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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING ________ B. WING ________	06/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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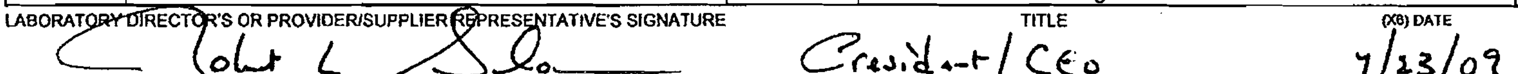
F 000	INITIAL COMMENTS A recertification survey was conducted on June 10 through 11, 2009. The follow deficiencies were based on observations, staff interview and record review. The sample size was 12 residents based on a census of 45 residents on the first day of survey. There were two (2) supplemental residents.	F 000		
F 157 SS=D	483.10(b) (11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	**F 157 - 483.10(b) (11) Notification of Changes** Sibley Memorial Hospital Renaissance SNF provides services that meet professional standards of quality. During the survey, it was determined that the facility failed to notify the physician in a timely manner when a patient refused Megace, an appetite stimulant. Findings for Resident #7 1. Resident #7 has been discharged home. No further corrective action is applicable for this resident. 2. There were no other refusals of Megace for other residents with orders for Megace. Other residents having the potential to be affected by the same deficient practice will be identified upon admission through chart reviews, physician orders and medication administration records. Physicians and dieticians will be notified as soon as possible of residents that refuse Megace to alert them of the potential for additional weight loss. 3. The following systemic changes have been or will be put in place to ensure that the deficient practice will not recur and staff education was done on the following: •A QA monitoring tool has been developed to track all residents on Megace. •The DON, Quality Nurse or designee will monitor physician orders and MARS for the identification of residents on Megace on a daily basis. •Physician and dietician will be notified as soon as possible when a resident refuses Megace. •The 24 hour chart check will be utilized to monitor physician orders for all orders written for the medication Megace.	7/10/09 7/26/09 7/26/09

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



President/CEO — 7/23/09

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

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 12 sampled residents, it was determined that facility staff failed to notify the physician that Resident #7, with a significant weight loss, refused Megace, an appetite stimulant, for four (4) days. The findings include: During a medication pass observation that was conducted on June 10, 2009 at 9:30 AM, Resident #7 refused Megace 400 mg. Resident #7 stated, "My appetite is fine. I don't need that medicine. I have been refusing it for several days." A review of Resident #7's record revealed a physician's order dated May 9, 2009 at 2:30 PM that directed "Megace 2 TSP po (orally) daily for appetite." The resident was admitted on April 28, 2009, initially severely depressed and ate less than 25% of his/her meals. According to the June 2006 Medication Administration Record, the resident refused Megace on June 6, 8, 9 and 10, 2009. There was no evidence in the resident's record that the physician had been notified that the resident had refused the medication. A face-to-face interview was conducted with Employee #5 on June 10, 2009 at 11:00 AM. After reviewing the record, he/she acknowledged that there was no documentation present to	F 157	•The nutritional care plan will show that the resident is on the appetite stimulant Megace and will be reviewed in the weekly care plan meetings. •Nursing staff will be in-serviced on importance of reporting refusal of appetite stimulants such as Megace and the effect that has on a resident with unintended weight loss. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	7/26/09

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F 157	Continued From page 2 indicate that nursing staff had notified the physician regarding the resident's refusal of the Megace. A review of the record on June 11, 2009 revealed that the physician had been notified of the resident's refusal of Megace, the medication had been discontinued and the resident was scheduled to return to his/her home on June 11, 2009. The record was reviewed June 11, 2009.	F 157		
F 253 SS=D	483.15(h) (2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: venetian blind slats damaged and soiled with dust in residents' rooms and common areas in six (6) of nine (9) room and common area observations, Heating Ventilation and Air Conditioning (HVAC) covers soiled with accumulated dust on louver surfaces in six (6) of nine (9) HVAC units observed, wall surfaces in the rear of faucets and sinks damaged in residents' rooms in four (4) of nine (9) rooms observed. These observations were made in the presence of Employees #4 and 13. The findings include: 1. The slat surfaces of venetian blinds were soiled	F 253	F253 – 483.15(h)(2) Housekeeping/Maintenance Sibley Memorial Hospital's Renaissance SNF provides housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. During the survey a number of problem areas were identified that have been cited in this report. The following plan of corrections addresses the few deficiencies that were identified: Findings 1 & 2 1. No specific residents were identified in the survey report as being affected by the deficient practices. The following corrective actions have been taken to address the survey findings. • Finding 1: The slat surfaces of Venetian blinds have been cleaned and will continue to be cleaned on a regular basis. • Finding 2: Heating ventilation and air conditioning covers have been cleaned. 2. All rooms were checked and cleaned as needed. 3. The following systemic changes have been or will be put in place to ensure the deficient practice will not recur and housekeeping staff was educated on the following: • Finding 1: ▫Venetian blind slats will be cleaned by the housekeeper to ensure that dust does not affect the wellbeing of the patient. This will be done on an on-going and regular schedule. ▫ Employees will have retraining on the importance of dusting for the safety and health of the patient. They will review the 7 step cleaning method to make certain all areas of the room are cleaned in the proper way for yearly evaluations. ▫ Team leaders and managers will make daily rounds to areas and verify that housekeepers are using the 7 step cleaning method. ▫ All blinds in patient rooms will be replaced by curtains. This replacement process is on-going. ▫All blinds will be replaced and in full capacity by the end of August.	7/10/09 7/26/09 7/26/09 8/31/09

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F 253	Continued From page 3 and damaged in residents ' rooms and common areas in rooms 303, 305, 307, 315, 324 and Activity Room in six (6) of nine (9) room observations between 9:41 AM and 10:45 AM on June 11, 2009. 2. Heating Ventilation And Air Conditioning covers were soiled with accumulated dust on louver surfaces in rooms 303, 305, 307, 315, 318 and 324 in six (6) of nine (9) room observations between 9:41 AM and 10:45 AM on June 11, 2009. 3. Wall surfaces were damaged and in need of repair and caulking in residents' bathrooms in rooms 303, 307, 315 and 320 in four (4) of nine (9) room observations between 9:41 AM and 10:45 AM on June 11, 2009. Employees #4 and 13 acknowledged the findings at the time of the observations.	F 253	• Finding 2: ▫ Heating and cooling covers will be cleaned by the housekeeper to ensure that dust does not affect the wellbeing of the patient. ▫ Employees will be retrained to ensure that the ventilation covers and vertical surfaces are cleaned for the safety of the patients using the 7 step program August 31, 2009. ▫Team leaders and managers will make daily rounds to areas and verify that housekeepers are using the 7 step cleaning method. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. • The Administrator will check on cleanliness during weekly rounds • Finding 3: 1. All walls cited in this report will be repaired. Repair damaged wall surfaces and caulk as necessary. Work orders #6414, 6415, 6416, and 6417 have been submitted. Work should be completed by the end of August 2009. 2. The walls in the rooms and bathrooms of other residents were inspected and will be repaired as needed. 3. Inspection of the wall conditions were added to environmental rounds on a weekly basis. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting.	8/31/2009 7/26/2009 8/31/09 7/26/09 7/26/09 7/26/09
F 279 SS=D	483.20(d), 483.20(k) (1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279	F279 – 483.20(d), 483.20(k)(1) Comprehensive Care Plans Comprehensive Care Plans are developed for all SNF residents. During the survey, three of twelve sampled residents did not have a satisfactory care plan. The following plan of correction addresses this important issue: Findings for residents #1,#3 and #10 1. Facility staff failed to initiate a satisfactory plan of care with objectives, goals, and approaches to address the residents' nutritional needs. We recognize this failure although no further corrections are needed on these specific residents since they have all been discharged home in good health.	7/10/09

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F 279	Continued From page 4 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b) (4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 12 sampled residents, it was determined that facility staff failed to initiate a care plan with goals and approaches to address the resident's nutritional needs and significant weight loss. Residents #1, 3 and 10. The findings include: 1. A review of the clinical record for Resident #1 revealed that facility staff failed to initiate a plan of care with objectives, goals and approaches to address the resident's nutritional needs. According to the history and physical examination completed by the physician on May 23, 2009, the resident's diagnoses included: status post hip fracture with total hip replacement, dehydration, macular degeneration, mitral insufficiency and congestive heart failure. According to the dietary consultation dated May 24, 2009, the resident's admission weight of 102 pounds was below the calculated Ideal Body Weight (IBW) of approximately 125 pounds. The Dietician's assessment dated May 28, 2009 revealed that Resident #1 sustained a significant weight loss of 7% (current weight 94 pounds) over one week.	F 279	2. All other resident care plans were reviewed and changed as needed. 3. The following systemic changes have been or will be implemented to prevent the same deficient practice from recurring and staff was educated on the following: • The multi-disciplinary care team will review nutritional care plans at each meeting to monitor compliance and update as indicated. • Weekly weights will be monitored on Wednesdays for all residents assessed to be at nutritional risk for weight loss. • The dietician will attach copy of consult to each nutritional care plan of residents deemed as moderate to high nutritional risk (Level 2). • QA tool will be implemented to randomly monitor careplans for compliance. • Dietician to notify the DON and/or Quality Nurse of all residents that exhibit weight loss. • Careplans will be implemented to identify goals, approaches and interventions to ensure compliance with identification of residents at risk for weight loss. • The dietician will provide inservices to staff on ongoing basis to give feed back. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	7/26/09 7/26/09 7/26/09

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F 279	Continued From page 5 The Dietician implemented recommendations and interventions to address the resident's nutritional concerns, however; the care plan developed by the interdisciplinary team, signed on May 28, 2009, June 1 and June 8, 2009 lacked evidence of problem identification, goals and approaches to address the resident's nutritional concerns and weight loss. The findings were reviewed and confirmed during a face-to-face interview with Employee #2 on June 10, 2009 at approximately 4:30 PM. The record was reviewed on June 10, 2009. 2. A review of the clinical record for Resident #3 revealed that facility staff failed to initiate a plan of care with objectives, goals and approaches to address the resident's nutritional needs. According to the history and physical examination completed by the physician on May 16, 2009, the resident's diagnoses included generalized weakness, failure to thrive and status post right hip replacement. According to the dietary consultation dated May 21, 2009, Resident #3 sustained a 4.6% weight loss one week post admission. The Dietician deemed the resident as a moderate to high nutritional risk (Level 2 protocol per facility policy) and implemented recommendations and interventions to address the resident's nutritional concerns. A review of the plan of care developed by the Interdisciplinary team lacked evidence of problem identification, goals and approaches to address the resident's nutritional concerns and weight loss. The findings were reviewed and confirmed during a face-to-face interview with Employee #2 on	F 279		

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F 279	Continued From page 6 June 10, 2009 at approximately 5:00 PM. The record was reviewed June 10, 2009. 3. A review of the clinical record for Resident #10 revealed that facility staff failed to initiate a plan of care with objectives, goals and approaches to address the resident's nutritional needs. According to the history and physical examination completed by the physician on April 3, 2009, the resident's diagnoses included status post hip fracture, diabetes mellitus, atrial fibrillation, hypertension, hypercholesterolemia and gout. According to the clinical record, the weight history for Resident #10 was 171 pounds upon admission on April 3, 2009 and on April 20, 2009 his/her weight was assessed at 154 pounds, an approximate 17 pound weight loss. Dietician consultations performed April 4, 2009 through June 9, 2009 deemed the resident a moderate to high nutritional risk (Level 2 protocol) and implemented recommendations and interventions to address the resident's nutritional concerns. A review of the Interdisciplinary care team (IDT) notes revealed a care plan was developed by the IDT on April 13, 2009 and subsequently reviewed on April 16, 20, 23, 27, 30; May 4, 7, 11, 14, 21, 26; June 1, 4, and 11, 2009. The plan of care lacked evidence of problem identification, goals and approaches to address the resident's nutritional concerns and weight loss. The record was reviewed on June 11, 2009.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	**F309-483.25 Quality of Care** The Rensaissance SNF provides services that meet professional standards of quality. During the most recent survey, a number of problems were identified that have been cited in this report. The following plan of correction addresses them:	

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F 309	Continued From page 7 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for three (3) of 12 sampled residents and one (1) of two (2) supplemental residents, it was determined that facility staff failed to: follow physician's orders for monitoring pulse oxcyemetry for one (1) resident, obtain complete medication orders for two (2) residents and clarify the indication for when to administer multiple pain medications for two (2) residents. Residents #1, 7, 12, and 13. The findings include: 1. A review of the clinical record for Resident #1 revealed facility staff failed to follow physician's orders for the assessment of oxygen saturation levels. Resident #1 was admitted May 23, 2009, post operative total hip replacement. Diagnoses included status post hip fracture, dehydration, macular degeneration, mitral insufficiency and congestive heart failure. Physician's orders dated May 31, 2009 directed "P02 sat q shift (pulse oximetry saturation level every shift) if =93% no oxygen, if =92% administer 2 liters of oxygen per minute via nasal cannula." A review of the electronic documentation related to the assessment of the resident's oxygen saturation levels revealed oxygen saturation levels were not done on the following dates during the day and evening shifts: June 3, 4, 7 and 9, 2009. On June 5, 2009, the oxygen saturation	F 309	Finding for Resident #1 1. There are no further corrective actions for resident #1 who has been discharged from the facility in good health. 2. Other resident oximetry records/TARS are corrected. 3. The following systemic changes have been or will be put in place to ensure that the deficient practice will not recur and staff was in-serviced on the following: • A QA tool has been developed to monitor the treatment administration record and electronic record to verify that oximetries have been carried out and signed off. • Ten charts will be reviewed randomly on a monthly basis. Findings for Resident #7 1. There are no further corrective actions as resident #7 has been discharged home in good health. 2. Other residents' medication orders for Megace and eyedrops were checked to ensure orders were clear. 3. The following systemic changes have been or will be put in place to ensure the deficient practice does not recur and staff was in-serviced on the following: • The nursing staff and secretarial associates will monitor physician orders and medication administration records to ensure the medication route/strength has been identified and transcribed correctly. The five rights and indications must be present. •The 24 hour chart review of the medication administration record will be utilized to monitor orders for accuracy and completeness. • The nursing staff will receive in-service training on the importance of clarification of medication orders to prevent a delay in treatment for all residents to maintain safety. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	7/10/09 7/26/09 7/26/09 7/10/09 7/26/09 7/26/09 7/26/09

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F 309	Continued From page 8 level was not obtained during the night shift. The electronic record was retrieved by Employee #2 and the findings reviewed and confirmed in the presence of this employee on June 10, 2009 at 3:30 PM. The record was reviewed June 10, 2009. 2. Facility staff failed to clarify a physician's order for Megace for Resident #7. A review of Resident #7's record revealed a physician's order dated May 9, 2009 that directed, "Megace 2 TSP orally daily for appetitive." The order lacked the dosage for the medication. A face-to-face interview was conducted with Employee #11 on June 11, 2009 at 10:00 AM. He/she stated, "Megace comes in one strength, 40 ml per cc. A teaspoon is 5 cc so the doctor ordered 10 cc of Megace or 400 milligrams. The order as written is not really a complete order. The number of milligrams should be there." The record was reviewed June 11, 2009. 3. Facility staff failed to clarify the indication for when to administer two (2) pain medications for Resident #12. A review of Resident #12's record revealed orders signed by the physician on May 5, 2009 that directed, "Tylenol 650 mg every 4 hours orally for mild pain" and" Tramadol 50 mg every 4 hours orally for mild pain." There was no evidence that facility staff had clarified the indication for when to administer two (2) medications, both prescribed for mild pain. The resident was administered Tylenol 650 mg on May 7, 2009. The resident never received the Tramadol. There was no explanation in the	F 309	• The charge nurse and the Quality Nurse will review the nursing staff worksheets on an ongoing basis to monitor that oximetry orders are communicated shift-to-shift. • In-service staff on the importance of ensuring all treatments are carried out and documented. • The "alteration in respiratory status" care plan will be updated to reflect pulse oximetry as indicated. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. Findings for Residents #12 and #13 1. There are no further corrective actions as the residents have been discharged to home in good health. 2. All other residents' physician orders and medication administration records have been reviewed and transcribed correctly. 3. The following systemic changes have been or will be put in place to ensure the deficient practices do not recur and staff was in-serviced on the following: • The staff will monitor the medication administration record and physician orders to ensure that the strength and dosages for each pain medication is clarified for each level of pain. • A QA monitoring tool has been implemented to check compliance of physician orders on a daily basis. • The charge nurse will remind physicians to specify which pain medication is to be administered base on scale 1-10 (mild, moderate, severe). • Additional secretary associate and nurse education will be given on the importance of verifying that all orders are written out correctly before transcribing. • The 24 chart check will be utilized to monitor physician order clarity and to obtain order clarification if so indicated. • Ten charts will be reviewed randomly on a monthly basis.	7/26/09 7/10/09 7/26/09 7/26/09

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F 309	Continued From page 9 resident's record why the nurse administered Tylenol instead of Tramadol. A face-to-face interview was conducted with Employee #1 on June 10, 2009 at 1:00 PM. He/she acknowledged the above cited findings. The record was reviewed June 10, 2009. 4. Facility staff failed to clarify the indication for when to administer two (2) pain medications and eye drops Resident #13. A. Review of Resident #13's record revealed a physician's orders dated April 28, 2009 that directed, "Acetaminophen 650 mg every 4 hour orally for mild pain" and "Percocet 1 tab every 4 hours for pain." There was no evidence that facility staff had clarified with the physician the indication for when to administer two (2) medications, both prescribed for pain. The resident received Tylenol as follows: April 30 at 7:10 AM, May 2 at 2:43 PM and May 3 at 9:30 AM and 3:00 PM. The resident received Percocet as follows: April 29 at 8:35 AM and 10:30 PM, April 30 at 9:55 AM and 10:30 PM, May 2 at 8:34 AM and 10:00 PM and May 3 at 9:30 AM, 3:00 PM and 11:15 PM. There was no explanation in the record why the nurse administered the particular pain medications as identified in the above cited occasions. B. A physician's order dated April 28, 2009, directed, " Timolol 0.5% gel/solution, 1 drop q HS (at bedtime)." The order failed to identify the eye(s) for which the medication was prescribed.	F 309	• The Quality Nurse on the Renaissance Unit will sample charts on a regular basis to ensure that physician orders are clear and precise. Reports will be provided to the DON and the Medical Director. Follow up action that is necessary will be identified and reported at the Quality Assurance meeting. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	8/31/09 7/26/09

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F 309	Continued From page 10 A face-to-face interview was conducted with Employee #5 on June 10, 2009 at 1:00 PM. He/she acknowledged the above cited findings. The record was reviewed June 10, 2009.	F 309		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 12 sampled residents, it was determined that facility staff failed to assess residents' weights per dietician recommendations and facility policy. Residents #1, 3, 10. The findings include: Facility Policy entitled "Monitoring Resident Weights" stipulated: "Residents will be weighed on a weekly or monthly basis, dependent upon their nutritional risk, as determined by the dietitian and the nutrition risk policy. Residents deemed to be at a moderate or high nutritional risk (Level 1 or 2) will be weighed weekly until nutritionally stable and then monthly thereafter ...re-weight completed for any weight change of greater than or less than five (5) pounds within 30-days. Reweighs must be completed within 48-hours on	F 325	<u>F 325 – 483.25(i) Nutrition</u> Based on a resident's comprehensive assessment, the facility must ensure that a resident (i) maintains acceptable parameters of nutritional status, such as body weight and protein levels unless the residents condition demonstrates this is not possible; and (ii) receives a therapeutic diet when there is a nutritional problem. <u>Findings for Residents #1, #3, and #10</u> 1. There are no further corrective actions as all residents have been discharged to home in good health. 2. Other residents having the potential to be affected by the same deficient practice will be identified through the initial nursing admission assessment, weights and physician orders, and review of nursing assistant flow sheets. All residents meeting the criteria for nutritional assessments will be identified upon admission and a dietary consult will be entered into the computer system to flag the dietician. Other residents on the unit identified as needing weekly weights were weighed as requested. 3. The following systemic changes have been or will be put in place to ensure that the deficient practice does not recur and staff was in-serviced on the following: • The charge nurse, Quality Nurse and/or her designee will review all initial clinical documentation to ensure that the appropriate action is taken for those residents meeting criteria for nutritional assessment/screens or dietary consults. • Quality monitoring tool is in progress to track admitting, weekly and reassessment weights. • Random audits of food intake will be conducted on specific residents to confirm that there is accurate documentation of the percent of food consumed on the ADL flowsheet. • All weights will be documented into the clinical record upon completion.	7/10/09 7/26/09 7/26/09

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F 325	Continued From page 11 the same scale, with the same amount of clothing and at approximately the same time of day to verify the weight change. Reweighs must be documented into the medical record." 1. A review of the clinical record for Resident #1 revealed facility staff failed to monitor the resident's weight in accordance with the dietician's recommendations and pursuant to facility policy. The effectiveness of nutritional interventions was limited due to the lack of weight assessments. Resident #1 was admitted May 23, 2009 with diagnoses that included status post hip fracture with total hip replacement, dehydration, macular degeneration, mitral insufficiency and congestive heart failure. According to the admission Minimum Data Set (MDS) assessment signed June 4, 2009, the resident's vision was severely impaired, height 65 inches, weight 102 pounds and according to Section K, Oral/Nutritional status, he/she was coded for a swallowing problem. A gastroenterology (GI) consultation was conducted May 25, 2009 to address the resident's swallowing problem. The consultant determined no evidence of dysphagia or esophageal dysfunction was identified. An initial dietary consultation was conducted May 24, 2009 that revealed the resident's admission weight was 102 pounds and Ideal Body Weight (IBW) was approximately 125 pounds. He/she was below IBW upon admission due to a history of inadequate intake secondary to appetite. Megace 400 mg daily, an appetite stimulate, was ordered by the physician upon admission. The dietary plan included a regular diet, encourage the intake of ensure (dietary supplement) and ice cream and assistance with meals secondary to visual deficits. Weekly weights were requested.	F 325	• Dietician re-inserviced staff on weights, consults, and nutrition/reassessment, weight loss in elderly. •Copies of dietary consults will be attached to the nutritional care plan to validate completion and communicate nutritional status. •Weekly weights will be done every Wednesday to track potential weight loss/gain. •Re-weights will be done as directed by the physician or dietician for ongoing monitoring. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting.	6/17/09 & 6/29/09 6/12/09 6/11/09 7/26/09

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F 325	Continued From page 12 The subsequent dietary consultation dated May 28, 2009 revealed a current weight of 94 pounds, identified as an unintentional 7% significant weight loss. The resident's intake was variable at approximately 50% consumption and diet texture was changed to mechanical soft. Dietician follow up visits would follow the "Level 1 Nutrition Risk Protocol." The recommendations included encourage, monitor and assist with oral intake. Physician's orders dated May 28, 2009 directed a 1200 milliliter per day fluid restriction and the order was discontinued on May 29, 2009. The weight record for Resident #1 revealed weights were assessed on May 23, 2009 and May 28, 2009. The record lacked evidence of weight assessments subsequent to May 28, 2009. According to the facility policy delineated above, individuals deemed as a moderate/high nutritional risk (Level 1 or 2) must have weights assessed on a weekly basis and a re-weights within 48-hours of a 5 pound variance. The record lacked evidence of a re-weight when it was determined that the resident sustained a significant weight loss. Additionally, staff failed to follow the facility's weight monitoring policy and the dietitian's request for weekly weights. Subsequent dietary consultations revealed continued requests for weight assessments. The dietary summaries revealed the resident's intake improved as evidenced by the intake monitoring record entitled Activities of Daily Living (ADL) Flowsheets. The flow sheets revealed the resident's intake increased 50-75% and 50-100% respectively. The resident and the resident's responsible party verbalized that mealtime intake and appetite had improved. The findings were reviewed and confirmed during a face-to-face interview with Employee #2 on June 10, 2009 at approximately 4:30 PM. The	F 325		

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F 325	Continued From page 13 record was reviewed on June 10, 2009. 2. A review of the clinical record for Resident #3 revealed facility staff failed to monitor the resident's weight in accordance with the dietician's recommendations and in accordance with facility policy. Resident #3, an 88 year old, was admitted May 15, 2009 with diagnoses that included, generalized weakness, failure to thrive and status post right hip replacement. According to the admission MDS assessment, signed May 28, 2009, the resident's height was 69 inches and weight 174 pounds. Section G, Physical functioning, revealed the resident required extensive assistance with eating and according to Section K, Oral/Nutritional status, he/she did not have oral problems and left 25% or more of food uneaten at most meals. The resident's drug regimen on admission included Megace 400 mg daily as an appetite stimulant. According to the dietary consultation dated May 21, 2009, Resident #3 sustained a 4.6% weight loss in one week post admission (current weight 166 pounds on May 20, 2009). The dietician determined the resident to be a Level 2 nutritional risk and interventions included homemade ensure shakes three times daily, re-weight and weekly weights. The dietary consultation dated June 9, 2009 revealed the resident's weight was assessed on June 3, 2009 at 161 pounds, a 7.4% significant weight loss since admission. The dietician recommended a re-weight to verify the accuracy of the June 3, 2009 weight. Again, weekly weights were requested. A review of the resident's weight history revealed the resident's weight was assessed on May 15, 2009; May 20, 2009 and June 3, 2009. The record lacked evidence that facility staff	F 325		

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F 325	Continued From page 14 performed weekly weights as per the dietician's request and in accordance with facility policy. Additionally, re-weights were not assessed within 48 hours as per policy and as per the dietician's request. The findings were reviewed and confirmed during a face-to-face interview with Employee #2 on June 10, 2009 at approximately 5:00 PM. The record was reviewed June 10, 2009. 3. A review of the clinical record for Resident #10 revealed facility staff failed to monitor the resident's weight in accordance with the dietician's recommendations and in accordance with facility policy. The effectiveness of nutritional interventions was limited due to the lack of weight assessments. Resident #10, a 91 year old, was admitted April 3, 2009 with diagnoses that included status post hip fracture, diabetes mellitus, atrial fibrillation, hypertension, hypercholesterolemia and gout. According to the initial nutritional consult dated April 4, 2009, the resident's admission weight was 173 pounds and height 70 inches. The dietician determined the resident to be a Level 2 nutritional risk. Nutritional interventions included an 1800 calorie ADA (American Diabetic Association) diet and Glucerna supplements three times daily. The physician ordered Megace 400 mg daily upon admission, as an appetite stimulant. Dietician consultations performed May 21, 2009 and June 9, 2009 revealed repeated requests for weekly weights and a determination of the Level 2 nutritional protocol. The record revealed Resident #10's weights were assessed as follows: April 3, 2009, 173 pounds; April 8, 2009, 171 pounds; April 20, 2009, 154 pounds; April 22, 2009, 156 pounds;	F 325		

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F 325	Continued From page 15 April 24, 2009, 152 pounds; May 5, 2009, 155 pounds May 8, 2009 149 pounds. There was no evidence of weights assessed subsequent to May 8, 2009. The record lacked evidence that facility staff performed weekly weights as per the dietician's request and in accordance with facility policy. The record was reviewed June 11, 2009.	F 325		
F 371 SS=D	483.35(i) SANITARY CONDITIONS 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: Based on observations during the survey period it, was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: improper storage of mops and brooms on floor surfaces in two (2) of two (2) areas observed, foods stored in the walk in refrigerator beyond the use by date in four (4) of seven (7) containers of stored food observed, the interior and exterior surfaces of salamander pans soiled with leftover foods and stored wet and ready for reuse in 19 of 20 pans observed, five (5) of five (5) sheet pans soiled with grease and leftover foods and stored for reuse before drying, coffee cups stained after washing in 16 of 16	F 371	**F 371 – 483.35(i) Sanitary Conditions** Sibley Memorial Hospital's Renaissance SNF stores, prepares, distributions, and serves food under sanitary conditions. During the survey, a few deficiencies were identified that have been cited in this report. The following plan of correction addresses the deficiencies. 1. The following plan of correction addresses the deficiencies so they will not adversely impact residents: Finding 1: Mops and brooms have been properly stored. Finding 2: All food identified in the citation were discarded. Finding 3: Interior and exterior surfaces of Salamander and sheet pans were cleaned. Finding 4: The interior surfaces of the plastic coffee cups were cleaned and dark stains removed. Finding 5: Shelf surfaces of storage racks were cleaned. 2. All other areas affected by the deficient practices were corrected as follows: Finding 1: All janitor closets will be inspected to ensure that mops and brooms are stored correctly. Finding 2: All walk-in refrigerators will be inspected to ensure that food beyond its expiration date is found and discarded as needed. Finding 3: All pots and pans will be inspected and cleaned as needed. Finding 4: All coffee cups will be inspected and cleaned as needed.	7/10/09 7/26/09

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F 371	Continued From page 16 coffee cups observed, and the shelf surfaces of storage racks in the pot and pan wash area stained and soiled with debris in two (2) of three (3) shelves observed. These observations were made in the presence of the Employees #4 and 12. The findings include: 1. Mops and brooms were improperly stored on floor surfaces in the Salad Room and near the tray line in the main kitchen in two (2) of two (2) areas observed at 9:20 AM on June 10, 2009. 2. Foods were stored in the walk in refrigerator beyond the use by or preparation date such as: Beef Roast labeled 5/29/09, Deli Meat in a pan labeled 5/19/09, Banana Pudding labeled 6/7/09 and Chocolate Pudding labeled 6/7/09 in four (4) of seven (7) containers of stored foods observed at 9:30 AM and 10:30 AM on June 10, 2009. 3. The interior and exterior surfaces of 19 of 20 salamander pans and five (5) of five (5) sheet pans were observed soiled with leftover food or grease and were stored on shelves for reuse before pans were allowed to dry between 10:30 AM and 10:45 AM on June 10, 2009: 4. The interior surfaces of 16 of 16 plastic coffee cups were soiled with dark stains after washing in the dish machine at 11:00 AM on June 10, 2009. 5. The shelf surfaces of two (2) of three (3) storage racks in the pot and pan wash area were soiled with stains and other debris observed at 11:10 AM on June 10, 2009. Employees #4 and 12 acknowledged the findings	F 371	Finding 5: All shelf surfaces will be inspected and cleaned as needed.	
			3. The following system measures will be put in place to ensure the deficient practices do not recur and staff was trained on the following:	7/26/09
			Finding 1: • Training will be completed for all employees who use mops and brooms in the department on how to properly store the mops and brooms. • Mop and broom storage will be added to the weekly checklists and rounding to monitor compliance.	7/31/09
			Finding 2: • All production staff will be re-trained on Hazard Analysis & Critical Control Program (HACCP); Production Manager will monitor the process. • Production Manager and supervisor will complete daily rounding to make sure production staff follows procedures.	7/31/09
			Finding 3: • Nutrition services will complete a monthly audit on pans to ensure proper procedures are followed. • Staff will be in-serviced and trained on the proper way to wash/dry pans and replacement pans will be purchased.	8/31/09
			Finding 4: Retraining will be given to the dishroom staff to ensure that mugs/cups are being soaked weekly. • Supervisors and Patient Service Manager will complete sanitation audits weekly and daily rounds to ensure mugs/cups are clean.	8/31/09
			Finding 5: • Sanitation staff will be in-serviced on proper cleaning to racks. All racks in pot and pan area will be put on a special rotation for cleaning and be added to the sanitation checklist to monitor compliance.	8/31/09
			4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	7/26/09

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F 371	Continued From page 17 at the time of the observations	F 371		
F 425 SS=D	483.60(a), (b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations during the medication storage area inspection in four (4) of four (4) medication carts, it was determined that facility staff failed to date medications when opened. The findings include: A review of the two (2) medication carts was conducted on 3 South on June 11, 2009 at 10:30 AM in the presence of Employee #2. Three (3) of three (3) medications were observed undated when opened:	F 425	**F-425 483.60(a), (b) Pharmacy Services** Sibley Memorial Hospital Renaissance SNF provides pharmaceutic services (including procedures that assure that accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals) to meet the needs of each resident. Findings 1. Medications cited in this report were removed. 2. All carts were inspected and other medications that were unlabelled and open were removed. 3. The following systemic changes have been or will be put in place to ensure that deficient practice will not recur and staff was in-serviced on the following: • All medications that are multi-use will be dated once that bottle is opened and discarded in the time frame that it expires once opened. • The Quality Nurse or Charge Nurse will ensure medications have open dates on the labels/bottles utilizing medication cart inspection tool. • The nursing staff will be in-serviced and informed of importance of labeling/dating of medications once the original package/seal is broken. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting.	7/10/09 7/26/09 7/26/09 7/26/09

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F 425	Continued From page 18 Advair dispensed from the pharmacy on June 9, 2009 Maalox dispensed from the pharmacy on June 9, 2009 Hydrocortisone 1% cream dispensed from the pharmacy on June 9, 2009 A review of the two (2) medication carts was conducted on 3 North on June 11, 2009 at 10:45 AM in the presence of Employee #2. Three (3) of three (3) medications were observed undated when opened: Bacitracin ointment dispensed from the pharmacy on June 7, 2009 Deep Sea Nasal Spray dispensed from the pharmacy on June 7, 2009 Hydrocortisone 1% cream dispensed from the pharmacy on June 7, 2009 Employee #2 acknowledged the findings at the time of the observations.	F 425		
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it was determined that facility staff failed to comply with state regulations as evidence by failing to: report unusual incidents/events to the state agency and ensure that medical screening was	F 492	**F 492 – 483.75(b) Administration** Sibley Memorial Hospital Renaissance SNF operates and provides services in compliance with all applicable federal, state and local laws, regulations and codes. During the survey, several problem areas were identified that have been cited in this report. Finding #1 1. All reports from May 2009 to June 11, 2009, were sent to DOH. 2. The facility occurrence reporting system will be utilized to identify other potential residents that could be affected by the deficient practice. Other occurrence reports from 6/12/2009 to 7/26/2009 will be sent to DOH. 3. The following systemic changes are in place to ensure the deficient practice will not recur and nursing staff will be in-serviced on the following:	7/26/09 7/26/09 7/26/09

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F 492	Continued From page 19 completed for one (1) of six newly hired employees. The findings include: 1. Facility staff failed to report unusual incident/events to the state agency. According to 22DCMR 3232.4,"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." The unusual incident/event reports were reviewed from March through May 2009. A total of 29 reports were generated by the facility. Of the 29 incident reports reviewed, there were no reports of resident abuse or events that resulted in resident injury. A face-to-face interview with Employee #1 was conducted on June 11, 2009 at 8:30 AM. He/she acknowledged that none of the incident/event reports were sent to the state agency. 2. Facility staff failed to ensure that one (1) of six (6) newly hired employees completed the health requirements by the 15th day of employment as per facility policy. According to 22DCMR 3202.2, "Each facility shall develop and maintain personnel policies which shall include methods used to document the presence or absence of communicable disease." According to the facility's policy, "Employment	F 492	• Immediately upon notification of an occurrence and subsequent investigation of the incident, the state agency will be notified electronically within the mandated reporting time frame of forty-eight (48) hours or eight (8) hour time frame if the incidence results in injury or harm to the resident. • The SNF will track all occurrence in the organization reporting system to ensure no occurrences have been missed and to report immediately to state on a daily basis. • All residents will be screened by the medical/surgical house officer or admitting physician upon each occurrence. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting. Findings for S1 1. Immediately had physical, PPD, and immunization per hospital policy (Hospital Policy #03-40-14). 2. All employees hired in the past 30-60 days were compliant as required. 3. The following systemic changes are in place to prevent reoccurrence of the deficient practice: • The employees will receive a physical upon hire. • To assure compliance, Employee Health will notify the Director of Environmental Services with a written report with health clearance status of the department employees within two weeks of orientation. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting.	7/26/09 7/10/09 7/26/09 7/26/09 7/26/09

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	095030	A. BUILDING ______ B. WING ______	06/11/2009

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F 492	Continued From page 20 and Annual Physical Examination and TST Requirements" number 03-40-14, effective March 26, 2009, page 2, " New employee physical examination shall include medical history and directed physical exam, review of immunization record or immunization history, tuberculin skin test (TST) or chest x-ray (if history or positive TST) and Hepatitis B vaccination ...New employees will be suspended from duty if health requirements are not met by the 15th day of employment." A review of Employ S1's record revealed that the employee was hired on May 4, 2009. There was no evidence in the record that the employee had received a physical examination, reviewed his/her immunization record or received the tuberculin skin test. The employee worked May 5, 6, 12, 14, 16, 17, 19, 28, 29, 30 and 31 on the night shift in areas were resident/patient were not present. A face-to-face interview with Employee #7 was conducted on June 11, 2009 at 1:30 PM. He/she acknowledged the above cited finding.	F 492		
F 514 SS=D	483.75(l) (1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514	<u>F 514 – 483.75(l) (1) Clinical Records</u> The Renaissance SFN maintains clinical records on each resident in accordance with accepted professional standards. During the survey, a problem area was identified that has been cited in this report. The following plan of correction addresses them. <u>Findings for Resident #1</u> 1. No further corrective action for this resident who has been discharged to home in good health. 2. Other residents had all mood and behavior monitoring initiated, assessed, reassessed, and documented correctly in the clinical record per policy.	7/10/09 7/26/09

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F 514	Continued From page 21 and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 12 sampled residents, it was determined that facility staff inconsistently documented on: behavior monitoring for one (1) resident receiving antipsychotic medication, administration of pain medication for one (1) resident and the status of wounds for two (2) residents. Residents #1, 5, and 10. The findings include: Facility policy entitled "Skin Protocol - Management of Residents at risk for Skin Breakdown and Presenting with Skin Breakdown" stipulated: page 5, "Specific Ulcer Interventions; Stage I, ...measure and document size, location and color ...do not use any dressings for intact skin of a stage I pressure area in order to monitor the pressure area site every shift. Stage II ...Document the pressure ulcer characteristics (size location, wound bed color, odor and appearance of the surrounding tissue) with each dressing change ...Measure weekly and document on pressure ulcer record." Facility policy entitled "Daily Behavior Symptom Checklist Guidelines" stipulated: "The Daily Behavior Symptoms Checklist is initiated when a resident exhibits behaviors(s) and symptoms identified on the Behavior/Symptom checklist or a resident is taking mood-altering medication such as anti-depressants, psychotropic medication and/or anti-psychotic medication ...documentation on form is completed every shift." 1. Facility staff failed to consistently document the	F 514	3. The following systemic changes have been or will put in place to ensure the deficient practices not recur and nursing staff was educated on the following: • All residents on psychoactive medications or with mood and behavior symptoms will have their behavior assessed and document on a shift-by-shift basis. • The Quality Nurse, DON, or her designee will review resident clinical record to ensure that the daily mood and behavior documentation is being completed on all residents with mood and behavior symptoms or on psychotropics on a daily basis. • In-service education was provided by the DON to the staff on the significance of addressing, monitoring, and documenting residents' mood and behavior. Education will be on-going. • The mood and behavior QA monitoring tool will be used to monitor compliance. • The nursing staff will review the MAR daily to assess for presence of psychotropics. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting. Findings for Residents #1 and #10 1. No further corrective actions are needed for residents #1 and #10 as they have been discharged to home. 2. Resident #5 and other residents on the unit have been assessed, measured for staging and documented appropriately in the Affinity computer system and on skin assessment sheets. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur and staff was educated on the following: • The nursing staff received additional training on wound care policy and procedures.	7/26/09 7/10/09 7/26/09 7/10/09 7/26/09 7/26/09 6/16/09

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F 514	Continued From page 22	F 514		

status of the Resident #1's pressure sores as per facility policy, consistently document the monitoring of behaviors and clarify the usage of pain medication.
A. According to documentation reviewed in the nurses' progress notes, redness on the left heel area was identified on May 25, 2009 and a Stage II pressure sore was identified on the back on June 2, 2009.
There was no documentation after the initial assessment of May 25, 2009 regarding the status of the left heel area. The left heel area was observed on June 10, 2009 at 4:10 PM. The skin was intact and there was no redness on the left heel area.
There was no evidence that facility staff documented weekly on the status of the resident's heel as per facility policy.
A physician's orders dated June 2, 2009 directed, "Cleanse pressure sore on back with normal saline and apply Mepilex dressing every 7 days."
The June 2009 Treatment Administration Record (TAR) revealed the treatment was applied on June 2, 2009 and the subsequent treatment was scheduled on June 9, 2009. The box annotated for the next wound treatment was June 9, 2009 and was blank, indicating that the treatment was not administered.
A face-to-face interview was conducted with Employee #2 on June 10, 2009 at approximately 4:30 PM. He/she stated that the resident's skin was currently intact. The site of the former pressure sore on the resident's back was observed in the presence of Employee #2 and was intact. Employee #2 acknowledged the lack of documentation related to the status of the resident's alteration in skin integrity.
The record lacked weekly documentation of the resident's left heel and that the Stage II pressure sore on the resident's back had heeled. The

Provider's Plan of Correction (F 514):

- The Quality Nurse or charge nurse will monitor the wound care skin assessment sheets every Wednesday to ensure wound staging and other characteristics are carried out as ordered.
- Direct observation will be conducted randomly to monitor compliance with wound care and documentation follow-through.
- Physician orders will be monitored daily to alert staff where wound care monitoring is indicated.
- Initial nursing assessments will be utilized to identify residents needing wound care to promote compliance with documentation in the clinical record and proper wound care orders.
- In-service by facility wound nurse will be scheduled.

4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting. — 7/26/09

Finding for Resident #5

1. Resident #5 remains on the unit at this time and the medication administration record and on-going pain assessment/reassessment sheet is now in compliance with documentation policy and procedures. — 7/10/09
2. Other residents' medication administration records and on-going pain assessment/reassessment records have been reviewed and are compliant. — 7/26/09
3. The following systemic changes have been or will be put in place to sure the same deficient practice will not recur and staff will be educated on the following: — 7/26/09

- Upon request for pain medication by the resident, the nurse will review the medication administration record, carry the record and assessment sheet to the Pyxis system, remove the medication, proceed to resident's room with both record and medication, check identification band, assess pain level, administer medication, and sign off on medication record and assessment sheet at the bedside. The action will be immediately documented.

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F 514	Continued From page 23 record was reviewed June 10, 2009. B. A review of the clinical record for Resident #1 revealed facility staff failed to consistently document the monitoring of behaviors in accordance with facility policy. According to physician's orders dated May 26, 2009, the resident's drug regimen included Remeron 7.5 mg at bedtime for depression, Risperdal 1/8 mg every 8 hours for agitation and Ativan 0.5 mg every 8 hours as needed for anxiety. The record revealed ongoing assessments by the psychiatrist and modifications in the psychotropic medication regimen. A review of the electronic documentation related to behavioral monitoring lacked evidence of consistent monitoring every shift as per facility policy. The electronic data was ascertained by Employee #2 and the findings reviewed and confirmed in the presence of this employee on June 10, 2009. The record was reviewed on June 10, 2009. C. A review of the clinical record for Resident #1 revealed licensed staff failed to clarify the indication for the usage of two (2) medications prescribed for pain. Physician's orders signed by the physician June 1, 2009 directed, "Percocet 1 tablet orally every 4 hours as needed for mild pain" and " Tylenol 325 mg 2 tablets orally every 4 hours as needed for mild pain." The medication administration record for June 2009 revealed Percocet was administered June 2, 3, 5, 6, 7 and 8, 2009. The record lacked evidence that licensed staff clarified between the uses of the two (2) medications, both prescribed for mild pain. The record was reviewed June 10, 2009. 2. Facility staff failed to consistently document on	F 514	• A stand-up in-service was provided to review proper medication administration process. • MedPass QA by direct observation will be conducted by the DON and/or Quality Nurse on a weekly basis. •In-service was done on assessment/ reassessment of pain medication for nursing staff. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance Committee meeting.	6/16/09 6/16/09 7/26/09

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F 514	Continued From page 24 the administration of pain medication for Resident #5. A review of Resident #5's record revealed a physician's order dated April 29, 2009 that directed, "Tylenol 650 mg every 4 hours as needed for mild pain." The resident was medicated with Tylenol on June 1, June 2, June 3, June 4 and June 8, 2008. According to the nurses' notes for June 1, 2, 3, 4 and 8, 2008, there was no documentation related to the resident's pain. Additionally, there were no entries on the "On-Going Pain Assessment" sheet for June 1, 2, 3, 4 and 8, 2008. A face-to-face interview was conducted with Employee #5 on June 11, 2009 at 10:30 AM. After reviewing the record, he/she acknowledged that documentation related to the resident's pain was not in the record for the above cited dates. The record was reviewed June 11, 2009. 3. Facility staff failed to consistently document the status of Resident #10's pressure sores as per facility policy. According to documentation reviewed in the nurses' progress notes, a Stage II lumbar pressure sore was identified on May 9, 2009. A nursing entry dated May 15, 2009 revealed the identification of a second pressure sore as follows, "Pressure ulcer site #2 @ spine." The documentation of May 15, 2009 lacked evidence of wound characteristics and/or staging. A subsequent nursing entry dated May 31, 2009 revealed pressure ulcer #1 was currently characterized as "Stage I, non-blanchable erythema of intact skin." The site was cleansed	F 514		

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

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F 514	Continued From page 25 with normal saline and Mepilex dressing was applied in accordance with physician's orders. The record lacked any further documentation related to the status of Resident #10's pressure sores. The electronic documentation related to the resident's pressure sores was obtained by Employee #2 on June 11, 2009 at approximately 3:00 PM. He/she stated that the resident's skin was currently intact. The record was reviewed June 11, 2009.	F 514		