Post exception 3/7/06

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	02/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted on January 31 through February 2, 2006. The following deficiencies were based on record review observations and interviews with staff and residents. The sample included 15 residents based on a census of 59 residents on the first day of the survey and one (1) supplemental resident.	F 000		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to identify a geri-chair as a restraint for one (1) of 15 sampled residents. Resident #11. The findings include: The resident was observed on January 31, 2006 at 9:30 AM and at 11:45 AM sitting in his/her room in a geri-chair with the lap table secured in front of the resident. A review of the resident's record revealed that the resident was admitted to the facility on November 1, 2005. According to the quarterly Minimum Data Set completed January 27, 2006, the resident was coded with long and short-term	F 221	1. Policy on Restraints was reviewed with the staff for immediate implementation for resident # 11 A corresponding care plan addressing restraints also developed. (attachment A) 2/2/06 2. Inservice informing staff that use of gerichairs with secured table top on residents who are unable to remove the table top is now considered to be a form of restraint and requires implementation of the Restraint Policy SNS.61 . (attachment B) 2/2/06 3. All residents using gerichairs with secured table top and the residents are unable to remove the table top will be monitored if the nursing staff are implementing the Restraint Policy during the care of the resident 2/2/06 4. Monitoring outcomes will be reported to the Performance Improvement monthly 3/1906	

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

Mildred Boyle — CEO — 2/22/06

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

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F 221	Continued From page 1 memory loss and severely impaired skills for cognitive decision-making and for restlessness and mental functioning that varied over the course of the day. The resident was coded as being restless up to five (5) days per week (Section B- Cognitive Function). In Section G4d (Functional Limitations in Range of Motion), the resident was coded with limitations in range of motion of both legs with no voluntary loss of movement. A face-to-face interview with the resident's son was conducted on February 1, 2006 at 2:30 PM. He stated, " [Resident #11] was always in a wheelchair before coming here. The chair with the table top [Resident 11] is in now, doesn't let [him/her] get up and I think it's safer. It's better than a wheelchair, because [Resident #11] could get up from the wheelchair." Resident #11 received physical therapy from November 2 through December 8, 2005. According to the physical therapist's note dated November 15, 2005 at 11:45 AM, " Sit to stand with contact guard assist/minimum assist. Ambulated about 150' x3 (three times) with rolling walker and contact guard assist for guiding walker. Static standing balance with contact guard assist. Patient appears to have increased endurance with gait ... " A face-to-face interview was conducted with the Director of Rehabilitation Services on February 2 , 2006 at 11:30 AM. He/she was asked why Resident #11 was seated in a geri-chair with the table top secured and replied, " I don't know. The geri-chair was not recommended by physical therapy. "	F 221		

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F 221	Continued From page 2 A face-to-face interview was conducted with a Certified Nurse Aide on February 2, 2006 at 11: 25 AM, who had cared for Resident #11 since admission to the facility. He/she stated, "We have always used a geri-chair with the table for his/her safety." A face-to-face interview was conducted with the Resident Care Coordinator on January 31, 2006 at 2:30 PM. The charge nurse was asked why Resident #11 was seated in a geri-chair and not in a wheelchair. The charge nurse replied, " It is for his/her safety." Facility staff failed to identify and assess the resident for the use of a geri-chair with the table top secured as a restraint. The record was reviewed February 2, 2006.	F 221		
F 241 SS=D	483.15(a) DIGNITY 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 observation and staff interview for one (1) supplemental resident, it was determined that a Certified Nurse Aide (CNA) failed to maintain an environment that enhanced Resident A1's dignity as evidenced by failing to verbally communicate and be seated while assisting him/ her with the breakfast meal.	F 241	1. The Resident Care Coordinator spoke to the involved nursing assistant about the standard practice of feeding residents. 2/2/06 2. The standard practice of feeding residents was reviewed with the nursing staff at the unit staff meeting 2/15/06. (attachment C) 2/15/06 3. The RCC/designee will conduct rounds during mealtimes to ensure that the proper protocol for feeding residents is being practiced 2/2/06 4. Monitoring outcomes will be reported to the Performance Improvement Committee meeting monthly 3/9/06	

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F 241	Continued From page 3 The findings include: During the breakfast meal on January 31, 2006 at 8:45 AM, the surveyor observed a CNA assisting Resident A1 to eat breakfast. The CNA stood beside the resident throughout the entire breakfast meal and failed to verbally converse with the resident. A face-to-face interview with the Resident Care Coordinator was conducted on January 31, 2006 at 9:15 AM. The surveyor inquired about the usual process by which residents are assisted to eat. He/she acknowledged that the CNA should have been sitting beside the resident, interacting, and verbally communicating with the resident as he/she assisted the resident to eat. The observation was made on January 31, 2006 between 8:45 AM and 9:30 AM.	F 241		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that maintenance services were not adequate to ensure that the facility was maintained in a safe manner as evidenced by scarred, marred and splintered edges on entrance and bathroom doors. These findings were observed in the presence of the maintenance director.	F 253	F 253 1. Identified marred doors will have a protective material called Kydex installed on them. 2. All entrance doors to rooms and bathroom doors are being covered by a protective material called Kydex. This will keep the doors from being damaged by wheelchairs and beds. 3. Doors will be monitored during safety rounds and doors in need of being covered will be given a work order to complete. 4. Outcomes monitoring of the entrance and bathroom doors will be reported to the Performance Improvement Team.	2/10/06 3/19/06 3/19/06 3/19/06

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F 253	Continued From page 4 The findings include: The frontal and edge surfaces of entrance and bathroom doors were marred and splintered in rooms 312, 331, 332, 340, 343 and 344 in six (6) of 17 observations between 8:30 AM and 4:45 AM on January 31, 2006 and between 10:30 AM and 3:00 PM on February 1, 2006.	F 253		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

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F 278	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review for three (3) of 15 sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS) for one (1) resident with a fall; two (2) residents for behavioral events; and one (1) resident for restorative nursing care. Residents # 3, 4, and 7. The findings include: 1. Facility staff failed to code Resident #3 as having a fall when the resident fell during the assessment period and sustained a fracture. A review of Resident #3's record revealed that the resident fell on August 25, 2005 and sustained a fracture of the right femur. The annual MDS completed January 19, 2006, was blank in Section J4b - "Fell in past 31-180 days." The resident's fall of August 25, 2005 fell within the assessment period. The record was reviewed January 31, 2006. 2. Facility staff failed to code Resident #4 as receiving restorative nursing care and inaccurately coded the resident for behavioral symptoms. A. A review of Resident #4's quarterly MDS completed October 13, 2005 and significant change MDS completed November 7, 2005, coded in Section P3 (Nursing Rehabilitation/ Restorative Care) that the resident did not	F 278 1	1. MDS of resident #3 was corrected to include fall that occurred 8/25/05 (attachment D) 2/16/06 2. MDS of residents who had falls during the last 3 months were reviewed for proper documentation in the MDS 2/16/06 3. Accuracy of coding MDS for falls will be monitored weekly by the IDT during the weekly care plan meeting (MDS will be made available for review at the mtg. 2/23/06 4. Monitoring outcomes will be reported to the Performance Improvement Committee monthly by the RCC/designee 3/19/06 F 278 2A 1. Quarterly MDS of resident #4 completed 10/13/05 & 11/7/05 were corrected to include restorative nursing administered to the resident in section P.(attachment E) 2/16/06 2. MDS of residents receiving restorative nursing were reviewed for accurate coding for restorative nursing received. 2/16/06 3. Accuracy of coding in MDS for restorative nursing will be monitored by the IDT during the care plan meeting weekly. (completed MDS will be made available to the IDT for review during the weekly care plan meeting 2/23/06 4. Monitoring outcomes will be reported to the Performance Improvement Committee monthly 3/19/06	

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F 278	Continued From page 6 receive restorative nursing care. A review of the " Restorative Nursing Log Sheet " revealed that the resident received restorative nursing care for range of motion, communication, transfer and dressing/grooming twice daily from July 6 through December 31, 2005. The MDS was inaccurately coded for Rehabilitation/Restorative care. The record was reviewed January 31, 2006 B. Facility staff failed to accurately code Resident #4 in Section E4 "Behavioral Symptoms - occurring in the last 7 days." The resident was coded for verbal abuse and resisting care on the October 13, 2005 quarterly MDS. On the November 7, 2005 significant change MDS, the resident was coded for verbal abuse, socially inappropriate/disruptive behavioral symptoms and resisting care. The nurses' notes were reviewed from September 1 through November 30, 2005. There were no documented episodes of the behaviors listed above. The resident was being monitored on each shift for the following behaviors: outburst, agitation and restlessness. A review of the October and November 2005 behavior monitoring sheets noted no episodes of the monitored behaviors. Facility staff incorrectly coded the MDS for behavioral symptoms. The record was reviewed January 31, 2006. 3. Facility staff failed to accurately code behavorial symptoms for Resident #7 on the	F 278	2B 1. Quarterly MDS of resident #4 completed 10/13/05 & 11/7/07 were corrected. Section E4 was corrected to code no verbal abusive behavior was exhibited by the resident w/in the past 7 days, since there were no documentation in the nurses progress notes nor in the behavior monitoring flow sheet that the resident had exhibited abusive behavior (attachment E) 2/16/06 2. MDS of residents with documented abusive behavior were reviewed for accuracy in coding of abusive behavior and behavior symptoms 2/16/06 3. Accuracy of coding in MDS for behavioral symptoms will be reviewed by the IDT during the weekly care plan meeting. (completed MDS will be made available to the IDT for review during the meeting) 3/23/06 4. Monitoring outcomes will be reported to the Performance Committee monthly 3/19/06	

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F 278	Continued From page 7 quarterly MDS. A review of Resident #7's quarterly MDS dated January 5, 2006, documented that the resident had no behavioral symptoms that occurred in the last seven (7) or 30 days (Section E). According to a nurse note's dated December 29, 2005 at 8:30 AM, " I saw [Resident] wheel to [Charge Nurse's] office ... [Resident] was angry and stated ... "You are nothing ... "and cursing out [Charge Nurse] ..." Facility staff failed to accurately code Resident # 7 as having behavioral symptoms on the quarterly MDS completed January 5, 2006. The record was reviewed February 1, 2006.	F 278	2B 1. Quarterly MDS of resident #7 dated 1/5/06 was corrected to include verbal abusive behavior in in section E4 as documented in the nurses progress notes to have occurred within the past 7days. (attachment F) 2/16/06 2. MDS of residents with documented abusive behavior were reviewed for accuracy in coding abusive behavior and behavioral symptoms 2/16/06 3. Accuracy in coding MDS for behavioral symptoms will be monitored by the IDT during the care plan meeting weekly. (completed MDS will be made available to the IDT for review during the meeting 2/23/06 4. Monitoring outcomes will be reported to the Performance Committee monthly 3/19/06	
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25; and any services that would otherwise be required under §483.25 but are not provided due	F 279		

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F 279	Continued From page 8 to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483 .10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review for one (1) of 15 sampled residents, facility staff failed to develop a care plan with goals and approaches for one (1) resident receiving oxygen. Resident #2. The findings include: Resident #2 was observed on January 31, 2006 at 10:00 AM and February 1 and 2, 2006 at 11:30 AM on both days, receiving oxygen via nasal cannula at 2 liters/minute. A review of Resident #2's record revealed a physician's telephone order dated January 10, 2006, "O2 @ 2L/NC PRN (Oxygen at 2 liters per nasal cannula as needed)." The care plan did not include goals and approaches for the use of oxygen. A face-to-face interview was conducted with the charge nurse on January 31, 2006 at 3:45 PM. He/she acknowledged that there was no care plan for oxygen and that the care plan could be updated at any time. The record was reviewed January 31, 2006.	F 279	F279 SSD 1. Nursing care plan addressing Oxygen Therapy was developed on resident #2 (attachment) ☞ 2. Medical records of residents receiving Oxygen Therapy were reviewed for the presence of a care plan addressing oxygen therapy. Care plans were updated as needed 3. When residents are started on Oxygen therapy a care plan will be developed by Respiratory Therapy. 4. Records of residents receiving Oxygen therapy will be reviewed during weekly care plan meetings. Review outcomes will be reported to the Performance Improvement committee monthly	02/22/06 02/22/06 02/22/06 02/22/06
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS	F 280		

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SPECIALTY HOSPITAL OF WASHINGTON - HADLEY SNF	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 280	Continued From page 9	F 280		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review for two (2) of 15 sampled residents, facility staff failed to update care plans for one (1) resident with multiple pressure sores and one (1) resident with two (2) falls. Residents #2 and 7.

The findings include:

1. Facility staff failed to update Resident #2's care plan for multiple pressure sores.

The resident was observed on January 31, 2006 at 11:20 AM during a wound treatment with one (1) pressure sore on the right heel, one (1) pressure sore on the back of the right leg and one (1) pressure sore (necrotic area) on the left heel.

A review of Resident #2's care plan included problem #3, "Potential for skin breakdown related to limited mobility and incontinence." The care plan was evaluated and updated on December 29, 2005 and included, " Healed for now - repositioning done."

The quarterly Minimum Data Set completed January 19, 2006, was coded in Section M1c (Ulcers due to any cause) and M2a (Types of Ulcers) that the resident had three (3) Stage III pressure sores.

A face-to-face interview was conducted with the charge nurse on January 31, 2006 at 3:45 PM. He/she acknowledged that there was no update for the pressure sore care plan and that the care plan could be updated at any time. The record

Revised 3/3/06 LJ

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

PRINTED: 02/14/20
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F 280	Continued From page 10 heel. A review of Resident #2's care plan included problem #3, "Potential for skin breakdown related to limited mobility and incontinence." The care plan was evaluated and updated on December 29, 2005 and included, " Healed for now - repositioning done." The quarterly Minimum Data Set completed January 19, 2006, was coded in Section M1c (Ulcers due to any cause) and M2a (Types of Ulcers) that the resident had three (3) Stage III pressure sores. A face-to-face interview was conducted with the charge nurse on January 31, 2006 at 3:45 PM. He/she acknowledged that there was no update for the pressure sore care plan and that the care plan could be updated at any time. The record was reviewed January 31, 2006. There was no evidence that the care plan was updated to include goals and approaches for the three (3) Stage III pressure sores identified on January 10, 2006. The record was reviewed January 31, 2006. 2. Facility staff failed to update and initiate goals and approaches for Resident #7 who had two (2) falls without injury. A review of Resident #7's record revealed that the resident fell on December 25, 2005 and January 9, 2006. A review of the care plan, last updated on January 5, 2006 included problem #5, " Potential	F 280	1. Nursing Care Plan was updated for resident # 2 to include multiple pressures. (attachment previously submitted) Physician notified. Orders carried out. 2/2/06 2. Medical records of residents with multiple pressure ulcers were reviewed to include multiple pressure ulcers in their care plan. 2/2/06 3. Residents admitted with multiple pressure ulcers will have a nursing care plan developed within 7 days of admission to the facility addressing multiple pressure ulcers. When a resident developed multiple pressure ulcers while in the facility a care plan will be developed within 7 days from the assessment that multiple pressure ulcers have developed 3/19/06 4. Monitoring and evaluation of resident's care plan addressing multiple pressure ulcers will be conducted monthly and monitorinbg outcomes will be reported to the Performance committee. 3/19/06	

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F 280	Continued From page 10 heel. A review of Resident #2's care plan included problem #3, "Potential for skin breakdown related to limited mobility and incontinence." The care plan was evaluated and updated on December 29, 2005 and included, " Healed for now - repositioning done." The quarterly Minimum Data Set completed January 19, 2006, was coded in Section M1c (Ulcers due to any cause) and M2a (Types of Ulcers) that the resident had three (3) Stage III pressure sores. A face-to-face interview was conducted with the charge nurse on January 31, 2006 at 3:45 PM. He/she acknowledged that there was no update for the pressure sore care plan and that the care plan could be updated at any time. The record was reviewed January 31, 2006. There was no evidence that the care plan was updated to include goals and approaches for the three (3) Stage III pressure sores identified on January 10, 2006. The record was reviewed January 31, 2006. 2. Facility staff failed to update and initiate goals and approaches for Resident #7 who had two (2) falls without injury. A review of Resident #7's record revealed that the resident fell on December 25, 2005 and January 9, 2006. A review of the care plan, last updated on January 5, 2006 included problem #5, " Potential	F 280	F 280 2 1. Nursing Care Plan was updated for Resident # 7 to include approaches to be implemented subsequent to the 2 falls, 12/05 & 1/06 (attachment H) 2/2/06 2. Medical records of residents with multiple falls were reviewed and updated to include addditional goals and approaches after each fall reoccurring. 2/2/06 3. Nursing Care Plan will be updated after each resident's fall. Care plan will include additional goals and approaches after each fall reoccurring. 3/19/06 4. Monitoring for compliance will be conducted monthly. Outcomes will be reported to the Performance Improvement Committee monthly 3/19/06	

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F 280	Continued From page 11 for falls/injuries secondary to weakness and unsteady gait." There was no evidence that the facility initiated additional approaches to prevent the resident from further falls. A face-to-face interview was conducted with the charge nurse on January 31, 2006 at 3:45 PM. He/she acknowledged that there was no update for the falls care plan and that the care plan could be updated at any time. The record was reviewed January 31, 2006.	F 280		
F 284 SS=D	483.20(l)(3) DISCHARGE SUMMARY When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on the record review for one (1) of two (2) closed records, it was determined that facility staff failed to include Resident #15 and his/her family in the development of a post discharge plan of care. The findings include: Resident #15 was discharged to the community (home) accompanied by his/her son on June 21, 2006. Diagnoses included Cerebrovascular Accident (CVA) Left Hemiplegia, Gastrostomy Tube (G-tube), Diabetes Mellitus, Hypertension, and Dementia.	F 284	F 284 1. Social Work will send post discharge plan of care form certified mail to responsible party. 2. Any resident that is slated for discharge planning will participate in the discharge planning process which will include his/her responsible party and the IDT team. At the time of discharge, resident or responsible party will sign the post discharge plan of care or will be sent certified mail with self addressed postage paid envelope. 3. Discharge plan of care will be re-viewed in the discharge planning meeting which will include social worker, IDT team, as well as resident and responsible party to ensure a safe and proper discharge. Signature of responsible party will be obtained on post discharge plan of care or will be sent certified mail with a self addressed postage paid envelope. 4. Discharged charts will be moni-tored and reported in Performance Improvement meeting to ensure compliance.	3/19/06 3/19/06 3/19/06 3/19/06.

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F 284	Continued From page 12 Physician's orders signed and dated June 2, 2005, included, "Insulin Human N (NPH) 8 Units subcutaneously every morning for IDDM (Insulin Dependent Diabetes Mellitus), Insulin Human R (Regular) 3 Units subcutaneously for BS (Blood Sugar) greater than 250." On June 15, a physician's order indicated, " Enteral Feeding via G-Tube 6:00 AM - 12:00 AM 65 ml/hour via pump, water 30 mls before and after medication, water bolus 250mls via G-Tube three (3) time a day, Check residual and patency every day for placement every shift and elevate head of bed 30 degrees." The "Post-Discharge Plan of Care" dated June 15, 2005 did not indicate that the resident's son was instructed in the administration of insulin injections and G-Tube feeding. At the section of the "Discharge- Plan of Care" for medications, it was documented to "See Nurse note with list of medications." The nurse's discharge note listed approximately 14 medications without the reason for the medicine and there was no documentation to indicate that the medications were discussed with the resident's son. The " Post-Discharge Plan of Care" was not signed by the resident's son to indicate that the discharge instructions were reviewed and understood. A care plan meeting was held on June 8, 2005. However, the care plan progress note did not indicate that the resident's son received instructions and demonstrations for the administration of insulin and G-Tube feeding with the staffs' observation of a return demonstration.	F 284		

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F 284	Continued From page 13 A face-to-face interview was conducted with the nurse manager on February 2, 2006 at approximately 9:20 AM and he/she indicated that the resident's medical and physical status was discussed in the care plan meeting, however, the resident's son did not have a demonstration for the insulin and tube feeding prior to the resident's discharge. The record was reviewed on February 2, 2006.	F 284		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, for two (2) of 15 sampled residents, it was determined that facility staff failed to: follow-up on a physician's order for gait training for one (1) resident upon readmission to the facility after a fall and subsequent fracture and hold one (1) resident's blood pressure medications according to the physician's orders. Residents #3 and 6. The findings include: 1. Rehabilitative Services failed to follow-up on a physician's order for gait training for Resident #3 after his/her return from the hospital for a fall and subsequent fracture. The resident was walking	F 309		

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F 309	Continued From page 14 using a walker with assistance prior to the fall with fracture. The resident has not walked since his/her return from the hospital (September 3, 2005). A review of Resident #3's record revealed that he /she fell and sustained a fracture of the right distal femur and was hospitalized from August 26 , 2005 to September 3, 2005. Resident #3 was ambulating during physical therapy with an assistive device (walker) prior to the right femoral fracture. Following his/her return from the hospital for treatment of the fracture, he/she has not been assessed for the ability to walk. According to a nurse's note dated August 25, 2005 at 11:00 PM, "Writer called to resident's room where I observed resident on the floor near the door lying face down ... " . According to the X-ray report of August 26, 2005, " Impression: fractures of the distal right femur extending from the mid and distal third of the lateral femoral condyle " . Resident was admitted to the hospital on August 26, 2005 for further assessment and treatment. Resident #3 was readmitted to the facility on September 3, 2005. Physician readmission orders dated September 3, 2005 included " Physical Therapy order gait training for Monday, Wednesday & Friday 9/3/05." A review of the Physical Therapy (PT) note dated July 1, 2005 revealed that the resident received physical therapy prior to the fall. A PT note dated July 28, 2005 documented, " ... amb.(ambulating) with standard walker with minimal assist at 30 ft x 2 (times two) ... " There was no evidence in	F 309	F 309 #1 1. Reassessment for rehab services was performed by the Clinical Supervisor of the Rehab Dept. on Resident #3. 2/2/06 2. A review of all residents readmitted during the last quarter 2005 thru January 2006, will be performed and reassessments will be done as indicated. (see attached form) 2/20/06 3. The Admitting Coordinator will notify the Clinical Supervisor of the Rehab Dept. via e-mail of all residents returning to the facility. 2/10/06 A request form for screening of new admits, readmits and change of status will be submitted to the Rehab. Dept. by the SNF nursing staff. (see attached form) 4. Records of residents readmitted to the facility will be reviewed for compliance with the reassessment protocol. Review outcomes will be reported to the Performance Improvement committee monthly. 3/19/06	

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F 309	Continued From page 15 the record that Resident #3 was assessed by PT following readmission to the facility on September 3, 2005. According to the facility's policy, "Rehabilitative Screening," policy number PT 05-018, page 1 of 1 " Residents in the SNF (Skilled Nursing Facility) will be screened by Rehabilitative Services department within 5 days of admission ... Reassessment will be done annually and when a change in status is reported by nursing or physician." A face-to-face interview was conducted with the Director of Rehabilitation Services on February 1 , 2006 at 2:30 PM. He/she stated that he/she was aware that Resident #3 was admitted to the hospital. However, he/she was not aware that the resident was readmitted to the facility. The director acknowledged that the resident had not been seen in the rehabilitation department for the last several months. A face-to-face interview with the Resident Care Coordinator was conducted on February 1, 2006 at 1:00 PM. The surveyor inquired about the process by which PT is notified of evaluation orders. He/She stated " PT is notified by telephone, but no telephone log is kept in reference to these calls." According to the Minimum Data Set, dated January 19, 2006, Resident #3 had no long or short term memory problems and was independent of cognitive daily decision making skills (Section-B). A face-to-face interview with Resident #3 was	F 309		

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F 309	Continued From page 16 conducted on February 1, 2006 at 11:30 AM. The resident stated that he/she remembered the fall but does not remember the exact date. The resident also stated that he/she was walking with a walker prior to the fall. He/she added that when he/she returned from the hospital he/she had not walked with his/her walker again. After the surveyor identified the lack of a physical therapy assessment, the Director of Rehabilitation Services assessed Resident #3 on February 2, 2006 at 11:00 AM. Physical therapy, Occupational therapy and Speech language pathology evaluations were recommended with the impression of "potential for rehab - fair." The record was reviewed January 31, 2006. 2. Facility staff failed to follow physician's orders to hold Resident #6's blood pressure medication when the systolic pressure was 120 or below. A review of Resident #6's record revealed a physician's order with an origination date of July 1, 2003 which read: "Hold blood pressure medications if patient's systolic blood pressure is 120 or less." The following medications were indicated for Hypertension on the physician's orders: Lasix 40 mg via G-tube every day; Lisinopril 2.5 mg via G-tube every day; and Nitrek 0.2 mg/1 HR Patch to skin every day on at 6 AM off at 6 PM. A review of the MARs (Medication Administration Records) revealed the following medications were given when the systolic blood pressure was 120 or below:	F 309		
F 309	2	1. Occurrence reports were completed on the discovered errors. Involved licensed staff were counselled by the Resident Care Coordinator. Attending Physician was notified of the error. Parameter to hold antihypertensive meds were changed to 110 systolic pressure. (attachment I) 2/15/06 2. Medication Administration Records of all residents receiving antihypertensive medications with orders of parameters when to hold meds were reviewed for compliance. Outcomes were reviewed with involved staff. 2/15/06 3. Policy on Medication Administration was reviewed with Nursing Staff at the unit staff meeting 2/15/06. (attachment J) 2/15/06 4. Monitoring outcomes will be reported to the Performance Improvement Committee monthly 3/19/06	

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F 309	Continued From page 17 Lasix - November 9, 11 and 12, 2005; December 11, 23, 24, 25 and 26, 2005; and January 3, 5, 7, 8, 15 and 24, 2006 Lisinopril - November 7, 9, 11 and 12, 2005; December 1, 23, 24 and 26, 2005; and January 3 , 5, 7, 8, 15 and 24, 2006. Nitrek patch - November 4 and 5, 2005; and January 1, 10, 21, 23 and 24, 2006. Facility staff failed to hold blood pressure medication as per the physician's order. The record was reviewed on February 1, 2006.	F 309		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review for one (1) of 15 sampled residents, licensed staff failed to assess and treat a necrotic area on Resident #2's left heel. The findings include: A review of Resident #2's record revealed that the quarterly MDS completed January 19, 2006	F 314		

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F 314	Continued From page 18 was coded in Section M with three (3) Stage III pressure sores. The resident was observed on January 31, 2006 at 11:20 AM during a wound treatment with one (1) pressure sore on the right heel, one (1) pressure sore on the back of the right leg and one (1) pressure sore (necrotic area) on the left heel. The nurse completed treatments to the wounds on the right leg. There was no treatment for the left heel. When queried about the care of the necrotic area on the left heel, the nurse stated that the resident had no treatment for it. A review of the resident's record revealed physician's orders dated January 10, 2006 for the treatment of the two (2) right leg wounds. There were no orders for the treatment of the left heel. A review of the skin monitoring sheets revealed both right leg wounds had been assessed weekly from January 10 through February 2, 2006. There was no assessment for the necrotic area on the left heel. A nurse's note dated January 10, 2006 at 11:30 PM documented, " ...Stage II pressure ulcer on right outer leg. No drainage 9 cm x 2 cm. Right heel hard and necrotic 5 cm x 4 cm ... " There was no evidence in the record that the left heel necrotic area had been assessed. The Director of Nursing (DON) accompanied the surveyor to the resident's room on January 31, 2006 at 11:30 AM. He/she observed the left heel necrotic area and acknowledged that the area should have been assessed and treated. The record was reviewed January 31, 2006.	F 314	1. The necrotic ulcer on resident #2's left heel was assessed. Physican was notified and prescribed treatment was followed. (attachment K) 1/31/06 2. Daily Skin Assessment Protocol was reviewed with the nursing staff at the unit staff meeting on 2/15/06 (attachment B) A copy of the Braden Scale tool was given to each nursing staff to review as resource material and assist staff in identifying stage 1's 2/2/06 2/15/06 3. Team Leaders were instructed to include the outcomes of daily skin assessments in their shift report to the incoming shift. This is to be implemented in all shifts effective 2/15/06 2/15/06 4. Pressure Ulcers developed in the facility will be included in the monthly report to the Performance Improvement Committee 3/19/06	

Revised 3/3/06 JS

MENT OF HEALTH AND HUMAN SERVICES
IS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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Continued From page 19 483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a residen with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to apply Resident #6's ankle splints for over five (5) months. The findings include: The readmission orders dated November 30, 2005 [origination date of September 1, 2005] included the following order: "Ankle contracture splints". The physician signed an order for the purchase of two (2) ankle contracture splints from a medical supply company on August 10, 2005. The physical therapist evaluated the resident and documented the following on the "Plan Of Treatment For Outpatient Rehabilitation" form on August 10, 2005: "...Is total dependant with ankle contractures and susceptible to heel ulcers. Patient requires total assistance ... Provide caregiver education. Order written for wearing schedule for multipodis boots."	F 318	1. Nursing staff on the unit were counselled for failure to apply the ankle splints for resident # 6. The schedule for the application of the splints were reviewed with the staff. The ankle splints were applied as of 2/2/06. The attending physician was notified that the ankle splints were not consistently applied. 2/02/06 2. All residents with order for ankle splints and other adaptive devices were reviewed for nursing staff compliance to the order. 2/2/06 3. The schedule was reviewed with Rehabilitative Services staff for a revision of the time schedule and allow time for the resident sleep time during the night. The attending physician was notified of the revised schedule and he gave the order to implement it and was implemented by the nursing staff. (attachment L) 2/3/06 4. Daily rounds by RCC /designee to ensure compliance to the schedule of application of splints and other adaptive devices will be conducted and outcomes reported to the Performance Improvement Committee monthly 2/15/06	

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F 318	Continued From page 20 The form "Medical Rehabilitation Goal" was in the record, dated August 10, 2005 and included the following written by the physical therapist: "...Short Range Goal: Multipodis Boot splints (wearing schedule) ... 12 PM - 4 PM - On; 4 PM - 8 PM - Off; 8 PM - 12 AM - On; 12 AM - 4 PM - Off; 4 AM - 8 AM - On; and 8 AM - 12 PM - Off." A physical therapy progress note dated August 10, 2005 read as follows: "Nursing staff education on multipodis boot ... Discontinue skilled PT (physical therapy)." The resident was observed in his/her room on February 1, 2006 at 12:20 PM. He/She did not have ankle splints on. A face-to-face interview was conducted with the RCC (Resident Care Coordinator) on February 1, 2006 at 2:35 PM and acknowledged that the resident never had ankle splints applied. He/She stated, "The physical therapist recommended many things for residents. I don't remember [resident] having splints." The RCC checked the resident's closet and stated, "They are in his/her closet." The facility staff failed to apply the ankle splints as ordered. The record was reviewed on February 1, 2006.	F 318		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible.	F 323	F 323 1. A new water temperature log book has been created. Sample of log attached. 2/20/06 2. Water temperatures to be monitored a minimum of 3 times a week with rooms being randomly selected. No less than 3 rooms per floor will be checked. 2/20/06 3. Water temperatures will be taken at the faucets in residents' rooms and day rooms with a thermometer and then recorded in the log book. All 2/20/06	

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F 323	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on an observation during the survey period, it was determined that documentation was not available to ensure that hot water temperatures were monitored on a regular basis. This finding was observed in the presence of the maintenance director. The findings include: Documentation was not available to show that maintenance staff conducted random hot water temperature monitoring on a consistent basis, to ensure that hot water temperatures were below 110 degrees Fahrenheit (F) in residents' rooms and common areas between June 30, 2005 and December 31, 2005. This was observed on February 2, 2006.	F 323	temperatures will be monitored according to the regulations 4. Results of monitoring will be reported at the Performance Improvement meetings on a quarterly basis.	3/19/06
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that food was served in a safe and sanitary manner as evidenced by: oil drippings from a gasket over the potato mixer; soiled dessert bowls; expired cartons of milk; and cutting boards that were not thoroughly cleaned after washing. These findings were observed in	F 371		

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F 371	Continued From page 22 the presence of the food service supervisor and director. The findings include: 1. Oil was observed dripping from a gasket over the bowl of the potato mixer in one (1) of one (1) observation at approximately 8:40 AM on January 31, 2006. 2. Dessert bowls with visible leftover food were stored on top of the counter and were ready for reuse by staff during the lunch meal at approximately 12:10 PM on January 31, 2006 in 17 of 17 observations. 3. Cartons of milk were observed stored in the walk in refrigerator with expired dates: super milk dated January 26, 27 and 30, 2006 in seven of (7) of 20 cartons; skim milk dated January 30, 2006 in two (2) of 20 cartons; and regular milk dated January 26 and 27, 2006 in two (2) of 10 cartons between 8:35 AM and 8:45 AM on January 31, 2006. 4. Cutting boards stored on a rack and ready for reuse were not thoroughly cleaned after washing as evidenced by food and dark stains on board surfaces in two (2) of seven (7) observations at 2 :30 PM on February 1, 2006.	F 371	#1 1. Identified the oil dripping gasket over the mixer bowl has been tightened to stop dripping. 1/31/06 2. Before and after each use of the mixer bowl the gasket is checked for drips and wiped if needed. 1/31/06 3. Monitor and Spot checks conducted by the Director and production manager of dietary daily. 1/31/06 4. Outcomes will be reported to Performance improvement committee. 3/19/06 #2 1 Identified all bowls and rewashed to remove residual food particles. 1/31/06 2. Bowls will be included in the washing procedures. Dietary staff retrained on proper washing dishes. 2/6/06 3. Spot check will be completed by the Director and Supervisor of Dietary. 1/31/06 4. Outcome will be reported to performance improvement committee. 3/19/06 #3 1. Identified expired milk was immediately thrown away. 1/31/06 2. Checking and Rotation procedures reinforced when stocking the milk supply. 1/31/06 3. Daily spot checks will be conducted by the production manager and Supervisor of Dietary. 1/31/06 4. Outcomes will be reported to performance improvement committee. 3/19/06	
F 385 SS=D	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.	F 385	#4 1. Identified the dirty cutting boards and cleaned immediately. 2/1/06 2. Ordered and replaced the cutting boards with the dark stains. 2/6/06 3. Cutting boards will be washed and sanitized after every use. 2/1/06 4. Outcomes will be reported to PI. 3/19/06	

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

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F 385	Continued From page 23 The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review for two (2) of 15 sampled residents, the physician failed to: complete an annual history and physical examination for one (1) resident, and include a sacral pressure sore on the history and physical for one (1) resident. Residents # 8 and 10. The findings include: 1. A review of Resident #8's record revealed that the physician failed to complete an annual history and physical examination. A review of Resident #8's record revealed the last history and physical examination was completed on December 12, 2004. A face-to-face interview with the Resident Care Coordinator was conducted in January 31, 2006 at 3:30 PM. After reviewing the record, he/she acknowledged that there was no recent history and physical examination in the record. The record was reviewed February 1, 2006. 2. The physician failed to include the presence of a Stage 4 sacral ulcer on the History and Physical (H&P) for Resident #10.	F 385	F385 #1 1. History and Physical of resident #8 was completed on February 24th, 2006. (attachment) 2. Medical Records on both nursing units were reviewed if History and Physical were completed according to the regulation. Non-compliant physicians will be addressed to complete the H and P. 3. Review of medical records for timeliness of History and Physical will be completed by Medical Records monthly. 4. Reviewed outcomes will be reported to the Performance Improvement committee monthly.	3/24/06 3/1/06 3/1/06 3/19/06

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F 385	Continued From page 24 The following nurses' note was dated January 10 , 2006 at 2:00 PM: "Admitted ... has sacral ulcer Stage IV, also ulcers on both heels ..." The admission orders dated January 10, 2006 revealed the following order: " Sacral wound cleanse with Microklenz. Apply ¼ inch of Silvadene to wound surface. Pack wound with fluffed Mesalt and cover with abdominal pads QD (daily). " A review of the record for Resident #10 revealed a history and physical signed and dated by the physician on January 12, 2006. On physical examination, the physician documented the presence of bilateral heel ulcers [no indication of a sacral ulcer]. The history and physical lacked evidence of the Stage 4 sacral ulcer. The record was reviewed on February 2, 2006.	F 385	2 1. History and Physical 3/3/06 for resident # 10 include both sacral ulcers and bilateral heel ulcers. attachment previously submitted. 2. Medical records of residents admitted with pressure ulcers were reviewed to ensure that multiple pressure ulcers sites were included in the history and physical exam reports 3. Residents admitted with pressure ulcers on admission will be reviewed to ensure that the pressure ulcer sites will all be included in the history and physical exam reports. Deficiencies will be reported to the Medical Director and SNF Administrator 4. Compiled monthly review outcome reports will be reported to the Performance Improvement Committee monthly.	3/3/20 3/3/20 3/19/20 3/16/20
F 386 SS=D	483.40(b) PHYSICIAN VISITS 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:	F 386		

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F 386	Continued From page 25 Based on record review, observation and staff interview for three (3) of 15 sampled residents, it was determined that the attending physician failed to: sign and date re-admission orders and identify a necrotic area to the left heel for one (1) resident; follow up and re-evaluate the resident's use of ankle splints and sign and date orders during resident visits for one (1) resident; and review the total plan of care for one (1) resident. Residents #2, 6 and 14. The findings include: 1. The physician failed to sign re-admission orders and identify a necrotic area to the left heel during his/her visits with Resident #2. A. The physician failed to sign re-admission orders during his/her visits with Resident #2. Re-admission telephone orders were dated by the nurse as January 10, 2006. At the time of this review (21 days later), there was no physician signature. There were progress notes written by the physician dated January 11 and January 16, 2006. The physician failed to sign the re-admission orders during his/her visits with the resident. B. The physician failed to identify a necrotic area to the left heel during his/her visits with Resident #2. A review of Resident #2's record revealed that the quarterly MDS completed January 19, 2006	F 386	F386 #1A, B 1. The Attending Physician of Resident #2 has been informed of the deficiencies and received a copy of the Medical Staff Attending Physician policy outlining the time frame for signing re-admission orders and resident assessment. 2. All residents' orders and progress notes will be reviewed by Nursing and Medical Records for compliance to the policy and accuracy of the resident's condition. 3. Medical Records will document any non-compliant physicians and outline the needed signatures on each resident's chart. Medical Records will also send a copy of the summary report to the Medical Director for follow-up.	3/19/06 3/19/06 3/19/06

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F 386	Continued From page 26 was coded in Section M with three (3) Stage III pressure sores. The resident was observed on January 31, 2006 at 11:20 AM during a wound treatment with one (1) pressure sore on the right heel, one (1) pressure sore on the back of the right leg and one (1) pressure sore (necrotic area) on the left heel. A review of the resident's record revealed physician's orders dated January 10, 2006 for the treatment of the two (2) right leg wounds. There were no orders for the treatment of the left heel. There were progress notes written by the physician dated January 11 and January 16, 2006. The progress notes lacked evidence of a necrotic area to the left heel. The record was reviewed January 31, 2006. 2. The attending physician failed to re-evaluate Resident #6 for the use of ankle splints and sign and date orders during resident visits. A. The attending physician failed to re-evaluate the resident for the use of ankle splints. The physician signed an order for the purchase of two (2) ankle contracture splints from a medical supply company on August 10, 2005. The readmission orders dated November 30, 2005 [origination date of September 1, 2005] included the following order: " Ankle contracture splints " . A face-to-face interview was conducted with the	F 386	Non-compliant physicians will be reported to the Administrator. 4. Outcomes will be reported to the Performance Improvement Committee. F386 #2A, B 1. The Attending Physician of Resident #6 has been informed of the deficiency and received a copy of the Medical Staff Attending Physician outlining the assessment of residents, timeframe for signing and dating orders and monthly progress notes. 2. All residents' medical records will be reviewed by Nursing and Medical Records for accuracy and physician signature and date of orders.	3/19/06 3/19/06 3/19/06

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F 386	Continued From page 27 RCC (Resident Care Coordinator) on February 1, 2006 at 2:35 PM and acknowledged that the resident never had ankle splints applied. He/She stated, " The physical therapist recommended many things for residents. I don't remember [resident] having splints." The RCC checked the resident's closet and stated," They are in his/her closet." The physician visited the resident monthly after the order for the ankle splints was written. The monthly progress notes failed to include documentation regarding the ankle splints. B. The attending physician failed to sign and date orders during visits with the resident. A review of Resident #6's record revealed the following telephone orders: November 25, 2005, "Transfer resident to Emergency room to have GT reinserted" and November 30, 2005, readmission orders. These orders were not signed by the attending physician. There were progress notes written by the attending physician dated December 28, 2005 and January 18, 2006. The physician failed to sign the readmission orders during his/her visits with the resident. The record was reviewed on February 1, 2006. 3. The physician failed to review Resident #14's total plan of care at the time death. During the review of the clinical record for Resident #14, it was noted on December 24, 2005 at 2:50 PM that the resident was found	F 386	3. Nursing and/or Medical Records will inform and document any non-compliant physicians. Medical Records will also send a copy of the summary report to the Medical Director for follow-up. Non-compliant physicians will be reported to the Administrator. 4. Outcomes will be reported to the Performance Improvement Team. F386 #3 1. The Attending Physician of Resident #14 was notified of the deficiency and a copy of the report was placed in the Medical Staff file. 2. In the event, a resident is found unresponsive, the attending physicians will be notified of the DNR status of the	3/19/06 3/19/06 3/19/06 3/19/06

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F 386	Continued From page 28 unresponsive. According to a nurse's note dated December 24, 2005 at 4:30 PM, "Resident was full code and there was no prior order for DNR (Do Not Resuscitate)." The physician's progress note dated December 24, 2005 at 4:30 PM indicated, "I was called to see patient who was found unresponsive. The paramedics have been called in and they had pronounced her dead. No ACLS (Advanced Cardiac Life Support) was initiated because Pt. (patient was a DNR..." The review of facility's "Advance Directive Information Sheet" indicated: "1. Is this resident competent to make decisions regarding his/her care"; "No" was coded. "2. If this resident is competent, has an advance directive been executed"; "DNR" was coded "No ". The form was signed and dated by the social worker on August 18, 2005. There was no DNR order observed on the physician's plan of care that was signed and dated by the physician on December 24, 2005. On February 1, 2006 at approximately 1:00 PM a face-to-face interview was conducted with the Director of Nurses who acknowledged that the resident was not a DNR. She/he indicated, " The resident did not have a DNR order." The physician failed to review the resident's total plan of care at the time of death. The record was reviewed on February 1, 2006.	F 386	resident. 3. The nurse will document in the Medical Record the relay of information to the Attending Physician. 4. Outcomes will be reported to Performance Improvement.	3/19/06 3/19/06
F 456 SS=E	483.70(c)(2) SPACE AND EQUIPMENT	F 456		

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F 456	Continued From page 29 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 during the survey, it was determined that documentation of the pressures and temperatures of domestic water booster pumps, chilled and hot water temperatures for the air handler units and exhaust fans were not in log books to show that equipment was serviced, monitored and operating in a safe manner. These findings was observed in the presence of the maintenance director. The findings include: 1. Temperatures and pressures of domestic booster water pumps were not entered in log books on a regular basis in the east boiler rooms between May 25 through May 31, 2005, July 1 through July 7, 2005, July 29 through July 31, 2005 and August 1 through 14, 2005, In five (5) of 12 observations on February 2, 2006 at approximately 1:00 PM. 2. Chilled and hot water temperatures from air handler units were not entered in log books on a regular basis from the east and west penthouses between May 10 through May 16, 2005, July 1 through July 7, 2005, August 1 through August 14, 2005 and October 28 through October 30, 2005 in four (4) of 12 observations at 1:20 PM on February 2, 2006. 3. Supply air and temperatures of exhaust fans	F 456	F 456 #1, 2, and 3 1. Temperatures and pressure of domestic water pumps, chilled and hot water temperatures from air handlers and supply air and temperatures of exhaust fans will be constantly monitored and documented in logs to be done in order to ensure their completeness. 2/20/06 2. All temperatures will be monitored on a regular basis. Personnel reprimands (according to policy) will be taken when employees fail to or falsify the information in the log books. 2/20/06 3. A user friendly log book will be developed to make equipment rounds easier to identify and complete. 3/19/06 4. During weekly Plant shop meetings the log books will be checked and discussed. Each log book will be signed off at the end of the month for completeness by the Director. 3/19/06	

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F 456	Continued From page 30 were not entered in log books on a regular basis from the east and west penthouses between May 10 through May 16, 2005, July 1 through July 14, 2005, August 1 through August 14, 2005 and October 7 through October 10, 2005 in four (4) of 12 observations at approximately 1:40 PM on February 2, 2006.	F 456		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review for two (2) of 15 sampled records, facility staff failed to consistently document on the restorative log sheet for one (1) resident and accurately document on the behavioral monitoring sheets for one (1) resident. Residents #3 and 7. The findings include: 1. Facility staff failed to document the restorative care provided to Resident #3.	F 514		

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F 514	Continued From page 31 Resident #3's physician orders dated December 1, 2004, and subsequently renewed April 1, 2005 , directed, "Restorative care every day ". A review of Resident #3's "Restorative Nursing Log Sheet" on January 31, 2006 revealed that the restorative nursing assistants did not document the restorative care provided to Resident #3 as ordered for the following days: June 2005: 9, 13, 14, 16, 17, 28, 29 and 30. A face-to-face interview with the Resident Care Coordinator was conducted on January 31, 2006 at 3:00 PM. He/she acknowledged that Resident #3 had received restorative care daily during the past year and the log sheet was not accurate. The record was reviewed on January 31, 2006. 2. Facility staff failed to accurately document on the behavior monitoring sheets for Resident #7. A review of Resident #4's record revealed that the January 2006 monthly behavior monitoring sheet indicated that the resident was being monitored for, "Outburst," "Restlessness," and " Agitation." Staff recorded that no incidents occurred under any behavior for January 2006. A nurse's note dated January 14, 2006 at 3:10 PM documented, " ...When told not to open the window, [resident] became verbally abusive to the CNA (Certified Nurse Aide)." On January 24, 2006 at 7:10 AM, a nurse's note documented, " Resident was walking out of	F 514	1 1. Restorative Log record of resident #3 was reviewed with the nursing staff of the unit. Nursing staff involved were counselled. 2/2/06 2. All residents records receiving restorative nursing services were reviewed for compliance in documentation 2/15/06 3. Licensed staff were instructed to include documentation compliance to the restorative nursing services received by the resident from team members during the end of shift report from team members assigned in their team. Licensed staff are to checked the restorative log record of residents assigned to their team for documentation compliance. Repeated non compliance will be reported to the RCC to be included in the employee's performance appraissals. 2/15/06 4. Monthly record review of documentation of restorative nursing services in the restorative nursing flow sheet will be included in the Performance Improvement Committee report 3/19/06	

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F 514	Continued From page 31 Resident #3's physician orders dated December 1, 2004, and subsequently renewed April 1, 2005 , directed, "Restorative care every day ". A review of Resident #3's "Restorative Nursing Log Sheet" on January 31, 2006 revealed that the restorative nursing assistants did not document the restorative care provided to Resident #3 as ordered for the following days: June 2005: 9, 13, 14, 16, 17, 28, 29 and 30. A face-to-face interview with the Resident Care Coordinator was conducted on January 31, 2006 at 3:00 PM. He/she acknowledged that Resident #3 had received restorative care daily during the past year and the log sheet was not accurate. The record was reviewed on January 31, 2006. 2. Facility staff failed to accurately document on the behavior monitoring sheets for Resident #7. A review of Resident #4's record revealed that the January 2006 monthly behavior monitoring sheet indicated that the resident was being monitored for, "Outburst," "Restlessness," and " Agitation." Staff recorded that no incidents occurred under any behavior for January 2006. A nurse's note dated January 14, 2006 at 3:10 PM documented, " ...When told not to open the window, [resident] became verbally abusive to the CNA (Certified Nurse Aide)." On January 24, 2006 at 7:10 AM, a nurse's note documented, " Resident was walking out of	F 514	1 1. Restorative Log record of resident #3 was reviewed with the nursing staff of the unit. Nursing staff involved were counselled. 2/2/06 2. All residents records receiving restorative nursing services were reviewed for compliance in documentation 2/15/06 3. Licensed staff were instructed to include documentation compliance to the restorative nursing services received by the resident from team members during the end of shift report from team members assigned in their team. Repeated non compliance will be reported to the RCC to be included in the employee's performance appraissals. 2/15/06 4. Monthly record review of documentation of restorative nursing services in the restorative nursing flow sheet will be included in the Performance Improvement Committee report 3/19/06 F 514 2 1. Behavior monitoring sheet for resident # 7 was reviewed with the nursing staff on the unit. Nursing staff involved were counselled 2/2/06 2. All residents records receiving medications for behavioral symptoms were reviewed for appropriate documentation in the behavior monitoring sheet. 2/15/06 3. License staff were instructed to include asking the team members working with them whether any outburst in behavior, verbal abuse, agitation, outburst of any nature were exhibited by the residents in their care to be included and documented in the behavior monitoring sheet each shift 2/15/06 4. Record review of the behavior monitoring sheets for appropriate and accurate documentation will be reported to the Performance Improvement Committee monthly 3/19/06 3/19/06	

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HADLEY HOSP SKILLED NURS UNIT	4601 ML KING AVE SW WASHINGTON, DC 20032

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F 514	Continued From page 32 bathroom while staff was making morning rounds, refused to move out of the way for the staff. Rather [resident] started cursing the staff with no apparent reason ..." According to a nurse's note dated January 26, 2006 at 7:10 AM, " CNA ...reported that resident attempted to trip [CNA] ...nurse asked " What are you trying to do? Are you trying to trip me? " [Resident] stated, " Yes, now tie my shoe. " According to a nurse's note dated January 26, 2006 at 7:15 AM, " Housekeeping employee ... stated [resident] refused to move and started cursing him/her for no reason ... " The four (4) above cited incidents were not reflected on the behavior monitoring sheet for January 2006. The record was reviewed February 1, 2006.	F 514		