. F279- 483.20(d), 483.20(k)(1)DEVELOP COMPREHENSIVE CARE PLANS**<br><br>1. Resident #7's care plan was updated to include potential adverse interaction of the use of nine (9) or more medications.<br><br>2. All residents were reviewed for receiving nine (9) or more meds; care plans were generated for potential adverse interaction of the use of nine (9) or more medications when applicable.<br><br>3. All licensed staff will be in-serviced on initiating care plans for potential adverse interaction of the use of nine (9) or more medication for residents receiving nine (9) or more meds.<br><br>4. Monthly care plan audits will be conducted by Nurse Managers/designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | 9/15/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 279 | Continued From page 8<br>completed on June 30, 2010, the resident was coded in Section O (1) (Number of medications), for "12".<br>A further review of the resident's 'Medication Administration Records' (MAR) for the months of August and September 2010 revealed that the resident was administered the aforementioned medications except for the resident's occasional refusals as evidenced by the initials across the entries for the aforementioned medications on the MAR.<br>A review of the resident's clinical record revealed that the resident's care plans were reviewed and revised after the completion of the resident's annual assessment on June 30 2010.<br>There was no evidence that a care plan with appropriate goals and approaches was initiated for 9 (nine) or more medications for the resident.<br>A face-to-face interview was conducted with Employee #5 on September 15, 2010 at approximately 11:00 AM. After a review of the resident's clinical record, he/she acknowledged the aforementioned findings. He she/she added, I will go and work on it right away. He/she returned moments later with a copy of the newly initiated care plan. The record was reviewed September 15, 2010.<br><br>3. Facility staff failed to develop a care plan for the potential adverse interaction of nine (9) or more medications for Resident #15.<br><br>A review of the POS (Physician ' s Order Sheet) dated and signed by the physician on September 3, 2010 revealed the following medications that were prescribed for Resident #15, Glyburide, Atenolol, Folic Acid, Vitamin B-12, Gemfibrozil, senokot, Namenda, Gabapentin, Cetirizine, Acetamenophine. | F 279 | **3. F279- 483.20(d), 483.20(k)(1)DEVELOP COMPREHENSIVE CARE PLANS**<br><br>1. Resident #15's care plan was updated to include potential adverse interaction of the use of nine (9) or more medications.<br><br>2. All residents were reviewed for receiving nine (9) or more meds; Care plans were generated for potential adverse interaction of the use of nine (9) or more medications when applicable<br><br>3. All licensed staff will be in-serviced on initiating care plans for potential adverse interaction of the use of nine (9) or more medication for residents receiving nine (9) or more meds.<br><br>4. Monthly care plan audits will be conducted by Nurse Managers/designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | 9/15/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 279 | Continued From page 9<br><br>A review of the care plans last updated July 26, 2010 lacked documented evidence of a care plan for the potential adverse interaction of nine (9) or more medications.<br><br>A face-to-face interview was conducted with Employee #5 on September 15, 2010 at approximately 11:15 AM. After a review of the clinical record he/she acknowledged that the record lacked evidence of a care plan for the potential adverse interaction of nine (9) or more medications. The record was reviewed on September 15, 2010.<br><br>4. Facility staff failed to initiate a pressure ulcer care plan for Resident #17.<br><br>A review of Resident # 17's clinical record revealed the followings:<br><br>A nursing note dated September 5, 2010 at 1130 that noted: "Resident observed with open area on the right posterior thigh measuring 2cm X 1cm. Supervisor, MD [Medical Doctor] and responsible party made aware. New order to cleanse area on [the] Rt. [Right] posterior thigh with soap and H2O [Water], pat dry apply 'Baza' cream and leave open X 15days after each incontinent care and PRN."<br><br>A nursing note dated September 10, 2010 at 0600 that noted: "Resident was upset staying in the bed without diaper. Resident try to get out of the bed screaming calling from the room and stated 'I want diaper right now, explained the fact why no diaper. Resident disagreed states 'That's my dignity. I am going to report it '[Resident] | F 279 | **4. F279- 483.20(d), 483.20(k)(1)DEVELOP COMPREHENSIVE CARE PLANS**<br><br>1. Resident #17's care plan was updated to include right thigh pressure ulcer.<br><br>2. All care plans for residents with identified pressure ulcers will be reviewed. A pressure ulcer plan of care will be initiated when applicable.<br><br>3. All licensed staff will be in-serviced on initiating care plans for residents identified with pressure ulcers.<br><br>4. Monthly care plan audits will be conducted by Nurse Managers/designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | 9/17/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 279 | Continued From page 10<br>offered diaper, resident became calm."<br><br>A review of the resident's clinical record lacked documented evidence that a care plan was initiated with appropriate goals and approaches for the resident's right thigh pressure ulcer.<br><br>A face-to-face interview was conducted with Employee #5 on September 17, 2010 at approximately 2:30 PM. After a review of the resident's clinical record, he/she acknowledged the aforementioned findings. The record was reviewed September 17, 2010.<br><br>5. The facility staff failed to develop a care plan for the use of a diuretic for Resident #28.<br>The Admission Orders dated July 14, 2010 revealed, " Lasix 20 mg po (by mouth) one (1) tab daily for edema. "<br>A review of the July 2010 Medication Administration Record revealed that the Lasix 20 mg was administered from July 14 - 31, 2010; and the August 2010 Medication Administration Record revealed that the Lasix 20 mg was administered from August 1- 18, 2010.<br>A nutrition note dated August 5, 2010 at 3:30 PM documented the following: "...Weekly weights done on 8/4/10. Wt recorded @ 156.8. Last week weight @ 166.2 lbs (pounds). Wt loss of 9.4 lbs. x 1 week and about 30 lbs wt loss since admission. Resident on Lasix 20 mg daily for edema. Wt loss expected. Will continue with plan of care. "<br>A review of the care plans located in the clinical record lacked evidence that a care plan was initiated for the use of Lasix.<br>A face-to-face interview was conducted on September 17, 2010 at approximately 3:47 PM with Employee #4. He/she acknowledged that the | F 279 | **5. F279- 483.20(d), 483.20(k)(1)DEVELOP COMPREHENSIVE CARE PLANS**<br><br>1. Resident #28 was discharged on 8/18/10.<br><br>2. All residents were assessed for diuretic use and a care plan was initiated for residents on diuretics when applicable.<br><br>3. All licensed staff will be in-serviced on initiating care plans for residents receiving diuretics.<br><br>4. Monthly care plan audits will be conducted by Nurse Managers/designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | 8/18/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 279 | Continued From page 11<br>there was no care plan initiated for the use of Lasix. The record was reviewed on September 17, 2010. | F 279 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to revise and/or update the care plan for skin integrity for Resident #28.<br>The findings include:<br>Resident #28's "Care Plan and Family Meeting Sign In Sheet" revealed that care plans initiated on July 14, 2010 were reviewed by the facility on | F 280 | **F 280- 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP**<br><br>1. Resident #28 was discharged on 8/18/10.<br><br>2. All care plans for residents with identified pressure ulcers will be reviewed. A pressure ulcer plan of care will be initiated when applicable.<br><br>3. All licensed staff will be in-serviced on generating and/or updating care plans for residents identified with pressure ulcers to include preventive measures.<br><br>4. Monthly care plan audits will be conducted by Nurse Managers/designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | 8/18/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 280 | Continued From page 12<br>July 21 and 27 and August 3, 4, 11 and 18, 2010. Problem #3 [initiated July 14, 2010], revealed "Altered Skin Integrity, pressure related; potential for skin breakdown" was included in the care plan. The goal was "Resident will experience no compromise of skin integrity related to pressure over the next 30 days."<br><br>There was no evidence that a plan of care was updated to reflect the development of the unstageable (Stage IV) right heel pressure wound on July 20, 2010 and the Stage II coccyx on July 29, 2010 wound.<br><br>A face-to-face interview was conducted on September 17, 2010 at approximately 3:47 PM with Employee #4. He/she acknowledged that the "Altered Skin Integrity " care plan was not updated/revised. The record was reviewed on September 17, 2010. | F 280 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to assess and provide appropriate interventions to prevent complications of constipation for Resident # 7. | F 309 | | |

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| F 309 | Continued From page 13<br><br>The findings include:<br><br>According to the facility's policy: Bowel Management/Constipation Number:1242.2 effective December 1999, revised August 2004 and last reviewed August 1, 2009:<br>I. Policy It is the policy of this facility to prevent fecal impaction secondary to inadequate elimination of feces."<br>II. Purpose "To provide guidelines that ensure proper monitoring of residents regarding adequate elimination of feces. To prevent complications of constipation, fecal impaction, and bowel obstruction which have the potential for occasional hospital admission.<br>III. Supportive Data: "Constipation is a decrease in the number of bowel movements along with prolonged or difficult passage of stools. Constipation ...May progress to fecal impaction, which predisposes individuals to urinary tract infection and urinary incontinence.<br>VII. Intervention: If the resident complains of being constipated and / or has not had a bowel movement within 72 hours after admission...Obtain a physician's order for bulk laxative...If Milk of Magnesia (MOM) is unsuccessful after 6 hours, obtain a physician's order for a fleets enema.<br>V. Assessment: ...Validate complaints with further history ...stool frequency is less often than every three days unless the resident has been NPO [No oral intake] or if there is an acute change in the resident ' s bowel pattern.<br>V111. Documentation: ...Document the presence / absence of constipation, stool consistency, and frequency in the 'Nurses Progress Notes' section of the resident's clinical record. | F 309 | | |

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| F 309 | Continued From page 14<br><br>Facility staff failed to provide appropriate interventions to prevent complications of constipation for Resident #7 and accurately document the resident's elimination pattern in the monthly summaries.<br><br>The resident was observed on September 15, 2010 at approximately 10:30 AM seated in a wheelchair in his/her room. He/she said, "I use the bathroom by myself. I like it here in my room."<br><br>A review of the resident's clinical record revealed the followings:<br>An electronic "Resident Bowel and Bladder by shift Chart" that documented that the resident did not have bowel movement from April 8 to12, 2010, May 3 to 7, 2010 and June 21 to 24, 2010..<br><br>A nursing note of May 8, 2010 at 1420 that noted "Resident C/O [Complained of] feeling constipated, stated [he/she] has not had a bowel movement in a week. Resident abd. [Abdomen] is distended soft and obese...Resident assisted to bed, checked for impaction. Large amount of stool palpated. Resident unable to pass stool. Call placed to the PMD [Primary Care Provider] Order obtained for enema. Enema administered, moderate amt. [Amount] of soft, formed...brown stool passed. However, moderate amt. of stool palpated in rectum. Resident states [he/she feels better after administration of enema and [he/she] will stay in bed because [he/she] continues to feel some stool coming out. Order also obtained for Lactulose 30ml po [By mouth]. QHS [At hour of sleep]. Will continue to monitor resident for safety/comfort."<br><br>A nursing note of May 8, 2010 at 1500 that noted: | F 309 | **F 309- 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**<br><br>1. Resident #7 was assessed for regular bowel elimination pattern. He/she is having regular bowel movements. Physician notified, Resident #7 is currently getting colace BID and fleet enema every 3 days as needed for constipation. 9/15/10<br><br>2. All residents were re-assessed for constipation to ensure interventions are in place to prevent complications from constipation when applicable. 11/26/10<br><br>3. All staff will be in-serviced on facility bowel elimination protocol. 11/26/10<br><br>4. Monthly audits will be conducted on bowel elimination pattern by Nurse Managers/ designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. On-going | |

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| F 309 | Continued From page 15<br>"Resident c/o not having BM [Bowel movement] x 1wk [1 (one) week], found to be impacted. MD [Medical doctor] notified. order for enema given and carried out. Had med. [Medium] BM. Continue to monitor."<br><br>A nursing note of May 8, 2010 at 2240 that noted: "...Multiple bms after receiving enema for C/O constipation. Encouraged PO H2O [Water} intake BS (+) [Positive bowel sound] in quadrants x4. Abd. soft, non-tender/non-distended. Resident reports 'It's a whole lot better ' initiated Lactulose for bowel regularity at HS [At time of sleep]."<br><br>A nursing note of May 16, 2010 at 0800 that noted: Lactulose discontinued. "Resident to continue Colace cap. [Capsule] one twice daily. "<br><br>A nursing note of May 9, 2010 at 8:00AM that noted: "Resident alert and verbally responsive. Soft loose stool x2 during this shift, no C/O stomach discomfort."<br><br>A nursing note of May 12, 2010 at 2230 that noted: "Resident seen by Dr. {Name of doctor] for F/U [Follow-up]. Next visit in one year. Colace 100mg p.o. twice daily for bowel motility ordered per Dr. [Name of doctor]."<br><br>A nursing note of May 8, 2010 at 1420 that noted: "Medicated for right leg pain. Scale 6/10 given Tylenol #3 two tabs. [Tablets] p.o. at 1900. Relief reported after 30 minutes. [Decreased] scale 2/10.Pain at present 0/10."<br><br>An attending note of May 13, 2010 at 1930 that noted: "Pt. [Patient] had problem with constipation now is better...seen by ophthalmology for diabetes retinopathy. Continue to refuse med. | F 309 | | |

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| F 309 | Continued From page 16<br>[Medication] from time to time...continue current med."<br><br>A May 2010 "Medication Administration Record' [MAR] that revealed that the resident was administered Fleet enema per rectum on May 8, 2010 as evidence by the initials across from the entry for "Fleet Enema: Give 1 enema per rectum x1 now."<br><br>A May monthly summary dated June 1, 2010 that inaccurately documented regular bowel for the resident and failed to check constipation, incontinent, laxatives and enemas.<br><br>A June monthly summary dated July 5, 2010 that inaccurately documented regular bowel for the resident and failed to check constipation, Incontinent and laxatives.<br><br>A further review of the resident's clinical record lacked documented evidence that facility staff provided appropriate interventions to prevent complications of constipation when Resident #7 and failed to accurately document the resident's elimination pattern in the monthly summaries.<br><br>A face-to-face interview was conducted with Employee #5 on September 15, 2010 at approximately 10:45 AM. After a review of the resident's clinical record, he/she acknowledged the aforementioned findings. The record was reviewed September 15, 2010. | F 309 | **F 309- 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**<br><br>1. Resident #7's monthly summaries were reviewed and accurately documented to reflect resident's actual elimination pattern. 9/15/10<br><br>2. Monthly summaries will be reviewed on all residents to ensure accurate documentation of elimination pattern when applicable. 11/26/10<br><br>3. All licensed staff will be in-serviced on accurately documenting resident's elimination pattern on monthly summary. 11/26/10<br><br>4. Summary audits will be conducted monthly by Nurse Managers/designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. On-going | |
| F 314 SS=G | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores | F 314 | | |

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| F 314 | Continued From page 17<br>does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on staff interviews and record reviewed for one (1) of 30 sample residents, it was determined that facility staff failed to implement measures to prevent the development of a Stage IV right heel pressure sore and a Stage II coccyx pressure sore and provide necessary treatment and services to promote healing for Resident #28.<br>The findings include:<br><br>A review of Resident #28 ' s record revealed that he/she was born on October 15, 1953 and was admitted to the facility on July 14, 2010. According to the admission Minimum Data Set assessment completed July 27, 2010, the resident was coded for long and short term memory problems with moderately impaired cognitive skills for daily decision making in Section B (Cognitive Patterns). Resident #28 was coded as requiring extensive assistance for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing in Section G (Physical Functioning and Structural Problems). Disease diagnoses listed in Section I included: Hypertension, Arthritis, Status Post Hip Fracture, and Anemia.<br><br>A review of the Braden Pressure Ulcer Risk Assessment dated July 21, 2010 revealed a total score of 13. | F 314 | **F 314- 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES**<br><br>1. Resident #28 was discharged on 8/18/10 Skin protection detail report contained in CareTracker documentation system reflects evidence of measures initiated to prevent development of pressure ulcers from admission through her entire stay in the facility. Measures put in place included turning and repositioning every 2 hours, floating heels, application of protective barrier to skin and use of chair cushion. | 8/18/10 |
| | | | 2. All residents will be re-assessed for pressure ulcers and the risk of developing pressure ulcers, and facility staff will document preventive measures for developing pressure ulcers as well as treatment when applicable. | 11/26/10 |
| | | | 3. All staff will be in-serviced on facility pressure ulcer prevention/treatment protocol. | 11/26/10 |
| | | | 4. Monthly audits for documentation of preventive measures for developing pressure ulcers/treatment will be conducted by Nurse Managers/designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | On-going |

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| F 314 | Continued From page 18<br><br>A face-to-face interview was conducted with Employee #2 at approximately 3:47 PM. He/she stated, "A score less than 18 means that [facility staff] will implement pressure prevention protocol. We [facility staff] would obtain an order to float heels."<br><br>A review of the nurse's admission assessment completed July 14, 2010, revealed the following: "Resident admitted from [hospital] with multiple old black skin discolorations on body. Has surgical incision with thirteen staples on right hip, smaller incision on right mid-thigh and knee with three staples ...redness on right toe 1 x 0.8 cm ... " There was no documentation in the clinical record that the resident was admitted with a right heel pressure sore and a Stage II coccyx ulcer.<br><br>According to a nurse's note dated July 20, 2010 at 11:00 AM (six days after admission): "During morning rounds noted resident's right heel with dark red deep tissue injury measuring approximately 6 cm x 7 cm. Resident denies any pain; able to move his/her foot without any problems. His/her right leg is edematous to +2. Notified [physician] and family member ...Received order for Ehob boots to bilateral foot [feet] while in bed. Will continue to monitor resident as needed " .<br><br>A nurse's note dated July 21, 2010 at 8:30 AM documented, "Resident admitted on 7/14. Alert and verbalizes well. Noted on the right heel suspected deep tissue injury with dry scaly skin around the edges measures 6 x 6 cm; dark area appearance of the wound does not suggest any [unable to read]. Ehob boots and keep heels floated." | F 314 | | |

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| F 314 | Continued From page 19<br><br>According to a nurse's note dated August 4, 2010 at 9:00 AM: "Follow up coccyx Stage II ulcer healing well with pale, pink epithelial tissue. Currently on Vasolex. Right heel SDTI (Suspected Deep Tissue Injury) now appears unstageable measuring approximately 4.5 x 4.5 cm. Soft necrotic area; peri-wound clean; currently with Ehob boots. Continue to keep the heels floated."<br><br>A review of the " Pressure Ulcer Report ", undated, documented, "Right heel, unstageable, dark deep red discoloration, acquired, 6 cm x 7 cm treatment EHOB boots." The second entry was, "Coccyx Stage II resolving area from wound report August 20, 2010, acquired, 6 cm x 0.5 cm treatment Vasolex."<br><br>Resident #28's weekly "Skin Sheets" were unable to be located at the time of this investigation.<br><br>A review of the Problem #3, care plan initiated and last updated July 14, 2010 revealed, "Altered skin integrity, pressure related; potential for skin breakdown " was included in the care plan. The goal was "Resident will experience no compromise of skin integrity related to pressure over the next 30 days." There was no evidence that a plan of care was updated to reflect the development of the unstageable (Stage IV) right heel pressure wound and the Stage II coccyx wound.<br><br>The admission "Nutritional Assessment" was completed July 15, 2010. The area labeled "Lab Results" was blank for FBS (Fasting Blood Sugar), HGB (Hemoglobin), HCT (Hematocrit), AlB (Albumin), T.Pro (Total Protein) and K | F 314 | | |

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| F 314 | Continued From page 20<br>(Potassium). BUN was listed as "32" and CREA was listed as "1.0 "<br><br>Under "Physical Indicators of Nutritional Status" edema was not checked. However, this was addressed in the accompanying note on the back of the form: "Some edema noted with Lasix given. Weight expected to fluctuate secondary to the use of diuretics." The dietician recommended a regular, 2 gram sodium diet, with no additional supplements.<br><br>The admission laboratory tests drawn on July 14, 2010, revealed the following:<br>HGB 11.4 (normal 11.5-16.0 g/dl<br>HCT 33.8 (normal 37.0-47.0%)<br>Glucose 106 (normal 74-105 mg/dl)<br>Laboratory values that accompanied the resident from the hospital and dated July 12, 2010, documented the following:<br>T Protein 5.2 (normal 6.0-8.5 mg/dl)<br>Albumin 1.6 (normal 3.2 - 5.5 mg/dl)<br>Potassium 5.2 (normal 3.5-5.3 meq/L)<br><br>According to the Merck manual at merck.com, " Treatment-Treating a pressure sore is much more difficult than preventing one. The main goals of treatment are to relieve pressure on the sores, keep them clean and free of infection, and provide adequate nutrition. Adequate nutrition is important in helping pressure sores heal and in preventing new sores from forming. A well-balanced, high-protein diet is recommended as well as a daily high-potency vitamin and mineral supplement. Supplemental vitamin C and zinc may help with healing as well ... "<br><br>There was no evidence that the dietician reviewed the above cited laboratory values and | F 314 | | |

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| F 314 | Continued From page 21<br>recommended interventions to improve the total protein, albumin, Hemoglobin and glucose. Additionally, the dietician failed to update the care plan to reflect the resident ' s abnormal laboratory values.<br><br>A nutrition note dated August 5, 2010 at 3:30 PM documented the following: " Appetite good = 80-90% P.O oral) intake. Weekly weights done on 8/4/10...Will continue with plan of care. "<br>There was no evidence that the dietician included the right heel pressure ulcer in his/her aforementioned assessment of the resident.<br><br>A face-to-face interview was conducted with Employee #12 on September 17, 2010 at 3:56 PM. After reviewing the resident ' s record, he/she acknowledged that the resident ' s admission labs were not included in the initial assessment; the resident ' s wounds were not re-assessed from a nutritional perspective and that the resident ' s care plan was not updated as needed to reflect the resident ' s status.<br><br>Additionally, the physician documented the resident's status in the "Interdisciplinary Progress Notes" on July 15 and 27, August 5 and August 10, 2010. There was no evidence that the physician reviewed Resident #28's total plan of care and addressed the status of the resident's right heel wound and subsequent coccyx wound. A physician's note dated August 3, 2010 documented, "Right heel eschar noted ...elevate right foot/heel and continue Ehob boots."<br>A face-to-face interview was conducted on September 17, 2010 at 3:47 PM with Employees #3 and #4. After reviewing the resident's record, both employees acknowledged that the resident's right heel wound was not identified prior to July | F 314 | **F 314- 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES**<br><br>1. Resident #28 was discharged on 8/18/10.<br>2. All care plans for residents identified to be at risk for pressure ulcers will be reviewed. Dietitian will make recommendations for interventions and care plan abnormal lab values. All sections of the admission Nutritional Assessment will be completed to reflect resident's skin condition as applicable.<br>3. The dietitian who completed this assessment no longer works in this facility. The Dietitian staff will be in-serviced on making recommendation for interventions and care planning abnormal labs, as well as fully completing admission Nutritional Assessment to reflect residents' current status<br>4. Monthly admission Nutritional Assessment audits will be conducted by the Dietitian to ensure appropriate recommendations have been made to address residents' current status and care plan has been updated. Findings will be presented in the quarterly QI/QA meeting.<br><br>**F 314- 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES**<br><br>1. Resident #28 was discharged on 8/18/10.<br><br>2. All charts of residents with identified pressure ulcers will be reviewed for adequate physician documentation.<br><br>3. Medical staff will be educated on the adequacy on documentation related to skin integrity and condition change. | 8/18/10<br><br>12/15/10<br><br>12/15/10<br><br>On-going<br><br>8/18/10<br><br>12/15/10<br><br>12/15/10 |

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| F 314 | Continued From page 22<br>20, 2010 when it was noted as unstageable; the skin care plan was not developed and/or updated to reflect the resident's right heel and coccyx wounds. The record was reviewed September 17, 2010.<br><br>There was no documented evidence that facility staff implemented measures to prevent Resident #28's right heel pressure ulcer from developing. | F 314 | 4. Monthly audits will be conducted by the wound care nurse or designee to ensure physician documentation is reflective of residents skin condition and results will be submitted to the DON for presentation at the quarterly QA/QI meeting. | On-going |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made during the environmental tour of the facility on September 15 and 16, 2010, it was determined that the facility failed to provide an environment that is free from accident hazards as evidenced by the lack of a stopper to prevent a window from fully opening in a resident room.<br><br>The findings include:<br><br>The window in room #228 lacked a stopper to prevent the window from fully opening.<br>These observations were made in the presence of Employees # 14 and # 15 who acknowledged this finding during the survey. | F 323 | **F 323- 483.25(H)**<br><br>1. The window stopped missing in room 328 was immediately installed on the day of inspection.<br><br>2. All windows were inspected and stoppers will be installed as necessary.<br><br>3. All windows will be inspected quarterly as part of the preventative maintenance plan.<br><br>4. Preventative maintenance will be done monthly to ensure compliance by the CM Maintenance Supervisor/designee. Findings will be reported to the quarterly QA/QI meeting. | 9/15/10<br><br>12/15/10<br><br>12/15/10<br><br>On-going |

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| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and staff interview for three (3) of 30 sampled residents, it was determined that facility staff failed to provide documented evidence of gradual dose reductions for one (1) resident and adequately monitor for the use of psychotropic medications for two residents. Residents #5, 7, and 26.<br><br>The findings include: | F 329 | **1. F 329- 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS**<br><br>1. Resident #5's behavior/intervention monthly flow record was reviewed and updated to include monitoring and targeted behaviors.<br><br>2. All residents with behavior/intervention monthly flow records were reviewed to ensure all monitoring and targeted behaviors are identified when applicable.<br><br>3. All staff will be in-serviced on monitoring and identifying targeted behaviors on behavior/intervention monthly flow record.<br><br>4. Monthly audits on the behavior/intervention record will be conducted by Nurse Managers/ designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | 9/14/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 329 | Continued From page 24<br><br>1. Facility staff failed to adequately monitor the use of Seroquel for Resident #5.<br><br>A review of Resident #5's clinical record revealed routine medication orders signed and dated by the physician on July 30, 2010 directed, "Seroquel 12.5 mg every AM (morning) for Psychosis...".<br><br>According to the " Behavioral Health Service Consultation Notes " completed and signed by the Psychiatrist on April 8, 2010 directed " ...continue low dose Seroquel "<br><br>A review of the " Behavior/Intervention Monthly Flow Record " revealed that the targeted behaviors were not identified, for the months of July, August and September 2010.<br><br>The July 2010 "Behavior/Intervention Monthly Flow Record" tool revealed that on July 22, and 29th there was no documented monitoring for the 7:00 AM -3:00 PM shift. On the September 2010 monitoring tool for September 2nd, and 9th there was no documented monitoring for the 7:00 AM - 3:00PM shift.<br><br>A face-to-face interview was conducted with Employee #6 on September 14, 2010 at approximately 11:15 AM. After a review of the "Behavior/Intervention Monthly Flow Record " , he/she acknowledged that the tool was not completed, documented or monitored. The record was reviewed on September 14, 2010.<br><br>2. Facility staff failed to attempt a gradual dose reduction for Resident #7 who was receiving Sertraline100 mg by mouth daily for depression. | F 329 | **2. F 329- 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS**<br><br>1. Resident #7's psychotropic drug use and depressive disorder care plan was reviewed and updated to include physician's and/or the psychiatrist's directed attempted GDR as appropriate goals and approaches.<br><br>2. All residents' care plans for psychotropic drug use and depressive disorder were reviewed and updated to include physicians and psychiatrists directed attempted GDR as appropriate goals and approaches.<br><br>3. All licensed staff will be in-serviced on including physicians' and psychiatrists' directed attempted GDR as appropriate goals and approaches on psychotropic drug use and depressive disorder care plan.<br><br>4. Monthly care plan audits will be conducted by Nurse Managers/designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | 9/17/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 329 | Continued From page 25<br><br>The resident was observed on September 15, 2010 at approximately 10:30 AM sitting calmly in a wheelchair in his/her room. He/she said, "I like it best here in my room." He/she was alert and responsive to name when addressed.<br><br>The "Physician's order sheets" for January through September 2010 that directed, "Sertraline HCL 100mg tablet. 1 tablet by mouth daily for depression".<br><br>According to Resident #7's Medication Administration Record [MAR] he/she was administered "Sertraline HCL 100mg tablet 1 tablet by mouth daily for depression" January through September 14, 2010.<br>The resident was seen by the psychiatrist on January 21, 2010 as evidenced by the psychiatrist signed and dated consultation record. The resident was seen by the attending physician on January 28, May 13, and July 12, 2010 as evidenced by the attending physician's signed and dated documentation on the resident's "Interdisciplinary Progress Notes."<br>There was no evidence in the psychiatrist and/or physician's documentations that gradual dose reduction [GDR] was attempted or documentation present to indicate that a dose reduction was clinically contraindicated for the use of " Sertraline HCL 100mg tablet. 1 tablet by mouth daily for depression."<br><br>According to the annual Minimum Data Set assessment completed June 30, 2010, the resident was not coded for displaying moods and/or behaviors in Section E (Mood and Behavior Patterns). | F 329 | **2. F329-483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS**<br><br>1. Resident #7 had a Psychiatry consult done on 10/7/10 and GDR initiated. | 10/7/10 |
| | | | 2. All residents receiving psychotropic medications will be reviewed for appropriation of GDR. | 12/15/10 |
| | | | 3. Psychiatry will document evidence of GDR documentation on psychiatry consult form. | 12/15/10 |
| | | | 4. Monthly audit will be conducted by Nurse Manager/designee for evidence of GDR documentation on the psychiatrist consult form. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting. | On-going |

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| F 329 | Continued From page 26<br><br>The resident's "Psychotropic Drug Use and Depressive Disorder" care plans completed on June 30, 2010 failed to include the physician's and or the psychiatrist's directed attempted GDR as appropriate goals and approaches.<br><br>A face-to-face interview was conducted with Employee #5 on September 15, 2010 at approximately 10:45 AM and with Employee #16 on September 17, 2010 at approximately 12: 15 AM. After a review of the resident's clinical record, they both acknowledged the above findings. The record was reviewed September 17, 2010.<br><br>3. Facility staff failed to identify targeted behaviors and consistently monitor the targeted behaviors for the use of Clonazepam for Resident #26.<br><br>A review of Resident #26's clinical record revealed routine medication orders signed and dated by the physician on August 11, 2010 directed, "Clonazepam 0.5 mg tablet, 1/2 (half) tablet by mouth at bedtime for anxiety (1/2 tablet = 0.25 mg)".<br><br>A review of the August 2010 "Behavior/Intervention Monthly Flow Record" tool revealed that once a week monitoring was conducted for the use of Clonazepam but targeted behaviors were not identified.<br><br>A face-to-face interview was conducted with Employee #6 on September 14, 2010 at approximately 11:15 AM. After a review of the | F 329 | **3. F 329- 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS**<br><br>1. Resident #26's behavior/intervention monthly flow record was reviewed and updated to include monitoring and targeted behaviors.<br><br>2. All residents with behavior/intervention monthly flow record were reviewed to ensure all monitoring and targeted behaviors were identified when applicable.<br><br>3. All staff will be in-serviced on monitoring and identifying targeted behaviors on behavior/intervention monthly flow record.<br><br>4. Monthly audits on behavior/intervention flow record will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | 9/14/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 329 | Continued From page 27<br>"Behavior/Intervention Monthly Flow Record". He/she acknowledged that the tool lacked identification of targeted behaviors and consistent monitoring of the behaviors. The record was reviewed on September 14, 2010. | F 329 | | |
| F 334 SS=D | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the pneumococcal immunization, each resident, or the resident's | F 334 | | |

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| F 334 | Continued From page 28<br>legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that the facility staff failed to obtain a consent for the pneumococcal immunization for Resident #3. | F 334 | **F 334- 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS**<br><br>1. Resident #3's Pneumovac consent was obtained.<br><br>2. All residents' medical records were reviewed to ensure that influenza and Pneumococcal immunization consent forms were completed when applicable.<br><br>3. All licensed staff will be in-serviced on Influenza/Pneumococcal policy.<br><br>4. Monthly audits on influenza and Pneumococcal consent forms will be conducted on an on-going by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | 9/14/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 334 | Continued From page 29<br><br>The findings include:<br><br>According to the "Policy for Influenza Vaccination/Pneumovac " effective date 09/21/1996, revised date August 1, 2004 stipulated; " It is the policy of this facility that upon admission, the resident and/or responsible agent will be informed of the purpose and possible side effects of the flu vaccine and Pneumovac. The written consent obtained upon admission from the resident and/or responsible agent will serve as consent for future annual vaccinations. "<br><br>According to the Admission Minimum Data Set [MDS] completed June 7, 2010, revealed under Section W(3b) Supplemental MDS Items, Pneumococcal Vaccine: If PPV [Pneumococcal Polysaccharide Vaccine] not received, state reason: (3) Not offered. "<br><br>A review of the Resident Care Plan revealed, " Problem #13: Risk for Influenza and Pneumococcal disease- Under Approach and Frequency: Administer Pneumococcal vaccine every 5 [five] years except contraindicated and document any episodes of refusal. "<br><br>A review of the residents clinical record revealed , that the "Immunization Consent and Acknowledgment" was blank. There was no signature indicating that the resident and/or responsible party were offered and accepted or declined the Pneumococcal Vaccine.<br><br>There was no documented evidence on the clinical record indicating that the resident/responsible party gave the facility | F 334 | | |

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| F 334 | Continued From page 30<br>permission to administer a pneumococcal vaccination or declined.<br><br>A face-to-face interview was conducted on September 13, 2010 at approximately 10:30 AM, with Employee #19. He/she acknowledged that the facility staff failed to obtain a consent for the pneumococcal immunization. The record was reviewed on September 13, 2010. | F 334 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations that were made during a tour of the dietary services on September 13, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by a low wash water temperature in the three compartment sink, a slippery kitchen floor, three (3) of three (3) soiled ice machines, three (3) of three (3) outdated health drinks, two (2) of five (5) damaged well covers handles, two (2) of nine (9) floor drains extended too far into the drains, a high temperature of one(1) of one (1) refrigerator on the fourth floor pantry and a carton of milk that was measured at 47.7 degrees Fahrenheit (F) on the second floor pantry. | F 371 | **F 371-483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY**<br><br>**1.**<br>1. A corrective order was generated for the three-compartment sink and was corrected.<br>2. Floor mats and wet floor signs were placed at indicated areas. Flooring company was contacted and asked to come back to resurface kitchen floor. This will be completed by the plan of correction date.<br>3. The ice machines were cleaned immediately.<br>4. The strawberry flavored health shakes were discarded.<br>5. A corrective order was generated for the Steam table handles and was corrected.<br>6. A corrective order was generated for floor drains at indicated areas and was corrected<br>7. A sign was placed on the identified. refrigerator "NOT TO BE USED". All contents were removed and disposed of. The items located in this refrigerator were not for residents<br>8. The carton of milk was discarded.<br><br>**2.** A comprehensive inspection was conducted in the main kitchen and floor pantries. This included all food items in the refrigerators and freezers and all items were inspected for expiration dates. All food items that were past the expiration date or above appropriate temperatures were discarded. All refrigerators and freezers were checked for appropriate temperatures. All remaining ice machines were inspected. An environmental check was done on all pantries for damaged steam table handles and floor drain air gaps. | 9/13/10<br><br>12/15/10<br>9/13/10<br>9/13/10<br>9/13/10<br>9/13/10<br>9/13/10<br>9/13/10<br><br>9/30/10 |

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| F 371 | Continued From page 31<br>The findings include:<br>1. The wash water temperature in the three compartment sink was 98.6 degrees F, the required temperature by company ' s policy is 110 degrees F.<br>2. The kitchen floor was slippery and presented a safety hazard.<br>3. Ice machines on the first, second, third and fourth floor pantries were soiled.<br>4. Three (3) of three (3) strawberry flavored health shake drinks stored in the refrigerator on the second floor were expired as of August 10, 2010.<br>5. The handles from two (2) of five (5) well covers on the second floor steam table were damaged.<br>6. Floor drains from the kettle in the main kitchen and the three compartment sink on the third floor provided insufficient air gap or separation from the drain.<br>7. The temperature of the refrigerator on the fourth floor, located in the pantry area, was 80 degrees F. Milk and other liquid food items were discarded.<br>8. A carton of milk was measured at 47.7 degrees F on the second floor pantry.<br>These observations were made in the presence of Employees #13 and #15 who acknowledged the findings. | F 371 | **F 371-483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (continued)**<br><br>3. The Food Service staff will be re-educated on the storage, preparation and distribution of food as well as cleanliness of equipment. The Sanitation Check List will be revised to include items identified in survey. The supervisors will be re-educated on the sanitation of the kitchen. The Maintenance staff have modified preventative maintenance program to include floor drains in the main kitchen and floor pantries.<br><br>4. Sanitation audits will be done by the dietary Manager/designee monthly to ensure compliance. Results will be submitted quarterly to the QA/QI committee. | 12/7/10<br><br>On-going |
| F 386 SS=D | 483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS<br><br>The physician must review the resident's total program of care; including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be | F 386 | | |

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| F 386 | Continued From page 32<br>administered per physician-approved facility policy after an assessment for contraindications.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on staff interview and record review for one (1) of 30 residents, it was determined that the physician failed to include in his/her progress notes Resident #28's coccyx ulcer failed to consistently document in his/her progress note a review of the Right heel ulcer in the total plan of care.<br><br>The findings include:<br><br>A review of Resident #28 ' s record revealed the following nurses' notes:<br><br>July 20, 2010 at 11:00 AM, "Skin Assessment: During morning rounds noted resident's right heel with dark red deep tissue injury measuring approximately 6 cm x 7 cm. Resident denies any pain; able to move his/her foot without any problem. Right leg is edematous to +2. Notified [physician] [family member]. Received order for Ehob boots to bilateral feet while in bed. Will continue to monitor resident as needed."<br><br>July 21, 2010 at 8:30 AM: "Resident admitted on July 14 (2010). Alert; verbalizes well. Noted on the right heel suspected deep tissue injury with dry scaly skin around the edges. Measures 6 x 6 cm; dark purple area. Appearance of the wound does not suggest any [unable to read] state. Ehob boots and keep the heels floated."<br><br>August 4, 2010 at 9:00 AM: "Follow up on coccyx Stage II ulcer healing well with pale pink epithelial | F 386 | **F386-483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS**<br><br>1.Resident #28 was discharged on 8/18/10.<br><br>2. All charts of residents with identified pressure ulcers will be reviewed for adequate physician documentation.<br><br>3. Medical staff will be educated on the adequacy on documentation related to skin integrity and condition change.<br><br>4. Monthly audits will be conducted by the wound care nurse or designee to ensure physician documentation is reflective of residents skin condition and results will be submitted to the DON for presentation at the quarterly QA/QI meeting. | 8/18/10<br><br>12/15/10<br><br>12/15/10<br><br>ongoing |

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| F 386 | Continued From page 33<br>tissue. Currently on Vasolex. Right heel deep tissue injury now appears unstageable measuring approximately 4.5 x 4.5 cm. Soft necrotic area...currently with Ehob boots. Continue to keep the heels floated. "<br>A review of the "Pressure Ulcer Report", undated, documented, "Right heel, unstageable, dark deep red discoloration, acquired, 6 (cm) x 7 (cm) treatment EHOB boots." The second entry was, "Coccyx Stage II resolving area from wound report August 20, 2010, acquired, 6 (cm) x 0.5 (cm) treatment Vasolex."<br><br>Weekly "Skin Sheets" were unable to be located at the time of this investigation.<br><br>The resident was discharged home on August 17, 2010.<br><br>According to the July and August 2010 Treatment Administration Record, both pressures ulcers were treated daily.<br><br>The attending physician visited the resident on July 15, 27, 2010 and August 10, 13 and 17, 2010. The physician failed to address the resident's unstageable right heel ulcer and Stage II coccyx pressure ulcer.<br><br>The physician's note dated August 3, 2010 documented, "Right heel eschar noted...elevate right foot/heel ..."<br><br>There was no evidence that the physician documented in his/her progress note(s) a review of Resident #28's Coccyx ulcer and failed to consistently document in his/her progress note a review of the Right heel ulcer. | F 386 | | |

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| F 386 | Continued From page 34<br>A face-to-face interview was conducted with Employee #12 on September 17, 2010 at approximately 3:54 PM. He/she acknowledged that the physician failed to include the resident's two (2) pressure wounds in the above cited progress notes. The record was reviewed September 17, 2010. | F 386 | | |
| F 463 SS=D | 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br><br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made during environmental tours of the facility on September 15, and 16, 2010, it was determined that the facility failed to provide effective maintenance services as evidenced by a call bell not functioning in one (1) residents room.<br><br>The findings include:<br><br>The call bell was not functioning in room #229.<br><br>These observations were made in the presence of Employees # 14 and # 15 who acknowledged these findings during the survey. | F 463 | **F 463-483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH**<br>**1.**<br>1. The call bell in room 229 was repaired on the day of inspection.<br><br>2. All call bells were inspected and repaired if necessary on the day of inspection.<br><br>3. The Nursing staff will check call bells daily and will report all issues to call center for repair. All resident rooms will be inspected quarterly as part of the preventative maintenance plan.<br><br>4. Preventative maintenance will be done quarterly to ensure compliance by the CM Maintenance Supervisor/designee. Findings will be reported to the quarterly QA/QI meeting. | 9/17/10<br><br>9/17/10<br><br>12/15/10<br><br>On-going |
| F 469 SS=D | 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM<br><br>The facility must maintain an effective pest control program so that the facility is free of pests and rodents. | F 469 | | |

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| F 469 | Continued From page 35<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations made during the environmental tour of the facility on September 15, and 16, 2010, it was determined that the facility failed to maintain an effective pest control program as evidenced by the presence of crawling and flying pests observed in different areas in the facility.<br><br>The findings include:<br><br>Crawling and flying insects were observed on the second and fifth floor.<br><br>These observations were made in the presence of Employees # 14 and # 15 who acknowledged these findings during the survey. | F 469 | **F 469-483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM**<br><br>1. Areas identified were immediately treated.<br><br>2. All units were inspected for crawling and flying insects.<br><br>3. A communication book was placed on each nursing unit to document pest and insects. Trash will be removed from the lounge areas three times daily. Ecolab representative will conduct bi-weekly treatment throughout the building which includes facility identified targeted areas.<br><br>4. Monthly audits will be conducted by the Housekeeping Manager/designee to ensure compliance. The findings will be reported quarterly to the QA/QI Committee. | 9/16/10<br><br>9/16/10<br><br>9/16/10<br><br>Ongoing |
| F 504 SS=D | 483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN<br><br>The facility must provide or obtain laboratory services only when ordered by the attending physician.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 30 sampled residents it was determined that facility staff failed to obtain routine labs as ordered by the physician for one (1) resident for Resident #5.<br><br>The findings include: | F 504 | | |

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| F 504 | Continued From page 36<br><br>A review of the Physician's Order Form for the month of September 2010 revealed "Labs: CBC with diff (complete blood count with differential), CR (creatine), LIV2 (Liver functions), Fasting Lipid panel every 6 months (February and August) R/T (related to) Lisinipril, ASA (Acetylsalicylic Acid), Simvastatin."<br><br>A review of the clinical record lacked evidence of the above labs were obtained/drawn for Resident #5 for August 2010.<br><br>A face-to-face interview was conducted with Employee #6 on September 14, 2010 at approximately 11:30 AM. After a review of the clinical record he/she acknowledged that the record lacked evidence of labs for August 2010 and immediately placed a request for labs to be drawn. The record was reviewed on September 14, 2010. | F 504 | **F 504- 483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN**<br><br>1. Resident #5 had CBC with diff, CR, LIV2, and Fasting Lipid Panel drawn on 9/14/10.<br><br>2. All residents' with routine labs were reviewed to ensure they were completed as ordered when applicable.<br><br>3. All licensed staff will be in serviced on lab protocol regarding medication administration.<br><br>4. Monthly audits on routine labs will be conducted by Nurse Managers or designee to ensure compliance, and the results will be submitted to the DON for presentation at the QA/QI meeting. | 9/14/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>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.<br><br>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; | F 514 | | |

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| F 514 | Continued From page 37<br>and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 30 sampled residents, there was no evidence that facility staff failed to perform neurological checks for one (1) resident for Residents #5.<br><br>The findings include:<br><br>Review of the Interdisciplinary Progress Notes dated and signed March 25, 2010 at 0630 revealed that Resident #5 had an unwitnessed fall. The Progress Note revealed the following Resident #5 " Was observed on the floor beside his/her bed in a lying position. When asked by the C.N.A. resident stated that he/she was trying to make up his/her bed when he/she fell. Assessment done, no apparent injury noted ...v/s (vital signs) 97.4 [temperature], 70 [pulse], 18 [respirations], 130/70 [blood pressure], continue to monitor. "<br><br>A further review of the Interdisciplinary Progress Notes dated and signed March 25, 2010 at 1500 revealed that the resident was transferred to the hospital for further evaluation secondary to s/p (status/post) fall, left hip and lower back pain. "<br><br>There was no documented evidence that neurochecks were performed on Resident #5 after he/she had an unwitnessed fall.<br><br>A face-to-face interview was conducted with Employee #6 on September 14, 2010 at approximately 11:15 AM. A query was made if a | F 514 | **F 514- 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE**<br><br>1. Resident #5 was assessed and no neurological deficits were observed.<br><br>2. All residents with unwitnessed falls were reviewed to ensure Neuro checks were done when applicable.<br><br>3. All licensed staff will be in-serviced on the neurological check protocol.<br><br>4. Monthly audits will be conducted by Nurse Managers/designee to ensure neurological checks were completed for all un-witnessed falls to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. | 9/14/10<br><br>11/26/10<br><br>11/26/10<br><br>On-going |

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| F 514 | Continued From page 38<br>neurological check was performed after the unwitnessed fall. After a review of the clinical record he/she acknowledged that the record lacked evidence of neurological checks following an unwitnessed fall. The record was reviewed on September 14, 2010. | F 514 | | |