STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	09/22/2006

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L 000	Initial Comments An annual licensure survey was conducted September 19 through 22, 2006. The following deficiencies were based on observations, record reviews and staff interviews. The sample included 30 residents based on a census of 202 residents on the first day of survey.	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on staff interview and record review for two (2) of 30 sampled residents, it was determined that the charge nurse failed to follow the interventions for the care plan problem, "	L 051	L 051 3210.4 Nursing Facilities 1. Resident #12 was re-assessed by the RCC and the Recreation Director. Following the reassessment the team decided to continue with current approaches. Additionally, the resident was involved in an activity later that same afternoon. Music was played and interaction took place. No adverse reaction was noted to resident. Resident #18 was reassessed by the clinical team. The falls care plan was updated to reflect risk factors and appropriate interventions. 2. A review of the residents with "Severe Alzheimer's Disease" was conducted to ensure appropriate care plan in place and being followed. The care plan for all residents with a fall within the last quarter was reviewed. No other resident was found to be affected by this practice. 3. The Director of Nursing and Director of Therapeutic Recreation had a meeting regarding approaches for residents with Alzheimer's disease. The staff have been re-educated regarding following approaches as indicated in the care plan. Additionally, the staff was re-educated on fall prevention and post fall management and care planning. 4. The comprehensive care plan is audited monthly. Focus audits of the care plans following a fall will be incorporated into the audit. Additionally the audit tool has been updated to reflect the care plan being followed as written. This information is presented at the quality assurance meetings.	10/31/06

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L 051	Continued From page 1 Severe Alzheimer's Disease" for Resident #12 and update the falls care plan to include approaches and interventions for Resident #18 following one (1) fall with a fracture. The findings include: 1. The charge nurse failed to follow the interventions for the care plan problem, "Severe Alzheimer's Disease" for Resident #12 According to the quarterly Minimum Data Set (MDS) completed September 1, 2006, the resident was coded with long and short-term memory problems and severely impaired skills for cognitive decision-making (Section B). Resident #12 was observed from 11:10 AM until 12:50 PM on September 19, 2006. The resident was accompanied by his/her daughter from 11:10 AM until 12:10 PM. The resident was positioned facing away from the other residents gathered in the day room. Facility staff acknowledged the daughter but failed to address the resident. The resident's position in the day room was not changed when his/her daughter left. Two (2) recreational therapists came into the day room at 11:50 AM and left at 12:20 PM. There was no interaction between the recreational therapists and Resident #12. Facility staff approached the resident at 12:40 PM . The staff member spent one (1) minute standing beside the resident checking the feeding tube pump. He/she did not touch or talk to the resident. According to the resident's care plan for "Severe Alzheimer's Disease," reviewed September 9,	L 051		

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L 051	Continued From page 2 2006, approaches included the following: "Talk to resident throughout the day, including topics of current events. Touch resident while taking. Position for maximum stimulation." According to the evaluation of the approaches dated September 7, 2006, "Resident responds to verbal and tactile stimulation." A face-to-face interview with the Resident Care Coordinator was conducted on September 19, 2006 at 1:00 PM. He/she reviewed the resident ' s record and acknowledged that the resident's care plan interventions were not followed. The record was reviewed September 19, 2006. 2. The charge nurse failed to update the falls care plan to include approaches and interventions for Resident #18 following one (1) fall with a fracture. A review of Resident #18's record revealed that on July 19, 2006 an x-ray report confirmed that the resident had a subcapital fracture to the right hip from a previous fall. The resident was sent out via stretcher with paramedic staff to the emergency room. The resident was readmitted to the facility on July 26, 2006 with diagnoses that included ORIF [Open Reduction Internal Fixation] to Right Hip. On September 20, 2006 at 12:20 AM a nurse's note documented the following: " Resident was noted on the floor sitting inside the closet ... Resident stated that he/she climbed out of the bed from the foot end [of the bed] and slide to the floor. " A review of Resident #18's " Resident Care Plan " revealed that upon readmission to the facility on July 26, 2006 the " Falls Care Plan " was not	L 051		

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L 051	Continued From page 3 updated or revised with new approaches or interventions to address the resident's fall status. Subsequently, the resident sustained a fall without injury on September 20, 2006. A face-to-face interview was conducted with the Resident Care Coordinator on September 20, 2006 at 9:15 AM. He/she acknowledged that no interventions were initiated after the above cited fall. The record was reviewed September 20, 2006.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers; (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers,	L 052	L 052 3211.1 Nursing Facilities 1. The physician's orders and MARs for Resident #7 were reviewed and medications were administered. No adverse reaction was noted to resident. 2. The physician's orders and MARs for the residents have been reviewed to ensure that MARs reflect the current needs of the residents. No other resident was found to be affected by this practice. 3. The nurse responsible for the error was in-serviced and counseled. The licensed staff have been re-educated on medication administration and requirements. 4. Medication pass audits and tool has been reviewed and updated to include formula for calculation of medication error. These audits continue to be done monthly and additional audits are done by pharmacy. This is presented at the Quality Improvement Meetings.	10/31/06

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L 052	Continued From page 4 which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, staff interview and record review, it was determined that one (1) significant and one (1) non-significant error occurred during the morning medication pass on September 20, 2006 for Resident #7. The findings include: At approximately 9:05 AM on Wednesday, September 20, 2006, the medication nurse prepared medication for Resident #7. The nurse administered five (5) morning medications. A review of the resident's Medication Administration Record (MAR) revealed that the nurse omitted two (2) medications from the morning medication pass, Spironolactone 50mg tablet, taken daily for Congestive Heart Failure (CHF) and Oyst-Cal-D 500mg/200u tablet taken	L 052		

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L 052	Continued From page 5 daily as a nutritional supplement. The physician's order for Spironolactone and Oyst-Cal-D was written on December 6, 2005 and renewed on September 12, 2006. A face-to-face interview was conducted with the medication nurse immediately after he/she administered medications to Resident #7. After reviewing the MAR, the nurse acknowledged his/her error and administered the Spironolactone 50 mg tablet and Oyst-Cal-D 500mg/200u.	L 052		
L 152	3227.3 Nursing Facilities Proper storage temperature shall be maintained for each medication according to the manufacturer's direction. This Statute is not met as evidenced by: Based on observation, staff interview and record review, it was determined, that the refrigerator temperatures were out of range for the 3 Orange medication refrigerator. The findings included: The Facility's policy, "5.3 - Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles," stipulates under, "(8) Drugs and biologicals are stored at their appropriate temperatures. (8.2) Refrigeration: 36° F - 46° F (Fahrenheit) or 2° to 8° C." On September 19, 2006, at approximately 9:30 AM and 3:30 PM the refrigerator temperature on 3 Orange was 60° F. The medication refrigerator stores vaccines, insulins and suppositories. The Facility's "Refrigerator Temperature Record" and the pharmacist's "Monthly Inspection" report	L 152	L 152 3227.3 Nursing Facilities 1. The medications in the identified refrigerator were removed immediately. The thermostat in the refrigerator had been changed within the last month and the temperature readings were within the appropriate range with some fluctuations, as a result a new refrigerator was purchased, installed and checked for appropriate temperature. 2. All medication refrigerators were checked and no other refrigerator was found to be affected by this practice. 3. The medication refrigerators will continue to be checked by the nursing department. Additionally, the engineering department will include the medication refrigerators on their preventive maintenance program. 4. Checking the medication temperatures is a part of the daily nursing and monthly pharmacy inspections. This is also now included in the engineering inspections. The information will be presented at the quality assurance meetings.	10/6/06

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L 152	Continued From page 6 revealed that the refrigerator had fluctuating temperatures in August and September 2006 between 56 and 60 degrees F. The 3 Orange Resident Care Coordinator stated that a work order request had been sent to the maintenance department. The work order was unable to be located at time of inspection. On September 19, 2006, at approximately 4:30 PM, a face-to-face interview was conducted with the engineer. He/she stated, "The work order is being filled out now. I just replaced the refrigerator. There was no work order submitted for the refrigerator before today."	L 152		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled exhaust vents in residents ' rooms and common areas and marred and damaged entrance doors. These findings were observed in the presence of Maintenance and Housekeeping Directors. The findings include: 1. The exterior and interior surfaces of exhaust vents in residents' bathrooms and common areas were soiled with accumulated dust and debris.	L 410	L 410 3256.1 Nursing Facilities 1. The exterior and interior surfaces of exhaust vents identified on the first, second and third floor and in the common areas have been cleaned. The resident entrance, bathroom and closet doors identified to be marred or damaged have been repaired and/or painted. 2. All exterior and interior vents have been inspected for dust and debris and cleaned if indicated. All entrance, bathroom and closet doors were inspected and repaired or painted as needed. No resident was affected by this practice. 3. The Director of Engineering reviewed the Preventive Maintenance program and re-educated staff on expectations. The exhaust vents and doors are a part of the daily inspection logs. 4. The Director of Engineering and Environmental Services will collaboratively conduct quarterly audits on the exhaust vents. Additionally, audits will be conducted on the doors. Findings will be presented at the Quality Assurance meeting.	10/6/06

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L 410	Continued From page 7 First Floor Rooms 102, 111, 153, 156, 178, 181 and women's toilet room in seven (7) of 19 observations between 11:19 AM and 12:20 PM on September 19, 2006 and between 11:30 AM and 2:00 PM on September 20, 2006. Second Floor Rooms 235, 273, 281, toilet room, custodial closet and women's bathroom in six (6) of 24 observations between 9:00 AM and 1:30 PM on September 21, 2006. Third Floor Rooms 359, 382, 388 and men's shower room in four (4) of 19 observations between 2:12 PM and 4:45 PM on September 21, 2006. 2. Residents' entrance, bathroom and closet doors were marred and damaged on the frontal and edge surfaces in the following areas: First Floor Rooms 153, 160, 189 in three (3) of 20 observations between 11:19 AM and 12:20 PM on September 19, 2006 and 11:30 AM and 4:45 PM on September 20, 2006. Second Floor Rooms 239, 235, 272, 273, 282 and 288 in six (6) of 24 observations between 9: 00 AM and 1:30 PM on September 21, 2006. Third Floor Rooms 336, 337, 385, 388 and 380 in five (5) of 19 observations between 2:12 PM and 4:45 PM on September 21, 2006.	L 410		