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	HFD02-0023	A. BUILDING _____ B. WING _____	11/20/2009

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L 000	Initial Comments A Licensure survey was conducted from November 18 through 20, 2009. The following deficiencies were based on observations, record review and staff and resident interviews. The sample included 15 residents based on a census of 58 residents on the first day of survey and 3 supplemental residents.	L 000	Start Typing Here	
L 036	3207.11 Nursing Facilities Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that the physician failed to complete an annual history and physical for one (1) resident. Resident #9. The findings include: According to 22DCMR 3207.11, "Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. A review of Resident #9's record revealed that the last history and physical examination was completed August 31, 2008. A face-to-face interview was conducted with Employee #6 on November 18, 2009 at 3:35 PM. He/she acknowledged that an annual history and physical examination was not completed. The record was reviewed November 18, 2009.	L 036	A) The annual H&P on resident #9 was completed . 11/19/09. B) All residents were identified for the period 11/20 thru 12/31. No other residents were affected by this deficient practice. C) A written directive was sent to all the SNF attending physicians by the Medical Director and Administrator advising them of the importance of prompt completion of all annual H&P chart documentation. D) Presence of H&P and chart documentation will be reviewed to determine compliance. Medical Records department performs a QA monitor that is presented at the QA meetings. 1/22/10	

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L 051	Continued From page 1	L 051		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observations, record review and staff interview for seven (8) of 15 sampled residents, it was determined that the charge nurse failed to initiate and or develop care plans for: the use of restraints for two (2) residents, the potential drug interactions for the use of nine (9) or more medications for two (2) residents, scalp impairment for one (1) resident, use of a geri-chair with lap tray for one (1) resident, pain for one (1) resident, post cataract surgery care for one (1) resident and to notify the physician when the resident's blood pressure was low and of	L 051		

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L 051	Continued From page 2 repeated omissions of respiratory medications for one resident. . Residents #3, 6, 7, 8, 9, 10, 11, and 14. The findings include: 1. A Charge nurse failed to. notify the physician when the resident's blood pressure was low and of repeated omissions of respiratory medications for Resident. #14. Blood pressure reading of 90 millimeters of mercury (mm Hg) or less systolic blood pressure (the top number in a blood pressure reading) or 60 mm Hg or less diastolic blood pressure (the bottom number) is generally considered low blood pressure. (www.nhli/nih). A physician's order dated July 1, 2009 directed, "Metoprolol Tartrate 25 mg one tablet twice daily for Hypertension." A review of the Medication Administration Record [MAR] for Resident #14 revealed the following blood pressure readings: " July 15, 2009 at 10:00 AM- 86/40, Metoprolol was administered; July 18, 2009 at 10:00 AM- 96/58, Metoprolol was administered and on July 20, 2009 at 10:00 AM 101/49, Metoprolol was administered. A further review of the back of the MAR and the medical record lacked documented evidence that Metroprolol was held and the attending physician was notified of the aforementioned blood pressure readings. A review of the clinical record revealed the May 2009 " Graphic Record " which list the following blood pressure readings: May 2, 2009 [no time indicated] 98/54, May 3, 2009 -84/54, May 22, 2009-85/38, June 14, 2009 83/48, June 15, 2009-94/51, July 17, 2009 - 87/52, July 20, 2009 101/49, July 23, 2009 - 115/39, and July 25,	L 051	1A. 1. A) Resident #14 passed away prior to survey. B) All residents on blood pressure medications were identified for the period 11/20 thru 12/31. No other residents were affected by this deficient practice. C) A policy was written by the Medical Director setting blood pressure parameters and when to hold medications and notify the physician. It states to hold medication when Systolic is <110 and diastolic is <60, and to call the doctor when systolic is>170 and diastolic is >100. The Charge Nurse for each shift will verify that there are no medication administration omissions or holds and that hypertensive medications were only given when blood pressure was within normal parameters. The doctor will be notified of any medications held or omitted. All licensed staff will be in-serviced on use of B/P parameters and MD notification.	1/22/10

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L 051	Continued From page 3 2009-97/55. There was no evidence that the physician was notified of the resident's low blood pressure readings. Antihypertensive medication, Metoprolol Tartrate 25 mg was administered to the resident on each of the above cited dates. Face-to-face interviews were conducted with Employees #3 and #14 on November 11, 2009 at 12:42 PM. Both acknowledged that the physician should have been notified of the resident's hypotensive episodes. The record was reviewed November 19, 2009. 1 B. The respiratory therapist failed to notify the physician of repeated missed doses of medication for Resident #14. A physician's order dated July 1, 2009 directed, "Albuterol Sulfate 2.5mg/3ml one vial via nebulizer 3 times a day while awake for COPD" and "Atrovent 0.2ml/1ml one vial via nebulizer three times a day while awake." A review of the July 2009 MAR revealed that 32 doses of Albuterol and 36 doses of Atrovent were not administered. There was no evidence in the record that the respiratory therapist notified the physician that the resident had missed the above cited doses. Albuteral was discontinued on July 23, 2009. A review of the August 2009 MAR revealed that 20 doses of Atrovent were not administered. There was no evidence in the record that the physician was notified that the resident had missed the above cited doses.	L 051	D) Nurse Mangers will present weekly monitoring findings of B/P and hypertensive medications at monthly QA meetings. Corrective actions will be monitored via shift to shift review by Charge Nurses. Also, Nurse Managers will review MARs weekly and produce a compliance rate entered on a QA monitor to ensure blood pressures were within normal parameters and doctors were notified when applicable. Findings recorded on this QA monitor will be presented at monthly QA meetings. 1.B. A) Resident #14 passed away prior to survey. B) The respiratory MAR/TAR for all residents receiving respiratory Meds and treatments were reviewed for the period of 11/20 thru 12/31. No other residents were affected by the deficient practice. C) a. The Supervisor of Respiratory Therapy will review the respiratory MAR/TAR each morning and record any instances of missed or held doses of medication or treatments. The Supervisor will ensure that the physician is notified if applicable. b. Respiratory Therapists will be in-serviced by Supervisor on proper reporting procedures.	1/22/10

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L 051	Continued From page 4 A face-to-face interview was conducted with Employee #10 on November 19, 2009 at 12:42 PM. He/she acknowledged that the physician should have been notified of the number of missed doses. The record was reviewed November 19, 2009. 1.C. Facility staff failed to review and revise Resident #14's "Falls" care plan after multiple falls/incidents. A review of the resident's record revealed that the resident fell on the following days: May 23, 2009 at 12:00 PM, "... slipped from the wheelchair to the floor... with no injury". June 5, 2009 at 3:30 PM, "...slipped from the wheelchair to the floor... with no injury." June 18, 2009 at 11:30 PM, "...found on the floor with hematoma..." August 17, 2009 at 4:30 PM, "...Resident sat down on floor with lap buddy...no injury." A review of the resident's "Falls" care plan revealed that interventions were initiated on May 4 and June 18, 2009. There was no evidence that facility staff initiated additional interventions after the falls that occurred on May 23 and June 5, 2009. A face-to-face interview was conducted with Employee #3 on November 20, 2009 at 3:20 PM. He/she acknowledged that there were no interventions initiated after the falls of May 4 and June 5, 2009 prior to the fall of June 18, 2009 where the resident sustained a hematoma. The record was reviewed November 19, 2009. 1. D. Facility staff failed to initiate a plan of care for the potential drug interactions for the use of nine (9) or more medications for Resident #14.	L 051	D) The Supervisor will maintain a new QA monitor which has been developed In which (s)he will record all omitted or held medications/treatments. The results will be presented at the Quality Assurance meetings for a period of three months and in found to be in compliance then reported quarterly thereafter. 1.C A) Resident #14 passed away prior to survey. B) The clinical team conducted a review of all resident care plans for falls. No other documentation deficiencies were found. . C) A care plan in-service will be conducted for all Nurse managers, IDT team and nursing supervisors by 1/22/10. Care plans for residents with a fall will continue to be discussed at weekly Risk Management Meeting. All residents who fall will be referred to the Rehab department for safety transfers and ambulation training and assessed for any device to prevent further falls. Resident's medications will be reviewed to determine their possible contribution to the fall.	1/22/10 11/23/09

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L 051	Continued From page 5 A review of the August 2009 physician ' s orders signed [no date indicated] directed, " Ativan, Aricept, Cyanocobalamin, Keppra, Magnesium Oxide, Metoprolol, multivitamin, Prilosec, Dilantin, Risperdal, Simvastatin, Xalatan, Desyrel, Megace, and Atrovent. " A review of the plan of care for Resident #14 lacked documented evidence that facility staff developed a care plan with goals and approaches for the potential drug interactions for the use of nine (9) or more medications. A face-to-face interview was conducted on November 19, 2009 at 1:21 PM with Employee #3. He/she acknowledged that a care plan for the use of nine (9) or more medications was not initiated. The record was reviewed November 19, 2009. 2. A review of the clinical record for Resident #3 revealed charge nurse failed to initiate a plan of care for restraints. A lap tray restraint was implemented for Resident #3 as evidenced by the following physician' s orders: interim orders dated March 7, 2009 directed, "Use of table top with wheelchair to prevent falls. " Interim orders dated March 9, 2009 directed. "Release table top every 2-3 hours to perform pressure relief/change position and perform other items identified by restraint release protocol." A review of the plan of care for Resident #3 lacked evidence that charge nurse developed a care plan for restraints. A face-to-face interview with Employee #7 on	L 051	D) There will be monthly QA monitoring for residents who have had falls. Nurse Managers will present this updated care plan QA monitor at the monthly QA meetings. 1D. A) Resident #14 passed away prior to survey. B) All residents on 9 or more medications were identified and there were 9 and more Medication Care Plans for each of them. C) There will be weekly monitoring of residents on 9 or more medications during weekly interdisciplinary care plan team meetings. The Nurse Managers will make sure that a 9 or More Medication Care Plan is developed for each resident with 9 or more medications in order to catch potential drug interactions. All licensed staff will be in-serviced on 9 and more Medication Care Plans by 1/22/10. D) IDT will monitor and review all residents on 9 or more medications at the weekly Risk Management and monthly QA meetings.	1/22/10 1/22/10

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L 051	Continued From page 6 November 18, 2009 at 3:00 PM revealed the lap tray restraint for Resident #3 was implemented on March 7, 2009 in accordance with physician's orders and was discontinued per physician's orders on September 1, 2009. He/she acknowledged that the record lacked evidence of a care plan for the use of restraints. The record was reviewed November 18, 2009. 3. Charge nurse failed to initiate a care plan for the potential drug interactions for the use of nine (9) or more medications for Resident #6. A review of the clinical record for Resident #6 failed to reveal a care plan for use of nine (9) or more medications. A review of the quarterly Minimum Data Set (MDS) with a completion date of November 12, 2009 revealed that the resident was coded for "11" in Section O1 (number of medications). A review of the Physician's Order Sheets (POS) signed September 9, 2009 revealed the following medications, Acarbose, Aspirin, Cogentin, Calcium, Diovan, Prolixin, Glipizide, Lamotrigine, Metformin, Simvastatin, Tab-A-Vite. Vitamin D and Novolin R Insulin. Charge nurse failed to initiate a care plan for the potential drug interactions for the use of nine (9) or more medications for Resident #6. A face-to-face interview was conducted with Employee #6 at approximately 10:05 AM on November 20, 2009. He/she acknowledged that there was no care plan for use of nine (9) or more medications on the resident's record. He/she added, "I will put one on the chart." The record was reviewed on November 19, 2009.	L 051	2. A) Resident #3 was not adversely affected by the deficient practice. A restraint care plan was developed by the Nurse Manager on 11/23/09. B) The two residents that were on restraints were re-assessed and comprehensive care plans were developed on 11/23/09for each resident with measurable objectives and time tables to meet each resident's need as identified during nursing comprehensive assessment.. C) There will be continuous monitoring of Restraint Care Plans by the Nurse Managers and Nursing Supervisors to make sure the Restraint Care Plan developed meets individual resident's needs. All licensed staff will be in-serviced by 1/30/10 D) Restraint Care Plans will be reviewed during weekly risk management and monthly QA meetings. 3. A) Resident #6 was not affected by the deficient practice. There was no evidence of any adverse medication interaction. A 9 or more Medication Care Plan was developed by the Nurse Manager on 11/23/09. B) All residents on 9 or more medications were identified and there were 9 or more Medication Care Plans for each of them.	1/22/10

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L 051	Continued From page 7 4. Charge nurse failed to amend the fall care plan for Resident #7. Resident #7 sustained a fall without injury on October 16, 2009. Physician's interim orders dated October 16, 2009 directed for the use of a bed and chair alarm for patient safety. The care plan lacked evidence of the implementation of the bed/chair alarm as an approach to address the resident's risk for falls. A face-to-face interview was conducted with Employee #7 on November 18, 2009 at 3:00 PM. He/she acknowledged the bed/chair alarm had been implemented however, the care plan lacked documentation regarding the new approaches. The record was reviewed November 18, 2009. 5. The Charge Nurse failed to develop a comprehensive care plan for nine (9) or more medications. Resident #8. According to the quarterly Assessment MDS completed " September 17, 2009 Section O1 number of medications as 10. " According to the Physician ' s Order Sheet signed November 26, 2009, and the Medication Administration Record (MAR) for the Month of November 2009 identified the following medications: Norvasc, Asprin, Celexa, Lasix, Plavix, Zocor, Multivitamin, Lantus, Novolog, Oxycodeine. According to the " Plan of Care Problem List " revised October 11, 2009 for Resident #8, revealed that the list lacked evidence of nine (9) or more medications and that a care plan was not	L 051	C) There will be weekly monitoring of residents on 9 or more medications during weekly interdisciplinary care plan team meetings. The Nurse Managers will make sure that a 9 or More Medication Care Plan is developed for each resident with 9 or more medications in order to catch potential drug interactions. All licensed staff will be in-serviced on 9 or more Medication Care Plans by 1/30/10. D) IDT will monitor and review all residents on 9 or more medications at the weekly Risk Management and monthly QA meetings. 4. A) Resident #7 had multiple falls. All Physician interim orders dated 10/16/09 were implemented. Low bed and chair safety alarm were already implemented for resident's safety. The care plan was updated to reflect the use of low bed and chair alarm by Nurse Manager on 11/23/09. B) The clinical team conducted a review of all resident care plans for falls. No other documentation deficiencies were found. C) A care plan in-service was conducted for all Nurse managers, IDT team and nursing supervisors. Care plans for residents with a fall will continue to be discussed at weekly Risk Management Meeting.	1/22/10 1/7/10

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L 051	Continued From page 8 developed to address the adverse effect for the use of nine (9) or more medications. A face-to-face interview was conducted on November 19, 2009 at approximately 11:00 AM with Employee #7. He/she acknowledged that there is no care plan for nine of more medications for Resident #8. The record was reviewed on November 19, 2009. 6. Facility staff failed to initiate a plan of care for restraints for Resident #9. On November 17, 2009 at 11:40 AM Resident #9 was observed in the dayroom sitting in a geri-chair with a lap tray in place. A review of the November 2009 physician ' s orders signed November 8, 2009 directed, " ...Geri-chair with lap top for proper positioning and to prevent falls ...Lap tray while in geri chair to reduce risk of fall. " A review of the plan of care for Resident #9 lacked documented evidence that the charge nurse developed a care plan with goals and approaches for the use of a lap tray/top as a restraint. A face-to-face interview was conducted on November 18, 2009 at 3:35 PM with Employee #9. He/she acknowledged that a care plan for the use of a lap tray/top as a restraint was not developed. The record was reviewed November 18, 2009. 7. Charge nurse failed to develop a plan of care for scalp impairment for resident #10 A review of the clinical record reveals:	L 051	D) There will be monthly QA monitoring for residents who have had falls. Nurse Managers will present this updated care plan QA monitor at the monthly QA meetings. 5 A) Resident #8 was not affected by the deficient practice. There was no evidence of any adverse medication interaction. A 9 or more Medication Care Plan was developed by the Nurse Manager. B) All residents on 9 or more medications were identified and there were 9 and more Medication Care Plans for each of them C) There will be weekly monitoring of residents on 9 and more medications during weekly interdisciplinary care plan team meetings. The Nurse Managers will make sure that a 9 or More Medication Care Plan is developed for each resident with 9 or more medications in order to catch potential drug interactions. All licensed staff will be in-serviced on 9 or more Medication Care Plans by 1/30/10. D) IDT will monitor and review all residents on 9 or more medications at the weekly Risk Management and monthly QA meetings.	1/22/10 11/23/09 1/22/10

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L 051	Continued From page 9 "Physician's interim orders dated March 11, 2009 directed clotrimazole ointment 1% apply to scalp lesions B.I.D " "Physician's interim orders dated June 22, 2009 at 12:45 PM directed discontinue Lotrimin to scalp lesions area healed. " "Physician's interim orders dated November 06, 2009 directed Lotrimin apply to scalp lesions twice daily until healed 1% . " The care plan titled Alteration in Skin Integrity initiated December 12, 2008 last updated November 9, 2009, lacked problem identification, objectives and approaches to care for the resident's scalp lesions. 8. Facility staff failed to develop a plan of care for Resident #11 following eye cataract surgery. The physician's interim orders dated September 17, 2009 at 9:20 PM directed, "...for cataract surgery on October 30, 2009." Nurse's progress notes dated on October 30, 2009 at 11:30 PM revealed, "Resident s/p [status post] rt [right] eye surgery. Rt [right] eye shield on at this time." The care plan, last updated October 22, 2009, lacked problem identification, objectives and approaches to care for the resident's eye post operatively. A face-to-face interview was conducted on November 20, 2009 at 11:00AM with Employee #7. He/She acknowledged that a care plan for Resident #11's cataract eye surgery was not developed. The record was reviewed on	L 051	6. A) Resident #9 was not adversely affected by the deficient practice. An individualized care plan was put into place to identify the goals and approaches for the use of the lap tray. B) The two residents that were using lap trays were re-assessed and restraint care plans were developed for each resident with measurable objectives and time tables to meet each resident's needs as identified during nursing assessment. C) There will be continuous monitoring of Restraint Care Plans by the Nurse Managers and Nursing Supervisors to make sure the Restraint Care Plan developed meets individual resident's needs All licensed staff will be in-serviced on restraint care plans. D) The lap tray restraint care plan will be reviewed at the weekly risk management meeting and monthly QA meeting. 7. A) Resident #10 scalp lesion was healed on 1/7/10 and Clotrimazole 1% ointment was discontinued. B) All residents with skin condition care plans were reviewed and updated to include problem identification, measurable objectives and approaches to meet the individual resident's needs.	11/23/09 1/22/10 1/22/10 1/7/10

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L 051	Continued From page 10 November 20, 2009.	L 051	C) Nurse Managers and Supervisors will monitor all residents with alteration in skin integrity to ensure care plans are updated.	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating;	L 052	All licensed staff will be in-serviced on skin integrity care plans. D) QA monitoring of alteration in skin integrity will be reported at the monthly QA meeting. 8. A) The care plan for post operative cataract surgery was developed for resident #11. The resident did not experience any complications resulting from the deficient practice. B) There were no other residents affected by the deficient practice. C) The Nurse Manager and/or QA Coordinator will ensure that any resident undergoing cataract surgery will have a care plan. All licensed staff will be in-serviced on proper completion of care plans for post operative cataract surgery. D) Any resident undergoing cataract surgery or other surgical procedure will be discussed at the weekly Risk Management meeting and monthly QA meeting.	1/30/10 1/22/10 11/18/09. 1/22/10

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L 052	Continued From page 11 (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, record review and interview for five (5) of 15 sampled residents, it was determined facility staff failed to follow physician ' s orders for foot care for one (1) resident; obtain weights for one (1) resident; obtain an annual electrocardiogram and psychiatric consultation for one (1) resident; perform tracheostomy care for one (1) resident and administer respiratory medications and act on the compromised hemodynamic status of one (1) resident. Residents #3, 4, 6, 11 and 14. The findings include: 1. A review of the clinical record for Resident #3 revealed facility staff failed to ensure that the resident ' s foot care was performed in accordance with physician ' s orders. Physician ' s orders dated October 30, 2009 and originated September 27, 2004 directed, " debridement of mycotic toe nails every 3 months. " The clinical record revealed one (1) Podiatry consultation, dated May 6, 2009 was performed during the calendar year of 2009. A face-to-face interview conducted with	L 052	1. A) Resident #3 was seen at 6:20pm on 11/18/09. Debridement of toe nails 1-5 done on right and left foot. B) The physician orders of all residents were reviewed for orders of Podiatry consult. There were no other residents affected by this deficiency. C) Our Podiatry consults book will be kept updated by the Nurse Managers to reflect Podiatry visits to each resident as scheduled and according to physicians orders.	

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L 052	Continued From page 12 Employee #7 on November 18, 2009 at 3:30 PM revealed that toenail debridement was a treatment performed by the podiatrist. He/she acknowledged that the podiatrist saw the resident on one (1) occasion this year and that the resident's nail debridement was not performed as ordered. The record was reviewed November 18, 2009. 2. Facility staff failed to follow Physician Orders which directed, weekly weights times four (4) for Resident #4. According to the "New Admissions Physician ' s Order Sheet/Plan of Care dated signed June 5, 2009 (no time indicated) directed, weight on admissions, weight weekly x (times) 4 (four) weeks, weight every month. " According to the " Resident Monthly Weight Record" the admissions weight was recorded for the Month of June [2009] as 166.4 [pounds]. The "Resident Monthly Weight Record" lacked evidence of weekly weights x 4. The June 2009 Medication Administration Record revealed the following weights: June 5, 2009 166.4 lbs and June 16, 2009, 163 lbs. The sheet lacked evidence of any other weights taken after June 16, 2009. The " Resident Monthly Weight Record revealed: June 166.4 pounds July 164.8 pounds August 167.6 pounds September 175 pounds reweight 173.6 October 174.6 pounds November 177.7 pounds	L 052	D) Nurse Managers will monitor Podiatry Visits to every resident. Results will be reported at the monthly QA meetings for a period of 3 months and if found to be in compliance will then be reported quarterly. 2. A) The resident did not experience any adverse effects due to the lack of 4 weeks of documentation of weights. B) The medical record of all new admissions from November 1 thru December 31, 2009 were reviewed. All the weekly weights x4 were present. C) A log was developed to be used for all new admissions to record admission weights and the subsequent weekly weight for 4 weeks. Staff in-service on the use of the form will be completed by 1/22/10. Nurse managers will follow up weekly to ensure weekly weights are performed. In addition, monthly monitoring will be performed by DON and Nurse Educator to ensure compliance. D) Results of monitoring will be shared at monthly QA meeting for a period of 3 months and if found to be in compliance will then be reported quarterly.	1/22/10 1/22/10

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L 052	Continued From page 13 The Resident Monthly weight record lacked evidence that weekly weights were completed in accordance with the physicians order. Face-to-face interviews were conducted on November 19, 2009 at 10:25 AM with Employee #7 and 11. They acknowledged that the weights were not done. The record was reviewed on November 19, 2009. 3A. Facility staff failed to follow a physician's order to obtain an Electrocardiogram (EKG) annually for Resident #6. A review of the resident's clinical record revealed a physician ' s order with an initial date of April 1, 2002 and signed by the physician on September 9, 2009 which instructed " EKG every year - June. " Further review of the record failed to reveal a copy of a completed EKG for 2009. A face-to-face interview was conducted with Employee #6 at approximately 10:05 AM on November 20, 2009. During the interview the employee acknowledged that the EKG was not done. The record was reviewed on November 19, 2009. B. Facility staff failed to follow a physician ' s order to obtain a Psychiatric (Psych) Consult every six (6) months for Resident #6. A review of the resident's clinical record revealed a physician ' s order with an initial date of February 24, 2009 and signed by the physician on September 9, 2009. The order instructed " Psych Consult every six (6) months and as needed. " Further review of the record revealed a Psychiatric Evaluation dated January 21, 2009	L 052	3A. A) The annual EKG on resident #6 was performed on 11/25/09. B) Records of all residents were reviewed. All residents due for annual EKGs had received them. C) Monitoring by the Nurse Managers will be performed via a log book that lists EKG due dates to make sure that annual EKGs are performed on the scheduled month. D) Results of monitoring will be shared at monthly QA meeting for a period of 3 months and if found to be in compliance will then be reported quarterly 3B. A) Further review of the record revealed that the undated psych consult was from a visit on June 29. 2009 as evidenced by the orders written by the Psychiatrist on the same day of visit. (See attached copies.) The nurse made an entry on 6/29/09 at 3:30pm of the psychiatrist visit. Subsequent psych visit was done December 12, 2009. B) All residents with psych consults from November 18 thru December 31 were reviewed. All eleven identified residents with psych consults had a psych consult every 6 months.	1/22/10

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L 052	Continued From page 14 and one (1) undated psychiatric consult. Further review of the record failed to reveal any documentation to specify that the Psych Consult was done every six (6) months as ordered. The record was reviewed on November 19, 2009. A face-to-face interview was conducted with Employee #6 at approximately 10:05AM on November 20, 2009. During the interview the employee acknowledged that the Psych Consult was not done every six (6) months as ordered by the physician. The record was reviewed on November 19, 2009. 4. Facility staff failed to follow physician ' s orders for tracheostomy care for Resident #11. Physician ' s Order dated September, 2009 and November 10, 2009, directed " Trach [tracheostomy] care every shift and as needed. " A review of the " Respiratory Care Assessment and Progress note " for November 10, 2009, lacked documented evidence that tracheostomy care was performed. . Face-to-face interviews were conducted on November 20, 2009 at approximately 12:30PM with Employee #10 and Employee #21. After reviewing the Resident ' s clinical record, it was acknowledged that there was no evidence that Resident #11 had tracheostomy care on November 10, 2009. The record was reviewed November 20, 2009. 5. Facility staff failed to administer Atrovent and Albuterol to Resident #14 as directed by the physician. A physician's order dated July 1, 2009 directed,	L 052	C) A Psych Consult log book has been set up to indicate on a monthly basis the due date for the resident's 6-month psych consultation. This will be reviewed monthly by nurse managers. D Results of monitoring will be shared at monthly QA meeting for a period of 3 months and if found to be in compliance will then be reported quarterly. 4. A) Resident #11 immediately received tracheostomy care as ordered by the physician.. The resident was not adversely affected by the deficient practice. B) The respiratory MAR/TAR for all residents receiving respiratory Meds and treatments will be reviewed by respiratory personnel each shift daily to ensure protocols are being followed. C) The respiratory MAR/TAR for all residents receiving respiratory Meds and treatments will be reviewed by respiratory personnel each shift to ensure protocols are being followed. a. The Supervisor of Respiratory Therapy and/or respiratory therapists will review the respiratory MAR/TAR each shift and record and correct any instances of missed or held doses of medication or treatments. The Supervisor and/or Therapists will ensure that the physician is notified if applicable. b. Respiratory Therapists will be in-serviced on proper reporting procedures.	1/22/10

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L 052	Continued From page 15 "Albuterol Sulfate 2.5mg/3ml one vial via nebulizer 3 times a day while awake for COPD" and "Atrovent 0.2ml/1ml one vial via nebulizer three times a day while awake." A review of the Medication Administration Record for July 2009 revealed that Albuterol was omitted 32 times out of 90 treatments due to: "patient not being in [his/her] room or unavailable on 25 occasions, Pt [patient] sleeping on three (3) occasions and therapist other priorities treatment not given four (4) occasions". Atrovent was omitted 36 out of 90 treatments due to: "Patient unavailable/out of room on 29 occasions; sleeping on three (3) occasions and therapist had other priorities on four (4) occasions." Albuterol was discontinued on July 23, 2009. A review of the Medication Administration Record for August 2009 revealed that Atrovent was omitted 20 out of 51 treatments due to: "patient not in room/not available for 13 times. Reasons were not identified for the other seven (7) missed doses." Face-to-face interviews were conducted on November 19, 2009 at approximately 12:42 PM with Employee #3 and Employee #10. They acknowledged that Atrovent and Albuterol were not administered as directed by the physician and that the therapist administering the treatment did not notify nursing when the patient did not receive the respiratory treatment. Employee #10 stated, "We should notified when the patient returns back to his/her room and the physician should have been notified. The record was reviewed	L 052	D) The Supervisor will maintain a QA monitor In which (s)he will record all omitted or held medications/treatments. The threshold will be set at 100% compliance. The results will be presented at the Quality Assurance meetings for 3 months and if in compliance quarterly thereafter. 5. A) Resident #14 passed away prior to survey. B) The respiratory MAR/TAR for all residents receiving respiratory Meds and treatments were reviewed for the period of 11/20 thru 12/31. No other residents were affected by the deficient practice. C) The respiratory MAR/TAR for all residents receiving respiratory Meds and treatments will be reviewed by respiratory personnel each shift to ensure protocols are being followed. a. The Supervisor of Respiratory Therapy and/or respiratory therapists will review the respiratory MAR/TAR each shift and record and correct any instances of missed or held doses of medication or treatments. The Supervisor and/or Therapists will ensure that the physician is notified if applicable. b. Respiratory Therapists will be in-serviced on proper reporting procedures.	1/22/10

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L 052	Continued From page 16 November 19, 2009. Based on record review and staff interviews for one (1) of 15 sampled residents, it was determined that facility staff failed to ensure that one (1) resident received adequate supervision to prevent accidents. Resident # 14. The findings include: 1. Facility staff failed to initiate interventions for Resident #14, who experienced multiple falls with subsequent injury. A review of the resident's record revealed that the resident fell on the following days: May 23, 2009 at 12:00 PM, "... slipped from the wheelchair to the floor... with no injury". June 5, 2009 at 3:30 PM, "...slipped from the wheelchair to the floor... with no injury." June 18, 2009 at 11:30 PM, "...found on the floor with hematoma..." August 17, 2009 at 4:30 PM, "...Resident sat down on floor with lap buddy...no injury." A review of the resident's "Falls" care plan revealed that interventions were initiated on May 4 and June 18, 2009. There was no evidence that facility staff initiated additional interventions after the falls that occurred on May 23 and June 5, 2009. An interdisciplinary team meeting was held on July 2, 2009, 13 days after the resident fell and sustained an injury. A summary of the previously identified interventions was documented as having been discussed at the meeting. There were no new interventions identified to help prevent future falls.	L 052	D) The Supervisor will maintain a QA monitor In which (s)he will record all omitted or held medications/treatments. The threshold will be set at 100% compliance. The results will be presented at the Quality Assurance meetings monthly for 3 months and if in compliance then quarterly thereafter. 1. A) This is a closed chart. Resident #14 has passed away. B) The clinical team conducted a review of all residents care plans for falls. No other documentation deficiencies were found. C) An on-going care plan in-service is conducted for all Nurse managers, IDT team and nursing supervisors. Care plans for residents with a fall will continue to be discussed at weekly Risk Management meetings. D) There will be monthly QA monitoring for residents who have had falls. A QA monitor that captures the number of updated care plans divided by the number of falls will reveal the actual compliance rate. The threshold will be set at 100% for compliance. Nurse Managers will present this updated care plan QA monitor at the monthly QA meetings.	1/22/10 1/22/10

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L 052	Continued From page 17 A face-to-face interview was conducted with Employee #3 on November 20, 2009 at 3:20 PM. He/she acknowledged that there were no interventions initiated after the falls of May 4 and June 5, 2009 prior to the fall of June 18, 2009 where the resident sustained a hematoma. The record was reviewed November 19, 2009.	L 052	1. A) No residents were affected by this deficient practice. B) The expired cartons of milk were discarded immediately. Staff was in-serviced on the correct process to monitor dates on milk cartons.	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made during a tour of the dietary services on November 18, 2009 between 7:50 am and 10:30 AM, and a tour of Unit Three (3) East on November 18, 2009 at 11:30 am it was determined that dietary services failed to store and serve food under sanitary conditions. The findings include: Kitchen 1. Seven (7) of seventeen (17) four ounce cartons of 2% milk were expired as of November 11, 2009. 2. Four (4) of four (4) loaves of rye bread were expired as of November 16, 20009. These observations were made in the presence of employee #4 who acknowledged these findings.	L 099	C) Milk cartons stored in walk in refrigerator #1 and trayline refrigerator will be monitored daily for expiration dates. This will be included on a daily walk through check list. D) Findings from daily walk through will be reported to the QA Committee at least quarterly.	1/22/10
			2. A) No residents were affected by this deficient practice. B) The expired loaves of rye bread were discarded immediately. Staff was in-serviced on the correct process to monitor dates on the bread bags. C) Bread stored on bread racks in the kitchen and in cafeteria serving area will be monitored daily for expiration dates. This will be included on a daily walk through check list. D) Findings from daily monitoring will be reported to the QA Committee at least quarterly.	1/22/10

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L 099	Continued From page 18 Three (3) East 1. Four (4) of ten (10) four ounce cartons of 2% milk were expired as of November 16, 2009. 2. One (1) of one (1) ice machine on 3 east lacked a pre-filter and the ice chute was stained with mineral deposits. These observations were made in the presence of employee # 22 who acknowledged these findings.	L 099	1.A) No residents were affected by this deficient practice. B) The expired cartons of milk were discarded immediately. Staff was in-serviced on the correct process to monitor dates on milk cartons. C) All nursing staff will check expiration dates of milk received from dietary department. Nurse Managers will monitor. D) All issues of found expired supplies will be discussed at monthly QA meetings. 2.	12/1/09 1/22/10
L 184	3229.6 Nursing Facilities Each facility shall provide space which ensures visual and auditory privacy for social service interviews with residents. This Statute is not met as evidenced by: Facility staff failed to perform quarterly and annual social work assessments. Resident # 3 According to 22DCMR 3229.6, " The social assessment and evaluation, plan of care and progress notes, including changes in the resident ' s social condition, shall be incorporated in each resident ' s medical record, reviewed quarterly and revised as necessary. " A review of Resident #3 ' s clinical record revealed quarterly social services assessments were documented April 23, 2009, July 23, 2009 and October 23, 2009. The most recent annual evaluation was dated October 23, 2008. The record lacked evidence of a quarterly social work assessment for January 2009 and an annual assessment for October 2009. The record	L 184	A) Administration has authorized the purchase of a water filter for the 3east ice machine. To be installed upon delivery. B) Both ice machines were examined. A New machine was ordered for 3East and a filter was ordered for the ice machine on 3West. C) A New machine was ordered for 3East and a filter was ordered for the ice machine on 3West .Ice chute cleaning put on Housekeeping check list for weekly cleaning. Ice machines added to monthly rounds list and checked for necessary repairs. D) Equipment maintenance issues are discussed at monthly QA meetings A) Mineral deposits were removed by Housekeeping. B) Both ice machines on floor were examined and cleaned. C) Cleaning of Ice machines was added to Housekeeping check list for weekly cleaning. D) Cleaning of ice machines is now part of Housekeeping QA monitor for cleanliness.	1/13/10 1/13/10 1/22/10 11/18/09 1/22/10

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L 184	Continued From page 19 was reviewed November 18, 2009.	L 184	A) Our Social Work Consultant has Reviewed the records of residents #3 and is responding according to the residents' needs.	1/22/10
L 199	3231.10 Nursing Facilities Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 15 sampled residents, it was determined that the facility staff failed to consistently document one (1) resident ' s behavior on the behavior flow sheet and complete an initial assessment and/or documentation on the psychosocial status of one (1) resident who was newly admitted to facility. Residents #1 and #14. The findings include: 1. Facility staff failed to document on the psychosocial status for a new resident. Resident #1 A review of the clinical record revealed that the social worker failed to document the resident's psychosocial needs since admission on September 21, 2009 A review of the clinical record revealed no documentation under the " social worker's progress notes " in the social worker section of the resident chart. A face-to-face interview was conducted with Employee # 6 on November 18, 2009 at 1:00 PM. He//she acknowledges that he/she did not complete an initial assessment and/or	L 199	B) A review of all charts for period 11/20 thru 12/31 revealed missing assessments. These were addressed by the Social Work Consultant. C) In order to ensure that assessments and other necessary documentation is performed timely and appropriately for other residents, the MDS Coordinator will notify the Social Worker and Administrator when her monthly Chart reviews reveal a Social Service discrepancy. In addition, our Medical Records department conducts a monthly Review that generates a chart deficiency list. Also, our SW Consultant will review all resident records monthly for completeness. The current Social Worker has received disciplinary action. A more experienced long term care Social Worker will start 2/1/10. Our Consultant will assist with covering residents' needs. D) The Medical Record Department will conduct a monthly review of residents' records to verify the timely notation of assessments .This will be presented at the monthly QA meetings. In addition, the Social Worker and/or Consultant will generate a monitor reviewing the timely documentation of assessments and social service notes to be presented at the monthly QA meeting	1/22/10

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L 199	Continued From page 20 documentation on the resident because he/she was newly hired as a social worker to the facility. The clinical record lacked evidence of the social worker's assessment of the residents' psychosocial status for initial assessment. The record was reviewed November 19, 2009. 2. Facility staff failed to document episodes of agitation on the "Behavior Monitoring Flow Record" for Resident #14. A review of the "Behavior Monitoring Flow Record" for July and August 2009 revealed that the resident experienced no episodes of agitation during either month. A review of the nurses' notes revealed: July 6, 2009 at 3:15 PM: "Episode of agitation noted. Gave Ativan 0.5 ml..." July 12, 2009 at 3:30 PM: "Resident alert and verbally responsive with periods of confusion . Behavior issues noted. Ativan given..." July 15, 2009 at 4:00 PM: "Agitated, seeing people who are not seen by staff. Given Ativan 0.5ml IM..." July 16, 2009 at 5:00 AM: "Agitated. Seeing people who are not seen by staff. Confused Given Ativan 0.5 mg IM..." August 11, 2009 at 2:00 AM: "...Given Ativan 0.5 ml for agitation..." August 12, 2009 at 11:00 AM: "Yelling cannot or will not stay in chair...Ativan 0.5ml given..." August 17, 2009 at 6:00 AM: "...periods of confusion. Ativan 0.5ml given IM for agitation August 17, 2009 at 3:00PM: "Agitation issues. Ativan 0.5ml given IM..." August 17, 2009 at 4:10 PM: "Resident had severe agitation during this shift..called (physician)...Ativan 0.5 ml given..."	L 199	1. A) Our Social Work Consultant has reviewed the records of resident #1 and is responding according to the residents' needs. 1/22/10 B) A review of clinical records for the period of 11/20 thru 12/31 revealed other missing psychosocial assessments. These were addressed by the Social Worker Consultant C)Our Medical Records department conducts a monthly review that generates a chart deficiency list. Our SW Consultant will review all resident records for completeness and address needs as identified. The current Social Worker has received disciplinary action. A more experienced long term care Social Worker will start 2/1/10. Our Consultant will assist with covering residents' needs. In order to ensure that assessments and other necessary documentation is performed timely and appropriately for other residents, the MDS Coordinator will notify the Social Worker and Administrator when her monthly Chart reviews reveal a Social Service Discrepancy. D) The Medical Record Department will conduct a monthly review of residents' records to verify the timely notation of assessments .This will be presented at the monthly QA meetings. In addition, the Social Worker and/or Consultant will generate a monitor reviewing the timely documentation of assessments and social service notes to be presented at the monthly QA meeting. 1/22/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0023	A. BUILDING _____ B. WING _____	11/20/2009

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L 199	Continued From page 21 A face-to-face interview with Employee #3 was conducted on November 20, 2009 at 3:20 PM. He/she acknowledged that the "Behavior Monitoring Flow Record" did not accurately document the resident's agitated behaviors. The record was reviewed November 19, 2009.	L 199	2. A) Resident #14 passed away prior to survey B) Behavior monitoring records of all residents receiving psychotropic medications were reviewed. Resident records identified with inaccurate documentation of agitated behaviors were addressed by nurse managers and QA Coordinator. The staff were in-serviced on proper and accurate documentation of agitated behavior on the behavior monitoring form on December 30, 2009. C) Nursing documentation monitoring will be performed to determine proper and accurate documentation and use of behavior monitoring form, D) Monitoring results will be shared at the monthly QA meeting for 3 months and if found in compliance then quarterly thereafter. L235 A) On day of survey, 11/20/09, hot water temperatures were identified as too high and adjusted to 95-110 while surveyor was here. B) Water temperatures are monitored at the source daily and 3x a week four rooms are randomly selected from each unit where temperatures are taken at resident room sinks. Any discrepancies are reported and addressed immediately. C) Water temperatures will continue to be Monitored as stated in above procedure. Temperatures will be re-checked at the source whenever work has been performed in the boiler area.	1/22/10
L 235	3236.4 Nursing Facilities The temperature of hot water of each fixture that is used by each resident shall be automatically controlled and shall not exceed one-hundred and ten degrees Fahrenheit (110 F) nor be less than ninety-five degrees Fahrenheit (95 F). This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on 11/18 2009 at approximately 11:30 am, it was determined that the facility failed to maintain water temperatures at or below 110 degrees of Fahrenheit (F) as evidenced by elevated water temperatures in seven (7) of nine (9) residents rooms located on 3 east. The findings include: Water temperatures in residents rooms were above 110 degrees of Fahrenheit (F) in rooms #303 (121 degrees of F), #306 (122 degrees of F), #312 (127 degrees of F), #316 (134 degrees of F), #317 (132 degrees of F), #318 (131 degrees of F) and the shower room (121 degrees of F). These findings were made and acknowledged in the presence of employee # 22.	L 235		

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L 292	Continued From page 22	L 292		
L 292	3243.3 Nursing Facilities Each ramp, stairway, and corridor that is used by a resident shall be equipped with firmly secured handrails or banisters on each side. This Statute is not met as evidenced by: Based on observations made during an environmental survey of the facility, it was determined that the facility failed to maintain secure handrails as evidenced by loose handrails in common areas: The findings include: Ten (10) of thirty-nine (39) handrails were not properly secured in the following areas: Between rooms #330 and #331, #332 and #333 and next to #335. Next to the soiled utility room on 3 west. Next to the clean utility room on 3 west. Next to #317 on 3 east. Across from room #311 on 3 east. Next to the sink room on 3 east. These observations were made in the presence of employee #22.	L 292	D) Water temperature monitoring will be discussed at the QA meeting with the rest of maintenance QA data. L292 A) The identified hand rails were tightened back to the wall on 12/12/09. B) All hand rails were examined and if loose were tightened to the wall. C) Maintenance will use a rounds check list to identify problems with hand rails or other facility fixtures. D) Equipment maintenance issues are discussed at monthly QA meetings	1/22/10 1/22/10
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations during the environmental tour November18, 2009 at 11:30 AM it was determined that facility staff failed to maintain two (2) of two (2) ice machines in a safe operating condition.	L 442		

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L 442	Continued From page 23 The findings include: 1. One (1) of two (2) ice machines was observed inoperable on 3 West. 2. One (1) of two (2) ice machines was observed without a filter on 3 East. The observations were made in the presence of Employee #22 and acknowledged at the time of the observation.	L 442	1. A) Administration has authorized the replacement of the broken ice machine on 3west. Parts are unavailable for this older model. To be installed upon delivery. B) Both ice machines were examined. A New machine was ordered for 3East and a filter was ordered for the ice machine on 3West. C) A New machine was ordered for 3East and a filter was ordered for the ice machine on 3West .Ice chute cleaning put on Housekeeping check list for weekly cleaning. Ice machines added to monthly rounds list and checked for necessary repairs. D) Equipment maintenance issues are discussed at monthly QA meetings. 2. A) Administration has authorized the purchase of a water filter for the 3east ice machine. To be installed upon delivery. B) Both ice machines were examined. A New machine was ordered for 3East and a filter was ordered for the ice machine on 3West. C) A New machine was ordered for 3East and a filter was ordered for the ice machine on 3West.Ice chute cleaning put on Housekeeping check list for weekly cleaning. Ice machines added to monthly rounds list and checked for necessary repairs. D) Equipment maintenance issues are discussed at monthly QA meetings	1/13/10 1/22/10 1/13/10 1/22/10