STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	08/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

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F 000	INITIAL COMMENTS An annual re-certification survey was conducted from August 4 through 11, 2008. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size was 15 residents based on a census of 165 the first day of survey. 33 supplemental residents were also included in the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	F 157 483.10 Notification of Changes 1. #P1 – this resident has never been transferred #JH2 - The physician was made aware #3 - The family was made aware 2. Review of the census will identify those residents who have had a room change. Once identified family and physicians will be notified. 3. The Social Worker will develop a room change policy and procedure. Initiate the DC 6108 Form for all facility room changes Educate the licensed nursing staff on the new form and the room change policy and procedure. The licensed staff will initiate the DC6108, notify the MD, Family and or the responsible party and document this information in the medical record. The DC6108 must be turned into the Social Worker	8/30/08 10/2/08 10/2/08 ongoing 10/2/08 ongoing ongoing

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

Ann R. Schuff, Administrator | 9/25/08

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

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for one (1) of 15 sampled residents and two (2) supplemental residents, it was determined that upon relocation of residents to another room within the facility, facility staff failed to notify the responsible party for one (1) resident and the physician for two (2) residents. Residents #3, P1, JH2. The findings include: 1. Facility staff failed to notify Resident #3's responsible party when he/she was relocated to another room within the facility. A review of Resident #3's clinical record revealed an "Interim Order Form" that indicated "Transfer pt. [patient] to the LL [Lower Level] Unit Rm. [Room] # 076 with medication and all personal belonging..." There was no evidence in the resident's record that the responsible party was informed of the aforementioned resident's room change order. A face-to-face interview was conducted on August 5, 2008 at approximately 4:15 PM with Employee #2. He/she acknowledged that the resident's clinical record lacked evidence that the responsible party was notified when the resident changed rooms. The record was reviewed August 5, 2008 2. Facility staff failed to notify the physician when	F 157	The room change must be documented on on the 24 hour report. 4 The Social Worker will audit daily census for occurrences of room changes and insure there is a completed DC6108 The Social Worker will present to The QA Committee the systemic measures put in place to insure compliance and for QA Committee recommendations. The Social Worker will review the audits looking at trends and areas of non compliance. The QA Committee will discuss the trends and non compliance areas, the effectiveness of the plan of correction and make corrections to the plan to insure consistent compliance.	ongoing ongoing ongoing

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F 157	Continued From page 2 Residents JH2 and P1 were relocated within the facility. A. Review of Resident JH2's record revealed the following nurse's note dated July 11, 2008 at 10:00 PM, "Resident moved from [room number] to [room number]." There was no evidence in the record that the physician was notified of the resident's relocation. B. On August 4, 2008 at 9:38 AM, Resident P1 stated, "I just moved. I don't like my room." A review of Resident P1's record revealed a nurse's note dated July 19, 2008 at 11:00 PM, " ... [Resident P1] was transferred from [room number] to [room number]." There was no evidence in the record that the physician was notified of either resident's relocation. A face-to-face interview with Employee #12 was conducted on August 7, 2008 at 9:15 AM. He/she stated, "Both residents were moved to different rooms. I notified their families. I didn't know that I needed to notify the physician." The records were reviewed August 4, 2008.	F 157	F 160 483.10 Conveyance upon Death 1. Residents #14, # M1 and M2 Chevy Chase Federal Saving Bank (the holder of the account funds) was notified immediately on 5/16/08 to change the status of their account to "Hold Funds" and return future direct deposits. The case worker was contacted by phone to verify if funds were to be returned to the resident families or probate jurisdiction administering the residents estate. 2. The Business Office did an audit on all deceased residents to insure a status change was completed 3. The Business office will do a daily Census Reconciliation Form to insure those that have deceased are captured.	8/16/08 Ongoing Ongoing
F 160 SS=D	483.10(c) (6) CONVEYANCE 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.	F 160		

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F 160	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of the Resident Fund Management Service Trial Balance, dated August 4, 2008, it was determined that facility staff failed to convey the personal funds of three (3) of three (3) deceased residents within 30 days of expiration. Residents #14, M1 and M2 The findings include: 1. A review of Resident #14's medical record revealed that he/she expired on May 12, 2008. A review of Resident Fund Management Service Trial Balance dated August 4, 2008 indicated a balance of $817.55 in Resident #14's account, 85 days after the resident expired. A face-to-face interview was conducted on August 5, 2008 at 2:30 PM with Employee #1. He/she acknowledged that the money in Resident #23's account should have cleared by June, 2008. 2. A review of Resident M1's medical record revealed that he/she expired on May 6, 2008. A review of Resident Fund Management Service Trial Balance dated August 4, 2008 indicated a balance of $895.33 in Resident M1's account, 91 days after the resident expired. A face-to-face interview was conducted on August 5, 2008 at 2:30 PM with Employee #1. He/she acknowledged that the money in Resident M1's account should have cleared by June, 2008.	F 160	The Business Office will verify if the resident has an active/open RFMS account. i If it is verified that a RFMS account exist then a status change form is faxed over to Chevy Chas Bank advising them of the expired resident. The Case Worker will be notified that the resident has expired to verify with them if the residents money must go to the District of Columbia. If no money is to be returned to the District then a letter will be sent to the family advising them there is money in the account a letter will needed from the Register of Wills. If the family does not get the letter of Administration from the Registrar of Wills, the funds will be returned to unclaimed property. 4. The Business Office Manager will present to the QA Committee the systemic changes made to insure that the deficient practice does not reoccur. The Business Office Manager	Ongoing Ongoing Ongoing 9/18/08 Ongoing

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F 160	Continued From page 4 3. A review of Resident M2's medical record revealed that he/she expired on May 13, 2008. A review of Resident Fund Management Service Trial Balance dated August 4, 2008 indicated a balance of $701.41 in Resident M1's account, 86 days after the resident expired. A face-to-face interview was conducted on August 5, 2008 at 2:30 PM with Employee #1. He/she acknowledged that the money in Resident M1's account should have cleared by June, 2008.	F 160	will review the audits looking for trends and areas of noncompliance. Trends and areas of noncompliance will be discussed by the QA Committee. The QA committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance.	
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to post a notice of the availability of the survey results for review and their location. The findings include: Observations in the facility's lobby areas and nursing units failed to reveal a notice of where	F 167	F 167 483.10 Examination of Survey Results 1. The survey results were posted on each unit by 8/6/2008 2. During the monthly Administrative Rounds the Administrator/ designee will monitor the units to insure the Survey results are posted on each unit. 3. Upon receipt of the new survey the Administrator/designee will copy the results and post on each unit in a place assessable for all to view . 4. The Administrator/designee will bring the results of the Administrator Rounds to the quarterly QA meeting to present findings and discuss areas of noncompliance.	8/6/08 ongoing Ongoing 9/18/08

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F 167	Continued From page 5 survey results could be found. A face-to-face interview was conducted August 7, 2008 at approximately 5:00 PM with Employee #1. He/she acknowledged that notices were not posted to direct residents and/or family members/responsible parties to the location of the survey results. On August 8, 2008, it was observed that notices were posted throughout the facility identifying the location of survey results.	F 167		
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for one (1) supplemental resident, it was determined that facility staff failed to assess Resident JH1 for the ability to self medicate and obtain a physician's order to self administer eye drops. The findings include: A review of Resident JH1's record revealed the following physician's orders signed August 1, 2008: " Alphagan P 0.1% drops, Instill [1] drop in each eye twice daily for glaucoma. Betoptic S Droptainer 0.25% drops, instill [1] drop in each eye twice daily for glaucoma.	F 176	F 176 483.10 Self Administration of Drugs 1. The resident is no longer giving her own eye drops 2. There are no other residents at this time that administer their own medications. 3. Educate the licensed nurses on the policy and procedure of Self Administration of medications. An order must be obtained from the MD The interdisciplinary team must assess the Resident for the ability to Administer their own medications. The Resident must take a test for Self Administration of Meds and pass with a 100% rate. The test must be filed on the medical record.	8/5/08 8/5/08 10/2/08 Ongoing Ongoing Ongoing

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F 176	Continued From page 6 Trusopt Ocumeter Plus 2% drops, instill [1] drop in each eye [3] times a day for glaucoma." On August 5, 2008, at approximately 8: 15 AM, during the medication pass for Resident JH1, Employee #10 allowed the resident to self administer the above three (3) prescribed eye medications. The resident dropped the medication on his/her eyelids, instead of the in the eyes and did not wait 5 minutes between the administration of the other eye drops. The resident did not wash his/her hands prior to placing the eye drops in his/her eyes. According to the facility's Policy 2.1, "Self Administering Medications -(2) The Facility, in conjunction with the interdisciplinary team, should assess and determine, with respect to each resident, whether self-administration of drugs is safe and appropriate... (4) Facility should ensure that orders for self-administration list the specific medication (s) the resident may self-administer... (5) If the resident self-administers his/her medications, the Facility, in conjunction with the interdisciplinary team, should routinely assess the resident's cognitive, physical and visual ability to carry out this responsibility..." There was no evidence in the record that the Interdisciplinary Care Team (IDT) determined that Resident JH1 was safe for self administration of medications. There was no physician's order to self administer medications. The record lacked evidence that a routine assessment was conducted by the IDT to assess the resident's ability to self medication.	F 176	The policy must be reviewed with the Resident and the Resident must agree to follow the facility policy. If a resident request to self administer after admission an order must be obtained .The Resident must be assessed, tested, policy review, and agree to follow the Self Administration policy. Place the Resident on the 24 hour report and in the Supervisors Book The Resident must be evaluated quarterly and if there is a change in condition. 4. The Unit Manager using the 24 hour chart audit will monitor self administration of medications. The 3-11 Supervisor will audit all Admission Charts for orders for self administration The DON will present systemic measures made to insure the deficiency does not occur again and for QA Committee recommendations The DON will review trends and areas of non compliance. The QA committee will discuss the trends and areas of	Ongoing Ongoing Ongoing Ongoing 9/18/08 Ongoing

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F 176	Continued From page 7 A face-to-face interview was conducted on August 5, 2008 at 9:40 AM with Employee #10. He/she stated, "Resident JH1 wants to give [his/her] own medications. [He/she] wants to put drops on [his/her] eyelids and let the fluid drop in [his/her] eyes. I explained to [Resident JH1] that it was unsanitary." The record was review August 5, 2008.	F 176	noncompliance and make recommendations for the plan of correction to insure consistent compliance.	
F 224 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on an observation, staff interview and record review for one (1) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff to provide appropriate and timely care for: (1) resident wearing a soiled hand splint and incontinent care for two (2) residents. Residents # 2 and A3. The findings include: 1. Facility staff failed to provide incontinent care to Resident #2 in a timely manner and change a soiled hand splint. During an observation of the Day Room/Activity Area on August 6, 2008 at 10:25 AM, Resident #2 was observed sitting in his/her wheel chair. A strong odor emanated from the resident. The resident was wearing a hand splint which was observed to be soiled with accumulated food	F 224	F 224 483.13 Staff Treatment of Residents 1. Resident #2 was given incontinent care. and the splint was washed Resident A3 was given incontinent care at 12:30pm 2. There are no residents in the facility that are wearing a splints The nursing assistants were instructed to check all residents that are incontinent or need to be toileted on 8/6 and 8/7 to insure incontinent care was given to incontinent residents. 3. Develop a policy and procedure for cleaning splints Educate all nursing staff on : Splint care Abuse Incontinent care Corrective Action for employees # 3 and #8	8/6/08 8/7/08 8/7/08 8/6/08 & 8/7/08 10/02/08 10/02/08 8/18/08

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F 224	Continued From page 8 stuffs. At 10:10 AM on August 6, 2008, Employee #3 was taken over to the resident. He/she was told that the resident needed to be changed and that the splint needed to be cleaned. Employee #3 responded "I will get the assigned CNA (Certified Nursing Aide) to take care of [him/her]." Employee #3 returned approximately five (5) minutes later and stated "I told the CNA. [He/she] is taking care of another resident and will come as soon as [he/she] is finished." At 10:50 AM, 40 minutes later Employee #3 returned and stated "I went to check on the CNA. [He/She] is still with the other resident. I reminded [him/her] to come and take care of this resident when [he/she] is finished over there." At 11:20 AM Employee #8 approached the resident and proceeded to wheel him/her out of the room. When asked where he/she was taking the resident, the employee responded, "I am going to change [him/her]." At 11:35 AM, Employee #8 wheeled the resident back into the day room. The resident was still wearing the soiled splint. Employee #8 was asked about the soiled hand splint. He/she stated, "That looks like the stuff from dinner last night, macaroni and cheese. If I take it off, I don't have another one to put on and it has to be washed." The record was reviewed August 6, 2008. 2. Facility staff failed to provide timely incontinence care for Resident A3. The resident was observed seated in wheelchair in the day room on August 7, 2008. At	F 224	An order for cleaning the splint will be obtained and put on the TAR with days the splint will be cleaned The Charge Nurse will initial the TAR indicating the splint has been cleaned. Each nursing unit will conduct incontinent rounds every 2 hours and document on the nursing assistant rounds sheet indicating that incontinent care has been done. The Charge Nurse will check the rounds sheets daily and document on the TAR that incontinent care has been done. Disciplinary action will occur for noncompliance 4. The Unit Manager will audit the nursing rounds sheets weekly. The DON will present to the QA Committee the systemic measures put in place to insure the deficient practice does not reoccur. The DON/designee will present findings from the audit to the QA Committee to discuss trends and areas of non compliance, the effectiveness of the plan of correction	Ongoing Ongoing Ongoing Ongoing Ongoing 9/18/08 Ongoing

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F 224	Continued From page 9 approximately 2:30 PM, the resident emanated a strong urine odor and was observed wet bilaterally from the thighs to the waist. Approaches and intervention for an "Incontinence Care Plan" [related to recent decreased mobility] dated June 30, 2008 indicated: "Toilet every two (2) hours and as needed to decrease number of incontinent episodes. Keep resident dry, especially after each episode of incontinence." A face-to-face interview was conducted with Employee#10 on August 7, 2008 at approximately 12:30 AM. He/she said, "I am taking the resident back to [his/her] room now to provide incontinence care." Employee #10 acknowledged that the resident was last provided incontinent care in the morning, before breakfast at approximately 8:30 AM. The record was reviewed on August 7, 2008.	F 224	and make changes to plan to insure consistent compliance.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225	F 225 483.13 Staff Treatment of Residents Regarding not reporting and investigation incidence 1. Resident #14, M12, M13, M14 M7 M9 have been discharged. Resident #2 #9 #13 A3 F6 M3 M4 M8 M10 were investigated to determine if the residents were abused and if disciplinary action needed for staff involved and the incident report sent to the DOH. No evidence of abuse found so no action needed. 2. All incident reports dating back to August 11th to present involving injuries of unknown origin will be investigated and reported to the DOH 3. Educate all staff on Abuse. Further educate the licensed staff on their responsibility for investigating and reporting abuse and suspected abuse	8/30/08 10/2/08 10/2/08 10/2/08

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F 225	Continued From page 10 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for four (4) of 15 sampled residents and 11 supplemental residents, it was determined that the facility failed to ensure that all alleged violations of neglect or abuse and injuries of unknown source were investigated and reported to the State Agency. Residents: #2, #9, #13, #14, A3, F6, M3, M4, M6, M7, M8, M9, M10, M12, M13 and M14. The findings include: 1. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident #2. A review of Facility Incident /Accident reports	F 225	and about disciplinary action for the employee involved in abuse. Revise the Incident Report policy and procedure to include a receipt must be obtained when the incident report and the DOH form is faxed to the DOH. The DOH Form attached to incident form must include interventions to keep the resident safe and the investigation of the incident. Once the DOH form is complete with the description of the incident and the new interventions it must be faxed to the DOH The Care Plan must be updated by the licensed nurse with new interventions that prevent reoccurrence of the incident.. The Incident Investigation Form must be completed and attached to the incident report along with the DOH form and the receipt and put in the Supervisors book. The interdisciplinary team will review incident reports at Stand Up meeting daily to insure new interventions are in place or if	10/2/08 Ongoing Ongoing Ongoing Ongoing Ongoing

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	095028	A. BUILDING _____ B. WING _____	08/11/2008

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F 225	Continued From page 11 revealed: July 14, 2008 at 11:30 AM; "[Resident #2] Dark purple bruise R arm 4cm X 3cm Noted cause unknown. " July 30 2008 at 12:00 Noon "[Resident #2] Skin tear noted on Right Nostril ...Cause unknown." There was no evidence that either injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incidents had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 2. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident #9. A review of the Facility Incident /Accident reports revealed: July 9, 2008 at 4:30 PM: "Resident skin tear noted on right upper arm." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008.	F 225	further investigation is needed. Once the Incidents are complete they are submitted to the Don to be audited. 4. The DON will submit to the QA Committee the systemic measure put in place to prevent the deficient practice for QA Committee recommendations The DON will trend the incident reports looking at Patterns involving staff Diagnosis Mental States Types of injuries Time of Day Need for training and other areas suggested by the QA Committee. The QA Committee will discuss trends and areas of noncompliance, effectiveness of the plan of correction , and recommend corrections to the plan to insure consistent compliance.	Ongoing 9/18/08 Ongoing Ongoin

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F 225	Continued From page 12 3. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident #13. A review of Facility Incident /Accident reports revealed: June 28, 2008 at 5:00 PM: "Resident #13 was observed with bluish discoloration and swelling of right cheek. Bilateral upper arm and right forehead also noted with bluish discoloration. Cause unknown." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 4. Facility staff failed to investigate an injury of unknown source for Resident #14 A review of Facility Incident /Accident reports revealed: May 1, 2008 at 1:30 PM: "Resident #14 was observed skin tear right elbow during lunch time. Origin unknown." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30	F 225		

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F 225	Continued From page 13 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 5. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident A3. A review of Facility Incident /Accident reports revealed: June 24, 2008 at 10:00 PM: "While CNA was giving PM Care to Resident A3 a bruise on left upper arm 4cmX2cm and bruise Left hip 7cmX7cm was observed ,dark purple in color. Etiology Unknown." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 6. Facility staff failed to investigate and/or report an injury of unknown source to the State Agency for Resident F6, who was observed with skin tear right wrist, skin tear left arm and bilateral darkened red eyes. A review of Facility Incident /Accident reports revealed: May 7 , 2008 at 10:52 AM: "[Resident F6] was noted with skin tear on an old bruise 4cm X 1cm	F 225		

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F 225	Continued From page 14 Left arm color is red.. Origin unknown." May 26, 2008 "[Resident F6]...with both eyes dark red...see chart." "June 15, 2008 "Skin tear observed on right wrist." A review of Resident F6's record revealed the following nursing notes: May 26, 2008 at 11:00 [AM/PM not indicated], " ...Left eye 2 x 1.75 x 0x 0 cm (centimeters) no opening dark red in color. Right eye 1.25 x 2.5 x 0 x 0 no opening dark red in color. RCC [resident care coordinator] made aware, nursing will continue to monitor ... " May 27, 2008 at 11:00 [AM/PM not indicated], " ...Resident receives eye drops, that [his/her] skin is also fragile and that [he/she] bruises easily. Staff has been made aware that gentle pressure should be applied when administering eye drops. " A face-to-face interview was conducted with Employee #2 on August 7, 2008 at approximately 2:30 PM. He/ she stated, "There was no investigation and we didn't report it to the state." The record was reviewed August 7, 2008. 7. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident M3. A review of Facility Incident /Accident reports revealed: July 1, 2008 at 10:00 PM, "...skin tear on the right lower anterior extremity ...Resident unable to explain."	F 225		

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F 225	Continued From page 15 There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incidents had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 8. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident M4. A review of Facility Incident /Accident reports revealed: July 12 2008 at 1:00 PM, "...observed dark purple bruise on right/ left buttock. Etiology Unknown." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incidents had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 9. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident M6. A review of Facility Incident /Accident reports	F 225		

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F 225	Continued From page 16 revealed: July 29, 2008 at 8:30 PM, " ... bruise /abrasion on residents right lower arm; noted with skin tear on right arm with small amount of bleeding area cleansed and dressing applied." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incidents had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 10. Facility staff failed to investigate and report an injury of unknown source to the State Agency for Resident M7. A review of Facility Incident /Accident reports revealed: May 12, 2008 at 2:40 PM, "... skin tear on right elbow possibly due to bed rail..." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008.	F 225		

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F 225	Continued From page 17 11. Facility staff failed to investigate an injury of unknown source for Resident M8 A review of Facility Incident /Accident reports revealed: May 26, 2008 at 2:45 PM: "Resident...with bruise corner of right eye and nose bridge dark red ... unaware as to how it happened or what caused the bruise." May 28, 2008 at 1:30 PM: "Resident M8 was observed skin tear right lower extremity ...Not aware how it happened." There was no evidence that either injury of unknown source was investigated. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incidents had not been investigated. Employee #1 stated that both incidents were reported to the State Agency on May 27 and June 2, 2008 respectfully. The record was reviewed August 7, 2008. 12. Facility staff failed to investigate an injury of unknown source for Resident M9. A review of Facility Incident /Accident reports revealed: May 9, 2008 at 1:00 PM: "[Resident M9] was observed with skin tear right elbow ... Origin unknown." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency.	F 225		

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F 225	Continued From page 18 Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 13. Facility staff failed to investigate an injury of unknown source for Resident M10. A review of Facility Incident /Accident reports revealed: June 10, 2008 at 11:15 AM, "Resident ...with skin tear below right ankle measured 2cm X 2cm." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 14. Facility staff failed to investigate an injury of unknown source for Resident M12. A review of Facility Incident /Accident reports revealed: June 10, 2008 at 8:30 PM: "[Resident M12] was noted with skin tear right outer lower leg 1cm X ,5cm and 2cm X 1 cm with minimal bloody drainage	F 225		

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F 225	Continued From page 19 June 16, 2008 at 7:50 PM: "Left hand and middle finger with dark bruise ...Etiology Unknown..." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 15. Facility staff failed to investigate an injury of unknown source for Resident M13. A review of Facility Incident /Accident reports revealed: June 19, 2008 at 1:55 PM: "Resident M13 ... skin tear noted right Lateral leg when transferring from wheel chair to bed." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008. 16. Facility staff failed to investigate an injury of unknown source for Resident M14. A review of Facility Incident /Accident reports	F 225		

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F 225	Continued From page 20 revealed: June 19, 2008 at 2:00 PM: "Resident M14 CNA reported ... noted skin tear on resident ' s left wrist while giving care." There was no evidence that the injury of unknown source was investigated and/or reported to State Agency. Face-to-face interviews with Employees #1 and #2 were conducted on August 7 , 2008 at 4:30 PM. Both employees stated the above incident had not been investigated or reported to the State Agency. The record was reviewed August 7, 2008.	F 225		
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 observations, staff interview and record review for one (1) of 15 sampled residents and three (3) supplemental residents, it was determined that facility staff failed to: change a soiled hand splint for one (1) resident, respond timely to three (3) residents' request for incontinent care, address one (1) resident by his/her name and entering one (1) resident's room without knocking and waiting for permission to enter. Residents # 2, A3, F1, and JH5 The findings include:	F 241	F 241 483.15 Dignity 1. Resident #2, #A3 had incontinent care and the splint for A3 was cleaned and an order was received to discontinue the splint do to non compliance. 2. The nursing staff was asked to check all residents for incontinent care needs on 8/6 and 8/7 3. All staff will be educated on Residents Rights which will include training on how to address a resident appropriately and to knock when entering a room. There will be incontinent rounds every 2 hours on the units to insure that residents have incontinent care. There will be a nursing assistant rounds form in every residents room they will	8/6/08 8/7/08 8/6/08 & 8/7/08 10/2/08 Ongoing

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F 241	Continued From page 21 1. Facility staff failed to provide incontinent care to Resident #2 in a timely manner and change a soiled hand splint. During an observation of the Day Room/Activity Area on August 6, 2008 at 10:25 AM, Resident #2 was observed sitting in his/her wheel chair. A strong odor emanated from the resident. The resident was wearing a hand splint which was observed to be soiled with accumulated food stuffs. At 10:10 AM on August 6, 2008, Employee #3 was taken over to the resident. He/she was told that the resident needed to be changed and that the splint needed to be cleaned. Employee #3 responded "I will get the assigned CNA (Certified Nursing Aide) to take care of [him/her]." Employee #3 returned approximately five (5) minutes later and stated "I told the CNA. [He/she] is taking care of another resident and will come as soon as [he/she] is finished." At 10:50 AM, 40 minutes later Employee #3 returned and stated "I went to check on the CNA. [He/She] is still with the other resident. I reminded [him/her] to come and take care of this resident when [he/she] is finished over there." At 11:20 AM Employee #8 approached the resident and proceeded to wheel him/her out of the room. When asked where he/she was taking the resident, the employee responded, "I am going to change [him/her]." At 11:35 AM, Employee #8 wheeled the resident back into the day room. The resident was still wearing the soiled splint. Employee #8 was asked about the soiled hand splint. He/she stated,	F 241	initial. The license nurse will check the nursing assistant rounds list every shift and document on the TAR that the incontinence care was given. Disciplinary action will occur for noncompliance. Managers are to observe staff entering residents rooms and how residents are addressed and educate or initiate Corrective Action as necessary . 4. The Unit Manager will audit the nursing rounds sheets weekly and initiate Corrective Action as needed. The DON will present to the QA Committee the systemic measures put in place to insure the deficient practice does not reoccur. The DON will review the audits looking for trends, and areas of noncompliance. The QA Committee will discuss trends and areas of noncompliance . The QA Committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance..	Ongoing Ongoing Ongoing Ongoing 9/18/08 Ongoing Ongoing

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F 241	Continued From page 22 "That looks like the stuff from dinner last night, macaroni and cheese. If I take it off, I don't have another one to put on and it has to be washed." The record was reviewed August 6, 2008. 2. Facility staff failed to provide timely incontinence care for Resident A3. The resident was observed seated in wheelchair in the day room on August 7, 2008. At approximately 12:30 PM, the resident was observed wet in urine bilaterally from the thighs to the waist. Approaches and intervention for an " Incontinence Care Plan " [related to recent decreased mobility] dated June 30, 2008 indicated: "Toilet every two (2) hours and as needed to decrease number of incontinent episodes. Keep resident dry, especially after each episode of incontinence." A face-to-face interview was conducted with Employee#10 on August 7, 2008 at approximately 12:30 AM. He/she said, "I am taking the resident back to [his/her] room now to provide incontinence care." Employee #10 acknowledged that the resident was last provided incontinent care in the morning, before breakfast at approximately 8:30 AM. The record was reviewed on August 7, 2008. 3. Facility staff failed to respect and give full recognition to Resident F1 when addressing resident by a name not of his/her choice. During the environmental tour on August 5, 2008 at 3:45 PM, the surveyor, while in the presence of and Employee #29 heard Employee #5 state to	F 241		

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F 241	Continued From page 23 Resident F1 while in the resident's room, "Sounds like you need your ears checked baby. " Upon exiting from Resident F1's room, Employee #5 was queried as to the components of abuse and resident rights. While the employee was able to recall/recite the components of abuse, he/she was then asked, about the aforementioned statement. Employee #5 stated, that he/she was talking loud because the resident doesn't hear very will and the resident had questions about a meeting that he/she had just attended. However he/she should have addressed the resident by his/her last name. " 4. Facility staff failed to knock on Resident JH5's door and wait for permission to enter. On August 4, 2008 at 8:45 AM, during the medication pass observation, Employee #13 entered Resident JH5's room without knocking and waiting for permission to enter. A face-to-face interview was conducted with Employee #13 at the time of the observation. The employee acknowledged that he/she should have knocked and waited for the resident to give permission to enter the room.	F 241		
F 253 SS=F	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 housekeeping and	F 253	F 253 483.15 Housekeeping/Maintenance Dietary A , B, C, D,E, F, G, H, I, J, K, I, M, N, O were all cleaned Item G , Trash receptacle was replaced. Item C. Additional Hangers installed. Item D Addition dunnage rack purchased and items removed from	8/7/08 9/19/08 8/5/08 8/5/08

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	095028	A. BUILDING _____ B. WING _____	08/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

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F 253	Continued From page 24 maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled kitchen appliances, drains, compressor in the walk-in refrigerator, floors, wheelchairs/chairs/gerichairs; damaged and/or marred/scarred baseboards, walls, ceiling tiles, dusty and/or soiled medication rooms and carts. A tour of the main kitchen was conducted on August 4, 2008 from 8:45 AM to 11:45 AM in the presence of Employee #27 and the findings were acknowledged at the time of the observations. The environmental tour was conducted on August 5, 2008 from 11:20 AM to 3:30 PM and August 6, 2008 from 9:40 AM to 10:20 AM in the presence of Employees #27 and 28. The findings were acknowledged at the time of the observations. An inspection of the facility's medication carts was conducted on August 11, 2008 between approximately 8:30 AM and 9:00 AM in the presence of Employees # 3, 14, 13 and 20. The findings were acknowledged at the time of observations. The findings include: 1. The following appliances and areas were observed soiled in the main kitchen and pantries on the health care unit(s): A. Gas stove in one (1) of one (1) stove observed; B. Double Convection ovens in two (2) of two (2) ovens observed; C. Deep fryer in one (1) of one (1) deep fryer observed; D. Double Steamer in one (1) of one (1) steamer	F 253	the floor during inspection 2. All equipment is on a daily cleaning schedule which includes floors, drains, ice machines, walls Utility workers are responsible for all equipment in the closet including mops, buckets and squeeges During deliveries all boxes will be delivered to proper locations off the floor. 3. Cleaning list includes a supervisor check to be monitored weekly. The Food Director will complete a grand check monthly Staff have been in- serviced on the cleaning schedules Utility staff have been in-serviced on hanging items 4. The Food Service Director/designee will present the systemic changes made to the QA Committee for recommendations to insure the deficient practice does not reoccur. The Food Service Director/designee will review audits/schedules looking for trends and areas of noncompliance. The trends and areas of noncompliance	Ongoing Ongoing Ongoing 9/4/08 9/14/08 9/22/08 9/18/08 Ongoing

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F 253	Continued From page 25 observed; E. Broiler in one (1) of one (1) broiler observed; F. Hot box near stove in one (1) of one (1) hot box observed; G. Juice machine upper level pantry in one (1) of three (3) juice machines observed; H. Ice machine in the main kitchen and both pantries on the health care unit(s) in three (3) of three (3) ice machines observed; I. Tilt skillet soiled in one (1) of one (1) tilt grill observed; J. Drains in main kitchen near ice machine and the kettles in two (2) of two (2) observed; K. Soiled compressor in walk-in refrigerator in one (1) of one (1) observed; L. Floors in the main kitchen and floor in the pantries were observed soiled; M. Refrigerator and freezer floors were observed soiled in eight (8) of eight (8) refrigerators and two (2) of two (2) freezers were observed; N. Kitchen floor mats were observed soiled in three (3) of three (3) floor mats observed; O. Soiled floor in beverage closet in one (1) of one (1) observed; P. The women bathroom/locker room was observed with solid ceiling tiles in one (1) of one (1) observed; Q. Ceiling tiles were stained/soiled in both pantries in the health care units; 2. Additional areas in the facility were observed as follows: A. Ceiling tiles were soiled in Rooms 43, rehab dining room, lower level day room and the rehabilitation gym B. In the Beauty Shop: Hair rollers stored for reuse observed with hair in five (5) of five (5) containers of rollers observed; C. Carpeting in five(5) of 26 rooms observed,	F 253	will be discussed by the QA Committee . The QA Committee will determine the effectiveness of the plan of correction and make recommendations for correction to the plan to insure consistent compliance. Housekeeping and Maintenance 1. P, Q, A all ceiling tiles replaced C carpet in room 182 and 190 were replaced D the two Geri Chairs have been cleaned F. The horizontal surfaces of the bed frames for rooms 41,45,.71 and 80 were completed. G The damaged bedside commode in 70 was discarded. A. The day room will have wall guards installed along the walls C The arms chairs in the first floor day room were cleaned B. The ceiling tiles will replaced C Damaged light fixture UL and missing light bulbs on LL level were replaced D.The light was repaired and cover replaced on 9/18 in men's bathroom E. The hole in the women's bathroom was repaired. 9/18	9/16/08 9/16/08 9/6/08 8/26/08 8/5/08 10/2/08 8/17/08 10/2/08 9/18/08 9/18/08 9/18/08

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F 253	Continued From page 26 rooms 41, 81, 88, 182 and 190, the linen closet and the corridor on rehabilitation unit were observed D. Chairs gerichairs and/or wheel chair were observed soiled in six (6) of six (6) observed rooms 80, 94 and 170 and three (3) in the lower level dining room in six (6) of 12 observed E. 0xygen concentrator filters were observed to soiled in two (2) of five (5) filters observed, rooms 170 and 88; F. Horizontal surfaces of bed frames in four (4) of 26 rooms observed, rooms 41, 45, 71 and 80; G. A bedside commode in room 70 was observed with a brown substance on the lid in one (1) of 26 rooms observed 2. The following items/areas were observed marred/scarred: A. The day room walls in two (2) of three (3) day rooms observed. B. Walls were observed in four (4) of 26 rooms observed, rooms #42, 45, 46 and 97 C. Arm chairs in the first floor day room in seven (7) of seven (7) chairs observed, rehabilitation unit dining room six (6) of six (6) chairs 3. The following items/areas were observed damaged: A. The wall near the preparation sink and across from steam kettle was observed damaged in one (1) of one (1) wall observed in the main kitchen; the wall in the nursing station on rehabilitation unit was observed damaged; B. Ceiling tiles were missing/damaged in both pantries in the health care units, in the beverage closet in located in the main kitchen and in the laundry room; C. Damaged light fixtures: upper pantry damage light fixture, lower had missing light bulbs in two	F 253	H. The rusted air vent was primed and painted I. The lights in rooms 41, 43, 42, and 46 were placed on K. Night lights in room 71,72, 80 .81, 97 were replaced 8/5/08 L. The damaged night stands were removed from room 190 and the table stand and dresser were removed from room 80 8/7 5. The unit Med Rooms were cleaned 8/15 Both kitchen walls were repaired, and the rehab unit nursing station wall was also repaired by maintenance. 2. All areas of the Health Center will be audited for areas that need maintenance attention The Facilities Dept. will make rounds weekly looking for opportunity for repairs. Repairs will be noted and placed on a work order for repairs. The Maintenance Dept. will audit the Room and Space inspection Form Weekly by making rounds x 90 days then monthly to insure items have been repaired. Cleaning schedules will be established for carpets to be cleaned daily. The Housekeeping Supervisor will make rounds daily and	9/18/08 8/5/08 8/5/08 8/15/08 10/2/08 Ongoing 8/15/08 8/15/08

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F 253	Continued From page 27 (2) of two (2) observed D. The men's bathroom/locker room for kitchen employees was observed with a non-functioning light and missing cover over the light. E. The women bathroom/locker room was observed with a hole in wall in one (1) of one (1) observed. F. Beverage closet had broken light cover in one (1) of one (1) observed G. The foot pedal of the trash receptacle in the upper pantry did not engage when pressed, and manual opening of the lid was required to dispose of trash in one (1) of two (2) trash receptacles on August 7, 2008 at 8:18 AM. H. Rusted air vent in the pot and pan wash area in one (1) of two (2) air vents observed; I. Lights were observed to be missing and/or not working four (4) of 26 rooms observed, rooms 41, 43, 42 and 46; J. An arm rest was observed to be damaged on one (1) of one (1) bedside commode observed in room 70; K. Night lights were not in working six (6) of 26 rooms observed, rooms 71, 72, 80, 81, 88 and 97; L. In two (2) of 26 rooms observed the following was damaged: Night stand and missing drawer was observed to be damaged in 190 and a table stand missing a leg and a missing knob on dresser in room 80; 4. The following items were observed stored on floor(s): A. The linen closet on the rehab unit was observed to have approximately two (2) air mattresses stored on the floor of the closet B. Four (4) of four boxes were observed stored on the floor in the electrical closet on the lower level and one (1) of one (1) box was observed on	F 253	document on the Housekeeping rounds list the carpets that have been cleaned The med rooms will be included in the Housekeeping daily cleaning schedule. Wheelchairs will be cleaned daily by room number on each unit. The wheelchair schedules will be posted on the units. The Housekeeping Supervisor will do a weekly audit to insure the wheelchairs are being cleaned 4. The Director of Facilities will present the systemic changes to the QA Committee for recommendations to insure the deficient practice does not reoccur. The Director of Facilities will review the schedules and audits looking for trends, and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for correction to the plan to insure consistent compliance.	Ongoing 9/18/08 Ongoing

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F 253	Continued From page 28 the upper level C. Brooms were observed stored on the floor in the janitor ' s closet in the main kitchen two (2) of three (3) brooms observed. D. Boxes of dishes stored on floor in the dry storage area in six (6) of six (6) boxes observed. 5. Medication rooms: Medication room floors were observed soiled in two (2) of two (2) medication rooms observed on August 6, 2008 at approximately 8:30 AM. 6. Medication carts were observed soiled: Four (4) of four (4) medication carts were observed soiled with dirt, dust and spilled medications both inside and outside.	F 253	6. Medication Carts – New medication carts were obtained 8/30. All nurses will be required to clean their carts after every shift. They will be monitored on the nursing weekly rounds. 11-7 will do a though cleaning every Wednesday. The weekly audits will be reviewed during QA.	8/30/08
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	F 278	F 278 483.20 Resident Assessment 1. Residents #3. #8 #13 their MDS Assessment will be corrected and submitted to CMS. 2. All MDS Assessments for August and September will be audited to insure correct diagnosis and falls have been coded to the MDS. An MDS Correction Assessment will be completed for any MDS with inaccurate information or additional information needed and submitted. 3. The MDS Coordinator will audit the MDS Assessments monthly to insure the correct diagnosis and falls have been coded to the MDS. A Correction MDS will be completed and submitted when necessary. Part of the audit will include how many Correction MDS Assessment have been completed during the month.	10/2/08 10/2/08 Ongoing

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F 278	Continued From page 29 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 observation, staff interview and record review for three (3) of 15 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) assessment for one (1) resident for C-diff [Clostridium Difficile], one (1) resident for Diabetes Mellitus, and one (1) resident for falls. Residents # 3, 8 and 13. The findings include: 1. Facility staff failed to code Resident #3 for C. diff. A review of Resident #1's record revealed the following physician's orders: "May 19, 2008 at 6:30 PM "...Isolation Precautions for C-Diff..." "July 15, 2008 at 2:00 PM "...D/C [Discontinue] Isolation precaution for C-Diff ..." A review of the resident's quarterly MDS in Section I 2 (b) "Infections" completed on July 8, 2008 failed to code the resident for "Clostridium Difficile." A face-to-face interview was conducted with Employee #15 on August 7, 2008 at approximately 3:00 PM. He/she acknowledged	F 278	4. The MDS Coordinator will present to the QA Committee systemic measures put in place to insure the deficiency does not reoccur The MDS Coordinator will review the audits and present to the QA Committee trends and non compliance areas. The QA Committee will discuss trends, areas of non compliance, effectiveness of the plan of correction and make recommendations to correct the plan to insure consistent compliance.	9/18/08 Ongoing

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F 278	Continued From page 30 that the resident was not coded for C.diff. The record was reviewed August 7, 2008. 2. Facility staff failed to accurately code Resident #8 for Diabetes Mellitus. A review of Resident #8's annual MDS assessment completed October 3, 2007 and the quarterly MDS assessments completed January 21 and April 21, 2008 revealed that the resident was coded for Diabetes Mellitus under Section I (Diagnosis). The annual MDS assessment dated July 3, 2008 did not code the resident for Diabetes Mellitus. A review of the clinical record revealed that there was no evidence that the resident was a diabetic. A face-to-face interview was conducted with Employee #15 at approximately 10:00 AM on August 6, 2008. He/she acknowledged that the resident was not diabetic and that the MDS was incorrectly coded. The record was reviewed on August 6, 2008. 3. Facility staff failed to accurately code Resident #13 for a fall. A review of the clinical record for Resident #13 revealed the following nurses' notes: June 28, 2008 at 3:05 PM, "Resident observed with bluish discoloration and swelling on right cheek, bilateral upper arm and right forehead also noted with bluish discoloration..." June 29, 2008 at 1:00 AM "...Resident stated [he/she] fell..."	F 278		

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F 278	Continued From page 31 A review of the resident's admission MDS in Section J4 "Accidents" completed on July 9, 2008 failed to code the resident for "Fell in past 30 days." A face-to-face interview was conducted with Employee #15 on August 7, 2008 at approximately 3:00 PM. He/she acknowledged that the resident was not coded for falls. The record was reviewed August 7, 2008.	F 278		
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 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 interviews for nine (9) of 15 sampled residents and three (3)	F 279	F 279 483.20 Comprehensive Care Plans 1. Care Plans for Residents 1,3, 4, 5, 6, 9, 10, 12, 15, F6, JH3 ,P1 will be updated 2. The Unit Managers will audit all Health Center charts and update all care plans to include: 9 or more meds, pain management, noncompliance, Dialysis, Allergies 3. Educate the interdisciplinary team on the care planning process to include The Interdisciplinary Team meets weekly to review care plans the care plans must be updated during this conference insuring an interdisciplinary approach. The care plan process must include reviewing and care planning for diagnosis, infections, labs, psych consults, other MD consults, injuries.	10/2/08 10/2/08 10/2/08 Ongoing

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F 279	Continued From page 32 supplemental residents, it was determined that facility staff failed to initiate care plans with appropriate goals and approaches for two (2) residents with Allergies, one (1) resident for Dialysis, one resident for IV (Intravenous) Antibiotics, nine (9) residents for the potential adverse interaction for the use of nine (9) or more medications and one (1) resident for pain and noncompliance with being weighed. Residents #1, 3, 4, 5, 6, 9, 10, 12,15, F6, JH3 and P1. The findings include: 1. Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #1. A review of the clinical record for Resident #1 revealed physician orders dated and signed, July 7, and August 1, 2008 that included the following medications: "Ascorbic Acid, Aspirin, Caltrate, Levothyroxine, Metoclopramide, Metoprolol, Multi-Vitamin, Pantoprazole, Zinc Sulfate." There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications. On August 5, 2008 at approximately 4:15 PM, a face-to-face interview was conducted with Employee #2. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on August 5, 2008.	F 279	The Care Plan policy and Procedure will revised Interventions for prevention must be included. 4. The MDS Coordinator will audit all care plans due for review for the month based on the MDS schedule to insure they are complete and up to date. The audit will be turned. The MDS Coordinator will present to the QA Committee systemic changes put in place to prevent the deficiency from reoccurring and for QA Committee recommendations. The MDS Coordinator will review the audits looking for trends and areas of noncompliance to the QA Committee to discuss. The QA Committee will discuss the trends, areas of non compliance, effectiveness of the plan of correction and make corrections to the plan to insure consistent compliance.	10/2/08 Ongoing 9/18/08 Ongoing

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F 279	Continued From page 33 2. Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #3. A review of the clinical record for Resident #3 revealed physician orders dated and signed May 31, 2008 that included the following medications: "Norvasc, Aricept, Namenda, Tamsulosin, Prinivil, Lactulose, Pericolace, Multivitamins, Xalatan, Percocet, and Tylenol. There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications. On August 5, 2008 at approximately 4:15 PM, a face-to-face interview was conducted with Employee #2. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on August 5, 2008. 3. Facility staff failed to develop a care plan with appropriate goals and approaches for Resident #4's pain and use of pain medications and for continuously refused to be weighed. A. Review of the clinical record revealed that the resident was admitted to the facility on February 20, 2008 with diagnoses which include Post Polio Syndrome, Lumbar Spondylosis, UTI, Pyelonephritis, Hyperkalemia, Hyponatremia, Altered Mental Status, Acute Renal Insufficiency and Obstructive Uropathy.	F 279		

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F 279	Continued From page 34 Physician's admission orders dated February 20, 2008, directed, "Darvocet 100/650 one (1) tab PO (by mouth) q 6hrs (every six hours) prn (as needed) for pain." A review of the MARs (Medication Administration Record) for March, April and May revealed that the resident received Darvocet as follows: for March 2008 the resident received Darvocet at least once daily for 20 of 31 days and two (2) or three (3) times a day for seven (7) of the 20 days. A review of April's MAR revealed that the resident received Darvocet at least once daily for 20 of 30 days and two (2) or three (3) times a day for seven (7) of 20 days. A review of May's MAR revealed that the resident received Darvocet 26 of 31 days and two (2) or three (3) times a day for 10 of 31 days. On June 11, 2008 a physician's order directed, "Duragesic patch 25 mg q (every) 72 hrs. Discontinue Darvocet." On June 12, 2008, a physician's order directed, " Darvocet N 100 one (1) tab q 6 hrs. prn for pain." The care plan, last reviewed on June 11, 2008, failed to reveal a care plan with appropriate goals and objectives for pain and the use of pain medications. A face-to-face interview was conducted with Employee #15 on August 11, 2008 at approximately 9:30 AM. He/she acknowledged that the record lacked a care plan for pain and the use of pain medications. The record was	F 279		

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F 279	Continued From page 35 reviewed on August 8, 2008. B. A review of the clinical record revealed an admission note from the registered dietician which documented, "Refused to be weighed. On regular diet. Will continue assessment when weight is available." On February 26, 2008 the dietician documented, "Resident continues [to] not be weighed." The next dietary note was dated May 22, 2008 and documented, "Quarterly assessment completed." There was no mention of the resident's weight in this documentation. Review of the nurse's note dated March 11, 2008 revealed the following, "Continues to refuse wt. [weight]." The care plan, last reviewed on June 11, 2008, failed to reveal a care plan with appropriate goals and objectives for the resident's refusing to be weighed. A face-to-face interview was conducted with the Registered Dietician on August 5, 2008 at approximately 3:30 PM. He/she acknowledged that the record lacked a care plan for refusing to be weighed. The record was reviewed on August 5, 2008. 4. Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #5. A review of the clinical record for Resident #5 revealed physician orders dated and signed, June 20, and July 12, 2008 that included the following	F 279		

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F 279	Continued From page 36 medications: "Brimonidine Tartrate 0.2%, Bupropion, Cosopt Ocumeter Plus, Finadteride, Lorazepam, Metoprolol, Midorine, Mutivitamin, Omeprazole, and Pyridostigmine." There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications. On August 5, 2008 at approximately 4:15 PM, a face-to-face interview was conducted with Employee #1. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on August 5, 2008. 5. Facility staff failed to develop a care plan with appropriate goals and approaches for nine (9) or more medications for Resident #6. The review of the clinical record for Resident #6 revealed a physician's order dated and signed June 10, 2008 that included the following medications: Amiodipine Besylate, Aspirin, and Calcarb. W/Vit. D, Catapress-TTS, Certagen, Cymbalta, Digoxin, Colace, Ferrous Sulfate, Lisinopril, Metolazone, Metoprolol, Lopressor and Prilosec. A review of the care plan that was last updated on July 24, 2008 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of	F 279		

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F 279	Continued From page 37 nine (9) or more medications. A face-to-face interview was conducted with Employee #12 on August 8, 2008 at approximately 10:00 AM. He/she acknowledged that the record lacked a care plan for use of nine (9) or more medications. The record was reviewed on August 8, 2008 6. Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #9. A review of the clinical record for Resident #9 revealed physician orders dated and signed, May 9, June 5, and July 10, 2008 that included the following medications: "Amiodarone, Aricept, Certagen, Docusate Sodium, Lisinopril, Metamucil, Namenda, Pantoprazole, Seroquel, Viron-C, and Albuterol Sulphate." There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications. On August 6, 2008 at approximately 5:05 PM, a face-to-face interview was conducted with Employee #1. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on August 6, 2008. 7 Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of	F 279		

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F 279	Continued From page 38 nine (9) or more medications and dialysis for Resident #10. A. Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #10. The review of the clinical record for Resident #10 revealed a physician's order dated and signed July 1, 2008 that included the following medications: Amiodarone, Aricept, Allegra, Flomax, Lasix, Pravachol, Mysoline, Inderal, Rena-Vite, Senokot and Trazadone. A review of the care plan, last updated on June 30,2008, revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee # 12 at approximately 10:00 AM on August 8, 2008. He/she acknowledged that the record lacked a care plan for use of nine (9) or more medications. The record was reviewed on August 8, 2008. B. Facility staff failed to develop a care plan with appropriate goals and approaches for Dialysis for Resident #10. A review of the clinical record for the resident revealed that the resident was admitted to the facility on March 24, 2008 with diagnoses including ESRD (End Stage Renal Disease) and a physician's order directing, "Dialysis M, W (Monday, Wednesday) and Friday."	F 279		

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F 279	Continued From page 39 A review of the care plans revealed no care plan with goals and approaches for dialysis. A face-to-face interview was conducted with Employee #12 on August 8, 2008 at approximately 10:00 AM. He/she acknowledged that the record lacked a care plan for dialysis. The record was reviewed on August 8, 2008. 8. Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #12. The review of the clinical record for Resident # 12 revealed a physician's order dated and signed July 25, 2008 that included the following medications: Rocaltrol, Cardizem, Prograf, Bactrim SS, Valcyte, Clonidine, Nystatin Swish & Swallow, Stress Tabs, Nexium, Pepcid, Prednisone and Keppra. A review of the care plan, last updated on August 5, 2008, revealed that there was no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving use of nine (9) or more medications. A face-to-face interview was conducted with Employee #12 on August 8, 2008 at approximately 10:00 AM. He/she acknowledged that the record lacked a care plan for use of nine (9) or more medications. The record was reviewed on August 8, 2008. 9. Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #15. A. Review of the clinical record for Resident #15	F 279		

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F 279	Continued From page 40	F 279		

revealed physician orders dated and signed June 2008 that included the following medications:

"CalciumCarb-VitD, Benadryl, Ferrous Sulfate, Advair, Neutrontin, Oxycontin, Senna S, Dyaziade, Dilaudid, Klor-Con, Prilosec, and Cefepime."

There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications.

On August 8, 2008 at approximately 9:10 AM, a face-to-face interview was conducted with Employee #2. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on August 8, 2008.

10. Facility staff failed to develop a care plan for Resident F6 with allergies.

A review of the "Physician Order Sheet and Plan on Care" dated February 21, 2008 and signed by the physician on February 29, 2008 revealed, "Allergies cephalosporins, codeine, penicillins and tramadol ..."

A review of the care plans last updated on June 30, 2008 lacked evidence that a care plan for allergies was developed with goals and approaches to address the resident's allergies to cephalosporins, codeine, penicillins and tramadol.

A face-to-face interview was conducted on August 8, 2008 at 9:30 AM with Employee

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F 279	Continued From page 41 #Angela. He/she acknowledged that a care plan for Resident F6's allergies was developed. The record was reviewed on August 8, 2008. 11. Facility staff failed to initiate a care plan for adverse drug interactions for the use of nine (9) or more medications for Resident JH3. A review of Resident JH3's record revealed a physician's order form signed July 19, 2008, included 11 medications. The following medications were ordered: "Ascorbic Acid 500 mg tablet, Diovan 160 mg tablet, Folic Acid 1 mg tablet, Gabapentin 300 mg Capsule, Metoprolol Succinate 50 mg tablet , Multi-vitamin table, Polyethylene glycol 100% powder, Simvastin 20 mg tablet, Thiamine 100 mg tablet, Milk of magnesium 400 mg/5 ml oral suspension and Oxycodone IR 5 mg capsule." A face-to-face interview was conducted with Employee #11 on August 4, 2008 at 11:30 AM. He/she acknowledged a care plan for Resident JH3 for adverse drug interactions for the use of nine (9) or more medications was not initiated. The record was reviewed 4, 2008. 12. The Facility staff failed to initiate a care plan for adverse drug interactions for the use of nine (9) or more medications for Resident P1. A review of Resident P1's record revealed a physician's order signed July 2, 2008 that included the following 11 routine medications: "Atenolol 25 mg tablet, Docusate sodium 100 mg capsule, Gabapentin 100 mg capsule, Lidoderm 5% patch, Meloxicam 7.5 mg tablet, Multi-vitamin	F 279		

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F 279	Continued From page 42 tablet, Omega-3 softgell 1000mg capsule, Oxybutynin Cl ER 5mg tablet, Sertralilne 25 mg tablet, Sertaline 50 mg tablet, Systane 0.3% - 0.4% ophthalmic drop, Warfarin 1 mg tablet, Warfarin 2.5 mg tablet, and Warfarin 4 mg tablet." A face-to-face interview was conducted with Employee #12 on August 4, 2008 at 3:10 PM. He/she acknowledged a care plan for adverse drug interactions for the use of nine (9) or more medications was not initiated for Resident P1. The record was reviewed August 4, 2008.	F 279	F 280 483.20 Comprehensive Care Plans 1, Care Plans for resident 1,2,6,F4 Were updated. Care plans for resident #1 for discharge, pain, incontinence, self Care deficit, hypertension, anticoagulant, Wound care, pressure ulcer & infection Were updated. Care plans for resident #2 for diabetes, use of Lovenox, aspirin, psychoactive drug, dementia, ADL's, incontinence & socialization were updated.Care plans for resident #6 for	10/2/08
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 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. This REQUIREMENT is not met as evidenced by:	F 280	Cardiac disease, anemia, decubitus L heel, discharge planning, use of aspirin, ADLs & incontinence were updated. Care plans for resident # F4 for fall prevention for resident with multiple falls, bruises of unknown origin, & hourly monitoring were updated. 2. The Unit Manager audited all unit records And updated the care plans to insure Compliance. 3. The Interdisciplinary Team was educated On the need for timeliness of care plans Based on the regulations. The Interdisciplinary Team developed a Schedule for care plans & due dates Based on the MDS assessment date.	10/02/08 10/02/08

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F 280	Continued From page 43 Based on record review and staff interview for three (3) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to update the care plans with new goals and approaches for: three (3) residents with multiple care plans, one resident with bruises, and one (1) resident for hourly monitoring. Residents # 1, 2, 6 and F4. The findings include: 1. A review of Resident #1's record revealed that the resident was admitted to the facility on March 26, 2008. Care plans for discharge, pain, incontinence, self care deficit, hypertension, anticoagulation, wound care, pressure ulcer and infection were initiated on April 3 and 14, 2008. Minimum Data Set (MDS) assessments were conducted on May 28, June 4 and July 7, 2008. There was no evidence in the record that the above mentioned care plans were reviewed, evaluated and updated after the aforementioned assessments. A face-to-face interview was conducted with Employee #2 on August 5, 2008 at approximately 4:15 PM. He/she acknowledged that the above mentioned care plans were not reviewed, evaluated and updated after the they were first initiated. The record was reviewed August 5, 2008. 2. Facility staff failed to review and update care plans for Resident #2 for treatment of Diabetes, Use of Lovenox, Aspirin, Psychoactive Drug use,	F 280	The interdisciplinary team will use new interventions for each incident and each new problem. 4. The MDS Coordinator will do a monthly audit of care plans to insure date compliance and new interventions are in place. The audit will be submitted to the DON The MDS Coordinator will present to the QA Committee the systemic changes made to prevent the deficiency from reoccurring and for QA Committee recommendations. The MDS Coordinator will present the results of the audit to the QA Committee to discuss trends and areas of noncompliance , the effectiveness of the plan of correction and make corrections and recommendations to the plan to insure consistent compliance.	Ongoing Ongoing 9/18/08 Ongoing

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F 280	Continued From page 44 Dementia, ADLs (Activities of Daily Living), Incontinence and Socialization. An annual MDS assessment was completed May 8, 2008 and a quarterly MDS assessment was completed August 13, 2008. There was no evidence that the care plans were revised and/or revised after the aforementioned assessments. A face-to-face interview was conducted with Employee #2 at 10:05 AM on August 5, 2008. He/she acknowledged that the aforementioned care plans were not updated. He/she added "Care plans are updated quarterly and as needed. We've done a lot of work with her I just wish my care plans had reflected that." The record was reviewed on August 4, 2008. 3. Facility staff failed to review and update care plans for Resident #6 for treatment of Cardiac Disease, Anemia, Decubitus L Heel, Discharge Planning, Use of Aspirin, ADLs (Activities of Daily Living) and Incontinence. A significant change MDS was completed July 2, 2008. There was no evidence that the care plan was revised and/or reviewed after this assessment. A face-to-face interview was conducted with the Employee #2 at 10:05 AM on August 5, 2008. He/she acknowledged that the aforementioned care plans were not updated. He/she added "Care plans are updated quarterly and as needed." The record was reviewed on August 5, 2008. 4. Facility staff failed to update "Fall Prevention Care Plan" last updated June 10, 2008 for	F 280		

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F 280	Continued From page 45 Resident F4 with multiple falls. A review of the nursing notes revealed the following: March 1, 2008 time [unable to read] " ...slid down from wheel chair to floor ... no pain/discomfort ... " Under "Evaluation - continue with same goals and approaches." April 25, 2008 at 11:42 [am/pm not indicated] " ...medicated p.o [by mouth] as ordered, c/o [complain of] pain to right wrist, wrist purple, black, and red. No swelling noted. " Under "Evaluation - continue with same goals and approaches." June 5, 2008 at 4:00 PM " Resident found on the floor in his/her room next to his/her w/c [wheel chair]... no apparent injuries ... " Under "Evaluation - continue with same goals and approaches." July 28, 2008 at 2:00 PM " ...went to observe the hand. It was swollen-hematoma like, which was not like that when he/she was medicated at 9:30 AM ... MD [name] was called awaiting call back. " Under "Evaluation - continue with same goals and approaches." July 28, 2008 at 11:00 PM " ...Right forearm x-ray result received. No evidence of fracture noted. Area still remains swollen ... " Under "Evaluation - continue with same goals and approaches." The Falls care plan lacked evidence that it was amended with new goals and approaches for Resident F4 with multiple falls and bruises of	F 280		

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F 280	Continued From page 46 unknown origin. A face-to-face interview was conducted on August 8, 2008 at 9:30 AM with Employee #Sherry. He/she acknowledged that a care plan for Resident F4's was not updated to address the Residents falls and bruises. The record was reviewed on August 8, 2008.	F 280		
F 285 SS=D	483.20(m), 483.20(e) PREADMISSION SCREENING A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 285	F 285 483.20 Preadmission Screening 1. Resident #10 MIMR has been completed. Resident #12 has been discharged. 2. The Admissions Director will do a chart audit on all admissions from August 11th until present to insure they all have a MIMR Screen. 3. Admission Guidelines will be developed for Admission to Ingleside. These guidelines will also be the guidelines for Residents entering the Health Center from Independent and Assisted Living. All Ingleside feeder hospitals (Caseworkers) will receive a copy of the guidelines.	8/30/08 10/2/08 10/2/08 10/2/08

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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 285	Continued From page 47 and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 15 sampled residents it was determined, that facility staff failed to provide completed MI/MR (Mental Illness/Mental Retardation) screening, for Residents #10 and 12 The findings include: 1. A review of the clinical record for Resident #10 revealed that he/she was admitted to the facility on March 24, 2008 and there was no MI/MR screening on the record. A face-to-face interview was conducted with Employee #7. He/she acknowledged that the record lacked a copy of the MI/MR screening. He/she added, "The admissions clerk usually puts them on the chart." The MI/MR screen was not located at the time of this review. The record was reviewed on August 7, 2008. 2. A review of the clinical record for Resident #12	F 285	4. The Admissions Director will do a monthly chart audit on all admission to determine if the MIMR is on the record. The Director of Admissions will present to the QA Committee the systemic changes made to prevent the deficiency for reoccurring. The Director of Admissions will present the trends and areas of noncompliance based on the monthly audit to the QA Committee. The QA Committee will discuss trends, noncompliance areas, the effectiveness of the plan of correction. Make recommendations and corrections to the plan to insure consistent compliance.	Ongoing 9/18/08 Ongoing

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	095028	A. BUILDING _____ B. WING _____	08/11/2008

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F 285	Continued From page 48 revealed that he/she was admitted to the facility on July 22, 2008 and there was no MI/MR screening on the record. A face-to-face interview was conducted with Employee #7. He/she acknowledged that the record lacked a copy of the MI/MR screening. He/she added, "The admissions clerk usually puts them on the chart." The MI/MR screen was not located at the time of this review. The record was reviewed on August 7, 2008.	F 285	F 309 483.25 Quality of Care 1-1. The physician gave an order for the splint to be discontinued due to noncompliance for resident #2 1-2. The Resident #4 pain was addressed on June 11. The Resident was given routine pain patch every 72 hours. A current Pain Assessment 9/2/08 1-3 The Resident #F4 bed alarm was replaced 1-4 The Resident JH4 the nurse was counseled on administration of eye drops. 2. Unit Manager will audit all medical records to insure a noncompliant care plan is in place . 3. The Unit Manager will assess all residents with the potential for pain (Hospice pts., DJD. Arthritis,cancer etc.) and insure there is a pain assessment Failure to follow physicians order for a noncompliant resident Facility failed to apply bed/chair alarm The Unit Manager/designee will audit all residents that should have a bed/chair alarm and insure an alarm is in place.	8/13/08 9/2/08 8/7/08 8/8/08 10/2/08 10/2/08 10/2/08
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to: follow physician's orders for the use of a wrist immobilizer for one (1) resident, consistently evaluate the use of pain medications for one (1) resident, and apply a bed/chair alarm for one (1) resident. Residents #2, 4 and F4. The findings include: 1. Facility staff failed to follow a physician's order for a hand splint for Resident #2.	F 309		

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F 309	Continued From page 49 A review of the clinical record revealed an x-ray dated April 29, 2008 with the impression, "Fracture of the head of the fifth metacarpal." A second x-ray, dated June 12, 2008, documented, "Degenerative Joint Disease of Hand and Wrist with healing incompletely united spiral fracture of the distal ulna." A Report of Consultation from an orthopedic specialist dated July 31, 2008, documented, "Cast removed ... Wear protective splint for three (3) weeks. Follow up prn (as needed)." On August 4, 2008 at approximately 9:30 AM, from 11:00 AM to 12:30 PM and from 2:30 PM to 3:20 PM, Resident #2 was observed without the hand splint on his/her right arm. On August 5, 2008 from 10:00 AM to approximately 12:00 PM the resident was again observed without the hand splint. On August 6, 2008 at 10:25 AM, Resident #2 was observed seated in a wheel chair in the day room wearing a soiled hand splint on the right arm. A face-to-face interview was conducted with Employee #13 on August 4, 2008 at 3:20 PM. He/she acknowledged that the resident was not wearing a splint at that time. He/she added "[He/she] keeps removing the splint. I will call the doctor and let [him/her] know." The record was reviewed on August 4, 2008. 2. Facility staff failed to address pain management for Resident # 4. Physician's Order Sheet (POS) dated February	F 309	Facility staff failed to administer eye drops according to manufacturer specifications. Charge Nurses were educated on the importance of administering eye drops according to specifications. 3. Educate the Nursing staff on the Pain Management policy and procedure Revise the Change in Condition policy and procedure to include non compliance as a change in condition so that the physician will be notified for further direction. The licensed nursing staff will be given a competency for administration of eye drops. The licensed nurse will audit every shift the bed and chair alarm for each residents. 4. Pain management The Unit Manager will do a monthly pain audit to insure that assessments are in place and care plans initiated and or updated. The pain audit will be turned into the DON	8/5/08 10/2/08 10/2/08 10/2/08 Ongoing Ongoing

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F 309	Continued From page 50 20, 2008 revealed an order for "Propoxyphene Napsylate W/APAP 100mg/650mg tablet (WF: Darvocet-N 100) 1 [one] tab by mouth every 6 [six] hours as needed for pain." A review of the MARs (Medication Administration Record) for March, April and May 2008, revealed that the resident received Darvocet almost daily. During the month of March 2008 the resident received Darvocet at least once daily for 20 of 31 days and two (2) or three (3) times a day for seven (7) of the 20 days. A review of April' s MAR revealed that the resident received Darvocet at least once daily for 20 of 30 days and two (2) or three (3) times a day for seven (7) of 20 days. A review of May' s MAR revealed that the resident received Darvocet 26 of 31 days and two (2) or three (3) times a day for 10 of 31 days. A physician's order dated June 11, 2008, directed, "Duragesic patch 25 mcg q 72 hours. D/C (discontinue) Propoxyphene." A physician's telephone order dated June 12, 2008, unsigned by the physician, directed, "Darvocet - N100 1 tab po q 6 hrs PRN for pain." There was no evidence in the record that facility staff consistently assessed the resident's pain, and notified the physician of the resident's need for daily "as needed" pain medication for at least 90 days. A face-to-face interview was conducted with Employee #15 at approximately 9:45 AM on August 11, 2008. He/she acknowledged that the record lacked consistent documentation of the	F 309	Bed/chair alarm The Unit Manager/designee will audit daily for compliance with Chair and bed alarms. Eye Drops The Staff Development Coordinator will submit results of eye drop competencies. 4. The Don will present the systemic measure put in place to insure the deficiencies do not reoccur for QA Committee recommendation The Don will review all audits looking for trends and non compliance areas. The QA committee will discuss the trends, noncompliance areas, the effectiveness of the plan . Make corrections and recommendations to the plan to insure consistent compliance.	Ongoing Ongoing 9/18/08 Ongoing

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F 309	Continued From page 51	F 309		

evaluation of the resident's pain. The record was reviewed on August 5, 2008.

3. Facility staff failed to apply a bed/chair alarm to Resident F4 as per the physician's order.

A review of the physician's order sign and not dated February 2008 directed, "Personal [name] alarm while in bed and out of bed in chair for safety."

An observation of Resident F4's room and of Resident was conducted on August 7, 2008. There were no bed and/or chair alarms observed in the resident's room or on the resident's wheel chair.

A face-to-face interview was conducted on August 8, 2008 at 7:44 AM with Employee #11 He/she acknowledged that the bed and/or chair alarm was not on the resident's wheel chair or in the room. The record was reviewed on August 8, 2008.

4. Facility staff failed to administer eye drops to Resident JH4 as per manufacturer specifications.

The physician orders date directed," Alphafan P 0.1% drops, Instill [1] drop in each eye twice daily for Glaucoma, Trusopt ocumeter plus 2% Drops, Instill [1] drop in each eye [3] times a day for Glaucoma and Betoptic S Droptainer 0.25% drop Susp., Instill [1] drop in each eye twice daily for Glaucoma."

The manufacturer's specifications for Alphagan 0.1% eye drops stipulates, " If more that one topical ophthalmic product is being used, the products should be administered at least [5]

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F 309	Continued From page 52 minutes apart." The manufacturer's specifications for Trusopt 2% eye drops stipulates," If more that one topical ophthalmic product is being used, the products should be administered at least [10] minutes apart." The manufacturer's specifications stipules for Betopic 0.25% eye drops stipulates, "Keep the eyes closed for 1 or 2 minutes to allow the medicine to absorb." On Tuesday, August 5, 2008, at approximately 8:00 AM, during the morning medication pass. Employee # 10 observed Resident JH4 self administer eye drops. Employee # 10 offered the Resident, for self administration, one vial of eye drop a time. The Alphagan 0.1%, Trusopt 2% and the Betoptic 0.25% eye drops were all given less than one minute apart from each other. A face to face interview was conduct on August 5, 2008 at approximately 9:40 AM with Employee #10. He/she acknowledged that the medication was not administered according to the manufacturer's specifications.	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.	F 314	F 314 483.25 Pressure Ulcers 1. Resident #1 and #6 The nurses were educated on infection control practices for dressing change and proper use of treatment products 2. All residents who have wounds have the potential to be affected by the deficient practice.	8/5/08

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F 314	Continued From page 53 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview for two (2) of (two) 2 dressing changes, it was determined that proper infection control procedures were not followed to prevent infection during pressure ulcer treatments. Residents #1 and 6. The findings include: On August 5, 2008 at approximately 12:10 PM a pressure ulcer treatment was observed for Resident #1. A physician's telephone order dated August 4, 2008, directed, "Cleanse sacral wound with wound cleanser, pat dry, apply Hydrogel ointment and cover with Allevyn dressing daily. Reevaluate in 14 days." Employee #11 entered Resident #1's room with a container filled with wound care supplies for all the residents on his/her assigned care team. Employee #11 used hydrogel (wound care treatment medication) labeled for another resident. At the completion of the treatment, the soiled dressing was discarded in a plastic bag which was closed, removed from the resident's room and placed in a biohazard container in the dirty utility room. Employee #11 failed to wash his/her hands in the dirty utility room. He/she went around the unit to wash his/her hands in the medication room. The treatment basket was then removed from	F 314	Each nurse having a resident with a wound was observed doing a dressing change. 3. All licensed staff will be required to pass a competency for dressing change yearly and as needed as issues arise. The current licensed staff will be monitored for the next 30 days for compliance with infection control and the dressing change process by the Staff Development Coordinator /designee. The competency will be the tool used to measure the nurses strengths and weaknesses in the infection control process. Treatment carts will be purchased to insure each resident has their own labeled supplies. New licensed employees will have to pass a infection control competency that will include dressing change and the infection control process. The Staffing Coordinator will educate all nursing staff the infection control process.	8/30/08 Ongoing 10/30/08 8/30/08 Ongoing 10/2/08

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F 314	Continued From page 54 Resident #1's room and returned to the supply room. A face-to-face interview was conducted on August 7, 2008 at approximately 1:15 PM with Employee #11. He/she acknowledged: using hydrogel (wound care treatment medication) labeled for another resident's use, failing to wash his/her hands immediately after discarding the trash bag containing the soiled dressing from Resident #1, and using without cleaning it, the carrier containing wound care supplies after removing it from the resident's room. He/she said, "We will purchase baskets for each resident's wound care supplies from now on." 2. On August 6, 2008 at approximately 9:15 AM a dressing change was observed on Resident #6's right heel, left heel and right shin. Employee #14 washed his/her hands prior to beginning the procedure but failed to cleanse the over bed table prior to using it. The employee tore two pieces of paper towel from the towel dispenser in the bathroom. He/she placed the two pieces of paper on the table and placed the dressing change supplies on top of the paper. Upon completion of the procedure, the employee placed the bag with soiled dressings on the resident's over bed table. The employee removed the bag and placed it in the soiled utility room but failed to clean the over bed table after its use. A face-to-face interview was conducted with the employee at approximately 9:45 AM on August 6, 2008. He/she acknowledged that he/she did not clean the table after using it and added, " I always clean it off, but I was nervous because I	F 314	4. The DON will present to the QA Committee the systemic measure put in place to insure that the deficient practice does not reoccur and for recommendations. The Staff Development Coordinator will bring to the QA Committee evidence of the competencies for the 30 day competency review for the license staff, the quarterly competency review for the licensed staff, and the evidence of the orientation competency for new employees. The QA committee will discuss areas of non compliance, the effectiveness of the plan of correction . make recommendations and corrections to the plan of correction as needed.	9/18/08 Ongoing

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F 314	Continued From page 55 knew you were watching me. "	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for one (1) of 15 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to provide appropriate treatment for incontinence. Residents #2 and A3. The findings include: 1. Facility staff failed to provide incontinent care to Resident #2 in a timely manner. During an observation of the Day Room/Activity Area on August 6, 2008 at 10:25 AM, Resident #2 was observed sitting in his/her wheel chair. The resident emanated a strong odor of urine. At 10:10 AM on August 6, 2008, Employee #3 was taken over to the resident. He was told that the resident needed to be changed and that the splint needed to be cleaned. Employee #3 responded "I will get the assigned CNA (Certified Nursing Aide) to take care of	F 315	F 315 482 Urinary Incontinence 1. Resident #2, and A3 were given incontinent care. 2. All resident will checked to insure continence care was given on 8/6 and 8/7 3. Incontinent Rounds will be done every 2 hours. The nursing assistants will initial on the nursing assistant rounds sheet that they have given incontinent care. The rounds sheets will be in each residents rooms. The licensed staff will check the nursing assistant rounds sheet daily and document on the TAR that incontinent care has been given. The Unit manager will review the nursing rounds list weekly and submit to the DON 4. The DON will present the systemic changes made to insure the deficient practice does not reoccur and for QA recommendations The DON will review the audits looking for trends and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee . The QA Committee will determine the effectiveness of the plan of	8/6 & 8/7/08 Ongoing 9/18/08 Ongoing

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F 315	Continued From page 56 [him/her]." Employee #3 returned approximately five (5) minutes later and stated "I told the CNA. [He/she] is taking care of another resident and will come as soon as [he/she] is finished." At 10:50 AM, 40 minutes later Employee # 3 returned and stated "I went to check on the CNA. [He/She] is still with the other resident. I reminded [him/her] to come and take care of this resident when [he/she] is finished over there. " At 11:20 AM Employee # 8 walked over to the resident and proceeded to wheel him/her out of the room. When asked where he/she was taking the resident, the employee responded, "I am going to change [him/her]." At 11:35 AM, Employee #8 wheeled the resident back into the day room. The record was reviewed August 6, 2008. 2. Facility staff failed to provide timely incontinence care for Resident A3. The resident was observed seated in wheelchair in the day room on August 7, 2008. At approximately 2:30 PM, the resident was observed wet with a strong urine odor bilaterally from the thighs to the waist. Approaches and intervention for an "Incontinence Care Plan" [related to recent decreased mobility] dated June 30, 2008 indicated: "Toilet every two (2) hours and as needed to decrease number of incontinent episodes. Keep resident dry, especially after each episode of incontinence." A face-to-face interview was conducted with Employee#10 on August 7, 2008 at approximately	F 315	the plan of correction and make recommendations to the plan to insure consistent compliance.	

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F 315	Continued From page 57 1. Facility staff failed to provide adequate supervision for Resident #2 who had multiple falls and multiple injuries. Resident #2 sustained a fracture of the fifth metacarpal of the left hand, a fracture of the left distal ulna, a hematoma to the left side of the forehead and a skin tear to the nostril. According to the following nurses' notes: April 20, 2008 at 7:55 PM, "Resident observed lying on floor by her w/c [wheel chair] lying on her right side in her room. No visible injury noted." On April 20, 2008 the Fall Prevention Care Plan initiated March 31, 2008 was updated to include : "...neuro[neurological] checks..., Rehab [rehabilitation] referral and X-ray to bilateral hips." On April 22, 2008 [no time noted] the resident was again observed sitting in the dining room. The nurse documented on the care plan that "[Resident] pushed self out of the wheel chair. " The additions to the Fall Prevention Care Plan on April 22, 2008 were: "Will encourage resident to participate in activities and distract from doing things of this nature." Nursing note dated April 24, 2008 at 3:00 PM states: ..."Bruises visible on both arms." Nurse's note on April 26, 2008 at 11:45[no AM or PM noted], "Resident was observed sliding out of her wheel chair in the dining room. Upon assessment 0 [no] skin tear was sustained. ROM [Range of Motion] WNL [Within Normal Limits]. "	F 315	F 323 483.25 Accidents and Supervision Nursing 1. Resident #1 Update care plans Continue psych evaluations Insure unit staff understand the plan care Monitor for change in condition	10/2/08
F 323 SS=E		F 323	Resident #F6 Update care plans Give the resident preventive care (Protective stocking net, padded side rails) Insure the unit staff know the plan of care Monitor for change in condition	10/2/08
			Resident # 13 Update the plan of care. Continue hourly rounds Continue fall precautions. Monitor for change in condition	10/2/08
			2. All residents that are risk for falls, have a diagnosis of dementia, poor gait ,wander risk, fragile skin , poor eye sight etc. have the potential for accidents and physical injury without proper supervision All care plans for residents that have the potential for injury will be reviewed to insure that care plans and preventive measure are in place.	10/2/08

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	12:30 AM. He/she said, "I am taking the resident back to [his/her] room now to provide incontinence care." Employee #10 acknowledged that the resident was last provided incontinent care in the morning, before breakfast at approximately 8:30 AM. The record was reviewed on August 7, 2008. 483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for three (3) of 15 residents and one (1) supplemental residents, it was determined that facility staff failed to provide adequate supervision for: two (2) residents with multiple falls and subsequent injuries, supervise residents in the day rooms and dining rooms, one (1) resident with bruises of unknown origin and maintain a hazard free environment as evidenced by fluctuating water temperatures in residents' rooms, eye drops and chemicals in resident rooms, extension cords present in residents' rooms, fray resident bed cords, burner to gas oven failed to ignite, unsecured oxygen tanks, access panel to trash compactor opened, unsecured window screen in a resident's room and torn carpet. Residents #2,13, and F6. The findings include:		3. <u>Education</u> Educate all nursing staff on the prevention of accidents Continue to educate nursing staff on transfer training Educate the licensed staff regarding their responsibility in accident and supervision of staff in the prevention of accidents. Educate all staff regarding what constitutes abuse <u>Staff Accountability</u> Staff will be disciplined for not following a resident plan of care. The name of the staff involved in the incident will be recorded to look for patterns for opportunity to educate. The DON will conduct weekly unit rounds x 60 days with a unit nursing assistant, charge nurse, unit manager to monitor the units for possible accidents During mealtimes the charge nurse must insure staff are in the dining room supervising (1) charge nurse (1) nursing assistant at all times	10/2/08 Ongoing 10/2/08 10/2/08 Ongoin Ongoin Ongoing

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	095028	A. BUILDING _____ B. WING _____	08/11/2008

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F 323	Continued From page 59 April 26, 2008 at 9:50 PM, "Resident purposely [threw] herself on the floor x 3 [three]. No injury noted. MD [Medical Doctor] aware. Call placed to R/P [Responsible Party]." Nurse's note dated April 29, 2008 at 3:00 PM states: Resident's right hand is swollen and discolored....Resident states she did not know how it happen. MD [Medical Doctor] made aware order given for X- Rays of L [Left] hand...". A fracture of the head of the fifth metacarpal was confirmed by an x-ray report dated April 29, 2008. May 3, 2008 at 10:20 AM, "Writer observed resident on the floor in t. v [television] room Resident stated, 'I was reaching for something on the floor.' On assessment bump visible on (L) [left] side of forehead ... Resident transferred to [hospital] via [by means of] stretcher. An X-ray reported dated May 5, 2008 documented the following note: "Views of the skull show no fracture or osseous lesion." Review of Consultation report dated May 6, 2008 of Dr. Marc Danzier [orthopedic]revealed: Return in two (2) weeks ... X-ray left hand and send X-ray with patient. Review of Consultation report dated May 22, 2008 of Dr. Marc Danzier [orthopedic]revealed: "...pain Distal Ulna ..X-ray left hand and left forearm..." Review of Consultation report dated July 10, 2008 of Dr. Marc Danzier [orthopedic]revealed: s/p left forearm fracture..."	F 323	This information will noted on the nursing assignment sheet. The Unit Managers will conduct a Managers Report 2x a week to review incidents and accidents, resident plans of care. This report will be written and reviewed with staff and will be able available for the weekend supervisors to review with staff. The managers will be required to come in on off shifts to do the Managers report. A letter will be sent to all families and residents to educate them on the hazards of unsecured medications at the bedside as well as chemicals (sprays etc.) The 3-11 supervisor will be responsible for checking the oxygen rooms to insure the oxygen tanks are secure. They will required to initial the oxygen check sheet. Recreation Therapy will provide activities in the dayroom as part of keeping the residents safe Resident can never be alone in the dayrooms. Rules will be developed to insure that residents are safe. All incident reports dating fromAugust 11th up until present will be reviewed and faxed to the state if they have not already been faxed.	Ongoing Ongoing 10/2/08 Ongoing Ongoing Ongoing 10/2/08

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F 323	Continued From page 60 According to an x-ray report dated June 12, 2008, "The left forearm reveals an incompletely united healing fracture of the distal ulna in good alignment. Impression: Healing Fracture of Distal Ulna. " The medical record lacked evidence that Facility staff provided adequate supervision to prevent resident #2 from having repeated falls and subsequently sustaining injuries. A face-to-face interview was conducted with Employee #2 on August 11, 2008 at approximately 9:15 AM. He/she acknowledged the x-ray result of June 12, 2008 which confirmed the fracture of the distal ulna. However, Employee #2 stated that he/she had no knowledge of the fracture of the distal ulna and stated, "I was aware of the fracture of the fifth metacarpal." Employee #2 added, "We did a lot of work with [him/her] and [he/she] has improved. I just wish the care plans would have reflected that." The record was reviewed on August 4, 2008. 2. Facility staff failed to provide adequate supervision for Resident #13 who fell and subsequently sustained an injury. A review of the resident's clinical record revealed that he/she was admitted to the facility on June 27, 2008. According to the Minimum Data Set (MDS) assessment, complete on July 9, 2008, Section I1 " Diseases " , the resident's diagnosis included "Seizure disorder, epileptic grand mal status." Section J1 " Problem conditions" included "Delusions."	F 323	4. The DON will present to the QA Committee the systemic changes made to insure the deficient practice does not reoccur. The DON will present the incident reports , trends and areas of noncompliance as a result of the review of the incident reports. The DON will trend the incident report and look at the following areas: Time of day Diagnosis Nursing Assistant /Charge nurse looking for patterns and opportunity for education and disciplinary action Medications Adequacy of staffing. The QA Committee will discuss the trends, areas of noncompliance, the effectiveness of the plan of correction. Make recommendations and corrections to the plan of correction to insure consistent compliance.	9/18/08 Ongoing

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F 323	Continued From page 61 A review of the nurses' notes revealed the followings: June 27, 2008, time not indicated, "Rs. [Resident] alert and pleasantly confused ... " June 28, 2008 at 2:30 PM, " Resident alert and oriented x 1, [with] periods of confusions ...new-admit ... " June 28, 2008, no time indicated, "Resident observed with bluish discoloration and swelling on right cheek, bilateral upper arm and right forehead also noted with bluish discoloration ... " A face-to-face interview was conducted with Employee #1 on August 7, 2008 at 3:00 PM. He/she stated, "An investigation was conducted regarding concerns from the daughter about her mother's bruises. We found out that staff on the evening shift found [Resident #13] on the floor." There was no evidence that facility staff initiated interventions to prevent the resident from falling. Facility staff failed to provide adequate supervision for the resident who was a new admission to the facility and with documented periods of confusion and diagnosis of seizure disorder. Face-to-face interview was conducted with Employee #12 on August 7, 2008 2:00 PM. He/she acknowledged that the newly admitted resident lacked adequate supervision. The record was reviewed on August 7, 2008. 3. Facility staff failed to provide adequate supervision for residents while in the dining rooms and day rooms.	F 323		

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F 323	Continued From page 62 A. On August 5, 2008 at approximately 7:45 AM, on the lower level unit, Resident #9 was observed alone in the dayroom playing with his/her wheelchair, pushing the wheelchair against the door back and forth. Resident# 9 then attempted to get out of his/her wheelchair. The resident's chair alarm went off. It took approximately 15 minutes before Employee #11 came to readjust the resident in the wheelchair and reset the chair alarm. A review of the resident's record revealed a nurse's note dated July 24, 2008 at 8:15 PM, "Resident observed on the floor..." Face-to-face interview was conducted with Employee #11 on August 5, 2008 at approximately 1:30 PM 2:00 PM. He/she acknowledged that the aforementioned resident lacked adequate supervision. B On August 7, 2008 at 8:40 AM, Resident F7 was observed eating breakfast in the upper level dining room with a nose bleed from the right nostril. At the time of the observation, facility staff was not present in the dining room. The surveyor summoned a facility staff member to assist Resident F7 in the dining room. 4. Facility staff failed to provide adequate supervision for Resident F6 who was observed with bilateral darken red eyes. A review of Resident F6's record revealed the following nursing notes: May 26, 2008 at 11:00 [am/pm not indicated], "...Left eye 2 x 1.75 x 0x 0 cm (centimeters) no opening dark red in color. Right eye 1.25 x 2.5 x 0 x 0 no opening dark red in color. RCC [resident	F 323		

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F 323	Continued From page 63 care coordinator] made aware, nursing will continue to monitor ... " May 27, 2008 at 11:00 [am/pm not indicated], " ..Resident receives eye drops that his /her skin is also fragile and that he/she bruises easily. Staff has been made aware that gentle pressure should be applied when administering eye drops." A face-to-face interview was conducted with Employee #2 on August 7, 2008 at approximately 2:30 PM. He/ she stated, "There was no investigation and we didn't report it to the state." The record was reviewed August 7, 2008. 5. During a tour of the rehabilitation unit kitchen on August 4, 2008 at 12:45 PM, the hand washing sink water temperature was recorded as 123 degrees Fahrenheit (F). On August 4, 2008 from 1:10 PM until 2:30 PM additional water temperatures were taken in at sinks located in resident rooms on the rehabilitation unit. These observations were made in the presence of Employee #28. On August 4, 2008 from 1:10 PM until 2:20 PM, the water temperature readings of the sinks in six (6) occupied resident rooms were as follows: 46 111 F 45 116.9 F 44 122.8 F 43 120.5 F 42 119.8 F 41 122.3 F 40 120.8 F A face-to-face was conducted with Resident F8 at 3:00 PM on August 4, 2008. He/she stated, "I	F 323	F 323 483.25 Accident and Supervision Maintenance – Water Temperature 1. All 7 Rehab room temperature were adjusted to under 110 degrees 2. All rooms the Health Center are affected A Maintenance employee will be assigned daily to inspect 6 rooms in the Health Center to inspect. (2) Upper Level (2) Lower Level (2) on the Rehab Unit. 3. Develop a Water Temperature Policy and Procedure The Maintenance Manger will do random checks weekly and record them in the Water Temperature Log Book 4. The Facilities Director will present to the QA Committee the systemic changes made to insure the deficient practice does not reoccur and for QA Committee recommendations. The Facilities Director will present findings of the Water Temperature	8/4/08 Ongoing 10/2/08 Ongoing 9/18/08 Ongoing

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F 323	Continued From page 64 mix the water just like it like it. " A face-to-face interview was conducted on August 4, 2008 at approximately 6:25 PM with Employee #31. He/she acknowledged that the water temperatures were too high. " They [the water temperatures] were above 120 degrees Fahrenheit. We adjusted the mixing valves in all seven (7) rooms. The water temperatures are now below 110 degrees. " At 6:30 PM on August 7, 2008 the following water temperatures were recorded at the sinks in resident rooms: 46 104.4 F 45 104.0 F 44 108.2 F 43 105.8 F 42 109.4 F 41 108 F 40 106 F 6. Unsecured medications and chemicals were observed in the following resident rooms: Alphagan 0.15% ophthalmic solution on the counter top of room 45's bathroom. Lysol wipes and spray bottle in room 46 at 12:06 PM in August 5, 2008 Woolite carpet cleaner and one (1) can of Lysol spray in room 88 on August 5, 2008 at 3:15 PM One (1) Lysol spray can in room 92 at 3:20 PM on August 5, 2008 Tube of Lantiseptic skin protect ant on overbed table in room 97 on August 5, 2008 at 3:30 PM The above cited rooms were on the Lower Level. Staff identified five (5) wanders located in rooms 78, 88, 93, 94, and 99. These findings were acknowledged by Employees #28 and 29 at the	F 323	Audits and discuss trends, noncompliance issues, the effectiveness of the plan of correction. The QA Committee will recommend corrections to plan as needed to insure compliance. Nursing 6. Unsecured medications and chemicals. 1. All unsecured medications and chemicals were removed from residents in room #'s 78, 88, 93, 94, 99 2. All resident rooms in the Health Center were checked unsecured medications and chemical. Any unsecured medications and chemicals were removed. 3. Weekly Nursing Rounds will be conducted weekly x 60days then monthly. Nursing will be educated on unsecured medications and chemicals by the Educator A letter will be sent to all families and residents to help them understand the risk of having unsecured medications and chemicals in residents room. The weekly rounds list will be reviewed at QA.	8/7/08 8/7/08 Ongoing

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F 323	Continued From page 65 time of the observations. 7. Extension cords were observed in the following residents' rooms: Room 92 plugged into wall not attached to any device at 1:00 PM on August 4, 2008 Room 72 plugged into a television on August 5, 2008 at 2:30 PM Room 170 attached to a television at 3:40 PM on August 5, 2008 Room 189 plugged into a multi-plug outlet on August 6, 2008 at 9:50 AM These findings were acknowledged by Employees #28 and 29 at the time of the observations. 8. Frayed bed cords were observed in rooms 42 and 43 on August 5, 2008 at 11:55 AM. A face-to-face interview was conducted with the resident in room 43 at the time of the observation. He/she stated, "A frayed bed cord does not cause me any discomfort." These findings were acknowledged by Employees #28 and 29 at the time of the observations. 9. On August 4, 2008 at 9:20 AM, in the main kitchen, Employee #27 turned on the front middle burner of the gas stove. One side of the burner did not ignite. Employee #27 stated at the time of the observation, "We use the lighter to light the burner." 10. Three (3) of seven (7) oxygen tanks were observed stored on the follow in the oxygen closet and in room 192. These findings were acknowledged by Employees #28 and 29 at the time of the observations. 11. An electrical plug was observed tied with a string to the electrical outlet in room 70 on August 5, 2008 at 2:10 PM. These findings were acknowledged by Employees #28 and 29 at the time of the observations.	F 323	Maintenance Electrical Cords 1. All extension cords were removed from rooms 92, 72, 170 and 189. Frayed electrical cords found in rooms 42,43 were repaired The burner that would not ignite was repaired the next day All oxygen tanks that were stored on the floor were put into appropriate holders. Employees were educated about the proper way to store oxygen tanks. The string was removed from room 70 The Maintenance Supervisor secured the activation box 8/5 The screen in room 45 was secured on 8/5 The carpet in room 41 was repaired. 2. All rooms in the Health Center were reviewed for potential areas for accidents or unsafe conditions. The Maintenance Department will conduct rounds weekly for 30 days and then monthly.	8/5/08 8/5/08 8/5/08 8/5/08 8/5/08 10/2/08 10/2/08

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F 323	Continued From page 66 12. On August 4, 2008 at approximately 3:45 PM the activation box for the trash compactor was observed opened. On August 5, 2008 at 11:15 AM the activation box for the trash compactor was again observed opened. A face-to-face interview with Employee #28 acknowledged that the pad lock to secure the door was missing. 13. In room 45 a screen to an outside window was not secured and the window was partly opened on August 5, 2008 at 12:01 PM on ground floor. These findings were acknowledged by Employee #28 at the time of the observations. 14. Carpet was observed torn and/or damage in the walking path of room 41 on August 5, 2008 at 11:28 AM. These findings were acknowledged by Employees #28 and 29 at the time of the observations.	F 323	4. The Facilities Director will present to the QA Committee the systemic measures put in place to insure the deficient practice does not reoccur. The QA Committee will give recommendations regarding the systemic measures. The Facilities Director will present trends, areas of noncompliance from the Maintenance Rounds . The QA Committee will discuss the trends , areas of noncompliance, the effectiveness of the plan of correction . Make recommendations for corrections for the plan of correction to insure consistent compliance.	9/18/08 Ongoing
F 332 SS=F	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for two (2) of 33 supplemental residents, it was determined that facility staff failed to ensure a medication error rate less than five (5) percent during medication administration. Thirty-nine opportunities were observed with four (4) errors for an error rate of 10.25%. Resident's JH1 and JH4. The findings include: Licensed staff failed to ensure that the facility was	F 332		

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F 332	Continued From page 67 free of a medication error rate of 5% or greater. The medication error rate for the facility was 10.25 % based on the results of the medication passes observed on August 4 through 5, 2008; one (1) significant medication error and three (3) non-significant medication errors. 1. During the medication pass observation on August 5, 2008 at 9:00 AM, Resident JH4 was observed chewing a potassium chloride capsule. A physician's order dated August 5, 2008, directed, "KCL 10 mEq, give 2 capsules q d (daily)." According to the manufacturer's recommendations on the package insert, "Do not crush, chew, break, or suck on an extended-release table or capsule. Swallow the pill whole." A face-to-face interview was conducted with Employee #13 at the time of the observation. He/she acknowledged that the resident should not have chewed the capsule. The record was reviewed August 5, 2008. 2. Facility staff failed to administer eye drops to Resident JH1 as per manufacturer specifications. The physician orders dated August 5, 2008, directed," Alphagan P 0.1% drops, Instill [1] drop in each eye twice daily for Glaucoma, Trusopt ocumeter plus 2% Drops, Instill [1] drop in each eye [3] times a day for Glaucoma and Betoptic S Droptainer 0.25% drop Susp., Instill [1] drop in each eye twice daily for Glaucoma." The manufacturer's specifications for Alphagan	F 332	F 332 483.25 Medication Errors 1. The nurse was counseled for resident # JH4 chewing the Potassium Capsule. The order was changed to liquid potassium on 9/24/08 The nurses giving this residents eye drops were counseled and instructed to read the manufacturers specifications. 2. All medications were assessed by the charge nurse for each resident to insure that medications that should not be crushed or chewed were given as the manufacturer suggest and that the resident took the medication as specified. If the resident did not the MD was notified and the order changed. 3. Educate all licensed nurses regarding medication administration. All licensed staff will be given a competency for medication administration. New licensed staff will be required to pass a competency during orientation. Supply each MAR with a do not crush list.	8/5/08 8/5/08 8/5/08 & 8/6/08 10/2/08 Ongoing 10/2/08

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F 332	Continued From page 68 0.1% eye drops stipulates, " If more that one topical ophthalmic product is being used, the products should be administered at least [5] minutes apart." The manufacturer's specifications for Trusopt 2% eye drops stipulates," If more that one topical ophthalmic product is being used, the products should be administered at least [10] minutes apart." The manufacturer's specifications stipules for Betopic 0.25% eye drops stipulates, "Keep the eyes closed for 1 or 2 minutes to allow the medicine to absorb." On Tuesday August 5, 2008, at approximately 8:00 AM, during the morning medication pass. Employee #10 observed Resident JH1 self administer eye drops. Employee #10 offered the eye drops to the resident for self administration one (1) vial at a time. The Alphagan 0.1%, Trusopt 2% and the Betoptic 0.25% eye drops were all given less than one minute apart from each other. A face-to-face interview was conduct on August 5, 2008 at approximately 9:40 AM with Employee #10. He/she acknowledged that the medication was not administered according to the manufacturer's specifications. The record was reviewed August 5, 2008.	F 332	The Staff Development Coordinator will do random med pass monthly x 60 days and then quarterly to insure compliance with medication administration. Med errors determine during the audit will be captured to be included in the Med Error QA. 4. The DON will present to the QA Committee the systemic changes made to insure compliance and for QA Committee recommendations. The Staff Development /designee will present to the QA Committee trends, areas of noncompliance regarding med pass results. The QA Committee will discuss trends, areas of noncompliance, the effectiveness of the plan of correction. Make recommendations for corrections to the plan to insure consistent compliance.	Ongoing Ongoing 9/18/08 Ongoing
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 333		

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F 333	Continued From page 69 by: Based on observation, record review and staff interview, it was determined that the facility staff failed to ensure that JH4 was free from a significant medication error. The findings include: During the medication pass observation on August 5, 2008 at 9:00 AM, Resident JH4 was observed chewing a potassium chloride capsule. A physician's order dated August 5, 2008, directed, "KCL 10 meq, give 2 capsules q d (daily)." According to the manufacturer's recommendations on the package insert, "Do not crush, chew, break, or suck on an extended-release table or capsule. Swallow the pill whole." A face-to-face interview was conducted with Employee #13 at the time of the observation. He/she acknowledged that the resident should not have chewed the capsule. The record was reviewed August 5, 2008.	F 333	F 333 483.25 Medication Errors 1. The order for resident JH4 was changed to liquid KCL daily. The nurse was counseled regarding the error. 2. All medication was assessed by the charge nurses to insure that those medications that should not be crushed or chewed were taken properly. If the resident could not take the medication correctly the MD was notified for further orders. 3. Educate all licensed nursing staff on medication administration. All licensed nurses will be required to pass a competency for medication administration. Newly hired licensed nurses will required to pass a competency during orientation. Supply each med cart with a DO Not Crush list The Staff Development Coordinator will do random med pass monthly x 60days then quarterly	9/24/08 10/2/08 10/2/08 Ongoing
F 371 SS=F	483.35(i)(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 a tour of the main	F 371		

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	095028	A. BUILDING _____ B. WING _____	08/11/2008

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F 371	Continued From page 70 kitchen on August 4, 2008 between 8:45 AM and 1:18 PM and August 5, 2008 from 10:00 AM to 12:30 PM, it was determined that facility staff failed to prepare, store and serve food in a safe and sanitary manner as evidenced by the following: soiled hotel pans, storage bins, shelves, exterior surface of storage bins; unlabeled, undated and/or expired foods stored in refrigerators, sanitizer bucket stored near food, no trash receptacles near hand washing sinks, bins with no covers, residents entering the kitchen area without hairnets and one (1) employee not washing hands or changing gloves between tasks. These observations were made in the presence of Employees #27 and 30. The findings include: 1. Hotel pans were stored wet or soiled after washing in six (6) of 11 hotel pans of various sizes observed in the main kitchen. This is a repeat deficiency from the annual certification survey completed September 26, 2007. 2. Two (2) storage bins used for flour and sugar were observed soiled on the exterior with accumulated debris in two (2) of two (2) bins observed. This is a repeat deficiency from the annual certification survey completed September 26, 2007. 3. Storage bins used for clean utensils were observed soiled with an accumulated white substance on the bottom of the bin in three (3) of (8) eight bins observed. This is a repeat deficiency from the annual certification survey completed September 26, 2007. 4. Shelves in the main kitchen across from the	F 371	4. The DON will present to the QA Committee the systemic measures put in place to insure the deficient practice does not reoccur and take recommendations from the QA Committee The Staff Development Coordinator will present trends and areas of non compliance to the QA Committee to discuss the trends, areas of noncompliance, the effectiveness of the plan of correction . Make corrections and recommendations to the plan to insure compliance. F 371 483.35 Food Service Prep 1. Kitchen re-organized, placed drying rack next to 3 compartment sink .9/18/08 2. After inspection of the kitchen it was agreed to reorganize 9/18 3.Clean and dry items are stored in a separate location away from dirty and drying area. In- serviced staff on 9/19 4. A Pot and Pan inspection is done every morning and documented on the Pot and Pan inspection Form The Assistant Director of dining	9/18/08 Ongoing 9/18/08 9/18/08 9/19/08 Ongoing 9/18/08

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F 371	Continued From page 71 gas stove in one (1) of three (3) counter tops observed soiled. 5. Exterior surface of flour and pasta bins in two (2) of two (2) bins observed with accumulated grease. 6. Food was observed unlabeled, undated and/or expired in refrigerators in the main kitchen and upper and lower level pantries. This is a repeat deficiency from the annual certification survey completed September 26, 2007. Main Kitchen: Refrigerator #2 One (1) hotel pan of assorted fresh cut melons Six (6) of six (6) undated containers of assorted salad dressings Four (4) hotel pans of assorted fresh vegetables undated and unlabeled One (1) hotel pan of blueberries and strawberries undated and unlabeled Refrigerator #3 One (1) container of whipped topping undated when opened. One (1) package each of Swiss, Goat, Provolone and Pepper Jack cheese undated when opened. One (1) package of blue cheese and Cheddar cheese with a green substance on the top, bottom and sides. One (1) package of cheese with expiration date of August 3, 2008. Two (2) packages of cream cheese expired May 9, 2008. Four (4) packages of cream cheese expired July 4, 2008. Refrigerator #4	F 371	services and Executive Chef will present the systemic changes made to insure the deficient practice does not reoccur. The Executive Chef and the Assistant Director of Dining Services will review the trends and areas of noncompliance .The QA committee will discuss the trends and areas of noncompliance to determine the effectiveness of the plan of correction and make recommendations for the plan to insure consistent compliance. Sugar and Flour Bins 1.Flour and Sugar Bins were placed on daily cleaning list for the receiver 2. The areas must be checked daily 3. The Cleaning Check list includes a supervisor check. Grand check to be completed by the Director monthly There is a daily check for the cleaning list. 4. The Assistant Director Dining Services will present the systemic changes made to insure the deficient practice does not reoccur and for recommendations from the QA Committee. The Assistant Director of Dining will review the schedules and inspections looking for trends and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA committee.	Ongoing 8/30/08 Ongoing Ongoing 9/18/08 Ongoing

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F 371	Continued From page 72 One (1) bottle of horseradish sauce with no open date. One (1) container of hard boiled eggs dated July 6, 2008. One (1) jar of capers with expiration date of June 22, 2008. One (1) container of chocolate pudding dated July 14, 2008. Refrigerator #6 Seven (7) of seven (7) containers of brown and withered fresh herbs. One (1) box of breakfast sausage with manufacturer ' s direction of " Keep Frozen " One (1) hotel pan of fish with no label or date. One (1) package of turkey bacon undated. One (1) package each of sirloin, quarter chicken legs and beef top round uncooked and undated. One (1) pan of cooked lasagna undated. One (1) container of mixed greens undated and unlabeled. (1) hotel pan each of uncooked flank steak and chicken parts undated, unlabeled and uncovered. One (1) piece of lamb, uncooked, dated June 8, 2008. 12 containers of tofu with expiration date of June 17, 2008. One (1) package of bacon with open date of July 18, 2008. One (1) container of chopped onions dated July 26, 2008. One (1) package of scrapple with " Use by July " with no expiration date. One (1) storage rack inside the refrigerator had accumulated red, thick liquid. 7. A bucket of sanitizer was observed sitting on the shelf of the steam kettle where food was being prepared.	F 371	The QA Committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance. Unlabeled, undated and no use by dates Refrigerators listed; #2, #3, #4. #6 1. All food that is delivered is to be dated. Any food not in its original container will be identified by the RED Label. This label contains: Product name, today's date, expiration date and initials of the person labeling the product. The products in refrigerator #2,3.4. and 6 were disposed.of. 2. 2. Dressing are another areas of concern. Upon opening they need to be given an expiration date. The expiration date is 30 days after opening. 3. All staff inserviced on the labeling procedure. The Chef and Sous Chef do daily checks on the check list to insure that the food products are dated , labeled and initialed. 4. The Assistant Director of Food Service will present the systemic changes made to insure the deficient practice does not reoccur.	Ongoing 8/6/08 Ongoing 10/2/08 Ongoing 9/18/08

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F 371	Continued From page 73 8. There were no trash receptacles near the hand washing sinks in three (3) of three (3) sinks observed. 9. Bins containing onions and rice were observed with no covers in two (2) of two (2) bins observed in the dry storage room. 10. Facility staff failed to ensure that residents entering the kitchen applied a hair net. According to 22 DCMR 3219.6 " Each food service employee shall wear either a hair net or other head covering. " During a tour of the main kitchen and pantry kitchen the following was observed: On August 4, 2008 at approximately 9:10 AM one (1) resident was observed in the main kitchen with out a hair net. On August 4, 2008 at approximately 9:35 AM two (2) residents were observed in the main kitchen without hair nets. On August 7, 2008 at 8:16 AM one (1) resident was observed in the kitchen without a hair net preparing a tray his/her family member. 11. On August 7, 2008 at 8:25 AM it was observed that Employee #21 entered the kitchen wearing a pair of white plastic gloves. He/she secured a thermometer from his/her pocket, took temperatures of the food on the serving line, failed to clean the temperature probe between different foods, plated one (1) resident's food, left the kitchen, went into the dining room and took residents ' orders, opened sugar packs, peeled a banana, opened milk cartons, returned to the kitchen and plated food. Hands were no washed	F 371	The Assistant Director of Food Service will review the inspections and check list looking for trends and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance.	Ongoing

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F 371	Continued From page 74 and gloves were not changed between any of these activities. 12. One (1) scooper was observed stored in the flour bin in the main kitchen. Employees #27 and 30 acknowledged the above findings at the time of the observations. 3219.1 as is with no changes needed	F 371		
F 372 SS=D	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations during the tour of the main kitchen, it was determined that trash was not disposed of properly and trash was not disposed of properly in the loading dock area. The findings include: 1. On August 4, 2008 during the tour of the main kitchen two (2) of two (2) trash receptacles were observed to have paper trash not separated with no lid on one (1) of the trash receptacles. 2. On August 4, 2008 at 3:45 PM and August 5, 2008 at 10:15 AM trash was observed on the ground outside around trash compactor. Employees #27 and 29 acknowledged the trash around dumpster at the time of the observations.	F 372	F 372 483.36 Sanitary conditions 1. The main kitchen trash was emptied. 8/4/08 The trash was removed around the trash compactor on 8/5/08 2. All trash receptacles were checked to insure they were not overflowing and had a lid on top. 3. The Kitchen Supervisor will add to the daily kitchen check trash receptacles to insure the trash is properly disposed of. Educate kitchen staff on the proper disposal of garbage and refuse. The Maintenance Supervisor will add to the daily check the compactor to insure the trash around the compactor is properly placed. 4. The Supervisors for the kitchen and Maintenance will present to the QA Committee the systemic changes made to insure the deficient practice does not reoccur. The Supervisors will present findings of the audits looking at trends and areas of noncompliance. The QA Committee will made	8/4/08 8/5/08 8/5/08 Ongoing 10/2/08 Ongoing 9/18/08

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F 372	Continued From page 75 3237.2 - Sounds good Kind of a catch all	F 372	F 366 483.40 Physician Visits F 386 483.40 Physician Visits	
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: Based on record review and staff interview for one (1) of 15 sampled residents and one (1) supplemental resident, it was determined that the physician failed to: address pain management for one (1) resident and to write an order to include the diagnosis of Lipidemia for one (1) . Residents #4 and P1. The findings include: 1. Physician failed to address pain management for Resident #4. Physician's Order Sheet (POS) dated February 20, 2008 revealed an order for "Propoxyphene Napsylate W/APAP 100mg/650mg tablet (WF: Darvocet-N 100) 1 [one] tab by mouth every 6 [six] hours as needed for pain." A review of the MARs (Medication Administration Record) for March, April and May 2008, revealed that the resident received Darvocet almost daily.	F 386	1. Resident P1 the diagnosis of Lipidemia was added to the medical record 9/25/08 A pain assessment was completed for resident #4 and the resident is on routine pain medication the physician will be notified to address the residents pain in the progress note by 10/2/08 2. All the medical records will be assessed to determine if any resident that may have a pain care plan that the MD addressed the pain status in the monthly progress note. If not the MD will be notified . All medical record will be assessed to insure all diagnosis are current. If not the diagnosis will be added to the POS. 3. The Medical Director will respond to the facility physicians via a letter to inform them about the deficiencies obtained during survey and remind them of the regulation requirements for physicians in long term care.	9/25/08 10/2/08 10/2/08 10/2/08 10/2/08

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F 386	Continued From page 76 During the month of March 2008 the resident received Darvocet at least once daily for 20 of 31 days and two (2) or three (3) times a day for seven (7) of the 20 days. A review of April's MAR revealed that the resident received Darvocet at least once daily for 20 of 30 days and two (2) or three (3) times a day for seven (7) of 20 days. A review of May's MAR revealed that the resident received Darvocet 26 of 31 days and two (2) or three (3) times a day for 10 of 31 days. A physician's order dated June 11, 2008, directed, "Duragesic patch 25 mcg q 72 hours. D/C (discontinue) Propoxyphene." A physician's telephone order dated June 12, 2008, unsigned by the physician, directed, "Darvocet - N100 1 tab po q 6 hrs PRM for pain." The physician visited the resident on February 26, 2008, March 18, 2008, May 10, 2008, June 11, 2008 and June 23, 2008 but failed to address the resident's pain status in the progress notes for the aforementioned dates. A face-to-face interview was conducted with the DON. He/she acknowledged that the physician failed to document on the resident's pain status. The record was reviewed on August 5, 2008. 2. The physician failed to write an order to include the diagnosis of Lipidemia in Resident P1's record. On August 4, 2006, at approximately 2:30 PM, during the reconciliation of the medication pass	F 386	The Unit Managers will audit the medical record monthly for those residents that have a diagnosis of pain or have a condition that may cause pain to insure there is a care plan in place and updated, current pain assessment in place. The audit will be turned into the DON The Unit Managers will audit the unit medical records to insure that all medications have a diagnosis. The audit will be turned into the DON The monthly pharmacy reports will be reviewed by the DON /Medical Director to see which physician are not incompliance with making sure diagnosis accompany the medication ordered. 4. The DON will present to the QA Committee the systemic changes put in place to insure the deficient practice does not reoccur. The DON will summarize the Unit Managers audit and present trends and areas of noncompliance to the QA Committee. The QA Committee will discuss trends, areas of noncompliance, the effectiveness of the plan of correction and make recommendations for correction to the plan of correction.	Ongoing Ongoing Ongoing 9/18/08 Ongoing

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F 386	Continued From page 77 for Resident P1, while reviewing the Pharmacist's "Consultant Report", dated May 1, 2008 the pharmacist recommended to add a diagnosis to justify the use of Omega-3. The Physician signed and dated the response on May 12, 2008 for a diagnosis of Lipidemia. There was no evidence that the physician wrote an order to include the diagnosis of Lipidemia or discontinue the Omega-3 in the resident's record. A face-to-face interview was conducted on August 4, 2008 at 3:00 PM with Employee #12. He/she acknowledged that the physician failed to write the diagnosis. The record was reviewed August 4, 2008.	F 386	F 387 483.40 Frequency of Physician Visits. 1.. The physician for F4 will be notified that he needs to see his patient by 10/2. 2. All Medical Records will be audited by the Unit Clerk to insure all residents have been seen by their physician in the last 30/60days. Any physician that does not have a 30/60 progress note will be notified that they are behind and deficient in practice. 3. The Unit Clerks will audit the medical record monthly to insure physician visits are timely. The Unit Clerk will give the physician a reminder via phone to let them know they are not incompliance. If the physician does not comply within 10 days the Medical Director will be notified for follow up. All the facility physicians will be notified via a letter from the Medical Director about the deficiencies obtained that are pertinent to physician care. 4. The DON will present to the QA Committee the systemic changes made to insure the deficient practice does not reoccur.	10/2/08 10/2/08 10/2/08 Ongoing Ongoing 10/2/08 9/18/08
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) supplemental resident, it was determined that the physician failed to visit Resident F4 every 60 days. The findings include: A review of Resident F4's physician progress	F 387		

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F 387	Continued From page 78 notes revealed the last attending note was dated February 12, 2008. A review of the physician's orders revealed the last signed orders were undated, however signed for February 2008. A review of the nursing notes revealed the following: April 25, 2008 at 11:42 [AM/PM not indicated] " ...medicated p.o [by mouth] as ordered, c/o [complain of] pain to right wrist, wrist purple, black, and red. No swelling noted. June 5, 2008 at 4:00 PM " Resident found on the floor in his/her room next to his/her w/c [wheel chair]... no apparent injuries ... " July 28, 2008 at 2:00 PM " ...went to observe the hand. It was swollen-hematoma like, which was not like that when he/she was medicated at 9:30 AM ... MD [name] was called awaiting call back. July 28, 2008 at 11:00 PM " ...Right forearm x-ray result received. No evidence of fracture noted. Area still remains swollen ... " The record lacked evidence that the physician had visited the resident since February 18, 2008 and reviewed the total program of care after the resident had documented falls and a bruise of unknown origin. A face-to-face interview was conducted on August 7, 2008 at 8:30 AM with Employee #12. He/she acknowledged that the last physician noted and signed orders were February 12, 2008. The record was reviewed on August 7, 2008.	F 387	The Medical Director/designee will review the audits looking at the trends and areas of non compliance . The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance.	Ongoing

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F 412 SS=D	483.55(b) DENTAL SERVICES - NF The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to provide an annual dental screen for Resident #4. The findings include: A review of the resident's record revealed a dental screen dated May 1, 2007. There was no evidence in the record that the dentist had screened the resident after May 1, 2007. A face-to-face interview was conducted with Employee #4 on August 6, 2008 at approximately 4:00 PM. He/she acknowledged that the dental screen has not been done. The record was reviewed on August 5, 2008.	F 412	F 412 483.55 Dental Services 1. A Dental appointment will be made for resident #4 2. An audit will be conducted by the nurse manager to identify all residents that need to have a annual dental exam. All residents needing a exam the family and MD will be notified and an appointment made for the exam. 3.The unit manager will note on the physician order sheet the date of the residents annual dental exam so that it is present on the kardex. The Unit Manager will audit the medical record weekly x 90 days then monthly to insure all residents have a annual dental exam 4. The DON /designee will present to the QA Committee the systemic changes made to insure that the deficient practice does not reoccur. The DON/designee will review the audits looking for trends and areas of noncompliance. The QA Committee will discuss the trends and areas on noncompliance and make recommendations for corrections to the plan to insure consistent compliance.	10/2/08 10/2/08 Ongoing Ongoing 9/18/08 Ongoing
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	08/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 425	Continued From page 80 law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation of two (2) of three (3) medication rooms, and staff interview it was determined that the facility staff failed to remove expired medication from currently dated medications, replace emergency box and date and initial four (4) of seven (7) multi-dose medication vials when first opened. The findings include: 1. The facility failed the remove expired medication from currently dated medication from the IV Interim Infusion box, the Oral/ Injection Interim box , the cabinets in medication rooms and a medication cart. Facility ' s policy 5.3, Sec. 3, " Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles " stipulated " the Facility should ensure that drugs and biological that: (have an	F 425	F 425 483.60 Pharmacy Services 1. All expired pharmacy boxes and medications were removed from the Medication Rooms. All interim boxes were removed from the Health Center. The only box remaining is the Emergency Box which has to remain due to regulations. 2. All med rooms and med carts were checked to insure there were no expired /discharge med in the carts. 3. In discussion with the pharmacy we will no longer be using the interim boxes. The emergency box remains due to regulations. The Omnicell will be updated to contain the same medications that were in the interim and narcotic boxes. A list of medications is posted near the Omnicell All licensed staff will educated on how to use the Omnicell. All licensed staff will be educated on dating open vials, returning discharge meds, 5 rights of medication administration, proper handling of expired meds	8/6 & 8/7/08 8/7/08 8/6 & 8/7/08 8/7/08 8/30/08 8//7/08 Ongoing 10/2/08

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F 425	Continued From page 81 expired date on the label: ... are stored separate from other medications until destroyed or returned to the supplier. " On August 6, 2008, between 8:15 AM and 11:30 AM, the facility ' s medication storage areas, which included the IV Interim Infusion box, the Oral/Injection Interim Box, medication room cabinets, the medication refrigerator and carts were inspected on each unit. A. The IV Infusion Interim box ' s expiration date of January 2008 was on the outside of the box. The box was located in the upper level medication room. Upon opening the interim box the following injections and IV fluids were found expired: Quantity Description Expiration Date 1 Methyl prednisone 125 mg vial 1/2008 4 Nafcillin 1 gm vial 1/2008 2 Sterile Vancomycin 1 gm vial 7/1/2008 3 Clindamycin 900mg/6 ml vial 11/1/2007 2 Sterile Water 20 ml Vial 6/162008 3 Ampicillin Sublactam 1.5 gm vial 6/2008 3 Unasyn 1.5 gm vial 4/1/2008, 10/1/2007 (2) 3 Promethazine 50 mg/ml vial 10/2007 3 Zosyn 2.25 gm vial 3/2008, 5/2008 (2) 2 Tazicef 1 gm vial 7/1/2008	F 425	All nurses will be educated to check every shift for expired medications and labeling and initialing when new vials of medication are opened. The 11-7 charge nurses on each unit will be responsible for checking the med carts and the med rooms for expired medications and disposing of them. The 11-7 Supervisor will insure the Emergency Box is exchanged The 11-7 Supervisor will do a random weekly audit of each med cart and med room to insure that there are no expired meds on the carts or in the med room, audit for unlabeled vials that have been opened and not initialed. The Consultant Pharmacist will continue to inspect the nurses stations monthly and report any expired medications, and unlabeled meds and assist in noting that the Emergency box has expired and call the pharmacy for pick up The med rooms and the med carts will be apart of the weekly nursing unit rounds with the DON , Unit manager, nursing assistant and charge nurse. Weekly times 60days and then monthly.	10/2/08 Ongoing Ongoing Ongoing Ongoing Ongoing

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F 425	Continued From page 82 1 50% Dextrose Injection %0ml Syringe 2/1/2008 18 0.9% NaCl 5 ml filled syringes 6/2008, 5/2008 5 0.9% NaCl 100 ml IV bags 12/2007, 1/2008, 3/2008 1 10% Dextrose 1000 ml IV bag 7/2008 1 5% Dextrose IV bag 3/2008 1 KCl 20 mEq in Dextrose IV bag 3/2008 B. The following expired medications were found in the upper level cabinets : 2 Glutose 15 oral glucose gel tube 4/2008 25 Duo neb Ipratropium Br/Albuterol Sulfate 5/2008 100 Saline flushes 1/11/2008 The following medication was found in the lower level medication cart: 2 Lorazepam 0.5 mg tablets 8/3/2008 C. The inspection of the medication storage area on the lower level, included the Oral/Injection interim box. The box ' s expiration date of November 2007 was located on the outside of the box. Upon opening the Interim box the following medications were expired: Amoxicillin 250 mg 7of 10 tablets expired November, 2007	F 425	4. The DON will present the systemic changes made to insure the deficient practice does not reoccur. The DON will review the audits looking at the trends and areas of noncompliance . The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction make recommendations for corrections to the plan to insure consistent compliance.	9/18/08 Ongoing

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F 425	Continued From page 83 Duricef 500 mg, 6 of 6 tablets expired June 2008 Ciprofloxacin 250 mg, 5 of 5 tablets expired between April and June, 2008 Ceftriaxone 1 Gm vial, 1 of 4 vials expired May, 2008 Clonidine 0.1 mg, 11 of 11 tablets expired January through March, 2008 Aspirin 325 mg, 13 tablets expired between November 2007 and February 2008 Nitrofuranton 50 mg, 4 of 4 tablets expired between February and June, 2008 Lasix 20 mg, 6 of 12 tablets expired December 2007. Employees #14 and #15 were present during the inspection of the medication rooms. Both acknowledged the expired medications at the time of the above cited observations. A face-to face interview was conducted on August 6, 2008, at approximately 11:00 AM, with Employee #16. He/she stated that both interim boxes should have been returned to the pharmacy when the automated dispensing machine was installed. 2. The facility staff failed to exchange the Emergency box. The facility ' s policy 6.6, Sec.6.1.1, " Interim/Stat/Emergency Supply of Medications, Exchange Drug Product Replacement System, and Emergency boxes " stipulated " Facility should ensure that emergency boxes remain on the nursing unit until either an item is withdrawn or one of its contents is about to expire. In either case, Facility should contact the Pharmacy for a replacement. "	F 425		

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F 425	Continued From page 84 On August 6, 2008, at approximately 9:30 AM, the upper level Emergency Box #832 was observed. The box was unlocked, and upon reviewing the withdrawal forms in the box, two (2) Vitamin K ampoules and one (1) Lidocaine 2% 20 ml vial were removed. A face-to-face interview was conducted at that time of the observation with Employee #14. He/she acknowledged that the emergency box should have been replaced. 3. The Facility failed to date and initial multi-dose medication vials when opened. On August 6, 2008, at approximately 11:00 AM, during the inspection of the upper and lower level medication storage areas, the following medications were opened with no date or initials: PPD 10 Test Aplisol Tuberculin Purified Protein Derivative 5 TU Lorazepam 2 mg/ml inj. 4ml vial Bacteriostatic Water 30 ml Morphine Sulfate 20mg/ml 30 ml bottle During a face-to-face interview, with Employees #14 and #16. They acknowledged that the vials listed above were not dated and/or initialed at the time of the observations.	F 425		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	F 431 480 Pharmacy Services 1. The Lorazepam and the Morphine Sulfate were discarded. 2. The other med carts were checked for other medications that should be under lock , and or improperly stored. Medications found out of compliance were properly initialed, and stored correctly if not expired.	8/6/08 8/7/08

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F 431	Continued From page 85 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed in five (5) of five (5) medications to properly store the medication in accordance to the manufacturer's specifications. The findings include: According to the facility's "Geriatric Drug Therapy Handbook, 2005-2006," pg.741,	F 431	3. The licensed staff will be educated on the proper handling and storage of controlled drugs (Schedule II) All license nurses will required every shift to check the med carts for medications that need to be under double lock and stored correctly according to specs. The 11-7 Supervisor will audit the unit med carts weekly to insure controlled drugs are stored properly and medications that need to be stored in the refrigerator are stored correctly. A list of drugs and biologicals that must be stored in the a controlled temperature will be put in the MAR Inspection of the med cart and med rooms will be part of the nursing rounds with the DON, Unit manager, Charge Nurse and Nursing Assistant 4. The Don will present to the QA Committee the systemic measures put in place to insure the deficient	10/2/08 Ongoing Ongoing 10/2/08 Ongoing 9/18/08

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F 431	Continued From page 86 for Lorazepam, "Intact vial should be refrigerated, protected from light; do not use discolored ... maybe stored at room temperature for up to 60 days." On the Morphine Sulfate 20 mg/ml bottle, the label directed, "Discard opened bottle after 90 days." On August 6, 2008, at approximately 9:45 AM, during the inspection of the medication cart, four (4) opened vials of Lorazepam 2 mg/ml injections and one (1) opened undated Morphine sulfate oral solution 20 mg/ml bottle were observed in medication carts. A face-to-face interview conducted at that same time with Employee #14. He/she acknowledged that the Lorazepam vials and Morphine Sulfate bottle were not dated when opened. The record was reviewed August 6, 2008.	F 431	Practice does not reoccur. The DON will review the audits looking for trends and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance.	Ongoing
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one	F 441		

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F 441	Continued From page 87 (1) of 15 sampled residents, facility staff failed to provide personal protective equipment for one (1) resident in isolation and ensure that the thermometer was cleansed between foods after testing for food temperatures and washed hands and changed gloves between tasks. Resident #12. The findings include: 1. Facility staff failed to provide Personal Protective Equipment (PPE) to be used while proving personal care to Resident #12 on Contact Isolation for Clostridium Difficile in the stool Readmission orders dated July 22, 2008 and signed by the physician on July 25, 2008, directed, "Contact Precautions - C-Diff (clostridium Difficile)." During an observation of a cart designated for PPE at approximately 3:00 PM on August 7, 2008, it was determined that the cart was empty, except for one (1) box of gloves and a small bottle of Normal Saline. There were no isolation gowns or red bags on the cart. The following information was contained within the facility ' s Contact Precautions Policy: PROCESS: 2. Place a "Precautions" sign on door. 3. Instruct staff, resident and visitors regarding precautions and the use of personal protective equipment (PPE) 3.1 Maintain equipment outside of resident ' s room 4. Use barrier precautions for all contact with resident and resident ' s immediate environment.	F 441	F 441 483.65 Infection Control 1. Equipment was obtained for Resident #12 2. All Residents in Isolation the isolation carts were replenished 3. Nursing Staff will be educated on infection control Isolation equipment will be apart of the weekly nursing rounds. Staff will be required to insure that equipment is available for use. The unit clerks will check daily using the Infection Control Check list. The list will be submitted to the Unit Manager for review weekly. 4. The DON will present to the QA Committee the systemic changes required to insure the deficient practice does not reoccur. The DON will review the audits looking for trends and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance.	8/7/08 8/7/08 10/2/08 Ongoing Ongoing 9/18/08 Ongoing Ongoing

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F 441	Continued From page 88 4.1 Wear gloves when entering the room. 4.2 Wear gown if potential contact with infectious material; 4.3 Wear eye protection if splashing of infectious material is likely; 5. Dedicate personal care equipment (thermometer, blood pressure cuff, stethoscope, etc) [etcetera]. On August 7, 2008 at approximately 3:00 PM when the observation was made gloves were the only PPE found outside of the room. A box of gloves was located within the isolation cart. A face-to-face interview was conducted with Employee #4 on August 7, 2007 at approximately 4:00 PM. He/she acknowledged that the isolation cart had no PPE except one (1) pair of gloves and added " I will replace the equipment immediately." 2. Facility staff failed to ensure that the thermometer was cleansed between foods after testing for food temperatures and washed hands and changed gloves between tasks. On August 7, 2008 at 8:25 AM, it was observed that Employee #21 entered the kitchen wearing a pair of white plastic gloves. He/she secured a thermometer from his/her pocket, took temperatures of the food on the serving line, failed to clean the temperature probe between different foods, plated one (1) resident's food, left the kitchen, went into the dining room and took residents' orders, opened sugar packs, peeled a banana, opened milk cartons, returned to the kitchen and plated food. Hands were not washed and gloves were not changed between any of these activities.	F 441	2 Dietary and Infection Control 1. The employee was educated on the use of single use gloves. 2.. All staff are at risk for not following the policy 3. Dietary staff was educated on hand washing and glove usage. The Dining Supervisors will do a random audit on appropriate glove usage daily x 60 days. Then weekly. 4. The Assistant Director of Food Service will present the systemic changes made to insure the deficient practice does not reoccur. The Assistant Director of Food Service will review the audits looking for trends and areas of non compliance. The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance.	8/7/08 8/5/08 8/14/08 8/28/08 9/18/08 Ongoing

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F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT 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 observation and staff interview, it was determined that facility staff failed to maintain equipment in a safe operating manner as evidence by broken and/or damaged faucet, drain cover, missing knobs on the stove and broiler, malfunctioning pilot light on gas stove, steam table vent door and reach-in and walk-in freezers. The findings include: 1. During the tour of the kitchen on August 4, 2008 the following equipment was observed damaged: A. A leaky faucet and damaged drain cover across from the stove in one (1) of one (1) observed B. Knobs were observed missing off of the gas stove in two (2) of six (6) knobs observed C. A burner on the gas stove failed to completely ignite was observed in one (1) of six (6) burners observed D. Knobs were observed to be missing off the broiler in three (3) of seven (7) knobs observed E. The walk-in freezer was observed with condensation on boxes and ceiling in one (1) of one (1) observed F. A broken steam table vent door was observed in one (1) of one (1) observed G. The top of the reach-in freezer was damaged in one (1) of one (1) observed	F 456	1. #A,B,C,D,E,F,G have all been repaired 8/30 2. Other areas in the kitchen reviewed and fixed if they were broken 8/30 3. The Assistant Director of Food Service will do a weekly audit to determine what equipment needs to be repaired and the turn around time will be recorded on the weekly audit. The equipment that needs to be repaired will be submitted to Maintenance. A turn around time of 48 hours will be allowed for equipment to be up and running. 4. The Assistant Director of Food Service will present the systemic measures to the QA Committee to insure the deficient practice does not reoccur.	

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F 466	Continued From page 90 The finding failed to store the amount of water in accordance with the "Water Service Emergency Plan". The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to maintain emergency water per the facility emergency preparedness plan. The findings include: This REQUIREMENT is not met as evidenced by: A review the "Water Service Emergency Plan" [no date] revealed, "...[facility] has 500 gallons of bottled water exclusively for drinking purposes. This water dispersed throughout the facility by bottled water dispensers. An additional 350 gallons are stored in the Emergency Response Centers (Chapel and Art Room)." On August 5, 2008 at approximately 10:30 AM a tour of the water storage area revealed approximately 35-5 gallon bottles of water, a total of 175 gallons. 1. August 4, 2008 at 11:25 AM in the main kitchen. 2. August 4, 2008 during the tour of the main kitchen in the dry storage room. 3. August 5, 2008 at 3:25 PM lower level dining room. A face-to-face interview was conducted with Employee #27 at the time of the observation. He/she acknowledged the findings at the time of the observation.	F 466		
F 466 SS=F	483.70(h)(4) OTHER ENVIRONMENTAL CONDITIONS- WATER A face-to-face interview was conducted with Employee #1 on August 11, 2008 at approximately 10:45 AM. He/she acknowledged that 350 gallons of water is not stored in the Emergency Response Centers (Chapel and Art Room).	F 466	F 469 483.70 Pest Control The main kitchen was exterminated on 9/8	9/8/08
F 469 SS=D	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469	The dry storage was exterminated on 9/5	9/5/08
			The Lower Level dining room was exterminated 9/24	9/24/28
			The cart was inspected no notice of any pest. A new cart was obtained 8/30	8/30/08
			2. Other areas noticed to have pest have been exterminated 9/30	9/30/08
			3. A weekly audit (Exterminator Log Book) of 10% of the rooms in the Health center are checked for pest.	Ongoing
			The exterminator comes weekly to inspect and treat and any other request for treatment identified the exterminator treats.	Ongoing
			The Facilities Director/designee will do	

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F 469	Continued From page 92 4. A crawling insect was observed on the outside of the medication cart on August 7, 2008 at approximately 8:25 AM. Theses findings were acknowledged by Employees #27 at the time of the observations. 3257.3 no changes	F 469	a educational flyer to go to all employees on prevention of pest.	10/2/08
F 490 SS=D	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the administrative staff failed to integrate, coordinate and monitor the facility's practices related to residents' care and safety. The findings include: 1. The review of residents' records revealed that facility staff failed to provide adequate supervision for residents who had multiple falls some with subsequent injuries and injuries of unknown origins. Cross reference CFR 483.25 Quality of Care F323. 2. The facility staff failed to ensure that residents' environment remained hazard free. Cross reference CFR 483.25 F323	F 490	F 490 483.75 Administration 1. The facility Administration will educate all Department Heads and Managers on their responsibility to coordinate and monitor their departments processes to insure that the residents receive quality care and have a safe environment. Focus areas will include: Staff accountability Monitoring processes Looking for ways to improve processes through the QA process. 2. Each department will be required to establish their plan of correction to include coordinating and monitoring the departmental policies and procedures consistently (daily, weekly, monthly, quarterly). 3. The data collected from the monitoring the process must be analyzed . Looking for patterns, trends and areas of noncompliance and using this information to discuss with their staff ways to improve processes and establish	10/2/08 9/25/08 Ongoing

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F 490	Continued From page 93 3. The review of records revealed that facility staff failed to initiate additional goals and approaches for residents with multiple falls and subsequent injuries. Cross reference 483.20 F280 4. The review of records revealed that the facility staff failed to ensure that all alleged violations of neglect or abuse, injuries of unknown source were investigated and reported to the State agency. Cross reference CFR 483.13 F 225	F 490	new goals and approaches. 4.Department Heads will be required to keep their staff accountable through the monitoring process. Corrective Action should be applied when the process that has been put in place is not followed. 5. QA will be used to discuss trends and areas of noncompliance, the effectiveness of the plan of correction, make recommendations for correction of the plans and to monitor staff accountability	Ongoing Ongoing
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review for three (3) of 15 sampled residents, it was determined that facility staff failed to: provide an annual health and physical examination for one (1) resident, write quarterly social services notes for three (3) residents, write quarterly activities note for one (1) resident, ensure that hair coverings were worn by residents entering the kitchen, maintain linen par levels, dispose of food waste properly and maintain a three (3) day supply of non-perishable staples. Residents #4, 6, and 10. The findings include:	F 492	F 492 483.75 Administration 1. The physician will be notified that resident #4 has not had a yearly physical. 2. A chart audit will be completed by the Unit Clerk on medical records to see if any other residents have not had a up to date yearly physical. The physician will be notified that the physical needs to be done by 10/2/08 3. A letter will be sent out to the physician by the Medical Director informing the facility physicians about their responsibility in following the regulations in regards to	9/23/08 10/2/08 10/2/08

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F 492	Continued From page 94 1. Facility staff failed to provide an annual health and physical examination for Resident #4. A review of Resident #4's record revealed an annual health and physical evaluation report dated July 1, 2007. There was no evidence in the record that a health and physical examination had been conducted after July 1, 2007. According to 22DCMR 3207.11, "Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record." A face-to-face interview was conducted with Employee #4 on August 6, 2008 at approximately 4:00 PM. He/she acknowledged that the physical examination had not been completed. The record was reviewed on August 5, 2008. 2. Facility staff failed to write quarterly social service notes for Residents #4, #6 and #10. According to 22DCMR 3229.5, "The social assessment and evaluation, plan of care and progress notes, including changes in the resident's social condition, shall be incorporated in each resident's medical record, reviewed quarterly and revised as necessary." A. Review of the clinical record for Resident #4 revealed that the record lacked evidence of a current quarterly social work notes. The last quarterly social work note on the record was dated April 11, 2008. A face-to-face interview was conducted with Employee #6 on August 7, 2008 at approximately	F 492	H & P's The Unit Clerk will do a monthly audit to determine which H &P's have not been completed. Those physicians who have not completed there H & P's will be notified . If they remain non compliant the DON, Administrator and the Medical Director will be contacted for further follow up. 4. The DON will present to the QA Committee the systemic changes put in place to insure the deficient practice does not reoccur. The DON will review the audits looking for trends and areas of noncompliance . The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance. Social Work. 1. Resident #4, #5 and #10 have a completed Social Work note on the medical record. 2. Resident #4 has a completed social work note on the medical record.	10/2/08 9/18/08 Ongoing 10/2/08 10/2/08

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F 492	Continued From page 95 4:00 PM. He/she acknowledged that the note was not on the record. He/she added, "I have only been here a few months. I am trying to catch up and remain current but I am not going back. I am moving forward." The record was reviewed on August 5, 2008. B. A review of the clinical record for Resident # 6 revealed that the record lacked evidence of a current quarterly social work note. The last quarterly social work note on the record was dated April 17, 2008. A face-to-face interview was conducted with Employee # 6 on August 7, 2008 at approximately 4:00 PM. He/she acknowledged that the note was not on the record. He/she added, "I have only been here a few months. I am trying to catch up and remain current but I am not going back. I am moving forward." The record was reviewed on August 6, 2008. C. A review of the clinical record for Resident #10 revealed that the record lacked evidence of a current quarterly social work note. The last quarterly social work note on the record was dated April 15, 2008. A face-to-face interview was conducted with Employee #6 on August 7, 2008 A at approximately 4:00 PM. He/she acknowledged that the note was not on the record. He/she added, "I have only been here a few months. I am trying to catch up and remain current but I am not going back. I am moving forward." The record was reviewed on August 7, 2008. 3. Facility staff failed to provide quarterly Activities notes for Resident #4.	F 492	2. A chart audit of all the medical records will be completed by social work to insure all social work notes are in place. A chart audit of all medical records will be completed by activities to insure notes are in place 3. The Social Worker and Activities will complete a monthly audit to insure all social work and activity notes are in place 4. The Social Worker and Activities Director will present to the QA Committee the systemic measure put in place to insure the deficient practice does not reoccur. The Social Worker and Activities Director will review the audits looking for trends and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for corrections to the plan to insure consistent compliance.	10/2/08 10/2/08 9/18/08 Ongoing

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F 492	Continued From page 96 According to 22DCMR 3230.5 (j), "To participate in the development of an interdisciplinary care plan and reassess each resident's response to activities at least quarterly after reviewing with each resident his or her participation in the activities program." A review of the clinical record for Resident #4 revealed that the record lacked evidence of a current quarterly activities note. The last quarterly Activities note on the record was dated March 11, 2008. A face-to-face interview was conducted with Employee #5 at approximately 9:30 AM on August 6, 2008. He/she stated "The supervisor usually writes the notes. I am not the supervisor. I am only acting in that capacity." The record was reviewed on August 5, 2008. 4. Facility staff failed to ensure that residents entering the kitchen applied a hair net. According to 22 DCMR 3219.6 " Each food service employee shall wear either a hair net or other head covering. " During a tour of the main kitchen and pantry kitchen the following was observed: On August 4, 2008 at approximately 9:10AM one (1) resident was observed in the main kitchen with out a hair net. On August 4, 2008 at approximately 9:35 AM two (2) residents were observed in the main kitchen without hair nets. On August 7, 2008 at 8:16 AM one (1) resident was observed in the kitchen without a hair net	F 492	4. Dietary 1. Residents have been identified and told if they come into the kitchen they must wear a hair restraint 2. Hair restraints are provided at both entrances to the kitchen area and pantries. 3. Supervisors will monitor residents that may want to come into the pantries and assist them will their request 4. The Food Service Director will present systemic changes to the QA Committee to insure that the deficient practice does not reoccur. The Food Service Director will make this part of their daily inspection rounds and bring the audit results , trends and areas of noncompliance to the QA Committee. The QA Committee will discuss the areas of noncompliance and determine the effectiveness of the plan of correction and make recommendations to the plan for consistent compliance.	8/30/08 8/30/08 Ongoing 9/18/08 Ongoing

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F 492	Continued From page 97 preparing a tray his/her family member. The aforementioned observations were acknowledged at the time of the observations presence of Employee #21 and #27. 5. Facility failed to maintain the linen par level at three (3) times the amount needed for licensed occupancy. The facility's licensed occupancy is 73 beds. A tour of the laundry storage area was conducted with Employees #28 and 29. According to 22 DCMR 3254.5 " The linen supply shall be at least three (3) times the amount that is needed for the licensed occupancy. " On August 6, 2008 at approximately 10:35 AM a tour of the laundry storage room revealed three (3) boxes of pillow cases, seven (7) dozen flat sheets, six (6) dozen fitted sheets, 24 dozen wash clothes and 10 dozen towels. A face-to-face interview was conducted with Employee #2 and #29 on August 6, 2008 at 1:50 PM. They stated, "We [the facility] use the linen [in the storage room] for our assisted living and the health care unit residents. We [the facility] have disposable wash clothes. We are probably going to start using them regularly. We have not spoken with the Resident Council to discuss the use of the disposable wash clothes on a regular base. We now use the disposable wash clothes as an emergency fix when we run short of regular wash clothes. We do not have sufficient par levels for the health care unit. How much linen should we have? I have a purchase order out that is waiting for approval to purchase more linen."	F 492	5 Facility linen par level 1 and 2 – All the facility residents have been affected by lack of linen. The laundry will purchase line to meet the regulations. 3. Par levels will be established in Laundry to meet the regulations. Unit Par Levels will be established to insure that the residents have adequate linen for each shift. Linen will be purchase when the Laundry PAR Levels are at 30% below the regulation PAR Levels 4. The Housekeeping Supervisor will audit the laundry weekly to insure proper par levels. The Housekeeping Supervisor will review the audits looking for trends and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations for correction to the plan to insure consistent compliance.	10/2/08 8/30/08 8/30/08 Ongoing Ongoing

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F 492	Continued From page 98 6. Facility staff failed to dispose of food waste as required by State law. According to 22 DCMR 3219.8, "Food waste shall be disposed in a garbage disposal system or garbage grinder which is conveniently located near each activity and which has adequate capacity to dispose of all readily grindable food waste (garbage) produced." A tour of the main kitchen was conducted on August 4, 2008 between 8:45 AM and 12:00 PM, dietary staff was observed disposing of food and paper waste in a trash receptacle. It was further observed that food, paper and metal waste were disposed of in the same trash receptacles. Employee #27 acknowledged the above findings at the time of the observation and stated that there were two (2) working garbage disposals in the kitchen. 7. Facility staff failed to maintain a three (3) day supply of non-perishable staples on the premises as required by state law. According to 22 DCMR 3222.3, "A three (3) day supply of non-perishable staples shall be maintained on the premises. " A tour of the emergency food area was conducted on August 4, 2008 at 4:15 PM and the following was observed: one (1) case of tropical fruit, cranberry juice four (4) cases, approximately 3 cases of pudding cups, one (1) case of tuna fish. A face-to-face interview was conducted with Employee #27 at the time of the observation. He/she acknowledged the above findings at the	F 492	6. Facility staff failed to dispose of food waste as required by State law. 1. The trash receptacle was emptied on 8/4/08 2. All trash receptacles were checked on 8/4/08 for compliance 3. The Kitchen Supervisor will add the trash receptacles to the daily kitchen check. The kitchen staff will be educated on proper disposal of trash 10/2/08 4. The kitchen Supervisor will review the audits looking for trends. The kitchen supervisor will present the audit material to the QA Committee to insure compliance. 7. Emergency Food Supply 1. Emergency food supply was obtained during time of inspection. 2. These items are assigned a separate area in the Dry Storage Room. The Emergency Food is shelf stable but has a 6 month shelf life, the food will be utilized in the Café and replaced so that a constant supply of food is available. 3. The Disaster Plan for dining services is in place. All emergency food is assigned for use in a 3 day period. This food is on a separate inventory	8/4/08 8/4/08 10/2/08 10/2/08 Ongoing 8/8/08 Ongoing Ongoing

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F 492	Continued From page 99 time of the observation and stated, " We don't have enough food for three (3) days."	F 492	so that it is not included in the regular food supply.	
F 493 SS=D	483.75(d)(1)-(2) GOVERNING BODY The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the governing body, or designated persons functioning as a governing body failed to establish and implement policies regarding the management and operation of the facility related to residents' care and safety. The findings include: 1. The review of residents' records revealed that facility staff failed to provide adequate supervision for residents who had multiple falls some with subsequent injuries. Cross reference CFR 483.25 Quality of Care F323. 2. The facility staff failed to ensure that residents' environment remained as free of accidents hazards as is possible. Cross reference CFR 483.25 F323 3. The review of records revealed that facility staff failed to initiate additional goals and	F 493	4. The Food Service Director will audit the use and the inventory supply monthly. The Food Service Director will present the systemic changes to the QA Committee to insure the deficient practice does not reoccur. The Food Service Director will review the audits looking for trends and areas of noncompliance. The trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction and make recommendations to the plan to insure consistent compliance. F 493 483.75 Governing Body 1. The Administrator and the QA Committee which is made up of Department Heads will develop a plan of correction that will provide adequate supervision of residents and maintain the safety of the residents. This will be established by : Reviewing adequacy of staffing to insure supervision Establishing monitoring tools Enforcing staff accountability to following policy and procedure	Ongoing 9/18/08 Ongoing 9/25/08

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F 493	Continued From page 100 approaches for residents with multiple falls and subsequent injuries. Cross reference 483.20 F280 4. The review of records revealed that the facility staff failed to ensure that all alleged violations of neglect or abuse, injuries of unknown source were investigated and reported to the State agency. Cross reference CFR 483.13 F 225	F 493	Investigating all alleged abuse of residents and terminating any employee accused and reporting the incident and the employee to the state agencies. Conduct environmental rounds ,safety rounds and nursing rounds on regular basis (daily, weekly, monthly, quarterly as established in the department policy and procedures)	Ongoing
F 497 SS=D	483.75(e)(8) REGULAR IN-SERVICE EDUCATION The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on a review of in-service records for five (5) of five (5) Certified Nurse Aides (CNA) and staff interview, facility staff failed to complete a performance review of each CNA at least once every 12 months and provide documentation of 12 hours of inservice education per year. Employees #22, #23, #24, #25 and #26. The findings include:	F 497	Educate other agencies regarding our abuse policy and procedure. Helping them to understand abuse will not be tolerated within the facility Insure on hire that criminal background checks are in place before hire. Educating employees on abuse The facility QA process will look at trends, areas of noncompliance, the plan of correction. The QA committee will make recommendations as needed to improve plans of correction.	10/2/08 Ongoing 10/2/08 Ongoing

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F 497	Continued From page 101 On August 7, 2008 annual performance reviews and documentation of inservice education for the pass 12 months were requested for five (5) randomly selected CNAs. Record review of Employee #22, hire date May 5, 1998, revealed an annual performance review dated April 10, 2004. The following self test documented in-service training provided on May 21, 2008: Elder Abuse, HIPAA, Back Safety, Chemical Hazards, Standard Precautions, Hepatitis B Virus, Sexual Harassment, Workplace Violence and Changes of Aging. According to the "Staff Education Compliance Record" the above cited inservices totaled 6.25 hours. There was no evidence that additional inservices were completed by this CNA after May 18, 2008. Record review of Employee #23, hire date September 25, 1995 revealed an annual performance review dated October 11, 2004. There was no performance evaluation or inservice documentation for 2005 and 2006. The following self test documented inservice training provided on October 12, 2007: Elder Abuse, HIPAA, Back Safety, Chemical Hazards, Standard Precautions, Hepatitis B Virus, Sexual Harassment and Workplace Violence. According to the "Staff Education Compliance Record" the above cited inservices totaled 6.25 hours. There was no signature by the staff educator to document the completion of the inservices. No evidence of an annual performance review or documentation of inservice education was provided by facility staff during the survey period for Employee #24 with a hire date of September 19, 2006.	F 497	F 497 483.75 Regular In –Service Education 1. All nursing assistants are affected by the deficient practice. 10/2/08 2. HR will audit all nursing assistant records and identify staff who have not had an employee review in the past calendar year based on hire month. 10/2/08 HR will develop a list of employees by month of hire and provide that list to the Unit Managers. Months to be included are August and September2008 10/2/08 3. Human Resources will develop a policy and procedure for performance evaluations. 10/2/08 The Staff Development Coordinator will develop a policy and procedure for in- service education. The policy will allow for 12 hours of in-service training for nursing assistants. Management Staff will be educated on the policies and procedures. Human Resources will notify the Unit Manager and the DON 30 days in advance of the employee anniversary hire date via –e-mail and hard copy. Ongoing	

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F 497	Continued From page 102 Record review of Employee #25 with a hire date of October 10, 1986, revealed an annual performance review signed December 19, 2006 by Employee #2. No documentation of inservice education was provided by facility staff for Employee #25 after December 19, 2006. Record review of Employee #26 with a hire date of May 3, 2001, revealed an annual performance review dated May 11, 2007. The following self test documented inservice training provided on May 21, 2008: Elder Abuse, HIPAA, Back Safety, Chemical Hazards, Standard Precautions, Hepatitis B Virus, Sexual Harassment, Workplace Violence and Changes of Aging. According to the "Staff Education Compliance Record" the above cited inservices totaled 6.25 hours. There was no evidence that additional inservices were completed by this CNA after May 21, 2008. A face-to face interview was conducted with Employee #2 on August 7, 2008 at 2:30 PM who acknowledge the above findings.	F 497	The nursing assistants supervisor must notify the Staff Development Coordinator of the training needs for the employee via the Staff Development Competency Form once the performance review is complete. The Staff Development Coordinator will develop a list of competencies to be completed annually. 4. Human Resources will do a monthly audit to verify that a completed annual performance review has been completed for those employees that are due for that month. Evaluations out of compliance the DON and the Unit Manager will be notified. The Staff Development Coordinator will do a monthly audit to insure all in- services do for the month have been completed. The Human Resource Director and the Staff Development Coordinator will present the systemic changes made to the QA Committee for recommendations. The Human Resource Director /designee and the Staff Development Coordinator will review their monthly audits looking for trends	Ongoing 10/2/08 Ongoing Ongoing 9/18/08 Ongoing
F 520 SS=E	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	08/11/2008

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F 520	Continued From page 103 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility's physician failed to attend the quarterly Quality Assurance (QA) Committee meetings and that the QA Committee failed to develop and implement appropriate plans of action to correct identified quality deficiencies. The findings include: 1. The facility's physician failed to attend quarterly QA Committee meetings. On August 8, 2008 at 11:30 AM the sign-in sheets for QA meetings were reviewed with Employees #1, 2 and 15. At the time of the review it was determined that a designated physician was not present at the QA meetings held in January 2008, April 2008 and July 2008. The aforementioned findings were acknowledged by Employees #1, 2 and 15 at the time of the review.	F 520	and areas of noncompliance. The Trends and areas of noncompliance will be discussed by the QA Committee. The QA Committee will determine the effectiveness of the plan of correction. Make recommendations for corrections to the plan to insure consistent compliance. F 520 483.75 Quality Assessment and Assurance 1. The QA Committee focus will be to: • Review trend and identify issues • Brainstorm as a interdisciplinary team to solve facility issues regarding survey deficiencies. • Establishing education and training opportunities • Front line staff will be added to the QA Committee 2. The QA Committee will review the plan of correction and submit recommendations to the plan	Ongoing Ongoing

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F 520	Continued From page 104 2. The QA Committee failed to develop and implement appropriate plans of action to correct identified quality deficiencies. This is a repeat deficiency from the annual certification survey completed September 26, 2007. On August 8, 2008 at approximately 11:30 AM, a face-to-face interview was conducted with Employees #1, 2 and 15, who were standing in for the QA coordinator. Based on on-going surveyor concerns, the QA coordinator was asked if the committee monitored falls, skin tears, injuries and bruises of unknown origin, infection control practices, medication and pharmacy practices, and environmental hazards. Employee #15 replied, "We are not monitoring skin tears, injuries and bruises of unknown origin, and environmental rounds." Employee #2 replied, "We are looking at falls and discuss falls at the QA meeting. Falls are also discussed at the morning meetings. The Nurse Managers investigate the fall and make the decision of what to do. We have the Leaping Deer program, but we do not formally track fall incidents. We do environmental rounds but the findings are not presented at QA/QI." There was no evidence that the quality assurance committee developed or implemented appropriate plans of action to correct identified deficiencies as evidenced by the following: A. Actual harm that is not immediate jeopardy - Isolated deficiency for F323.	F 520	3. The Format for the minutes will include follow up and completion dates for projects and target dates for problem solving. 4. Quarterly meetings will held in January, April, July and October. 5. The facility will require the Medical Director to be present at the Quarterly meetings. 6. The QA Committee will do on going monitoring of all deficient practices of : • Actual harm that is not immediate jeopardy. • Potential for more than minimal harm • Potential for more than minimal harm- Pattern for deficiencies • Potential for more than minimal harm- Isolated for deficiencies.	Ongoing Ongoing Ongoing Ongoing

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F 520	Continued From page 105 B. Potential for more than minimal harm - Widespread deficiencies for F253, F332, F371, F441 and F466. C. Potential for more than minimal harm - Pattern for deficiencies for F225 and F520. D. Potential for more than minimal harm - Isolated for deficiencies F157, F160, F176, F224, F241, F278, F279, F280, F285, F309, F314, F315, F333, F372, F386, F387, F412, F431, F456, F469, and F497.	F 520	This will be accomplished by: • Investing and reporting injuries of unknown origin. • Incident reports will be reviewed in QA meeting for recommendation and follow up. • Deficient practice will be follow up on until resolved. • Department audits will be reviewed for compliance and trends • Develop policies and procedures	Ongoing