STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	04/26/2010

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F 000	INITIAL COMMENTS A recertification survey was conducted on April 19 through 26, 2010. The deficiencies are based on observation, record review and resident and staff interview for 30 sampled residents based on a census of 267 residents on the first day of survey. Additionally, there were 24 supplemental residents.	F 000	Deanwood Rehabilitation Wellness Center makes its best efforts to operate in substantial compliance with both Federal and State Law. 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 alleged or the validity of the conditions set forth on the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by federal and state law.	
F 160 SS=D	483.10(c) (6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on a review of the "Funds Balance Report" and staff interview for three (3) of four (4) closed records, it was determined that facility staff failed to convey Resident's F1, F2 and F3 funds within 30 days of death. The findings include: A review of the "Funds Balance Report" revealed the following: Resident F1's account balance = $863.85 and the account was coded as inactive Resident F2's account balance = $2, 0001.28 and the account was coded as inactive Resident F3's account balance = $10.00 and the account was coded as inactive	F 160		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

Willestine D. Page Executive Director 6/21/10

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F 160	Continued From page 1 On April 23, 2010 facility staff presented the following documentation to the State Agency: Resident F1 was discharged from the facility on October 23, 2008. Resident F2 was discharged from the facility and expired at the [hospital] on December 20, 2009. Resident F3 expired on December 18, 2002. There was no evidence that facility staff conveyed the funds of Resident F2 within 30 days of his/her death; and there was no documented evidence that the facility attempted to contact the estates of Residents F1 and F3 to determine their status in order to convey their funds. A face-to-face interview was conducted with Employee #21 on April 20, 2009 at 2:46 PM. He/she acknowledged that the funds were not conveyed to Resident's F1, F2 and F3 within 30 days of their death.	F 160	1) Residents F1, F2, F3 funds were conveyed to appropriate parties. 2) All residents with personal funds account have potential to be affected. A/P has reviewed personal funds account ledger and Identified no other outstanding balance. 3) Re-accounts payable department will review all residents personal funds monthly at the end of every month. All identified accounts needed to be conveyed will be closed no later than 30-days residents death/discharge. 4) Accounts payable will audit accounts monthly. All negative findings will be reported to the Administrator. All negative findings will be reported to QI committee for recommendations and follow-up.	5/15/10 5/15/10 5/30/10 6/7/10 on-going
F 164 SS=D	483.10(e), 483.75(l) (4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e) (3) of this section, the resident may approve or refuse the	F 164	1) Staff received on-site in-service and counseling. Resident was provided appropriate privacy immediately. 2) Director of Nursing/ designee will developed a list of residents, who have supra pubic cather. This list will be provided to all units and maintained in nursing office and nursing units. Unit managers/ supervisors will be required to review and maintain a list of routine rounds. Supervisor and unit managers will ensure residents privacy will be maintained.	6/18/10

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F 164	Continued From page 2 Release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 30 sampled residents, it was determined that facility staff failed to provide privacy during suprapubic catheter care. Resident #4. The findings include: Facility staff failed to provide privacy during suprapubic catheter care for Resident #4. Employee #35 was observed providing suprapubic catheter care to Resident #4 on April 22, 2010 at approximately 11:40AM. The resident was positioned in the gerichair in front of the entry door. The privacy curtain was not pulled. Employees # 36 and 37 came in and out of the room while the resident was being provided catheter care. Resident # 4's bed was by the entry door to the room. He/she has a roommate who was not in the	F 164	3) All staff will be re-educated regarding privacy and dignity. Facility policy and procedure will be reviewed and revised accordingly by Director of Nursing and Administrator. staff will be re-educated to any changes required. 4) All appropriate staff will be reviewed for knowledge & competency by observational audit conducted by QI nurse, supervisors, & unit managers. random audit will be conducted weekly and monthly, and 3-months and quarterly thereafter. All results will report to QI committee. All negative findings will be reported to Director of Nursing and Administrator for immediate follow-up.	7/15/10 7/23/10

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F 164	Continued From page 3 room at the time of the observation. Facility staff failed to provide privacy during supra pubic catheter change for Resident #4. A face-to-face interview was conducted with Employee #35 on April 22, 2010 at approximately 2:00PM. He she acknowledged the findings. The observation was made on April 22, 2010.	F 164		
F 166 SS=D	483.10(f) (2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to ensure that Resident #7's grievance related to hair care was completely resolved. The findings include: During a tour of the facility on April 19, 2010 at approximately 8:40 AM, Resident #7 stated "They cut all my hair off and I did not want it cut. All he/she [facility barber] said is that your hair is going to look good." The resident indicated that this happened three (3) to four (4) weeks ago. Another face-to-face interview was conducted on April 21, 2010 at approximately 10:10 AM. Resident # 7 stated, "My hair was cut three (3) to four (4) weeks ago. The weave was cut out with	F 166	1) The Director of Recreation Therapy will complete grievance /complaint form for resident #7 issues reported. The completed grievance/compliant form will be forward to Director of Social Services as per facility policy. 2) All complaint & grievance will be documented formally per grievance policy and procedure. 3 All appropriate staff shall be re-educated about grievance policy & procedure; Director of Social Services and Administrator will review current log to determine completeness of grievance. 4) Monthly review of all grievances presented at the QA monthly for follow-up and recommending by the Director of Social Services	6/18/10 6/18/10 7/15/10 7/23/10

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F 166	Continued From page 4 my hair. The weave had stitches and he/she [facility barber] cut it out all together." A query was made as to who was made aware of this incident. He/She stated, "Employee #15 was aware, and I cried for two days." A face-to-face interview was conducted on April 22, 2010 with Employee #15 at approximately 2:30 PM. He/she stated, "The barber attempted to take the thread out, [his/her] hair was breaking because it [the hair weave] had been in too long. The barber ended up taking hair out along with the weave. " Employee #15 was asked did the barber explain to the resident concerns about the condition of the hair. Employee #15 replied, "After it had happened. The next day we [the facility] offered to color, and style the resident 's hair with no charge." Employee #15 also acknowledged that self esteem building took place by offering styling tips, and jewelry to fit the hair style. Employee #15 was then asked was this complaint documented as a grievance and was an incident report completed and sent to the State Agency? Employee #15 indicated that he/she did not document this as a grievance nor did he/she send an incident report to the State Agency as a complaint. Employee #15 stated, "I thought the measures taken to correct the hair style worked, and everything was over and ok." There was no evidence that the facility staff followed up on the complaint/grievance to ensure that the issue was resolved with Resident #7 after his/her hair was cut. The grievance was reviewed on April 22, 2010.	F 166		
F 174	483.10(k) RIGHT TO TELEPHONE ACCESS	F 174		

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F 174 SS=D	Continued From page 5 WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on April 26, 2010 it was determined that the facility failed to provide telephone access to residents as evidenced by: one (1) of five (5) telephones was missing on one (1) of five (5) floors and one (1) of four (4) telephones was not functioning properly. The findings include: 1. Telephone access was not provided to residents as evidenced by the absence of a telephone(s) on 2 South and the lack of a dial tone from the telephone located on 5 South. These observations were made In the presence of Employee #13 who acknowledged these findings at the time of the observations.	F 174	1) Missing telephone will be replaced, Verizon was notified on 6/11/10 and will send an technician to install new telephone. 2) All phones were checked by Director of Engineering and will be inspected by Verizon. 3) Director of Engineering/designee will check all public phones monthly to assess proper functioning. 4) Director of Engineering will report any negative findings to the Administrator immediately. All findings will be reported to QI committee for follow-up and recommendation.	7/1/10 6/18/10 7/1/10 7/23/10
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview for one (1)	F 241		

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F 241	Continued From page 6 of 30 sampled residents, it was determined that facility staff failed to promote care for a resident in manner to enhance the residents dignity and respect in full recognition of his or her individuality as evidenced by failing to obtain Resident #7's grooming preferences and permission prior to cutting his/her hair. The findings include: During a tour of the facility on April 19, 2010 at approximately 8:40 AM, Resident #7 stated, "They cut all my hair off and I did not want it cut. All he/she [facility barber] said is that your hair is going to look good." The resident indicated that this happened three (3) to four (4) weeks ago. Another face-to-face interview was conducted with the resident on April 21, 2010 at approximately 10:10 AM. Resident # 7 stated, "My hair was cut three (3) to four (4) weeks ago. The weave was cut out with my hair. The weave had stitches and he/she [facility barber] cut it out all together." A query was made as to who was made aware of this incident. He/She stated, "Employee #15 was aware, and I cried for two days." A face-to-face interview was conducted on April 22, 2010 with Employee #15 at approximately 2:30 PM. He/she stated, "The barber attempted to take the thread out, [his/her] hair was breaking because it [the hair weave] had been in too long. The barber ended up taking hair out along with the weave. " Employee #15 was asked did the barber explain to the resident concerns about the condition of the hair. Employee #15 replied, "After it had	F 241	1) Supportive counseling was provided Director of Recreation Therapy. A self esteem care plan was initiated personal accessory were provided to resident in order to accentuate new hair style. 2) No other resident has been identified facility recreation staff as having dissatisfaction with the current beauty and barber services. 3) Upon resident/family requesting beauty & barber services the nurse or recreation therapy will complete appointment slip that identifies preference. The recreation therapy will then provide a visual aid demonstrating hair style selected to assure choice is accurate. Residents will than sign request slip. If resident cannot sign staff will witness selection. 4) A resident satisfaction survey will be completed and collected by the recreation therapy to audit for any discrepancies dissatisfaction. Any and all complaints will be forward to the Director of Recreation of Therapy and Administrator for immediate correction. All negative findings will be reported to QI Committee monthly for follow-up recommendations.	6/18/10 7/1/10 7/23/10

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F 241	Continued From page 7 happened. The next day we [the facility] offered to color, and style the resident 's hair with no charge." Employee #15 also acknowledged that self esteem building took place by offering styling tips, and jewelry to fit the hair style. Employee #15 was then asked was this complaint documented as a grievance and was an incident report completed and sent to the State Agency? Employee #15 indicated that he/she did not document this as a grievance nor did he/she send an incident report to the State Agency as a complaint. Employee #15 stated, "I thought the measures taken to correct the hair style worked, and everything was over and ok." There was no evidence that facility staff sought and obtained Resident #7's grooming preferences and permission prior to cutting his/her hair. The complaint/grievance was reviewed April 22, 2010.	F 241		
F 253 SS=D	483.15(h) (2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility from April 20 through 26, 2010, it was determined that the facility failed to provide effective maintenance services in residents rooms including 15 of 64 marred doors and door jambs, six (6) of 12 missing and/or detached privacy curtains, two (2) of two (2) staff and visitors bathroom with no access to hot water, two (2) of two (2) roach baits	F 253	1) Privacy curtains identified as being off its hooks was corrected. Missing privacy curtains was replaced in identified rooms. Staff bathrooms on the 5th floor were properly identified as to staff/ visitor. 2nd floor bathroom with out hot water faucet was repaired. Roaches baits in room 325 & 406 were removed. Resident bathrooms in room 310, 319,330 were repaired. All medications carts were cleaned and free of feast, paper, and drainage.	5/1/10

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F 253	Continued From page 8 next to a heater, three (3) of three (3) resident bathrooms out of order, twelve 12 of 14 soiled medication carts and six (6) of eight (8) soiled medication rooms. The findings include: 1. Entrance and bathroom doors and door jambs were marred in 15 of 64 resident's rooms. 2. Three (3) of three (3) privacy curtains were obstructed by furniture and could not be used as intended in rooms # 205, 210 and 217 and in the Rehabilitation clinic one (1) of three (3) privacy curtain rods was not securely attached, one (1) of three (3) privacy curtains was hanging off its hooks and one (1) of three (3) privacy curtains was missing. 3. Two (2) of two (2) staff and visitor bathrooms on the fifth floor were not clearly identified and one (1) of one (1) such bathroom on the second floor lacked a faucet for the hot water. 4. Two (2) of two (2) roach baits were observed on the floor next to the heater in rooms # 325 and # 406. 5. Three (3) of three (3) resident bathrooms were not usable as evidenced by an 'out of order' signs posted in rooms # 310, 319 and 330. 6. On April 20, 2010 at approximately 1:45 PM, six (6) of seven (7) medication carts were observed to be soiled with particles of dust, pieces of paper and drainage from liquid medications. 7. On April 21, 2010 at approximately 2:45 PM,	F 253	All medications rooms were cleaned by housekeeping staff, maintained assessed and repaired. Maintenance has contracted with outside contractor for other repaired all marred door in the facility have been identified by Director of Engineering.	5/1/10
			2) All doors and door jambs in the facility were inspected by the Director of Engineering. An outside contractor has been contracted to assist in repairs of all identified doors. Director of Housekeeping has inspected all facility privacy curtain and assured all were on hooks and clean. All areas requiring a privacy curtain were reviewed and present. All rooms were inspected for roach traps, none were found. All resident rooms, bathroom were inspected for proper functioning. All facility med carts have been cleaned by housekeeping. All med rooms have been cleaned by housekeeping.	5/30/10
			3) Director of Engineering has placed door and door jams on weekly maintenance rounds by tech. Director of Housekeeping has placed privacy curtains on daily housekeeping rounds. Housekeeping Director has re-educated all housekeeper staff to inspect for roach traps. Facility will notify residents and facility to educate them on the concerns of placing unauthorized roach traps in resident's rooms.	6/30/10

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F 253	Continued From page 9 six (6) of seven (7) medication carts were observed to be soiled with particles of dust, pieces of paper and drainage from liquid medications. 8. On April 22, 2010 at approximately 11:45 AM, two (2) of four (4) medication rooms were observed to be soiled with particles of dust, broken cupboard door, pieces of paper and marred surface son floors and furniture's. 9. On April 23, 2010 at approximately 12:45 PM, two(2) of eight (4) medication rooms were observed to be soiled with particles of dust, broken cupboard door, pieces of paper and marred surface on floors and furniture's. These findings were acknowledged by Employees #5, 6, 7, 8, 10 11, 12, 13 and 14, who acknowledged the findings at the time of the observations.	F 253	Director of Engineering has re-educated maintenance technician to notify director immediately for any issues regarding resident room bathrooms. Director has added bathrooms inspection on too room rounds. Medication carts have been placed on weekly cleaning scheduled by Director of Housekeeping. 4 Director of Engineering has developed a daily rounds for maintenance tech these rounds include but not limited to door and door jabs bathroom inspection. All abnormal findings will be immediately addressed by director. All abnormal findings will be reported to QI committee for recommendations and follow-up these rounds will be on-going. Director of Housekeeping has developed a daily rounds check for housekeeping to include been not limited to privacy curtains, inspection for roach traps, medication carts. Any abnormal findings will be referred to Director of Housekeeping for immediate follow-up. Any abnormal findings will be reported monthly to QI committee for follow-up and recommendation. These audits will on-going	7/23/10 on-going
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 30 sampled residents, it was determined that facility staff failed to complete the quarterly Minimum Data Set (MDS) for Resident #24. The findings include:	F 276		

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F 276	Continued From page 10 According to the MDS 2.0 User's Manual, page 2-15, "At a minimum, three Quarterly assessments and one comprehensive assessment are required in each 12-month period. Federal CFR 483.20 specifies that a Quarterly assessment must be conducted not less frequently than once every three months. Timing edits in the MDS standard system count 92 day intervals because there are never more than 92 days in any consecutive three-month interval. These 92 days are measured from the date at MDS Item R2b of one assessment to Item R2b of the next assessment." A review of Resident #24's record revealed that a quarterly assessment MDS was completed on October 16, 2010 and a "Significant change in status" assessment MDS was completed on January 11, 2010. A further review of the resident's clinical record lacked documented evidence that a quarterly assessment MDS due for April 2010 was completed. Facility staff failed to complete a quarterly assessment MDS for Resident #24. A face-to-face interview was conducted with Employee #10 on April 23, 2010 at approximately 12:10 PM, after reviewing the resident's clinical record he/she acknowledged the above findings saying: "There is none in there." The record was reviewed April 23, 2010.	F 276	1) Resident #24 MDS assessment for April has been completed. ADR 2) Residents in facility with MDS due dates and completion date to MDS nurse to access for any missing MDS assessment it was completed immediately. 3) MDS Nurse Coordinator/Director of Nursing will generate a list of all missing MDS weekly. A list will be forwarded to the Director of Nursing and Unit Managers for immediate follow-up. 4) MDS Nurse/ Director of Nursing will audit all MDS scheduled and identify all MDS that have not been completely weekly. The audit will be on-going. All negative finding will be reported to Administrator/ Director of Nursing for Immediate follow-up. All negative findings will be reported to QI committee monthly as scheduled.	6/1/10 7/23/10 Monthly
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278		

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F 278	Continued From page 11 resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for 13 of 30 sampled residents, it was determined that facility staff failed to: accurately code the Minimum Data Sets (MDS) for the use of side rails for four (4) residents, code one (1) resident for mental retardation, one (1) resident for fall, weight change for three (3) residents, sign the R2b to indicate that the MDS was accurate and complete for four (4) residents, complete Item	F 278	1) Resident #1 was re-assessed for for continued use of side rails and MDS corrected. Resident #5 sight was corrected on MDS. Resident # 6 section K was corrected. Resident #8 MDS correction request form was submitted. Resident #9 was signed by RN assessment coordinated for 4/21/10 assessment. Resident #12 was signed by RN. Resident #13 was re-assessed for continued use of ¼ side rails, MDS revised to reflect usage. Resident #16 correction request was submitted. Resident # 20 MDS was corrected for accidents. Resident #20 MDS was corrected for J4. Resident #24 MDS for Mental Retardation was corrected. Resident #26 weight changes section K was corrected On MDS. MDS on resident 3&4 were corrected with RN signature. A correction request was submitted for all changes. 2) All MDS completed since exit were and reviewed by MDS nurses for signatures by all disciplines within time frame set by RAI. MDS nurses along with RN reviewed all MDS since exit to assure RN signature for beta R2B & ADA. That MDS is completed after all participating disciplines have signed sections within the time frame per RAI guidelines.	6/18/10 6/30/10

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F 278	Continued From page 12 AT5a-c for two (2) residents, complete Item ADa for one (1) resident, and__ for six (6) residents. Residents #1, 3, 4, 5, 6, 8, 9, 12, 13, 16, 20 24, and 26. The findings include: 1. Facility staff failed to accurately code Resident #1's Minimum Data Set for the use of side rails. The resident was observed in bed daily April 19 through April 23, 2010. Elevated rails were observed on each side of the bed at each observation. A review of the clinical failed to reveal any documentation regarding the use of side rails. A review of the significant change MDS which was completed on February 22, 2010 failed to reveal any indication of the use of side rails. The MDS was coded 0 for all areas of Section P (Devices and restraints). The resident was observed in bed daily April 19 through April 23, 2010. Elevated rails were observed on each side of the bed at each observation. A face-to-face interview was conducted with Employee #7 at approximately 10:00AM on April 22, 2010. He/she acknowledged the finding. The record was reviewed on April 19, 2010. 2. A review of Resident #3's Annual Assessment MDS (Minimum Data Set) Section R Assessment Information, R2b was signed and dated by the RN (Registered Nurse) November 18, 2009 and further review revealed that the Attestation Statement of Accuracy was signed and dated	F 278	All completed MDS assessment will be brought to morning meeting for signature and required signatures. The completed assessment will be filed into residents clinical records. 4) The designated RN Coordinator/ Designee will complete a monthly audit for signature review and presented at scheduled QI meeting for follow-up and recommendations	6/30/10 7/23/10 on-going

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F 278	Continued From page 13 November 19, 2009 by all other disciplines. According to "Long-Term Care Facility Resident Assessment Instrument User's Manual Version 2.0 Section R Assessment Information revealed the RN (Registered Nurse) Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS." A face-to-face interview was conducted on April 19, 2010 with the Employee #32 at approximately 10:00 AM. After review of the annual assessment he/she acknowledged that it was not her signature and that the RN who signed this section is no longer here. He/She also acknowledged that in Section R Assessment Information, R2b was signed and dated prior to the other disciplines in the Attestation Statement of Accuracy. The RN failed to sign and date Section R2b, completion of the assessment, after the other disciplines have finished their portions of the MDS. The record was reviewed on April 19, 2010. 3. The RN Assessment Coordinator failed to ensure that all assessments were complete on one quarterly and one annual prior to signing at Item R2b for Resident #4. A. A Review of Resident #4's clinical record revealed an annual assessment MDS signed and dated by the RN Coordinator at Item R2b, on November 24, 2009, indicating that all assessments were completed. A further review of the November 24, 2009 annual	F 278		

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F 278	Continued From page 14 assessment MDS revealed that facility staff signed the assessment Tracking Form, at Item AA9a-e on November 25, 2009. According to the "MDS 2.0 User's Manual" page 3-212, "The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS." The RN Assessment Coordinator failed to ensure that all other assessors finished their portions prior to signing Resident #4's annual assessment MDS of November 24, 2009 at Item R2b. A face-to-face interview was conducted with Employee # 32 on April 22, 2010 at approximately 11:45AM. After reviewing the resident's clinical record, He/she acknowledged the above findings. The record was reviewed on April 22, 2010. B. A review of Resident #4's clinical record revealed a quarterly assessment MDS signed and dated by the RN Coordinator at Item R2b, on February 25, 2010, indicating that all assessments were completed. A further review of the resident's February 25, 2010 quarterly assessment MDS revealed that facility staff signed the assessment Tracking Form, at Item AA9a-e on March 1, 2010, after the RN Coordinator signed the assessment as complete on February 25, 2010.. According to the "MDS 2.0 User's Manual" page 3-212, "The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS."	F 278		

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F 278	Continued From page 15 The RN Assessment Coordinator failed to ensure that all other assessors finished their portions prior to signing Resident #4's quarterly assessment MDS of February 25, 2010 at Item R2b. A face-to-face interview was conducted with Employee # 32 on April 22, 2010 at approximately 11:45AM. After reviewing the resident's clinical record, He/she acknowledged the above findings. The record was reviewed on April 22, 2010. 4. Facility staff failed to accurately code Resident #5's Minimum Data Set (MDS) for weight gain. A review of the admission MDS which was completed on October 30, 2009 revealed that the resident's admission weight was recorded as 293lb. A review of the quarterly MDS which was completed on January 21, 2010 revealed that the resident's weight was coded as 310lb. The resident's weight of 310lb represented a weight gain of 17lb or 5.8%. The review of the January 21, 2010's MDS revealed that the resident's weight gain was coded as a one (1) in Section K3 (Weight Changes). Section K3a refers to a weight loss. A code of one (1) in Section K3a is indicative of a weight loss. The resident's MDS is coded with a one (1) in K3a and a zero (0) in K3b indicating that there was no weight gain. A face-to-face interview was conducted with Employee #29 at approximately 11:30AM on April 23, 2010. The employee reviewed the MDS and acknowledged that the resident's weight was coded incorrectly and that the resident sustained a weight gain and not a weight loss. The record	F 278		

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F 278	Continued From page 16 was reviewed on April 21, 2010. 5. Facility staff failed to accurately code Section K, Oral/Nutritional status of the quarterly Minimum Data Set [MDS] completed April 2, 2010 for Resident #6. Section K, Oral/Nutritional status was coded as "0" [none] for weight change. According to the dietician's note dated March 10, 2010, the resident sustained a significant weight loss of 11.1% over 30 days. The findings were reviewed and confirmed with Employee #30 on April 23, 2010. 6.The RN Assessment Coordinator failed to:(A) ensure that all assessments were complete on an annual assessment MDS prior to signing at Item R2b and (B) sign Item AT5a-c as specified on the "Correction Request Form" for Resident #8. 6A. A review of Resident #8's clinical record revealed an annual assessment MDS dated by the RN Coordinator at Item R2b, on December 31, 2009, indicating that all assessments were completed. A further review of the December 31, 2009 annual assessment MDS revealed that facility staff signed the assessment Tracking Form, Item AA9a-e on January 1, 2010. According to the "MDS 2.0 User's Manual" page 3-212, "The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS." After reviewing the resident's clinical record, He/she	F 278		

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F 278	Continued From page 17 acknowledged the above findings. A face-to-face interview was conducted with Employee # 32 on April 22, 2010 at approximatetly11:45 ARE. The record was reviewed on April 22, 2010. The RN Assessment Coordinator failed to ensure that all other assessors finished their portions prior to signing at Item R2b for Resident #8's "Annual Assessment" MDS of December 31, 2009. A face-to-face interview was conducted with Employee # 32 on April 22, 2010 at approximately 11:45AM. After reviewing the resident's clinical record, He/she acknowledged the above findings. The record was reviewed on April 22, 2010. 6b. Facility staff failed to follow the specified instruction that a "RN" [Registered Nurse] complete Items AT5a-e of a "Correction Request Form" of an annual assessment MDS dated January 27, 2010 for Resident # 8. The findings include: A review of Resident #8's clinical record revealed an annual assessment MDS of January 27, 2020 "Correction Request Form" dated January 27, 2010. A further review of the January 27, 2010 annual assessment MDS revealed that a "LPN" (Licensed Practical Nurse) completed Items AT5a-c as the "Attesting Individual." The "Correction Request Form" specified that Items AT5a-e be completed by a registered nurse (RN) when it stated "RN Coordinator Attestation	F 278		

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F 278	Continued From page 18 of Completion." Facility staff failed to ensure that Item AT5a-c of a "Correction Request Form" for an annual assessment MDS dated January 27, 2010, was completed by a "RN" as specified on the "Correction Request Form". A face-to-face interview was conducted with Employee # 32 on April 22, 2010 at approximately 11: 45AM. After reviewing the resident's clinical record, He/she acknowledged the above findings. The record was reviewed on April 22, 2010. 7. The facility staff failed to sign Resident #9's Minimum Data Set [MDS] to indicate that it was completed and accurate. A review of the quarterly MDS with a completion date of October 16, 2009 revealed that the Registered Nurse [RN] Assessment Coordinator failed to sign at Sections AA9 and R2 [Signature of person attesting to the accuracy of the assessment and coordinating the completion of the assessment]. Under the heading of R2a and R2b. Signatures of Persons Completing the Assessment on page 3-211 of the MDS 2.0 User's Manual states, " Federal regulations at 42 CFR 483.20 © (1) and (2) require each individual who completes a portion of the assessment to sign and certify its accuracy in item AA9. These regulations also require the RN Assessment Coordinator to sign and certify that the assessment is complete in Items R2a and R2b". A face-to-face interview was conducted with Employee #6 at approximately 3:00PM on April	F 278		

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F 278	Continued From page 19 22, 2010. He/she looked at the MDS and acknowledged that there was no RN signature at AA9 and R2. The record was reviewed on April 21, 2010. 8. The RN [Registered Nurse] failed to sign the admission MDS of March 26, 2010 at Item AD (a) for Resident # 12 The findings include: A review of Resident # 12's clinical record revealed an admission MDS completed on March 26, 2010. A further review of the admission MDS revealed that the RN coordinator failed to sign the admission MDS of March 26, 2010. According to the MDS 2.0 page 3-27, "The RN Coordinator who worked on the background (Face Sheet) Information at Admission must enter his or her signature on the day it is complete. Also, to the right of the name, enter the date the form was signed. If, for some technical reason, such as computer or printer breakdown, the Background (Face Sheet) Information at Admission cannot be signed. It is recommended that the staff document the reason for the discrepancy in the clinical record." 9. Facility staff failed to accurately code Resident #13's Minimum Data Set for the use of side rails. A review of the clinical record failed to reveal any documentation regarding the use of side rails. A review of the admission MDS which was completed on March 02 2010 failed to reveal any	F 278		

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F 278	Continued From page 20 indication of the use of side rails. The MDS was coded 0 for all areas of Section P4 (Devices and restraints). The resident was observed in bed on April 23, 2010 at approximately 2:00PM. Elevated rails were observed on each side of the bed at that time. The observation was made in the presence of Employee #6. A face-to-face interview was conducted with Employee #6 at approximately 2:30PM on April 23, 2010. He/she acknowledged the finding. The employee stated that the rails were not coded because they were not considered to be restraints. The record was reviewed on April 23, 2010. 10.The RN Assessment Coordinator failed to:(a) ensure that all assessments were complete on a "Significant Change in Status Assessment" MDS prior to signing at Item R2b and (b) sign Item AT5a-c as specified on the "Correction Request Form" for Resident #16. 10a .Facility staff failed to ensure that Item AT5a-c of a "Correction Request Form" for a quarterly assessment MDS signed and dated November 20, 2009, was completed as specified for Resident #16. A review of Resident # 16's clinical record revealed a quarterly MDS "Correction Request Form "dated November 20, 2009. A further review of the quarterly MDS revealed that a "LPN" (Licensed Practical Nurse) completed Items AT5a-c as the "Attesting Individual".	F 278		

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F 278	Continued From page 21 The "Correction Request Form" specified that Items AT5a-e be completed by a registered nurse (RN) when it stated "RN Coordinator Attestation of Completion." Facility staff failed to ensure that Item AT5a-c of a " Correction Request Form " of Resident # 16 ' s quarterly assessment MDS dated November 20, 2009, was completed by a registered nurse (RN) as specified on the MDS. A face-to-face interview was conducted with Employee # 32 on April 22, 2010 at approximately 11:45AM. After reviewing the resident's clinical record, He/she acknowledged the above findings. The record was reviewed on April 22, 2010. 10b. A review of Resident #16's clinical record revealed a "Significant Change in Status Assessment" MDS signed and dated by the RN Coordinator at Item R2b, on January 10, 2010, indicating that all assessments were completed. A further review of the MDS revealed that the facility staff signed the assessment Tracking Form, Item AA9a-e on January 11, 2010. According to the "MDS 2.0 User's Manual" page 3-212, "The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS." The RN Assessment Coordinator failed to ensure that all other assessors finished their portions prior to signing at Item R2b for Resident #16's "Significant Change in Status Assessment" of January 10, 2010.	F 278		

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A face-to-face interview was conducted with Employee # 32 on April 22, 2010 at approximatetly11:45ARE. After reviewing the resident's clinical record, He/she acknowledged the above findings. The record was reviewed on April 22, 2010.

11. Facility staff failed to code for accidents on the admission MDS completed on April 19, 2010 for Resident # 20.

A review of the resident's clinical record revealed the following:
An April 17, 2010 at 11:00PM's "Progress notes" that stated "...Resident was observed on the floor in the dinning room at 7PM. Resident was unable to give an account of the incident. MD [Medical doctor] made aware at 7:30PM and R/P [Responsible Party] notified at 7:50PM. No New orders, neuro [Neurological] check in progress. [No] pain voiced, [No] s/s [Sign and Symptoms] of acute distress noted. V/s [Vital signs] was BP 120/68 P74 R20 T97.5.

An April 18, 2010 at 0600 progress note read "Resident day one S/P [After] fall, [No] injury noted..."

An April 18, 2010 at 7:00PM progress note read "Resident is alert and stable. P/fall [Post fall]. No delayed injuries noted ...Voiced no complain of pain /discomfort. Seen by PCP [Primary care provider]. No new orders given ..."

An April 18, 2010 at 10:50PM progress note read "Resident observed lying in bed alert and responsive. During care, resident observed mourning. Assessment [Conducted] by the nurse

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 23 and the supervisor. Resident denies pain on assessment ..." A further review of Resident #20's admission MDS completed April 19, 2010 lacked evidence of coding in Item J4 (Health Conditions: Accidents): "Fell in past 30 days". A face-to-face interview was conducted with Employee #32 on April 23, 2010 at approximately 12:45PM. After reviewing the resident's admission MDS of April 19, 2010, he/she acknowledged the above findings. The record was reviewed April 23, 2010. 12. Facility staff failed to code Resident #24 for mental retardation on a quarterly and a significant change in status MDS assessments. A review of the resident's clinical record revealed the following: A "History and Physical" signed and dated by the physician on July 30, 2009 that included mental retardation in the "Chief complains" and "Working diagnosis". A quarterly MDS completed on August 12, 2009 that included Mental Retardation as a diagnosis in Item I3 "Other Current Diagnosis and ICD-9 Codes". An October 16, 2010 quarterly MDS assessment and a January 11, 2010 significant change in status assessment that failed to include/write-in mental retardation in Item I3. Facility staff failed to code Resident #24 for	F 278		

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F 278	Continued From page 24 mental retardation on an October 16, 2010 quarterly MDS assessment and a January 11, 2010 significant change in status assessment. A face-to-face interview was conducted with Employee #32 on April 23, 2010 at approximately 2: 45 PM, after reviewing the resident's clinical record he/she acknowledged the above findings. The record was reviewed April 23, 2010. 13. Facility staff failed to accurately code Section K, Oral/Nutritional status of the quarterly Minimum Data Set [MDS] completed March 11, 2010 for Resident #26. Section K, Oral/Nutritional status was coded as "0" [none] for weight change. According to the clinical record, the resident's admission weight in September 2009 was 109 pounds and current weight as of March 2010 was 132 pounds, indicative a significant weight gain. The findings were reviewed and confirmed with Employee #30 on April 23, 2010.	F 278		
F 279 SS=D	483.20(d), 483.20(k) (1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		

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F 279	Continued From page 25 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b) (4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for six (6) of 30 sampled and one (1) of 24 supplemental residents, it was determined that facility staff failed to develop a care plan for: One (1) resident that eloped; for one (1) resident with Diagnosis and treatment of diabetes; anticoagulant therapy for 1 (one) resident, chair coded as a restraint for 1 (one) resident, three (3) residents for side rails, and one (1) resident for Mental Retardation (MR). Residents #1, 9, 13, 19, 24, 28 and M2. The findings include: 1. Facility staff failed to initiate a care plan with goals and initiatives for the use of side rails for Resident #1. A review of Resident #1's clinical record revealed that there was no care plan for the resident's use of side rails on the record. The resident was observed in bed daily April 19 through April 23, 2010. Elevated rails were in use on both sides of the bed at each observation. A face-to-face interview was conducted with Employee #7 at approximately 2:00PM on April 22, 2010. He/she acknowledged that the rails	F 279	1) Side rail assessment was completed. Resident #1 to assess for continued use of ¼ rail, side rail bed is to encourage resident to assist In turning and positioning activity. The care plan updated to reflect. Same Resident # 9 MDS was corrected for chair that prevents rising, correction submitted. Resident does not have or does not use side rail. Assessment completed to evaluate continued use of ¼ rails. Resident participates in T&P act and uses ¼ side rail as evaluated for ADL task. Resident #13 was re-assessed for side rails. Resident utilizes rails as they are available to assist in T&P activity. Care plan was amended to Include side rails. Resident #19 is discharged from the facility. 2) All residents identified as potential risk for elopement. All resident in the elopement risk. Care Plans and interventions for those resident and risk be reviewed and revised to assure compliance with facility P&P. This shal include but not limited to wander guard, photo identification and security book is current with photos of potential elopements. All resident's utilization side rails were re-assessed for continued use as enable for turning and positing, and care planned accordingly.	6/30/10

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F 279	Continued From page 26 were elevated but said he/she did not write a care plan because the rails are not used as a restraint but to assist the resident in turning and positioning while in bed. The record was reviewed on April 19, 2010. 2. The facility's staff failed to initiate care plans with goals and objectives for (a) the use of side rails and (b) for the use of a chair that prevents the resident from rising for Resident #9. (a) The resident was observed lying in bed with both side rails elevated. A review of the care plans on the clinical record revealed that the record lacked a care plan for the use of side rails when in bed. A face-to-face interview was conducted with Employee #6 at approximately 2:30PM on April 23, 2010. He/she acknowledged that the record lacked a care plan for the use of side rails. The record was reviewed on April 21, 2010. (b) The facility staff failed to initiate a care plan with goals and objectives for the use of a chair that prevented the resident from rising for Resident #9. A review of the resident's clinical record revealed a quarterly Minimum Data Set (MDS) with a completion date of March 10, 2010. The MDS was coded with a zero in all areas of Section P4a, b, c and d (Devices and Restraints) except P4e (Chair prevents rising) which was coded with a two (2). A face-to-face interview was conducted with Employee #6 at approximately 2:30PM on April 23, 2010. He/she acknowledged that the record	F 279	3) All staff & Department Heads will be re-educated to facility policy procedure for elopement risk, as well as notification procedure where identified. Director of Nursing will review and revise P&P accordingly. All staff shall be in-serviced. Any changes were required all residents will continue to be assessed for elopement potential and but not limited to admission. Quality and significant change. 4) The Director of Nursing has developed a audit tool to monitor compliance with facility elopement P&P. All admissions and re-admissions will be included in audit sample. Audit will be completed weekly sample audit will be completed monthly.	7/15/10 7/23/10 on-going

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F 279	Continued From page 27 lacked a care plan for the use of a chair as a restraint (that prevents the resident from rising). The record was reviewed on April 21, 2010. 3. The facility's staff failed to initiate care plans with goals and objectives for (a) the use of side rails for Resident #13. At approximately 10:00AM on April 23, 2010 the resident was observed lying in bed with the upper rails elevated on both sides of the bed. Employee #6 was present during the observation. A review of the resident's care plans on the clinical record failed to reveal a care plan for the use of side rails. A face-to-face interview was conducted with Employee #6 at approximately 3:00PM on April 23, 2010. He/she acknowledged that the side rails on the bed were elevated and that no care plan was initiated for the use of the side rails. The record was reviewed on April 23, 2010. 4. Facility staff failed to develop a care plan for a Resident #19 with elopement behaviors. Facility Policy 2.4, "Elopement Prevention & Management" revised 09/07, stipulated: "Procedure: 1. Evaluate all residents/patients on admission for risk of elopement. All new admissions that are at risk for elopement will have interventions put in place immediately until further assessment is complete. Interventions include but are not limited to: Environmental modifications to prevent undetected exit (doors alarms, wander alerts) increased frequency of ' resident location ' rounds ... 2. Obtain a current photograph of resident/patients identified for risk	F 279		

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F 279	Continued From page 28 elopement. 3. Complete the Elopement Risk alert (FSE 3-2-1)...5. Develop the care plan with input from the interdisciplinary team and the resident/patient and family/legal representative..." A Social Progress note dated March 9, 2010 at 3:00 PM read, "...Resident says [he/she] will sign out tomorrow and go to the [named] Shelter ....Security notified of possible elopement risk. A Social Progress Note dated March 9, 2010 at 3:30 PM read, "Met with resident due to alcohol use, resident denied using alcohol ...redirect resident to room, resident stated [he/she] wanted leave tomorrow but is unable to live with family members ...security to obtain resident's picture to safeguard for elopement risk ..." An "Incident/Accident Report dated April 8, 2010 revealed Resident #19 left the facility without authorization. The following nurse's notes detailed the unauthorized departure: April 8, 2010 at 5:45 PM "called to unit at 5:15 PM. Informed that resident last seen on unit at 1:30 PM (after) charge nurse administered medications... " April 8, 2010 at 7:00 PM " ...Evening C.N.A (Certified Nursing Assistant) stated resident is not in [his/her] room ...called to safety to know if resident is at lobby, reply no ...called to Employee #35 to know if having a meeting ...resident can't be found ...code 13 called [elopement management] .. " April 8, 2010 at 6:10PM, "received phone call	F 279		

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F 279	Continued From page 29 from CNA who had gone out in search of resident ...informed that CNA found him/her [at local park away from facility] at 6:05 PM ..." The resident's whereabouts were unknown for a period of approximately five (5) hours, from 1:30 PM through 6:30 PM on April 8, 2010. Observations during the survey period of the facility's Security Division lacked evidence that Resident #19 was identified as an elopement risk. There was no picture of the resident and no elopement risk alert [form] as per the aforementioned facility policy. The clinical record revealed the resident exhibited elopement risk behaviors and was a potential elopement risk as evidenced by documentation in the social progress notes and admission assessments. The record lacked evidence that facility staff implemented a care plan with interventions directed toward minimizing the resident's risk of elopement. Additionally, there was no evidence that an elopement risk assessment was conducted at the time of admission as per facility policy. A face-to-face interview was conducted on April 22, 2010 with Employee # 12 at approximately 1:40 PM. After review of the clinical record he/she acknowledged that the resident did not have an elopement screen completed prior to the elopement. The findings were reviewed and acknowledged by interviews with Employees #1, 2 and 3 on April 23, 2010 at approximately 4:30 PM.	F 279		

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F 279	Continued From page 30	F 279		

Facility staff failed to develop a care plan with goals and approaches for Resident #19 to prevent unauthorized departure from the facility. The record was reviewed April 23, 2010.

5. Facility staff failed to initiate a care plan for mental retardation for Resident # 24.

A review of the resident's clinical record revealed the followings:

A "History and Physical" signed and dated by the physician on July 30, 2009 that included mental retardation in the "Chief complains" and "Working diagnosis."

"Social Progress Notes" that stated that care plan conference was conducted on October 22, 2009, January 14, 2010 and April 15, 2010.

Quarterly Minimum Data Set (MDS) assessments completed on August 12, 2009 and October 16, 2009 and a significant change in status assessment completed on January 11, 2010 included Mental Retardation as a diagnosis in Item I3 "Other Current Diagnosis and ICD-9 Codes".

A further review of the resident's clinical record revealed that a care plan was not initiated for mental retardation.

Facility staff failed to initiate mental retardation care plan for Resident #24.

A face-to-face interview was conducted with Employee #10 on April 23, 2010 at approximately 12:30PM, after reviewing the resident's clinical

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F 279	Continued From page 31 record he/she acknowledged the above findings. The record was reviewed April 23, 2010. 6. Facility staff failed to initiate a care plan with goals and approaches for Resident #28 with a diagnosis of Diabetes Mellitus II. The History and Physical signed and completed on November13, 2009, revealed, " Chief Complaint: ...1. CVA (Cerebral Vascular Accident) 2. Depressive Disorder, 3. Gout, 4. Hyperlipidemia, 5. HTN (Hypertension), and DM II (Diabetes Mellitus II) ..." According to the physician's order sheet signed and dated April 2, 2010 directed, "Novolog Insulin 100 units vial inject sq (subcutaneous) per sliding scale. Check b/s (blood sugars) 3 times daily before meal ..." A review of the clinical record lacked evidence that a care plan was initiated with goals and approaches for Resident #28 for Diabetes Mellitus II. A face-to-face interview was conducted on April 23, 2010 at 12:10 PM with Employee #11. He/she acknowledged that there was no care plan developed for goals and approaches for the diagnosis of Diabetes Mellitus II. The record was reviewed on April 23, 2010. 7. Facility staff failed to initiate a care plan for the potential adverse interactions for the use of Anticoagulant medications for Resident M2. A review of Resident #M2's April 2010 Medication Administration Record and "Physician Admission	F 279		

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F 279	Continued From page 32 Orders and Plan of Care" signed and dated April 4, 2010 by Physician revealed a medication order that reads "Heparin 5000 units subcutaneously (3) three times a day until patient are able to ambulate independently ". There was no care plan for the potential adverse interactions for the use of Heparin medications found in the resident #M2's clinical records. A face-to-face interview was conducted with Employee #9 on April 21, 2010 at approximately11:45 ARE. He/she acknowledged that the care plan was not initiated. The record was reviewed on April 21, 2010.	F 279		
F 280 SS=D	483.20(d) (3), 483.10(k) (2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	1) Resident #3 care plan was updated to include blindness. Resident #10 care plan was revised for alteration in skin integrity. Resident #26 care plan was updated and revised. Resident #28 care plan was reviewed, revised and updated to include but not limited to smoking, side effects psychotropic drugs use full code, alteration in skin integrity and seizure disorder. 2) All residents care plan will be reviewed to reflect current status including but not limited identified areas. 3) All clinical changes regarding Residents will be reflected in care plan as accurate. Unit managers and all license. Staff will be re-educated regarding updating of care plans.	6/18/10 6/30/10 7/7/10

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F 280	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 30 sampled residents, it was determined that facility staff failed to review and revise the comprehensive plans of care for visual impairment associated with blindness for one (1) resident; skin integrity for one (1) resident; impaired memory for one (1) resident; and falls, smoking, skin integrity, pain, psychotropic medication, advanced directives, seizures and cardiac output for one (1) resident. Residents # 3, 10, 26 and 28. The findings include: 1. Facility staff failed to review and update a plan of care for visual impairment associated with blindness for Resident #3. According to the quarterly Minimum Data set (MDS) completed, " March 8, 2010 Section D1 Vision is coded four (4) for severely impaired - no vision or sees only light, colors, or shapes, eye do not appear to follow objects." According to the History and Physical dated "March 20, 2010 Resident #3 has a working diagnosis of Blindness." Review of the clinical record overflow records revealed a care plan with a date and problem onset as 12/14/2009 (December 14, 2009) for alteration in vision r/t (related to) visual impairment associated with blindness. A face-to-face interview was conducted on April 23, 2010 with Employees #7 and 8 at	F 280	The QI nurse/designee will review 24hrs report and assure all important information/changes have been care planned a daily basis. 4) The Director of Nursing has developed A QI tool to evaluate care plan reflective of resident status. The Director of Nursing. MDS Nurse will complete audit at times of MDS review for each resident. All negative findings will be reported to QI committee for recommendations and updates. This audit will be on-going.	7/23/10

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F 280	Continued From page 34 approximately 12:15 PM. After review of the clinical record they acknowledged that the record lacked evidence of further documentation for a care plan for visual impairment for Resident # 3. The record was reviewed on April 23, 2010. 2. Facility staff failed to revise the skin integrity plan of care for Resident #10. Actual skin breakdown related to surgical wound was identified as a problem for Resident #10. A review of the clinical record revealed a stage II pressure sore was identified and treated on March 25, 2010. The plan of care for "Actual Skin Breakdown", most recently reviewed April 2, 2010, lacked evidence of revisions to include the stage II pressure sore identified on March 25, 2010. The record was reviewed April 21, 2010. 3. A review of the clinical record for Resident #26 revealed facility staff failed to revise the care plan as it relates to memory. Impaired memory, short/long term memory problem and impaired decision making was identified as a problem for Resident #26 at the time of admission September 21, 2009. The care plan was most recently revised March 4, 2010 and continued impaired memory as a problem. A review of the quarterly Minimum Data Set [MDS] completed March 11, 2010 and interview with Resident #26 lacked evidence of a current	F 280		

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F 280	Continued From page 35 memory problem. The findings were reviewed and confirmed with Employee #10 on April 22, 2010 at 3:00 PM. H/she stated the resident was no longer identified with impaired memory. The record was reviewed on April 22, 2010. 4. Facility staff failed to review and revise multiple care plans for Resident #28. A review of the care plans revealed the following: Fall Risk Identification-had no date of implementation, Smoking- last updated December 10, 2009, Altered Cardiac Output, and Alteration in Comfort R/T (related to) Acute Pain Episodes -was last reviewed/revised November 13, 2009; Potential for Side Effects from Psychotropic Drug Use, Full Code, Risk for Alteration in Skin Integrity R/T Continuous Itching over Areas of Body, and Seizure Disorder - were last reviewed/revised November 12, 2009. There was no evidence that the aforementioned care plans had been reviewed or revised after the quarterly assessment last completed February 2, 2010. A face-to-face interview was conducted on April 23, 2010 at 12:10 PM with Employee #11. He/she acknowledged that the aforementioned care plans were not reviewed and revised after the last assessment. The record was reviewed on April 23, 2010.	F 280		
F 281 SS=D	483.20(k) (3) (i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observations during the medication pass conducted on April 19, 2010 at 10:30 AM, it was determined that facility staff failed to provide an identification arm band for one (1) Resident; and to use correct placement of blood pressure cuff to measure one (1) resident ' s blood pressure Resident #4, 6 The findings include: 1. Facility staff failed to provide an identification arm band for Resident #4. On April 19, 2010 at 9:45AM during med pass facility staff was observed prior to administering medications looking on both arms of resident #4 for his/her arm band to identify resident. No identification arm band was observed on Resident #4 at that time. Facility staff failed to provide the resident an armband as a form of identification. A face-to-face interview was conducted with Employee #27 on April 3, 2010 at approximately 10:30AM. He/she acknowledged that there was no arm band but that he/she knows this is the correct resident. The record was reviewed April 19, 2010. 2. Facility staff failed to obtain blood pressures in accordance with professional standard of measuring blood pressure for Resident #6.	F 281	1) ID Badge was provided by Nursing to resident #4, on 4/19/10. 2) Resident #6 blood pressure was obtained corrected at the time of finding by the Director of Nursing at the time of review Potential to affect the other resident. All resident having potential to be affected by the identified practice, all residents in the facility were checked for lack of ID Bands. All residents identified as lack of ID bands. All residents identified as lacking ID bands were provided and proper required identifications. All units were provided and proper sizes blood pressure cuff is addition to bariatric blood pressure cuff. 3) All appropriate staff was in-service regarding resident having proper facility identification at all times. 3-11 supervisors will ensure that all admissions and re-admissions have proper identification I place. All appropriate employees were in-service about proper placement of blood pressure cuff. 4) The Director of Nursing and Administrators have developed a QA tracking tools to monitor placement of ID bands and a skill assessment for taking blood pressure. All findings will be reported. To QA committee for further recommendations monthly.	6/30/10 7/23/10

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F 281	Continued From page 37 During an observation conducted on April 19, 2010 at 10:30 AM, the facility staff was observed applying a regular adult blood pressure cuff around the resident ' s left upper arm over his/her clothing. The blood pressure cuff contained white markings utilizing an arrow to identify proper placement at the ante-cubital space. The cuff wrapped around Resident #6's left upper arm was inaccurately placed as determined by the placement of the markings on the cuff. The cuff was wrapped around Resident #6 ' s left upper arm was secured approximately 1 " (one inch) past the white markings of the manufacture's identified range for use placing arrow away from the ante-cubital space. A face-to-face interview was conducted with Employee #25 at the time of the observation. He/she acknowledged that the blood pressure cuff was not in the correct position with it being placed over the resident clothing. The record was reviewed on April 19, 2010.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for five (5) of 30 sampled residents and	F 309		

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F 309	Continued From page 38 one (1) supplemental resident, it was determined that facility staff failed to: obtain stool testing, perform clinical assessments and clarify physician ' s orders for one (1) resident; to perform a wound treatment, pre-medicate for pain prior to wound treatments and verify a weight variance greater than 5 pounds for one (1) resident; to administer Amoxicillin and follow up on an order to be seen by Speech Language Pathology for one (1) Resident; administer Clindamycin for one (1) resident; and administer Vitamin D in accordance with physician ' s orders for one (1) resident; Residents #2, 6, 14, 28, 30 and M3 The findings include: 1. A review of the clinical record for Resident #2 revealed that facility staff failed to obtain stool testing, perform clinical assessments and clarify physician ' s orders. A. Resident #2 ' s diagnoses included end stage renal disease with hemodialysis, atrial fibrillation, lower extremity weakness, coronary artery disease, sacral decubitus and clostridium difficile. Physician's orders dated March 13, 2010 directed "stool guaiac daily X3." A review of the activities of daily living care record for March and April 2010 revealed Resident #2 ' s bowel elimination was regular. The record lacked evidence of stool guaiac testing as per physician's orders. Licensed staff failed to act on a physician's order for stool testing. The findings were reviewed and	F 309	1) Resident #2 medical Doctor was notified with regards to missing stool for quaic. No further orders resident #2's dialysis communication sheet is reviewed by the unit manager daily, prior to dialysis and post dialysis. Resident # 2's acetaminophen order has been clarified with physician for indication of use. Resident #6 TAR have been reviewed for any continued omission; none identified. Resident #6's MAR and pain assessment documentations were reviewed for omission and clarifications of omissions. No other deficiency identified. Resident # 14 may weights are 150.6 lbs. No significant weight variation was identified by the Director of Nursing. Resident #28 incident report was completed and on-sight counseling and in-service was provided. Speech evaluation has been completed. Resident #30 incident medication error form was completed and staff of question was in-service. Resident's #M2's incident medication error form was competed and staff in question was in-serviced.	6/18/10

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F 309	Continued From page 39 confirmed during an interview with Employee #6 on April 19, 2010 at approximately 2:30 PM. B. Resident #2 ' s record revealed facility staff failed to consistently conduct pre/post hemodialysis assessments in accordance with facility policy. The facility's policy entitled Residents Receiving Dialysis stipulated " weights will be done prior to and after dialysis by dialysis staff. If resident is mechanically lifted, the weight is obtained by the unit staff prior to and after treatment ...unit nurses will complete Pre-dialysis section of dialysis communication ...upon return licensed nurses will assess resident and document findings on Post Dialysis section of communication sheet ... " Resident #2's diagnosis included end stage renal disease and he/she received hemodialysis on Mondays, Wednesdays and Fridays. A review of the dialysis communication sheets for the month of April 2010 revealed facility staff inconsistently assessed vital signs and weights before and after hemodialysis treatments. The spaces designated for documenting weights and/or blood pressure assessments on the dialysis communication forms were left blank and/or inaccurate. Facility staff failed to fully assess Resident #2 before and after hemodialysis treatments as evidenced by the absence of consistent weight and/or blood pressure assessments. The record was reviewed April 19, 2010. C. A review of the clinical record for Resident #2 revealed facility staff failed to clarify a prn (as	F 309	2) All residents May weights were re-evaluated by the chief clinical Registered Dietician for variances requiring re-weights. Director of Rehab reviewed all outstanding requests for speech and language for screens and evaluations. All April and May's MARs were reviewed by the Director of Nursing/ designee for omission is any identified, a medication error report was completed and Medical Doctor made aware.	7/7/10
			3) All appropriate staff will be re-educated to monitoring diagnostic testing, obtaining completed medication orders pertaining to pain medication and completion of dialysis communication sheets. Unit managers and charge nurses will be responsible for noting and signing completed dialysis communication sheet. All pain medication orders will be reviewed and counter signed by RN supervisors and monitored for completeness. Director of Nursing has developed a Guaic tracking sheet to monitored pending orders. Supervisors will review Tracking sheets during routine rounds. Incoming and off going Nursing Staff will review MARs together to assess for charting omissions.	7/14/10

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F 309	Continued From page 40 needed) physician's order. Physician ' s orders dated April 3, 2010 directed " acetaminophen 325mg, 2 tablets by mouth every 6 hours as needed. " The order lacked evidence of an indication for use of the acetaminophen. There was no evidence that licensed staff queried the physician to clarify the order. The above findings were reviewed and confirmed during an interview with Employee #6 on April 19, 2010 at approximately 2:30 PM. 2. A review of the clinical record for Resident #6 revealed facility staff failed to perform a wound treatment, pre-medicate for pain prior to wound treatments and administer Vitamin D in accordance with physician ' s orders. According to the history and physical examination dated December 20, 2009, the resident ' s diagnoses included hypertension, anemia, pelvic and perianal abscesses, seizure disorder and cancer. A. Physician' s orders dated March 10, 2010 directed for the administration of wet to dry wound treatments to multiple surgical wounds on the resident ' s ischium and iliac crest daily and as needed. A review of the Treatment Administration Record [TAR] for April 2010 revealed the wound treatments were omitted April 13, 2010 as evidenced by encircled initials annotating an omission. The record lacked evidence of an explanation related to the omission of the wound	F 309	4) A QA tracking tool had been developed by the Director of Nursing and the Administrator to monitor compliance in pain medication orders, guaic test monitoring, and dialysis communication document for completeness. These audits shall be completed weekly X 4weeks, monthly X 3months and quarterly there after. All negative findings shall be reported to the Director of Nursing for immediate follow-ups. All findings shall be reported to the QI Committee for recommendations and follow-ups.	7/23/10

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F 309	Continued From page 41 treatment. Licensed staff failed to administer a wound treatment in accordance with physician's orders. The findings were reviewed and confirmed during an interview with Employee #11 on April 22, 2010 at approximately 12:30 PM. B. A Physician ' s order dated March 10, 2010 directed " Percocet 5/325mg, 2 tablets by mouth 30 minutes before wound dressing " [pain management]. A review of the Medication Administration Record [MAR] for April 2010 revealed Percocet was not administered prior to wound treatments on April 9th - 12th and 17th - 19th 2010. Additionally, Percocet was documented as administered on April 13, 2010, however; the record lacked evidence that wound treatment was administered on April 13th. The record lacked evidence of an explanation related to the reason for the omissions. A face-to-face interview was conducted with Employee #11 on April 22, 2010 at 12:30 PM. In response to query regarding the omission of the Percocet, h/she responded that the resident refused medications on occasions. H/she acknowledged that refusal of medication would warrant correlating documentation. Licensed staff failed to administer medications for pain management in accordance with physician's orders. The record was reviewed April 22, 2010.	F 309		

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F 309	Continued From page 42 3. A review of the clinical record for Resident #14 revealed facility staff failed to verify a weight variance greater than 5 pounds in accordance with facility policy. According to facility ' s nutrition services manual, policy #4-10-2 " Weight Process " revised June 2009, " ,,.reweigh resident immediately if weight change is exhibited as follows: under 100 pounds, +/- 3 pounds; over 100 pounds, +/- 5 pounds. According to the clinical record, the resident's weight history was documented as follows: January 2010 159.7 pounds February 2010 165.0 pounds March 2010 157.6 pounds April 2010 150.0 pounds There was a weight variance [greater or lesser] of 5 pounds or more between the periods of January thru April 2010 without evidence of verification per reweight. The record lacked evidence of a reassessment of the resident's weight as per facility policy. The findings were reviewed and confirmed during an interview with Employee #29 on April 19, 2010 at 2:00 PM. 4. The facility staff failed to administer Amoxicillin and follow up on an order for Resident #28 to be seen by Speech Language Pathology in accordance with the physician ' s order. A. The facility staff failed to administer Amoxicillin in accordance with the physician's order. The telephone order [from the physician] dated	F 309		

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F 309	Continued From page 43 April 14, 2010 at 9:00 AM directed, "Amoxicillin 500 mg po [by mouth] TID (three times daily) times 10 days for UTI (Urinary Tract Infection) ". A review of the April 2010 Medication Administration Record revealed that Amoxicillin was initialed [indicating that the medication was given] on April 16, 2010 at 0600, 1400 and 2200. There was no evidence that facility staff administered Amoxicillin on April 14 and 15, 2010 in accordance with the physician's order. A face-to-face interview was conducted on April 23, 2010 at approximately 12:10 PM with Employee #11. He/she acknowledged that Amoxicillin was not administered on April 14 and 15, 2010 as ordered by the physician. The record was reviewed on April 23, 2010 B. The facility staff failed to follow up on an order to be seen by Speech Language Pathology in accordance with the physician' s order for Resident #28. The telephone order [from the physician] dated March 25, 2010 at 2300 (11:00 PM) directed, "Schedule resident for SLP chewing and swallowing due to chewing difficulties ". A review of the medical record lacked evidence that the Speech and Language Pathologist had screened and/or evaluated Resident #28 at the time of the record review. A face-to-face interview was conducted on April 23, 2010 at approximately 12:10 PM with Employee #11. He/she acknowledged that no screen and/or an evaluation had been conducted	F 309		

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F 309	Continued From page 44 by the Speech and Language Pathologist as ordered by the physician. The record was reviewed on April 23, 2010. 5. Facility staff failed to administer Clindamycin for Resident #30 in accordance with the physician's order. The admission orders dated March 25, 2010 [no time indicated] directed, " Clindamycin 600 mg po [by mouth] Q8 hours (every eight hours) times 7 days for labia abscess ". A review of the April 2010 Medication Administration Record (MAR) revealed that Clindamycin was initialed and circled for three (3) doses on March 26, 2010 [indicating that the medication was not given] on March 26, 2010 at 0600, 1400 and 2200. The back of the April 2010 MAR revealed that on March 26, 2010 at 2200 the Clindamycin was on order and the pharmacy was called; and March 26, 2010 at 0600 the Clindamycin was on order. There was no evidence that facility staff administered Clindamycin on March 25 and 26, 2010 in accordance with the physician's order. A face-to-face interview was conducted on April 26, 2010 at approximately 8:50 AM with Employee #5. He/she acknowledged that the Clindamycin was not given as directed by the physician on March 25 and 26, 2010. The record was reviewed on April 26, 2010. 6. Facility staff failed to administer right dose of vitamin D3 medication per Physician's order for	F 309		

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F 309	Continued From page 45 Resident #M3 A review of resident # M3 clinical record revealed a "Physician's order that was signed and dated on March 12, 2010 on the physician ' s telephone order sheet that reads, " Vitamin D 2000 unit every day by mouth for low vitamin D". Review of resident #M3 Medication Administration Record [MAR} revealed physician order that reads " Vitamin D3 1,000 Unit tablet, (2) two tablets (2000 units) by mouth every day ". On April 22, 2010, at approximately 9:45 AM, during the medication pass for Resident #M2, Employee #24 administered Vitamin D3 1,000 Unit tablet one (1) tablet to the resident instead of two (2) tablets. A face-to-face interview was conduct with Employee #24 on April 22, 2010, at 2:00 PM with Employee #24. He/she acknowledged that Vitamin D3 1,000 Unit tablet one (1) tablet was administered to the resident instead of two (2) tablets. The record was reviewed April 22, 2010.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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	F 323	1) Resident is no longer a resident of Deanwood. Resident in the community, discharged to the community on 5/8/10. Resident #22, K1, K2 were inspected by Director of Rehab and Director of Engineering. Any and all areas requiring repairs were immediately repaired.	

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F 323	Continued From page 46 by: Based on record review and staff interview for two (2) of 30 sampled and two (2) of 24 supplemental residents, it was determined that facility staff failed to adequately supervise one (1) resident who eloped and failed to provide an environment free of accident hazards as evidenced by three (3) residents with wheelchairs in a state of disrepair. Residents #19, 22, K1 and K2. The findings include: 1. A review of the clinical record for Resident #19 revealed facility staff failed to adequately supervise the resident as to prevent elopement. Facility Policy 2.4, "Elopement Prevention & Management" revised 09/07, stipulated: "Procedure: 1. Evaluate all residents/patients on admission for risk of elopement. All new admissions that are at risk for elopement will have interventions put in place immediately until further assessment is complete. Interventions include but are not limited to: Environmental modifications to prevent undetected exit (doors alarms, wander alerts) increased frequency of 'resident location ' rounds ... 2. Obtain a current photograph of resident/patients identified for risk elopement. 3. Complete the Elopement Risk alert (FSE 3-2-1)...5. Develop the care plan with input from the interdisciplinary team and the resident/patient and family/legal representative..." Resident #19 was admitted to the facility December 4, 2009. According to the history and physical examination dated December 11, 2009, diagnoses included rheumatoid arthritis, depression, renal insufficiency, gastritis, clostridium difficile, colitis, endocarditis and	F 323	2 To assure all residents at risk for elopement are assessed for elopement risk. All resident will be re-evaluated assessed for potential for elopement. Potential resident that were identified for elopement, QI nurse will review compliance with facility policy and procedure. a) Wander guard b) ID Photo c) Create a bright color ID Badge d) Current list of elopement resident at the nursing station, and at security booth. Director of Engineering and Rehab reviewed all resident wheelchairs for repairs. All wheelchairs requiring repairs were repaired wheelchairs parts ordered. 3) Nursing Supervisors will review all new admission, elopement assessment and potential for elopement times 72 hours post admission. Director of Engineering has developed a plan program to evaluate wheelchairs for any needed repair. 4) QI Nurse along with the Administrator will develop order tool to track elopement assessment and to ensure compliance with facility and procedure. Director of Engineering has developed a QI tool to monitor prior wheelchair to assure all wheelchairs are in proper repair wheelchair. QI shall be on-going, all results will be reported to QI community for follow up recommendation monthly as scheduled.	6/30/10 7/7/10 7/23/10

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F 323	Continued From page 47 hypertension. The nurse's admission Behavior Data Collection form dated December 4, 2009 revealed the resident exhibited "wandering on admission." The Social/Psychosocial Data Collection & Evaluation form dated December 10, 2009 revealed Resident #19's relative [next of kin] reported that the resident ' s history included "ETOH [alcohol] abuse with passing out." He/She stated there was history of the resident walking away and people can't find [him/her] ..." A Social Progress note dated March 9, 2010 at 3:00 PM read, "...Resident says [he/she] will sign out tomorrow and go to the [named] Shelter ....Security notified of possible elopement risk. A Social Progress Note dated March 9, 2010 at 3:30 PM read, "Met with resident due to alcohol use, resident denied using alcohol ...redirect resident to room, resident stated [he/she] wanted leave tomorrow but is unable to live with family members ...security to obtain resident's picture to safeguard for elopement risk ..." An "Incident/Accident Report dated April 8, 2010 revealed Resident #19 left the facility without authorization. The following nurse's notes detailed the unauthorized departure: April 8, 2010 at 5:45 PM "called to unit at 5:15 PM. Informed that resident last seen on unit at 1:30 PM (after) charge nurse administered medications... "	F 323		

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F 323	Continued From page 48 April 8, 2010 at 7:00 PM " ...Evening C.N.A (Certified Nursing Assistant) stated resident is not in [his/her] room ...called to safety to know if resident is at lobby, reply no ...called to Employee #35 to know if having a meeting ...resident can't be found ...code 13 called [elopement management] .. " April 8, 2010 at 6:10PM, " received phone call from CNA who had gone out in search of resident ...informed that CNA found him/her [at local park away from facility] at 6:05 PM ..." The resident was returned to the facility by facility staff with no indication of injury. The resident's whereabouts were unknown for a period of approximately five (5) hours, from 1:30 PM through 6:30 PM on April 8, 2010. Observations during the survey period of the facility's Security Division lacked evidence that Resident #19 was identified as an elopement risk. There was no picture of the resident and no elopement risk alert [form] as per the aforementioned facility policy. The clinical record revealed the resident exhibited elopement risk behaviors and was a potential elopement risk as evidenced by documentation in the social progress notes and admission assessments. The record lacked evidence that facility staff implemented interventions directed toward minimizing the resident's risk of elopement. Additionally, there was no evidence that an elopement risk assessment was conducted at the time of admission as per facility policy.	F 323		

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F 323	Continued From page 49 A face-to-face interview was conducted on April 22, 2010 with Employee # 12 at approximately 1:40 PM. After review of the clinical record he/she acknowledged that the resident did not have an elopement screen completed prior to the elopement. The findings were reviewed and acknowledged by interviews with Employees #1, 2 and 3 on April 23, 2010 at approximately 4:30 PM. Facility staff failed to adequately supervise Resident #19 to prevent unauthorized departure from the facility. The record was reviewed April 23, 2010. 2. Three (3) of 10 wheelchairs observed during the survey period for Residents #22, K1 and K2 had inoperable brakes, broken or absent foot rests, torn/damaged arm rests and/or inadequate seating. The observations were reviewed and confirmed by Employee #18.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on record review, observations and interview, it was determined that facility staff failed to implement a therapeutic dietary modification for an isolated resident with low protein stores and weight loss. Resident #14. The findings include: Facility staff failed to implement a therapeutic dietary modification for Resident #14 as evidenced by a failure to implement double portion entrees. A review of Section I, Disease Diagnosis, of the annual Minimum Data Set (MDS) signed March 29, 2010 revealed Resident #14 ' s diagnoses included diabetes mellitus, hypertension, peripheral vascular disease, aphasia, cerebral vascular accident, hypertension and hypothyroidism. Section G, Physical Functioning and Structural Problems, revealed the Resident #14 had partial loss of voluntary movement and limitation of range of motion of upper and lower extremities on one side and required total assistance for nutritional intake. A review of the resident ' s monthly weight record revealed the resident sustained a weight loss of approximately fifteen (15) pounds over the period of February - April 2010. The adequacy of resident's meal intake was undetermined. A review of the Activity of Daily Living [ADL] sheets for the period of February - April 2010 lacked evidence of the percentage of meal consumption. Through interview with Employee #29, it was determined that variances	F 325	1) Immediate action was taken for the effected resident #14. The dietitian corrected the diet order, portion size, and the tray card ticket for the therapeutic diet for resident # 14. 2) The dietitians have reviewed all diet orders and tray card tickets for accuracy of therapeutic diet orders and orders and orders and portions sizes for all facility residents. 3) The Dietician and the food service director spelled out diet order ticket and are written in full term, prior abbreviations were used. 4) Dietitians will audit ten residents per unit using the diet orders and tray card tickets per unit weekly for 30-days. audit residents diet orders and tray card tickets monthly for 3 months and quarterly. The audit tools will be submitted to quality improvement month meeting.	6/18/10 6/18/10 7/23/10

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F 325	Continued From page 51	F 325		

in meal consumption were to be reported by the CNA [certified nursing assistant] to licensed staff and acted upon accordingly. H/she confirmed that Resident #14 required total feeding assistance and that the record lacked documentation related to the tracking of the percentage of meal consumption.

A review of nutrition progress notes dated March 22, 2010 revealed Resident #14 ' s ideal body weight was 135 pounds +/- 10% and therapeutic diet consisted of no added salt, no concentrated sweets, mechanical soft diet. Laboratory results revealed "slightly low protein stores." A protein supplement, Prosource was implemented twice daily to address the resident's "low protein stores." A subsequent entry dated April 3, 2010 revealed the resident refused to drink the protein supplement and the dietician recommended double portion entrees at lunch and dinner to increase albumin [level 3.2; normal: 3.5-5.0] in the place of the protein supplement.

A carbon copy of the facility ' s Diet Order and Communication form dated April 5, 2010 was observed in the clinical record. The following dietary modification was documented on the form: "add double portion entrees at lunch and dinner."

A review of the dietary slip that accompanied the Resident's lunch tray on April 19, 2010 lacked evidence of a double portion entrée.

Employee # 29 contacted the Dietary Services Division on April 19, 2010 during the lunch service; h/she was informed that Resident #14 ' s current dietary regimen did not include " double portions " [large portions].

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F 325	Continued From page 52 Facility staff failed to implement a therapeutic dietary modification of double portions for Resident #14 who sustained an unplanned weight loss of approximately 15 pounds in 60 days and was assessed with "low protein stores." Additionally, the record lacked evidence of the percentage of the resident's nutritional intake at each meal. The findings were reviewed and confirmed during an interview with Employee #29 on April 19, 2010 at 2:00 PM.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	1) Resident #11 targeted behavior and monitoring record was indicated on resident #11. Resident MI was assessed by nursing for significant symptoms of bleeding and heparium side effects.	6/18/10
			2) All Resident with identified targeted behavior were reviewed. The Director of Nursing and the Behavior Specialist have reviewed all charts of resident receiving psychotic medications to ensure behavior monitoring tracking sheet is in placed. The Director of Nursing has received a list from pharmacy identifying all residents on heparins therapy. All residents an heprin therapy will be assessed by an RN for signs and symptoms and side effects. Any identified symptom will be referred to attending medical doctor for follow up.	6/30/10
			3) The Behavior Specialist will upon Psychosis visit receive a list of residents being seen by the Psychiatrist. Behavior specialist will ensure any behavior monitoring record with targeted behavior is completed and in place.	7/7/10

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F 329	Continued From page 53 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents, it was determined that the facility staff failed to monitor targeted behaviors for one (1) resident receiving psychotropic medications and to monitor one (1) resident for the use of anticoagulant medication. Resident's #11, M2 The findings include: 1.A review of the " Psychiatric evaluation dated 12-26-2010, revealed Resident #11 ' s mental health diagnosis included dementia with depression. The psychotropic medication regimen included Lexapro for depression and Abilify for agitation of depression. The psychiatrist recommended that the resident be monitored for mood, aggressiveness, agitation and poor appetite. The clinical record lacked evidence that facility staff initiated monitoring of the targeted behaviors identified by the psychiatrist. A face-to-face interview was conducted on April 22, 2010 with Employee #7, at approximately 9:30 AM. After review of the clinical record he/she acknowledged that the clinical record lacked evidence of monitoring for targeted behaviors identified by the psychiatrist. The record was reviewed on April 22, 2010. 2. Facility staff failed to monitor resident #M2 while on heparin for right hip fracture.	F 329	All resident with heparin will have weekly notes by unit manager assessing for signs and symptoms of heparin and any abnormal findings reported to the Physicians. The Director of Nursing and Administrator has reviewed policy and procedure, behavior monitoring and heparins monitoring. Staff to be in-serviced on the aforementioned policy and procedure. 4) The behavior specialist had developed an audit tool to assess for compliance with tracking targeted behavior monitoring. Audit will be conducted monthly and all findings will be presented for QI monitoring and follow-up. The Director of Nursing had developed and audit tool to assess for compliance with tracking tool for heparin therapy. Audit will be conducted monthly and all findings will be presented for QI monitoring and follow-up.	7/23/10 on-going

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F 329	Continued From page 54 A review of resident M1 ' s record " Physician Admission Orders and Plan of Care " signed and dated April 4, 2010 by the Physician revealed a medication order that reads " Heparin 5000 units subcutaneously (3) three times a day until patient is able to ambulate independently " . A review of the resident M2' s April 2010 "MAR" [Medication Administration Record] in the clinical record revealed that resident was administered Heparin 5000 units subcutaneously (3) three times a day every day from April 8 through April 25, 2010. The clinical record lacked evidence that facility staff monitored resident #M2 for the use of heparin. A face-to-face interview was conducted with Employee #9 on April 26, 2010 at approximately 9: 45 AM, after reviewing the resident's clinical record he/she acknowledged the above findings. The record was reviewed April 26, 2010.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (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; (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;	F 334	1) Resident # 28, Fy,F5,F6,F7,F8 Findings reviewed with Medical Director. No recommendations was made to administrator was made to Administer flu vaccine due to end of flu season. 2) No further intervention due to end of Flu season.	6/18/10 6/18/10

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F 334	Continued From page 55 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 334	3) All license Nursing staff will be in-serviced to assure compliance with facility policy and procedure. Infection Control nurse will monitor and track all interventions administered and assure compliance with same. Infection Control nurse will assure all immunization records are updated as per policy. The Administrator, Director of Nursing, Infection Control nurse have reviewed facility P&P to assure compliance with established regulations and revised as necessary. 4) Infection Control nurse will assure compliance with flu vaccination documentation by auditing all immunization records on a on-going basics during flu season for compliance. Any negative findings will be reported to QI committee to follow-up and recommendations.	6/30/10 7/23/10

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F 334	Continued From page 56 contraindication or refusal. (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. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview for one (1) of 30 sampled residents and five (5) of 24 supplemental residents, it was determined that the facility staff failed to ensure that the resident's medical record included documentation that residents received the influenza immunization. Residents '# 28, F4, F5, F6, F7 and F8. The findings include: According to the Policy for Infection Prevention " Immunizations: Standing Orders "Original Date: 8/04 stipulated, "...8. Offer the resident/patient the Influenza vaccine, annually, unless there is a documented contraindication. 9. Document all immunizations on the Immunization Record and maintain in the resident/patients medical record. " A review of Resident # 28, F4, F5, F6, F7 and F8 records revealed that the immunization records were not maintained on the medical record. Additionally, there was no evidence in the medical record for Residents #28, F4, F5, F6, F7 and F8 that the Influenza vaccine was offered, received and/or declined.	F 334		

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F 334	Continued From page 57 A face-to-face interview was conducted on April 23, 2010 at approximately 12:10 PM, with Employees # 5, 7, 9, 10 and 11. They acknowledged that Residents ' 28, F4, F5, F6, F7 and F8 medical records had no evidence of the residents being offered, received and/or declined the influenza vaccination. The record was reviewed on April 26, 2010.	F 334		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations that were made during a tour of the dietary services on April 19 and 20, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions: seven (7) of 13 vent covers were improperly secured, one (1) of one (1) prep sink was hanging off the wall, one (1) of three (3) temperature gauge on the warmer and one (1) of one (1) pressure gauge on the dishwasher provided incorrect readings, two (2) of seven (7) staff members were observed serving food with bare hands, nine (9) of 17 damaged cans of food were not segregated, 280 of 280 residents serving trays were badly damaged, 12 of 22 spice	F 371	1) seven hoods filters were placed On order. No other filters are located In kitchen. Cardboard was taken out to hold vent filters up. Engineering secured prep sink. Gage a temperature was put inside the unit. A dishwasher thermometer is being used for the final rinse. Employees was in-serviced on wearing gloves to prevent cross-contamination. All Dented cans was removed from the storage shelf's. All worn serving tray was removed. All Spice container was wiped down. Engineering immediately fixed the air Gap under the larger kettle and Dishwasher. All completes date Identified. 2) Seven hood Filters was placed on Order. Engineering secured prep Sink. All other sinks were inspected And none identified. A work order was placed on the food warmer temperature gage. The pressure gage. The pressure gage on dishwasher was placed on ordered and fixed April 25, 2010. An In-service was done on employees to insure prevention of cross contamination. All dented cans was identified and removed from storage shelf. All serving tray was inspected. 150 trays was removed from service.	5/1/10 5/1/10

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F 371	Continued From page 58 containers were soiled and 18 of 18 muffin trays were soiled with grease deposits, two (2) of two (2) drain pipes extended into the drain, the kitchen floor was soiled, five (5) of nine (9) therapeutic diets orders did not match physician's orders and four (4) of eight (8) ice machines were soiled. The findings include: 1. Seven (7) of 13 vent covers located above the grill and the fryer were held shut by pieces of cardboard to prevent them from falling off. 2. One (1) of one (1) prep sink was loose and detached from the wall. 3. One (1) of three (3) temperature gauge on one (1) of one (1) food warmer was defective and needed to be replaced. 4. One (1) of three (3) pressure gauge from the dishwasher fluctuated continuously and did not register correct pressure. 5. Two (2) of seven (7) staff members were observed handling clean plates, utensils and serving food in an unsanitary manner. 6. Two (2) of three (3) dented cans of yellow peaches, two (2) of four (4) dented cans of sliced apple, three (3) of three (3) dented cans of pineapple juice and two (2) of seven (7) cans of turkey gravy were not separated from undamaged cans of food in the storage area. 7. Approximately 280 of 280 residents serving trays were chipped and worn around the edges.	F 371	All spiced container was wiped down. In-service was given to employees. Engineers fixed the 2 areas of concern on the air gaps all sinks and equipment requiring air gaps was inspected. No other finding were identified. A contract/work order was put in to re-grout dish room floor. Staff was in-service on proper way of mopping and drying floor. The dietitian reviewed all diet orders and tray card tickets for accuracy of therapeutic diet orders and portion sizes. 3) Inspect vent filters daily to insure filters Are put in properly. Check all sinks to Insure they are secure to wall daily Documented food warmer temperature gage are checked daily and documented pressure are check daily and documented. Wearing of gloves in handling plates and food checked daily and documented. Storage room shelves are checked daily fro wear and damage daily and documented spices are used and wiped down after each use daily and documented. All sinks are checked for air gaps daily and documented. Floor are checked after each mopping of floor and grouting of tile daily and documented. The F371 #11 is the same as F325.	5/1/10

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F 371	Continued From page 59 8.12 of 22 spice containers and eighteen 18 of 18 muffin trays were soiled. 9. Two (2) of two (2) drain pipes from the dishwasher and the large kettle provided no air gap from the drain. 10. The kitchen floor, specifically in the dishwashing area was soiled and damaged. 11. Therapeutic diets were inconsistent with physician's orders on five (5) of nine (9) records reviewed. 12. Four (4) of eight (8) ice machines were soiled in nourishment rooms located on 2 south, 4 north, 5 south and 5 north. These observations were made in the presence of employee # 16 who acknowledged these findings.	F 371	4) The food Service Director or his/ Her designee will check hood filters Prep sinks, food warmer temperature Gage, dishwasher pressure gages wearing of gloves, dented cans, serving trays, spice rack when not in use, all air gaps on drains and sinks, mopping of floors, grouting in dish room, and insuring diet orders are followed and entered on tray card tickets correctly. All are checked daily and documented. All findings from F-371 1-11. Will be reported to the quality assurance committee for recommendation and review.	6/18/10
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS 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 administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview for two (2) of 30 sampled residents, it was determined the	F 386	1) Medical Doctor reviewed and revised resident #12 to included tracheotomy in monthly review. Resident #18 Lovenox was D/C on 5/27 2) All residents with tracheotomy were reviewed by Medical Director and Director of Nursing for compliance with Medical Director orders and exclusion on Medical Director Documentation. Director of Nursing along with the Medical Director prepared a list of all residents receiving Lovenox to assess if vascular follow up was completed as recommended and for continued use of Lovenox.	6/18/10 6/30/10

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DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

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F 386	Continued From page 60 physician failed to include tracheostomy care in the total plan of care for one (1) resident and to follow through with a request for a specialty consultation for another. Residents #12 and 18. The findings include: 1. The physician failed to include tracheostomy care in the total plan of care for Resident #12. Resident #12 was admitted to the facility on March 17, 2010. A review of the resident's clinical record revealed the following: The resident had an annual "Health & Physical" assessment of March 19, 2010 that documented that the resident was status post tracheostomy. Resident #12 had an "Admission Minimum Data Set" [MDS] completed on March 26, 2010, that coded the resident at Item P1j, "Special Treatment and Procedures" for tracheostomy care. The resident was observed in bed on April 20, 2010 at approximately 10:00 AM, with the tracheostomy in place. He/she expressed desire to have the tracheostomy discontinued. Resident #12's "Physician's order" form signed and dated by the physician on April 1, 2010 failed to include tracheostomy care. The physician failed to include tracheostomy care in the total plan of care for Resident #12. A face-to-face interview was conducted with	F 386	All appropriate licenses staff will Be re-educated on MDS orders required for care tracheotomy residents. Medical Director will In-service and review with attending Medical Doctor requirements of documentation. Medical Director will review policy procedure for continued Lovenox administration. Medical Director will in-service attending Medical Doctor to same. 7/15/10 4) The Director of Nursing has Developed an audit tool to assess for completeness of Tracheotomy orders and Medical Doctor documentation. All negative findings will be immediate addressed by the Medical Director. All findings will be submitted to the Medical Director for follow-up and recommendation. The Medical Director has developed and audit tool to monitor residents receiving Lovenox. Any negative findings will be corrected by Medical Director and brought to the attention of the residents attending Medical Doctor. QI's will be done weekly X4weeks than monthly and thereafter by recommendation of QI committee. 7/23/10	

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F 386	Continued From page 61 Employee #3 on April 22, 2010 at approximately 4:00 PM, after reviewing the resident's clinical record, he she acknowledged the above findings. He/she obtained a telephone order from the physician for tracheostomy care and suctioning. The record was reviewed April 22, 2010. 2. A review of the clinical record for Resident #18 revealed that the physician failed to follow through with a request for a vascular surgery consultation. According to the history and physical examination dated October 23, 2009, Resident #18 ' s diagnoses included hypertension, dementia, osteoarthritis, status post hip fracture with hemiarthroplasty and hypoalbuminemia. An arterial study (ultrasound) of the right lower extremity dated December 4, 2009 revealed mild to moderate arterial occlusive disease in the right leg. A physician's telephone order dated February 15, 2010 directed the administration of Lovenox [anticoagulant] 0.3 milliliters subcutaneously daily "until seen by vascular surgeon." The clinical record lacked evidence that the physician initiated a consult request for an evaluation by the vascular surgeon. A review of the April 2010 Medication and Treatment Record revealed the resident's medication regimen included Lovenox. The physician failed to follow through on a request for a vascular surgery consultation as stipulated in the medication administration directive.	F 386		

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F 386	Continued From page 62 The findings were reviewed and confirmed during an interview with Employee #6 on April 20, 2010 at 11:30 AM.	F 386		
F 407 SS=E	483.45(b) REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents and 12 of 24 supplemental residents, it was determined that facility failed to provide rehabilitative services by a qualified personnel for Residents #14, 20, F9, F10, F11, F12, F13, F14, F15, F16, F17 and F18. The findings include: A review of facility's personnel records was conducted on April 21, 2010. During the review it was determined that Employee # 26 was employed as the Speech and Language Pathologist for the facility on February 1, 2010. He/she did not have a licensed or was being supervised by a licensed/accredited Speech and Language Pathologist from February 1, 2010 through April 21, 2010 without being supervised. Through record review view it was determined that he/she currently had14 Residents on his/her case load. A face-to-face interview was conducted on April 21, 2010 at approximately 4:54 PM, with	F 407	1) The employee was immediately removed from the building effective 4/22/10 and terminated from employment by the Director of Rehabilitation. All 14 residents that were actively on caseload were immediately removed from Speech and Language services. Residents that were cognitive dysfunction were referred to Occupational Therapy and residents that were seen for dysphagia were downgraded to a safe consistency and monitored closely by nursing staff. Contract was signed with a District of Columbia licensed Speech and Language Pathologist on 4/26/10 and residents suffering from Dysphagia were re-evaluated and placed Speech and Language caseload. 2) Meeting was held by the Director of Rehabilitation with all unit nurse managers informing them that a new Speech and Language Pathologist was in place and any new referrals would be given to the Director of Rehabilitation and then issued to the Speech and Language Pathologist. 3) All licenses are currently checked and verified through The Department of Health for the District of Columbia by the Director of Rehabilitation and Human Resources. This includes applicants and current clinical staff. 4) Copies of current licenses are kept by Human Resources and the Rehabilitation Department and reviewed on a monthly basis for renewal dates. A list of licenses has been established which includes all expiration dates and clinicians are given their expiration date one prior to expiration. Each clinician has been instructed to submit their renewed licenses prior to expiration or removed from building if they are unable to produce their license by the Director of Rehabilitation.	4/28/10 5/1/10 5/1/10 5/7/10

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F 407	Continued From page 63 Employee # 18. He/she acknowledged that Employee #26 was employed as the Speech and Language Pathologist and did not have a current licensed or was being supervised by a licensed/accredited Speech and Language Pathologist from February 1, 2010 through April 21, 2010 without being supervised. The record was reviewed on April 26, 2010.	F 407		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	1) No Immediate action 2) Infection Control policy and procedure regarding but not limited to hand washing was reviewed with staff. 3) Facility policy and procedure for preventing infection was reviewed by the Administrator, Director of Nursing and Infection Control Nurse policy was revised as required. All Nursing staff was re-educated to facility policy and procedure as well as general infection prevention practices. 4 Infection control nurse will conduct weekly staff performance audit for infection control practices to assess for compliance with general acceptable practices. This audit will be reviewed by QI Committee all negative findings will be reported to QI committee as scheduled for recommendation & follow up.	6/30/10 6/30/10 7/23/10

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F 441	Continued From page 64 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 30 sampled residents it was determined that facility staff failed to observe infection control practices after a suprapubic catheter change and to wash hands between providing care for different residents. Resident #4. The findings include: Facility staff failed to observe infection control practices after a suprapubic catheter change. for Resident #4 and between providing care to different residents. . Employee #35 was observed providing suprapubic catheter care to Resident #4's on April 22, 2010 at approximately 11:40AM. The resident was positioned in the geri chair in front of the entry door. At the completion of the catheter care, Employee # 35 took the trash to the dirty utility room. He/She did not wash his/her hands. He/she entered into Resident A1's room, opened the resident's closet and handed the resident a bottle of baby oil from the closet. Employee #35	F 441		

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F 441	Continued From page 65 returned to Resident #4's room without washing his/her hands. Facility staff failed to observe infection control practices after a suprapubic catheter change for Resident #4 and between providing care to different residents. A face-to-face interview was conducted with Employee #35 on April 22, 2010 at approximately 2:00PM. He she acknowledged the findings. He /she said, "I should not have gone into the resident's room and should have washed my hands after dumping the trash."	F 441		
F 456 SS=D	483.70(c) (2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made during the environmental tour of the facility from April 20 to April 26, 2010, it was determined that the facility failed to maintain essential patient care equipment in safe operating condition such as: ten (10) of sixty-four (64) residents call bells were not operating properly, calibration records for three (3) of three (3) wheelchair scales were not available, one (1) of one (1) hot water storage tank was leaking and seven (7) of sixteen (16) generator logs were inconsistent. The findings include: 1. Residents call bells were not operating as	F 456	1) scales were inspected by Director of Engineering for accuracy using a know weight. Capital Boiler was contracted to repaire boiler at and time of finding. A new log was initiated. Director of Engineering was counseled by Administrator on use of white out and maintaining accurate records. 2) All facility call bells were inspected And found operational. Facility has contracted with scale service company to accurately calculate scales on a quarterly basis. Service contract is in place with Capital Boiler company for monthly inspection. New log was implemented all records will be maintained free of whit out. 3) The Director of Engineering has implemented a prevention Maintenance system for Identified areas. All preventive maintenance QI will be on-going. Call bells 10 rooms will be checked per unit per day. Scales will be checked weekly by engineering and Quarterly by scale company.	6/18/10 6/18/10 7/17/10

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F 456	Continued From page 66 intended in ten (10) of sixty-four (64) resident's rooms. 2. There were no preventive maintenance or calibration documentation for three (3) of three (3) wheelchair/step-on scales. 3. The hot water storage tank located in the boiler room has been leaking since February 15, 2010 as noted in the engineering equipment daily log book. 4. The State agency could not determine the authenticity of the generator logs due to the use of " white-out " to erase or correct entries made on seven (7) of 16 logs reviewed. These observations were made in the presence of employee # 13 who acknowledged these findings during the survey.	F 456	Director of Engineering will inspect Boiler as part of daily PM QI, and report any negative findings to Administrator and Capital Boiler immediately. Director of Engineering will present all logs to Administrator/Assistant Administrator For review to assure all records from All white out. All findings to be reported to QI committee for recommendation and follow-up as Scheduled.	7/23/10
F 514 SS=D	483.75(l) (1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	1) Delmarva was contacted with regarding to resident #3 PASRR. Delmarva is in the process reviewing resident #3 records to conclude actual mental retardation and diagnosis. Initial PASRR from 1983 is negative. Resident's # date of birth has been corrected on MDS. Resident #11 behavior monitoring record was updated to reflect identification behaviors. Delmarva was contacted as to procedure required to correct PASRR for any identified discrepancies for resident # 2 and #3. Resident #30 PASRR assessment has been updated to reflect clinical documentation staff responsible to received onsite in-service.	6/18/10

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F 514	Continued From page 67 by: Based on record review and staff interviews for six (4) of 30 sampled residents, it was determined that facility staff failed to accurately document the Preadmission Screening for Mentally Ill Individuals and Individuals with Mental Retardation for two (2) residents; accurately document the name and date of birth in clinical record for 1 (one) resident, failed to document agitated behavior on the " Behavioral Monitoring " Sheet for one (1) resident and document an assessment for pain for one (1) resident. Residents #3, 11, 25 and 30. The findings include: 1. A. Facility staff failed to accurately document the Preadmission Screening for Mentally Ill Individuals and Individuals with Mental Retardation for Resident #3. According to the quarterly Minimum Data set (MDS) completed "March 8, 2010 Section Residential History 5 (five) years prior to entry (AB5e) MR/MI (Mental Illness/Mental Retardation) setting was coded (1)." According to the History and Physical dated March 20, 210 Resident #3 has a working diagnosis as Mental Retardation. Review of the most recent PASRR (Pre-Admission Screen/Resident Review for Mental Illness and/or Mental Retardation) dated November 30, 2009 Part B Mental Retardation recorded the following answers: Question 1 (one) Does the client have a diagnosis of mental retardation or related condition? Was	F 514	2) All residents with MR diagnosis will be reviewed for accuracy of assessment. Any and all discrepancy will be corrected as per Delmarva direction. All residents receiving Psychotropic medication were identified and were reviewed by Behavior Specialist and Director of Nursing/ designee to assure all targeted behaviors were identified. All residents receiving pain medication were identified by the Director of Nursing. Director of Nursing/ designee along with unit managers reviewed. All residents with pain medications orders to assure all medication assessment are accurate. MDS staff will review all MDS for birth dates accuracy. 3) Director of Social Service in-serviced All Social Service staff on PASRR accuracy and how to initiate changes as required. MDS staff has been In-serviced to facility policy and procedure pertaining to required documentation for pain medication. All appropriate nursing staff will be in-service to facility policy and provider related to behavior monitoring and tracking. Administrator and Director of Nursing have reviewed and revised as necessary policy and procedure related to PASRR, behavior monitoring and pain medication.	6/30/10 7/7/10

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F 514	Continued From page 68 marked (no); Question 2 (two) was the client diagnosed with mental retardation or a similar condition prior to age 18? Was marked (no); Question 3 (three) is there any presenting evidence (cognitive or behavior functions) that indicate that the client has mental retardation or a related condition? Was marked (no) Question 4 (four) is the client being referred by and deemed eligible for services by an agency, which serves individuals with mental retardation or a related condition? Was marked (no). Part D. Results of Mental Illness/Mental Retardation screening Question 2 (two) client has a negative screen for mental retardation and no further action is necessary. A face-to-face interview was conducted on April 23, 2010 with Employee #7, 8, 23 at approximately 12:11 PM. After review of the PASRR screen dated November 30, they acknowledged that the screen was documented incorrectly. The clinical record was reviewed on April 23, 2010. B. Review of Resident #3's Annual MDS (Minimum Data Set) completed November 18, 2009 Section AA (3) Identification information revealed the date of birth for Resident #3 was documented as October 25, 1928. A review of the quarterly MDS completed March 8, 2010 revealed the date of birth for Resident #3	F 514	The Director of Social Services has developed a QI tool to monitor resident's PASRR for completeness and accuracy. The Director of Nursing and Behavior Specialist has developed a QI tool to track behavior monitoring record. Director of Nursing and Behavior Specialist or designee will conduct audit weekly X 4 weeks and monthly thereafter. All negative findings will be referred to QI committee for follow up recommendation. The Director of Nursing has developed an audit tool monitor compliance with pain medication documentation. Audit will be conducted weekly by the Director of Nursing and designee X 4 weeks and monthly. All findings will be presented to QI committee for accommodations and follow-up. MDS coordinator/designee will audit accuracy o birth date recorded on MDS at the time of all residents. MDS, all negative findings will be presented to QI committee for follow up and recommendations.	7/23/10

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F 514	Continued From page 69 as October 25, 1928. Review of the "Resident Face Sheet" with a run date of April 5, 2010 identified Resident #3 date of birth as October 25, 1928. Review of the April 2010 Physician's Orders revealed a date of birth for Resident #3 as October 21, 1925. A face-to-face interview was conducted on April 23, 2010 with Employees #7, 8, and 23 at approximately 12:11 PM. After review of the clinical records they acknowledged that Resident #3 has different birth dates. Employee # 23 called the admissions office to verify the resident's date of birth. He/She revealed that the correct date of birth is identified on the Physician's Order sheet as October 21, 1925. The record was reviewed on April 23, 2010. 2. Facility staff failed to document Resident # 11's agitated behavior on the "Behavioral Monitoring "Sheet. Review of the resident's clinical record revealed a code of one [1] indicating Socially Inappropriate/Disruptive Behavioral Symptoms in Section E4 [Behavioral Symptoms] of the quarterly Minimum Data Set [MDS] completed March 19, 2010. Nursing documentation in the progress notes on March 18, 2010 revealed that the resident threw objects at another resident. Review of the Doctor ' s Progress Notes revealed documentation from the psychiatrist dated March 22, 2010 which stated, " Resident seen today following verbal	F 514		

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F 514	Continued From page 70 altercation with another resident on 3/18/10. ... Dx. [Diagnosis] Bipolar with Psychosis." Additional documentation on a "Non-Emergency Referral Form" revealed "Resident observed with agitation 4/4/10, 4/6/10 "as the reason for the referral. On April 7, 2010 the psychiatrist documented "Also agitated on 3/19/10. Threw cup at other resident". A review of the Behavior Monitoring Sheet revealed that the facility staff failed to document the resident's episodes of agitated behavior on April 6. A face-to-face interview was conducted with Employee #6 at approximately 3:00PM on April 22, 2010. He/she reviewed the "Behavior Monitoring Sheet" with the surveyor and acknowledged that the resident's episode of agitated behavior on April 6, 2010 was not documented on the record. The record was reviewed on April 21, 2010. 3. Facility staff failed to ensure that the Pre-Admission Screening and Resident Review (PASRR) form was accurately coded for Resident #25. A review of the clinical record for the resident revealed that the PASRR form was checked indicating that the resident had a negative screening for Mental Retardation [MR]. The form was dated July 31, 2006. Further review of the clinical record revealed that the resident was coded for MR in Section I3 [Other Current or More Detailed Diagnoses] of an	F 514		

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F 514	Continued From page 71 annual Minimum Data Set [MDS] which was dated May 24, 2009. MR was listed as a diagnosis on the Physician's Order Sheets [POS]; and the resident was also care planned for MR. The care plan was last reviewed on April 20, 2010. A face-to-face interview was conducted with Employee #5 on April 23, 2010 at approximately 11:00AM. He/she acknowledged the finding. The record was reviewed on April 23, 2010. 4. Facility staff failed to document an assessment for pain, Resident #30. A. Review of Resident #30's record revealed the following physician 's telephone order dated March 30, 2010 at 2100 (9:00 PM), signed by the physician on April 4, 2010, that directed, "Percocet 5mg/ 325 mg two tablets po (orally) now for pain and Percocet 5 mg/325 mg two tablets po q 6 hours PRN (as needed) for pain." According to the March 2010 and Medication Administration Record (MAR), the resident was administered Percocet two tablets on March 30, 2010 at 10:30 PM. There was no documentation on the back of the March 2010 MAR of the medication type, date "Reason "and "Result "for the above cited Percocet. There was no evidence in the nurses' notes for March 30, 2010 that a pain assessment had been completed prior to or after the administration of the Percocet. There was no evidence in the record that a "Discomfort and Pain Data Collection" form was completed on March 30, 2010, documenting the cause of the resident's pain and the effectiveness of the Percocet. A face-to-face interview was conducted with	F 514		

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	095019	A. BUILDING _____ B. WING _____	04/26/2010

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DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

(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 514	Continued From page 72 Employee #5 April 26, 2010 at 8:20 AM. He/she reviewed the record and acknowledged that a pain assessment was not completed on March 30, 2010. The record was reviewed	F 514		