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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095025	A. BUILDING ____ B. WING ____	07/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISNER LOUISE DICKSON HURTHOME	5425 WESTERN AVE NW, WASHINGTON, DC 20015

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F 000	INITIAL COMMENTS An annual recertification survey was conducted on July 19, 20 and 23, 2010. The following deficiencies were based on observations, staff and resident interviews and record review. The total sample was 15 residents based on a census of 60 on the first day of survey. There were four (4) supplemental records.	F 000	**F157 Notification of Changes** **1. Immediate Response:** Resident #1's physician was informed of resident's change in depressive symptoms and behaviors. Resident evaluated.	7/23/10
			2. Risk Identification: All resident records were reviewed for documentation of significant change in depressive symptoms and behaviors and subsequent physician notification for the last quarter.	9/3/10
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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	F 157	**3. Systemic Changes:** Social Service and licensed nurses were in-serviced on physician notification when observing and documenting significant change in resident's symptoms of depression and/or behaviors.	9/3/10
			4. Monitoring: The Director of Social Services or her designee will perform a sample audit of records to assure the physician was notified of residents with significant change in depressive symptoms and/or behaviors. Findings of this audit will be presented at the Quarterly Quality Assurance Meeting.	9/15/10
			F176 Resident Self-Administration of Medication **1. Immediate Response:** Assessments completed with Interdisciplinary Team which concluded that both residents were able to safely self-administer prescribed medication. Care Plans and physician orders added and updated.	7/23/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan McHaig LNHA — TITLE: Administrator — (X6) DATE: 9/3/10

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

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 15 sampled residents, it was determined that facility staff failed to notify the physician of Resident #1's depressive symptoms and behaviors. The findings include: Resident #1 was admitted to the facility on January 6, 2010. According to an admission Minimum Data Sets [MDS] completed January 15, 2010, his/her diagnoses included: Cerebrovascular accident, Emphysema, Glaucoma, Cervical Stenosis, Ataxia, BPH, and peripheral neuropathy. A review of the resident's clinical records revealed a "Physician Order Record" signed and dated June 29, 2010 that directed the following: medications: "Calcarb 600/D oral tablet 600-400 mg -unit 1 tablet PO [By mouth] before dinner 4 PM special instructions ..." "Colace oral capsule 100mg 1 capsule PO 1 time a day 9 AM ..." "Ensure plus oral liquid 1 cans PO 3 times a day ..." "Ensure plus oral liquid 1 cans PO 3 times a day ...for a total of 6cans per day ..." "Flomax oral capsule extended release 24 hour 0.4 mg 1 capsule PO 8:00 PM ..." "Lasix ...oral tablet 20mg 1 tablet PO 1 time a	F 157	**(F176 Resident Self-Administration of Medication Continued)** **2. Risk Identification:** Records checked to make sure that any resident self-administering medications had assessments and care plans in place. No other residents self administer medication at present. **3. Systemic Changes:** The Care Plan team was in-serviced on the need for an assessment for residents who request to self administer medication. If the assessment indicates that the resident may safely administer medication by return demonstration after education, a care plan and physician's order will be implemented. **4. Monitoring:** Audit of Care Plans for residents who self administer will be evaluated on a quarterly basis to determine if they can safely continue to self administer and to determine if assessment, care plan and physician orders are in place. Results of audit will be reported at Quarterly Meetings. **F241 Dignity & Respect of Individuality** **1. Immediate Response:** DON attempted face to face interview (X5) with resident #3 to find out food service preferences. Resident #3 was unable to participate due to severe cognitive and severe communication deficits as documented in resident's MDS dated 4/13/10, 7/12/10 and 8/13/10. DON observed resident #3 during meal times.	7/23/10 9/2/10 9/15/10 8/2/10

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F 157	Continued From page 2 day ..." "Loratadine oral tablet 1 tablet PO ..." "Multi-minerals oral tablet 1 tablet PO ..." "Potassium chloride crys CR oral table extended release 10 meq 1 tablet ..." "Acetaminophen Extra strength 500mg 2 tablets PO PRN every 6 hours-PRN for temperature >100 ..." A further review of the resident's clinical record revealed the following: Social Service Progress Notes: " April 20, 2010 " ...Resident demonstrates some symptoms of depression including irritable mood, feelings of hopelessness and uselessness, and a decline in socialization in the past 6 week ...Resident also can become verbally aggressive, swearing at nurses providing care and making sexually inappropriate comments. These behaviors are also easily redirected ..." The resident's clinical record lacked documented evidence that the physician was notified of the aforementioned resident's presentations. A further review of the physician's progress notes in the resident's clinical record lacked documented evidence that the physician addressed Resident #1's depressive symptoms and behaviors. A face-to-face interview was conducted on July 23, 2010, at approximately 9:00 AM with Employees #1 and 11. After reviewing the resident's clinical record, they both acknowledged that the resident's clinical record lacked documented evidence that the physician was notified of Resident #1's depressive symptoms	F 157	**(F241 Dignity and Respect of Individuality Continued)** Resident #3 to be fed at the same time, at the same table space as others or to be fed in his room as clinical condition and preference dictates. **2. Risk Management:** Residents at the same table space will receive their meals at the same time. If a resident at that table needs to be fed, the resident will be fed at the same time the other residents will be eating. **3. Systemic Changes:** Special Care unit staff in-serviced on proper tray passing and feeding assistance to assure dignity and preference. **4. Monitoring:** DON or designee will observe meal pass (X4) per quarter for tray pass and feeding on special care unit and report findings to the Quality Assurance Committee. **F246 Reasonable Accommodation of Needs/preferences** **1. Immediate Response:** Resident provided with requested alternative to lunch. **2. Risk Identification:** Residents with concerning or significant weight loss trends will have prn nutrition care by the RD/LD or designee, to include documentation of the residents known (stated or observed) food, beverage, and meal preferences. **3. Systemic Changes:** Catering Associates in-serviced on the proper completion of the Food Preference Record.	9/7/10 9/7/10 9/15/10 7/19/10 9/15/10 8/31/10

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F 157	Continued From page 3 and behaviors. According to Employees #1 and 11 after the face-to-face interview [July 23, 2010], the resident was seen by a psychiatrist and was prescribed medication for depression. The record was reviewed July 23, 2010.	F 157	**(F246 Reasonable Accommodation of Needs/preferences – Continued)** **4. Monitoring:** RD/LD or designee will audit all medical records for residents with concerning or significant weight loss trends for documentation of the residents known (stated or observed) food, beverage, and meal preferences. Findings to be reported at Quarterly QA meetings.	9/15/10
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE 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 observation, resident and staff interviews and record review for two (2) of 15 sampled residents, it was determined that the interdisciplinary team failed to assess one (1) resident for the ability to self administer eye drops and one (1) resident for the ability to self administer facial cream. Residents #5 and 13. The findings include: Review of the facility ' s policy " Self Administration of Medication, " (no date indicated for initiation of the policy or last review) lacked evidence of a procedure that indicated that the Interdisciplinary team must determine that it is safe for the resident to self-administer drugs before the resident may exercise that right. 1. Facility staff failed to assess Resident #5 for the ability to self administer eye drops. According to an "Interim Order Form" dated and signed March 23, 2010, it directed "resident	F 176	**F253 Housekeeping and Maintenance Services** **1. Immediate Response:** Unable to remove ink stain from privacy curtains in room 105 and 123 therefore privacy curtains were replaced. **2. Risk Identification:** All other privacy curtains were inspected and replaced if indicated. **3. Systemic Changes:** Staff in-serviced on checking privacy curtains for cleanliness and lack of stains. **4. Monitoring:** Privacy curtains will be inspected on a monthly basis and findings will be reported at Quarterly QA meetings. **F272 Comprehensive Assessments** **1. Immediate Response:** RAP documentation for the medical record of resident #3 completed. **2. Risk Identification:** Presence of RAP documentation on medical records checked and those not found will be added from 7/23/10 forward.	7/20/10 7/20/10 9/1/10 9/15/10 8/26/10 9/15/10

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F 176	Continued From page 4 may self administer eye drop with nurse supervision. " According to Resident #5's April 2010 Physician's Order Sheet signed by the physician on April 13, 2010 directed, " Azopt Ophthalmic Suspension 1% 1[one] drop both eyes 2 [two] times a day. Dx [diagnosis] Glaucoma, Resident may self-administer eye drops with nurse supervision. " A review of the Medication Administration Records (MAR ' s) for May, June, and July 2010, revealed initials indicating " Azopt Ophthalmic Suspension 1% to both eyes " was administered daily at 9:00 AM and 5:00 PM. Medication to be secured in medication cart and documentation of administration to be completed by nurse. " There was no evidence in the record that the Interdisciplinary Care Team (IDT) determined that Resident #5 was safe for self administration of medications. The record lacked evidence that a routine assessment was conducted by the IDT to assess the resident's ability to self medicates. A face-to-face interview was conducted on July 20, 2010 at approximately 1:30 PM with Resident #5. He/she stated, "Yes, I put my own eye drops in my eyes, and it is for my Glaucoma." A face-to-face interview was conducted on July 20, 2010 at approximately 3:00 PM with Employees #4 and Employee #17. They stated, "[Resident #5] self administers his/her eye drops." The record was reviewed July 20, 2010.	F 176	**(F272 Comprehensive Assessments Continued)**	
			3. Systemic Changes: MDS consultant reeducated MDS coordinator regarding the need for RAP documentation on chart. Care plan team in-serviced on need for RAP documentation on chart.	**9/2/10**
			4. Monitoring: MDS consultant to audit during monthly visit on a random basis to assure RAP completion and presence on chart. Audit results will be reported by DON or designee at the quarterly QA meeting.	**9/15/10**
			F278 Assessment **(1)MDS Coding for overall change in status** **1. Immediate Response:** Identified coding on MDS for resident #1 was adjusted to reflect correct resident weight in section K2.	**8/31/10**
			2. Risk Identification: The medical records of all residents having a concerning or significant weight loss over the past 90 days were reviewed for proper coding for section K2.	**9/10/10**
			3. Systemic Changes: The MDS coordinator was educated on proper coding of section K2.	**8/26/10**

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F 176	Continued From page 5 2. Facility staff failed to assess Resident #13 for the ability to self administer facial cream. According to an "Interim Order Form "dated July 1, 2010 at 2:00 PM directed, "Monsbenzone/HC Valarate Cream apply to affected darkened areas on face two times a day. Resident may self apply and keep in locked box in room." On July 19, 2010 at approximately 8:54 AM a tour of Resident #13's room was conduct. Medication was not observed outside of the locked box in the closet. There was no evidence in the record that the Interdisciplinary Care Team (IDT) determined that Resident #13 was safe for self administer facial cream. The record lacked evidence that a routine assessment was conducted by the IDT to assess the resident's ability to self administer facial cream. A face-to-face interview was conducted on July 20, 2010 at 1:13 PM with Employee #4. He/she acknowledged that interdisciplinary team had not conducted a review to determine that it was safe for Resident #13 to self administer facial cream. The record was reviewed July 20, 2010.	F 176	**(F278 Assessment** **(1)MDS Coding for overall change in status Continued)** **4. Monitoring:** The RD/LD or designee to audit proper coding of section K2 of the MDS for residents who have had concerning or significant weight loss over the past 90 days. These findings will be reported to Quarterly QA Meeting. **F278 Assessment** **(2)MDS Coding for overall change in status** **1. Immediate Response:** Identified coding on MDS for resident #3 was adjusted to reflect correct resident status. **2. Risk Identification:** The medical records of all residents having a change in status in MDS over the past 90 days were reviewed for proper coding for section Q. **3. Systemic Changes:** The MDS coordinator was educated on proper coding of section Q. **4. Monitoring:** ADON or designee to audit section Q of the MDS for residents who have had a change in status to assure proper coding. These findings will be reported to Quarterly QA Meeting.	9/15/10 8/26/10 8/26/10 8/26/10 9/15/10
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 6	F 241		

This REQUIREMENT is not met as evidenced by:

Based on observations and staff interview and resident interview for one (1) of 15 sampled residents, it was determined that facility staff failed to promote dignity during the lunch and dinner meals for Resident #3.

The findings include:

On July 19, 2010 at approximately 12:25 PM, lunch was observed being served to eight (8) residents in the special care dining area on the first floor. At 12:35 PM, all residents were being assisted with eating his/her lunch by three (3) employees. Resident #3 was sitting in chair near window with legs crossed and eyes close.

Resident #3 was served his/her lunch at approximately 1:00 PM and was being assisted by a CNA [Certified Nursing Assistant].

On July 19, 2010 at approximately 5:05 PM, dinner was observed being served to ten (10) residents in special care dining area on the first floor. At 5:10 PM, all residents were observed being assisted by two employees. Resident #3 was sitting in chair by doorway with eyes closed.

Resident #3 was served his/her tray at 5:45 PM and was being assisted with eating.

A face-to-face interview was conducted with Resident #3 on July 23, 2010 at approximately 9:30AM, he/she stated, " Yes, it does bother me when I am served last. "

A face-to-face interview was conducted with

F278 Assessment
(1b)MDS Coding for overall change in status

1. Immediate Response: — **8/26/10**
The medical record for resident #1 will reflect documentation to include depression, anxiety, sad mood, socially inappropriate and disruptive behaviors to support resident's current clinical condition.

2. Risk Identification: — **9/15/10**
The documentation in the medical record for residents who have indications of depression, anxiety, sad mood, socially inappropriate and disruptive behaviors will reflect the residents' current clinical condition.

3. Systemic Changes: — **9/3/10**
Staff were in-serviced on appropriately documenting mood and behavioral indicators in the medical record.

4. Monitoring: — **9/15/10**
The Director of Social Services or designee will perform a sample audit of resident records to assure proper documentation of depressive symptoms and behaviors is completed to support proper MDS coding of the residents condition. These findings will be reported at Quarterly QA Meeting.

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F 241	Continued From page 7 Employee #10 at approximately 6:00 PM. He/she stated, " He/she received their tray last, because he/she needs assistance with eating. "The record was reviewed on July 20. 2010.	F 241	**F279 Develop Comprehensive Care Plans**	
			1. Immediate Response: Care Plan for resident #3 was completed for the use of 9 or more medications. Care plan for resident #5 was completed for self administration.	7/23//10
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	**2. Risk Management:** An audit was completed of the care plans for all residents (a) using 9 or more medications (b) self administering medication. Care plans in place.	9/15/10
	This REQUIREMENT is not met as evidenced by:		**3. Systemic Changes:** Staff were in-serviced on the need to care plan for residents on 9 or residents who self medicate.	9/2/10
	Based on record review, staff and resident ' s interviews, it was determined that facility staff failed to provide nutritional services with reasonable accommodations of one (1) resident ' s individual needs and preferences. Resident #1. The findings include:		**4. Monitoring:** A random sample of 10% of care plans will be reviewed by DON/designees monthly to check for presence of care plans for 9 or more meds and self administering medications. Findings will be reported at QA meeting.	9/15/10
	A review of the resident ' s clinical record revealed that the resident was admitted to the facility on January 6, 2010. A " Nutrition risk assessment " completed on January 7, 2010 noted a slight weight loss. The risk assessment indicated goals that included weight in the 140 ' s pound, and interventions that included regular diet, night time snacks, weekly weights and " consider ensure plus twice daily ... " According to the nutritional risk assessment, the resident weight on admission was 138 pounds. The resident ' s weight in March, 60days after admission to the facility was128.		**F309 (1)Allergy** **1. Immediate Response:** Family contacted for clarification of fish allergy. Order written that states resident is allergic to fish, not shellfish.	7/27/10
			2. Risk Identification: Residents with food allergies reviewed. There were no other residents affected.	9/1/10

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F 246	Continued From page 8 The resident was first observed asleep in his/her room on July 19, 2010 at approximately 11:20 AM and at lunch at approximately 12:30 PM. A face-to-face interview was conducted with the resident in his/her room on July 19, 2010 at approximately 12:45 PM during lunch. He/she said, I worked night shift all of my life. As I headed home to sleep, others were heading to work, when I wake up, I do not want this heavy meal, I want something light to start with and then lunch. I am not eating this. I do not want that pie; I prefer apple or cherry pie. I do not like nuts. " A bag of cashew nuts was observed on his/her night stand. A follow-up face-to-face interview was conducted on July 26, 2010 at approximately 12:00 PM at lunch in his/her room. The resident refused to eat the contents of his lunch tray. He/she said, " I will eat some grilled cheese sandwich to start with. A follow-up face-to-face interview was conducted with the resident on July 23, 2010 at approximately 10:00 AM he/she said " I ate some nuts. ...I sometimes get confused though. " Facility staff failed to provide nutritional services with reasonable accommodations of Resident #1 ' s individual needs: He/she sleeps during breakfast and prefers something light before the heavy lunch tray. He/she verbalized need for varied choices. The nutritional risk assessment dated January 7, 2010 and subsequent nutrition reviews/updates in the " Nutrition Care Progress Notes " dated January 7, March 11, April 19, 2010 and a " PRN Note " failed to include the resident ' s individual nutritional needs and preferences.	F 246	**(F309 (1) Allergy Continued)** **3. Systemic Changes:** Staff will be in-serviced on correctly documenting food allergies, and need to have allergies stated on POS. **4. Monitoring:** DON/designees to audit records and report findings to QA committee. **F309 (2)Labs** **1. Immediate Response:** Labs obtained. **2. Risk Identification:** Audit of physician's progress notes completed for past 90 days. Charge Nurse/DON to review physician's charts after visits to assure orders are correctly entered. **3. Systemic Changes:** Physician in-served on procedure of flagging orders when written. **4. Monitoring:** Audit of 10% of physician charts by DON or designee done monthly and reported at quarterly QA meeting. **F309 (3)Physician Order** **1. Immediate Response:** Order for self administration of eye drops obtained. **2. Risk Identification:** Records checked to make sure that any resident self-administering medications has orders in place.	9/15/10 9/15/10 7/13/10 9/10/10 8/31/10 9/15/10 7/22/10 7/23/10

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F 246	Continued From page 9 A face-to-face interview was conducted with Employee # 11 on July 20, 2010 at approximately 11:45 AM. He/she said, I do not spend any time on food preferences, the catering assistants [Employee #11 gave the names of two other employees] Employees #12 and 16 do the meal preferences. I offered [Resident ' s name] the grilled cheese sandwich when he/she refused the content of the lunch tray. Employee # 11 acknowledged the aforementioned findings. The record was reviewed July 20, 2010.	F 246	**(F309 (3)Physician Order Continued)** **3. Systemic Changes:** Licensed nursing staff in-serviced on need to obtain physicians order for all self-administered medications. **4. Monitoring:** DON/designee will audit the medical record for all residents who self administer medication to assure physician order in place. Results of audit will be reported at Quarterly Meetings.	**9/15/10** **9/15/10**
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on July 20, 2010, it was determined that the facility failed to provide effective maintenance services in residents rooms as evidenced by soiled privacy curtains in two (2) of 13 rooms surveyed, water was dripping from a ceiling vent on one (1) of three (3) units surveyed, a faulty call bell cord in one (1) of 13 rooms surveyed and a damaged air conditioner cover and grill in one(1) of 13 rooms surveyed. The findings include: 1. Privacy curtains were soiled and stained in rooms # 105 and # 123. 2. Water was dripping from the ceiling vent in the special care dayroom located in the Lisner	F 253	**F323 Free of Accident Hazards/Supervision/Devices** **1. Immediate Response:** Resident #12 was immediately assessed to insure that safety measures and assisted devices were in place to protect against accidents. Safety measures include extensive assistance of two (2) persons for bed mobility and transfer. Assisted devices include two half side rails on a specially ordered bariatric bed. All assisted devices and safety measures were found to be in place and in compliance with physician orders and assessments. **2. Risk Identification:** The DON's RN designee went room by room to inspect each resident bed and its side rails to assure compliance with physician orders. The DON's RN designee reviewed each resident's MDS to assure all residents are provided with the necessary assistance for bed mobility and transfer.	**7/20/10** **7/22/10** **9/8/10**

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F 253	Continued From page 10 Lane unit. 3. The cover and grill to the air conditioning system in room #134 were damaged. These findings were acknowledged by Employees # 4 and # 9 who were present at the time of observation.	F 253	**(F323 Free of Accident Hazards/ Supervision/ Devices Continued)** **3. Systemic Changes:** Rehab manager in-serviced staff on resident #12's safe bed mobility techniques, need for extensive assistance during transfer, and placement on bed pan. DON spoke with licensed nurses about supervision of C.N.A. staff to follow amount of assistance requirement to minimize potential for accidents. Rehab manager in-serviced nursing staff on safe bed mobility techniques for all residents.	**7/22/10**
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and	F 272	DON in-serviced nursing staff on the necessity of providing extensive assistance for bed mobility or transfer as indicated. **4. Monitoring:** Rehab manager will report any changes to side rail orders at safety committee weekly. DON/ or RN designee will conduct an audit of all beds and side rails with corresponding physician orders. The findings will be reported at the Quarterly QA meetings. Each resident will be reviewed on admission quarterly and as needed for level of assistance to maximize safety. The findings will be reported at weekly safety committee meetings.	**8/30/10** **9/15/10**

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F 272	Continued From page 11 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled records, it was determined facility staff failed to include the Resident Assessment Protocol (RAP)documentation in the medical record. Residents #3. The findings include: A review of the clinical record for Resident #3 revealed facility staff failed to ensure that the Resident Assessment Protocol (RAP) assessment documentation was accessible in the resident ' s record. The significant change MDS signed April 13, 2010 included a RAP Summary form that lacked assessment documentation as identified in the " location of information " column. The " location of information column " referred the reviewer to " MDS footnotes on [various dates]" to locate the RAP review and decision-making documentation; however, there were no MDS footnotes in the record. A face-to-face interview was conducted with Employee #13 on July 23, 2010 at approximately 10:30 AM. He/she acknowledged the MDS footnotes were absent from the clinical record. The record was reviewed on July 23, 2010.	F 272	**(F323 Free of Accident Hazards/ Supervision/ Devices Continued)** RN managers will perform random observations of resident care every shift, every month to monitor appropriate level of assistance provided for bed mobility and transfer. The DON or her designee will review RN Manager audits and report findings at quarterly QA. **F329 Drug Regimen is free from unnecessary drugs** **1. Immediate Response:** Identified resident #4 per resident roster, revealed no such medication regimen. Further review indicates that resident #7 medication regimen matches description. Resident medical record reviewed (a) physician order of 7/11/10 states Midrodine for orthostatic hypotension; (b) antipsychotic Risperdal was reduced from twice daily to daily on 5/22/10; (c) on 8/27/10 the antidepressant Lexapro was reduced from 10mg to 5mg daily; (d) resident referred to psychiatrist for gradual dose reduction of Ritalin. **2. Risk Management:** Pharmacist reviewed medical records for all residents' prescribed psychotropic medication, monitoring documentation and need for gradual dose reduction. Referrals to psychiatrist as needed.	9/10/10 9/1/10
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278		

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F 278	Continued From page 12 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 two (2) of 15 sampled residents, it was determined that facility staff failed to accurately code the MDS (Minimum Data Set) assessment for one (1) resident for behaviors and weight and one (1) resident for overall change in care needs. Resident's #1 and 3. The findings include:	F 278	**(F329 Drug Regimen is free from unnecessary drugs Continued)** **3. Systemic Changes:** Psychiatrist and licensed nurses were in-serviced on need for monitoring and gradual dose reduction of psychotropic medication. **4. Monitoring:** DON/designee will perform random audit on 10% of residents taking psychotropic medication and corresponding gradual dose reduction where indicated. Findings will be reported at QA committee. **F371 Food Procure, Store/ Prepare/ Serve – Sanitary** **(1) Soiled Toaster Oven and Convection Oven** **1. Immediate Response:** Convection oven, toaster and stove were cleaned. **2. Risk Management:** All cooking equipment was checked for cleanliness. **3. Systemic Changes:** All Dietary staff was in-serviced on cleaning cooking equipment. Every Cook will be responsible for cleaning equipment after every meal.	9/1/10 9/15/10 7/19/10 7/19/10 7/27/10

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F 278	Continued From page 13 1A. Facility staff failed to accurately code Resident #1's weight. A review of the resident's " Nutritional Care Progress Notes " in his/her clinical record revealed the following: The resident was admitted to the facility on January 6, 2010. The resident had a quarterly nutrition review was completed on April 19, 2010. On April 12, 2010 the resident ' s documented current weight was 130 pounds and on April 19, 2010 the documented weight was 128 lbs. According to a quarterly Minimum Data Set (MDS) assessment completed on April 19, 2010, the resident was coded in Section K2 " Height and Weight for 138 pounds. A face-to-face interview was conducted on July 20, 2010 at 11:45 AM with Employee #11. He/she acknowledged that the resident' s weight was miscoded. The record was reviewed July 20, 2010. 1B. Facility staff inaccurately coded Resident #1 for indicators of depression, anxiety, sad mood, mood persistence and behavioral symptoms. A review of Resident #1 ' s quarterly MDS completed on April 19, 2010 with an Assessment Reference Date [ARD] (last date for observations) of April 19, 2010 revealed that he/she was coded as making negative statements, asking repetitive questions in the last 30 days prior to the ARD. He/she was also coded as exhibiting one or more indicators of depressed, sad or anxious mood,	F 278	**(F371 Food Procure, Store/ Prepare/ Serve – Sanitary Continued)** **(1) Soiled Toaster Oven and Convection Oven** **4. Monitoring:** Cooks will sign daily "Opening Procedures" and "Closing Procedures" checklist. Heavy cleaning will be added to Tuesday cleaning schedule and signed off by cleaning personnel. Supervisor on Duty will check cleanliness and monitor aforementioned checklists. Director or designee will audit and report findings at Quarterly QA. **F371 Food Procure, Store/ Prepare/ Serve – Sanitary** **(2) Rinse water in 3 compartment sink was not holding water** **1. Immediate Response:** Maintenance repaired mechanical stopper. **2. Risk Management:** All stoppers on sinks throughout the kitchen were checked. **3. Systemic Changes:** Dietary Staff was in-serviced on importance or reporting malfunctioning equipment to a supervisor immediately. **4. Monitoring:** Dietary Personnel will check stoppers daily and report any malfunction immediately. Work orders will be submitted to Maintenance. Director will report work orders submitted at Quarterly QA.	9/15/10 7/19/10 7/19/10 7/27/10 9/15/10

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F 278	Continued From page 14 exhibiting socially inappropriate /disruptive behavioral symptoms in last 7 days prior to the ARD. Section E 1, 2 and 4 (Indicators of depression, anxiety, sad mood, Mood persistence and Behavioral symptoms). A review of Resident #1's Clinical record including the " Nurses' notes" for March and April 2010 revealed no documented episodes of the aforementioned behaviors. A face-to-face interview was conducted with Employees #13 and 15 on July 23, 2010 at approximately 9:00 AM. They both acknowledged that there were no documented episodes for indicators of depression, anxiety, sad mood, mood persistence and behavioral symptoms. The record was reviewed on July 23, 2010. 2. The facility staff failed to accurately code Section Q (Discharge potential and Overall Status) on Resident #3 ' s Significant Change MDS (Minimum Data Set). According to the significant change MDS completed April 13, 2010, the resident was coded in Section Q2 for overall change care needs as zero (0) indicating no change. The ARD (Assessment Reference Date) was April 7, 2010. The resident had a significant change MDS completed April 13, 2010. In Section G (Physical Functioning and Structural Problems), was coded as needed supervision and one (1) person to two (2) person physical assist with bed mobility, transfer, walk in room, locomotion on the unit, locomotion off the unit, dressing, eating, toilet use, personal hygiene and bathing; Section H (Continence in last 14 days), was coded as	F 278	**F371 Food Procure, Store/ Prepare/ Serve - Sanitary** **(3) Temperature of pot wash sink was 104 degrees** **1. Immediate Response:** Water was emptied and refilled with 110 degree water. **2. Risk Management:** sink water temperatures were checked throughout kitchen. **3. Systemic Changes:** Food Service Staff was in-serviced and temperature of water will be over 110 degrees. **4. Monitoring:** Temperature log implemented and temperature will be taken and recorded three times per day. Director and supervisor on duty will monitor. Director will report findings at Quarterly QA. **F371 Food Procure, Store/ Prepare/ Serve - Sanitary** **(4) Rug in front of freezer stained and soiled** **1. Immediate Response:** Rug was thrown away. **2. Risk Management:** All floors were checked throughout kitchen. **3. Systemic Changes:** Rubber safety mat was purchased to replace rug.	**7/19/10** **7/19/10** **7/27/10** **9/15/10** **7/19/10** **7/19/10** **7/28/10**

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F 278	Continued From page 15 frequently incontinent of bowel and bladder. Section J (Health Conditions), was coded as sustained a fracture in last 180 days, and Section K (Oral/Nutritional Status), was coded weight loss in the last 30 days. This area represented a decline in Resident #3's overall condition. A face-to-face interview was conducted with Employee #13 on July 23, 2010 at approximately 10:30 AM. After review of Significant change MDS Section Q Discharge potential and Overall Status he/she acknowledged that Section Q2 was inaccurately coded. The record was reviewed on July 23, 2010.	F 278	**(F371 Food Procure, Store/ Prepare/ Serve - Sanitary** **(4) Rug in front of freezer stained and soiled Continued)** **4. Monitoring:** Rubber safety mat was added to the Tuesday heavy cleaning list to check for rips and soil. Director will report any finding at Quarterly QA. **F371 Food Procure, Store/ Prepare/ Serve - Sanitary** **(5) Apple juice and Pineapple/carrot/raisin salad were 48 degrees**	9/15/10
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are 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).	F 279	**1. Immediate Response:** Juice and pineapple/carrot/raisin salad were thrown away. **2. Risk Management:** Cold temperatures were checked on other trays. **3. Systemic Changes:** Food Service staff was in-serviced on proper point of service temperatures. Juices will be poured from Vitality Juice Dispenser immediately after each meal and put into refrigerator to chill before the next meal. All cold items will be chilled and served in an insulated Alladin cup. **4. Monitoring:** Test Tray temperatures will be taken every week by Catering Associate. Director will report any finding at Quarterly QA.	7/19/10 7/19/10 7/27/10 9/15/10

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

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F 279	Continued From page 16 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 initiate a care for the potential adverse interaction of the use of nine (9) or more medications for Resident #3 and self administration of eye drops for Resident #5. The findings include: 1. Facility staff failed to initiate a care for the potential adverse interaction of the use of nine (9) or more medications for Resident #3. A review of the Physician Order Record for Resident #3 for July 2010, signed by the physician on July 2, 2010, revealed the following medication orders: Aricept, Aspirin, Colace, Ensure, Miralax, Sinemet, Vitamin D3, Zyprexa, Ativan, and Tylenol. A review of the care plan that were last updated on July 14, 2010, 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 #4 on July 19, 2010 at approximately 11:30 AM. After review of the care plans he/she acknowledged that the record lacked a problem identified or a care plan for the potential adverse interaction of the use of nine (9) or more medications. The record was reviewed on July 19, 2010	F 279	**F371 Food Procure, Store/ Prepare/ Serve - Sanitary** **(6) Staff was not specific on how to properly test or verify the concentration of the sanitizing solution for the dishwasher.** **1. Immediate Response:** Test strips were replaced with Chlorine Test Paper that was easier to identify color. **2. Risk Management:** Ecolab was called immediately to check PPM. PPM was correct. **3. Systemic Changes:** All Dietary Personnel were in-serviced on how to use new Chlorine Test Paper. **4. Monitoring:** Supervisor will continue to monitor logs. Director will report any findings at Quarterly QA. **F371 Food Procure, Store/ Prepare/ Serve - Sanitary** **(7) Staff unable to state the expected temperature of the wash solution on the 3 compartment sink** **1. Immediate Response:** Dietary Director informed the Dietary Personnel that the correct temperature is 110 degrees or higher. Sink was emptied and refilled.	**7/19/10** **7/19/10** **7/27/10** **9/15/10** **7/19/10**

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F 279	Continued From page 17 2. Facility staff failed to initiate a care plan with appropriate goals and approaches for self administration of medication for Resident #5. According to an "Interim Order Form" dated and signed March 23, 2010, it directed "resident may self administer eye drop with nurse supervision." A review of the plan of care for Resident #5 lacked problem identification, objectives and approaches for self administration of eye drops. A face-to-face interview was conducted with Employee #4 on July 20, 2010 at approximately 3:00 PM. He/she acknowledged that the record lacked a care plan for self administration of eye drops. The record was reviewed on July 20, 2010.	F 279	**(F371 Food Procure, Store/ Prepare/ Serve - Sanitary** **(7) Staff unable to state the expected temperature of the wash solution on the 3 compartment sink Continued)** **2. Risk Management:** Water was emptied from sink and refilled with water and temperature was tested with thermometer. **3. Systemic Changes:** Dietary Personnel was in-serviced on correct temperatures. Temperature will be taken three times per day and recorded on log. **4. Monitoring:** Supervisor will check log daily. Director will report findings at Quarterly QA.	**7/19/10** **7/27/10** **9/15/10**
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 15 sampled residents, it was determined that facility staff to clarify allergy to shell fish for one (1) resident, failed to follow through with physician ' s plan to obtain labs for one (1) resident and failed to follow physician ' s	F 309	**F386 Physician Visits** **1. Immediate Response:** Resident seen by noted physician for indicators of depression and weight loss. **2. Risk Management:** The medical records of all residents having a concerning or significant weight loss and depressive mood behaviors over the past 90 days were reviewed to make sure weight was addressed by physician. **3. Systemic Changes:** In-serviced Interdisciplinary Team members to bring to the attention of the DON incidents of clinical changes which need physician attention.	**8/31/10** **9/15/10** **9/2/10**

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F 309	Continued From page 18 orders for self administration of eye drops for one (1) resident. Residents # 2, 3, and 5. The findings include: 1. Facility staff failed to clarify allergy to shellfish for Resident #2. History and Physical dated and signed November 3, 2009, directed " See H&P [History and Physical] Sibley [October 25, 2009] and [May 29, 2009]. The [hospital] H&P dated October 25, 2009 and May 29, 2009, revealed "Allergies: Shellfish." The "Initial Nutritional Assessment "completed November 8, 2009, revealed " *no baked, fried fish* tuna [and] shellfish OK." According to the "Nutritional Risk Care Plan" dated November 23, 2009, revealed "Other: Allergy/intolerance to fish (tuna OK and shellfish OK)" According to the "Nutrition Risk Care Plan" dated February 17, 2010, revealed "Intolerance to fish (shellfish and tuna OK)." The "Quarterly Nutrition Review " dated and signed May 24, 2020, revealed " no baked or fried fish, tuna/shellfish OK. " A face-to-face interview was conducted with Employees #4 and Employee #17, both stated, "Resident #2 is not allergic to shellfish, she has eaten shrimp with no problem, she prefers not to have baked and fried fish." After reviewing the resident's clinical record both acknowledged the record lacked evidence of clarifying resident's	F 309	**(F386 Physician Visits Continued)** **4. Monitoring:** As part of safety/QA weekly committee, those residents who are identified as having concerning or significant weight loss or depressed mood or agitated behaviors will be reported to physician by DON. DON/designee will report results at Quarterly QA meetings. **F387 Timeliness of Physician Visits** **1. Immediate Response:** Physician notified of missed visit and examined resident. **2. Risk Management:** All resident records for new admissions for past quarter were reviewed for proper physician visits. Physician visits scheduled if indicated. **3. Systemic Changes:** RN Coordinator responsible for physician schedule in-serviced on need for visits every 30 days for 1st 90 days following admission. Particular attention to Assisted Living Residents transferred to Nursing Facility, from our Assisted Living Residence, needing to be scheduled as a new admission. **4. Monitoring:** Unit manager/Supervisors will perform monthly audits of physician's visit of all new admissions and findings reported at Quarterly QA meetings by DON or designee.	9/15/10 8/26/10 9/15/10 9/1/10 9/15/10

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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 309	Continued From page 19 allergy to shellfish. The record was reviewed July 19, 2010. 2 Facility staff failed to follow through with physician's plan to obtain labs on Resident #3. A review of the physician ' s progress note dated and signed April 13, 2010 indicated ... no recent labs, check CBC (complete blood count) ... A review of the physician's orders for April 2010 lacked evidence of a CBC order. A review of the nurse's notes for April 2010 lacked documented evidence that a CBC was ordered. A review of the laboratory sheets lacked evidence that a CBC was ordered or drawn. A face-to-face interview was conducted on July 23, 2010 at approximately 10:30 AM with Employees #1, 2, and 13. After review of the clinical record he/she acknowledged that the clinical record lacked documented evidence that the CBC was ordered. Facility staff failed to follow through with the physician's plan to obtain labs on Resident #3. The record was reviewed on July 23, 2010. 3. Facility staff failed to obtain physician order for self administration of eye drops for Resident #5. A review of an Interim Order dated and signed June 22, 2010 directed, "Patanolol eye drops, ii gtts [two drops] ou [both eyes] twice a day [bid]."	F 309	**F431 Expired Drugs** **1. Immediate Response:** Identified expired and discontinued medications and removed from medication carts. **2. Risk Management:** Medications were checked in all storage areas to make sure there were no expired or discontinued medication. **3. Systemic Changes:** Education to nursing staff was done about necessity of removing meds upon discharge or expiration. **4. Monitoring:** Supervisor to monitor carts for expired/discharge medications. Findings will be reported by DON or designee at QA committee. **F441 Infection Control** **(1) Storage of Waste Boxes** **1. Immediate Response:** The two infectious waste boxes were immediately removed from the floor. **2. Risk Identification:** All areas of storage of waste boxes were checked, no other boxes were observed on the floor. **3. Systemic Changes:** All nursing, environmental and housekeeping staff in-serviced on the proper storage of medical waste boxes. **4. Monitoring:** ADON or designee will perform random audits and report findings at the Quarterly Quality Assurance Meeting.	**7/23/10** **9/15/10** **9/15/10** **9/15/10** **7/23/10** **7/23/10** **9/3/10** **9/15/10**

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F 309	Continued From page 20 According to "Physician Order Record "dated July 16, 2010, directed, "Patanol Ophthalmic Solution 0.1% [two] drops both eyes [two] times a day". According to the Medication Administration Record [MAR] for July 2010, the resident received Patanol Ophthalmic Solution at 9 AM and 5 PM every day. A face-to-face interview was conducted with Resident #5. He/she stated, "Yes, I put my own eye drops in my eyes, and it is for dry eyes." A face-to-face interview was conducted on July 20, 2010 at approximately 3:00 PM with Employees # 4 and Employee #17. Both stated, "[Resident #5] self administers his/her eye drops." The record was reviewed July 20, 2010.	F 309	**F441 Infection Control** **(2) Hand Washing during Meal Serving** **1. Immediate Response:** Identified employee and in-serviced on infectious control practices and hand washing technique. Employee was reassessed for hand washing between residents while providing care. Employee was observed to wash her hands between residents care. **2. Risk Identification:** All nursing staff was observed/ reassessed on hand washing practice while providing care. **3. Systemic Changes:** Staff in-serviced on infectious control practices and hand washing between residents while providing care. **4. Monitoring:** ADON or designee will perform a monthly staff observation for hand washing practices while providing care during mealtime and report findings at the Quarterly QA Meeting.	7/20/10 7/24/10 7/24/10 9/15/10
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to implement safety measures and assistance devices to ensure safety from accidents for one (1) Resident	F 323	**F463 Resident Call System** **1. Immediate Response:** Call bell cord replaced immediately. **2. Risk Management:** All call bells tested for proper functioning. No other malfunctions found.	7/20/10 7/20/10

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F 323	Continued From page 21 who sustained a fall with injury while being turned in bed for Resident #12? The findings include: According to the annual and quarterly Minimum Data Sets [MDS] dated February 1, 2010 and May 3, 2010 respectively, Section I, Disease Diagnoses included Diabetes, Hypertension, Arthritis, Osteoporosis, Allergies, Cardiovascular Disease, and Cancer. Section G, Physical Functioning revealed the resident required extensive assistance of two (2) persons for bed mobility and transfer. Bed rails were coded for bed mobility and transfer and a mechanical lift was required for transfer. The resident had limited range of motion and partial loss of voluntary movement of the arm and leg on one side. Section K, Nutritional Status revealed Resident #12' s height was 60 inches and weight 225 pounds. Physician's orders signed June 2, 2010 prescribed the use of two ½ side rails for safe bed mobility. According to the "Nursing Monthly Summary" report for May and June 2010, " Ambulation/Rehab: Requires total transfer by staff 2 [two] persons." Resident #12 sustained a fall with injury as evidenced by the following nurse's notes: June 19, 2010, 4:30 AM, "At 2:50 AM resident fell out of left side of bed while [staff] was trying to put [resident] on the bedpan. Resident observed lying prone [face down] on the floor. Hematomas with bleeding, skin tear [at] left eyebrow. No other	F 323	**(F463 Resident Call System Continued)** **3. Systemic Changes:** Staff instructed to report malfunctioning call bells immediately. Engineering educated as to necessity of responding to such requests immediately. Nursing staff in-serviced on cord replacement and location of extra call bell cords when needed. **4. Monitoring:** Call bell system to be checked monthly by Engineering Department and findings reported at QA quarterly. **F469 Maintains Effective Pest Control Program** **1. Immediate Response:** Room was cleaned and the pest control company was called. **2. Risk Identification:** Pest Control Company came out and checked all areas and treated appropriately. **3. Systemic Changes:** Staff educated as to how to prevent fruit flies and other insects and proper reporting of insect sightings so that areas can be treated. **4. Monitoring:** Pest control rounds will be conducted 3X monthly with action items addressed and results will be reported at Quarterly QA meetings.	9/5/10 9/15/10 7/20/10 7/20/10 9/15/10 9/15/10

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F 323 Continued From page 22

obvious injury. Neurochecks commenced. Ice packs applied to injured area. [Staff] reported that resident's head hit walker as [resident] fell. Besides head injury, no other obvious injury. Lifted to bed by staff, head supported. Ice pack applied to left brow/forehead [times] 20 minutes. Skin tear [at] left brow is superficial, 4cm [long] x 0.2 cm wide. "

June 19, 2010, 3:00 PM "...continues to complain of headache ...left eye swollen and dark colored ...new order to transfer to [hospital] emergency room at 10:50 AM."

According to the emergency department discharge summary dated June 19, 2010, the resident sustained the following injuries: closed head injury, forehead laceration, facial contusion, cervical strain and multiple contusions.

A face-to-face interview was conducted with Resident #12 on July 20, 2010 at approximately 3:45 PM. Resident stated, "I fell out of the bed 2-3 weeks ago. The nurse was trying to put me on the bedpan, when I turned [an] there was no side rail for me to hold onto. So, I tried grabbing the wall, and I fell and hit my head. My eyeglasses broke. I had to get another pair. I had a cut over my eye and I was bleeding into my eye and my head was hurting. "

A face-to-face interview was conducted with Employee #1 on July 23, 2010 at approximately 11:30 AM. He/she stated, "[Resident] had been complaining about the bed...the third replacement had one long side rail... the fall occurred while being assisted onto the bedpan."

According to the clinical record, Resident #12 was

F 323

F492 Documentation of Injury

1. Immediate Response: (9/2/10)
Corrected incident report sent to proper authorities.

2. Risk Identification: (9/4/10)
Other incident reports involving injury were reviewed for correct documentation of injury and proper transmission.

3. Systemic Changes: (9/15/10)
Licensed nursing staff in-serviced on proper documentation and transmission of incident reports.

4. Monitoring: (9/15/10)
A random audit will be done monthly at safety committee meetings. The findings will be reported at the Quarterly QA meetings.

F514 Resident Records
(1)Pharmacist

1. Immediate Response: (9/1/10)
Pharmacist will review the MRR for irregularities or lack thereof regarding resident #3.

2. Risk Management: (9/10/10)
Pharmacist will review the MRR for irregularities or lack thereof for all residents.

3. Systemic Changes: (9/1/10)
DON will in-service pharmacist on the necessity to document that either no irregularities were identified or the nature of any irregularities that were identified on the MRR.

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F 323	Continued From page 23 prescribed ½ side rails for bed mobility and extensive assistance of two (2) persons for bed mobility and transfer in accordance with the quarterly MDS completed May 3, 2010. The record lacked evidence that two (2) side rails were implemented in accordance with physician ' s orders to assist the resident with bed mobilization. Additionally, there was no evidence that staff utilized the number of individuals to assist the resident with bed mobility. Facility staff failed to implement safety measures and assistance devices to ensure the resident's safety from accidents. The resident sustained a fall out of bed with subsequent injuries. The record was reviewed on July 20, 2010.	F 323	**(F514 Resident Records (1)Pharmacist continued)** **4. Monitoring:** DON/designee will do a random audit of the MRR on a monthly basis to check for proper documentation of irregularities. Findings will be reported at Quarterly QA meeting. **F514 Resident Records (2)Documentation** **1. Immediate Response:** Identified resident #4 per resident roster, revealed no such medication regimen. Further review indicates that resident #7 medication regimen matches description. Monitoring tools for depression, agitation and narcolepsy behaviors were instituted for resident #7.	**9/15/10** **9/1/10**
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	**2. Risk Management:** The behavior monitoring tool for all residents receiving Lexapro, Risperdal, and/or Ritalin was reviewed for proper documentation. **3. Systemic Changes:** Pharmacist in-serviced licensed nursing staff on proper documentation for behaviors of residents on psychoactive medications. **4. Monitoring:** ADON/designee will do a 20% random audit monthly on behavior monitoring tool and will report at Quarterly QA meeting.	**9/1/10** **8/2/10** **9/15/10**

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F 329	Continued From page 24 contraindicated, in an effort to discontinue these drugs. 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 facility staff failed to include indication for the use of midodrine, monitor and attempt gradual dose reduction for the psychotropic medications prescribed for Resident #4. The findings include: Resident # 4 was admitted to the facility on May 12, 2006. According a significant change in status assessment Minimum Data Set (MDS) completed November 24, 2009, Resident #4' s, diagnosis included Arthritis, Dementia, Hypotension, Parkinson ' s disease, Seizure disorder and Depression. A review of the resident ' s clinical record revealed " Physician ' s Order Records " signed and dated by the physician on February 20, April 7, May 12, and Jul 1, 2010 that directed medications including: "Lexaporo oral tablet 10mg 1 tablet PO [By mouth] 1 time a day 9AM ....DX: anti-depressant... " "Risperdal (Risperidone) oral tablet 0.25mg PO 1 time a day 9AM ...for agitation ..." "Ritalin (Methylphendiate) oral tablet 10mg1 tablet PO 9:00Am, 1:00PM ...for narcolepsy."	F 329		

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F 329	Continued From page 25 "Midodrine HCL oral tablet 5mg 3 tablets PO 6:00 AM, 12:00 PM ..." "Midodrine HCL oral tablet 5mg 2 tablets PO 6:00 PM ..." According to the resident's medication administration record (MAR), the resident was administered: 1. Lexaporo oral tablet 10mg 1 tablet PO [By mouth] 1 time a day 9AM...DX: Anti-depressant October 1, through December 31, 2009 and January 1 to March 31, 2010 and May 1, through July 19, 2010 as evidenced by the initials across from the entries for Lexaporo oral tablet 10mg1 tablet PO [By mouth] 1 time a day 9AM. " April 2010's MAR was not available for this review. 2. " Risperdal (Risperidone) oral tablet 0.25mg PO 1 time a day 9AM ...for agitation ..." May 1, through July 20, 2010 as evidenced by the initials across from the entries for "Risperdal oral tablet 25 mg 1 tablet PO 1 time a day 9AM." 3. " Ritalin (Methylphendiate) oral tablet 10mg1 tablet PO 9:00Am, 1:00PM ...for narcolepsy." May 1, through July 19, 2010 as evidenced by the initials across from the entries for "Ritalin (Methylphendiate) oral tablet 10mg1 tablet PO 9:00AM, 1:00PM." 4. " Midodrine HCL oral tablet 10 mg 1 tablet PO 1 time a day 9AM and " Midodrine HCL oral tablet 5mg 2 tablets PO 6:00 PM ... " "October 1, through December 31, 2009 and January 1to March 31 2010 and May 1, through July 11, 2010 as evidenced by the initials across from the entries for " Midodrine HCL oral tablet 10 mg 1 tablet PO 1 time a day 9AM." April 2010's MAR was not available for this review	F 329		

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F 329	Continued From page 26 A further review of the resident's clinical record including Medication Administration record (MAR), Treatment Administration Record (TAR), nurse's notes and progress notes lacked documented evidence that facility staff: -Monitored Resident#4 while on psychotropic medications prescribed for depression, agitation and narcolepsy behavior. -Attempted gradual dose reduction for Lexapro for Resident #4. -Included indication for the use of midodrine for Resident #4. A face-to-face interview was conducted with Employee #4 on July 23, 2010 at approximately 9:45 AM. After reviewing the resident's clinical records, he/she acknowledged the aforementioned findings. The record was reviewed on July 23, 2010.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	Continued From page 27 Based on observations made during tours of the dietary services on July 19 and 20, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by: one (1) of one (1) soiled toaster oven, one (1) of one (1) soiled convection oven, and one (1) of one (1) soiled gas stove; out of range temperatures on the test tray; a leak in the three-compartment sink, a stained and soiled rug in front of the freezer and on one (1) of one (1) occasion a staff member failed to correctly state the expected temperature of the washing solution in the three-compartment sink and on two (2) of two (2) occasions staff members failed to correctly test and verify the concentration of the sanitizing solution in the dishwashing machine. The findings include: 1. The convection oven, the toaster oven and the gas stove were soiled. 2. Test tray temperatures for apple juice and pineapple/carrots/raisins salad were forty-eight degrees Fahrenheit (F) and exceeded allowable limit of forty-one degrees F. 3. The temperature of the wash solution in the three-compartment sink was 104 degrees F and was far below the expected minimum temperature of 110 degrees F. 4. The rinse water compartment of the three-compartment sink was constantly leaking and could not hold the rinse water solution efficiently. 5. The rug in front of the freezer was stained and soiled.	F 371		

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F 371	Continued From page 28 6. One (1) of one (1) staff member was unable to state the expected temperature of the washing solution for the three-compartment sink and two (2) of two (2) staff members failed to properly test and verify the concentration of the sanitizing solution for the dishwashing machine. These observations were made and acknowledged by Employee #7 who was present at the time of the observations.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the physician failed to review the total plan of care. Resident #1. The findings include: 1. The physician failed to review the total plan of care for Resident #1. A review of Resident #1's clinical record revealed the followings:	F 386		

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F 386	Continued From page 29 January 6, 2010: A social service progress note that stated: " Admission note: "Resident ...admitted to the nursing facility from the residential facility. " January 7, 2010: A ' Nutrition Risk Assessment ' noted that the resident ' s current weight is 138 pounds, and 6 feet 2 inches tall, is at risk for unintended Wt.[Weight] loss because of recent slight wt. loss and that the resident needed increase assistance and observation. March 11, 2010. A " Nutrition Care Progress Notes " stated " PRN Note: CW [Current Weight] 130#, ?3 x 30D, ?8# since adm. [Admission] to NF [Nursing facility], ?not sig. [Significant] but concerning ...Wt. loss trend, continue weekly wt., Ensure Plus TID [Four times daily] ... " April 19, 2010. "Quarterly: CW 130#?2# x 30D, ?8# x 90D (?5.7% not sig but concerning). " April 20, 201. A ' Social Service Progress Notes ' stated: " Resident demonstrates some symptoms of depression, including irritable mood, feelings of hopelessness, uselessness, and a decrease in socialization in the past 6 weeks. Mood is easily altered / redirected. Resident also can become verbally aggressive, swearing at nurses providing care and making sexually inappropriate comments. These behaviors are also easily redirected. " A review of Resident #1's clinical record revealed that the physician wrote progress notes dated January 6, March 30, May 30, and June 29, 2010. There was no evidence in the progress notes that the physician addressed the above cited weight	F 386		

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F 386	Continued From page 30 loss, symptoms of depression and or episodes of verbal aggressive behaviors. A face-to-face interview was conducted with Employee #4 on July 23, 2010 at approximately 8:30 AM. After reviewing the resident's clinical record, he/she acknowledged that the physician did not address the above incidents in the his/her progress notes. The record was reviewed July 23, 2010.	F 386		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT 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) of 15 sampled resident, it was determined that the physician failed to visit one (1) resident every 30 days for the first 90 days after a new admission to the nursing facility. Resident #1. The findings include: The physician failed to visit Resident #1 every 30 days for the first 90 days after a new admission to the nursing facility. A review of Resident #1's record revealed that the resident was admitted to the facility on January 6,	F 387		

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F 387	Continued From page 31 2010. A transfer progress note was completed on January 6, 2010 and a history and physical examination was completed by the physician on January 12, 2010. The physician saw the resident on March 30, May 30, and June 29, 2010 as evidenced by his/her progress notes in the resident's clinical record. The resident ' s clinical record lacked documented evidence that the physician saw the resident and wrote a progress every 30 days for the first 90 days after admission to the facility. A face-to-face interview was conducted with Employee #4 on July 23, 2010 at approximately 8:30 AM. After reviewing the resident's clinical record, he/she acknowledged the aforementioned findings. The record was reviewed July 23, 2010.	F 387		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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 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.	F 431		

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F 431	Continued From page 32 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 observations and staff interview, it was determined that the facility staff failed to remove four (4) expired medications and two (2) discontinued medication from the medication carts; and three (3)discontinued medications for one (1) resident from two (2) of three (3) medication carts observed. Resident # 7 The findings include: 1. The facility staff failed to remove expired medications and discontinued medications from the medication carts. On July 19, 2010, between 10:00 AM and 4:30 PM, during the inspection of the medication storage areas, expired and discontinued drugs were observed in the medication carts as follows:	F 431		

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Expired Medications:
1 Bottle of Guaituss 100 gm /5ml syrup, expired June 22, 2010
1 Bottle of Diabetic Tussin syrup, expired June 30, 2010
1 Bottle of Tussin CF 100gm/ 5ml syrup, expired July 11, 2010
1 Bottle of Nitro stat 40 mg capsule expired July 4, 2010

Discontinued Medications:
1 Bottle of Milk of Magnesia discontinued July 20, 2010
1 Tube of Glucose Gel 40%, (instant Glucose) discontinued July 19, 2010

The above findings for the medication carts were acknowledged by Employee #4 on July 19, 2010, at the same time of the observation.

2. The facility staff failed to remove Resident's #7 discontinued medications from the medication cart.

On July 19, 2010, between 10:00 AM and 4:30 PM, during the inspection of the medication carts, three (3) medication dose bags containing three (3) pills, Klor Con 20meq, Midodrine 10meq and Fludrocortisone 0.1mg each, were observed stored in Team A's medication cart. Each medication dose bag was marked discontinued (D/C) on the outside of the bags.

A face-to-face interview was conducted at the same time of the inspection with Employee #4. He/she acknowledged that the three (3) medications bag were mark discontinued should have been taken off the medication cart and given to director of nursing to be discarded.

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 35 This REQUIREMENT is not met as evidenced by: A. Based on observations made during environmental tours of the facility on July 20 and 23, 2010, it was determined that the facility failed to provide a safe, sanitary and comfortable environment as evidenced by the improper storage of medical waste boxes in the soiled utility room. The findings include: Two (2) of four (4) infectious waste boxes were stored upright and directly on the floor in the soiled utility room. These observations were made in the presence of Employees #8 and #9 who acknowledged these findings during the survey. B. Based on observations and staff interview for two (2) of 15 sampled residents and four (4) supplemental residents, it was determined that facility staff failed to wash hands after direct resident contact during dinner meal. Residents #3, 4, A1, A2, A3, and A4. The findings include: Residents #3, 4, A1, A2, A3 and A4 were observed during dinner in the special care unit ' s dayroom on July 19, 2010 at approximately 4:05 PM... Resident #3 was observed seated on a chair by himself/herself. Resident # 4 was observed seated on by a table by himself/herself. Resident #A1, A2, A3, and A4 were observed	F 441		

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F 441	Continued From page 36 seated together at the same table. Employee # 10 was observed serving the residents their dinner trays. After he/she completed passing out some of the trays, he/she moved between Residents #4, A1, A2, A3, and A4 and assisted the residents with setting up their dinner trays and feeding He/she stood next to Resident #4 and fed him/her for approximately five (5) minutes. Returned Resident # 4 ' s tray to the cart, outside the dayroom. Employee #4 returned to the dayroom with Resident A1 ' s dinner tray. Resident A1 presented with difficulty keeping food on his/her fork. Employee # 10 stood by Resident A1 and fed him/her. Resident A2 expressed frustration opening his/her drinking straw. Employee #10 left Resident A1 to assist Resident A2. Employee #10 touched the end point of the straw that Resident A2 put in his/her mouth with his/her unwashed hands. Employee #10 left Resident A2 to assist Resident A3 back to the dayroom from the hallway. He/she gave Resident A3 a cup of ice cream and returned to Resident A1. Employee #10 assisted Resident #4 to his/her room. He/she went to the community kitchen across from the nurses ' station to collect Resident #3 ' s dinner tray from the food warmer. He/she returned to the dayroom with Resident #3 ' s dinner tray. He/she stood next to the resident and fed him/her.	F 441		

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F 441	Continued From page 37 Throughout the period of the above observations, Employee #10 failed to wash his/her hands after direct residents contact during dinner meal on July 19, 2010 at approximately 4:05 PM. He/she failed to wash his/her hands between residents ' care: He/she provided care for multiple residents at the same time without washing his/her hands. A face-to-face interview conducted at with Employee #10 on July 23, 2010 at approximately 1:20 PM. He/she acknowledged the above observation. He/she said, " I was trying to hurry-up with the feeding. All the residents required my help as you can see. I know better than that. "	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made during environmental tours of the facility on July 19, 20 and 23, 2010, it was determined that the facility failed to maintain resident call system as evidenced by the failure of the call bell system to operate correctly in one (1) of 13 resident's room. The findings include: When engaged, the call bell system in room #	F 463		

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F 463	Continued From page 38 130 failed to activate a visual and/or an audible alarm to nursing staff. These observations were made in the presence of Employees #8 and #9 who acknowledged these findings during the survey.	F 463		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations made during environmental tours of the facility on July 20 and 23, 2010, it was determined that the facility failed to maintain an effective pest control program as evidenced by the presence of crawling and flying pests observed in different areas in the facility. The findings include: Flying insects were observed in room #123 and environmental services area. These findings were acknowledged by Employees # 8 and # 9 who were present at the time of observation.	F 469		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD 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	F 492		

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that apply to professionals providing services in such a facility.

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 facility staff failed to inform State Agency that a resident who fell sustained an injury. Resident #12.

The findings include:

22 DCMR 3232.4 stipulates, " Each incident shall be documented in the resident ' s record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. "

According to an incident report completed by the facility on June 19, 2010, " Resident fell out of bed to the floor while the CNA [Certified Nursing Assistant] was trying to put [his/her] (resident) on the bed pain. "

The nurse ' s note dated June 19, 2010 at 4:30 AM, documented, " At 2:50 AM resident fell out of left side of her bed while [Certified Nursing Assistant] was trying to put her on the bedpan. Resident observed lying prone on the floor. Hematomas with bleeding, skin tear [at] left eyebrow. No other obvious injury. Neurochecks commenced. Ice packs applied to injured area. CNA reported that resident ' s head hit walker as she fell. Besides head injury, no other obvious injury. Lifted to bed by staff, head supported. Ice

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F 492	Continued From page 40 pack applied to left brow/forehead [times] 20 minutes. Skin tear [at] left brow is superficial, 4cm {long] x 0.2 cm wide. " The record lacked evidence that the head injury was documented on the incident report A face-to-face interview with Employees #1 and Employee #2 conducted on July 23 at approximately 10:00AM. Both acknowledged the injury was not documented on the incident report. The record was reviewed July 20, 2010.	F 492		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews for two (2) of 15 sampled residents, it was determined that facility staff failed to document on the Medication Regimen Review (MRR) that either no irregularities were identified or the nature of any irregularities that were identified for one (1) resident and to document	F 514		

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behaviors one (1) resident. Residents # 3 and 4.

The findings include:

1. The pharmacist failed to document on the Medication Regimen Review (MRR) that either no irregularities were identified or the nature of any irregularities that were identified. Resident #3.

Review of the MRR form for Resident #3 for the months of November 2009, December 2009, January 2010, February 2010, March 2010, April 2010, May 2010, June 2010, and July 2010 lacked documented evidence that either no irregularities were identified or that the nature of any irregularities that were identified were place on the MRR.

A face-to-face interview was conducted on July 23, 2010 with Employees #1, 2, 3 at approximately 10:30 AM. After review of the MRR he/she acknowledged that the pharmacist failed to document either that no irregularities were identified or the nature of any identified irregularities. The record was reviewed on July 23, 2010.

2. Facility staff failed to document all behaviors for Resident #4 on medications for depression, agitation and narcolepsy.

Resident # 4 was admitted to the facility on May 12, 2006. According a significant change in status assessment Minimum Data Set (MDS) to Resident #4 ' s, his/her diagnoses included Dementia, Parkinson ' s disease, Seizure disorder and Depression.

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F 514	Continued From page 42 A review of the resident ' s clinical record revealed " Physician ' s Order Records " signed and dated by the physician on February 20, April 7, May 12, and July 1, 2010 that directed medication including: Lexaporo oral tablet 10mg 1 tablet PO [By mouth] 1 time a day 9AM ....DX: anti-depressant... " Risperdal (Risperidone) oral tablet 0.25mg PO 1 time a day 9AM ...for agitation ... " Ritalin (Methylphendiate) oral tablet 10mg1 tablet PO 9:00Am, 1:00PM ...for narcolepsy. " A further review of the resident ' s medication administration record (MAR) revealed that the resident was administered Lexaporo oral tablet 10mg 1 tablet PO [By mouth] 1 time a day 9AM...DX: Anti-depressant October 1, 20009 through July 19, 2010 as evidenced by the initials across from the entries for Lexaporo oral tablet 10mg 1 tablet PO [By mouth] 1 time a day 9AM. " A further review of the resident ' s clinical record failed to document evidence that the resident was monitored while on psychotropic medications for depression, agitation and narcolepsy behaviors. Facility staff failed to monitor Resident #4 while on Lexaporo for depression, " Risperdal for agitation and Ritalin for narcolepsy. " A face-to-face interview was conducted with Employee #4 on July 23, 2010 at approximately 9:45 AM. After reviewing the resident ' s clinical records, he/she acknowledged the aforementioned findings. The record was reviewed on July 23, 2010.	F 514		