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

POC accepted 7/18/06 Rec'd 7/3/06 SH

PRINTED: 06/15/2006
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
	095022	A. BUILDING _____ B. WING _____	05/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON NURSING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey was conducted on May 15 through 19, 2006. The following deficiencies were based on observations, record reviews and interviews with facility staff and residents. The sample included 30 records based on a census of 324 residents on the first day of survey and 17 supplemental records.	F 000	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the regulatory requirement of responding to these citations and to continue to provide quality resident care.	
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by : Based on record review and staff interview for five (5) of 30 sampled residents, it was determined that facility staff failed to address the possible reduction of restraints according to facility policy. Residents #1, 6, 12, 13 and 15. The findings include: According to the facility ' s policy, "Nursing Physical Restraints", policy #1404399A.000, dated August, 2005, page 2 under "Non-Emergency Restraints," #4, " The IDC (interdisciplinary care) team will review the restraint care plan at least monthly or as state regulation and document a systematic and gradual process toward reducing restraint ... " 1. Facility staff failed to complete the monthly restraint elimination for Resident #1.	F 221	**483.13(a) PHYSICAL RESTRAINTS** Residents #1, 6, 12, 13, and 15 1. Residents cited at the time of the survey have had their restraint elimination assessments and care plans updated. The facility's IDT team will assess these residents for restraint reduction each month to ensure that the residents are in the least restrictive and most appropriate device possible. 2. All other residents with restraints have been evaluated using the facility's restraint elimination assessment policy. Their care plans were updated as needed. The facility's IDT team will assess for restraint reduction each month to ensure that the residents are in the least restrictive and most appropriate device possible. 3. The nursing staff and IDT members were inserviced on the restraint reduction policy to ensure their understanding and compliance. The Clinical Mangers and Assistant Clinical Managers on each unit will monitor their residents to ensure that the facility's restraint reduction policy is followed with assessments done monthly.	6/30/06 6/30/06 6/30/06

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

Administrator 7/2/2006

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 221	Continued From page 1 A review of Resident #1's record revealed that the care plan was updated on April 18, 2006. According to care plan problem #9, "Use of Safety Device" under "Approaches" the following was checked, "Evaluate use of restraint every month." A "Restraints Elimination- Monthly Assessment" form was present in the record and was dated January 10, 2006. There were no additional restraint elimination forms in the record. A face-to-face interview was conducted with the charge nurse on May 17, 2006 at 9:30 AM. He/ she acknowledged that the restraint elimination form was not completed after January 2006. The record was reviewed May 15, 2006. 2. A review of Resident #6's record revealed that facility staff failed to reevaluate the resident for possible elimination of a seatbelt restraint. The care plan for Problem #20, " Use of Safety Device " with an origination date of March 13, 2005 and most recently updated April 2006 included the following: " Seatbelt (button release). Evaluate use of restraint every month. Address the possible reduction/discontinuation of restraint at IDT [interdisciplinary team] conference . A "Restraints Elimination- Monthly Assessment " form dated August 1, 2005 included: "Is the resident a candidate for restraint release program? No. " This was the only monthly assessment form found in the chart. The IDT conference summaries were reviewed	F 221	4. The Director of Nurses will oversee the monitoring of the nursing and IDT staffs. The results of her monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee which is chaired by the Administrator.	6/30/06

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F 221	Continued From page 2 for August 2 and November 1, 2005 and January 31 and April 25, 2006. The summaries failed to include reference to the possible reduction/ discontinuation of the restraint. The record was reviewed on May 16, 2006. 3. A review of Resident #12's record revealed that facility staff failed to reevaluate the resident for possible elimination of a seatbelt restraint. The care plan for Problem #13, " Use of Safety Device " with an origination April [date was illegible], 2005 and most recently updated March 21, 2006 included the following: " Seatbelt (button release). .. Address the possible reduction/ discontinuation of restraint at IDT conference... " A " Restraints Elimination- Monthly Assessment " form dated June 14, 2005 included: " Is the resident a candidate for restraint release program? No. " This was the only monthly assessment form found in the chart. The IDT conference summaries were reviewed for July 5, September 28 and December 27, 2005 and March 21, 2006. The summaries failed to include reference to the possible reduction/ discontinuation of the restraint. The record was reviewed on May 16, 2006. 4. Facility staff failed to do a monthly restraint evaluation for possible elimination or reduction for resident #13. A review of resident # 13's record, " Interdisciplinary Care Plan updated April 13, 2006 problem # 8 use of safety device seatbelt (button release), geri chair. Approaches were to evaluate	F 221		

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F 221	Continued From page 3 the use of restraint every month, address the possible reduction/discontinuation of restraint at IDT conference." A review of nursing monthly notes dated January 16, 2006 indicated, "Up in geri chair with lap tray on every morning, February 28, 2006 has order for geri chair with lap tray to be used when resident is out of bed in chair, March 15, 2006 up in Geri chair every day with lap tray on, and April 27, 2006 has Geri chair when out of bed with lap tray on to be removed for repositioning and incontinent care." There was no evidence in the record that the resident was assessed monthly for restraint reduction and possible elimination. A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 10:00 AM. He/ she acknowledged that there was no monthly assessment for the reduction or elimination of restraint in the record. The record was reviewed May 19, 2006. 5. A review of Resident #15's record revealed that facility staff failed to reevaluate the resident for possible elimination of a seatbelt restraint. The care plan for Problem #11, "Use of Safety Device " with an origination date of March 13, 2005 and most recently updated April 2006 included the following: "Seatbelt (velcro). .. Evaluate use of restraint. Address the possible reduction/discontinuation of restraint at IDT conference..." The "Restraints Elimination- Monthly Assessment " forms dated November 9, 2005 and January 3, 2006 included: "Is the resident a	F 221		

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F 221	Continued From page 4 candidate for restraint release program? "No" was listed for November 9, 2005; however, there was no answer for January 3, 2006. These were the only monthly assessment forms found in the chart. The IDT conference summaries were reviewed for July 5 and October 4, 2005 and January 3 and March 28, 2006. The summaries failed to include reference to the possible reduction/ discontinuation of the restraint. The record was reviewed May 16, 2006.	F 221	**483.15(h)(2) HOUSEKEEPING/MAINTENANCE** Door Jambs 1. The door jambs cited at the time of the survey have been repaired and/or painted. 2. All door jambs have been evaluated and repaired/repainted as needed. 3. The Maintenance Supervisor will evaluate the door jambs on a monthly basis, scheduling repainting or repair as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/30/06 6/30/06 6/30/06 6/30/06
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidence by: marred entrance and bathroom doors; soiled HVAC units; marred and damaged wall surfaces; an abundance of personal items in residents' rooms; damaged Venetian blinds; urine odors; accumulated dust in the gas dryer; supplies stored under the sink; soiled and/or torn privacy curtains; soiled and stained ceiling tiles; soiled and damaged baseboards; soiled sprinkler heads; damaged HVAC units; soiled exhaust vents; soiled parallel bars in the Rehabilitation	F 253	HVAC units 1. The HVAC units cited at the time of the survey have been thoroughly cleaned. 2. All HVAC units have been evaluated and cleaned when necessary. 3. The Housekeeping Supervisors evaluate the HVAC units on a monthly basis, scheduling their cleaning as needed. He will report his findings to the Director of Environmental Services. 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality	6/30/06 6/30/06 6/30/06 6/30/06

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F 253	Continued From page 5 Department; mops and buckets stored on the floor; soiled wheelchairs, straight back chairs and dining room table legs; and worn and torn arm surfaces of geri chairs. These findings were observed in the presence of the Directors of Housekeeping and Maintenance and nursing staff . The findings include: 1. Entrance and bathroom doors and door jams were marred on the frontal and rear surfaces in the following areas: 1 North rooms: 111 and tub room in two (2) of 10 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms: 106, 110, 122, 146, 160, supply room and shower room in seven (7) of 15 observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 North rooms: 209, 211, 215, 233, 237, 245, shower room and pantry in eight (8) of 16 observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 212, 232, and 238 in three (3) of eight (8) observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 305, 313, 323 and 327 in four (4) of nine (9) observations on May 18, 2006 from 8: 30 AM to 11:45 AM. 3 South rooms: 312, 326, 340, 348 and tub room in five (5) of nine (9) observations on May 18,	F 253	Improvement Committee, which is chaired by the Administrator. Wall surfaces 1. The wall surfaces cited at the time of the survey have been repaired and/or painted. 2. All wall surfaces have been evaluated and repaired/repainted as needed. 3. The Maintenance Supervisor will evaluate the wall surfaces on a monthly basis, scheduling repainting or repair as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Personal Items 1. The abundance of personal items cited at the time of the survey have been organized and/or removed and stored. 2. All residents with an abundance of personal items have been addressed and their items reorganized or stored as needed. 3. The Maintenance Supervisor will evaluate the abundance of personal items on a monthly basis, scheduling the reorganization and/or storing as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will	6/30/06 6/30/06 6/30/06 6/30/06 5/19/06 6/30/06 6/30/06 6/30/06

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F 253	Continued From page 6 2006 from 1:48 PM to 4:54 PM. Laundry room in one (1) of one (1) observation on May 18, 2006 at 5:50 PM. 2. HVAC units were soiled in the following areas: 1 North rooms: 105, 111, 113, 139, 141, 151, 159 and dining room in eight (8) of 13 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms, 106, 110, 114, 142, 144, and 154 in six (6) of 12 observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 North rooms: 203, 209, 215, 225, 233, 245 and 253 in seven (7) of 14 observations on May 17, 2006 from 2:33 PM to 4:54 PM. 2 South rooms: 226, 232, 236 and 238 in four (4) of seven (7) observations on May 17, 2006 from 2 :33 PM to 4:54 PM. 3 North rooms: 309, 313, 327, 335 and 353 in five (5) of 11 observations on May 18, 2006 from 8:30 AM to 11:45 PM. 3 South rooms: 312, 326 and 340 in three (3) of six (6) observations on May 18, 2006 from 1:48 PM to 4:54 PM. 3. Wall surfaces were marred and damaged in the following areas: 1 North rooms: 105, 111, 113, 123, 125, 141, 139 , toilet room, linen room and pantry in 10 of 17 observations on May 15, 2006 from 11:20 AM to 1:30 PM.	F 253	oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Venetian blinds 1. The Venetian blinds cited at the time of the survey have been repaired and/or replaced as needed. 2. All Venetian blinds have been evaluated and repaired/replaced as needed. 3. The Maintenance Supervisor will evaluate the Venetian blinds on a monthly basis, scheduling their repair or replacement as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Urine Odors 1. The urine odors noticed at the time of the survey have been addressed and eliminated. 2. All areas of the facility have been evaluated for the presence of odors and addressed as necessary. 3. The Nursing, Housekeeping, and Maintenance Supervisors will evaluate the cause of any odors on a monthly basis, scheduling inservices, ventilation repair,	6/30/06 6/30/06 6/30/06 6/30/06 5/19/06 6/30/06 6/30/06

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F 253	Continued From page 7 1 South rooms: 106, 114, 116, 122, 132, 142, 146 , 154, toilet room and dining room in 10 of 10 observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 North rooms: 203, 233 and 237 in three (3) of nine (9) observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 210, 212, 220, and tub room in four (4) of seven (7) observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 313, 353, hallway on H side and dining room in four (4) of nine (9) observations on May 18, 2006 from 8:30 AM to 11:45 PM 4. An abundance of personal items were in residents' rooms beside the bed and on the floor in the following areas: room 210 and 348 in two (2) of two (2) observations on May 17, 2006 at 2:38 PM and May 18, 2006 at 1:50 PM. 5. Venetian blinds were damaged in the following areas: 1 North rooms: 111, 113, 123, and 145 in four (4) of 10 observations May 15, 2006 from 11:20 AM to 1:30 PM. 1 South room 106 in one (1) of seven (7) observations on May 17, 2006 from 8:40 AM to 11:30 PM. 2 North rooms: 209, 211, 225, 233 and 245 in five (5) of eight (8) observations on May 17, 2006 from 11:33 AM to 2:30 PM.	F 253	or cleaning as needed. They will report their findings to their respective department heads. The facility implemented a new practice of providing disposable (rather than reusable) incontience products to its residents. This was done both for acceptability by the residents and staff as well as odor control. 4. The Directors of Nursing, Maintenance and Housekeeping will oversee the monitoring of the presence of odors. The results of their monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Interior of the dryer 1. The interior of the dryer cited at the time of the survey have been thoroughly cleaned. 2. All dryers have been evaluated and cleaned routinely through the day. 3. The Housekeeping Supervisors evaluate the interior of the dryers on a frequent basis, scheduling their cleaning as needed. He will report his findings to the Director of Environmental Services. 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Storing of supplies	6/30/06 5/19/06 5/19/06 6/30/06 6/30/06 revision required

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F 253	Continued From page 7 1 South rooms: 106, 114, 116, 122, 132, 142, 146 , 154, toilet room and dining room in 10 of 10 observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 North rooms: 203, 233 and 237 in three (3) of nine (9) observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 210, 212, 220, and tub room in four (4) of seven (7) observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 313, 353, hallway on H side and dining room in four (4) of nine (9) observations on May 18, 2006 from 8:30 AM to 11:45 PM 4. An abundance of personal items were in residents' rooms beside the bed and on the floor in the following areas: room 210 and 348 in two (2) of two (2) observations on May 17, 2006 at 2:38 PM and May 18, 2006 at 1:50 PM. 5. Venetian blinds were damaged in the following areas: 1 North rooms: 111, 113, 123, and 145 in four (4) of 10 observations May 15, 2006 from 11:20 AM to 1:30 PM. 1 South room 106 in one (1) of seven (7) observations on May 17, 2006 from 8:40 AM to 11:30 PM. 2 North rooms: 209, 211, 225, 233 and 245 in five (5) of eight (8) observations on May 17, 2006 from 11:33 AM to 2:30 PM.	F 253	or cleaning as needed. They will report their findings to their respective department heads. The facility implemented a new practice of providing disposable (rather than reusable) incontience products to its residents. This was done both for acceptability by the residents and staff as well as odor control. 4. The Directors of Nursing, Maintenance and Housekeeping will oversee the monitoring of the presence of odors. The results of their monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. 6/30/06 Interior of the dryer 1. The interior of the dryer cited at the time of the survey have been thoroughly cleaned. 5/19/06 2. All dryers have been evaluated and cleaned every 2 hours. 5/19/06 7/17/06 3. The Housekeeping Supervisors evaluate the interior of the dryers on a frequent basis, scheduling their cleaning as needed. He will report his findings to the Director of Environmental Services. 6/30/06 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. 6/30/06 Storing of supplies	

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F 253	Continued From page 8 2 South rooms 226, 232 and dining room in three (3) of 11 observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 313, 327, 349, 335 and 353 in five (5) of 10 observations on May 18, 2006 from 8:30 Am to 11:45 PM. 3 South rooms: 326 and 334 in two (2) of five (5) observations on May 18, 2006 from 1:48 PM to 4: 54 PM. 6. Urine odors were detected throughout the facility in the following areas during the survey period: first and third floor hallways near the main elevator, second floor hallway by the Rehabilitation Department and residents' rooms 106, 110, 111, 139, 145, 220, 228, 236, 253, 326, 334 and 353. 7. The interior of a gas dryer had accumulated dust in one (1) of one (1) observation on May 18, 2006 at 5:50 PM. 8. Supplies were stored under the sink in the following areas: 3 South janitor's closet, Rehabilitation Department and room 334 in three (3) of 11 observations throughout the survey period. 9. Soiled and/or torn privacy curtains were observed in the following areas: residents' rooms 116, 132, 145, 209, 225, 233 and 313 and the Rehabilitation Department in eight (8) of 26 observations throughout the survey period. 10. Ceiling tiles were soiled and stained in the	F 253	1. All areas noted at the time of the survey where supplies were inappropriately stored have been cleaned and supplies stored in an appropriate place. 2. Other similar areas have been evaluated for inappropriately stored supplies. The areas were cleaned when necessary and supplies moved to a safe and secure area. 3. The Housekeeping Supervisors evaluate the storage of supplies on a monthly basis, scheduling their cleaning and organization as needed. He will report his findings to the Director of Environmental Services. 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Privacy curtains 1. The privacy curtains cited at the time of the survey have been thoroughly cleaned and repaired when necessary. 2. All privacy curtains have been evaluated and clean/repaired when necessary. 3. The Housekeeping Supervisors evaluate the condition of the privacy curtains on a monthly basis, scheduling their cleaning and repair as needed. He will report his findings to the Director of Environmental Services. 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any	5/19/06 6/20/06 6/20/06 6/20/06 6/20/06 6/20/06 6/20/06

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F 253	Continued From page 9 following areas: 1 North rooms: 113, 123, 145, 149, 159, hallway, shower room, toilet room and pantry in nine (9) of 15 observations on May 15, 2006 from 11:20 AM to 1:30 PM, 1 South rooms: 104, 132, 142, 146, 160, toilet room, supply room and dining room in eight (8) of 17 observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 North rooms: 203, 205, 211, 215, 225, 233, 237 , dining room, pantry, Rehabilitation Department and soiled utility room in 11 of 13 observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 210, 212, 238, and janitor's closet in four (4) of 10 observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 305 and 349 in two (2) of seven (7) observations on May 18, 2006 from 8:30 AM to 11:45 PM. 3 South room 312 in one (1) of six (6) observations on May 18, 2006 from 1:48 PM to 4: 54 PM. 11. Baseboards were soiled and damaged in the following areas: 1 North rooms: 123, 125, 145, dining room and lounge in five (5) of 11 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms: 110, 122, 142, and toilet room in four (4) of nine (9) observations on May 17, 2006	F 253	action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Ceiling Tiles 1. The ceiling tiles cited at the time of the survey have been replaced. 2. All ceiling tiles have been evaluated and replaced when necessary. 3. The Maintenance Supervisor evaluates the ceiling tiles on a daily basis, scheduling their replacement as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Baseboards 1. The baseboards cited at the time of the survey have been cleaned and/or replaced. 2. All baseboards have been evaluated and cleaned or replaced when necessary. 3. The Maintenance and Housekeeping Supervisors evaluate the baseboards on a daily basis, scheduling their cleaning or replacement as needed. They will report their findings to their respective department heads.	5/19/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06

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	095022	A. BUILDING _____ B. WING _____	05/19/2006

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F 253	Continued From page 10 from 8:40 AM to 11:30 AM. 2 North rooms: 233, 237, 245 and soiled utility room in four (4) of 11 observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 220, 238 and dining room in three (3) of six (6) observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 321 and dining room in two (2) of seven (7) observations on May 18, 2006 from 8: 30 AM to 11:45 PM. 3 South room 302 in one (1) of nine (9) observations on May 18, 2006 from 1:48 PM to 4: 54 PM. 12. Sprinkler heads were soiled with dust and debris in rooms 110 and 151 in two (2) of 22 observations during the survey period. 13. HVAC units were damaged in the following areas: 1 North rooms: 111, 113, 145, 151 and the dining room in five (5) of 11 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms 142 and 146 in two (2) of six (6) observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 South rooms 210, 236 and the dining room in three (3) of nine (9) observations on May 17, 2006 at 3:30 PM. 3 North rooms 309 and the dining room in two (2)	F 253	4. The Directors of Housekeeping and Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Sprinkler Heads 1. The sprinkler heads cited at the time of the survey have been dusted. 2. All sprinkler heads have been evaluated and dusted when necessary. 3. The Maintenance Supervisor evaluates the sprinkler heads on a monthly basis, scheduling their dusting as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Damaged HVAC units 1. The HVAC units cited at the time of the survey have been repaired or replaced. 2. All HVAC units have been evaluated and repaired or replaced as deemed necessary. 3. The Maintenance Supervisor evaluates the interior of the HVAC units on a monthly basis, scheduling their repair or	6/30/06 5/19/06 6/30/06 6/30/06 6/30/06 5/19/06 6/30/06 6/30/06 nurses' report

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F 253	Continued From page 10 from 8:40 AM to 11:30 AM. 2 North rooms: 233, 237, 245 and soiled utility room in four (4) of 11 observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 220, 238 and dining room in three (3) of six (6) observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 321 and dining room in two (2) of seven (7) observations on May 18, 2006 from 8: 30 AM to 11:45 PM. 3 South room 302 in one (1) of nine (9) observations on May 18, 2006 from 1:48 PM to 4: 54 PM. 12. Sprinkler heads were soiled with dust and debris in rooms 110 and 151 in two (2) of 22 observations during the survey period. 13. HVAC units were damaged in the following areas: 1 North rooms: 111, 113, 145, 151 and the dining room in five (5) of 11 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms 142 and 146 in two (2) of six (6) observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 South rooms 210, 236 and the dining room in three (3) of nine (9) observations on May 17, 2006 at 3:30 PM. 3 North rooms 309 and the dining room in two (2)	F 253	4. The Directors of Housekeeping and Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Sprinkler Heads 1. The sprinkler heads cited at the time of the survey have been dusted. 2. All sprinkler heads have been evaluated and dusted when necessary. 3. The Maintenance Supervisor evaluates the sprinkler heads on a monthly basis, scheduling their dusting as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Damaged HVAC units 1. The HVAC units cited at the time of the survey have been repaired or replaced. 2. All HVAC units have been evaluated and repaired or replaced as deemed necessary. 3. The Maintenance Supervisor evaluates the interior of the HVAC units on a monthly basis, scheduling their repair or replacement as needed. 7/17/07 gs	6/30/06 5/19/06 6/30/06 6/30/06 6/30/06 5/19/06 6/30/06 6/30/06

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F 253	Continued From page 11 of eight (8) observations on May 18, 2006 from 8: 30 AM to 11:45 AM. 14. The interior surfaces of exhaust vents were soiled in the following areas: 1 North rooms: 105, 123, 125, 139, and 153 in five (5) of 11 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms: 110, 114, 142, 160 and toilet room in five (5) of nine (9) observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 North rooms: 209, 233, and staff bathroom in three (3) of five (5) observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 212, 232 and 238 in three (3) of 12 observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 305, 309, 335 and 353 in four (4) of eight (8) observations May 18, 2006 from 8:30 AM to 11: 45 AM. 3 South rooms: 312, 326 and 334 in three (3) of seven (7) observations on May 18, 2006 1:48 PM to 4:54 PM. 15. The flat surfaces of parallel bars in the Rehabilitation Department were soiled and stained in one (1) of one (1) observation on May 17, 2006 at 12:30 PM. 16. Mops and buckets were soiled and stored on the floor in the janitor's closet on 1 North, 2 North, 2 South, 3 North and 3 South in five (5) of six (6)	F 253	4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Interior surfaces of the exhaust vents 1. The interior surfaces of the exhaust vents cited at the time of the survey have been cleaned. 2. All interior surfaces of exhaust vents have been evaluated and cleaned when necessary. 3. The Maintenance Supervisor evaluates the interior surfaces of the exhaust vents on a quarterly basis, scheduling their routine cleaning as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Flat surfaces of the parallel bars 1. The flat surfaces of the parallel bars cited at the time of the survey have been cleaned. 2. All therapy equipment was evaluated for cleanliness and cleaned as necessary. 3. The Housekeeping Supervisor evaluates	6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 5/19/06 6/30/06 6/30/06

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F 253	Continued From page 14.	F 253	Improvement Committee, which is chaired by the Administrator. Arm surfaces of geri-chairs 1. The arm surfaces of geri-chairs cited at the time of the survey have been replaced. 2. All arm surfaces of geri-chairs have been evaluated and replaced when necessary. 3. The Maintenance Supervisor evaluates the arm surfaces of geri-chairs on a routine basis, scheduling their replacement as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	7/2/06 7/2/06 7/3/06 6/30/07

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F 253	Continued From page 12 observations during the survey period. 17. Wheelchairs were soiled on the spoke and frame surfaces and arms were worn in the following areas: 1 South rooms: 106, 110 and 146 in three (3) of 13 observations on May 17, 2006 at 8:40 AM to 11:30 AM. 2 North rooms: 209 and 215 in two (2) of 11 observations on May 18, 2006 at 11:33 AM to 2: 30 PM. 2 South room 338 in one (1) of five (5) observations on May 17, 2006 from 2:33 PM to 4: 54 PM. 3 North rooms: 305, 321, 349, and 357 in four (4) of eight (8) observations on May 18, 2006 from 8: 30 AM to 11:45 AM. 3 South rooms 326 and 334 in two (2) of seven (7) observations on May 18, 2006 at 1:48 to 4:54 PM. 18. Residents' straight back chairs were soiled on seat surfaces in three (3) of 11 observations on 3 North on May 18, 2006 from 8:30 AM to 11:45 AM and three (3) of 14 observations in 1 North lounge on May 15, 2006 from 11:20 AM to 1:30 PM. 19. Dining room table legs were soiled with dust and food in the 3 North dining room in 18 of 20 observations on May 18, 2006 from 8:30 AM to 11:45 PM. 21. Arm surfaces of geri chairs were torn and	F 253	the rehabilitation equipment on a monthly basis, scheduling their cleaning as needed. He will report his findings to the Director of Environmental Services. 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Storage of mops and buckets 1. The storage problems of mops and buckets cited at the time of the survey have been corrected. 2. All janitor's closets have been evaluated for the proper storage of mops and buckets and inservices were given when necessary to ensure compliance. 3. The Housekeeping Supervisor evaluates the janitor's closets on a daily basis, to ensure compliance in the storage of mops and buckets. Inservicing will be done for the floor maintenance staff regarding proper storage. He will report his findings to the Director of Maintenance. 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/30/06 6/30/06 6/30/06 6/30/06

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F 253	Continued From page 13 worn in rooms 220 and 253 during the survey period.	F 253	Soiled Wheelchairs and Straight Back Chairs 1. The wheelchairs and straight back chairs cited at the time of the survey have been cleaned. 2. All wheelchairs and straight back chairs have been evaluated and cleaned routinely and as needed. 3. The Housekeeping Supervisor evaluates the wheelchairs and straight back chairs on a daily basis, scheduling their cleaning outside of their routine schedule as needed. He will report his findings to the Director of Housekeeping. 4. The Director of Housekeeping will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Dining room table legs 1. The Dining room table legs cited at the time of the survey have been cleaned. 2. All Dining room table legs have been evaluated and cleaned when necessary. 3. The Housekeeping Supervisor evaluates the Dining room table legs on a routine basis, scheduling their cleaning as needed. He will report his findings to the Director of Environmental Services 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality	6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06

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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for three (3) of 30 sampled residents, it was determined that facility staff failed to assess conditions identified (triggered) on the Minimum	F 272	**483.20 (b)** **COMPREHENSIVE ASSESSMENTS** Residents #6, 8 an 15 1. Those conditions which were not assessed at the time of the survey have been corrected. 2. The RAPs of all residents were reviewed to ensure that each resident received a comprehensive assessment and that all areas of the MDS process were in compliance. 3. Inservicing was done for the staff responsible for the MDS/Care planning process. The Clinical Managers and ADONs will monitor for compliance on assessment of conditions triggered on the MDS. They will report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/30/06 6/30/06 6/30/06 6/30/06

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F 272	Continued From page 15 Data Set (MDS) in Section V, " Resident Assessment Protocol " (RAPs). Residents #6, 8, and 15. The findings include: According to the, " MDS 2.0 User's Manual " page 4 -1, " The goal of the RAPS is to guide the interdisciplinary team through a structured comprehensive assessment of a resident's functional status ...The MDS alone does not provide a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident problems, strengths and preferences. The RAPs are problem-oriented frameworks for additional assessment based on problem identification items (triggered conditions). " 1. A review of Resident #6's annual MDS (Minimum Data Set) completed April 25, 2006 revealed that the RN (Registered Nurse) failed to indicate which RAP (Resident Assessment Protocol) problem areas were addressed in the care plan. Section VAb (Care Planning Decision), of the Resident Assessment Protocol Summary, did not have any RAP problem areas checked to be addressed in the care plan. VB3 (Signature of Person Completing Care Planning Decision) and VB4 (Care Plan Decision Completion Date) were signed by the RN as completed on April 25, 2006. The record was reviewed on May 16, 2006. 2. Facility staff failed to perform additional assessments on the identified (triggered) items in Section V, " Resident Assessment Protocol " for	F 272		

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F 272	Continued From page 16 Resident #8. A review of the significant change MDS completed October 6, 2005 revealed a "RAP Narrative Report" containing the following: " Cognitive Loss - Trigger continue to be addressed under CP (care plan) #4; Urinary Incontinence/ Indwelling Catheter - trigger is addressed under CP #5; Falls - Trigger is addressed under CP #3." The facility failed to perform additional assessments for the above identified (triggered) items. A face-to-face interview with the charge nurse was conducted on May 16, 2006 at 3:30 PM. He/ she acknowledged that the RAPs did not include further assessments on the identified (triggered) areas. The record was reviewed May 16, 2006. 3. A review of Resident #15's annual MDS revealed that the RN failed to indicate which RAP problem areas were triggered and failed to date VB2 and VB4 and sign at VB3. The annual MDS dated March 28, 2006 at Section VAa (RAP problem area check if triggered) did not have any RAP problems checked. Section VB2 (RAPS completion date) was not dated and Section VB3 and VB4 were not signed and dated. The record was reviewed on May 16, 2006.	F 272		

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F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by : Based on observation, record review, and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to complete a quarterly Minimum Data Set that was due in February 2006. Resident #10. The findings include: A review of Resident #10's record revealed that he/she was admitted to the facility on July 21, 2005. An admission MDS was completed on August 4, 2005. A quarterly MDS was completed on November 7, 2005. A quarterly MDS was due in February 2006. A face-to-face interview was conducted with the Assistant Unit Manager on May 15, 2006 at 8:50 AM. He/she acknowledged that a quarterly MDS should have been done in February. The record was reviewed May 15, 2006.	F 276	**483.20©** **QUARTERLY REVIEW ASSESSMENT** Resident #10 1. The quarterly assessment not completed at the time of the survey was done immediately upon discovery. 2. The timeliness of all quarterly MDSs was evaluated and adjustments made as necessary. 3. The Clinical Managers will monitor the timeliness of the quarterly MDSs on their units. They will report their findings to the DON. Additionally, inservicing has been done for all staff involved in completing the MDS in a timely fashion. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/19/06 6/30/06 6/30/06 6/30/06

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F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for five (5) of 30 sampled residents and one (1) supplemental resident, it was determined that the Registered Nurse (RN) failed to: sign and ate the Minimum Data Set (MDS) as completed after the assessors for two (2) residents and accurately code the MDS assessment for one (1)	F 278	**F 278(g)-(j)** **RESIDENT ASSESSMENT** Residents #5, 6, 12, 15, 21, W3 1. Errors in timing of the RN signature, and of inaccurate coding and omissions on the MDS found at the time of the survey were all corrected upon discovery. 2. All current MDSs will be evaluated for similar error and omissions and adjustments made as necessary. 3. The Clinical Managers will monitor their unit's MDSs for accuracy and completeness. They will report their findings to the DON. Additionally, inservicing was done for the staff involved in the completion of the MDS to ensure their understanding of the errors and corrections. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/19/06 7/2/06 6/30/06 6/30/06

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F 278	Continued From page 19 resident with weight loss, one (1) resident for ostomy care, one (1) resident for resisting care and one (1) resident for an antibiotic resistant infection. Residents #5, 6, 12, 15, 21 and W3. The findings include: 1. The registered nurse failed to sign after the other assessors completed their portions of the MDS for Resident #5. A review of Resident #5's record revealed a quarterly MDS assessment was signed in Section R, "Assessment Information" as completed by the RN coordinator on September 24, 2006. In Section AA," Signature of Persons who completed a Portion of the Accompanying Assessment or Tracking Form," the licensed practical nurse, social worker, dietician and activities therapist signed on September 26, 2005 . According to the, " MDS 2.0 User's Manual," page 3-212, "The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS." A face-to-face interview was conducted with the clinical manager on May 15, 2006 at 1:05 PM. He /she acknowledged that the above identified disciplines signed after the RN coordinator's signature. The record was reviewed May 15, 2006. 2. A review of Resident #6's annual MDS (Minimum Data Set) revealed that the RN (	F 278		

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Registered Nurse) failed to date the MDS at R2b (Date RN assessment Coordinator signed as complete) after all other assessors finished their portions of the MDS.

The most recent annual MDS was signed (R2a) and dated (R2b)as complete on April 25, 2006. At Section AA9 (Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form) four (4) disciplines signed and dated on May 3, 2006.

The RN failed to sign and attest to completion of the assessment after all other disciplines finished their portions of the MDS. The record was reviewed on May 16, 2006.

3. A review of Resident #12' s record revealed that facility staff inaccurately coded the quarterly MDS for weight loss.

The most recent MDS dated March 21, 2006 at Section K3a coded weight loss-5% or more in last 30 days; or 10% or more in last 180 days.

A review of the " Vital Sign Flow Sheet " revealed the following:

Date	Weight
9/15/05	148
10/15/05	141
11/15/05	145
12/15/05	148
1/14/06	152
2/06	no weight reported
3/06	no weight reported

A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 2:38 PM. He/

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F 278	Continued From page 21 She acknowledged the missing weights for February and March 2006. The " Vital Sign Flow Sheet " failed to show a loss of weight of 5% from February 21 through March 21, 2006 due to no weight recorded for February or March 2006 and a loss of weight of 10% from September 15, 2005 through March 21, 2006. The record was reviewed on May 16, 2006. 4. A review of Resident #15's record revealed that facility staff failed to code ostomy care on the most recent annual MDS. The annual MDS dated March 28, 2006 at Section K5b (Oral/Nutritional Status) included a feeding tube. Section P1f (Special treatments and Procedures) failed to indicate ostomy care. The February and March 2006 TAR (Treatment Administration Records) indicated [by initials] that the resident received ostomy care. The record was reviewed on May 16, 2006. 5. Facility staff inaccurately coded Resident #21 for resisting care on the quarterly MDS dated April 17, 2006. A review of the quarterly MDS completed April 17, 2006 coded Resident #21 in Section E4, " Behavioral Symptoms " as " 1 - behaviors of this type occurred 1 to 3 days in the last 7 days. " According to the, " MDS 2.0 User ' s Manual " page 3-66, " [The] Intent [of this section is] To identify (A) the frequency and (B) the alterability of behavioral symptoms in the last seven days that cause distress to the resident, or are distressing or disruptive to facility residents or	F 278		

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F 278	Continued From page 22 staff members." The assessment reference date (end-point for a common observation period) was April 10, 2006. The nurses ' notes were reviewed from April 3 through 10, 2006. There was no evidence that Resident #21 resisted care during the identified time frame. According to the, " Interdisciplinary Summary, " which was a record of the discussion at care conference, dated April 11, 2006, under, " Problem 17: Resident has not exhibited behaviors unbecoming, but is monitored for [them]. " The record was reviewed May 17, 2006. 6. A review of Resident W3's record revealed that facility staff failed to accurately code the MDS for an antibiotic resistance infection. The annual MDS dated December 12, 2006 Section I2 (Infections) failed to code for antibiotic resistant infection The "Physician's Order Form" for May 2006 included the following: "Contact isolation secondary to MRSA eye discharge" [origination order date of October 17, 2005]. A physician's progress note dated December 6, 2005 included the following: Eye follow-up. Dx (Diagnosis) MRSA (Methicillin Resistant Staphylococcus Aureus of conjunctiva OD (right eye) ..." The Interdisciplinary Summary dated December 14, 2005 included the following: "...Problem #22 Contact Isolation secondary to MRSA - eye	F 278		

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F 278	Continued From page 23 discharge - antibiotic eye drop completed 12/13/05, repeat culture and sensitivity of right eye discharge due 12/15/05. Maintained on contact isolation." The record was reviewed on May 18, 2006.	F 278	**483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS** Resident #6 1A. 1. The family member of resident #6 received the facility's apologies for the oversight and assurances that she will be personally contacted for future meetings. 2. The social worker will document the communication which invites the resident and/or responsible party to the care planning meetings. 3. The unit clerks have included the evidence of this communication in their monthly audits of the medical records. They will report their findings to the Clinical Managers. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. 1B. 1. The approaches implemented for the use of psychoactive medications have been added to this resident's care plan. 2. The care plan for similar residents on psychoactive medications have been checked to ensure that approaches are in place 3. The Clinical Managers will monitor their unit's care plans for accuracy and completeness. They will report their findings to the DON. Additionally, inservicing was done for the staff involved in the completion of the care plans to ensure their understanding of the errors	7/2/06 7/2/06 7/1/06 6/30/06 5/31/06 6/30/06 6/30/06
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by : Based on observation, record review, and staff interview, for two (2) of 30 sampled residents, it was determined that facility staff failed to: invite the responsible party (RP) to the care planning	F 279		

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F 279	Continued From page 24 conferences and indicate which approaches were to be used on the psychoactive medication care plan for one (1) resident and develop a care plan for one (1) resident on hospice care. Residents # 6, and 24. The findings include: 1. A review of Resident #6's record revealed that facility staff failed to invite the responsible party to the care planning conferences and indicate on the care plan for psychoactive medications which approaches were to be implemented. A. Facility staff failed to invite the responsible party to the care planning conferences. The facility policy "Social Work Care Planning Conferences" #1702020A.000 included the following: " ...The care plan must be prepared by an interdisciplinary team ...and when practical the participation of the resident, the resident ' s family, significant other or responsible party. #3. The family will designate a staff member to send an invitation to families or legal representatives two weeks prior to the scheduled conference ... " A telephone interview was conducted with the responsible party on May 19, 2006 at 10:00 AM. He/She stated, " I come to the facility every-other -day around 1:00 PM. They [facility] just had one [care planning conference] last month. Before that they hadn't had one for over one year. I did get a letter for the recent one and when they have one they invite me. " The Interdisciplinary Summaries included the following:	F 279	and corrections. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. 2. Resident #24 1. The hospice care plan was initiated immediately upon discovery and integrated into the facility's care plan by the Clinical Manger on that unit. 2. The care plans of any other residents on Hospice were evaluated to ensure that the Hospice program's care plan was integrated with the facility's care plan. 3. The Clinical Managers were inserviced on ensuring current and accurate updates of the residents' care plans. The Clinical Managers will monitor their unit's care plans for accuracy and completeness. They will report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/30/06 5/19/06 5/19/06 6/30/06 6/30/06

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F 279	Continued From page 25 August 2, 2005, " ...No family members present ... " November 1, 2005, " ...RP not in attendance ... " January 31, 2006, " ...No family members in attendance ... " April 25, 2006, " ...[RP] attending (friend). The social service progress note included the following: April 5, 2006, " ...mailed invitation to responsible party for next IDT meeting on April 25, 2006 ... " April 26, 2006, " ...Family continues to be supportive and was present at meeting ... " There were care planning conferences held on February 22, May 10, August 2 and November 11 , 2005 and January 31, 2006. However, there was no evidence in the social service progress notes that the RP was notified of aforementioned care planning conferences. The record was reviewed on May 16, 2006. B. Facility staff failed to indicate on the care plan for psychoactive medications which approaches were to be implemented. The care plan "On psychoactive medication secondary to agitation" dated March 17, 2005 and most recently updated April 2006 listed ten approaches. The ten approaches had boxes in front of them. Approaches to be used by the facility would be indicated by a check mark in the box. There were no check marks in any of the boxes. A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 10:16 AM. He/ She acknowledged that there were no	F 279		

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F 279	Continued From page 26 approaches checked for this care plan. The record was reviewed on May 16, 2006. 2. Facility staff failed to initiate a Hospice care plan for Resident #24. A review of Resident #24's record revealed a physician's order dated May 3, 2006, " [Hospice] to evaluate resident for hospice care secondary to decline in medical condition. " The initial Hospice visit was May 5, 2006. Subsequently, Hospice staff visited May 8, 12 and 15, 2006. A review of the resident's care plan revealed that there was no problem with appropriate goals and approaches for Hospice care. A face-to-face interview with the charge nurse was conducted on May 17, 2006 at 10:30 AM. He /she acknowledged that the care plan lacked a problem with goals and approaches for Hospice care. The record was reviewed May 17, 2006.	F 279		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for three (3) of 30 sampled residents, it was determined that facility staff failed to: initiate new approaches after a fall for two (2) residents and initiate new interventions for one (1) resident with agitated behaviors. Residents #1, 2, and 14. The findings include: 1. Facility staff failed to initiate new approaches in the care plan after a fall for Resident #1. A review of Resident #1's nurse's note dated February 4, 2006 at 10:00 PM documented, " Resident found on the floor in [his/her] room in a	F 280	**483.20 (d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** Residents #1, 2, and 14. 1. The care plans of the residents cited at the time of the survey have been updated to reflect new approaches after a fall and new interventions for agitated behaviors. 2. The care plans of similar residents with falls and agitated behaviors have been reviewed to ensure that updates were recorded as appropriate. 3. The Clinical Managers will monitor their unit's care plans for appropriate updates, accuracy and completeness. They will report their findings to the DON. Additionally, inservicing was done for the staff involved in the completion of the residents' care plans to ensure their understanding of the errors and corrections. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/30/06 5/30/06 6/30/06 6/30/06

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side lying position. A pool of blood was noted on the floor around [him/her]. On assessment, [resident] was noted with a big hematoma and a laceration measuring 3 x 1 cm on the left side of the head ... [Resident] left the unit via 911 at 7:30 PM ... "

A review of care plan problem #3 on February 4, 2005," Need for safety [due to] limited mobility and blindness" revealed that the above incident was documented under the "Problems" column. However, there were no new approaches initiated as a result of the fall.

A face-to-face interview with the charge nurse was conducted on May 17, 2006 at 9:30 AM. He/ she acknowledged that there were no new approaches initiated after the above cited fall. The record was reviewed May 17, 2006.

2. A review of Resident #2's record revealed that facility staff failed to update the care plan after a fall.

The nurse's note dated March 30, 2006 at 2:50 PM revealed the following: "Resident remains alert and oriented x3. Resident stated that he stood up, close his door to the room, stepped to the bed and fell. I assessed the resident no physical injuries noted ..."

The care plan dated December 8, 2005 for " At risk for falls related to decreased mobility, use of psychoactive meds and use of antihypertensive meds" was last updated on March 10, 2006.

The facility staff failed to update the falls care plan with goals and approaches after the resident

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F 280	Continued From page 29 fell on March 30, 2006. 3. Facility staff failed to initiate new interventions for Resident #14 for agitation and verbal abuse. A review of Resident #14's record revealed a nurse's note dated March 15, 2006 at 3:00 PM, " Resident involved in an explosive verbal altercation with another resident ..." Care plan #12 dated April 21, 2004 and updated on November 14, 2005, "Period of agitation with use of abusive language" listed under "Problems" a verbal altercation with another resident that occurred November 14, 2005. The above cited incident was not listed under "Problems." There were no interventions initiated after the March 15, 2006 episode. A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 3:15 PM. He/ she acknowledged that the care plan was not reviewed after the above cited incident. The record was reviewed May 16, 2006.	F 280	**483.20(k)(3)(i)** **COMPREHENSIVE CARE PLANS** Resident #29 1. This resident expired at the hospital with a cause of death unrelated to the results of the PT/INR. 2. Any resident on Coumadin and signs and symptoms of bleeding will be cared for according to the facility's emergency policy. 3. The nursing staff was inserviced on the facility's Emergency Care and the need to contact the Medical Director, DON, or Administrator should the PMD not respond in a very timely manner. The House Supervisors and Clinical Managers will monitor the residents needs closely to ensure compliance with the facility policy The results of this monitoring will be forwarded to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement	4/18/06 5/30/06 6/30/06 6/30/06
F 281 SS=G	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by : Based on observations, staff interview and record review for nine (9) of 30 sampled residents and four (4) supplemental residents, it was determined that facility staff failed to follow the	F 281	Resident #S14 1. The behaviors noted by the Clinical Manager were related to confusion and not suicidal ideation. The resident was not trying to hang herself or choke herself with the shower hose. She was hallucinating that is was a snake. The resident was sent to the hospital ER to ensure that this was not suicidal ideation. The return diagnosis was acute schizophrenia and to continue present care.	3/15/06

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F 281	Continued From page 30 facility's policy regarding: the emergency care of one (1) resident on Coumadin with a nosebleed; observation of one (1) suicidal resident; weighing residents monthly for four (4) residents; re-weighing two (2) residents; initial social worker assessment for two (2) residents; and monthly laboratory tests for one (1) resident receiving anticoagulation therapy. Residents #29, S14, 1, 8, 9, 12, 15, 17, 21, 25, S11, S12 and S13. The findings include: 1. The staff failed to follow the facility's resident emergency care policy for Resident #29 who was taking Coumadin, an anticoagulant, and had a nosebleed. The resident subsequently died at the hospital on April 18, 2006. According to the facility's policy "Nursing Emergency Care-Residents - The facility will provide emergency medical care to all residents. Advanced directives will be followed when the emergency is due to the residents condition or diagnosis. A. In case of significant change in resident's condition: 2. Notify attending physician, associate or Medical Director. If no doctor can be reached call Nursing Director or Administrator regarding transfer of resident to the nearest emergency room. D. Epistaxis: 1. Sit resident upright and instruct him to breathe through his mouth 2. Apply pressure on one or both nostrils apply ice over nose; check vital signs 3. If bleeding does not stop within five	F 281	2. All residents with acute disease exacerbations will be promptly cared for and the continued documentation will reflect the results of the hospital visit. 3. The nursing staff was inserviced on assessment and proper documentation. The Clinical Managers will monitor their unit's care plans for appropriate updates, accuracy and completeness. They will report their findings to the DON. Additionally, inservicing was done for the staff involved in the completion of the residents' care plans to ensure their understanding of the errors and corrections. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Residents #1, 8, 9, 12, 15, 17, 21 Weights 1. Residents who were cited at the time of the survey for the facility's failure to follow the weight policy were weighed immediately. The Clinical Managers, corporate and facility dietician reviewed the charts and interventions implemented when indicated. 2. A weight audit was conducted in a cooperative effort of the Clinical Managers and Dieticians to address any other residents whose weights were not properly addressed. 3. Nursing staff and dieticians were	5/30/06 6/30/06 6/30/06 5/30/06 6/30/06 6/30/06

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F 281	Continued From page 31 minutes, notify doctor for further orders. Every change in resident condition, will be written on the nursing 24 hour report, reported to physician and family and documented in detail on nurses notes. " A review of the "Physician's Discharge Summary " dated April 25, 2006, under "Course of Diseases and Treatment" indicated: "Patient had started bleeding from the nose on 4/17/06. Nose bleeding was treated unsuccessfully with ice pack on the nasal bridge. PT/INR =134.4/19.84. [He/ she] was transferred to the ER for treatment. Reason For Discharge (Including cause of death if applicable): Nose bleed and Coumadin toxicity." The resident was admitted to the facility on March 22, 2006. According to the admission Minimum Data Set (MDS) signed and dated April 14, 2006, the resident ' s diagnoses included: Diabetes Mellitus (DM), Congestive Heart Failure, Hypertension, Cerebrovascular accident (stroke) Hemiparesis, and Depression (Section I). The admission orders dated March 22, 2006 included, "Warfarin Sodium 10mg (Coumadin) 1 tablet GT/PO daily blood thinning (3/21/06-3/28/ 06). Labs. (1) CBC every 6 months; (2) FBS every month DM." Physician Orders: March 22, 2006 at 10:00 PM, "Obtain PT/INR lab work in 3 days." March 24, 2006 at 12:30 AM, "Obtain U/A C&S (urinalysis with culture and sensitivity) in AM, to R/ O (rule out) UTI (urinary tract infection)." Resident c/o (complained of) burning sensation	F 281	inserviced on weight collection and a weight collection team per unit was implemented per a new weight policy. The Clinical Managers were inserviced on the accuracy of documentation specific to weight variations as mandated by policy and the MDS. The Clinical Managers will oversee and monitor the weight teams and the documentation of the weights. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Resident #S11 and S12 Monthly PT/INRs 1. The residents cited at the time of the survey for not having monthly or bi-weekly PT/INRs were ordered that lab test. Results were forwarded to the attending physician for review and comment, if necessary. 2. All residents on Coumadin (warfarin), Dicumarol have orders addressing their individual needs for PT/INRs ordered by the physician. The results were forwarded to the attending physician for review and comment, if necessary. 3. An inservice was done with the licensed nursing staff regarding the monitoring and ordering of lab tests. A 100% lab audit was performed and adjustments made as necessary.	6/30/06 5/30/06 5/30/06 6/30/06

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F 281	Continued From page 32 when urinating. March 24, 2006 at 2:00 PM, "Levaquin 500mg 1 tab po (by mouth) q (every) day for 7 days." [Drug Interactions... Elevations of the prothrombin time in the setting of concurrent Warfarin and levofloxacin use have been associated with episodes of bleeding. Prothrombin time, International Normalized Ration (INR), or other suitable anticoagulation tests should be closely monitored if levofloxacin is administered concomitantly with Warfarin... Manufacturer's [Ortho-McNeil] prescribing information for Levaquin (levofloxacin), August 2005]. March 28, 2006 at 2:00 PM, "Continue Warfarin Sodium 10mg, 1 tab. Qd (daily) GT/PO - blood thinning. Check PT/INR every month." April 17, 2006 at 7:00 AM "Continue to apply ice compress over bridge of nose. Do CBC (Complete Blood Count) and PT (Prothrombin Time) and INR (International Normalized Ratio) today; notify PMD of results. Hold Coumadin 4/18 /06." April 17, 2006 at 1:15 PM "Send resident to ER for Coumadin Toxicity." Laboratory Studies: March 28, 2006: coagulation collected 3/28/06 0620 (6:20 AM) PT 27.4 P (Patient) Normal Range 12.2-15.0 seconds C/T [call to] [name] at 1009 [10:09 AM], RRB (report read back) Protime INR 2.51 Therapeutic range: 2.0-3.0	F 281	Additionally, the consultant pharmacist was asked to specifically address this issue in her monthly chart audits. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Resident #14 Agitated Behavior 1. The care plans of the resident cited at the time of the survey have been updated to reflect new interventions for a episode of agitated behavior. 2. The care plans of similar residents with agitated behaviors have been reviewed to ensure that new interventions were recorded as appropriate. 3. The Clinical Managers will monitor their unit's care plans for appropriate updates, accuracy and completeness. They will report their findings to the DON. Additionally, inservicing was done for the staff involved in the completion of the residents' care plans to ensure their understanding of the errors and corrections. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the	6/30/06 5/30/06 5/30/06 6/30/06 6/30/06

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F 281	Continued From page 33 April 17, 2006 coagulation collected 4/17/06 0900 (9:00 AM) PT 134.4 P Normal Range 12.2-15.0 seconds Protime INR 19.84 Therapeutic range 2.0-3.0. Nurses' Notes: March 28, 2006 at 3:00 PM, "Resident continue on Levaquin 500mg, fluids encouraged and all routine meds given and tolerated. OOB (out of bed), appetite good, all ADLs (Activities of Daily Living) done and resting quietly, no obvious changes noted." March 28, 2006, at 3:30 PM, " Writer was called by lab regarding PT/INR result, PMD made aware, no new orders given but said to continue with Coumadin and was noted accordingly." April 16, 2006 at 11:00 PM, "Alert, verbal, oriented times 3. Consumed 75% of meal served . No S/S (signs/symptoms) of hypo/ hyperglycemia was noted. Able to verbalize needs. ADL care provided. No c/o pain/ discomfort." April 16, 2006 at 11:00 PM, "10:00 PM had nose bleed. Small amount. Ice compress applied over bridge of nose. Place a call to PMD [private medical doctor] and left message to the answering machine ... not responded at this time. Vital signs (V/S) B/P (Blood Pressure) 150/86, T (Temperature) 98.3, P (Pulse) 78, and R (Respiration) 20." April 17, 2006 at 7:35 AM, "Continue to have small amount of nose bleeding. Continue to apply ice compress over bridge of nose and nose packed with gauze. PMD responded and made	F 281	quarterly Quality Improvement Committee which is chaired by the Administrator.	

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F 281	Continued From page 34	F 281		

aware of the medical problem. Ordered to continue to apply ice compress and to do CBC, PT/INR today and to report result to PMD. Hold Warfarin until result of PT/INR arrives. Will endorse to oncoming nurse."

April 17, 2006 at 2:30 PM, "V/S 97.8 (T), 72 (P), 22 (R), 144/80(B/P). Resident was noted with a nose bleed, PT/INR result received. Pt. 134.4, INR 19.89. Family and MD notified order given to send resident to ER. Resident picked up at 2:00 PM. No acute distress on departure."

On May 19, 2006 at 9:45 AM a face-to-face interview was conducted with the Assistant Clinical Manager who indicated, "Residents who receive anticoagulant medications are to be monitored for bruising and bleeding. Blood tests are to be drawn monthly. The physician was to be called to report the results. Adjustments to the medication might be needed depending on the results if they are high or low. I remember that the resident was transferred to the hospital because of a nose bleed."

Facility staff failed to follow the facility's resident emergency care policy by not contacting the associate or Medical Director after no response from the resident's primary physician for nine (9) hours. The record was reviewed on May 17, 2006 . Cross referenced to CFR 483.25, F309.

2. The facility staff failed to follow the "Suicidal Residents" policy for Resident S14.

A review of Resident S14's record revealed a nurse's note dated March 15, 2006 at 7:30 AM, "...At 6:15 AM, resident pulled fire alarm on wing "

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F 281	Continued From page 35 A" . Resident stated "I did it, I pulled it. I don ' t care. I want to get out of here." Resident was helped out/away from fire alarm to [his/her] room. Fire safety was observed. Then staff went back to see resident. Found resident in the bath room using/getting shower head hose to wrap it around [his/her] neck. When asked resident why? Or what [he/she] was doing with it, resident said, "I was observing it looks like a snake." Resident was brought to the nursing station for close monitoring ..." According to a nurse's note dated March 15, 2006 at 2:40 (PM), "Resident on hourly watch. [Attending physician] was phoned at 8:35 AM about incident this AM with resident.. Telephone order of Haldol 2 mg po (orally) QID PRN (four times daily as needed) for agitation. Psyc (psychological) consult with [psychiatrist] and hourly monitoring. RP (responsible party) was notified of the incident. At 9:45 AM [psychiatrist] was phoned and telephone order of Haldol 2 mg po QID (four times daily) routine for agitation. Continue hourly monitoring. Psyc consult for 3/16 /06. Collect [urine for] UA and C&S (urinalysis and culture and sensitivity). Resident received Haldol at 8:30 AM and 1 PM. Resident is now sleeping." According to the facility's policy, "Nursing Suicidal Resident," policy #1404480A.000, dated September 1998, under, " Procedure - #3. Assign a staff member for one to one observation and to stay within the distant of an arm length of the resident until determination of the course of treatment has been made by a physician ...#7 (c) Obtain physician order for transfer or if the resident is to remain in the facility an order for an	F 281		

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F 281	Continued From page 36 emergency psychiatric consult. The psychiatrist should recommend the frequency and length of observation period." A face-to-face interview was conducted with the clinical manager and the charge nurse on May 19 , 2006 at 10:55 AM. The clinical manager stated, "When we found (the resident) with the shower hose around (his/her) neck, [Resident S14] was confused. The resident was brought out to the nurse ' s station and then a little later put back to bed. Then we called the doctor (attending physician) to tell [him/her] what happened." The charge nurse stated, " The resident pulled the fire alarm and was very confused. We called [attending physician] and the psychiatrist. When the Director of Nursing found out what was going on, [Resident S14] was sent out to the hospital." Facility staff failed to assign a staff member for one to one observation for Resident S14 from the time he/she was noted with the shower head hose around the neck after the fire alarm was sounded until the physician was contacted. The record was reviewed May 19, 2006. 3. Facility staff failed to obtain a weight for Resident #1 for March and April 2006. According to the facility's policy, "Nutritional Services - Weights and Heights" , Policy # 0504060A.00, dated April 2004, under, " Procedure -3. Monthly: (a) Weights will be done according to the facility schedule which indicates the person assigned and the date the weight is to be done ..."	F 281		

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F 281	Continued From page 37 According to the, "Vital Sign Flow Sheet" for Resident #1, the area for recording the weight for March and April 2006 was blank. A face-to-face interview was conducted with the clinical manager on May 15, 2006 at 3:35 PM. After reviewing the record, he/she acknowledged that the weights were not done for March and April 2006. The record was reviewed May 15, 2006. 4. Facility staff failed to obtain a weight for Resident #8 for February 2006. According to the, "Vital Sign Flow Sheet" for Resident #8, the area for recording the weight for February 2006 was blank. A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 10:30 AM. After reviewing the record, he/she acknowledged that the weight was not done for February 2006. The record was reviewed May 16, 2006. 5. A review of Resident #9's record revealed that facility staff failed to reweigh the resident according to facility policy. The "Vital Sign Flow Sheet" included the following weights: Date Weight 1/11/06 131 2/14/06 123.5 3/13/06 131 4/6/06 121 4/14/06 117 5/9/06 113	F 281		

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F 281	Continued From page 38 A face-to-face interview was conducted with the unit manager on May 15, 2006 at 3:12 PM. He/ She acknowledged that a reweight was not obtained in February, March and April 2006 according to policy. The unit manager was asked to weigh the resident. He/She later said that the resident ' s weight was 115 pounds. Facility Policy #0504060A.000, Nutritional Services Weights and Heights included the following: "...Monthly: b. check the previous weights for changes. If there is a change of + or - 5% in 30 days, 7.5% in 90 days ..., schedule resident to be reweighed within 24 hours ..." There was over a 5% weight decrease from January to February 2006, there was over a 5% increase in weight from February to March 2006 and there was over a 7% decrease in weight from March 13 to April 14, 2006. The facility failed to reweigh the resident. The record was reviewed on May 15, 2006. 6. A review of Resident #12's record revealed that facility staff failed to weigh the resident monthly according to facility policy. The "Vital Sign Flow Sheet" included the following weights: Date Weights 12/15/05 148 1/14/06 152 4/2006 148 There were no weights in the record for February and March 2006. A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 2:38 PM. He/	F 281		

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F 281	Continued From page 39 She acknowledged that the weights for February and March 2006 were not in the record. The record was reviewed on May 16, 2006. 7. A review of Resident #15's record revealed that the facility staff failed to reweigh the resident on readmission to the facility. Facility Policy #0504060A.000, Nutritional Services Weights and Heights included the following: " All residents will be weighed within 24 hours of admission/readmission, again after one week and then monthly, unless ordered more frequently ... 1. On Admission: Weight team member will measure the resident ' s weight and height within 24 hours of admission ... 3. a. weights will be done according to facility schedule ...When feasible 1-2 days each month will be designated for all monthly weights." The resident was readmitted to the facility on February 23, 2006. The nurse ' s readmission progress note included the following: " ...Wt (weight) 122 lbs ... " The "Vital Sign Flow Sheet [form SM-67)" included the following weights: Date Weight 12/11/05 147.5 1/11/06 148 2/14/06 147 3/16/06 147 4/no day/06 125 4/14/06 125 The readmission weight was not included on this form. The record lacked evidence of a reweight one (1)	F 281		

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F 281	Continued From page 40 week after readmission and a reweight when the resident ' s weight was determined to be 147 pounds on March 16, 2006 [increase of 25 pounds in 21 days]. The record was reviewed on May 16, 2006. 8. Facility staff failed to obtain a weight for Resident #17 for March 2006. According to the, "Vital Sign Flow Sheet" for Resident #17, the area for recording the weight for March 2006 was blank. A face-to-face interview was conducted with the charge nurse on May 17, 2006 at 12:30 PM. After reviewing the record, he/she acknowledged that the weight was not done for March 2006. The record was reviewed May 17, 2006. 9. Facility staff failed to obtain a weight for Resident #21 for January, February and March 2006. According to the, " Vital Sign Flow Sheet" for Resident #21, the area for recording the weight for January, February and March 2006 was blank. A face-to-face interview was conducted with the charge nurse on May 17, 2006 at 7:30 AM. After reviewing the record, he/she acknowledged that the weights were not done for January, February and March 2006. The record was reviewed May 17, 2006. 10. The social worker failed to do an initial social service assessment for Resident # 25. A review of Resident #25's record revealed that	F 281		

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F 281	Continued From page 40 week after readmission and a reweight when the resident ' s weight was determined to be 147 pounds on March 16, 2006 [increase of 25 pounds in 21 days]. The record was reviewed on May 16, 2006. 8. Facility staff failed to obtain a weight for Resident #17 for March 2006. According to the, "Vital Sign Flow Sheet" for Resident #17, the area for recording the weight for March 2006 was blank. A face-to-face interview was conducted with the charge nurse on May 17, 2006 at 12:30 PM. After reviewing the record, he/she acknowledged that the weight was not done for March 2006. The record was reviewed May 17, 2006. 9. Facility staff failed to obtain a weight for Resident #21 for January, February and March 2006. According to the, " Vital Sign Flow Sheet" for Resident #21, the area for recording the weight for January, February and March 2006 was blank. A face-to-face interview was conducted with the charge nurse on May 17, 2006 at 7:30 AM. After reviewing the record, he/she acknowledged that the weights were not done for January, February and March 2006. The record was reviewed May 17, 2006. 10. The social worker failed to do an initial social service assessment for Resident # 25. A review of Resident #25's record revealed that	F 281	F281 Social Work notes Resident # 25, 513 1. Social Work notes missing at the time of the survey have been evaluated by the Director of Social Work and corrections were made whenever possible. 2. A 100% audit of all social work notes was done by the Director of Medical Records and the results of that audit were forwarded to the Director of Social Work for correction. 3. Aggressive recruitment to fill 2 vacant social work positions is on-going. The facility signed a contract with Delta-T, an agency which supplies contract workers, and an LICSW has started with an LGSW to begin soon. The Director of Social Work will monitor the timely completion of evaluations and notes. 4. The results of his monitoring and any action plans for improvement will be presented to the quarterly Quality Improvement Committee which is chaired by the administrator.	6/30/06 6/30/06 6/30/06 6/30/06

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 41	F 281		

he/she was admitted to the facility on April 27, 2006. At the time of this review there was no initial social service assessment in the record. Resident #25 had been in the facility for 21 days from April 27, 2006 to May 17, 2006.

According to the facility's policy, "Social Work Initial History and Assessment," Policy #1702010 A.000, dated May 1997, under "Procedure - #3. The Psychosocial Evaluation will be entered into the resident's medical chart within 14 days of admission. This form will be maintained as part of the resident's medical record.

A face-to-face interview was conducted with a social worker on May 17, 2006 at 2:30 PM. He/ she stated, " We have a 14 day window to complete the initial social service assessment for the intermediate units which include [unit where Resident # 25 was admitted]. The initial social service assessment should have been completed ." The record was reviewed May 17,2006.

11. Facility staff failed to obtain a monthly INR (International Normalized Ratio) to measure blood clotting time for Resident S11.

A review of Resident S11's record revealed an initial physician's order dated January 5, 2006 and re-ordered February 7 and April 4, 2006 directing, " Warfarin (Coumadin) 7.5mg 1 tab by mouth every evening."

The most recent INR laboratory value was dated January 13, 2006.

According to the, "Long Term Care Pharmacy Policy and Procedure Manual," policy #7.1 "

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	095022	A. BUILDING _____ B. WING _____	05/19/2006

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F 281	Continued From page 42 Laboratory Monitoring of Drug Therapy " , effective date August 1, 2002, page 6, "11. INR or assessment of clotting function monthly, if on Warfarin (Coumadin), Dicumarol." A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 11:15 AM. He/ she acknowledged that the INR was not obtained after January 2006. The record was reviewed May 19, 2006. 12. Facility staff failed to obtain an INR as ordered by the physician for Resident S12. A review of Resident S12's record revealed an initial physician ' s order dated January 7, 2006 and re-ordered March 14, 2006 directing, " Warfarin (Coumadin) 2.5mg 1 tab by mouth every evening. " A physician's order dated March 14, 2006 directed, "PT/INR every other week - DVT (deep vein thrombosis)." The most recent PT/INR laboratory value was dated March 16, 2006. A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 11:30 AM. He/ she acknowledged that the PT/INR was not obtained after March 2006. The record was reviewed May 19, 2006. 13. The social worker failed to complete an initial Psychosocial Evaluation for Resident S13. According to the facility's policy, "Social Work Initial History and Assessment", policy #1702010	F 281		

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F 281	Continued From page 43 A.00, dated May 1997, under "Procedure - #3. The Psychosocial Evaluation will be entered into the residents's medical chart within 14 days of admission. This form will be maintained as part of the residents's medical. A review of the clinical record for Resident S13 revealed that the resident was admitted to the facility on February 16, 2006. At the time of this review, there was no social worker's initial Psychosocial Evaluation. The resident had been in the facility 89 days. The record was reviewed May 17, 2006.	F 281	**483.25** **QUALITY OF CARE** Resident #29 1. This resident expired at the hospital with a cause of death unrelated to the results of the PT/INR. 2. Any resident on Coumadin and signs and symptoms of bleeding will be cared for according to the facility's emergency policy. 3. The nursing staff was inserviced on the facility's Emergency Care and the need to contact the Medical Director, DON, or Administrator should the PMD not respond in a very timely manner. The House Supervisors and Clinical Managers will monitor the residents needs closely to ensure compliance with the facility policy The results of this monitoring will be forwarded to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Resident #19 1. Resident identified at the time of the survey has had pain management and neurological checks completed as required. 2. The charts of any resident involved in an altercation resulting in an ER visit were reviewed to ensure that proper return documentation was received by the hospital, pain assessments and neurological status was documented.	4/18/06 5/19/06 6/30/06 6/30/06 5/19/06 5/20/06
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by : Based on observations, record review and staff and resident interviews, it was determined that for seven (7) of 30 sampled residents and 12 supplemental residents that facility staff failed to: provide emergency care per facility policy to one (1) resident on an anticoagulant with a nosebleed; assess one (1) resident for pain after an emergency room visit; clarify the use of Lorazapam (Ativan) for two (2) residents; monitor one (1) resident's pulse prior to the administration	F 309		

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F 309	Continued From page 44 of an antihypertensive medication; administer multiple medications and sliding scale insulin coverage as ordered for one (1) resident; have blood drawn as ordered for six (6) residents; repeat a HGB A1C blood test and apply heel protectors and Ted stockings for one (1) resident; clarify sliding scale insulin coverage orders above 600 for five (5) residents and ensure one (1) resident was prepared for an appointment. Residents #29, 19, 2, 4, 6, 10, 21, S5, S6, S7, S8, S9, S11, S12, S13, W1, W2, W4 and W5. The findings include: 1. The staff failed to follow the facility's resident emergency care policy for Resident #29 who was taking Coumadin, an anticoagulant, and had a nosebleed. The resident subsequently died at the hospital on April 18, 2006. The resident was admitted to the facility on March 22, 2006. According to the admission Minimum Data Set (MDS) signed and dated April 14, 2006, the resident's diagnoses included: Diabetes Mellitus (DM), Congestive Heart Failure, Hypertension, Cerebrovascular accident (stroke) Hemiparesis, and Depression (Section I). The admission orders dated March 22, 2006 included, "Warfarin Sodium 10mg (Coumadin) 1 tablet GT/PO daily blood thinning (3/21/06-3/28/06). Labs. (1) CBC every 6 months; (2) FBS every month DM." Physician Orders: March 22, 2006 10: PM, "Obtain PT/INR lab work in 3 days."	F 309	3. Inservice was given to nursing staff regarding the importance of doing a thorough assessment with any and all changes in the residents condition. Reviewed the need to use policy manual as an excellent reference tool. The Clinical Managers on the units will monitor their residents to ensure compliance. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. Resident # 2 and S9 5/19/06 1. The orders for this resident were clarified with the facility's consultant psychiatrist. 2. The pharmacy is performing a 100% audit of all PRN medications to ensure that those with the same therapeutic effect for any given resident have a clarification order documenting the order in which these medications should be given. 3. The consultant pharmacist will monitor the orders for the PRN medications to ensure compliance. She will work directly through the DON and physicians when clarification orders are needed. 4. She will report the findings of her monitoring at the quarterly Quality Improvement Committee. Resident #4 1. Resident identified as not having a pulse taken prior to the administration of	6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 5/19/06

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F 309	Continued From page 45 March 24, 2006 12:30 AM, " Obtain U/A C&S (urinalysis with culture and sensitivity) in AM, to R/ O UTI (urinary tract infection). " Resident c/o (complained of) burning sensation when urinating. March 24, 2006 2:00 PM, "Levaquin 500mg 1 tab po (by mouth) q (every) day for 7 days." [Drug Interactions... Elevations of the prothrombin time in the setting of concurrent Warfarin and levofloxacin use have been associated with episodes of bleeding. Prothrombin time, International Normalized Ration (INR), or other suitable anticoagulation tests should be closely monitored if levofloxacin is administered concomitantly with Warfarin... Manufacturer's [Ortho-McNeil] prescribing information for Levaquin (levofloxacin), August 2005]. March 28, 2006 2:00 PM, "Continue Warfarin Sodium 10mg, I tab. Qd (daily) GT/PO - blood thinning. Check PT/INR every month." April 17, 2006 7:00 AM "Continue to apply ice compress over bridge of nose. Do CBC and PT and INR today; notify PMD of results. Hold Coumadin 4/18/06." April 17, 2006 1:15 PM "Send resident to ER for Coumadin Toxicity." Laboratory Studies: March 28, 2006: coagulation collected 3/28/06 06 :20 (6:20 AM) PT 27.4 P (Patient) Normal Range 12.2-15.0 sec. C/T [call to] [name] at 1009 [10:09 AM], RRB (report read back) Protime INR 2.51 Therapeutic range: 2.0-3.0	F 309	Clonidine has had her medical record reviewed and corrected immediately. There was no identified harm to the resident. 2. All other residents on similar medications requiring a pulse prior to administration have had their MARs reviewed and corrections done when necessary. 3. Staff were inserviced on the requirements of some hypertensive medications to have the pulse taken. MARs reviewed with the nursing staff. The Clinical Managers on the units will monitor those MARs for consistency of taking and recording the pulse. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. Resident #6 A. 1. The nurse who did not sign off this resident's 10 AM medications as administered has been counseled . The MAR was reviewed with no further correction needed. No harm was identified to the resident. 2. All MARs are consistently reviewed by the units to ensure that medications are documented as given. 3. Staff were inserviced on the requirements of documenting the administration of medications at the time they are given to the resident. MARs were	5/30/06 6/30/06 6/30/06 7/2/06 review requested 6/30/06 6/30/06

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F 309	Continued From page 46 April 17, 2006 coagulation collected 4/17/06 0900 (9:00 AM) PT 134.4 P Normal Range 12.2-15.0 sec. Protime INR 19.84 Therapeutic range 2.0-3.0: Nurses' Notes: March 28, 2006 3:00 PM, "Resident continue on Levaquin 500mg, fluids encouraged and all routine meds given and tolerated. OOB (out of bed), appetite good, all ADLs (Activities of Daily Living) done and resting quietly, no obvious changes noted. " March 28, 2006, 3:30 PM, " Writer was called by lab regarding PT/INR result, PMD made aware, no new orders given but said to continue with Coumadin and was noted accordingly." April 16, 2006 11:00 PM, "Alert, verbal, oriented times 3. Consumed 75% of meal served. No S/S (signs/symptoms) of hypo/hyperglycemia was noted. Able to verbalize needs. ADL care provided. No c/o pain/discomfort." April 16, 2006 11:00 PM, "10:00 PM had nose bleed. Small amount. Ice compress applied over bridge of nose. Place a call to PMD[private medical doctor]and left message to the answering machine ... not responded at this time. Vital signs (V/S) B/P (Blood Pressure) 150/86, T (Temperature) 98.3, P (Pulse) 78, and R (Respiration) 20." April 17, 2006 7:35 AM, "Continue to have small amount of nose bleeding. Continue to apply ice compress over bridge of nose and nose packed with gauze. PMD responded and made aware of the medical problem. Ordered to continue to	F 309	also reviewed with the nursing staff. The Clinical Managers on the units will monitor those MARs for consistency of documentation. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. B. 1. The resident identified at the time of the survey that was not afforded proper insulin coverage was reviewed. No actual harm was identified. The nurses involved were educated and counseled. 2. All sliding scale insulin orders were reviewed to ensure proper coverage was afforded the residents. 3. Staff were inserviced on the requirements of sliding scale insulin orders and the importance of ensuring accurate coverage. MARs reviewed with the nursing staff. The Clinical Managers on the units will monitor those MARs for accuracy of insulin coverage on sliding scale orders. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. Resident #10 1. BMP due ~~for~~ this resident was completed on 3/28/06. ~~The~~ results were located in the overflow file. The ~~EBS~~ was	6/30/06 5/19/06 5/30/06 6/30/06 6/30/06 3/28/06

Res. # 10 removed by IDR
7/14/06

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

PRINTED: 06/15/2006
FORM APPROVED
OMB NO. 0938-0391

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Continued From page 47

apply ice compress and to do CBC, PT/INR today and to report result to PMD. Hold Warfarin until result of PT/INR arrives. Will endorse to oncoming nurse."

April 17, 2006 2:30 PM, "V/S 97.8 (T), 72 (P), 22 (R), 144/80(B/P). Resident was noted with a nose bleed, PT/INR result received. Pt. 134.4, INR 19. 89. Family and MD notified order given to send resident to ER. Resident picked up at 2:00 PM. No acute distress on departure. "

On May 19, 2006 at 9:45 AM a face-to-face interview was conducted with the Assistant Clinical Manager who indicated, "Residents who receive anticoagulant medications are to be monitored for bruising and bleeding. Blood tests are to be drawn monthly. The physician was to be called to report the results. Adjustments to the medication might be needed depending on the results if they are high or low. I remember that the resident was transferred to the hospital because of a nose bleed."

According to the facility's policy "Nursing Emergency Care-Residents - The facility will provide emergency medical care to all residents. Advanced directives will be followed when the emergency is due to the residents condition or diagnosis.

A. In case of significant change in resident's condition:

2. Notify attending physician, associate or Medical Director. If no doctor can be reached call Nursing Director or Administrator regarding transfer of resident to the nearest emergency room.

F 309

due on 4/28/06. The resident went to the hospital on 4/17/06, readmitted on 4/19/06 with the order for the FBS discontinued. Instead, an HgA9C every 3 months was ordered on the 4/19/06 admission.

2. A lab audit was done on all charts to ensure accuracy and completeness of the orders and results. — 6/30/06

3. Staff were inserviced on the requirements of laboratory ordering and a new procedure was developed. The Clinical team met with the Director of the Southern Maryland Hospital lab to ensure accuracy of communications. The Clinical Managers on the units will monitor the residents' lab orders for consistency and accuracy. — 6/30/06

4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. — 6/30/06

Resident #7 [illegible]

A. 1. The resident identified with a missing lab had the test repeated at the time of its discovery. There was no harm to the resident. — 5/19/06

2. A lab audit was done on all charts to ensure accuracy and completeness of the orders and results. — 6/30/06

3. Staff were inserviced on the requirements of laboratory ordering and a new procedure was developed. The Clinical team met with the Director of the Southern Maryland Hospital lab to ensure — 6/30/06

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F 309	Continued From page 48 D. Epistaxis: 1. Sit resident upright and instruct him to breathe through his mouth 2. Apply pressure on one or both nostrils apply ice over nose; check vital signs 3. If bleeding does not stop within five minutes, notify doctor for further orders. Every change in resident condition, will be written on the nursing 24 hour report, reported to physician and family and documented in detail on nurses notes." A review of the "Physician's Discharge Summary " dated April 25, 2006, under "Course of Diseases and Treatment" indicated: "Patient had started bleeding from the nose on 4/17/06. Nose bleeding was treated unsuccessfully with ice pack on the nasal bridge. PT/INR =134.4/19.84. [He/ she] was transferred to the ER for treatment. Reason For Discharge (Including cause of death if applicable): Nose bleed and Coumadin toxicity." Facility staff failed to contact the associate or Medical Director after there was no response from the resident's primary physician for nine (9) hours. The record was reviewed on May 17, 2006 . 2. Facility staff failed to assess Resident #19 for pain after his/her return from the emergency room . According to the annual Minimum Data Set completed April 11, 2006, Resident #19 was coded in Section B, Cognitive Patterns" with no long or short-term memory problems. In Section D, "Vision Patterns" the resident was coded as being severely impaired (no vision or sees only	F 309	accuracy of communications. The Clinical Managers on the units will monitor the residents' lab orders for consistency and accuracy. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. B. 1. The resident identified at the time of the survey had heel protectors and Ted stockings applied when ordered at the time of the discovery. There was no harm to the resident. 2. A 100% review of physician's orders for similar protective devices was done with corrective actions made when necessary. 3. A lab audit was done on all charts to ensure accuracy and completeness of the orders and results. 3. Staff were inserviced on the importance of wearing such protective devices and following physician orders. The Clinical Managers on the units will monitor the residents for consistency and accuracy. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee.	6/20/06 6/20/06 5/19/06 6/20/06 6/20/06 6/20/06

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F 309	Continued From page 45 March 24, 2006 12:30 AM, " Obtain U/A C&S (urinalysis with culture and sensitivity) in AM, to R/ O UTI (urinary tract infection). " Resident c/o (complained of) burning sensation when urinating. March 24, 2006 2:00 PM, "Levaquin 500mg 1 tab po (by mouth) q (every) day for 7 days." [Drug Interactions... Elevations of the prothrombin time in the setting of concurrent Warfarin and levofloxacin use have been associated with episodes of bleeding. Prothrombin time, International Normalized Ration (INR), or other suitable anticoagulation tests should be closely monitored if levofloxacin is administered concomitantly with Warfarin... Manufacturer's [Ortho-McNeil] prescribing information for Levaquin (levofloxacin), August 2005]. March 28, 2006 2:00 PM, "Continue Warfarin Sodium 10mg, I tab. Qd (daily) GT/PO - blood thinning. Check PT/INR every month." April 17, 2006 7:00 AM "Continue to apply ice compress over bridge of nose. Do CBC and PT and INR today; notify PMD of results. Hold Coumadin 4/18/06." April 17, 2006 1:15 PM "Send resident to ER for Coumadin Toxicity." Laboratory Studies: March 28, 2006: coagulation collected 3/28/06 06 :20 (6:20 AM) PT 27.4 P (Patient) Normal Range 12.2-15.0 sec. C/T [call to] [name] at 1009 [10:09 AM], RRB (report read back) Protime INR 2.51 Therapeutic range: 2.0-3.0	F 309	Clonidine has had her medical record reviewed and corrected immediately. There was no identified harm to the resident. 2. All other residents on similar medications requiring a pulse prior to administration have had their MARs reviewed and corrections done when necessary. 3. Staff were inserviced on the requirements of some hypertensive medications to have the pulse taken. MARs reviewed with the nursing staff. The Clinical Managers on the units will monitor those MARs for consistency of taking and recording the pulse. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. Resident #6 A. 1. The nurse who did not sign off this resident's 10 AM medications as administered has been counseled . The MAR was reviewed with no further correction needed. No harm was identified to the resident. 2. All MARs are consistently reviewed by the unit clerks and Clinical managers to ensure completeness. gr 7/7/06 3. Staff were inserviced on the requirements of documenting the administration of medications at the time they are given to the resident. MARs were	5/30/06 6/30/06 6/30/06 7/2/06 6/30/06 6/30/06

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F 309	Continued From page 49 light, colors, or shapes; eyes do not appear to follow objects.) In Section I, " Disease Diagnoses" , the resident was coded for Glaucoma. A review of Resident #19's record revealed a nurse ' s note dated 12, 2006 at 9:15 PM, that documented, "Resident transferred to ER (emergency room) for evaluation secondary to being hit in the head by another resident ' s (roommate) visitor. Resident assessed by the writer. Vital signs taken and were within normal limit. Neurochecks initiated and WNL (within normal limits) ..." According to a nurse's note dated May 13, 2006 at 10:30 AM, "Resident returned from ER at 755 A via stretcher with 2 attendants ..." A nurse's note dated May 13, 2006 at 11:00 PM documented, "Alert and responsive. Complaining of pain [in] arm but when asked if want pain med refused ..." There was no evidence in the record that the arm causing the resident pain was assessed after returning from the hospital. The "General Emergency Department Discharge Instructions" documented studies done included a head computerized topography (CT), right hip x-ray and left wrist x-ray. There was no evidence in the record that the facility received information or contacted the hospital regarding the results of the studies performed in the emergency department. The facility obtained the results of the emergency room studies after they were requested by the	F 309	Resident #S5, S6, S7, S8 and W5 Sliding Scale Insulin 1. All residents identified at the time of the survey having sliding scale insulin orders which required the nurse to notify the physician when the blood glucose level was over 750 were clarified. The glucometers used by the facility reads blood glucose levels up to 600. Orders were changed to notify the physician when the levels reached 500. No harm came to any resident. 2. All sliding scale insulin orders were reviewed for similar issues and adjustments made when necessary. 3. Staff was inserviced on the upper limits reading of the facility's glucometer and the need to clarify physician The Clinical Managers on the units will monitor the residents' sliding scale insulin orders for consistency and accuracy. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. Resident #S11, S12, W1, W2, W4 Lab tests 1. The residents cited at the time of the survey for not having monthly or bi-weekly PT/INRs, PSA level, urinalysis, dilantin and albumin levels were ordered that lab test. Results were forwarded to the attending physician for review and comment, if necessary.	5/19/06 5/30/06 6/30/06 6/30/06 5/19/06

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F 309	Continued From page 50 surveyor on May 18, 2006, five (5) days after the studies were performed. The result of the head CT was, "No intracranial trauma is appreciated but there is question of a nondisplaced high left frontal calvarial fracture." The right hip x-ray showed no acute fracture or dislocation. The result of the left wrist x-ray showed, "There is cortical irregularity of the dorsum of the radial styloid on the lateral view that is suggestive of a tiny chip fracture. This should be considered acute if the patient is symptomatic in the same region." A face-to-face interview with the resident was conducted on May 18, 2006 at 8:30 AM with Resident #19. The resident was alert, oriented to date, time and place and spoke clearly. The resident stated, " I was watching the ball game, it was in the second inning. I don ' t see anything but shadows. I saw someone walk past my bed and pull the curtain between the two beds. I hollered "[roommates name] you there?" No one answered. I got my stick (cane) and walked to the end of my bed. I saw a lady standing there and asked " What do you want?" She had crutches and stunk of alcohol. She started cussing me out and hit me with her crutch on my head, my hip and my wrist. I started to yell and took my stick and hit her . I couldn ' t see where I hit her because I can ' t see that far. My right eye is blind and I only see shadows in my left eye. The nurse came quick and told the lady to wait outside. The cops came, too. I don ' t know what happened after that. They sent me to the hospital.	F 309	2. All resident with similar issues had their medical records reviewed and lab tests ordered if necessary. The results were forwarded to the attending physician for review and comment. 3. An inservice was done with the licensed nursing staff regarding the monitoring and ordering of lab tests. A 100% lab audit was performed and adjustments made as necessary. Additionally, the consultant pharmacist was asked to specifically address this issue in her monthly chart audits. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Resident #S13 1. The orthopedic appointment was rescheduled when the oversight was discovered. 2. A review of residents with outside appointments was done to ensure their readiness. 3. Inservicing was done with nursing staff regarding the need to pay close attention to their residents with outside appointments and use of the 24 hour report as the tool of preference for this kind of communication. The Clinical Managers will monitor this	6/30/06 6/30/06 6/30/06 5/19/06 5/19/06 6/30/06

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F 309	Continued From page 51 I came back about eight o'clock the next morning. My wrist hurt a lot. Still does. And it has been swollen since Friday. I tell them (the nurse) that it hurts and they just ask me if I want pain medicine and don't even look at my wrist. Been swollen like this all week. Can ' t hardly make a fist. " The resident demonstrated during the interview that he/she could only partially close the fingers of the left hand and could not make a fist. Additionally, the resident could not bend the left wrist up or down without complaining of pain. Facility staff initiated neurological checks after the resident returned from the hospital on May 13, 2006 at 10:00 AM. Neurological checks include an assessment of pupillary reaction, extremity strength and motion, sensorium and vital signs (temperature, pulse, respiratory rate and blood pressure). According to the, "Neurological Chart", the resident was consistently assessed as having a normal pupillary reaction in the left eye and strong strength and motion in all extremities. There was no pulse charted. The charge nurse assessed the resident's left wrist after the above cited interview at the request of the surveyor. The resident was sent to the emergency room for follow-up care. Facility staff failed to accurately assess the status of Resident #19 upon return from the emergency room after being struck by a crutch on the head, left wrist and right hip. Additionally, facility staff failed to accurately complete the neurological	F 309	issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/30/06

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F 309	Continued From page 52 checks as evidenced by failing to identify the resident's abnormal vision in the left eye and decreased strength and motion in the left wrist. The record was reviewed May 19, 2006. 3. A review of Resident #2's record revealed that facility staff failed to clarify orders for Lorazepam. The May 2006 Physician's Order Form included the following orders: "12/18/05, Lorazepam ½ ml (1 mg) intramuscularly (IM) every 4 hours as needed for agitation" ; and " 12/18/05, Lorazepam 1 mg 1 tablet by mouth every four hours as needed for agitation. " There was no information included with the orders that would determine which route, IM or po, would be used. A face-to-face interview was conducted on May 15, 2006 at 1:02 PM with the charge nurse. He/ She stated, "He gets po (by mouth)." The record was reviewed on May 15, 2006. 4. Facility staff failed to assess the pulse rate for Resident #4 according to physician orders. A review of physician orders dated December 12, 2005 indicated, "Clonidine 0.2 mg by mouth twice daily for hypertension. Hold for systolic blood pressure less than 100. Notify physician if systolic blood pressure is more than 160 or less than 100. Notify physician for pulse rate less 50 or more than 120." A review of the Medication Administration Record for March 2006 showed no evidence that the pulse rate was assessed prior to administration of Clonidine 0.2mg as ordered.	F 309		

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F 309	Continued From page 53 A face-to-face interview was conducted with the Assistant Clinical Manager on May 15, 2006 at 11 :00 AM. He/she said, "The nursing staff should have assessed the pulse rate prior to the administration of clonidine 0.2 mg as ordered. The record was reviewed May 15, 2006. 5. A review of the record for Resident #6 revealed that facility staff failed to administer five (5) medications as per physician's orders and administer the correct sliding scale insulin dose according to the physician's order A. Facility staff failed to administer five (5) medications as per physician's orders. The April 2006 MAR (Medication Administration Record) included the following medications: Docusate Sodium 100 mg capsule by mouth twice daily for bowel regimen; Lisinopril 10 mg tablet by mouth every day for hypertension; Megestrol Acetate 10 ml (400 mg) by mouth every day for weight loss; Senna 8.6 mg tablet by mouth every day for bowel management; and Sorbitol 70% solution 30 ml by mouth once daily for constipation. The licensed nurse failed to initial [indicating that the medication was administered] for the 10 AM dose of the above cited medications for April 30, 2006. A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 10:16 AM. He/ She acknowledged that the five (5) medications were not initialed as being administered on the MAR for the 10:00 AM dose on April 30, 2006.	F 309		

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F 309	Continued From page 54 B. Facility staff failed to follow physician's orders for the administration of sliding scale insulin. The May 2006 Physician's Order Form included the following order: Initial order date of January 3 , 2006, "Humalog vial - ins [insulin] Fingerstick blood sugar three times daily before meals inject subcutaneously with sliding scale coverage: 140-200 = 4 units, 201-280 = 6 units, 281-340 = 8 units, 341-400 = 10 units. Call MD if blood sugar less than 60 or greater than 400." The April MAR revealed the following insulin sliding scale coverage: Date Blood Sugar Coverage 4/7/06 at 4 PM 215 4 units 4/9/06 at 4 PM 127 4 units According to the physician's order the resident should have received 6 units of insulin on April 7 and no insulin coverage on April 9, 2006. The record was reviewed on May 16, 2006. 6. Facility staff failed to do laboratory studies for Resident #10 according to the physician orders. A review of the physician orders indicated, " Fasting Blood Sugar (FBS) every month; Basic Metabolic Panel (BMP) every six months: March and September." A review of Resident #10's laboratory reports indicated that BMP was not done in March 2006 and FBS was not done in April 2006 as ordered by the physician. A face-to-face interview was conducted with the Assistant Clinical Manager on May 19, 2006 at 10	F 309		

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F 309	Continued From page 55 :00 AM. He/she checked with the laboratory company and said that there was no evidence that the BMP was done in March 2006 and no evidence that the FBS was done in April 2006. The record was reviewed May 15, 2006. 7. Facility staff failed to follow-up on a laboratory value for a Hemoglobin A1C and follow physician's orders for the use of heel protectors and Ted stockings for Resident #21. A. A review Resident #21's record revealed a laboratory report for a Hemoglobin A1C drawn on April 13, 2006, "Cancelled: Quantity not sufficient for procedure." There was no evidence in the record that the Hemoglobin A1C had been repeated. A face-to-face interview with the charge nurse was conducted on May 17, 2006 at 7:30 AM. He/she acknowledged that the test had not been repeated. The record was reviewed May 17, 2006. B. Physician's orders for Resident #21 dated April 11, 2006 directed, "Heel protectors on at all times bilaterally when in bed" and "Ted Stockings to right foot/ankle/leg swelling to be worn daily." The resident was observed in bed on May 17, 2006 at 7:40 AM. A Certified Nursing Aide (CNA) removed the bed covers from the resident' feet. The resident was not wearing heel protectors. Additionally, the CNA stated that the resident wore socks daily and not Ted stockings. The CNA searched the resident ' s closet and drawers and neither heel protectors nor Ted stockings were found.	F 309		

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F 309	Continued From page 56 Resident #21 was observed on May 15, 2006 at 2 :10 PM, May 16, 2006 at 10:45 AM and May 17, 2006 at 1:15 PM sitting in a wheel chair wearing socks. The record was reviewed May 17, 2006. 8. Facility staff failed to clarify sliding scale insulin orders for Resident S5. According to the manufacturer's recommendations for the blood glucose monitoring meter currently used by the facility, a " Hi" message on the meter indicates blood glucose over 600. A review of Resident S5's record revealed a physician's order dated May 2, 2006, directing, "(blood glucose) 551-650 give 14 units (of insulin).. If greater than 651 call MD." Since the blood glucose meter registers "Hi" for blood glucose over 600, facility staff would be unable to determine if the blood glucose level was over 650. A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 2:30 PM. He/ she stated, "I never really looked at the order because [Resident S5's] blood glucose never was that high." The record was reviewed May 19, 2006. 9. Facility staff failed to clarify sliding scale insulin orders for Resident S6. A review of Resident S6's record revealed a physician's order dated April 11, 2006, directing, "(blood glucose) 551-650 give 8 units (of insulin)..	F 309		

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F 309	Continued From page 57 If greater than 651 give 10 units ...if greater than 651 call MD." Since the blood glucose meter registers "Hi" for blood glucose over 600, facility staff would be unable to determine if the blood glucose level was over 650. A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 2:45 PM. Residents S6, S7 and S8 resided on this unit. The charge nurse was asked if he/she was aware of the sliding scale insulin order. He/she stated, " The [blood glucose] meter registers " Hi " above 600. I would call the doctor if I got a reading like that. There is no way to tell how high the blood glucose is if it is above 600. I ' ve never had a reading that showed " Hi. " The record was reviewed May 19, 2006 10. Facility staff failed to clarify sliding scale insulin orders for Resident S7 . A review of Resident S7's record revealed a physician's order dated April 11, 2006, directing, "(blood glucose) 551-650 give 10 units (of insulin)..Over 651 notify MD." Since the blood glucose meter registers "Hi" for blood glucose over 600, facility staff would be unable to determine if the blood glucose level was over 650. The record was reviewed May 19, 2006. 11. Facility staff failed to clarify sliding scale insulin orders for Resident S8 . A review of Resident S8's record revealed a	F 309		

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F 309	Continued From page 58 physician's order dated March 14, 2006, directing, " (blood glucose) 551-650 give 10 units (of insulin)..551 - 750 give 12 units ...Call MD if greater than 750. " Since the blood glucose meter registers "Hi" for blood glucose over 600, facility staff would be unable to determine if the blood glucose level was over 750. The record was reviewed May 19, 2006. 12. Facility staff failed to clarify the use of oral or injectable Ativan for Resident S9. A review of Resident S9's record revealed a physician's order dated March 14, 2006, "Ativan 1 mg po (orally) or IM (intramuscularly) every 4 hrs PRN (as needed) for anxiety." There was no evidence that facility staff attempted to clarify when to use the oral form or the injectable form of the Ativan. A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 11:30 PM. The surveyor asked when each form of the Ativan would be used. The charge nurse stated, "If the resident is very agitated and won ' t take the pill, we would give him the injection. "The record was reviewed May 19, 2006. 13. Facility staff failed to obtain a monthly INR (International Normalized Ratio) to measure blood clotting time for Resident S11. A review of Resident S11's record revealed an initial physician ' s order dated January 5, 2006 and re-ordered February 7 and April 4, 2006	F 309		

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F 309	Continued From page 59 directing, " Warfarin (Coumadin) 7.5mg 1 tab by mouth every evening. " The most recent INR laboratory value was dated January 13, 2006. According to the, "Long Term Care Pharmacy Policy and Procedure Manual, "Policy #7.1 " Laboratory Monitoring of Drug Therapy" , effective date august 1, 2002, page 6, "11. INR or assessment of clotting function monthly, if on Warfarin (Coumadin), Dicumarol." A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 11:15 AM. He/ she acknowledged that the INR was not obtained after January 2006. The record was reviewed May 19, 2006. 14. Facility staff failed to obtain an INR as ordered by the physician for Resident S12. A review of Resident S12's record revealed an initial physician ' s order dated January 7, 2006 and re-ordered March 14, 2006 directing, " Warfarin (Coumadin) 2.5mg 1 tab by mouth every evening. " A physician's order dated March 14, 2006 directed, "PT/INR every other week - DVT (deep vein thrombosis)." The most recent PT/INR laboratory value was dated March 16, 2006. A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 11:30 AM. He/ she acknowledged that the PT/INR was not	F 309		

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F 309	Continued From page 60 obtained after March 2006. The record was reviewed May 19, 2006. 15. Facility staff failed to ensure that Resident S 13 kept a follow-up orthopedic appointment. According to the Resident S13's record, he/she was diagnosed with a nondisplaced fracture of the distal tibia on May 15, 2006. The resident was sent to the emergency room and returned with a soft cast. A follow-up appointment with the orthopedic physician was scheduled for May 19, 2006 at 8:30 AM. An observation was conducted on May 19, 2006 at 6:30 AM. A transportation company called to confirm Resident S13's pick-up time of 8:00 AM. The night charge nurse told the employee answering the phone that the appointment was at 9:00 AM or 10:00 AM. The employee told the transportation company that the resident could be picked-up two (2) hours before the appointment. At 7:15 AM, the day charge nurse gathered documents from Resident S13 ' s record to copy for the appointment to the orthopedic physician. The surveyor observed at 7:18 AM that the resident was in bed, dressed in night clothes and sleeping. The surveyor asked the assistant clinical manager (ACC) if the resident was going to have breakfast and receive the morning medications prior to leaving at 8:00 AM. The ACC called the dietary department for an early tray and the day charge nurse called the physician for an order to receive the morning medications, scheduled for 10:00 AM to be administered at 8:00 AM.	F 309		

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F 309	Continued From page 61 Posted on the counter of the nurse's station was a listing of resident appointment times for May 19, 2006. Resident S13's appointment time was 8:30 AM. At 8:00 AM the transportation company arrived to transport the resident. The resident was still in bed clothes and had not eaten breakfast. The transportation company left and the appointment was cancelled. The resident's daughter had taken off a day from work to be with the resident. The ACC called the transportation company and tried to re-schedule a pick-up time for later in the day. The transportation company was unable to accommodate the request. The surveyor asked if another transportation company could be contacted. The unit secretary stated that transportation companies require 24 hours notice. The appointment had to be rescheduled for the following week. Facility staff failed to ensure that the resident kept a scheduled appointment with the orthopedic physician. The record was reviewed May 19, 2006. 16. A review of Resident W1's record revealed that facility staff failed to ensure that a PSA level and Urinalysis was performed. The Interim Order Form included an order dated May 9, 2006 at 3:40 PM which included: "...(2) PSA (Prostatic Specific Antigen) (3) Repeat U/A (Urinalysis). The laboratory book included a laboratory slip for Resident W1 dated May 11, 2006 with the tests	F 309		

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F 309	Continued From page 62 PSA and U/A checked. The laboratory slip was not signed [indicating that the blood was not drawn] by the laboratory technician. There was no reason on the laboratory slip as to why the blood was not drawn. A face-to-face interview was conducted with the Assistant Director of Nursing on May 17, 2006 at approximately 1:35 PM. He/She acknowledged that the blood work was not performed. The record was reviewed on May 17, 2006. 17. A review of Resident W2's record revealed that facility staff failed to ensure that Dilantin and Albumin levels were drawn. The Interim Order Form included an order dated May 6, 2006 at 12:30 AM which included: " Dilantin and Albumin level in one week (Due 5/12/06)". The record did not include results for Dilantin and Albumin levels for May 2006. A face-to-face interview was conducted with the Assistant Director of Nursing on May 17, 2006 at approximately 1:35 PM. The laboratory was called and indicated that there was no record of blood drawn for Resident W1 on May 12, 2006.. The record was reviewed on May 17, 2006. 18. A review of Resident W4's record revealed that facility staff failed to ensure that weekly PT and INR levels were drawn as per physician's order. The Physician Order Sheet and interim Plan of Care dated March 2, 2006 included the following order: "PT/INR Q (every) week secondary to Coumadin Toxicity ".	F 309		

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F 309	Continued From page 63 The Interim Order Form dated May 15, 2006 at 10:00 PM included: "T/O (telephone order) PT/ INR for resident." The record included results for the PT/INR on April 3, 2006 - PT-31.6 and INR-3.0 and May 3, 2006 - PT -16.9 and INR 1.34. The physician's progress note dated April 3, 2006 included the following: " Attending-Blood draw was done on the anterior aspect of the left ankle for PT/PTT, INR, CBC, CMP. Patient is a hard stick and we could not get blood from any other site peripherally. " The physician also had progress notes dated April 17 and 18, 2006. There were laboratory slips in the laboratory book for Resident W4 for PT/INRs to be drawn dated March 3, April 12, May 10 and May 15, 2006. The resident ' s blood was not drawn on any of the aforementioned dates. A face-to-face interview was conducted with the clinical manager on May 17, 2006 at approximately 9:00 AM. He/She acknowledged that there were only two PT/INR levels drawn since the order. He/She stated that the staff and the physician were aware of the technician having difficulties drawing the labs. The PT/INR levels were not drawn weekly as ordered. The record was reviewed on May 17, 2006. 19. A review of Resident W5's record revealed that facility staff failed to clarify an order for sliding scale insulin coverage.	F 309		

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F 309	Continued From page 64 The Physician Order Sheet and Interim Plan of Care dated May 11, 2006 included the following order: " Fingerstick blood sugar (BS) TID (three times a day) with sliding scale coverage with Regular Insulin - <60 - Facility protocol; 200-249-o; 250-350-2 units; 351-450-4 units; 451-550-6 units; 551-650-8 units; If BS >651 Notify MD." A face-to-face interview was conducted with the charge nurse on May 18, 2006 at 7:00 AM. He/ She stated, "The glucometer goes up to 600 and gives a reading of "high" after that. We call the MD if it reads high." The May TAR (Treatment Administration Record) did not include any blood sugar levels of 600 or higher. The record was reviewed on May 18, 2006.	F 309	**483.25©** 7/12/06 **PRESSURE SORES** #24 mw 1. The nurse who did the wound dressings but failed to sign the Treatment Administration Record (TAR) was counseled and educated. 2. An audit of the TARs was done to ensure proper documentation. 3. Inservicing was done with the licensed staff to ensure their full understanding of signing each TAR upon completion of the order. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	7/2/06 7/2/06 6/30/06 6/30/06
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by : Based on observations, interviews and record review for one (1) of 30 sampled residents, it was	F 314		

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F 314	Continued From page 65	F 314		

determined that facility staff failed to administer wound treatments according to physician orders. Resident #24.

The findings include:

A review of Resident #24's record revealed physician's orders to treat the left hip wound, left elbow wound, and two (2) wounds on the right shin every three (3) days. According to the Treatment Administration Record for March 2006, March 10, 13, 16, 19, 22, 25, 28 and 31 were identified as days the wound treatments were to be performed. The above cited dates had boxes drawn on the day for the nurse to initial, indicating the wound treatments had been administered.

The boxes for the nurse's initials were blank for the left elbow and both shin wounds for March 10, 2006 and all the wounds for March 16, 2006 indicating the wound treatments had not been administered.

A review of the nurses' notes from March 10 through March 17, 2006 revealed that the resident was sent to the emergency room on March 13, 2006 at 3:50 AM and returned to the facility the same day at 11:00 AM. On March 17, 2006 at 12:30 PM the resident was sent to the hospital and returned March 22, 2006.

There was no evidence in the nurses' notes that wound treatments were administered on March 10 or 16, 2006.

A face-to-face interview was conducted with the charge nurse on May 17, 2006 at 10:30 AM. The charge nurse acknowledged that the above cited

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F 314	Continued From page 66 dates were blank indicating that wound treatments were not administered. He/she had no explanation as to why the wound treatments were not administered. The record was reviewed May 17, 2006.	F 314	483.25 URINARY INCONTINENCE #21 2/17/06 1. The catheter tubing was positioned correctly immediately upon discovery. 2. A review of the other catheters in the facility was done to ensure the proper positioning of the tubing. 3. Inservicing was done with the nursing staff to ensure their understanding of the importance of the positioning of the catheter tubing. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/19/06 5/19/06 6/30/06 6/30/06
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for one (1) of 30 sampled records, it was determined that facility staff failed to position the Foley catheter tubing to promote downward urinary flow for Resident #21. The findings include: Resident #21 was observed on May 15, 2006 at 2 :10 PM with the catheter tubing looped over the hand grips of the wheelchair causing the urine to flow upwards. According to " Guidelines for prevention of Catheter-associated Urinary Tract Infections,"	F 315		

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F 315	Continued From page 67 published by the Centers for Disease Control and Prevention, February, 1981, under,"8. Urinary Flow ...4) collecting bags should always be kept below the level of the bladder." A face-to-face interview was conducted with the clinical manager at the time of the observation. He/she stated that the catheter tubing was positioned incorrectly and called the resident's assigned Certified Nursing Aide to re-position the tubing so the urine would flow downward.	F 315	**483.25** **RANGE OF MOTION** #8 7/2/06 1.The record of this resident was reviewed for contracture management and adjustments made as needed. 2. All residents are screened quarterly by the rehab department as a way to ensure that their rehabilitative needs are met. 3. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	7/2/06 7/2/06 6/30/06 6/30/06
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to follow up on the management of a contracture. Resident #8. The findings include: A review of Resident #8's record revealed that the physical therapist initiated joint contracture management for the bilateral knee contractures on January 20, 2006. The resident was issued splints for both knees and prescribed range of	F 318		

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F 318	Continued From page 68 motion exercises. The physical therapist discharged the resident to the nursing rehabilitation (rehab) program on February 3, 2006. The occupational therapist treated the resident from February 19 through March 20, 2006 for arthritis to the fingers and contracture management. According to the " Nursing Rehab Treatment Record " the resident received range of motion exercises and knee splints applied from February 6 through February 22, 2006. A face-to-face interview with the nursing rehabilitation/restorative aide was conducted on May 16, 2006 at 1:15 PM. He/she stated that the splints were discontinued because the resident could not tolerate them. There was no evidence in the record that either the physical therapist or the occupational therapist re-evaluated the resident for additional interventions for contracture management. The record was reviewed May 16, 2006.	F 318	**483.25(h)(1) ACCIDENTS** 1. The issues found at the time of the survey (light covers, OTC meds on a window sill, unsecured toilets, inappropriate storage of detergent and bleach, running water, damaged floor tiles, long phone cord) were all corrected upon discovery. 2. The Maintenance Aides reviewed all the rooms through use of their PM punch list to ensure that accident prevention was given the utmost priority. 3. The Maintenance Supervisor will monitor this issue throughout the month and report their findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/19/06 6/30/06 6/30/06 6/30/06
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period,	F 323		

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F 318	Continued From page 68 motion exercises. The physical therapist discharged the resident to the nursing rehabilitation (rehab) program on February 3, 2006. The occupational therapist treated the resident from February 19 through March 20, 2006 for arthritis to the fingers and contracture management. According to the " Nursing Rehab Treatment Record " the resident received range of motion exercises and knee splints applied from February 6 through February 22, 2006. A face-to-face interview with the nursing rehabilitation/restorative aide was conducted on May 16, 2006 at 1:15 PM. He/she stated that the splints were discontinued because the resident could not tolerate them. There was no evidence in the record that either the physical therapist or the occupational therapist re-evaluated the resident for additional interventions for contracture management. The record was reviewed May 16, 2006.	F 318	**483.25(h)(1)** **ACCIDENTS** 1. The issues found at the time of the survey (light covers, OTC meds on a window sill, unsecured toilets, inappropriate storage of detergent and bleach, running water, damaged floor tiles, long phone cord) were all corrected upon discovery. 2. The Maintenance Aides reviewed all the rooms through use of their PM punch list to ensure that accident prevention was given the utmost priority. 3. The Maintenance Supervisor will monitor this issue throughout the month and report their findings to the Director of Maintenance. from the PM Punch lists 4. The Director of Maintenance will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/19/06 6/30/06 6/30/06 6/30/06
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period,	F 323		

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F 323	Continued From page 69 it was determined that facility staff failed to provide safety from environmental hazards as evidenced by: a broken night light cover, isopropyl alcohol and antibiotic ointment located on a windowsill, toilets not secured to the floor, detergent and bleach stored in an open area, water running in the shower room unattended, damaged floor tiles in the bathroom, a long phone cord in ambulatory areas, and overbed lamps with unsecured frontal covers. These observations were made in the presence of the Directors of Maintenance and Housekeeping and/or nursing staff. The findings include: 1. A night light cover was observed broken with jagged edges in room 326 in one (1) of one (1) observation on May 15, 2006 at 8:50 AM. 2. 70 % isopropyl alcohol and two (2) tubes of antibiotic ointment were stored on a windowsill and unsecured in room 348 in one (1) of one (1) observation on May 15, 2006 at 8:54 AM. 3. Toilets were not secured to the floor were observed in the 1 South shower room and rooms 142, 146, and 153 during the survey period. 4. Detergent and bleach were stored in an open area in room 225 on May 15, 2006 at 12:15 PM. 5. Water running in the shower room unattended was observed in the 3 South tub room on May 18, 1006 at 2:10 PM. 6. Damaged floor tiles in the 1 South dining room	F 323		

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F 323	Continued From page 70 and lounge and 3 North pantry area were observed during the survey period. 7. A long phone cord in a residents's room stretched across ambulating areas in room 146 on May 17, 2006 at 10:12 AM. 8. Overbed lamps with unsecured frontal covers were in the following areas: 1 North rooms: 125, 139 and 154 in three (3) of 10 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South room 160 in one (1) of six (6) observations on May 17, 2006 at 2:00 PM. 2 North rooms: 209, 231, 253 in three (3) of 10 observations on May 17, 2006 from 11:33 AM to 2:30 PM. 3 North room 313 in one (1) of five (5) observations on May 18, 2006 at 1:20 AM.	F 323	483.25(h)(2) **ACCIDENTS** Residents S1, S2 and S3 1. The safety devices (mats and chair alarm) found not in use at the time of the survey were immediately implemented upon discovery. 2. Other residents with similar safety devices were checked to ensure that everything was in use and in place. 3. Inservicing was done with the nursing staff to ensure their complete understanding of the use of safety devices such as fall mats and chair alarms. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/19/06 5/19/06 6/30/06 6/30/06
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that facility staff failed to adequately supervise residents as evidenced by: two (2) residents with bedside mats not in place	F 324		

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when the residents were in bed and one (1) resident with the chair alarm unconnected. These observations were made in the presence of the nursing staff. Residents S1, S2 and S3.

The findings include:

1. On May 15, 2006 at 9:35 AM, Resident S1 was observed lying his/her bed which was in the low position with the bedside mat standing upright against the wall. The nurse immediately placed the bedside mat on the floor next to the bed and stated that the resident attempts to get out of bed without assistance, but is unable to do so without assistance. The bedside mat is used to prevent injury.

2. On May 15, 2006 at 9:27 AM, the door to Resident S2's room was observed to be closed. After knocking, the surveyor and nurse entered the room. Resident S2 was in bed, the bed was in the high position. The bedside mat was upright and at the head of the bed. The nurse immediately lowered the bed and placed the bedside mat on the floor next to the bed. The nurse stated that Resident S2 is frequently found on the bedside mat after attempting to get out of bed without assistance.

3. On May 19, 2006 at 9:40 AM, Resident S3 was observed in a wheel chair wheeling from the room towards the nurse's station. A chair alarm was present on the back of the wheelchair. The alarm was not connected to the resident. The nurse immediately connected the alarm to the resident and stated that the chair alarm is used because the resident attempts to stand up without assistance and falls.

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F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident 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. This REQUIREMENT is not met as evidenced by : Based on record review and staff interviews for three (3) of 30 sampled residents, the dietician/ nutritionist failed to follow up on residents with weight loss. Residents #8, 9 and 16. The findings include: 1. A review of Resident #8's record revealed that the dietitian failed to follow up on the resident's continued weight loss. According to the "Vital Sign Flow Sheet" the residents's weights were as follows: Date Weight (pounds) 3/6/06 93.5 4/06 93.5 5/8/06 90 According to the dietary progress notes dated March 8, 2006, "Resident has experienced a 9.22 % weight loss since 1/06 (103#). This weight loss is significant and unrecommended...Resident is totally dependent on G-tube for nutrition and hydration' received Jevity 1.5, 1 can 5 x daily with 200 ml H2O (water) flush after each can. This remains appropriate...Will continue to monitor and	F 325	**483.25(I)(1)** **NUTRITION** Residents #8, 9, and 16 1. Residents found at the time of the survey to have issues with weight loss were reviewed by the dietician and changes to the diet orders made as necessary. 2. The dieticians, in cooperation with the Clinical Managers, are performing a 100% audit of all residents' weights to ensure that their needs are being addressed. 3. The dieticians and Clinical Managers will monitor this issue throughout the month and report their findings to the DON and the Director of Nutritional Services. 4. Both Directors will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	7/2/06 7/2/06 7/2/06 6/30/06

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F 325	Continued From page 73 f/u PRN (follow up as needed)." There were no progress notes by the dietician after March 8, 2006. There was no evidence that the dietician monitored the resident's weight for March or April 2006. A face-to-face interview was conducted with the dietician on May 16, 2006 at 1:00 PM. The dietician stated, "I don't review every resident's weight every month. I only review the weights if nursing notifies me that there is a problem. I don't have a list of residents that have continued weight loss." The record was reviewed May 16, 2006. 2. A review of Resident #9's record revealed that the dietician failed follow up on the resident with weight loss. The "Vital Sign Flow Sheet included the following weights: Date Weight 1/11/06 131 2/14/06 123.5 3/13/06 131 4/6/06 121 4/14/06 117 5/9/06 113 The annual nutritional assessment dated March 13, 2006 included the following: "Weight: 123. Weight History: There has been a 7# (pound) decrease in 1 year not significant. Additional Comments/Action Plan: Suggest Ensure Plus 240 cc BID (two times a day) secondary to decrease AWR." There were no other nutritional	F 325		

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	095022	A. BUILDING _____ B. WING _____	05/19/2006

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F 325	Continued From page 74 assessments in the record. A face-to-face interview was conducted with the clinical manager on May 15, 2006 at 3:12 PM. He /She stated, "The dietician puts it [action plan] on the recommendation sheet and gives a copy to the Director of Nursing and to us. We follow up and give it back to [dietician/nutritionist]." There was no evidence in the record that facility staff followed up on the suggestion from the dietician for Ensure. There was no order for Ensure in the record. A face-to-face interview was conducted with the nutritionist on May 15, 2006 at 4:45 PM. He/She stated, " He/She was getting ½ sandwich since December 2005. The weight, 7 pounds is not significant. I didn ' t know anything [continuing weight loss] after the annual assessment. I don't get a list of everybody's weights." The dietician failed to monitor Resident #9's weight loss and follow up on his/her recommendation for Ensure. The record was reviewed on May 15, 2006. 3. Facility staff failed to ensure that Resident #16 maintained an acceptable body weight. A review of Resident #16's record indicated that he/she was admitted to the facility on December 3 , 2004. He/she weighed 188.5 pounds according to the vital signs record for December 2004. A review of an annual nutritional assessment completed November 29, 2005 indicated that resident weighed 187.5 pounds.	F 325		

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F 325	Continued From page 75 A review of the vital signs flow sheet indicated the following weights: Date Weight (pounds) 5/05 192 6/05 195 7/05 190 8/05 192 9/05 188.2 10/05 190 11/05 187.5 12/05 189 1/06 168.2 2/06 168 3/06 190 4/06 186 5/06 192 A review of a dietary progress note dated February 21, 2006 indicated, " Weight: 168.2, this weight for January is questionable, secondary to weight history of in the 180 ' s. If this weight is correct a 12.39 % weight loss occurred in 180 days review. This weight change is significant and unrecommended in its severity. No new labs available for nutritional assessment. Diet remains mechanical soft, no added salt, appropriate and well tolerated mouth in take of 100%." The resident had a significant weight loss in January. There was no evidence in the record that a reweight was done. There were no dietary interventions initiated to address the weight loss A face-to-face interview was conducted with the dietician on May 16, 2006 at 12:50 PM. He/she acknowledged that Resident #16 lost a significant amount of weight in January and no dietary interventions were implemented to correct	F 325		

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F 325	Continued From page 76 the weight loss. The record was reviewed May 16, 2006.	F 325	**483.25(l)(1) UNNECESSARY DRUGS** 4/13 4/7/06 1. A request for a psych consult was written at the time of the survey and adjustments made as recommended.	5/19/06
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by : Based on observation, record review, and staff interview for one (1) of 30 sampled residents, it was determined that the facility failed to perform a psychiatric consult or attempt a dose reduction of an antipsychotic medication for one (1) resident. Resident #13. The findings include: A review of Resident #13's record revealed that he/she was admitted to the facility on April 21, 2005. Physician orders dated October 25, 2005 indicated, "Risperdal 0.5 mg 1 tablet by mouth at bed-time for psychosis." There was no psychiatry consult in the record.. There was no evidence in the chart to indicate that a dose reduction was attempted between October 2005 and May 2006. A face-to-face interview was conducted with the	F 329	2. Medication reviews by the psychiatrist were audited to ensure all residents on psych-active drugs are receiving the lowest does necessary. 3. This issue will be discussed at the Physician Services Meeting. The Clinical Managers and Consultant Pharmacist will monitor this issue throughout the month and report their findings to the DON and Medical Director. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	7/2/06 6/30/06 mes 7/19/06 6/30/06

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F 329	Continued From page 77 Charge Nurse on May 19, 2006 at 10:00 AM. He/ she stated that he/she was not sure that it [dose reduction] was done. The record was reviewed May 19, 2006.	F 329	**483.35(I)(2)** **SANITARY CONDITIONS - FOOD PREP & SERVICE** Floor Surfaces, Ceiling tiles, Ice Machine, Meat Slicer, Garbage Disposal, Pans and Muffin pans 1. All issues found at the time of the survey have been addressed and corrected. 2. Sanitation surveys of the entire kitchen are done on a routine basis by the Nutritional Services Staff to ensure on-going compliance. 3. The Nutritional Services Supervisors will monitor the kitchen sanitation issues throughout the month and report their findings to the Director of Nutritional Services. 4. The Director of Nutritional Services will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/30/06 7/9/06 6/30/06 6/30/06 6/30/06
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that facility staff failed to maintain dietary services in a safe and sanitary manner as evidenced by: damaged floor surfaces; soiled ceiling tiles, inner surfaces of the ice machine and meat slicer; water to the disposal unit failed to shut off; and hotel and muffin pans were stored wet. These observations were made in the presence of the Director of Dietary Services. The findings include: 1. Floor surfaces were damaged and in disrepair in the cart wash room, nourishment room, walk in freezer and refrigerator, chemical room, tilt skillet area, and under the steam table in seven (7) of seven (7) observations between 8:45 AM and 4: 30 PM on May 15, 2006. 2. Ceiling tiles over the food preparation area and	F 371		

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F 371	Continued From page 78 serving areas were soiled with food spillage and dust in two (2) of two (2) observations between 8: 45 AM and 4:30 PM on May 15, 2006. 3. The interior surfaces of the ice machine were soiled with accumulated mineral deposits and other products in one (1) of one (1) observations between 8:45 AM and 4:30 PM on May 15, 2006. 4. The inner and cutting areas of the meat slicer was not thoroughly cleaned after being used as evidenced by particles of leftover meats on the machine in one (1) of one (1) observation between 8:45 AM and 4:30 PM on May 15, 2006. 5. The water supply to the disposal unit in the pot and pan wash area failed to shut off after the unit had been turned off in one (1) of one (1) observation between 8:45 AM and 4:30 PM on May 15, 2006. 6. The interior of hotel pans (12"x10"x6") were wet and not allowed to dry before placing pans on racks for reuse in five (5) of five (5) observations between 8:45 AM and 4:30 PM on May 15, 2006. 7. Muffin pans stored on a rack in the cook's preparation area were not allowed to dry before placing pans on racks for reuse in 12 of 12 observations between 8:45 AM and 4:30 PM on May 15, 2006.	F 371		

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F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by : Based on observation and record review,for four (4) of 30 sampled records, the physician failed to: monitor anticoagulant therapy and respond to a telephone call from facility staff reporting a nose bleed for one (1) resident and review the total plan of care as evidenced by failing to document in the progress notes for three (3) residents who experienced weight changes. Residents #29, 8, 17, and 21. The findings include: 1. The physician failed to adequately monitor Resident #29 who was on anticoagulant therapy with an elevated PT (Prothrombin time) level and respond to a telephone call from facility staff to report that the resident had a nose bleed. A. Resident #29 was admitted to the facility on March 22, 2006. The admission orders included " Warfarin Sodium 10mg (Coumadin) 1 tab. GT/ PO daily blood thinning 3/2206 - 3/38/06 and Labs: CBC every 6 months and FBS (fasting blood sugar monthly for DM. " Signed by the nurse at 5:00 PM. Additionally on March 22, 2006	F 386	**483.40(b)** **PHYSICIAN VISITS** Residents #29, 8, 17, 21 1. Physicians involved in deficient practices at the time of the survey have been counseled regarding their errors. 2. Physician response time and documentation for residents with significant weight changes will be addressed to all physicians at the scheduled Physician Services Meeting which is chaired by the Medical Director. 3. The Clinical Mangers will monitor the physicians for response time and appropriate documentation on significant weight change and report their findings to the Director of Nurses and Medical Director. 4. The Medical Director will oversee this monitoring and report on his findings with any action plans for improvement at the quarterly Quality Improvement Committee which is chaired by the administrator.	7/2/06 7/2/06 7/2/06 6/30/06

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F 386	Continued From page 80 at 10:00 PM a telephone order was received, " Obtain PT/INR lab work in 3 days. " On March 24, 2006 12:30 AM a physician ' s order directed, " Obtain U/A C&S in AM to R/O UTI. " March 24, 2006 2:00 PM a physician ' s order directed, " Levaquin 500mg 1 tab po everyday for 7 days. " On March 26, 2006, a progress note was entered on the resident ' s record by the physician however, there was no documentation to indicate that the physician acknowledged the laboratory results requested for March 22, 2006 or that resident was receiving Levoquin (Severity 11 notification to monitor the use of Coumadin/ Levaquin.) March 28, 2006 at 2:00 PM a physician ' s order directed, " Continue on Warfarin Sodium 10mg 1 tab daily GT/PO blood thinning. March 29, 2006 2:40 PM a physician ' s telephone order directed, " Check PT/INR every month. " On March 28, 2006 at 3:30 PM a nurse's note indicated, "writer was called by lab regarding-PT/ INR result, PMD made aware, no new orders given but said to continue with Coumadin and was noted. " The PT collected on March 28, 2006 was 27.4, Normal range 12.2-15.0. The physician signed the laboratory result form on April 4, 2006. There were no progress notes in the record dated for April 4, 2006. On May 19, 2006 at approximately 9:45 AM, the	F 386		

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F 386	Continued From page 81 Unit Manager was interviewed and indicated if a call comes from the laboratory to report a specific level, it is usually indicative of an abnormal value/ level that needs to be addressed by the physician. The elevated PT report was communicated to the physician, however there were no adjustments made of the resident's Coumadin dosage. The physician failed to adequately monitor the resident's PT level after a reported elevated range. The record was reviewed May 19, 2006. B. The physician failed to respond to a telephone call from facility staff to report that the Resident # 29 had a nose bleed. On April 16, 2006 at 11:00 PM a nurse's note indicated, "10:00 PM had a nose bleed, small amount. Ice pack applied over bridge of nose. Place a call to PMD and left message to the answering machine. Has not responded as of this time." On April 17, 2006 at 7:35 AM a nurse's note indicated, " ...Continue to have small amount of nose bleeding. Continued to apply ice compress over bridge of nose ...PMD responded made aware of medical problem. Orders to continue to apply ice and to do CBC and PT/INR today and to report result to PMD. According to a nurse's note on April 17, 2006 at 2: 30 PM the laboratory results were received and the results indicated: PT 134.4 Normal range 12.2-15.0 INR 19.84 Normal range 2.0-3.0. The resident was transferred to the hospital.	F 386		

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F 386	Continued From page 82 There was an approximately nine(9) hour delay of the physician's response of an emergency call regarding the resident with a nose bleed. The record was reviewed no May 17, 2006. 2. A review of Resident #8's record revealed that the resident lost 19 pounds in nine (9) months with no assessment by the physician. According to the "Vital Sign Flow Sheet" the resident's weights were as follows: Date Weight (pounds) 8/8/05 119.3 9/13/05 98 10/6.05 100 11/11/05 94.5 12/4/05 106.4 1/06 103 2/06 (blank) 3/6/06 93.5 4/06 93/5 5/8/06 90 Physician progress notes were present in the record for August 16, September 14, November 22, December 20, 2005 and January 17, February 14, March 13, April 13, and May 2, 2006 . There was no assessment or reference to the resident's weight loss. The record was reviewed May 16, 2006. 3. A review of Resident #17's record revealed that the resident gained 7½ pounds in less than two (2) months with no assessment by the physician. According to the "Vital Sign Flow Sheet" the resident's weights were as follows:	F 386		

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F 386	Continued From page 83	F 386		

Date Weight (pounds)
1/12/06 130
2/23/06 134
3/2/06 137.5
4/06 (blank)
5/4/6 142

Physician progress notes were present in the record for January 24, February 6 and 15, March 29, April 11, and May 2, 2006. There was no assessment of or reference to the resident's weight gain. The record was reviewed May 16, 2006.

4. A review of Resident #21's record revealed that the resident lost 14 pounds in five (5) months with no assessment by the physician.

According to the "Vital Sign Flow Sheet" the resident's weights were as follows:
Date Weight (pounds)
12/14/05 159
1/06 (blank)
2/06 (blank)
3/06 (blank)
4/7/06 145

Physician progress notes were present in the record for February 6 and 23, March 19, and April 11, 2006. There was no assessment or reference to the resident's weight loss. The record was reviewed May 17, 2006.

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F 425 SS=D	483.60 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. This REQUIREMENT is not met as evidenced by : Based on observation, record review and staff interview for one (1) of six (6) six emergency boxes , it was determined that pharmacy services failed to ensure that emergency drugs were available for facility residents. The findings include: According to the facility's Policy and Procedure, # 3.4, "Emergency Drug Box" stipulates the purpose of this policy is (1) to provide ready access to emergency drugs that can be utilized in an emergency situation. (2) to ensure a standardize procedure for the replacing and charging of emergency drugs." On Monday, May 15, 2006, the nursing stations were inspected for the storage of medication. In an isolated incident an emergency box (Box #5) located on 2 South did not contain Glucagon injection. According to the emergency box receipt slip, on May 3, 2006, Glucagon was taken from the emergency box and used for a resident. A face-to-face interview was conducted with the charge nurse on May 15, 2006 [Monday] at	F 425	**483.60 PHARMACY SERVICES** 1. The emergency supply was replaced upon discovery. 2. It is the responsibility of the nursing staff to notify the pharmacy when a medication is used from the emergency box. The meds are replaced and the box is re-locked. The box is only exchanged as it approaches its date of expiration. 3. Inservicing was done with all licensed staff to ensure their understanding of the emergency drug policy and their need to contact the pharmacy whenever a drug is used. The Clinical Managers and Consultant Pharmacist will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/18/06 7/2/06 Review report 7/2/06 6/30/06

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F 425 SS=D	483.60 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. This REQUIREMENT is not met as evidenced by : Based on observation, record review and staff interview for one (1) of six (6) six emergency boxes , it was determined that pharmacy services failed to ensure that emergency drugs were available for facility residents. The findings include: According to the facility's Policy and Procedure, # 3.4, "Emergency Drug Box" stipulates the purpose of this policy is (1) to provide ready access to emergency drugs that can be utilized in an emergency situation. (2) to ensure a standardize procedure for the replacing and charging of emergency drugs." On Monday, May 15, 2006, the nursing stations were inspected for the storage of medication. In an isolated incident an emergency box (Box #5) located on 2 South did not contain Glucagon injection. According to the emergency box receipt slip, on May 3, 2006, Glucagon was taken from the emergency box and used for a resident. A face-to-face interview was conducted with the charge nurse on May 15, 2006 [Monday] at	F 425	**483.60 PHARMACY SERVICES** 1. The emergency supply was replaced upon discovery. 2. All emergency boxes were checked to ensure that their stock was both complete and within date. 7/17/06 gs 3. Inservicing was done with all licensed staff to ensure their understanding of the emergency drug policy and their need to contact the pharmacy whenever a drug is used. The Clinical Managers and Consultant Pharmacist will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/18/06 7/2/06 7/2/06 6/30/06

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 85 approximately 10:00 AM. He/She stated that the emergency box is replaced every Tuesday. The emergency box was not replaced until May 18, 2006 [Thursday]. Glucagon injection was in the emergency box.	F 425	**483.60(c)(1)** **DRUG REGIME REVIEW** 1. The drug regime review was done for this resident for May and June 2006 with no particular issues arising. 2. The pharmacy did an audit of the medical records and found no other record with a missing monthly audit. 3. The Consultant Pharmacist will be given an accurate census prior to each of her visits so that she can be assured of the current residents and their room numbers. Business Office coordinator to work with the pharmacist to ensure this is completed. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/31/06 5/31/06 7/2/06 6/30/06
F 428 SS=D	483.60(c)(1) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. This REQUIREMENT is not met as evidenced by : Based on observation, record review, and staff interview, it was determined that the contract pharmacist failed to complete a monthly drug regimen review for one (1) of 30 sampled residents. Resident #4. The findings include: A review of Resident #4's record revealed that a monthly drug regimen review was not done for April 2006. A face-to-face interview was conducted with the Assistant Unit Manager on May 15, 2006 at 11:00 AM. He/she acknowledged that the drug regimen review for April 2006 was not done. The record was reviewed May 15, 2006.	F 428		

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F 429 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities to the attending physician and the director of nursing . This REQUIREMENT is not met as evidenced by : Based on observation and record review for two (2) of 30 sampled residents, it was determined that the facility's contract pharmacist failed to report to the physician and Director of Nursing that orders for Lorazapam (Ativan), IM and PO (by mouth), had the same indication for use for two (2) residents. Residents #2 and S9's drug regimen. The findings include: 1. A review of Resident #2's record revealed that the pharmacist failed to report to the physician and Director of Nursing that the two (2) orders for Lorazepam, IM and PO, had the same indication for use. The May 2006 Physician's Order Form included the following orders: "12/18/05, Lorazepam ½ ml (1 mg) intramuscularly (IM) every 4 hours as needed for agitation"; and " 12/18/05, Lorazepam 1 mg 1 tablet by mouth every four hours as needed for agitation. " There was no information included with the orders that would determine which route, IM or po, would be used. The drug regimen review was done monthly, December 2005 through March 2006. There were no irregularities for the aforementioned months. The record was reviewed on May 15, 2006.	F 429	**483.60(c)(2)** **DRUG REGIME REVIEW** Residents #2 and S9 1. The orders for these residents were clarified with the residents' attending physicians. 2. The pharmacy is performing a 100% audit of all PRN medications to ensure that those with the same therapeutic effect for any given resident have a clarification order documenting the order in which these medications should be given. 3. The consultant pharmacist will monitor the orders for the PRN medications to ensure compliance. She will work directly through the DON and physicians when clarification orders are needed. 4. She will report the findings of her monitoring at the quarterly Quality Improvement Committee.	5/19/06 7/2/06 6/30/06 6/30/06

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F 429	Continued From page 87 2. The facility's contract pharmacist failed to report to the physician and Director of Nursing that the order for Lorazapam (Ativan) failed to specify when to use IM or PO. A review of Resident S9 ' s record revealed a physician's order dated March 14, 2006, " Ativan 1 mg po (orally) or IM (intramuscularly) every 4 hrs PRN (as needed) for anxiety. " There was no evidence that the contract pharmacist notified the physician of that to clarify when to use the oral form or the injectable form of the Ativan. The facility's contract pharmacist reviewed the record April 10 and May 11, 2006. "NI" (no irregularities" was circled for both review dates. The record was reviewed May 19, 2006.	F 429	**483.65(a)** **INFECTION CONTROL** 1. Improper infection control hand washing technique was corrected at the time of the survey. 2. Inservicing was done with all nursing staff to ensure their knowledge and technique of proper hand washing procedures. 3. The ADON and Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Soiled bedside mats, soiled shower chairs, shower stall with mildew, storage of plungers, linen chute	5/19/06 6/30/06 6/30/06 6/30/06
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by	F 441	1. All issues found at the time of the survey were corrected immediately. 2. A review of the other similar equipment was done and corrections made as necessary. 3. Inservicing was done with Environmental Services staff to ensure their knowledge of proper cleaning and infection control techniques when dealing with resident equipment. The Housekeeping Supervisors will monitor this issue throughout the month and report their findings to the Director of Environmental Services.	5/19/06 7/2/06 7/2/06

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F 441	Continued From page 88 Based on observations during the survey period, facility staff failed to prevent the development and transmission of disease as evidenced by: a nurse drying washed hands on a towel used by a resident; soiled and uncovered bedside floor mats with foot prints on the mat; soiled shower chairs, shower mats and shower stretcher; a shower stall with mildew; plungers stored uncovered in bathrooms and soiled and stained linen shoots. These findings were observed in the presence of Maintenance, Housekeeping and nursing staff. The findings include: 1. The clinical manager (CM) repositioned a resident who had a towel on his/her chest because of excessive drooling. The CM washed his/her hands and took the towel from the resident, dried his/her hands and disposed of the towel in the soiled linen bin in one (1) of one (1) observation on May 15, 2006 at 9:27 AM. 2. Soiled and /or uncovered bedside mats were observed in the following areas:106, 144, 225, and 237 during the survey period. 3. A soiled shower chair was observed in the 3 North shower room on May 18, 2006 at 11:00 AM in one (1) of one (1) observation. 5. A shower stall with mildew was observed in the 2 South shower room in one (1) of one (1) observation on May 17, 2006 at 4:00 PM. 6. Plungers were stored uncovered in bathrooms in room 204 and the 1 South staff bathroom. 7. Soiled and stained linen shoots were observed	F 441	4. The Director of Environmental Services will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/30/06

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F 441	Continued From page 89 on 1 North, 2 North and 3 North in three (3) of six (6) observations during the survey period.	F 441	**483.70(c)(2)** **SPACE AND EQUIPMENT** Oxygen concentrators 1. Any oxygen concentrator with an odometer reading over 10,000 hours has been pulled from the unit and replaced with another one.	6/30/06
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, facility staff failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by: lack of service tags for oxygen concentrators; non-functional amplifiers on telephones; failure of elevator indicator lamps to illuminate; and no logs to track preventive maintenance for equipment. These observations were made in the presence of nursing staff and/or the Directors of Maintenance and Housekeeping. The findings include: 1. Oxygen concentrators were observed without service tags and odometer readings in rooms 308 , 316, 337 and 349 in four (4) of four (4) observations on May 15, 2006 between 9:15 AM and 9:45 AM. 2. The amplifiers of public telephones were not functioning on 3 North on May 18, 2006 at 10:15 AM in one (1) of four (4) observations. 3. Elevator indicator lamps failed to illuminate on	F 456	2. NeighborCare is assisting the facility in developing an aggressive and effective preventative maintenance program for its oxygen concentrators. Logs have been developed for tracking. 3. Inservicing was done by NeighborCare of the Central Supply and Maintenance staff regarding the measuring of oxygen output to ensure therapeutic levels for the residents. Additionally, NeighborCare will provide preventative maintenance on the oxygen concentrators which have reached certain odometer readings. 4. The Director of Maintenance will report on the progress of the PM program for the facility's oxygen concentrators at the quarterly Quality Improvement Committee which is chaired by the administrator. Amplifiers and indicator lamps 1. Amplifiers on the public phones and indicator lamps on the elevators missing at the time of the survey have been repaired and/or replaced. 2. All public telephones and elevators were checked to ensure amplifiers and indicator lamps were present. 3. Maintenance aides will monitor the amplifiers and lamps on a monthly basis to	7/2/06 7/2/06 6/30/06 7/2/06 7/2/06 7/2/06

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F 441	Continued From page 89 on 1 North, 2 North and 3 North in three (3) of six (6) observations during the survey period.	F 441	483.70(c)(2) **SPACE AND EQUIPMENT** Oxygen concentrators 1. Any oxygen concentrator with an odometer reading over 10,000 hours has been pulled from the unit and replaced with another one.	6/20/06
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, facility staff failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by: lack of service tags for oxygen concentrators; non-functional amplifiers on telephones; failure of elevator indicator lamps to illuminate; and no logs to track preventive maintenance for equipment. These observations were made in the presence of nursing staff and/or the Directors of Maintenance and Housekeeping. The findings include: 1. Oxygen concentrators were observed without service tags and odometer readings in rooms 308 , 316, 337 and 349 in four (4) of four (4) observations on May 15, 2006 between 9:15 AM and 9:45 AM. 2. The amplifiers of public telephones were not functioning on 3 North on May 18, 2006 at 10:15 AM in one (1) of four (4) observations. 3. Elevator indicator lamps failed to illuminate on	F 456	2. With the assistance of NeighborCare, all oxygen concentrators were analyzed for their efficacy and efficent production of oxygen. Logs have been developed for tracking odometer readings. 3. Inservicing was done by NeighborCare of the Central Supply and Maintenance staff regarding the measuring of oxygen output to ensure therapeutic levels for the residents. Additionally, NeighborCare will provide preventative maintenance on the oxygen concentrators which have reached certain odometer readings. 4. The Director of Maintenance will report on the progress of the PM program for the facility's oxygen concentrators at the quarterly Quality Improvement Committee which is chaired by the administrator. Amplifiers and indicator lamps 1. Amplifiers on the public phones and indicator lamps on the elevators missing at the time of the survey have been repaired and/or replaced. 2. All public telephones and elevators were checked to ensure amplifiers and indicator lamps were present. 3. Maintenance aides will monitor the amplifiers and lamps on a monthly basis to	7/2/06 7/2/06 6/20/06 7/2/06 7/2/06 7/2/06

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F 456	Continued From page 90 the main elevator on May 15, 2006 at 8:30 AM. 4. Documentation was not available to show that temperatures/pressure checks, lubrication, coil cleaning and filter changes were performed on HVAC units, hot water boilers, laundry washers, gas dryers, circulation pumps, air handlers and exhaust fans during the survey period.	F 456	ensure compliance. They will report their findings to the Director of Maintenance. 4. The Director of Maintenance will report any action plans for the amplifiers and indicator lights at the quarterly Quality Improvement Committee which is chaired by the administrator. Logs 1. Logs have been developed as evidence that the temperatures, pressure checks, coil cleaning and filter changes were performed on HVAC units, hot water boilers, washers, dryers, circulation pumps, air handlers exhaust fans are being done on a consistent basis. 2. Logs are being kept on all of these areas on an on-going basis as part of the facility's preventative maintenance program. 3. The Maintenance Aides and Director will ensure the documentation of these logs on a routine and consistent basis. 4. The Director of Maintenance will report on the progress of the PM program at the quarterly Quality Improvement Committee which is chaired by the administrator.	6/30/06 7/2/06 7/2/06 7/2/06 6/30/06
F 490 SS=G	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by : Based on observations, record reviews and staff interviews, it was determined that the Administrator failed to integrate, coordinate and monitor the facility's practice related to residents' care. The findings include: 1. The Administrator failed to ensure that housekeeping and maintenance services were maintained in a safe and sanitary manner. Cross reference 483.15(h)(2), F253, Quality of Life. 2. The Administrator failed to ensure that services were provided or arranged by the facility to meet professional standards of quality. Cross reference 483.20(k)(3)(i), F281, Resident	F 490	**483.75 ADMINISTRATION** 1. See response to 483.15 (h)(2) 2. See response to 483.20 (k)(3)(I) 3. See response to 483.25	7/2/06 7/2/06 7/2/06

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F 490	Continued From page 91 Assessment. 3. The Administrator failed to ensure that residents received the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Cross reference 483.25, F309, Quality of Care.	F 490	**483.75(b)** **ADMINISTRATION** 1. The facility strives to attain 3.5 nursing hours per patient day. 2. Each day the staffing is evaluated and adjusted to ensure proper staff for the residents of the facility. 3. The staffing coordinator, ADON and DON will ensure proper staff of nurses and certified nursing assistants are present on the units to attain and maintain the residents' highest level of functioning.	5/19/06 5/19/06 5/19/06
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 observation, interview, record review and review of staffing sheets for four (4) of five (5) days of the survey period, the facility failed to maintain staffing at 3.5 nursing hours per resident per day to comply with 22 DCMR 3211.3 and for four (4) of 30 sampled residents, it was determined that the social worker failed to write quarterly progress notes to comply with 22 DCMR 3229.5. Residents #1, 12, 18 and 21. The findings include: 1. The facility failed to comply with 22 DCMR 3211.3 by failure to maintain 3.5 nursing hours per resident per day.	F 492	4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Social Work notes Resident #1, 12, 18, 21 1. Social Work notes missing at the time of the survey have been evaluated by the Director of Social Work and corrections were made whenever possible. 2. A 100% audit of all social work notes was done by the Director of Medical Records and the results of that audit were forwarded to the Director of Social Work for correction. 3. Aggressive recruitment to fill 2 vacant social work positions is on-going. The facility signed a contract with Delta-T, an agency which supplies contract workers, and an LICSW has started with an LGSW to begin soon. The Director of Social Work will monitor the timely completion	6/30/06 6/30/06 7/2/06

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F 492	Continued From page 92 According to 22 DCMR, Beginning no later that January 1, 2005, "Each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per resident per day ." The Nursing Daily Staffing Sheets were requested for May 14 through 21, 2006. The actual staffing schedules were reviewed with the DON for May 14, 15, 16, and 17. Three (3) of the four (4) days reviewed, revealed that the actual staffing was less than 3.5 nursing hours per resident per day. The same days were reviewed again by the DON (Director of Nurses) and ADON (Assistant Director of Nurses) and the result of the staffing schedule indicated: May 14, 2006 3.09 May 15, 2006 3.09 May 16, 2006 3.6 May 17, 2006 3.16. Three (3) of the four (4) days staffing reviewed by the DON and ADON remained below the required 3.5 nursing hours per resident per day. 2. The social worker failed to write a quarterly progress that included a social assessment and evaluation for Resident #1. A review of Resident #1's record revealed the last social worker's progress note was written on January 10, 2006. A progress note was due April 2005. A face-to-face interview was conducted with the Director of Social Services on May 16, 2006 at 9:	F 492	of evaluations and notes. 4. The results of his monitoring and any action plans for improvement will be presented to the quarterly Quality Improvement Committee which is chaired by the administrator.	6/30/06

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F 492	Continued From page 93 30 AM. He/she stated, "We know we are behind in the progress notes on all the units. We had a turn over in staff and are trying to catch up. We are trying to address residents with immediate needs first." The record was reviewed May 15, 2006. 3. The social worker failed to write a quarterly progress that included a social assessment and evaluation for Resident #12. A review of Resident #12's record revealed social worker progress notes were written on July 5, 2005 and December 27, 2005. A quarterly progress note was due October 2005. The record was reviewed May 16, 2006. 3. The social worker failed to write a quarterly progress that included a social assessment and evaluation for Resident #18. A review of Resident #18's record revealed social worker progress notes were written on November 1, 2005 and April 5, 2006. A quarterly progress note was due on February 2006. The record was reviewed May 16, 2006. 4. The social worker failed to write a quarterly progress that included a social assessment and evaluation for Resident #21. A review of Resident #21's record revealed the last social worker's progress note was written on January 17, 2006. A progress note was due April 2005. The record was reviewed May 17, 2006.	F 492		

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F 493 SS=G	483.75(d)(1)-(2) GOVERNING BODY The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by : Based on the observations, staff interview and record review, it was determined that the Governing Body failed to ensure that policies regarding the management and operation of the facility were implemented. The findings include: 1. The Governing Body failed to ensure that housekeeping and maintenance services were maintained in a safe and sanitary manner. Cross reference 483.15(h)(2), F253, Quality of Life. 2. The Governing Body failed to ensure that services were provided or arranged by the facility to meet professional standards of quality. Cross reference 483.20 (k)(3)(i), F281, Resident Assessment. 3. The Governing Body failed to ensure that residents received the necessary care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Cross reference	F 493	**483.75(d)(1)-(2)** **GOVERNING BODY** 1. See response to 483.15(h)(2) 2. See response to 483.20(k)(3)(I) 3. See response to 483.25	7/2/06 7/2/06 7/2/06

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F 493	Continued From page 95 483.25, F309, Quality of Care.	F 493	7/12/06 mn 483.75(l)(1) CLINICAL RECORDS #18 1. The admission MDS was completed and included in the discharged record. 2. The Director of Medical Records reviewed similar discharged records and found no other missing MDSs. 3. The Clinical Managers will monitor the completion of the MDSs to ensure that all are done in a timely manner. They will report the results of their monitoring to the DON. 4. The Director of Nursing will report on the timely completion of the MDSs and any action plans for improvement at the quarterly Quality Improvement Committee which is chaired by the administrator.	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by : Based on the review of one (1) of three (3) closed records, it was determined that facility staff failed to maintain a clinical record in accordance with acceptable professional standards and practice. Resident #18. The findings include: During the review of the clinical record for Resident #18 who was discharged home, it was determined that the record was incomplete. The resident was admitted to the facility on January 25, 2006 and was discharged home on February 16, 2006. The admission Minimum Data Set assessment was not included in the record on the day of the record review. The	F 514		7/2/06 7/2/06 7/2/06 6/30/06

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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	05/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON NURSING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 96 record was reviewed on May 17, 2006.	F 514		