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 _____	10/06/2006

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

Oct. 31, 2006 dw

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted October 4 through 6, 2006. The following deficiencies were based on observations, record reviews and staff interviews. The sample included 15 residents based on a census of 68 residents on the first day of survey with one (1) supplemental resident.	F 000		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by : Based on observation and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to maintain Resident #12's dignity as evidenced by failure to prevent exposure of the resident in the dayroom. The findings include: Resident #12 was observed on October 4, 2006 at 3:30 PM sitting in a wheelchair in the dayroom with seven (7) other residents present. Resident #12's dress was torn from under the left arm down the side seam to approximately three (3) inches above the hem. The resident was wearing no undergarments and the left upper torso, abdominal area and left upper thigh were exposed. A face-to-face-interview was conducted with the Certified Nurse Aide who assisted the resident	F 241	**F 241** It is the policy of Ingleside promote care of residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality. **Corrective Action for Affected Residents:** 1. Resident # 12 was redressed immediately at the time of the survey. 10/06/2006 **Procedure for Identifying Potentially Affected Residents:** 2. The Nursing Assistant's are required to check all residents clothing and apperance to insure that they are appropriate for the environment. 10/04/2006 **Measures Adopted for Systemic Change:** 3. The Nursing Staff will be re-educated on the dignity of residents in regards to dressing and appearance. Unit Managers will do rounds on the floor weekly. Checking for residents clothing will be include in those rounds. 11/19/2006	

REGULATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa M. Smith	Administrator	10/27/06

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 241	Continued From page 1 out of bed at 3:45 PM. He/she stated, "I didn't see the torn part of the dress or I would have changed it."	F 241	**Monitoring of Corrective Action and Quality Assurance:** 4. For the next 90 days, Unit managers will present the finding of their weekly rounds to be monitored by the Quality Assurance Committee Monthly. (November, December and January) Starting 11/06/2006.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled wheelchairs, exhaust vents in residents' rooms, Sonozaire deodorizer near the dumpster, the floor in the garage around the dumpster, floor and wall surfaces in the small laundry room, plastic vertical slats at the entrance to the laundry room, marred wall surfaces in the washer area and hallways outside of the main laundry, marred and worn dining room chairs and splintered entrance and bathroom doors. These findings were observed in the presence of maintenance, housekeeping and nursing staff. The findings include: 1. The wheelchairs that residents were sitting on in the Garden Level dayroom were soiled on the spoke and frame surfaces with accumulated dust and debris in five (5) of eight (8) observations at 12:20 PM on October 4, 2006.	F 253	**F253 Housekeeping and Maintenance** **Corrective Action for Affected Residents:** 1. All wheelchairs observed were cleaned and completed by 10/29/06 • The interior surfaces of exhaust vent identified will be cleaned and completed by 11/05/06. • The Sonozaire deodorizer located in the garage near the trash dumpster was cleaned and completed 10/25/06. • The paper and soiled products observed on the floor and surrounding areas of the trash dumpster in the garage were cleaned and completed on 10/06/2006. • The floor and surrounding areas of the small laundry room observed to be soiled were cleaned and completed by 10/25/06.	11/19/06

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F 253	Continued From page 2 Lower Level dayroom in seven (7) of nine (9) observations between 2:25 PM and 3:45 PM on October 5, 2006. 2. The interior surfaces of exhaust vents in residents' bathrooms were soiled with dust and debris. Garden Level rooms 169, 170, 173, 176, 180, 182, 186; 192, 194, 195 and 197 in 11 of 14 observations between 11:30 AM and approximately 1:00 PM on October 6, 2006. Beauty Shop in two (2) of four (4) observations at 10:30 AM on October 6, 2006. Lower Level rooms 087 and 094 in two (2) of nine (9) observations between 2:25 PM and 3:45 PM on October 5, 2006. 3. The Sonozaire deodorizer located in the garage near the trash dumpster was soiled on the outer surfaces in one (1) of one (1) observation at approximately 4:15 PM on October 4, 2006. 4. Paper and soiled products were observed on the floor and surrounding areas of the trash dumpster in the garage in one (1) of one (1) observations at 4:20 PM on October 4, 2006. 5. Floor surfaces and surrounding areas of the small laundry room were soiled in one (1) of one (1) observation at 4:25 PM on October 4, 2006. 6. Plastic vertical slats located at the entrance to the laundry area were soiled and stained in one (1) of one (1) observation at 4:27 PM on October 4,	F 253	• The plastic vertical slats identifies were cleaned and completed 10/06/2006. • The wall in the rear of the washers in the laundry room and hallway walls outside of the laundry observed damaged and soiled will be repaired, cleaned and completed by 11/12/06. • The armrest, backs and leg surfaces of dinning room chairs identified as worn marred and scarred will be repaired or replaced by 11/19/06. • The bathroom doors identified as damaged, marred, scarred and splintered will be repaired and completed by 11/19/2006. 2. Environmental Rounds were conducted 10/25/06 and no other deficiencies were noted. 3. The Maintenance Supervisor or designee will conduct monthly preventive maintenance rounds. All work generated will be completed within 48 – 72 hours with written affirmation.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/13/2006
CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391

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F 253	Continued From page 3 2006. 7. Wall surfaces in the rear of washers in the laundry room and hallway walls outside of the laundry were damaged and soiled in two (2) of two (2) observations at 4:28 PM on October 4, 2006. 8. The armrest, backs and leg surfaces of dining room chairs were worn, marred and scarred in the lower level dining room in seven (7) of nine (9) observations at approximately 2:45 PM on October 6, 2006. 9. The frontal surfaces of entrance and bathrooms doors were damaged, marred, scarred and splintered on the edges in rooms 070, 072, 085, 094 and 099 in five (5) of 14 observations between 2:25 PM and 3:45 PM on October 5, 2006.	F 253	4. The Facility Management Director will conduct random audits and will be presented monthly to the QA committee.	
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the facility staff failed to complete a quarterly Minimum Data Set (MDS) for Resident #8.	F 276	**Corrective Action for Affected Residents:** 1. Resident #8 has a completed quarterly MDS on the chart. 10/10/06	

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F 276	Continued From page 4 The findings include: A review of Resident #8's record revealed a quarterly MDS assessment completed April 14, 2006. There was no evidence that a quarterly or full MDS assessment was completed after April 14, 2006. A face-to-face interview was conducted with the Director of Nursing on October 5, 2006 at 10:00 AM. He/she acknowledged that the quarterly MDS assessment was not completed. The record was reviewed October 5, 2006.	F 276	**Procedure for Identifying Potentially Affected Residents:** 2. All records will be audited to insure quarterly and annual reviews are present. 10/10/06 **Measures Adopted for Systemic Change:** 3. All Unit Managers will be educated on the MDS process. All Unit Managers will be educated on the electronic process for MDS compliance The MDS coordinator will monitor MDS compliance weekly starting 11/01/06. On going. **Monitoring of Corrective Action and Quality Assurance:** 4. The MDS coordinator will report monthly on the MDS compliance over the next 90 days. Starting 10/10/2006. 01/10/2007	01/10/2007

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F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by : Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the facility staff failed to sign the Minimum Data Set (MDS) assessment to indicate completion at R2a (Signature of RN Assessment Coordinator). Resident #15.	F 278	**F 278** **Corrective Action for Affected Residents:** 1. Resident #15, R2a was signed as of 10/06/2006 **Procedures for Identifying Potentially Affected Residents:** 2. An audit of all Medical Record was conducted to insure that all R26 dates were appropriately signed. 10/31/2006 **Measures Adopted for Systemic Change:** 3. All Unit Managers will be educated on the MDS process. 11/19/2006 **Monitoring Corrective Action and Quality Assurance:** 4. The MDS coordinator will audit the Medical Records for a 90-day period November, December and January and report findings the QA committee monthly. 01/30/07	11/19/06

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F 278	Continued From page 6 The findings include: A review of Resident #15's closed record revealed an admission MDS completed August 1, 2006. Section R2a, "Signature of RN Assessment Coordinator", was blank. A face-to-face interview was conducted with the Director of Nursing on October 6, 2006 at 2:30 PM. He/she acknowledged that Section R2a was not signed. The record was reviewed October 5, 2006.	F 278		

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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 observation, staff interview and record review for two (2) of 15 sampled residents, it was determined that facility staff failed to initiate a care plan with appropriate goals and approaches for one (1) resident on anticoagulant therapy and one (1) resident for isolation, infection, IV [intravenous] ABT [antibiotic], pain, anticoagulant therapy and a left leg brace. Residents #6 and 11. The findings include: 1. Facility staff failed to initiate a care plan for anticoagulant therapy for Resident #6, admitted to	F 279	**Corrective Action for Affected Residents:** 1. Resident # 6 was given an anticoagulant care plan.10/06/06 **Procedures for Identifying Potentially Affected Residents:** 2. All residents on anticoagulants will be reviewed to insure that an anticoagulant care plan is in place. 10/30/06 **Measures Adopted for Systemic Change:** 3. All nursing staff will be in-service on the importants of adding an anti coagulant care plan when a resident is started on an anticoagulant. **Monitoring Corrective Action and Quality Assurance:** 4. The Unit Managers will complete a 24 hr. chart audit to insure that anticoagulant care plans are in place. 11/19/2006 Unit Managers will monitor Anticoagulant care plans compliance for 90 days and share finding with the QA committee monthly.	11/19/06

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F 279	Continued From page 8 the facility April 13, 2006. A review of Resident #6's record revealed a physician's order dated April 19, 2006, and renewed May 1, June 26, July 29 and September 16, 2006, "Lovenox 0.4 mg sq (subcutaneously) daily for DVT (Deep Vein Thrombosis)." The care plan, initiated April 24, 2006 and reviewed July 25, 2006, failed to include a care plan with appropriate goals and approaches for the use of Lovenox, an anticoagulant drug. A face-to-face interview with the Resident Care Coordinator was conducted on October 5, 2006 at 9:30 AM. He/she acknowledged the lack of a care plan for anticoagulant therapy. The record was reviewed October 4, 2006. 2. Facility staff failed to initiate a care plan for Resident #11 for isolation, infection, IV ABT, pain, anticoagulant therapy and a left leg brace. A review of Resident #11's record revealed that the resident was admitted to the facility on September 26, 2006 with diagnoses that included Periprosthetic infection with secondary loosening left distal and femoral replacement and clostridium difficile. According to the physician orders dated September 26, 2006 the resident was receiving Metronidazole for clostridium difficile, Vancomycin via IV for Periprosthetic infection of the left knee and Dilaudid for pain, Lovenox for prophylaxis deep vein thrombosis and Bledsoe brace for left leg support.	F 279	**F279** **Corrective Action for Affected Residents:** 1. Resident # 11 care plans have been completed. 10/06/06 **Procedures for Identifying Potentially Affected Residents:** 2. All residents Medical Records will be audited for care plan compliance. 10/30/06 **Measures Adopted for Systemic Change:** 3. Manager will use the daily 24hr. chart audits to monitor for care plan compliance. 10/06/06 **Monitoring Corrective Action and Quality Assurance:** 4. The Unit Managers will complete a 24 hr. chart audit to insure that anticoagulant care plans are in place. 11/19/2006 Unit Managers will monitor care plans compliance for 90 days and share finding with the QA committee monthly. November, December and January	11/19/06

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F 279	Continued From page 9 Further review of the clinical record lacked evidence that a care plan was initiated to address the resident's care needs for isolation, infection, IV ABT, pain, anticoagulant therapy and a left leg brace. A face-to-face interview with the Evening Supervisor was conducted on October 4, 2006 at 4:15 PM. He/she acknowledged that the record lacked care plans for isolation, infection, IV ABT, pain, anticoagulant therapy and a left leg brace. The record was reviewed October 4, 2006.	F 279		
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	**F 280** **Corrective Action for Affected Residents:** 1. Resident #13 Falls care plan has been brought up to date. 10/06/06. **Procedures for Identifying Potentially Affected Residents:** 2. All residents that have fallenin the last 90 days will be reviewed for care plan updates. 10/30/06	11/19/06

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F 280	Continued From page 10 Based on observation, staff interview and record review for one (1) of 15 sampled residents, it was determined that facility failed to update a fall care plan for one (1) resident with multiple falls. Residents #13. The findings include: The review of the interdisciplinary care plan for Resident #13 included a problem for "Fall Prevention" dating from April 13, 2004. The recent falls with no injuries were 1/3/06, 4/10/06, 7/5/06, 7/24/06, and 10/3/06. It was documented to "Continue with approaches" after each fall. The care plan was not updated to include new interventions. On October 5, 2006 at approximately 11:00 AM a face-to-face interview was conducted with the nurse manager who acknowledged that new interventions were not implemented. The record was reviewed on October 5, 2006.	F 280	**Measures Adopted for Systemic Change:** 3. For residents that fall, care plan review and updates will be taking place@ daily morning meeting as part of the fall prevention process. Licensed staff will be in-serviced on the falls prevention process and care plans updates. By 11/30/06 **Monitoring Corrective Action and Quality Assurance:** 4. Unit Managers will report falls care plan updates at the QA meeting monthly. 11/06/06	
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that facility staff failed to ensure that the environment was free from accidental hazards as evidenced by: excessive electrical appliances attached to extension cords, a candle	F 323		

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F 323	Continued From page 11 burning in a resident's room and unsecured oxygen tanks and a floor drain. These observations were made in the presence of the Directors of Maintenance and Housekeeping and nursing staff. The findings include: 1. Multiple electrical appliances were observed attached to extension cords in a resident's room. During the initial tour, an observation of room 70 was made on October 4, 2006 at 2:30 PM. A blender; refrigerator, fan and microwave oven were attached to a multi-plug which was attached to an extension cord. Additionally, a DVD and television unit was attached to an extension cord which ran across the top of the Heating Ventilation Air Conditioning unit, behind the bed and into a plug. The cords were held together with metal twist ties. 2. A candle was observed burning in a resident's room. During the initial tour, a candle was observed burning in room 71 on October 4, 2006 at 2:35 PM. The resident's family member was visiting in the room. A face-to-face interview with the resident was conducted immediately after the family member left. The resident stated, "My [family member] likes candles and burns them when [he/she] visits . Usually [he/she] blows the candle out when [he/she] leaves." The resident was asked if he/she had any matches, and replied, "No, I don't light the candle, I don't have any matches. My [family	F 323	**F323 Accidents** **1.** The multiple electrical appliances connected to a multi-plug that was attached to an extension cord and other electrical devices identified or observed were disconnected and removed on 10/04/2006. • Candle observed burning was removed in a residents room was removed immediately on 10/04/06. • All Oxygen tanks identified were secured and completed 10/06/06. • The floor drain cover observed unsecured in the apartments kitchen was repaired 10/25/06. 2. All rooms and resident areas were check for candles, unsecured oxygen tanks and unsecured floor drains related to these observations.	

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INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

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F 323	Continued From page 12 member] lights the candle." A face-to-face interview was conducted with the charge nurse on October 4, 2006 at 2:40 PM. He /she acknowledged that facility staff was aware that the family member lit a candle when visiting with his/her relative. 3. Oxygen tanks were observed unsecured on both resident units. Garden Level: Two (2) oxygen tanks were observed unsecured in two (2) of 2 observations on October 4, 2006 at 3:45 PM. Lower Level: Two (2) of five (5) oxygen tanks were observed unsecured on October 5, 2006 at 11:30 AM. 4. A floor drain cover was unsecured in the apartment kitchen. On October 4, 2006 at 2:00 PM, a floor drain cover located in the apartment kitchen was observed unsecured and moved when walked across.	F 323	**3.**The environmental Services Director or designee will add Items identified or observed during this survey to the environmental rounds schedule weekly. This compliance will continue weekly times 4 and random monthly thereafter. 11/01/06 **4.** Results of this audit will be presented to the QA committee monthly times three. Nov., Dec. & Jan. 2007 **F 371**	11/19/06
F 371 SS=E	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	F 371	**Corrective Action for Affected Residents:** 1. No residents were affected. • Walls, ceiling tile surfaces and air supply vents observed to be soiled were	

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F 371	Continued From page 13 Based on observations during the survey period it, was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: soiled walls, ceiling tiles, air supply vents over cooking areas, compressor fans and covers in the walk-in refrigerator, the pre-filter of the water supply line, dishwasher slats on the clean and soiled side, cutting surfaces of the mechanical can opener and holder, top and bottom surfaces of plates, hotel pans, the bottom surfaces of juice glasses, the broiler grill, cooking hood filters; the dumpster area outside of the suites kitchen and cartons of buttermilk were stored in the walk-in refrigerator beyond the expiration date. These findings were observed in the presence of the dietary managers. The findings include: 1. Walls, ceiling tile surfaces and air supply vents were soiled with accumulated dust over cooking areas in the apartment kitchen in one (1) of one (1) observation at 3:10 PM on October 4, 2006. 2. Compressor fans and covers were soiled with accumulated dust and debris in the walk-in apartment refrigerator in one (1) of two (2) observations at 3:40 PM on October 4, 2006. 3. The prefilter on the water supply line near cooking hoods was soiled with contaminants, accumulated mineral deposits and other products in the apartment kitchen in one (1) of one (1) observation at 3:15 PM on October 4, 2006. 4. Plastic slats on the clean and soiled side of the dishwasher in the apartment kitchen were soiled	F 371	cleaned and completed on 10/10/06. • Compressor fans and covers identified to be soiled in the apartments walk-in refrigerator was cleaned and completed on 10/06/06. • The pre filter identified on the water supply line near the cooking hoods was cleaned and completed 10/06/06. • The pastic slates identified on the clean and soiled side of the dish washer in the apartments was cleaned and completed on 10/10/06. • The cutting and holder of the mechanical can opener identified in the apartment kitchen was cleaned and completed on 10/06/06 • The hotel pans observed were cleaned and completed on 10/05/06. In-serviced the utility staff 10-22-06, concerning air-drying of equipment and the correct way that dishware should be placed in the dish machine. Also reviewed the correct temperature of the wash and rinse cycle of the machine.	

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F 371	Continued From page 14 with accumulated mineral deposits and other products in one (1) of one (1) observation at 3:15 PM on October 4, 20006. 5. The cutting and holder surfaces of the mechanical can opener in the apartment kitchen were soiled with leftover food and debris in one (1) of one (1) observation at 3:20 PM on October 4, 2006. 6. The top and bottom surfaces of plates were soiled with leftover foods and plates were stored before they were allowed to dry in eight (8) of 28 observations at 8:45 AM on October 5, 2006. 7. The interior and exterior surfaces of hotel pans (12 x 24 x 6 inch) were soiled with leftover food after washing in the pot and pan wash area and pans were not allowed to dry before storing on racks for reuse in eight (8) of eight (8) observations at 9:30 AM on October 5, 2006. 8. The bottom surfaces of juice glasses were soiled and stained with mineral deposits after washing in eight (8) of eight (8) observations at approximately 10:00 AM on October 5, 2006. 9. The broiler grill grates were soiled with accumulated food and carbon deposits in the cook's area of the apartment kitchen in one (1) of one (1) observation at 10:30 AM on October 5, 2006. 10. The interior areas of cooking hood filters were soiled with grease and dust in the suites kitchen in six (6) of six (6) observations at approximately 2:30 PM on October 4, 2006.	F 371	• The bottom surfaces of the juice glass observed were cleaned and completed 10/06/06. Water softener vessel was serviced during the inspection and will be placed on a PM schedule. Glassware with mineral deposits will be washed to eliminate this debris. • The broiler grill grates observed in the apartments kitchen was cleaned and completed on 10/06/06. • The interior areas of the cooking hood filters observerd soiled was cleaned and completed on 10/06/06. • The paper and soiled products observed on the floor and surrounding areas of the dumpster near the suites kitchen were cleaned and completed on 10/06/2006 • Cartons of Butermilk observed in the walk in refrigerator that were expired were destroyed on 10/05/06. 2.The Dining Service Director or designee in each of the	

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F 371	Continued From page 15 11. Paper and soiled products were observed on the ground outside of the dumpster near the suites kitchen in one (1) of one (1) observation at 2:25 PM on October 4, 2006. 12. Cartons of buttermilk in the walk-in refrigerator were stored beyond the expiration date. The date of expiration was October 2, 2006 in four (4) of 24 observations at 2:05 PM on October 4, 2006.	F 371	Ingleside kitchens will conduct a sanitation audit monthly. The Service Manager or designee will conduct weekly audits. 3 .The Dining Service Director will monitor daily and corrective action will be taken to maintain compliance with standards as needed based on the results of the audits. 4.Sanitation audits and need action plans will be reported at the QA committee meeting monthly. 11/06 **F 385** **Corrective Action for Affected Residents:** 1. Residents #1, 4 and 9 haves a completed H & P on the chart. 10/31/06 **Procedure for Identifying Potentially Affected Residents:** 2. Medical records audits will be completed to ensure the H&P are done. The MD will be contacted to complete any delinquent H&P's found. 10/30/06	11/19/06
F 385 SS=D	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for three (3) of 15 sampled residents, it was determined that the physician failed to complete the annual history and physical assessment for Residents #1, 4, and 9. The findings include: According to the facility's policy, "History and Physicals", effective 9/04, no policy number, "	F 385		

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F 385	Continued From page 16 under "Procedure - 1. All residents must have an annual history and physical by their attending physician after being in the facility (1) year." 1. The attending physician failed to complete an annual history and physical assessment for Resident #1. A review of Resident #1's record revealed that the most current History and Physical assessment was signed and dated September 25, 2005 by the attending physician. A face-to-face interview was conducted with medical records staff on October 6, 2006 at 9:30 AM. He/she stated, "I keep a list of when all the history and physicals are due. I place a blank history and physical form in the record about a month before it's due and flag it for the physician." The record lacked evidence of a blank history and physical form for the physician to complete. The record was reviewed on October 6, 2006. 2. A review of the clinical record for Resident #4 revealed that the physician failed to complete an annual history and physical (H&P) examination. The last H&P was dated August 31, 2005. A face-to-face interview was conducted with the nurse manager who acknowledged that the H&P was delinquent. The record was reviewed on October 5, 2006. 3. The physician failed to complete the annual history and physical assessment for Resident #9. A review of Resident #9's record revealed that the most current history and physical assessment in	F 385	**Measures Adopted for Systemic Change:** 3. MD 's will be educated on the facilities policy and procedures regarding H&P's and their completion. •If MD is not completing the H&P in a timely manner, he/she will be contacted by the Medical Director or Administrator. •The Medical Director will be required to complete the H&P if the attending Physician is not available. 11/06 **Monitoring of Corrective Action and Quality Assurance:** 4. The Medical Records Coordinator will audit records and report compliance of H&P's at monthly QA committee meetings. 11/06	11/19/06

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F 385	Continued From page 17 the record was dated September 8, 2005. A face-to-face interview was conducted with the Resident Care Coordinator on October 6, 2006 at 3:45 PM. He/she acknowledged that the history and physical assessment should have been completed September 2006. The record was reviewed October 6, 2006.	F 385		
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 observation, record review and staff interview for two (2) of 15 sampled residents, it was determined that the physician failed to sign telephone orders as per facility policy. Residents #5 and J1. The findings include: According to the facility's policy, "Physician Orders" with an effective date of 6/06, no policy number, under "Procedure - 1. All telephone orders must be signed within 14 days of receipt of the orders."	F 386	**F386** **Corrective Action for Affected Residents:** 1. Residents #5 and J1 telephone orders have been signed. 11/01/06 **Procedure for Identifying Potentially Affected Residents:** 2. All current residents records will be audited for MD signatures. MD's will be contacted to sign orders.	

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F 386	Continued From page 18 1. The physician failed to sign telephone orders for Resident #5 as per facility policy. A review of Resident #5's record revealed that the physician failed to sign the following 19 telephone orders: July 25, 29, 30 and 31, 2006, August 1, 6 (2 orders), 7, 9, 10, 11, 16, 17 (2 orders), 24 (2 orders) and September 21, 22 and 25, 2006. Physician progress notes were present in the record and dated July 25, 2006, August 4, 7, 19, 20 and 31, 2006 and September 13 and 28, 2006. A face-to-face interview was conducted with the Resident Care Coordinator (RCC) on October 5, 2006 at 7:00 AM. He/she acknowledged that the physician had not signed the above cited telephone orders. The record was reviewed October 5, 2006. 2. The physician failed to sign telephone orders for Resident J1 as per facility policy. A review of Resident J1's record revealed the physician failed to sign the following five (5) telephone orders: June 10 and 12, 2006, August 28 and 30, 2006 and September 10, 2006. A face-to-face interview was conducted on October 5, 2006 at 11:30 AM with the RCC. He/ she acknowledged that the above cited telephone orders were not signed by the physician. The record was reviewed October 5, 2006.	F 386	**Measures Adopted for Systemic Change:** 3. MD 's will be educated on the facilities policy and procedures regarding signing telephone orders and their completion. MD's not in compliance with signing telephone orders will be notified by the Medical Director or Administrator. The Medical Director will be required to sign telephone orders if the Attending physician is not available. **Monitoring of Corrective Action and Quality Assurance:** 4. Medical Record will report rates for 90 days of MD's signatures for telephone orders at the QA committee meeting monthly. November, December & January.	11/19/06

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F 441 SS=E	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 observations during the survey period, it was determined that infection control practices were not followed as evidenced by: particles in the Barbicide solution, soiled interior surfaces of hair dryers, a brush with hair in a container with clean rollers and interior and filter surfaces of oxygen concentrators. The findings include: Beauty Shop observations were made on October 6, 2006 at 10:30 AM. 1. Barbicide was cloudy with particles and debris in the solution in one (1) of one (1) observation. 2. The interior surfaces of hair dryers were soiled with dust in four (4) of six (6) observations. 3. A hair brush with accumulated hair in the bristles was lying on top of clean rollers in one (1) of one (1) observation.	F 441	**F441 Infection Control** **1.** No resident was affected by this deficiency. • The identified Barbicide was changed and completed 10/10/06. • The observed interior surface of the Hair dryers that were soiled was cleaned and completed 10/10/06. • The identified hair Brush with accumulated hair in the bristles was removed and discarded 10/10/06. • The interior and filter surfaces of the observed oxygen concentrator were cleaned and completed 10/10/06.	

received 11/7/06

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

PRINTED: 10/13/2006
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F 441	Continued From page 20 4. The interior and filter surfaces of an oxygen concentrator in room 170 and the filter in room 186 were observed with accumulated dust and debris in two (2) of 11 observations at 11:30 AM on October 5, 2006 and 12:25 PM on October 6, 2006.	F 441	3.The Environmental Services Director or designee will add Idems identified or observed during this survey to the environmental rounds schedule weekly. This compliance will continue weekly times 4 and random monthly thereafter. 11/01/06 4. Results of this audit will be presented to the QA committee monthly times three. Nov., Dec. & Jan. 2007 **F 514** **Corrective Action for Affected Residents:** 1. Resident #8 will continued the functional maintenance program. Flow sheets will be updated.	11/19/06
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the facility staff failed to document the resident's participation in the restorative program. Resident #8. The findings include: A review of Resident #8's record revealed that a " Rehab Screen" dated February 20, 2006 documented, "OT [occupational therapy] will write an order for functional maintenance program to	F 514		

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F 514	Continued From page 21 increase strength for ambulation to help prevent falls." The resident had a history of falls. An order dated February 21, 2006 at 11:00 AM, which was signed by the physician on March 7, 2006, directed, "Functional maintenance program : Ambulate resident with walker to all meals to increase bilateral lower extremity strength and ambulation ability." A review of the "Restorative Nursing -Flow Sheet" dated June 2006, revealed that facility staff began documenting the resident's participation in the functional maintenance program on June 18, 2006. There were no other Restorative Nursing-Flow Sheets found in the record prior to June 2006. A face-to-face interview was conducted with the Director of Nursing on October 5, 2006 at 3:00 PM. He/she stated, "The resident was participating in the functional maintenance program, but the staff did not start documenting until June 18, 2006. They just didn't document it." The record lacked evidence that the facility staff documented the resident's participation in the functional maintenance program from February 21, 2006 to June 17, 2006. The record was reviewed on October 4, 2006.	F 514	**Procedure for Identifying Potentially Affected Residents:** 2. The Rehab department will identify all residents on a "Functional Maintenance program". The Nurse Managers will insure that nursing flow sheets are up to date. **Measures Adopted for Systemic Change:** 3. The nursing staff will be educated on restorative nursing flow sheet documentation. 11/19/06 The Charge Nurses will review restorative flow sheets daily for documentation. Restorative flow sheets will be placed in the ADL books. **Monitoring of Corrective Action and Quality Assurance:** 4. The unit Managers will report restorative documentation compliance for 90 days at the monthly QA committee meeting. Nov., Dec. and Jan. 01/31/07	11/19/06