

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

PRINTED: 03/06/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>095015</b>	(X2) MULTIPLE CONSTRUCTION ..A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAROLYN BOONE LEWIS HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1380 SOUTHERN AVE SE WASHINGTON, DC 20032</b>
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F 000	<b>INITIAL COMMENTS</b>	F 000		
	A recertification survey was conducted on February 17 through 20, 2009. The following deficiencies were based on observations, record review, staff and resident interviews. The sample included 24 residents based on a census of 156 residents on the first day of survey and nine (9) supplemental residents.			
F 176 SS=D	<b>483.10(n) SELF ADMINISTRATION OF DRUGS</b>  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d) (2) (ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and staff interview for one (1) of eight (8) residents observed during medication pass, it was determined that facility staff failed to assess Resident F1 for the ability to self medicate and to obtain a physician's order to self administer inhalant medication for Resident F1.  The findings include:  According to Resident F1's February 2009 Physician's Order Sheet signed by the physician on February 2, 2009 directed, "Advair Diskus 100-50 MCG, inhale one puff by mouth twice daily for COPD [chronic obstructive pulmonary disease]."  On February 17, 2009 approximately 9:30AM, during the medication pass for Resident F1, Employee #21 allowed the resident to self administer Advair Diskus medication. The	F 176	1. The Physician was contacted and an order obtained for the Resident F1 to self-medicate the "Advair Diskus 100-50 MCG inhalant".  2. Residents that have the potential to be affected will be assessed for the ability to self-medicate and initiated as indicated.  3. Nurse Managers will educate licensed staff on the policy regarding self-medication to ensure proper assessment of residents with the potential to self-medicate.  4. Residents will be reviewed during quarterly for the ability to self-medicate. This assessment will be reviewed at the Quality IDT Conference. The findings of the Quarterly IDT Conference will be Submitted to the CQI Committee quarterly.	2-23-09  3-31-09  3/31/09  3-19-09

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

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 176	Continued From page 1 resident was observed holding the medication to his/her lips, inhaling deeply and sucking the medication into his/her mouth and held the medication for several seconds while Employee # 21 was at the hand washing sink [the resident was observed taking the Advair correctly].  According to the facility's policy " 2.2 Self Administering Medications, Effective dated August 1, 2002 " Each customer is given the opportunity to self-administer his/her medications if the interdisciplinary team, upon evaluation of a customer ' s ability to safely self-administer medications, has determined that this practice is safe.  There was no evidence in the record that the Interdisciplinary Care Team (IDT) determined that Resident F1 was safe for self administration of medications. There was no physician's order to self administer medications.  The record lacked evidence that a routine assessment was conducted by the IDT to assess the resident's ability to self medicate.  A face-to-face interview was conducted on February 17, 2009 at 9:00 AM with Employee # 21. He/she stated, "Resident F1 wants to give [his/her] own medications." The record was reviewed February 17, 2009.	F 176		
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.	F 221		

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F 221	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview for one (1) of 24 sampled residents, it was determined that the facility staff failed to inform Resident #7's responsible party of the resident's use of a seatbelt while seated in a wheelchair.</p> <p>The findings include:</p> <p>On February 20, 2009 at approximately 11:00 AM, Resident #7 was observed sitting in a wheel chair with a seat belt in place. The resident was unable to release the seat belt when asked.</p> <p>According to the annual Minimum Data Set assessment dated December 31, 2008 Section B2 (Cognitive Impairment) the resident was coded as cognitively impaired.</p> <p>A review of the resident's clinical record revealed an initial physician's order dated October 15, 2008, most recently renewed February 4, 2009, which documented the following: "Apply seat belt for seating and hip positioning when in wheelchair." There was no evidence in the record that the use of the seat belt, risks, benefits and alternatives to its use were ever discussed with the resident's responsible party.</p> <p>A face-to-face interview was conducted with Employee #2 on February 20, 2009 at approximately 11:30 AM. He/she acknowledged that the record lacked information documenting that the responsible party was ever notified of the resident's use of a seat belt. Employee # 2 added, "The responsible party lives in another state. I will call him/her to inform him/her of the</p>	F 221	<ol style="list-style-type: none"> <li>1. Resident #7's responsible party was contacted and consent for the seat belt was obtained.</li> <li>2. Resident with the potential to be affected were reviewed and corrections made when indicated.</li> <li>3. Nursing staff will be educated on the "Policy and Procedure for the Implementation of Restraints". The Fall/Restraint Committee will review restraint usage during the bi-weekly meeting to ensure compliance</li> <li>4. The Nurse Manager will audit residents utilizing any type of restrictive device monthly. The finding of the audit will be submitted to the CQI committee monthly x3 then quarterly.</li> </ol>	<p>2-23-09</p> <p>2-28-09</p> <p>3-31-09</p> <p>3-19-09</p>
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F 221	Continued From page 3 use of the seat belt and will obtain consent for its use at the same time. "The record was reviewed on February 17, 2009.	F 221			
F 241 SS=D	483.15(a) DIGNITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:  Based on an observation and staff interview for one (1) of five (5) dressing changes, it was determined that the facility staff failed to maintain Resident # 4's dignity by writing on the wound dressing tape after it was placed on the resident's body.  The findings include:  During an observation of a dressing change to Resident # 4's sacrum, Employee #17 wrote the time of the dressing change on the tape after the wound dressing was taped to the resident's body.  The observation of the dressing change was made at approximately 12:30 PM on February 19, 2009.  A face-to-face interview was conducted with Employee #17 immediately after the dressing change on February 19, 2009. He/she acknowledged writing the time on the tape while it was affixed to the resident's body.	F 241	1. Employee #17 received counseling on "Maintaining Residents Rights and Dignity" as well as proper Wound Care.  2. Rounds will be conducted on the units by the DON, ADON and Unit Managers to ensure resident dignity is maintained for residents having the potential to be affected.  3. The Licensed Staff member will be trained on "Resident Rights and Dignity and Wound Care".  4. The Educator will review employee educational profiles monthly to ensure mandatory educational compliance of employees.  Findings of the review as well as the results of the rounds by the DON, ADON and the Nurse Managers will be submitted to the CQI committee monthly X3 then quarterly.	2-23-09  2-23-09 Ongoing  3-31-09  3-31-09	
F 250 SS=D	483.15(g) (1) SOCIAL SERVICES  The facility must provide medically-related social	F 250			

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F 250	<p>Continued From page 4</p> <p>services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff and resident interviews for one (1) of nine (9) supplemental residents reviewed, it was determined that the social worker failed to assist Resident S1 in obtaining psychiatric services.</p> <p>The findings include:</p> <p>A face-to-face interview was conducted with Resident S1 on February 20, 2009 at 11:00 AM. He/she stated, "I wanted to go back to [behavior program]. I know I need help. I know that when I don't take my medicine I get crazy. The [hospital's behavior program] really helped me. I talked to the social worker more than a month ago and nothing has happened yet. I haven't seen the psychiatrist from here since October (2008). I need more frequent visits and more time than what [the psychiatrist] gives me."</p> <p>A review of the resident's record revealed a nurse's note dated December 1, 2008 at 3:30 PM, "Resident back from leave of absence. Care plan meeting held with family members in attendance. They expressed concerns about his/her inappropriate behavior. [Resident] refused to take any meds while on leave of absence. Wants resident to see a psychiatrist outside the facility. SS (Social Services) to discuss that with unit manager and follow up on it ..."</p>	F 250	<p>1. A chart review was completed and updated to reflect appropriate services and interventions for Resident S1.</p> <p>2. Assessment have been completed on residents with similar behavior management concerns to assure that appropriate interventions are carried out and care plans are in compliance.</p> <p>3. Staff will be educated on the use of appropriate resources and care plans to address the behavior management for residents.</p> <p>4. Monitoring and review will be completed monthly on behavior concerns and report findings and corrective actions implemented to the CQI Committee monthly x3 and quarterly.</p>	<p>2/25/09</p> <p>3/10/09</p> <p>3/31/09 On-going</p>

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F 250	Continued From page 5  A face-to-face interview was conducted with Employee #13 on February 20, 2009 at 3:30 PM. He/she stated, "I was in contact with the social worker from [hospital's behavior program] to help find housing for [Resident S1]. But I never asked about enrolling [Resident S1] into a program."  A review of the social service notes from October 30, 2008 through January 12, 2009 revealed that there was no evidence that the social worker attempted to contact the [hospital's behavior program].  The facility's psychiatrist saw the resident on June 24, September 23 and October 7, 2008. There was no evidence in the record that the psychiatrist visited the resident after October 7, 2008. The record was reviewed February 20, 2009.	F 250		
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 environmental tour conducted on February 17, 2009 from 12:30 through 4:00 PM and February 18, 2009 from 8:30 AM through 10:30 AM, it was determined that facility staff failed to maintain housekeeping and maintenance services to maintain a sanitary, orderly and comfortable environment as evidenced by: soiled window sills in 14 of 42 rooms , corners in 17 of 42 rooms , floors in 10 of 42 rooms , bathroom vents in five (5) of 42 rooms , privacy curtains in six (6) of 42 rooms , inside of	F 253		

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F 253	<p>Continued From page 6</p> <p>bathroom light fixtures in three (3) of 42 rooms , Heating Ventilation and Cooling (HVAC) in nine (9) of 42 rooms; items stored in two (2) of three (3) shower rooms, damaged walls and cove base in 13 of 42 rooms observed, and marred/scarred furniture in six (6) of 42 rooms .</p> <p>These observations were made in the presence of Employees #1, 2, 3, 8, and 9. The findings were acknowledged at the time of the observations.</p> <p>The findings include:</p> <p>The following items were observed soiled:</p> <p>1. Window sills: Rooms 108, 109, 111, 112, 115, 131, 142, 143, 146, 210, 218, 234, 237 and 320 in 14 of 42 rooms observed.</p> <p>2. Corners: Rooms 108, 109, 111, 115, 122, 131, 137, 143, 146, 210, 241, 309, 320, 335, 338, 341 and 343 in 17 of 42 rooms observed.</p> <p>3. Floors: Rooms 115, 127, 210, 218, 227, 237, 328, 335, 341 and 334 in 10 of 42 rooms observed.</p> <p>4. Bathroom vents: Rooms 108, 115, 213, 218 and 237 in five (5) of 42 rooms observed.</p> <p>5. Privacy curtains: Rooms 109, 111, 140, 334, 335 and 343 in six (6) of 42 rooms observed.</p> <p>6. Inside of bathroom light fixtures: Rooms 326, 338 and 343 in three (3) of 42 rooms observed.</p> <p>7. HVAC filters: Rooms 111, 137, 146, 227, 326, 334, 335, 337 and 338 in nine (9) of 42 rooms</p>	F 253	<p>#1 Window sills:</p> <p>1. Window sills observed with accumulated dust were cleaned and brought into Compliance. 2/21/09</p> <p>2. All windows were assessed for routine cleaning. 3/18/09</p> <p>3. Daily inspection will be done by the supervisor to ensure compliance. 3/16/09</p> <p>4. Staff In-serviced in Cleaning Rooms. (See attached document.) 3/12/09</p> <p>5. Monitor report will be given at the monthly CQI meeting. On-going</p> <p>#2 Corners in the rooms:</p> <p>1. Room corners identified will be cleaned. 3/27/09</p> <p>2. Assessment of all rooms was done and will be cleaned on a scheduled basis. 3/20/09</p> <p>3. Housekeeping staff was in-serviced in "How to Clean Resident's Room Properly". (See attached outline.) 3/11/09</p> <p>4. Process will be monitored by the House-keeping Supervisor to ensure compliance. 3/16/09</p> <p>5. Results and effectiveness of plan will be reported at the monthly CQI meeting. On-going</p> <p>#3 Soiled Floors:</p> <p>1. Floors identified will be stripped and cleaned. 4/11/09</p> <p>2. All rooms were assessed for cleanliness. Rooms identified as out of compliance will be stripped and floors refinished. 4/11/09</p> <p>3. Staff was in-serviced in "How to Strip and Refinish Floors". (See attachment.) 3/11/09</p> <p>4. Housekeeping supervisor will monitor for compliance. (See attachment) 4/11/09</p> <p>5. Results of the monitoring process will be reported at the monthly CQI meeting. On-going</p>	

F-Tag 253 continued

#4 Bathroom Vents:

1. Bathroom vents observed were cleaned immediately. 2/17/09
2. Bathroom vents were assessed for cleanliness and corrective actions made as needed. Vents were placed on schedule for routine cleaning. 2/20/09
3. Staff was in-serviced on "How to Clean Resident's Rooms". (See attachment) Process to be monitored by the House-keeping supervisor. 3/11/09
4. Results of the process will be reported at the monthly CQI meeting. On-going

#5 Privacy Curtains

1. Privacy curtains were cleaned immediately. 2/21/09
2. Privacy curtains of other rooms were inspected and corrections made as needed. 3/16/09
3. Daily inspections will be performed by Housekeeping Supervisor to ensure compliance. A monthly schedule has been implemented to wash or replace privacy curtains. 3/16/09
4. Housekeeping supervisor will audit rooms weekly and report findings monthly to CQI meeting. On-going

#6 Light Fixtures

1. Broken light fixtures identified were replaced. 3/11/09
2. Other light fixtures were inspected and replacements made as needed. 3/20/09
3. Maintenance staff will make monthly rounds to ensure all lights are working properly. Maintenance staff will be in-services on resident safety by Director of Maintenance. 3/20/09
4. Findings of monthly rounds will be reported monthly to the CQI Committee. On-going

F-Tag 253 continued

#7 HVAC - Filters

- |  |          |
|--|----------|
| 1. All filters were cleaned or replaced.   | 3/13/09  |
| 2. Other HVAC filters were inspected and cleaned and replaced as needed.   | 3/23/09  |
| 3. Maintenance staff will perform monthly rounds to ensure all filters are in proper working condition. Maintenance staff will be in-serviced by Director of Maintenance on schedule of cleaning the HVAC filters. | 3/20/09  |
| 4. Findings of monthly rounds will be reported monthly to the CQI meeting.   | On-going |

#8 Items in Shower Rooms

- |   |                    |
|---|--------------------|
| 1. Items have been removed from the shower rooms.   | 2/20/09            |
| 2. Other showers have been inspected and corrections made as needed.  | 2/23/09            |
| 3. Nursing personnel were instructed on not storing items in unauthorized places. The Safety Committee team will make biweekly rounds and document their findings to ensure compliance. | 3/16/09            |
| 4. Findings of the rounds will be submitted to the CQI Committee monthly.   | Ongoing<br>3/19/09 |

#9 Walls

- |   |          |
|---|----------|
| 1. Repair and painting of all walls will be completed.  | 3/20/09  |
| 2. Other rooms will be inspected for damaged walls and repairs will be made as needed.  | 3/31/09  |
| 3. Maintenance staff will perform monthly rounds to ensure all areas are in compliance. Maintenance staff will be in-serviced by the Director of Maintenance on Painting of the facility. | 3/20/09  |
| 4. Findings of monthly rounds will be reported monthly to the CQI meeting.  | On-going |

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F 253	Continued From page 7 observed.  8. Items stored in shower rooms: 1st floor -2 yellow isolation carts, five (5) IV poles; 2nd floor -1 yellow isolation cart and one (1) wheelchair weight scale.  The following items were damaged/soiled:  9. Walls: Rooms 112, 135, 140, 142, 213, 218, 225, 311, 313, 316, 326, 334 and 343 in 13 of 42 rooms observed.  10. Cove base: Rooms 108, 109, 111, 112, 127, 129, 131, 135, 137, 213, 216, 218, 220, 246, 309, 326 and 328 in 17 of 42 rooms observed.  The following items were observed marred/scarred:  11. Furniture: Rooms 112, 2nd floor dining room five (5) of seven (7) arm chairs, 326, 328, 335 and 338 in six (6) of 42 rooms observed.	F 253	#10 Cove base  1. Cove base in rooms identified were repaired or replaced. 2. Other rooms were inspected for damaged cove base and repairs made as needed. 3. Maintenance staff will perform monthly rounds to ensure all areas are in compliance. Maintenance staff will be in-serviced by the Director of Maintenance on repairing or replacing of base covers in the facility. 4. Findings of monthly rounds will be reported monthly to the CQI meeting.	3/12/09 2/23/09 3/20/09 On-going
F 275 SS=D	483.20(b) (2) (iii) RESIDENT ASSESSMENT-WHEN REQUIRED  A facility must conduct a comprehensive assessment of a resident not less than once every 12 months.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interview for two (2) of 24 sampled residents it was determined that the facility failed to complete a full Minimum Data Set (MDS) assessment within 12 months. Residents #12 and #19.	F 275	#11 Marred/Scarred Furniture  1. Furniture/chairs removed from rooms identified and will be painted or replaced with new furniture. 2. Other rooms were inspected for damaged/scarred furniture and will be painted or replaced as appropriate. 3. Condition of furniture in dayrooms and resident rooms will be monitored by the CQI committee and maintenance staff monthly. 4. Findings will be reported at the quarterly CQI meeting for appropriate action.	5/16/09 5/5/09 On-going On-going

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F 275	Continued From page 8 The findings include:  1. Facility failed to complete a full MDS for Resident #12 within 12 months.  A review of Resident #12's record revealed that the last full MDS was completed on November 5, 2007. The next full MDS assessment was due November 6, 2008.  The record lacked evidence that a full MDS assessment for November 6, 2008 was completed. The record was reviewed February 18, 2009.  2. Facility failed to complete a full MDS for Resident #19 within 12 months.  A review of Resident #19's record revealed that the last full MDS was completed on November 26, 2007. The next full MDS assessment was due November 27, 2008.  The record lacked evidence that a full MDS assessment for November 27, 2008 was completed. The record was reviewed February 20, 2009.  A face-to-face interview with Employee #11 was conducted on February 20, 2009 at 11:00 AM. He/she acknowledged that the MDS assessments were completed but were with the MDS coordinator.	F 275	1. Residents #12 and 19 Minimum Data Set (MDS) were brought in compliance.  2. The MDS Coordinator has audited resident's medical records to ensure compliance and corrections as indicated.  3. The MDS Coordinator will develop a system to ensure MDSs are placed on the medical record in a timely manner by: a. Developing an annual calendar; b. Alerting IDT members of the Scheduled Care Plans/MDS in a timely manner; c. Utilizing the Unit Secretary to ensure the MDS is placed on the medical record.  4. The MDS Coordinator will conduct a monthly review of the resident medical records that are due for their quarterly review. Those findings will be submitted to the CQI Committee monthly x3 then quarterly.	2-20-09  3-12-09  3-31-09  3-19-09
F 279 SS=D	483.20(d), 483.20(k) (1) COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	<p>Continued From page 9</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview for one (1) of 24 sampled residents, it was determined that facility staff failed to initiate a care plan with appropriate goals and approaches for the use of a seat belt for Resident # 7.</p> <p>The findings include:</p> <p>A review of the clinical record for Resident # 7 revealed a physician ' s order dated October 15, 2008 which documented the following; " Apply seat belt for seating and hip positioning when in wheelchair. " Further review of the record revealed that there was no care plan initiated for the resident's use of a seat belt.</p> <p>On February 20, 2009 at approximately 11:00 AM, Resident # 7 was observed sitting in a wheel</p>	F 279	<ol style="list-style-type: none"> <li>1. Resident #7 Care plan for seatbelt has been initiated. 2-23-09</li> <li>2. Residents having restrictive devices care plans have been reviewed and corrected as indicated. 2-28-09</li> <li>3. Nursing staff will be educated on the "Policy and Procedure for the Implementation of Restraints" . The Fall/Restraint Committee will review restraint usage during the bi-weekly meeting to ensure compliance 3-31-09</li> <li>4. The Nurse Manager will audit residents utilizing any type of restrictive device monthly. The finding of the audit will be submitted to the CQI committee monthly x3 then quarterly. 3-19-09</li> </ol>	
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F 279	Continued From page 10 chair with a seat belt in place. The resident was unable to release the seat belt when asked.  A face-to-face interview was conducted with Employee # 2 on February 20, 2009 at approximately 11:30 AM. He/she acknowledged that the record lacked a care plan for the use of a seat belt and added, "I will add one right away." The record was reviewed on February 18, 2009.	F 279		
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 record review and staff interview for one (1) of 24 sampled residents, it was determined that facility staff failed to update the	F 280	1. Resident #8 Care plan has been reviewed/updated for compliance.  2. A review has been completed of residents who have sustained a "Fall", corrections have been made as indicated.  3. Nursing staff will be educated on the "Policy and Procedure for Fall follow-up". The Fall/Restraint Committee will review Falls that have occurred during the bi-weekly meeting to ensure compliance  4. The Nurse Manager will audit residents that have fallen monthly. The finding of the audit will be submitted to the CQI committee monthly x3 then quarterly.	2-23-09  2/23/09  3-31-09  3-19-09

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F 280	<p>Continued From page 11</p> <p>care plan for one (1) resident with multiple falls with no injuries for Resident #8.</p> <p>The findings include:</p> <p>A review of Resident #8's nurses' notes dated January 26, 2009 at 7:30 PM and January 27, 2009 at 12:30 AM revealed that the resident fell with no injuries sustained.</p> <p>A review of the "Falls Prevention Care Plan" initiated April 4, 2008 revealed the following handwritten entry under "Evaluation: Resident observed on the floor in room by w/c (wheelchair) x 2. Napping @ time of fall. Observed on knee. No injuries or pain voiced."</p> <p>There was no evidence in the record that additional goals and approaches were initiated after the aforementioned falls with no injuries.</p> <p>A face-to-face interview was conducted with Employee #2 on February 19, 2009 at approximately 1:45 PM. He/she acknowledged that the resident's clinical record lacked evidence that additional goals and approaches were initiated after the aforementioned falls. The record was reviewed February 19, 2009.</p>	F 280		
F 286 SS=D	<p>483.20(d) RESIDENT ASSESSMENT - USE</p> <p>A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review for one (1) of 24 sampled residents, it was</p>	F 286		



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F 309	<p>Continued From page 13</p> <p>and one (1) of nine (9) supplemental residents, it was determined that facility staff failed to: perform a laboratory [lab] test as per physician's order for one (1) resident, stop a wound care treatment to re-assess for complaints of pain for one (1) resident, follow the physician's order for administration of medication for one (1) resident, crush medication without the physician's order for one (1) resident, and check for gastric tube placement prior to administering medications for (1) resident. Residents #1, 5, 11, and F2.</p> <p>The findings include:</p> <p>1. Facility staff failed to obtain a lab for Prolactin for Resident #1.</p> <p>A review of Resident #1's record revealed a physician's order dated December 10, 2008 which directed, "Prolactin level in the AM then Q [every] 6 months] June/Dec, Dx [diagnosis] Paranoid behavior."</p> <p>A review of the laboratory test log dated December 11, 2008 revealed, "[Resident #1]", type lab test ordered- Prolactin, date spec [specimen] obtained- Moved to December 12 [2008].</p> <p>A further review of the record lacked evidence that the Prolactin level was drawn on December 12, 2008 or thereafter.</p> <p>A face-to-face interview was conducted with Employee #2 on February 18, 2009 at 10:50 AM. He/she stated, "The lab has no record [of the specimen being tested]." The record was reviewed on February 18, 2009.</p>	F 309	<p><b>#1</b></p> <p>1. Physician was notified. Prolactin level was obtained.</p> <p>2. Laboratory orders were reviewed and corrections made as indicated.</p> <p>3. Unit Manager will train licensed staff on Procedure for Diagnostic testing and follow-up to ensure testing is performed, results obtained and physician notified in a timely manner.</p> <p>4. Unit Manager will audit Diagnostic tests, monthly. Findings of the audit will be submitted to the CQI committee monthly x3 then quarterly.</p>	<p>3-13-09</p> <p>3-13-09</p> <p>3-31-09</p> <p>3-19-09</p>	

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F 309	<p>Continued From page 14</p> <p>2. Facility staff failed to re-assess Resident #5 for complaint of pain during a wound treatment, and follow the physician's order to administer Fentanyl patch for chronic pain every 72 hours related to sacral ulcers.</p> <p>A review of the resident's clinical record revealed the following order first initiated on January 26, 2009 and renewed on the February 2009 Physician Order Form on February 2, 2009 directed:</p> <p>"...(2) Sacral Ulcer- Cleanse with normal sterile saline (NSS), pat dry then apply polysporin powder and Santyl ...QD &amp; PRN (Once daily and as needed) 14 days..."</p> <p>"(3) (L) [Left] buttock ulcer-cleanse with NSS, pat dry ..."</p> <p>"(4) Fentanyl patch (25mcg/hr) I patch. ...Q72hours (every 72 hours) for chronic pain related to sacral ulcers"</p> <p>"(5) Tylenol #3 (300-30) ii tabs [Tablets] via GT [Gastrointestinal Tube] QD [Once day] 30 minutes before wound treatment for pain management ..."</p> <p>A. On February 17, 2009 at 1:30 PM, a sacral and buttock wound care treatment observation was conducted for Resident #5.</p> <p>The resident was positioned on his/her right side, exposing both ulcers. Employee #17 cleansed the interior and exterior edges of the sacral ulcer twice with NSS moistened gauze and patted dry the exterior edges and skin, applied santyl ointment, polysporin powder, calcium alginate dressing and secured the dressing with a pre-initialed and dated piece of tape. Each time Employee #17 cleansed the wound; the resident grimaced and held tightly to the bed rail with both</p>	F 309	<p><b># 2</b></p> <p>1. <u>A.</u> Employee #17 was counseled. She/he received training in the following areas:</p> <p>a) pain management and assessment of pain</p> <p>2. The Unit Manager will monitor wound care records and procedure during dressing change weekly and document results to assure proper procedure is followed.</p> <p>3. Licensed staff will be trained on a) pain management.</p> <p>4. The findings of the weekly monitoring of dressings changes and wound care records will be submitted to the CQI committee monthly x3 then quarterly.</p>	<p>2-23-09</p> <p>3/13/09. Ongoing</p> <p>3-31-09</p> <p>3-19-09 Ongoing</p>

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F 309	Continued From page 15 hands.  After the completion of the treatment on the sacral wound, Employee #17 began treatment on the left buttock ulcer. Employee #17 cleansed twice the interior and exterior of the left buttock ulcer, patted dry the exterior of the ulcer, applied santyl ointment and polysporin powder on 4 x 4 gauze pads and secured with a pre-initialed and dated piece of tape.  At the initiation of the wound care procedure, while repositioning the resident on his/her right side and each time Employee #17 cleansed the wounds, the resident grimaced. Employee #17 responded to the resident, "I am sorry".  Employee #17 failed to stop the ulcer treatment and re-assess the resident's complaint of pain.  A face-to-face interview was conducted with Employee #2 on February 18, 2009 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The record was reviewed February 18, 2009.n aid  B. Facility staff failed to administer a Fentanyl patch as per physician's order to Resident #5.  A review of the resident's February 2009 Medication Administration Record revealed that Resident #5 was last administered a Fentanyl patch on February 4, 2009 at 6:00 AM as evidenced by the initials entered for that date. There was no evidence that the Fentanyl patch was administered on February 7, 10, 13 or 16, 2009, as per the physician's orders (stated above), by the absence of the initials on the aforementioned days.	F 309	<b>#2 (Continued)</b> 1. <b>B.</b> Resident# 5"s medication error corrected . Physician notified of omission. Medication Error Report completed. Employees counseled.  2. A review of pain management records has been conducted by the Unit Managers corrections were made as indicated.  3. Licensed Nurses will be trained on the Documentation of Pain Medication Administration.  4. Unit Manager will randomly audit resident MAR weekly to ensure compliance. Findings of the audit will be submitted to the CQI committee monthly.	2-23-09  3-13-09  3-31-09  3-19-09

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F 309	<p>Continued From page 16</p> <p>Facility staff failed to administer a Fentanyl patch as per the physician's order to Resident #5.</p> <p>A face-to-face interview was conducted on February 19, 2009 at approximately 11:00 AM with Employee #17. He/she acknowledged that the Fentanyl patch was not administered as per the physician's order. The record was reviewed February 19, 2009.</p> <p>3. Facility staff failed to obtain the physician's order prior to crushing Resident #11's medications.</p> <p>On February 19, 2009 at approximately 10:30 AM in the day room adjacent to the nursing station, Employee #20 was observed administering the morning medications to Resident #11. The medications were observed crushed and mixed in applesauce.</p> <p>A review of the resident's "Physician's Order Form" for February 2009 signed and dated February 4, 2009 directed the following:</p> <p>"Ferrous sulfate 325 mg tablet ...1[one] tab (tablet) by mouth twice daily for anemia. Multivitamin with iron tablet ...1[one] tab by mouth every day for supplement. Pentoxifylline 400 mg tablet ...1[one] tab by mouth every day for coronary artery disease. Omeprazole 20 mg capsule (Cap) ...2 [two] caps (40 mg) by mouth every day for GI [Gastrointestinal] distress. Simvastatin 40 mg tablet ...1 [one] tab by mouth every day hypercholesterolemia. Acetaminophen 325 mg tablet ...2 [two] tabs (650 mg) by mouth every four hours as needed for</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>elevated temperature above 100 F [Fahrenheit] / for pain...."</p> <p>According to a [pharmacy's] Long Term Care Center Pharmacy Policy and Procedure Manual, Policy # 6.0 Titled General Dose "Preparation and Medication Administration" dated August 1, 2002, page 2 of 4 Section 2.8: "Crushing oral medications REQUIRES a physician's order because some medications are not designed to be crushed (e.g. time released capsules, coated tablets, etc.). Crush medications only in accordance with pharmacy guidelines and /or Center policy."</p> <p>A review of Pentoxifylline important information included: "Do not break, crush or chew the tablets. Swallow them whole. They are specially coated to protect your stomach." Sources: &lt;<a href="http://www.drugs.com/mtm/trental/html">http://www.drugs.com/mtm/trental/html</a>&gt; and &lt;<a href="http://health.yahoo.com/heart-medications/pentoxifylline/healthwise-d00336a1.html">http://health.yahoo.com/heart-medications/pentoxifylline/healthwise-d00336a1.html</a>&gt;.</p> <p>According to the quarterly Minimum Data Set (MDS) completed December 4, 2008, the resident was coded as having chewing and swallowing problems in section K1 (Oral problems), and the annual MDS of September 9, 2008 coded the resident for mechanically altered diet in Section K5 (Nutritional Approaches).</p> <p>The resident was observed at lunch time on February 19, 2009 at approximately 12:45 PM. The contents of the resident's lunch tray included mechanically altered (mashed and soft consistency): potatoes, greens and chicken. Employee #19 was observed feeding the resident.</p>	F 309			

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F 309	<p>Continued From page 18</p> <p>Facility staff failed to obtain the physician's order prior to crushing Resident #11's medications.</p> <p>A face-to-face interview was conducted with Employee #20 on February 19, 2009 at approximately 12:00 PM. He/she acknowledged crushing the resident's medications prior to obtaining the physician's order. He/she said, "The resident has a problem swallowing his/her medications. I did not crush the Omeprazole capsule; I administered it whole in apple sauce. I only crushed the Ferrous sulfate, Multivitamin with iron tablet, and Pentoxifylline. I should have obtained an order from the physician. I have now obtained a telephone order to crush all his/her medications except the capsule." Employee #20 was observed calling the physician to obtain a telephone order to crush the medications immediately after the interview. The record was reviewed February 19, 2009.</p> <p>4. Facility staff failed to check for gastric tube placement prior to administering medications for Resident F2.</p> <p>A review of the February 2009 physician's order form signed on February 2, 2009 directed, "...Check tube for proper placement prior to each feeding, flush or medication administration ..."</p> <p>On February 17, 2009 approximately 8:53 AM, during the medication pass for Resident F2, Employee #21 was observed placing the feeding pump on hold, disconnecting the feeding set from the feeding tube, placing the feeding tube syringe into the feeding tube and flushing with approximately 30 cc's of water and then proceeded to administer the medication, with one (1) medication per cup, one (1) cup at a time and</p>	F 309	<p><b>#3</b></p> <ol style="list-style-type: none"> <li>1. Resident # 11. Order obtained for crushing medication, liquid medications obtained where appropriate and alternate medication and/or consistency requested for pentoxifylline. 2-19-09</li> <li>2. Medication review of residents with swallowing difficulties conducted to ensure appropriate consistency is being given. Corrections made where indicated. 2-27-09</li> <li>3. Licensed staff educated "Medications that cannot be Crushed" and process for determining need to crush medication. 3-31-09</li> <li>4. Nurse Manger will conduct a monthly audit of residents with swallowing difficulty to ensure medications are administered in the proper consistency. Findings of the audit will be submitted to CQI committee meeting monthly x3 then quarterly. 3-19-09</li> </ol> <p><b>#4</b></p> <ol style="list-style-type: none"> <li>1. Employee #21 was counseled on the Medication administration Policy and Procedure with emphasis on the Enteral Feeder and has successfully completed the " Medication Pass Observation Survey". 2 20-09</li> <li>2. Random Medication Pass Observation Survey will be conducted monthly by the Supervisors, ADON, and Unit Managers to ensure proper procedure in administration of medication via G-Tube. 3/18/09</li> </ol>	

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F 309	Continued From page 19 flushing with water between each administration of medication. Employee #21 then reconnected the feeding tube and proceeded with removing his/her gloves and washing hands.  Upon returning to the medication cart, Employee #21 signed his/her initial in the appropriate box on the 'Medication Administration Record' [MAR], indicating that medications were given. When he/she was about to initial the order directing, "Check tube for proper placement prior to each feeding, flush or medication administration" he/she stated, "I did not do that [check for gastric tube placement]."  Employee #21 acknowledged that he/she failed to check for gastric tube placement prior to administering the medication. The record was reviewed on February 17, 2009.	F 309	3. Licensed Nurses will be trained on Medication Administration via G-Tube.  4. Findings from the random Med. Pass Observation Survey will be submitted to the CQI committee monthly x3 then quarterly.	3-31-09  3-19-09	
F 312 SS=D	483.25(a) (3) ACTIVITIES OF DAILY LIVING  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview and record review for one (1) of 24 sampled residents, it was determined that facility staff failed to provide personal hygiene for one (1) resident. Resident #11.  The findings include:  According to the resident's clinical record, the	F 312			

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F 312	<p>Continued From page 20</p> <p>quarterly Minimum Data Set (MDS) completed on December 4, 2008, the Resident #11 was coded in Section G (Physical Functioning and Structural Problems) as being totally dependent for toileting and personal hygiene and in Section H (Continence) as being incontinent of bowel and bladder function.</p> <p>On February 19, 2009 at approximately 10:30 AM, Employee #20 was observed in the day room adjacent to the nursing station administering morning medication to Resident #11. The resident remained in the day room after the medication administration.</p> <p>Employee #19 was observed in the day room at about 12:15 PM assisting with lunch. At approximately 12:45 PM, Employee #19 was observed feeding the resident.</p> <p>At approximately 2:30 PM, Employee #19 was observed wheeling the resident to his/her room and then transferred the resident from the wheel chair to his/her bed. At approximately 3:10 PM, Employee #11 was observed leaving the resident's bedside with a wet incontinent pad with strong urine odor.</p> <p>On December 16, 2008 the resident was assessed by facility staff on the "Continence Assessment" as being incontinent of bladder control and totally dependent for toileting.</p> <p>According to the facility's policy #1010, "Assessing Residents Elimination Patterns" and dated 9/29/03, "Incontinent. Residents in this group have no control over their elimination. They will be placed on a two-hour change schedule with the objective of keeping them dry</p>	F 312	<p>1. Employee #20 was counseled on "Incontinence Care, Resident Rights, Dignity and Elder Abuse and Neglect".</p> <p>2. Unit Managers will be making rounds to ensure incontinence care is conducted as stated in the Policy and Procedure.</p> <p>3. A review of <u>Charge Nurse Responsibilities</u> is being conducted with the Licensed Nurses by the Unit Managers with emphasis on monitoring CNA's as well as training in Resident Rights/Dignity and Elder Abuse and Neglect for all nursing staff.</p> <p>4. The Unit Manager will conduct random rounds weekly to ensure Incontinence care is done in a timely manner and documented. Findings will be submitted to the CQI Committee monthly x3 then quarterly.</p>	<p>2-20-09</p> <p>2-23-09</p> <p>Ongoing</p> <p>3-31-09</p> <p>3-19-09</p>

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F 312	Continued From page 21 and preventing skin breakdown."  Facility staff failed to provide incontinent care for Resident #11 for approximately seven (7) hours.  A face-to face interview was conducted with Employee #19 on February 19, 2009 at approximately 3:25 PM. Employee #19 acknowledged that the resident was last given incontinent care at approximately 7:00 AM by the night shift. The record was reviewed February 19, 2009.	F 312		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:  Based on observations during the environmental tour and tour of the main kitchen, it was determined that facility staff failed to ensure that the environment remained free from accidents and hazards as evidence by: broken/damaged light fixtures in three (3) of 42 rooms, crack in the glass window in one (1) of 42 resident rooms, medications left at the bedside in two (2) of 42 resident rooms, razors stored on top of a cart in one (1) of three (3) shower rooms, and a broken pureed mixer in the main kitchen.  The environmental tour was conducted on February 17, 2009 from 12:30 through 4:00 PM	F 323	<b>#1.</b>  1. All broken/damaged light fixtures were replaced. 2. Maintenance staff will make monthly rounds to check light fixtures for safety. 3. Maintenance staff will be in-serviced by the Director of Maintenance on safety issues in shower rooms. 4. Findings will be reported at the Quarterly CQI Meeting.  <b>#2.</b>  1. New window panel installed. 2. Maintenance staff will check rooms and windows for safety on monthly rounds. 3. Maintenance Director will monitor during monthly rounds. 4. Findings will be reported at the Quarterly CQI meeting.	3/11/09 Ongoing 3/11/09 Ongoing 3/2/09 Ongoing Ongoing Ongoing

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F 323	Continued From page 22 and February 18, 2009 from 8:30 AM through 10:30 AM. These observations were made in the presence of Employees #8, 9, 1, 2, and 3. The findings were acknowledged at the time of the observations.  The tour of the main kitchen was conducted on February 17, 2009 from 8:45 AM through 10:30 AM in the presence of Employee #7.  The findings were acknowledged at the time of the observations.  The findings include:  1. Broken/damaged light fixtures were observed in rooms 140, 210 and the 3rd floor shower room in three (3) of 42 rooms observed.  2. A crack in the glass window was observed in room 244.  3. Medications were observed in the following resident's rooms: Room 122: open bottle of Dakin ' s Solution, 10 Curafil wound gel dressings, tube of Vitamin A&D ointment, three (3) tubes of Santyl ointment. Room 142: open bottle of Normal Sterile Saline and Calmoseptin ointment.  4. Four (4) straight edge disposable razors were stored on top of a yellow isolation cart stored in the 2nd floor shower room.  5. The base of a food processor, in the main kitchen, used to puree food was observed with duct tape around the middle of the base of the machine. When the duct tape was removed, the base separated into two pieces.	F 323	<b>#3</b> 1. Medication, dressings and creams were removed from bedside.  2. Resident rooms were check for unauthorized dressings, ointments, creams and removed where indicated.  3. Unit Manager reviewed with Nursing Staff the appropriate items to be kept at bedside.  4. Random rounds will be conducted biweekly by the Safety Committee to ensure resident areas are in compliance. Findings of the rounds will be submitted to the CQI Committee monthly x3 then quarterly.  <b>#5</b> 1. New food processor has been purchased with delivery week of March 16, 2009.  2. Safety inspection has been conducted on other Dietary equipment by the Director of Food Services.  3. Monitor maintenance of equipment with Food Safety Audit by Director of Food Services monthly.  4. Findings and corrections will be reported monthly to the CQI meeting.	2/27/09  2-27-09  2/27/09  Ongoing  3/16/09  3/16/09  3/16/09  On-going

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F 329 SS=D	<p><b>483.25(I) UNNECESSARY DRUGS</b></p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for two (2) of 24 sampled residents, it was determined that there was no attempted dose reduction for the use of psychotropic medications. Residents #13, and 16.</p> <p>The findings include:</p> <p>1. There was no evidence that an attempted dose reduction was initiated for Resident #13 who was</p>	F 329	<p><b>#1</b></p> <p>1. A review of Resident #16's medication has been completed by the psychiatrist and changes made as indicated. The MDS for Resident #16 has been corrected. 4/07/09</p> <p>2. An audit of residents receiving psychotropic medications will be completed by the Social Worker and discussion held with the psychiatrist to determine need for dose Reduction. 4/07/09</p> <p>3. Quarterly review of residents on antipsychotic medication will be completed by Social Worker. On-going</p> <p>4. A report will be provided to the CQI Committee quarterly by the Social Worker. On-going</p> <p><b>#2</b></p> <p>1. A review of Resident #13's medication has been completed by the psychiatrist and changes made as indicated. The MDS for Resident #13 has been corrected. 4/07/09</p> <p>2. An audit of residents receiving psychotropic medications will be completed by the Social Worker and discussion held with the psychiatrist to determine need for dose Reduction. 4/07/09</p> <p>3. Quarterly review of residents on antipsychotic medication will be completed by Social Worker. On-going</p> <p>4. A report will be provided to the CQI Committee quarterly by the Social Worker. On-going</p>		

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F 329	<p>Continued From page 24</p> <p>receiving Ativan 0.5 mg PO (by mouth) BID (twice daily).</p> <p>A review of Resident #13's record revealed the following medications were prescribed by the physician. On March 11, 2008 "Discontinue Clonazepam. Ativan 1 [one] mg [milligram] IM [Intramuscularly] every 8[eight] hours times one week for agitation. If resident agrees to switch to oral give 0.5 mg PO BID until seen by (name) psychiatrist." On March 12, 2008 another order instructed, "Change Ativan 1 mg IM to 0.5 mg PO bid until seen by [psychiatrist]."</p> <p>On March 11, 2008, the psychiatrist documented the following on a "Report of Consultation" under the heading of "Report." "Patient has been acting out despite on Aricept and Clonazepam. [He/She] has also been refusing meds [medications]. No acute medical issues reported." Under the heading of "Recommendations" the psychiatrist wrote the following: "1. D/C Clonazepam. 2. Ativan 1 mg IM every 8 [eight] hours X [times] one week for agitation - if patient agrees to switch to oral give Ativan 0.5 mg PO BID until seen by writer. 3. Hold #2 if falls, sedation or B/P [blood pressure] below 90/60."</p> <p>Further review of the record failed to reveal any other documentation from the psychiatrist.</p> <p>A face-to-face interview was conducted with Employee #3 at approximately 11:30 AM on February 19, 2009. He/she acknowledged that there was no attempt at dose reduction for the Lorazepam since March 11, 2008. The employee also acknowledged that there was no documentation from the psychiatrist since March 11, 2008. The record was reviewed on February</p>	F 329		

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F 329	<p>Continued From page 25 18, 2009.</p> <p>2. There was no evidence that an attempted dose reduction was initiated for Resident #16, who was receiving Haldol daily.</p> <p>A review of Resident #16's record revealed that he/she was initially prescribed the following by the psychiatrist, "Haldol 1 mg by mouth daily for psychosis" on December 19, 2006.</p> <p>On January 23, 2007 and August 21, 2007, the psychiatrist wrote, "Med Review done today." There was no evidence in the record that the psychiatrist saw the resident after August 21, 2007. An order signed by the attending physician dated November 20, 2007 directed, "Haldol 0.5 mg by mouth daily." There was no evidence in the record that the use of Haldol was assessed by the psychiatrist or the attending physician after the November 20, 2007 order.</p> <p>The resident was hospitalized from June 20 through June 25, 2008. Re-admission orders signed by the attending physician on June 29, 2008 directed "Haldol 0.5 mg by mouth every day for psychosis." The order was renewed monthly, most recently February 2, 2009.</p> <p>According to the annual Minimum Data Set assessment completed August 24, 2008, the resident was not coded in Section E (Mood and Behavior Patterns) for any behavior problems and in Section I, (Disease Diagnoses) for psychosis.</p> <p>The attending physician saw the resident on June 29, July 30, August 16, September 19, October 31, November 30 and December 27, 2008 and February 17, 2009. There was no evidence in the</p>	F 329		

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F 329	Continued From page 26 physician's notes that the use of Haldol was reviewed or a dose reduction attempted or documentation present to indicate that a dose reduction was clinically contraindicated.  There were two care plans that addressed the resident's psychotropic drug use and behaviors: "Psychoactive Drug Use" and "Behavior Management."  There were no non-pharmacologic measures listed in the "Psychoactive Drug Use" care plan.  There were no additional stressors listed in the "Behavior Management" care plan to help manage the resident's yelling and screaming.  The resident was observed sitting calmly in a wheelchair on February 19, 2009 at 11:00 AM in the day room. The resident was alert and responsive to name when called.  A face-to-face interview was conducted with Employee #3 on February 19, 2009 at 11:30 AM. He/she acknowledged the above findings. The record was reviewed February 19, 2009.	F 329		
F 371 SS=E	483.35(i) SANITARY CONDITIONS  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations during the tour of the main kitchen on February 17, 2009 from 8:45 AM through 10:30 AM in the presence of Employee #7, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidence by: lack of a trash receptacle by the hand wash sink by the tray line, components under the deep fryer soiled with accumulated grease, the condenser in the walk-in refrigerator dripping water, the door to the walk-in refrigerator failed to close tightly, caulking stained on the sink in the salad prep area, garbage disposal broken by salad prep area, food and paper waste disposed of in the same trash receptacle; and food unlabeled and undated in the 1st and 2nd floor pantries, two (2) of the three (3) pantries observed</p> <p>Employee #7 acknowledged these findings at the time of the observations.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. There was no trash receptacle by the hand wash sink by the tray line. The trash receptacle closest to the hand wash sink was a covered barrel and required lifting of the lid of the barrel to dispose of trash, thus re-contaminating hands.</li> <li>2. The electrical wires and components under the deep fryer were soiled with accumulated grease.</li> <li>3. The condenser in the walk-in refrigerator was observed dripping water onto the food stored below the condenser.</li> </ol>	F 371	<p>#1, #6 &amp; #7</p> <ol style="list-style-type: none"> <li>1. Facility staff has been trained to dispose of trash and food in the appropriate receptacle. Trash will be properly disposed in the correct receptacle. All food will be disposed of in the garbage disposal and paper waste will be disposed of in the trash cans provided for the staff. 3/11/09</li> <li>2. All areas of food disposal have been assessed and corrections made as needed. Food will be disposed of in one of two garbage disposals in the kitchen. 3/11/09</li> <li>3. In-service was done for all staff on March 11, 2009 on proper disposal of trash and food. 3/11/09</li> <li>4. Dish room and food prep areas will be checked during the hours of operation by the Food Services Director. Results will be reported at the monthly/quarterly CQI meetings. On-going</li> </ol> <p>#2</p> <ol style="list-style-type: none"> <li>1. A new cleaning product, Absorbit, is being purchased that will eliminate the carbon and grease in and around the fryer. 3/18/09</li> <li>2. Other equipment was checked for grease build up. 3/11/09</li> <li>3. Fryer is cleaned weekly and as needed. 3/11/09</li> </ol>		

F-Tag 371 continued

4. In-service was conducted for Utility staff on how to clean the deep fat fryer. Morning and evening checklist will be implemented to ensure all components of the fryer are clean. 3/10/09
5. Results will be monitored and reported monthly to the CQI Committee. On-going

#3

1. Maintenance Department was informed of the problem with the condenser leaking water onto the food during the February 20, 2009 survey and corrections have been made. 3/18/09
2. N/A
3. Staff will be in-services on how to use the door to prevent condensation. 3/30/09
4. Process will be monitored by the Food Services Supervisor and reported to the monthly CQI meeting. On-going

#4

1. Gasket was replaced on the walk-in refrigerator. 3/17/09
2. N/A
3. Refrigerator will be checked by the Director of Food Services for proper functioning. Maintenance staff will make monthly rounds to monitor refrigerator. 3/10/09
4. Findings will be reported in the monthly CQI meeting. On-going

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F 371	Continued From page 28 4. The door to the walk-in refrigerator failed to close tightly, leaving approximately a ¼ inch gap between the rubber gasket and the frame of the door. 5. The caulking above the sink in the salad prep area was stained brown. 6. The garbage disposal failed to function in the salad prep area. 7. Food such as onion skins and paper waste were observed in the same trash receptacle in the salad prep area. 8. Food in the 1st and 2nd floor pantries unlabeled and undated as follows:  1st floor pantry contained the following unlabeled, undated food in the refrigerator: Open bottles of shrimp sauce, Ranch dressing, tartar sauce, French dressing, red soda, dark colored soda; bowl of spaghetti, open box of Cream of Wheat, and container of Chinese food.  2nd floor pantry contained the following unlabeled, undated food in the refrigerator: Cheese sandwich, pot pie and ½ filled container of ice cream.	F 371	#5 1. Caulking above sink will be completed on 3/20/09. 2. Other sinks have been audited and correction will be made as needed. 3. Kitchen areas have been placed on preventive maintenance schedule. Staff have been educated on this schedule. 4. A report of findings will be reported to the CQI Committee quarterly.	3/20/09  3/30/09  3/11/09  On-going
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	F 386		

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F 386	<p>Continued From page 29 policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for two (2) of 24 sampled residents, it was determined that the physician failed to review the residents' total plan of care. Residents #8 and 16.</p> <p>The findings include:</p> <p>1. The physician failed to follow up with his/her plan of care to monitor HGA1C [Glycated Hemoglobin] laboratory values every three (3) months for Resident # 8.</p> <p>A review of the resident's clinical record revealed Physician's Order Forms signed by the nurse practitioner on December 3, 2008, January 9 and February 4, 2009 that directed "HGBA1C every 3 months Mar/Jun/Sep/Dec ..."</p> <p>The physician visited on January 7, 2009. There was no evidence in the physician's progress note dated January 7, 2009 that the resident's HGBA1C was addressed.</p> <p>A review of the resident's clinical record lacked evidence the physician followed up with his/her order to monitor the resident's HGBA1C. The resident's record lacked evidence that the aforementioned laboratory test was done for December 2008.</p> <p>A face-to-face interview was conducted with Employee #2 on February 17, 2009 at approximately 3:00 PM. He/She acknowledged the aforementioned findings. He/she received a</p>	F 386	<p>#1</p> <p>1. The physician reviewed the laboratory results and orders obtained as needed.</p> <p>2. An audit of residents with routine scheduled labs will be completed and corrections made as needed.</p> <p>3. A uniform time period has been identified for collection of routine scheduled labs. Staff will be educated on this process.</p> <p>4. A quarterly review of labs will be conducted by the Unit Managers. The results of these audits will be reported to the CQI Committee quarterly.</p>	<p>4/07/09</p> <p>On-going</p> <p>On-going</p> <p>On-going</p>	

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F 386	<p>Continued From page 30</p> <p>fax from the laboratory showing that the blood work was done on January 27, 2009. Employee #16 reviewed, signed and dated the laboratory result on February 18, 2009. The record was reviewed on February 18, 2009.</p> <p>2. The attending physician and/or the psychiatrist failed to initiate an attempted dose reduction for Resident #16, who was receiving Haldol daily.</p> <p>A review of Resident #16's record revealed that he/she was initially prescribed the following by the psychiatrist, "Haldol 1 mg by mouth daily for psychosis" on December 19, 2006.</p> <p>On January 23, 2007 and August 21, 2007, the psychiatrist wrote, "Med Review done today." There was no evidence in the record that the psychiatrist saw the resident after August 21, 2007. An order signed by the attending physician dated November 20, 2007 directed, "Haldol 0.5 mg by mouth daily." There was no evidence in the record that the use of Haldol was assessed by the psychiatrist or the attending physician after the November 20, 2007 order.</p> <p>The resident was hospitalized from June 20 through June 25, 2008. Re-admission orders signed by the attending physician on June 29, 2008 directed "Haldol 0.5 mg by mouth every day for psychosis." The order was renewed monthly, most recently February 2, 2009.</p> <p>According to the annual Minimum Data Set assessment completed August 24, 2008, the resident was not coded in Section E (Mood and Behavior Patterns) for any behavior problems and in Section I, (Disease Diagnoses) for psychosis.</p>	F 386	<p>#2</p> <p>1. A review of Resident #16's medication has been completed by the psychiatrist and changes made as indicated. The MDS for Resident #16 has been corrected.</p> <p>2. An audit of residents receiving psychotropic medications will be completed by the Social Worker and discussion held with the psychiatrist to determine need for dose Reduction.</p> <p>3. Quarterly review of residents on antipsychotic medication will be completed by Social Worker.</p> <p>4. A report will be provided to the CQI Committee quarterly by the Social Worker.</p>	<p>4/07/09</p> <p>4/07/09</p> <p>On-going</p> <p>On-going</p>

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F 386	Continued From page 31 The attending physician saw the resident on June 29, July 30, August 16, September 19, October 31, November 30 and December 27, 2008 and February 17, 2009. There was no evidence in the physician's notes that the use of Haldol was reviewed or a dose reduction attempted or documentation to indicate that a dose reduction was clinically contraindicated.  The resident was observed sitting calmly in a wheelchair on February 19, 2009 at 11:00 AM in the day room. The resident was alert and responsive to name when called.  A face-to-face interview was conducted with Employee #3 on February 19, 2009 at 11:30 AM. He/she acknowledged the above findings. The record was reviewed February 19, 2009.	F 386		
F 425 SS=E	483.60(a), (b) PHARMACY SERVICES  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		

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F 425	<p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for 10 of 28 residents receiving controlled substances, it was determined that facility staff failed to consistently sign the Controlled Medication Utilization Record and the Medication Administration Record (MAR) when administering controlled substances to residents and unlabeled and/or expired medications were present in two (2) of three (3) medication refrigerators. Residents #2, 7, 18, 20, S2, S3, S4, S5, S8, and S13.</p> <p>The findings include:</p> <p>A. The following residents' Medication Administration Records (MAR) and Control Medication Utilization Records were reviewed on February 18, 2009 from 10:30 AM until 12:30 PM and on February 19, 2009 from 8:15 AM until 8:45 AM.</p> <p>1. A review of Resident #2's record revealed a physician's order dated January 14, 2009 that directed, "Percocet two tabs via G-tube every 4 hours as needed for pain."</p> <p>Oxycodone w/APAP (Percocet), 5 mg/325 mg, two tablets, was signed on the Controlled Medication Utilization Record for February 3, 2009 at 6:00 AM as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were no nurses' initials in the area designated for</p>	F 425	<p><b>A.</b> <b>#1 Resident #2</b></p> <p>1. A medication error report completed and the physician was notified.</p> <p>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time.</p> <p>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances.</p> <p>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly.</p>	<p>3/18/09</p> <p>2-28-09</p> <p>3-31-09</p> <p>3-19-09 Ongoing</p>
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F 425	<p>Continued From page 33</p> <p>February 3, 2009 indicating that the medication was administrated to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and time.</p> <p>There was no evidence in the nurses' notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #4 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>2. A review of Resident #7' s record revealed a physician ' s order dated February 4, 2009 directed, " Lorazepam 1 mg by mouth every 8 hours as needed for agitation. "</p> <p>Lorazepam 1 mg was signed on the Controlled Medication Utilization Record for February 7, 2009 at 2:00 AM as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were no nurse's initials in the area designated for February 7, 2009 indicating that the medication was administrated to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and time.</p> <p>There was no evidence in the nurses' notes that</p>	F 425	<p><u>#2 Resident #7</u></p> <p>1. A medication error report completed and the physician was notified. 3/18/09</p> <p>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</p> <p>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</p> <p>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</p>	

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F 425	<p>Continued From page 34</p> <p>documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #6 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>3. A review of Resident #18' s record revealed a physician ' s order dated February 6, 2009 directed, " Morphine Sulfate (Roxanol) 5 mg every 4 hours for pain. "</p> <p>Morphine Sulfate 5 mg was signed on the Controlled Medication Utilization Record for February 9, 2009 at 11:30 PM as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were no nurse's initials in the area designated for February 9, 2009 indicating that the medication was administrated to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and time.</p> <p>There was no evidence in the nurses' notes that documented that the medication was administered to the resident on the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #5 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p>	F 425	<p><b>#3 Resident #18</b></p> <p>1. A medication error report completed and the physician was notified.</p> <p>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time.</p> <p>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances.</p> <p>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly.</p>	<p>3/18/09</p> <p>2-28-09</p> <p>3-31-09</p> <p>3-19-09 Ongoing</p>

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F 425	<p>Continued From page 35</p> <p>4. A review of Resident #20 's record revealed a physician ' s order dated February 2, 2009, directed, " Tylenol #3 1 tab by mouth every 6 hours as needed for severe pain ... "</p> <p>Acetaminophen w/Codeine #3 (Tylenol #3) was signed on the Controlled Medication Utilization Record for January 8, 2009 at 2:00 PM as being removed from the narcotics drawer.</p> <p>According to the January 2009 MAR, there were no nurses' initials in the area designated for January 8, 2009 indicating that the medication was administered to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and time.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #6 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>5. A review of Resident S2's record revealed a physician ' s order dated January 28, 2009 directed, " Percocet 1 tab by mouth every 6 hours as needed for pain. "</p> <p>Oxycodone w/APAP (Percocet) was signed on the Controlled Medication Utilization Record for January 8, 2009 at 2:00 PM as being removed from the narcotics drawer.</p>	F 425	<p><b><u>#4 Resident #20</u></b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</li> </ol> <p><b><u>#5 Resident S2</u></b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</li> </ol>	

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F 425	<p>Continued From page 36</p> <p>According to the January 2009 MAR, there were no nurses' initials in the area designated for January 8, 2009 indicating that the medication was administrated to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and time at the time of the observation.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #6 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>6. A review of Resident S3's record revealed a physician ' s order dated January 6, 2009 directed, " Klonopin 1 tab by mouth every day. " The medication was scheduled for 9:00 AM.</p> <p>According to the February 2009 MAR, there were nurses' initials in the area designated for February 13 and 16, 2009 indicating that the medication was administrated to the resident.</p> <p>Klonopin was not signed on the Controlled Medication Utilization Record for February 13 and 16, 2009 as being removed from the narcotics drawer. However, the number of tablets on the medication card equaled the number of tablets on the Controlled Medication Utilization Record.</p> <p>A face-to-face interview was conducted with</p>	F 425	<p><b>#6 Resident S3</b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</li> </ol>	

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F 425	<p>Continued From page 37</p> <p>Employee #4 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>7. A review of Resident S4's record revealed physician ' s orders dated January 30, 2009, directing, " Tylenol #3 two tabs every 8 hours via G-tube PRN (as needed) for severe pain. Lorazepam 2 mg 1 tab via G-tube every day PRN anxiety. "</p> <p>Acetaminophen w/codeine #3 was signed on the Controlled Medication Utilization Record for February 10, 2009 at 6:00 AM as being removed from the narcotics drawer.</p> <p>Lorazepam 2 mg was signed on the Controlled Medication Utilization Record for February 13, 2009 at 10:30 AM as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were no nurses' initials in the area designated for February 10, 2009 or February 13, 2009 indicating that the medication was administrated to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and times.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #5 at the time of the findings. He/she</p>	F 425	<p><b><u>#7 Resident S4</u></b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</li> </ol>	

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F 425	<p>Continued From page 38</p> <p>acknowledged the above findings at the time of the observation.</p> <p>8. A review of Resident S5's record revealed a physician's order dated January 19, 2009 directed, "Percocet 2 tabs by mouth every 6 hours as needed for pain."</p> <p>Oxycodone w/APAP (Percocet) 2 tabs, was signed on the Controlled Medication Utilization Record for February 16, 2009 at 2:00 PM and 9:00 PM as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were no nurses' initials in the area designated for February 16, 2009, 2:00 PM and 9:00 PM, indicating that the medication was administered to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered" documenting the administration of medication or the effectiveness of the medication for the above cited date and times.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time at the time of the observation.</p> <p>A face-to-face interview was conducted with Employee #4 at the time of the findings. He/she acknowledged the above findings.</p> <p>9. A review of Resident S8's record revealed a physician's order initiated December 26, 2009 directed, "Percocet 2 tab s po 45 min prior to wound care every other day." The facility designated January 1, 3, 5, 7, 9, 11, 13, 15, and</p>	F 425	<p><b>#8 Resident S5</b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</li> </ol> <p><b>#9 Resident S8</b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09</li> </ol>	
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F 425	<p>Continued From page 39 17, 2009.</p> <p>Oxycodone w/APAP (Percocet) 2 tabs, was signed on the Controlled Medication Utilization Record for February 12 and 16, 2009 as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were no nurses' initials in the area designated for February 12 and 16, 2009, indicating that the medication was administered to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered" documenting the administration of medication or the effectiveness of the medication for the above cited date and times.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #6 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>10. A review of Resident S13 's record revealed a physician 's order dated January 23, 2009 directed, " Tylenol #3 1 tab by mouth every 6 hours as needed for severe pain ... "</p> <p>Acetaminophen w/Codeine #3 (Tylenol #3) was signed on the Controlled Medication Utilization Record for February 2, 1:00 PM and 6:00 PM, February 8, and February 11, 2009 as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were</p>	F 425	<p><b>#10 Resident S13</b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</li> </ol>	

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F 425	<p>Continued From page 40</p> <p>no nurses' initials in the area designated for February 6 (two times) 8, and 16, 2009 indicating that the medication was administered to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and time.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #4 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>B. Facility staff failed to date vials when opened and/or remove expired medications from the current stock. These findings were observed on February 17, 2009 in the presence of Employees #10, 14 and 15. Employees #10, 14 and 15 acknowledged these findings at the time of the observations.</p> <p>1. The following items were observed in two (2) of three (3) medication refrigerators as undated when opened and /or expired:</p> <p>February 17, 2009 at 1:00 PM 1st Floor: One (1) of two (2) 10 ml vials of Ativan undated when opened. One (1) of 10 vials of PPD opened November 3, 2008 and January 17, 2009 and expired December 4, 2008.</p>	F 425	<p><u>B.</u> <u>#1</u></p> <p>1. Opened, undated medications were discarded.</p> <p>2. Refrigerators and Medication rooms were checked by the Unit Managers and corrections were made as needed.</p> <p>3. The DON/ADON will educate the Unit Managers and Clinical Supervisors of the "Medication: Expired/Undated Audit Sheet." An audit of refrigerators and Medication rooms will be completed by Unit Managers and supervisors weekly.</p> <p>4. Findings of the "Medication: Expired /Undated audit tool will be submitted to CQI Committee monthly.</p>	<p>3/15/09</p> <p>3-15-09</p> <p>3-15-09</p> <p>3-19-09 Ongoing</p>

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F 425	<p>Continued From page 41</p> <p>2nd floor February 17, 2009 at 12:25 PM</p> <p>One (1) of two (2) vials of Tuberculin Purified Protein Derivative (PPD) undated when opened.</p> <p>Two (2) of three (3) vials of Novolin 70/30 insulin opened January 14, 2009 and expired February 14, 2009.</p> <p>One (1) of three (3) vials of Novolog insulin opened January 14, 2009 and expired February 14, 2009.</p> <p>Two (2) of eight (8) vials of Lantus insulin opened January 14, 2009 and expired February 14, 2009.</p> <p>One (1) of three (3) vial of Novolin 70/30 insulin undated when opened.</p> <p>One (1) of three (3) vials of Novolog insulin undated when opened.</p> <p>One (1) of eight (8) vials of Lantus insulin undated when opened.</p>	F 425		
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 428		

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F 428	<p>Continued From page 42</p> <p>Based on record review and staff interview for one (1) of 24 sampled residents, it was determined that the pharmacist failed to recommend a dose reduction for Resident #16, who was receiving a psychotropic medication.</p> <p>The findings include:</p> <p>A review of Resident #16 ' s record revealed that he/she was initially prescribed the following by the psychiatrist, " Haldol 1 mg by mouth daily for psychosis " on December 19, 2006.</p> <p>On January 23, 2007 and August 21, 2007, the psychiatrist wrote, "Med Review done today." There was no evidence in the record that the psychiatrist saw the resident after August 21, 2007. An order signed by the attending physician dated November 20, 2007 directed, "Haldol 0.5 mg by mouth daily." There was no evidence in the record that the use of Haldol was assessed by the psychiatrist or the attending physician after the November 20, 2007 order.</p> <p>The resident was hospitalized from June 20 through until June 25, 2008. Re-admission orders signed by the attending physician on June 29, 2008 directed "Haldol 0.5 mg by mouth every day for psychosis." The order was renewed monthly, most recently February 2, 2009.</p> <p>According to the annual Minimum Data Set assessment completed August 24, 2008, the resident was not coded in Section E (Mood and Behavior Patterns) for any behavior problems and in Section I, (Disease Diagnoses) for psychosis.</p> <p>The pharmacist reviewed the resident's drug</p>	F 428	<ol style="list-style-type: none"> <li>1. On 3/13/09 the pharmacist reviewed the resident's medication regime and recommendation were made.</li> <li>2. The pharmacist will review other residents on psychotropic medication and recommendation made as needed.</li> <li>3. The pharmacist will audit psychotropic medications monthly.</li> <li>4. A report will be provided to the CQI Committee quarterly of results of those Audits.</li> </ol>	<p>3/13/09</p> <p>4/30/09</p> <p>3/11/09</p> <p>On-going</p>

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F 428	Continued From page 43 regimen on February 2, March 26, April 25, May 22, June 23, July 18, August 27, September 29, October 24, November 26, December 17, 2008 and January 29 and February 21, 2009. There was no evidence that the pharmacist recommended a dose reduction for Haldol.  The resident was observed sitting calmly in a wheelchair on February 19, 2009 at 11:00 AM in the day room. The resident was alert and responsive to name when called.  A face-to-face interview was conducted with Employee #3 on February 19, 2009 at 11:30 AM. He/she acknowledged the above findings. The record was reviewed February 19, 2009.	F 428		
F 442 SS=D	483.65(b) (1) PREVENTING SPREAD OF INFECTION  When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.  This REQUIREMENT is not met as evidenced by:  Based on an observation of one (1) of five (5) dressing changes, facility staff failed to maintain isolation techniques to prevent the spread of infection from a resident on Contact Isolation.  The findings include:  On February 19, 2009 at approximately 12:45 PM Employee # 17 removed the following items: Three (3) unopened 4 x 4 (Gauze pads). One (1) partially used tube of Bacitracin	F 442	1. (A) Employee #17 has received training on "Maintaining Isolation Techniques", "Proper Storage of Items used for a Resident In Isolation". (B) Medication cart and Room were Disinfected opened items discarded.  2. Other units were checked and corrections made as needed.  3. Staff has been educated on maintaining isolation technique a proper storage of items used in an Isolation Room.  4. Random audits of Isolation Technique and Storage of items will be conducted by the Unit Managers monthly and reported to the CQI Committee quarterly.	3/15/09  3-15-09  3-15-09  3/19/09 On-going

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F 442	Continued From page 44 ointment. One (1) partially used small bottle of Normal Saline Solution (120 ml bottle) from the room of a resident who was on Contact Isolation Precautions. Employee #17 removed the aforementioned items from the resident's room and then placed them on a Medication Cart. Employee # 17 later removed the items from the medication cart and placed them into a drawer in the Medication Room.  A face-to-face interview was conducted with Employee # 17 at approximately 1:00 PM on February 19, 2009. The employee acknowledged the observation but did not offer an explanation.	F 442		
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 observations, staff interview and review of 11 newly hired employee records, it was determined that facility staff failed to: complete a criminal background check for one (1) new employee, and administer a tuberculosis test for three (3) new employees; Food temperatures at the point of service were below 140 degrees Fahrenheit (F) for hot foods and above 45 F for cold foods for one (1) sample test tray; and that the facility failed to maintain a three (3) supply of non-perishable staples for emergency use.	F 492		

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F 492	<p>Continued From page 45</p> <p>The findings include:</p> <p>1. Facility staff failed to complete a criminal background check for one (1) new employee.</p> <p>According to 47DCMR 4701.2, " Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. "</p> <p>A review of personnel records revealed, Employee #24 was hired on December 29, 2008.</p> <p>On February 20, 2009 at approximately 11:00 AM a copy of Employee #24 ' s background report was presented which revealed, " ... Request Date: February 19, 2009 and Returned: February 20, 2009 ... No court records found in the jurisdictions searched. "</p> <p>The facility lacked evidence the criminal background check was conducted prior to hire.</p> <p>A face-to-face interview was conducted with Employee #23 on February 20, 2009 at 11:00 AM. He/she acknowledged that the criminal background was not conducted prior to hire.</p> <p>2. Facility staff failed to administer a tuberculosis test for three (3) new employees.</p> <p>According to 22 DCMR 3202.2, "Each facility shall develop and maintain personnel policies which shall include methods used to document the presence or absence of communicable disease."</p>	F 492	<p>1. Active and current employees will have TB Test administered and results within 48 hours.</p> <p>2. An audit of all new hires as of November 3, 2008 was conducted. See attached I.</p> <p>3. Human Resources staff will meet weekly to review pending applications to determine if all requirements are met prior to extending an offer of employment and scheduling an orientation date. See attached II. Human Resources new hire checklist will be used during recruitment and hiring process. Process will be monitored by the Human Resources Manager.</p> <p>4. Report of all new hires for the previous quarter will be reported at the monthly CQI meeting.</p>	<p>3/18/09</p> <p>3/09/09</p> <p>3/04/09 On-going</p> <p>On-going</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 492	<p>Continued From page 46</p> <p>A review of the " CBL Recruitment Checklist "[no date of initiation] revealed," ...PPD [purified protein derivative]/Nursing [indicating the a PPD is to be conducted]</p> <p>Employee # 24 was hired on December 29, 2008 Employee # 26 was hired on December 8, 2008 Employee # 25 was hired on January 26, 2009</p> <p>There was no evidence in the record that the above cited employees received a PPD test prior to the date of hire.</p> <p>A face-to-face interview was conducted with Employee #22 on February 19, 2009 at 3:30 PM. He/she acknowledged that the PPD were not administered prior to hire.</p> <p>3. Facility staff failed to ensure that food temperatures at the point of delivery to the resident were above 140 degrees Fahrenheit (F) for hot foods and did not exceed 45 F for cold foods. This observation was made in the presence of Employee #7 who acknowledged the findings at the time of the observations.</p> <p>A test tray was conducted on February 20, 2009 at the lunch meal. The test tray was placed on the delivery cart at 12:29 PM. The elevator arrived at 12:31 PM and was filled with residents. There was no room on the elevator for the delivery cart. The delivery cart was placed on the elevator at 12:40 PM and arrived on the unit at 12:44 PM. There were 13 resident trays on the delivery cart. The first tray was passed at 12:46 PM and the test tray temperatures were taken at 1:00 PM, after all trays had been passed and all residents were eating.</p>	F 492		

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F 492	<p>Continued From page 47</p> <p>Food temperatures were as follows: Hot water 130 F Coffee 130 F Zucchini 128 F Chicken Patty 130 F Chopped Chicken 132 F Tapioca Pudding 60 F</p> <p>4. Based on observations and staff interview during the tour of the main kitchen, it was determined that facility staff failed to maintain a three (3) day supply of non-perishable staples for emergency use. This observation was made in the presence of Employee #7 on February 17, 2009 from 8:45 AM through 10:30 AM. Employee #7 acknowledged these findings at the time of the observations.</p> <p>According to 22DCMR 3222.3, "A three (3) day supply non-perishable staples shall be maintained on the premises."</p> <p>Employee #7 presented a three (3) day "Cold Food" menu that was developed for use by the facility for emergencies. The following non-perishable items were included on the menu:</p> <p>Day One: cottage cheese and fruit plate for lunch and turkey and cheese sandwiches for dinner.</p> <p>Day Two: Cold Cut sandwich for dinner.</p> <p>Additionally, items on the menu and not stocked at the facility included potato chips, soda and dry milk.</p> <p>A face-to-face interview was conducted at the time of the observations. Employee #7 stated, "If the electricity goes out, we have about 4 to 6</p>	F 492	<p>F 492</p> <ol style="list-style-type: none"> <li>1. Emergency food items have been increased to meet regulations.</li> <li>2. Emergency menus have been changed to reflect the foods needed in case of power outage.</li> <li>3. The emergency food shelf will be monitored for rotation and needed items by the Food Services Supervisor.</li> <li>4. The results will be reported to the CQI CQI Committee meetings.</li> </ol>	<p>3/17/09</p> <p>3/17/09</p> <p>3/17/09</p> <p>Ongoing</p>



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F 514	<p>Continued From page 49</p> <p>order included treatments and the following three (3) routine medications:</p> <p>"Acetaminophen w/codeine #3 300mg-30mg Tablet"</p> <p>"Fentanyl 25 mcg/hr patch TD72 (WF: Duragesic)"</p> <p>"Tab-A-Vite Tablet (WF: Multi-vitamin)"</p> <p>The resident was hospitalized from January 16 through January 23, 2009. A review of the readmission orders signed January 26, 2009 included an additional 15 medications the above cited medications.</p> <p>A review of the resident's record revealed a February 2009 Medication Administration Record (MAR) listed the 15 additional medications that appeared on the January 26, 2009 POS. The resident received all 18 medications as prescribed by the physician on the January 26, 2009 readmission orders from January 26 through February 17, 2009.</p> <p>There was no evidence in the physician's progress notes or orders to indicate that the 15 medications on the January 26, 2009 orders were discontinued.</p> <p>The record lacked evidence that Resident #5's February 2009 Physician's Order Form was complete and accurately documented.</p> <p>A face-to-face interview was conducted with Employee #1 on February 17, 2009 at approximately 3:00 PM. He/she acknowledged that facility staff failed to ensure that Resident #5's February 2009 Physician Order Form was complete and accurately documented. The record</p>	F 514			

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F 514	<p>Continued From page 50 was reviewed February 17, 2009.</p> <p>2. The physician failed to follow up with his/her plan of care to monitor HGA1C [Glycated Hemoglobin] laboratory values every three (3) months for Resident # 8.</p> <p>A review of the resident's clinical record revealed Physician's Order Forms signed by the nurse practitioner on December 3, 2008, January 9 and February 4, 2009 that directed "HGBA1C every 3 months Mar/Jun/Sep/Dec ..."</p> <p>The physician visited on January 7, 2009. There was no evidence in the physician's progress note dated January 7, 2009 that the resident's HGBA1C was addressed.</p> <p>A review of the resident's clinical record lacked evidence the physician followed up with his/her order to monitor the resident's HBGA1C. The resident's record lacked evidence that the aforementioned laboratory test was done for December 2008.</p> <p>A face-to-face interview was conducted with Employee #2 on February 17, 2009 at approximately 3:00 PM. He/She acknowledged the aforementioned findings. He/she received a fax from the laboratory showing that the blood work was done on January 27, 2009. Employee #16 reviewed, signed and dated the laboratory result on February 18, 2009. The record was reviewed on February 18, 2009.</p>	F 514	<p><b>#2 Resident #8</b></p> <p>1. The physician reviewed the laboratory results and orders obtained as needed.</p> <p>2. An audit of residents with routine scheduled labs will be completed and corrections made as needed.</p> <p>3. A uniform time period has been identified for collection of routine scheduled labs. Staff will be educated on this process.</p> <p>4. A quarterly review of labs will be conducted by the Unit Managers. The results of these audits will be reported to the CQI Committee quarterly.</p>	4/07/09	4/07/07
				4/07/09	On-going

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F 000	INITIAL COMMENTS  A recertification survey was conducted on February 17 through 20, 2009. The following deficiencies were based on observations, record review, staff and resident interviews. The sample included 24 residents based on a census of 156 residents on the first day of survey and nine (9) supplemental residents.	F 000		
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d) (2) (ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and staff interview for one (1) of eight (8) residents observed during medication pass, it was determined that facility staff failed to assess Resident F1 for the ability to self medicate and to obtain a physician's order to self administer inhalant medication for Resident F1.  The findings include:  According to Resident F1's February 2009 Physician's Order Sheet signed by the physician on February 2, 2009 directed, "Advair Diskus 100-50 MCG, inhale one puff by mouth twice daily for COPD [chronic obstructive pulmonary disease]."  On February 17, 2009 approximately 9:30AM, during the medication pass for Resident F1, Employee #21 allowed the resident to self administer Advair Diskus medication. The	F 176	1. The Physician was contacted and an order obtained for the Resident F1 to self-medicate the "Advair Diskus 100-50 MCG inhalant".  2. Residents that have the potential to be affected will be assessed for the ability to self-medicate and initiated as indicated.  3. Nurse Managers will educate licensed staff on the policy regarding self-medication to ensure proper assessment of residents with the potential to self-medicate.  4. Residents will be reviewed during quarterly for the ability to self-medicate. This assessment will be reviewed at the Quality IDT Conference. The findings of the Quarterly IDT Conference will be Submitted to the CQI Committee quarterly.	2-23-09  3-31-09  3/31/09  3-19-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 176	<p>Continued From page 1</p> <p>resident was observed holding the medication to his/her lips, inhaling deeply and sucking the medication into his/her mouth and held the medication for several seconds while Employee # 21 was at the hand washing sink [the resident was observed taking the Advair correctly].</p> <p>According to the facility's policy " 2.2 Self Administering Medications, Effective dated August 1, 2002 " Each customer is given the opportunity to self-administer his/her medications if the interdisciplinary team, upon evaluation of a customer ' s ability to safely self-administer medications, has determined that this practice is safe.</p> <p>There was no evidence in the record that the Interdisciplinary Care Team (IDT) determined that Resident F1 was safe for self administration of medications. There was no physician's order to self administer medications.</p> <p>The record lacked evidence that a routine assessment was conducted by the IDT to assess the resident's ability to self medicate.</p> <p>A face-to-face interview was conducted on February 17, 2009 at 9:00 AM with Employee # 21. He/she stated, "Resident F1 wants to give [his/her] own medications." The record was reviewed February 17, 2009.</p>	F 176			
F 221 SS=D	<p>483.13(a) PHYSICAL RESTRAINTS</p> <p>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.</p>	F 221			

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F 221	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview for one (1) of 24 sampled residents, it was determined that the facility staff failed to inform Resident #7's responsible party of the resident's use of a seatbelt while seated in a wheelchair.</p> <p>The findings include:</p> <p>On February 20, 2009 at approximately 11:00 AM, Resident #7 was observed sitting in a wheel chair with a seat belt in place. The resident was unable to release the seat belt when asked.</p> <p>According to the annual Minimum Data Set assessment dated December 31, 2008 Section B2 (Cognitive Impairment) the resident was coded as cognitively impaired.</p> <p>A review of the resident's clinical record revealed an initial physician's order dated October 15, 2008, most recently renewed February 4, 2009, which documented the following: "Apply seat belt for seating and hip positioning when in wheelchair." There was no evidence in the record that the use of the seat belt, risks, benefits and alternatives to its use were ever discussed with the resident's responsible party.</p> <p>A face-to-face interview was conducted with Employee #2 on February 20, 2009 at approximately 11:30 AM. He/she acknowledged that the record lacked information documenting that the responsible party was ever notified of the resident's use of a seat belt. Employee # 2 added, "The responsible party lives in another state. I will call him/her to inform him/her of the</p>	F 221	<ol style="list-style-type: none"> <li>1. Resident #7's responsible party was contacted and consent for the seat belt was obtained.</li> <li>2. Resident with the potential to be affected were reviewed and corrections made when indicated.</li> <li>3. Nursing staff will be educated on the "Policy and Procedure for the Implementation of Restraints". The Fall/Restraint Committee will review restraint usage during the bi-weekly meeting to ensure compliance</li> <li>4. The Nurse Manager will audit residents utilizing any type of restrictive device monthly. The finding of the audit will be submitted to the CQI committee monthly x3 then quarterly.</li> </ol>	2-23-09	2-28-09	3-31-09	3-19-09

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F 221	Continued From page 3 use of the seat belt and will obtain consent for its use at the same time. "The record was reviewed on February 17, 2009.	F 221		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by:  Based on an observation and staff interview for one (1) of five (5) dressing changes, it was determined that the facility staff failed to maintain Resident # 4's dignity by writing on the wound dressing tape after it was placed on the resident's body.  The findings include:  During an observation of a dressing change to Resident # 4's sacrum, Employee #17 wrote the time of the dressing change on the tape after the wound dressing was taped to the resident's body.  The observation of the dressing change was made at approximately 12:30 PM on February 19, 2009.  A face-to-face interview was conducted with Employee #17 immediately after the dressing change on February 19, 2009. He/she acknowledged writing the time on the tape while it was affixed to the resident's body.	F 241	1. Employee #17 received counseling on "Maintaining Residents Rights and Dignity" as well as proper Wound Care.  2. Rounds will be conducted on the units by the DON, ADON and Unit Managers to ensure resident dignity is maintained for residents having the potential to be affected.  3. The Licensed Staff member will be trained on "Resident Rights and Dignity and Wound Care".  4. The Educator will review employee educational profiles monthly to ensure mandatory educational compliance of employees.  Findings of the review as well as the results of the rounds by the DON, ADON and the Nurse Managers will be submitted to the CQI committee monthly X3 then quarterly.	2-23-09  2-23-09 Ongoing  3-31-09  3-31-09
F 250 SS=D	483.15(g) (1) SOCIAL SERVICES The facility must provide medically-related social	F 250		

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F 250	<p>Continued From page 4</p> <p>services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff and resident interviews for one (1) of nine (9) supplemental residents reviewed, it was determined that the social worker failed to assist Resident S1 in obtaining psychiatric services.</p> <p>The findings include:</p> <p>A face-to-face interview was conducted with Resident S1 on February 20, 2009 at 11:00 AM. He/she stated, "I wanted to go back to [behavior program]. I know I need help. I know that when I don't take my medicine I get crazy. The [hospital's behavior program] really helped me. I talked to the social worker more than a month ago and nothing has happened yet. I haven't seen the psychiatrist from here since October (2008). I need more frequent visits and more time than what [the psychiatrist] gives me."</p> <p>A review of the resident's record revealed a nurse's note dated December 1, 2008 at 3:30 PM, "Resident back from leave of absence. Care plan meeting held with family members in attendance. They expressed concerns about his/her inappropriate behavior. [Resident] refused to take any meds while on leave of absence. Wants resident to see a psychiatrist outside the facility. SS (Social Services) to discuss that with unit manager and follow up on it ..."</p>	F 250	<p>1. A chart review was completed and updated to reflect appropriate services and interventions for Resident S1.</p> <p>2. Assessment have been completed on residents with similar behavior management concerns to assure that appropriate interventions are carried out and care plans are in compliance.</p> <p>3. Staff will be educated on the use of appropriate resources and care plans to address the behavior management for residents.</p> <p>4. Monitoring and review will be completed monthly on behavior concerns and report findings and corrective actions implemented to the CQI Committee monthly x3 and quarterly.</p>	<p>2/25/09</p> <p>3/10/09</p> <p>3/31/09 On-going</p>

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F 250	Continued From page 5  A face-to-face interview was conducted with Employee #13 on February 20, 2009 at 3:30 PM. He/she stated, "I was in contact with the social worker from [hospital's behavior program] to help find housing for [Resident S1]. But I never asked about enrolling [Resident S1] into a program."  A review of the social service notes from October 30, 2008 through January 12, 2009 revealed that there was no evidence that the social worker attempted to contact the [hospital's behavior program].  The facility's psychiatrist saw the resident on June 24, September 23 and October 7, 2008. There was no evidence in the record that the psychiatrist visited the resident after October 7, 2008. The record was reviewed February 20, 2009.	F 250	
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 environmental tour conducted on February 17, 2009 from 12:30 through 4:00 PM and February 18, 2009 from 8:30 AM through 10:30 AM, it was determined that facility staff failed to maintain housekeeping and maintenance services to maintain a sanitary, orderly and comfortable environment as evidenced by: soiled window sills in 14 of 42 rooms , corners in 17 of 42 rooms , floors in 10 of 42 rooms , bathroom vents in five (5) of 42 rooms , privacy curtains in six (6) of 42 rooms , inside of	F 253	

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F 253	<p>Continued From page 6</p> <p>bathroom light fixtures in three (3) of 42 rooms , Heating Ventilation and Cooling (HVAC) in nine (9) of 42 rooms; items stored in two (2) of three (3) shower rooms, damaged walls and cove base in 13 of 42 rooms observed, and marred/scarred furniture in six (6) of 42 rooms .</p> <p>These observations were made in the presence of Employees #1, 2, 3, 8, and 9. The findings were acknowledged at the time of the observations.</p> <p>The findings include:</p> <p>The following items were observed soiled:</p> <ol style="list-style-type: none"> <li>Window sills: Rooms 108, 109, 111, 112, 115, 131, 142, 143, 146, 210, 218, 234, 237 and 320 in 14 of 42 rooms observed.</li> <li>Corners: Rooms 108, 109, 111, 115, 122, 131, 137, 143, 146, 210, 241, 309, 320, 335, 338, 341 and 343 in 17 of 42 rooms observed.</li> <li>Floors: Rooms 115, 127, 210, 218, 227, 237, 328, 335, 341 and 334 in 10 of 42 rooms observed.</li> <li>Bathroom vents: Rooms 108, 115, 213, 218 and 237 in five (5) of 42 rooms observed.</li> <li>Privacy curtains: Rooms 109, 111, 140, 334, 335 and 343 in six (6) of 42 rooms observed.</li> <li>Inside of bathroom light fixtures: Rooms 326, 338 and 343 in three (3) of 42 rooms observed.</li> <li>HVAC filters: Rooms 111, 137, 146, 227, 326, 334, 335, 337 and 338 in nine (9) of 42 rooms</li> </ol>	F 253	<p>#1 Window sills:</p> <ol style="list-style-type: none"> <li>Window sills observed with accumulated dust were cleaned and brought into Compliance. 2/21/09</li> <li>All windows were assessed for routine cleaning. 3/18/09</li> <li>Daily inspection will be done by the supervisor to ensure compliance. 3/16/09</li> <li>Staff In-serviced in Cleaning Rooms. (See attached document.) 3/12/09</li> <li>Monitor report will be given at the monthly CQI meeting. On-going</li> </ol> <p>#2 Corners in the rooms:</p> <ol style="list-style-type: none"> <li>Room corners identified will be cleaned. 3/27/09</li> <li>Assessment of all rooms was done and will be cleaned on a scheduled basis. 3/20/09</li> <li>Housekeeping staff was in-serviced in "How to Clean Resident's Room Properly". (See attached outline.) 3/11/09</li> <li>Process will be monitored by the House-keeping Supervisor to ensure compliance. 3/16/09</li> <li>Results and effectiveness of plan will be reported at the monthly CQI meeting. On-going</li> </ol> <p>#3 Soiled Floors:</p> <ol style="list-style-type: none"> <li>Floors identified will be stripped and cleaned. 4/11/09</li> <li>All rooms were assessed for cleanliness. Rooms identified as out of compliance will be stripped and floors refinished. 4/11/09</li> <li>Staff was in-serviced in "How to Strip and Refinish Floors". (See attachment.) 3/11/09</li> <li>Housekeeping supervisor will monitor for compliance. (See attachment) 4/11/09</li> <li>Results of the monitoring process will be reported at the monthly CQI meeting. On-going</li> </ol>	

F-Tag 253 continued

#4 Bathroom Vents:

1. Bathroom vents observed were cleaned immediately. 2/17/09
2. Bathroom vents were assessed for cleanliness and corrective actions made as needed. Vents were placed on schedule for routine cleaning. 2/20/09
3. Staff was in-serviced on "How to Clean Resident's Rooms". (See attachment) Process to be monitored by the Housekeeping supervisor. 3/11/09
4. Results of the process will be reported at the monthly CQI meeting. On-going

#5 Privacy Curtains

1. Privacy curtains were cleaned immediately. 2/21/09
2. Privacy curtains of other rooms were inspected and corrections made as needed. 3/16/09
3. Daily inspections will be performed by Housekeeping Supervisor to ensure compliance. A monthly schedule has been implemented to wash or replace privacy curtains. 3/16/09
4. Housekeeping supervisor will audit rooms weekly and report findings monthly to CQI meeting. On-going

#6 Light Fixtures

1. Broken light fixtures identified were replaced. 3/11/09
2. Other light fixtures were inspected and replacements made as needed. 3/20/09
3. Maintenance staff will make monthly rounds to ensure all lights are working properly. Maintenance staff will be in-services on resident safety by Director of Maintenance. 3/20/09
4. Findings of monthly rounds will be reported monthly to the CQI Committee. On-going

F-Tag 253 continued

#7 HVAC - Filters

1. All filters were cleaned or replaced. 3/13/09
2. Other HVAC filters were inspected and cleaned and replaced as needed. 3/23/09
3. Maintenance staff will perform monthly rounds to ensure all filters are in proper working condition. Maintenance staff will be in-serviced by Director of Maintenance on schedule of cleaning the HVAC filters. 3/20/09
4. Findings of monthly rounds will be reported monthly to the CQI meeting. On-going

#8 Items in Shower Rooms

1. Items have been removed from the shower rooms. 2/20/09
2. Other showers have been inspected and corrections made as needed. 2/23/09
3. Nursing personnel were instructed on not storing items in unauthorized places. The Safety Committee team will make biweekly rounds and document their findings to ensure compliance. 3/16/09
4. Findings of the rounds will be submitted to the CQI Committee monthly. Ongoing 3/19/09

#9 Walls

1. Repair and painting of all walls will be completed. 3/20/09
2. Other rooms will be inspected for damaged walls and repairs will be made as needed. 3/31/09
3. Maintenance staff will perform monthly rounds to ensure all areas are in compliance. Maintenance staff will be in-serviced by the Director of Maintenance on Painting of the facility. 3/20/09
4. Findings of monthly rounds will be reported monthly to the CQI meeting. On-going

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F 253	Continued From page 7 observed.  8. Items stored in shower rooms: 1st floor -2 yellow isolation carts, five (5) IV poles; 2nd floor -1 yellow isolation cart and one (1) wheelchair weight scale.  The following items were damaged/soiled:  9. Walls: Rooms 112, 135, 140, 142, 213, 218, 225, 311, 313, 316, 326, 334 and 343 in 13 of 42 rooms observed.  10. Cove base: Rooms 108, 109, 111, 112, 127, 129, 131, 135, 137, 213, 216, 218, 220, 246, 309, 326 and 328 in 17 of 42 rooms observed.  The following items were observed marred/scarred:  11. Furniture: Rooms 112, 2nd floor dining room five (5) of seven (7) arm chairs, 326, 328, 335 and 338 in six (6) of 42 rooms observed.	F 253	<b>#10 Cove base</b>  1. Cove base in rooms identified were repaired or replaced. 2. Other rooms were inspected for damaged cove base and repairs made as needed. 3. Maintenance staff will perform monthly rounds to ensure all areas are in compliance. Maintenance staff will be in-serviced by the Director of Maintenance on repairing or replacing of base covers in the facility. 4. Findings of monthly rounds will be reported monthly to the CQI meeting.  <b>#11 Marred/Scarred Furniture</b>  1. Furniture/chairs removed from rooms identified and will be painted or replaced with new furniture. 2. Other rooms were inspected for damaged/scarred furniture and will be painted or replaced as appropriate. 3. Condition of furniture in dayrooms and resident rooms will be monitored by the CQI committee and maintenance staff monthly. 4. Findings will be reported at the quarterly CQI meeting for appropriate action.	3/12/09 2/23/09 3/20/09 On-going 5/16/09 5/5/09 On-going On-going	
F 275 SS=D	483.20(b) (2) (iii) RESIDENT ASSESSMENT-WHEN REQUIRED  A facility must conduct a comprehensive assessment of a resident not less than once every 12 months.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interview for two (2) of 24 sampled residents it was determined that the facility failed to complete a full Minimum Data Set (MDS) assessment within 12 months. Residents #12 and #19.	F 275		On-going On-going	

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F 275	Continued From page 8 The findings include:  1. Facility failed to complete a full MDS for Resident #12 within 12 months.  A review of Resident #12's record revealed that the last full MDS was completed on November 5, 2007. The next full MDS assessment was due November 6, 2008.  The record lacked evidence that a full MDS assessment for November 6, 2008 was completed. The record was reviewed February 18, 2009.  2. Facility failed to complete a full MDS for Resident #19 within 12 months.  A review of Resident #19's record revealed that the last full MDS was completed on November 26, 2007. The next full MDS assessment was due November 27, 2008.  The record lacked evidence that a full MDS assessment for November 27, 2008 was completed. The record was reviewed February 20, 2009.  A face-to-face interview with Employee #11 was conducted on February 20, 2009 at 11:00 AM. He/she acknowledged that the MDS assessments were completed but were with the MDS coordinator.	F 275	1. Residents #12 and 19 Minimum Data Set (MDS) were brought in compliance.  2. The MDS Coordinator has audited resident's medical records to ensure compliance and corrections as indicated.  3. The MDS Coordinator will develop a system to ensure MDSs are placed on the medical record in a timely manner by: a. Developing an annual calendar; b. Alerting IDT members of the Scheduled Care Plans/MDS in a timely manner; c. Utilizing the Unit Secretary to ensure the MDS is placed on the medical record.  4. The MDS Coordinator will conduct a monthly review of the resident medical records that are due for their quarterly review. Those findings will be submitted to the CQI Committee monthly x3 then quarterly.	2-20-09  3-12-09  3-31-09  3-19-09
F 279 SS=D	483.20(d), 483.20(k) (1) COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 9  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 one (1) of 24 sampled residents, it was determined that facility staff failed to initiate a care plan with appropriate goals and approaches for the use of a seat belt for Resident # 7.  The findings include:  A review of the clinical record for Resident # 7 revealed a physician ' s order dated October 15, 2008 which documented the following; " Apply seat belt for seating and hip positioning when in wheelchair. " Further review of the record revealed that there was no care plan initiated for the resident's use of a seat belt.  On February 20, 2009 at approximately 11:00 AM, Resident # 7 was observed sitting in a wheel	F 279	1. Resident #7 Care plan for seatbelt has been initiated.  2. Residents having restrictive devices care plans have been reviewed and corrected as indicated.  3. Nursing staff will be educated on the "Policy and Procedure for the Implementation of Restraints" . The Fall/Restraint Committee will review restraint usage during the bi-weekly meeting to ensure compliance  4. The Nurse Manager will audit residents utilizing any type of restrictive device monthly. The finding of the audit will be submitted to the CQI committee monthly x3 then quarterly.	2-23-09  2-28-09  3-31-09  3-19-09

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F 279	Continued From page 10 chair with a seat belt in place. The resident was unable to release the seat belt when asked.  A face-to-face interview was conducted with Employee # 2 on February 20, 2009 at approximately 11:30 AM. He/she acknowledged that the record lacked a care plan for the use of a seat belt and added, "I will add one right away." The record was reviewed on February 18, 2009.	F 279			
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 record review and staff interview for one (1) of 24 sampled residents, it was determined that facility staff failed to update the	F 280	1. Resident #8 Care plan has been reviewed/updated for compliance.  2. A review has been completed of residents who have sustained a "Fall", corrections have been made as indicated.  3. Nursing staff will be educated on the "Policy and Procedure for Fall follow-up". The Fall/Restraint Committee will review Falls that have occurred during the bi-weekly meeting to ensure compliance  4. The Nurse Manager will audit residents that have fallen monthly. The finding of the audit will be submitted to the CQI committee monthly x3 then quarterly.	2-23-09  2/23/09  3-31-09  3-19-09	

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F 280	Continued From page 11 care plan for one (1) resident with multiple falls with no injuries for Resident #8.  The findings include:  A review of Resident #8's nurses' notes dated January 26, 2009 at 7:30 PM and January 27, 2009 at 12:30 AM revealed that the resident fell with no injuries sustained.  A review of the "Falls Prevention Care Plan" initiated April 4, 2008 revealed the following handwritten entry under "Evaluation: Resident observed on the floor in room by w/c (wheelchair) x 2. Napping @ time of fall. Observed on knee. No injuries or pain voiced."  There was no evidence in the record that additional goals and approaches were initiated after the aforementioned falls with no injuries.  A face-to-face interview was conducted with Employee #2 on February 19, 2009 at approximately 1:45 PM. He/she acknowledged that the resident's clinical record lacked evidence that additional goals and approaches were initiated after the aforementioned falls. The record was reviewed February 19, 2009.	F 280		
F 286 SS=D	483.20(d) RESIDENT ASSESSMENT - USE  A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.  This REQUIREMENT is not met as evidenced by:  Based on staff interview and record review for one (1) of 24 sampled residents, it was	F 286		

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F 286	Continued From page 12 determined that facility staff failed to maintain 15 months of the Minimum Data Set (MDS) assessments on the active record for Resident #9.  The findings include:  A review of Resident #9's record revealed that the resident was readmitted to the facility on July 7, 2007. MDS assessments on the active record included November 5, 2007 (annual) and quarterly assessments dated February 5, May 6, and August 5, 2008.  The record lack evidence that an annual MDS was completed after November 5, 2007.  A face-to-face interview with Employee #11 was conducted on February 17, 2008 at 10:00 AM. He/she acknowledged that 12 months of the MDS were on the active record and additional MDS assessments were in the Medical Records department. The record was reviewed February 17, 2009.	F 286	1. Resident #9 medical record has been reviewed and brought into compliance.  2. The MDS Coordinator has audited resident's medical records to ensure compliance and corrections as indicated.  3. The MDS Coordinator will develop a system to ensure MDS's are placed on the medical record in a timely manner by: a. Developing an annual calendar; b. Alerting IDT members of the Scheduled Care Plans/MDS in a timely manner; c. Utilizing the Unit Secretary to ensure the MDS is placed on the medical record.  4. The MDS Coordinator will conduct a monthly review of the resident medical records that are due for their quarterly review. Those findings will be submitted to the CQI committee monthly x3 then quarterly	3/17/09  3-12-09  3-31-09  3-19-09
F 309 SS=D	483.25 QUALITY OF CARE  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by:  Based on observation, record review and staff interview for three (3) of 24 sampled residents,	F 309		

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F 309	<p>Continued From page 13</p> <p>and one (1) of nine (9) supplemental residents, it was determined that facility staff failed to: perform a laboratory [lab] test as per physician's order for one (1) resident, stop a wound care treatment to re-assess for complaints of pain for one (1) resident, follow the physician's order for administration of medication for one (1) resident, crush medication without the physician's order for one (1) resident, and check for gastric tube placement prior to administering medications for (1) resident. Residents #1, 5, 11, and F2.</p> <p>The findings include:</p> <p>1. Facility staff failed to obtain a lab for Prolactin for Resident #1.</p> <p>A review of Resident #1's record revealed a physician's order dated December 10, 2008 which directed, "Prolactin level in the AM then Q [every] 6 months] June/Dec, Dx [diagnosis] Paranoid behavior."</p> <p>A review of the laboratory test log dated December 11, 2008 revealed, "[Resident #1]", type lab test ordered- Prolactin, date spec [specimen] obtained- Moved to December 12 [2008].</p> <p>A further review of the record lacked evidence that the Prolactin level was drawn on December 12, 2008 or thereafter.</p> <p>A face-to-face interview was conducted with Employee #2 on February 18, 2009 at 10:50 AM. He/she stated, "The lab has no record [of the specimen being tested]." The record was reviewed on February 18, 2009.</p>	F 309	<p><b>#1</b></p> <p>1. Physician was notified. Prolactin level was obtained.</p> <p>2. Laboratory orders were reviewed and corrections made as indicated.</p> <p>3. Unit Manager will train licensed staff on Procedure for Diagnostic testing and follow-up to ensure testing is performed, results obtained and physician notified in a timely manner.</p> <p>4. Unit Manager will audit Diagnostic tests, monthly. Findings of the audit will be submitted to the CQI committee monthly x3 then quarterly.</p>	<p>3-13-09</p> <p>3-1309</p> <p>3-31-09</p> <p>3-19-09</p>

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F 309	<p>Continued From page 14</p> <p>2. Facility staff failed to re-assess Resident #5 for complaint of pain during a wound treatment, and follow the physician's order to administer Fentanyl patch for chronic pain every 72 hours related to sacral ulcers.</p> <p>A review of the resident's clinical record revealed the following order first initiated on January 26, 2009 and renewed on the February 2009 Physician Order Form on February 2, 2009 directed:</p> <p>"...(2) Sacral Ulcer- Cleanse with normal sterile saline (NSS), pat dry then apply polysporin powder and Santyl ...QD &amp; PRN (Once daily and as needed) 14 days..."</p> <p>"(3) (L) [Left] buttock ulcer-cleanse with NSS, pat dry ..."</p> <p>"(4) Fentanyl patch (25mcg/hr)   patch ...Q72hours (every 72 hours) for chronic pain related to sacral ulcers"</p> <p>"(5) Tylenol #3 (300-30) ii tabs [Tablets] via GT [Gastrointestinal Tube] QD [Once day] 30 minutes before wound treatment for pain management ..."</p> <p>A. On February 17, 2009 at 1:30 PM, a sacral and buttock wound care treatment observation was conducted for Resident #5.</p> <p>The resident was positioned on his/her right side, exposing both ulcers. Employee #17 cleansed the interior and exterior edges of the sacral ulcer twice with NSS moistened gauze and patted dry the exterior edges and skin, applied santyl ointment, polysporin powder, calcium alginate dressing and secured the dressing with a pre-initialed and dated piece of tape. Each time Employee #17 cleansed the wound; the resident grimaced and held tightly to the bed rail with both</p>	F 309	<p><b># 2</b></p> <p>1. <u>A.</u> Employee #17 was counseled. She/he received training in the following areas: a) pain management and assessment of pain</p> <p>2. The Unit Manager will monitor wound care records and procedure during dressing change weekly and document results to assure proper procedure is followed.</p> <p>3. Licensed staff will be trained on a) pain management.</p> <p>4. The findings of the weekly monitoring of dressings changes and wound care records will be submitted to the CQI committee monthly x3 then quarterly.</p>	<p>2-23-09</p> <p>3/13/09. Ongoing</p> <p>3-31-09</p> <p>3-19-09 Ongoing</p>
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F 309	<p>Continued From page 15 hands.</p> <p>After the completion of the treatment on the sacral wound, Employee #17 began treatment on the left buttock ulcer. Employee #17 cleansed twice the interior and exterior of the left buttock ulcer, patted dry the exterior of the ulcer, applied santyl ointment and polysporin powder on 4 x 4 gauze pads and secured with a pre-initialed and dated piece of tape.</p> <p>At the initiation of the wound care procedure, while repositioning the resident on his/her right side and each time Employee #17 cleansed the wounds, the resident grimaced. Employee #17 responded to the resident, "I am sorry".</p> <p>Employee #17 failed to stop the ulcer treatment and re-assess the resident's complaint of pain.</p> <p>A face-to-face interview was conducted with Employee #2 on February 18, 2009 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The record was reviewed February 18, 2009.n aid</p> <p>B. Facility staff failed to administer a Fentanyl patch as per physician's order to Resident #5.</p> <p>A review of the resident's February 2009 Medication Administration Record revealed that Resident #5 was last administered a Fentanyl patch on February 4, 2009 at 6:00 AM as evidenced by the initials entered for that date. There was no evidence that the Fentanyl patch was administered on February 7, 10, 13 or 16, 2009, as per the physician's orders (stated above), by the absence of the initials on the aforementioned days.</p>	F 309	<p><b>#2 (Continued)</b></p> <p>1. <b>B.</b> Resident# 5's medication error corrected . Physician notified of omission. Medication Error Report completed. Employees counseled.</p> <p>2. A review of pain management records has been conducted by the Unit Managers corrections were made as indicated.</p> <p>3. Licensed Nurses will be trained on the Documentation of Pain Medication Administration.</p> <p>4. Unit Manager will randomly audit resident MAR weekly to ensure compliance. Findings of the audit will be submitted to the CQI committee monthly.</p>	<p>2-23-09</p> <p>3-13-09</p> <p>3-31-09</p> <p>3-19-09</p>	

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F 309	<p>Continued From page 16</p> <p>Facility staff failed to administer a Fentanyl patch as per the physician's order to Resident #5.</p> <p>A face-to-face interview was conducted on February 19, 2009 at approximately 11:00 AM with Employee #17. He/she acknowledged that the Fentanyl patch was not administered as per the physician's order. The record was reviewed February 19, 2009.</p> <p>3. Facility staff failed to obtain the physician's order prior to crushing Resident #11's medications.</p> <p>On February 19, 2009 at approximately 10:30 AM in the day room adjacent to the nursing station, Employee #20 was observed administering the morning medications to Resident #11. The medications were observed crushed and mixed in applesauce.</p> <p>A review of the resident's "Physician's Order Form" for February 2009 signed and dated February 4, 2009 directed the following:</p> <p>"Ferrous sulfate 325 mg tablet ...1[one] tab (tablet) by mouth twice daily for anemia. Multivitamin with iron tablet ...1[one] tab by mouth every day for supplement. Pentoxifylline 400 mg tablet ...1[one] tab by mouth every day for coronary artery disease. Omeprazole 20 mg capsule (Cap) ...2 [two] caps (40 mg) by mouth every day for GI [Gastrointestinal] distress. Simvastatin 40 mg tablet ...1 [one] tab by mouth every day hypercholesterolemia. Acetaminophen 325 mg tablet ...2 [two] tabs (650 mg) by mouth every four hours as needed for</p>	F 309		

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F 309	<p>Continued From page 17</p> <p>elevated temperature above 100 F [Fahrenheit] / for pain...."</p> <p>According to a [pharmacy's] Long Term Care Center Pharmacy Policy and Procedure Manual, Policy # 6.0 Titled General Dose "Preparation and Medication Administration" dated August 1, 2002, page 2 of 4 Section 2.8: "Crushing oral medications REQUIRES a physician's order because some medications are not designed to be crushed (e.g. time released capsules, coated tablets, etc.). Crush medications only in accordance with pharmacy guidelines and /or Center policy."</p> <p>A review of Pentoxifylline important information included: "Do not break, crush or chew the tablets. Swallow them whole. They are specially coated to protect your stomach." Sources: &lt;<a href="http://www.drugs.com/mtm/trental/html">http://www.drugs.com/mtm/trental/html</a>&gt; and &lt;<a href="http://health.yahoo.com/heart-medications/pentoxifylline/healthwise-d00336a1.html">http://health.yahoo.com/heart-medications/pentoxifylline/healthwise-d00336a1.html</a>&gt;.</p> <p>According to the quarterly Minimum Data Set (MDS) completed December 4, 2008, the resident was coded as having chewing and swallowing problems in section K1 (Oral problems), and the annual MDS of September 9, 2008 coded the resident for mechanically altered diet in Section K5 (Nutritional Approaches).</p> <p>The resident was observed at lunch time on February 19, 2009 at approximately 12:45 PM. The contents of the resident's lunch tray included mechanically altered (mashed and soft consistency): potatoes, greens and chicken. Employee #19 was observed feeding the resident.</p>	F 309		

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F 309	<p>Continued From page 18</p> <p>Facility staff failed to obtain the physician's order prior to crushing Resident #11's medications.</p> <p>A face-to-face interview was conducted with Employee #20 on February 19, 2009 at approximately 12:00 PM. He/she acknowledged crushing the resident's medications prior to obtaining the physician's order. He/she said, "The resident has a problem swallowing his/her medications. I did not crush the Omeprazole capsule; I administered it whole in apple sauce. I only crushed the Ferrous sulfate, Multivitamin with iron tablet, and Pentoxifylline. I should have obtained an order from the physician. I have now obtained a telephone order to crush all his/her medications except the capsule." Employee #20 was observed calling the physician to obtain a telephone order to crush the medications immediately after the interview. The record was reviewed February 19, 2009.</p> <p>4. Facility staff failed to check for gastric tube placement prior to administering medications for Resident F2.</p> <p>A review of the February 2009 physician's order form signed on February 2, 2009 directed, "...Check tube for proper placement prior to each feeding, flush or medication administration ..."</p> <p>On February 17, 2009 approximately 8:53 AM, during the medication pass for Resident F2, Employee #21 was observed placing the feeding pump on hold, disconnecting the feeding set from the feeding tube, placing the feeding tube syringe into the feeding tube and flushing with approximately 30 cc's of water and then proceeded to administer the medication, with one (1) medication per cup, one (1) cup at a time and</p>	F 309	<p><b>#3</b></p> <ol style="list-style-type: none"> <li>Resident # 11. Order obtained for crushing medication, liquid medications obtained where appropriate and alternate medication and/or consistency requested for pentoxifylline. 2-19-09</li> <li>Medication review of residents with swallowing difficulties conducted to ensure appropriate consistency is being given. Corrections made where indicated. 2-27-09</li> <li>Licensed staff educated "Medications that cannot be Crushed" and process for determining need to crush medication. 3-31-09</li> <li>Nurse Manger will conduct a monthly audit of residents with swallowing difficulty to ensure medications are administered in the proper consistency. Findings of the audit will be submitted to CQI committee meeting monthly x3 then quarterly. 3-19-09</li> </ol> <p><b>#4</b></p> <ol style="list-style-type: none"> <li>Employee #21 was counseled on the Medication administration Policy and Procedure with emphasis on the Enteral Feeder and has successfully completed the " Medication Pass Observation Survey". 2 20-09</li> <li>Random Medication Pass Observation Survey will be conducted monthly by the Supervisors, ADON, and Unit Managers to ensure proper procedure in administration of medication via G-Tube. 3/18/09</li> </ol>	

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F 309	Continued From page 19 flushing with water between each administration of medication. Employee #21 then reconnected the feeding tube and proceeded with removing his/her gloves and washing hands.  Upon returning to the medication cart, Employee #21 signed his/her initial in the appropriate box on the 'Medication Administration Record' [MAR], indicating that medications were given. When he/she was about to initial the order directing, "Check tube for proper placement prior to each feeding, flush or medication administration" he/she stated, "I did not do that [check for gastric tube placement]."  Employee #21 acknowledged that he/she failed to check for gastric tube placement prior to administering the medication. The record was reviewed on February 17, 2009.	F 309	3. Licensed Nurses will be trained on Medication Administration via G-Tube.  4. Findings from the random Med. Pass Observation Survey will be submitted to the CQI committee monthly x3 then quarterly.	3-31-09  3-19-09
F 312 SS=D	483.25(a) (3) ACTIVITIES OF DAILY LIVING  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview and record review for one (1) of 24 sampled residents, it was determined that facility staff failed to provide personal hygiene for one (1) resident. Resident #11.  The findings include:  According to the resident's clinical record, the	F 312		

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F 312	<p>Continued From page 20</p> <p>quarterly Minimum Data Set (MDS) completed on December 4, 2008, the Resident #11 was coded in Section G (Physical Functioning and Structural Problems) as being totally dependent for toileting and personal hygiene and in Section H (Continence) as being incontinent of bowel and bladder function.</p> <p>On February 19, 2009 at approximately 10:30 AM, Employee #20 was observed in the day room adjacent to the nursing station administering morning medication to Resident #11. The resident remained in the day room after the medication administration.</p> <p>Employee #19 was observed in the day room at about 12:15 PM assisting with lunch. At approximately 12:45 PM, Employee #19 was observed feeding the resident.</p> <p>At approximately 2:30 PM, Employee #19 was observed wheeling the resident to his/her room and then transferred the resident from the wheel chair to his/her bed. At approximately 3:10 PM, Employee #11 was observed leaving the resident's bedside with a wet incontinent pad with strong urine odor.</p> <p>On December 16, 2008 the resident was assessed by facility staff on the "Continence Assessment" as being incontinent of bladder control and totally dependent for toileting.</p> <p>According to the facility's policy #1010, "Assessing Residents Elimination Patterns" and dated 9/29/03, "Incontinent. Residents in this group have no control over their elimination. They will be placed on a two-hour change schedule with the objective of keeping them dry</p>	F 312	<ol style="list-style-type: none"> <li>1. Employee #20 was counseled on "Incontinence Care, Resident Rights, Dignity and Elder Abuse and Neglect".</li> <li>2. Unit Managers will be making rounds to ensure incontinence care is conducted as stated in the Policy and Procedure.</li> <li>3. A review of <u>Charge Nurse Responsibilities</u> is being conducted with the Licensed Nurses by the Unit Managers with emphasis on monitoring CNA's as well as training in Resident Rights/Dignity and Elder Abuse and Neglect for all nursing staff.</li> <li>4. The Unit Manager will conduct random rounds weekly to ensure Incontinence care is done in a timely manner and documented. Findings will be submitted to the CQI Committee monthly x3 then quarterly.</li> </ol>	<p>2-20-09</p> <p>2-23-09 Ongoing</p> <p>3-31-09</p> <p>3-19-09</p>

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F 312	Continued From page 21 and preventing skin breakdown."  Facility staff failed to provide incontinent care for Resident #11 for approximately seven (7) hours.  A face-to face interview was conducted with Employee #19 on February 19, 2009 at approximately 3:25 PM. Employee #19 acknowledged that the resident was last given incontinent care at approximately 7:00 AM by the night shift. The record was reviewed February 19, 2009.	F 312		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:  Based on observations during the environmental tour and tour of the main kitchen, it was determined that facility staff failed to ensure that the environment remained free from accidents and hazards as evidence by: broken/damaged light fixtures in three (3) of 42 rooms, crack in the glass window in one (1) of 42 resident rooms, medications left at the bedside in two (2) of 42 resident rooms, razors stored on top of a cart in one (1) of three (3) shower rooms, and a broken pureed mixer in the main kitchen.  The environmental tour was conducted on February 17, 2009 from 12:30 through 4:00 PM	F 323	<b>#1.</b>  1. All broken/damaged light fixtures were replaced. 2. Maintenance staff will make monthly rounds to check light fixtures for safety. 3. Maintenance staff will be in-serviced by the Director of Maintenance on safety issues in shower rooms. 4. Findings will be reported at the Quarterly CQI Meeting.  <b>#2.</b>  1. New window panel installed. 2. Maintenance staff will check rooms and windows for safety on monthly rounds. 3. Maintenance Director will monitor during monthly rounds. 4. Findings will be reported at the Quarterly CQI meeting.	3/11/09 Ongoing 3/11/09 Ongoing  3/2/09 Ongoing Ongoing Ongoing

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F 323	<p>Continued From page 22</p> <p>and February 18, 2009 from 8:30 AM through 10:30 AM. These observations were made in the presence of Employees #8, 9, 1, 2, and 3. The findings were acknowledged at the time of the observations.</p> <p>The tour of the main kitchen was conducted on February 17, 2009 from 8:45 AM through 10:30 AM in the presence of Employee #7.</p> <p>The findings were acknowledged at the time of the observations.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Broken/damaged light fixtures were observed in rooms 140, 210 and the 3rd floor shower room in three (3) of 42 rooms observed.</li> <li>2. A crack in the glass window was observed in room 244.</li> <li>3. Medications were observed in the following resident's rooms: Room 122: open bottle of Dakin ' s Solution, 10 Curafil wound gel dressings, tube of Vitamin A&amp;D ointment, three (3) tubes of Santyl ointment. Room 142: open bottle of Normal Sterile Saline and Calmoseptin ointment.</li> <li>4. Four (4) straight edge disposable razors were stored on top of a yellow isolation cart stored in the 2nd floor shower room.</li> <li>5. The base of a food processor, in the main kitchen, used to puree food was observed with duct tape around the middle of the base of the machine. When the duct tape was removed, the base separated into two pieces.</li> </ol>	F 323	<p><b>#3</b></p> <ol style="list-style-type: none"> <li>1. Medication, dressings and creams were removed from bedside. 2/27/09</li> <li>2. Resident rooms were check for unauthorized dressings, ointments, creams and removed where indicated. 2-27-09</li> <li>3. Unit Manager reviewed with Nursing Staff the appropriate items to be kept at bedside. 2/27/09</li> <li>4. Random rounds will be conducted biweekly by the Safety Committee to ensure resident areas are in compliance. Findings of the rounds will be submitted to the CQI Committee monthly x3 then quarterly. Ongoing</li> </ol> <p><b>#5</b></p> <ol style="list-style-type: none"> <li>1. New food processor has been purchased with delivery week of March 16, 2009. 3/16/09</li> <li>2. Safety inspection has been conducted on other Dietary equipment by the Director of Food Services. 3/16/09</li> <li>3. Monitor maintenance of equipment with Food Safety Audit by Director of Food Services monthly. 3/16/09</li> <li>4. Findings and corrections will be reported monthly to the CQI meeting. On-going</li> </ol>	

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F 329 SS=D	<p><b>483.25(l) UNNECESSARY DRUGS</b></p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for two (2) of 24 sampled residents, it was determined that there was no attempted dose reduction for the use of psychotropic medications. Residents #13, and 16.</p> <p>The findings include:</p> <p>1. There was no evidence that an attempted dose reduction was initiated for Resident #13 who was</p>	F 329	<p><b>#1</b></p> <p>1. A review of Resident #16's medication has been completed by the psychiatrist and changes made as indicated. The MDS for Resident #16 has been corrected. 4/07/09</p> <p>2. An audit of residents receiving psychotropic medications will be completed by the Social Worker and discussion held with the psychiatrist to determine need for dose Reduction. 4/07/09</p> <p>3. Quarterly review of residents on antipsychotic medication will be completed by Social Worker. On-going</p> <p>4. A report will be provided to the CQI Committee quarterly by the Social Worker. On-going</p> <p><b>#2</b></p> <p>1. A review of Resident #13's medication has been completed by the psychiatrist and changes made as indicated. The MDS for Resident #13 has been corrected. 4/07/09</p> <p>2. An audit of residents receiving psychotropic medications will be completed by the Social Worker and discussion held with the psychiatrist to determine need for dose Reduction. 4/07/09</p> <p>3. Quarterly review of residents on antipsychotic medication will be completed by Social Worker. On-going</p> <p>4. A report will be provided to the CQI Committee quarterly by the Social Worker. On-going</p>	

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F 329	<p>Continued From page 24</p> <p>receiving Ativan 0.5 mg PO (by mouth) BID (twice daily).</p> <p>A review of Resident #13's record revealed the following medications were prescribed by the physician. On March 11, 2008 "Discontinue Clonazepam. Ativan 1 [one] mg [milligram] IM [Intramuscularly] every 8[eight] hours times one week for agitation. If resident agrees to switch to oral give 0.5 mg PO BID until seen by (name) psychiatrist." On March 12, 2008 another order instructed, "Change Ativan 1 mg IM to 0.5 mg PO bid until seen by [psychiatrist]."</p> <p>On March 11, 2008, the psychiatrist documented the following on a "Report of Consultation" under the heading of "Report." "Patient has been acting out despite on Aricept and Clonazepam. [He/She] has also been refusing meds [medications]. No acute medical issues reported." Under the heading of "Recommendations" the psychiatrist wrote the following: "1. D/C Clonazepam. 2. Ativan 1 mg IM every 8 [eight] hours X [times] one week for agitation - if patient agrees to switch to oral give Ativan 0.5 mg PO BID until seen by writer. 3. Hold #2 if falls, sedation or B/P [blood pressure] below 90/60. "</p> <p>Further review of the record failed to reveal any other documentation from the psychiatrist.</p> <p>A face-to-face interview was conducted with Employee #3 at approximately 11:30 AM on February 19, 2009. He/she acknowledged that there was no attempt at dose reduction for the Lorazepam since March 11, 2008. The employee also acknowledged that there was no documentation from the psychiatrist since March 11, 2008. The record was reviewed on February</p>	F 329		

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F 329	<p>Continued From page 25 18, 2009.</p> <p>2. There was no evidence that an attempted dose reduction was initiated for Resident #16, who was receiving Haldol daily.</p> <p>A review of Resident #16's record revealed that he/she was initially prescribed the following by the psychiatrist, "Haldol 1 mg by mouth daily for psychosis" on December 19, 2006.</p> <p>On January 23, 2007 and August 21, 2007, the psychiatrist wrote, "Med Review done today." There was no evidence in the record that the psychiatrist saw the resident after August 21, 2007. An order signed by the attending physician dated November 20, 2007 directed, "Haldol 0.5 mg by mouth daily." There was no evidence in the record that the use of Haldol was assessed by the psychiatrist or the attending physician after the November 20, 2007 order.</p> <p>The resident was hospitalized from June 20 through June 25, 2008. Re-admission orders signed by the attending physician on June 29, 2008 directed "Haldol 0.5 mg by mouth every day for psychosis." The order was renewed monthly, most recently February 2, 2009.</p> <p>According to the annual Minimum Data Set assessment completed August 24, 2008, the resident was not coded in Section E (Mood and Behavior Patterns) for any behavior problems and in Section I, (Disease Diagnoses) for psychosis.</p> <p>The attending physician saw the resident on June 29, July 30, August 16, September 19, October 31, November 30 and December 27, 2008 and February 17, 2009. There was no evidence in the</p>	F 329		

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F 329	Continued From page 26 physician's notes that the use of Haldol was reviewed or a dose reduction attempted or documentation present to indicate that a dose reduction was clinically contraindicated.  There were two care plans that addressed the resident's psychotropic drug use and behaviors: "Psychoactive Drug Use" and "Behavior Management."  There were no non-pharmacologic measures listed in the "Psychoactive Drug Use" care plan.  There were no additional stressors listed in the "Behavior Management" care plan to help manage the resident's yelling and screaming.  The resident was observed sitting calmly in a wheelchair on February 19, 2009 at 11:00 AM in the day room. The resident was alert and responsive to name when called.  A face-to-face interview was conducted with Employee #3 on February 19, 2009 at 11:30 AM. He/she acknowledged the above findings. The record was reviewed February 19, 2009.	F 329		
F 371 SS=E	483.35(i) SANITARY CONDITIONS  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 27  This REQUIREMENT is not met as evidenced by:  Based on observations during the tour of the main kitchen on February 17, 2009 from 8:45 AM through 10:30 AM in the presence of Employee #7, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidence by: lack of a trash receptacle by the hand wash sink by the tray line, components under the deep fryer soiled with accumulated grease, the condenser in the walk-in refrigerator dripping water, the door to the walk-in refrigerator failed to close tightly, caulking stained on the sink in the salad prep area, garbage disposal broken by salad prep area, food and paper waste disposed of in the same trash receptacle; and food unlabeled and undated in the 1st and 2nd floor pantries, two (2) of the three (3) pantries observed  Employee #7 acknowledged these findings at the time of the observations.  The findings include:  1. There was no trash receptacle by the hand wash sink by the tray line. The trash receptacle closest to the hand wash sink was a covered barrel and required lifting of the lid of the barrel to dispose of trash, thus re-contaminating hands.  2. The electrical wires and components under the deep fryer were soiled with accumulated grease.  3. The condenser in the walk-in refrigerator was observed dripping water onto the food stored below the condenser.	F 371	#1, #6 & #7  1. Facility staff has been trained to dispose of trash and food in the appropriate receptacle. Trash will be properly disposed in the correct receptacle. All food will be disposed of in the garbage disposal and paper waste will be disposed of in the trash cans provided for the staff.  2. All areas of food disposal have been assessed and corrections made as needed. Food will be disposed of in one of two garbage disposals in the kitchen.  3. In-service was done for all staff on March 11, 2009 on proper disposal of trash and food.  4. Dish room and food prep areas will be checked during the hours of operation by the Food Services Director. Results will be reported at the monthly/quarterly CQI meetings.  #2  1. A new cleaning product, Absorbit, is being purchased that will eliminate the carbon and grease in and around the fryer.  2. Other equipment was checked for grease build up.  3. Fryer is cleaned weekly and as needed.	3/11/09  3/11/09  3/11/09  On-going  3/18/09  3/11/09  3/11/09

F-Tag 371 continued

4. In-service was conducted for Utility staff on how to clean the deep fat fryer. Morning and evening checklist will be implemented to ensure all components of the fryer are clean. 3/10/09
5. Results will be monitored and reported monthly to the CQI Committee. On-going

#3

1. Maintenance Department was informed of the problem with the condenser leaking water onto the food during the February 20, 2009 survey and corrections have been made. 3/18/09
2. N/A
3. Staff will be in-services on how to use the door to prevent condensation. 3/30/09
4. Process will be monitored by the Food Services Supervisor and reported to the monthly CQI meeting. On-going

#4

1. Gasket was replaced on the walk-in refrigerator. 3/17/09
2. N/A
3. Refrigerator will be checked by the Director of Food Services for proper functioning. Maintenance staff will make monthly rounds to monitor refrigerator. 3/10/09
4. Findings will be reported in the monthly CQI meeting. On-going

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F 371	Continued From page 28 4. The door to the walk-in refrigerator failed to close tightly, leaving approximately a ¼ inch gap between the rubber gasket and the frame of the door. 5. The caulking above the sink in the salad prep area was stained brown. 6. The garbage disposal failed to function in the salad prep area. 7. Food such as onion skins and paper waste were observed in the same trash receptacle in the salad prep area. 8. Food in the 1st and 2nd floor pantries unlabeled and undated as follows:  1st floor pantry contained the following unlabeled, undated food in the refrigerator: Open bottles of shrimp sauce, Ranch dressing, tartar sauce, French dressing, red soda, dark colored soda; bowl of spaghetti, open box of Cream of Wheat, and container of Chinese food.  2nd floor pantry contained the following unlabeled, undated food in the refrigerator: Cheese sandwich, pot pie and ½ filled container of ice cream.	F 371	#5 1. Caulking above sink will be completed on 3/20/09. 2. Other sinks have been audited and correction will be made as needed. 3. Kitchen areas have been placed on preventive maintenance schedule. Staff have been educated on this schedule. 4. A report of findings will be reported to the CQI Committee quarterly.	3/20/09  3/30/09  3/11/09  On-going
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	F 386		

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F 386	<p>Continued From page 29 policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for two (2) of 24 sampled residents, it was determined that the physician failed to review the residents' total plan of care. Residents #8 and16.</p> <p>The findings include:</p> <p>1. The physician failed to follow up with his/her plan of care to monitor HGA1C [Glycated Hemoglobin] laboratory values every three (3) months for Resident # 8.</p> <p>A review of the resident's clinical record revealed Physician's Order Forms signed by the nurse practitioner on December 3, 2008, January 9 and February 4, 2009 that directed "HGBA1C every 3 months Mar/Jun/Sep/Dec ..."</p> <p>The physician visited on January 7, 2009. There was no evidence in the physician's progress note dated January 7, 2009 that the resident's HGBA1C was addressed.</p> <p>A review of the resident's clinical record lacked evidence the physician followed up with his/her order to monitor the resident's HBGA1C. The resident's record lacked evidence that the aforementioned laboratory test was done for December 2008.</p> <p>A face-to-face interview was conducted with Employee #2 on February 17, 2009 at approximately 3:00 PM. He/She acknowledged the aforementioned findings. He/she received a</p>	F 386	<p>#1</p> <p>1. The physician reviewed the laboratory results and orders obtained as needed.</p> <p>2. An audit of residents with routine scheduled labs will be completed and corrections made as needed.</p> <p>3. A uniform time period has been identified for collection of routine scheduled labs. Staff will be educated on this process.</p> <p>4. A quarterly review of labs will be conducted by the Unit Managers. The results of these audits will be reported to the CQI Committee quarterly.</p>	<p>4/07/09</p> <p>On-going</p> <p>On-going</p> <p>On-going</p>

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F 386	<p>Continued From page 30</p> <p>fax from the laboratory showing that the blood work was done on January 27, 2009. Employee #16 reviewed, signed and dated the laboratory result on February 18, 2009. The record was reviewed on February 18, 2009.</p> <p>2. The attending physician and/or the psychiatrist failed to initiate an attempted dose reduction for Resident #16, who was receiving Haldol daily.</p> <p>A review of Resident #16's record revealed that he/she was initially prescribed the following by the psychiatrist, "Haldol 1 mg by mouth daily for psychosis" on December 19, 2006.</p> <p>On January 23, 2007 and August 21, 2007, the psychiatrist wrote, "Med Review done today." There was no evidence in the record that the psychiatrist saw the resident after August 21, 2007. An order signed by the attending physician dated November 20, 2007 directed, "Haldol 0.5 mg by mouth daily." There was no evidence in the record that the use of Haldol was assessed by the psychiatrist or the attending physician after the November 20, 2007 order.</p> <p>The resident was hospitalized from June 20 through June 25, 2008. Re-admission orders signed by the attending physician on June 29, 2008 directed "Haldol 0.5 mg by mouth every day for psychosis." The order was renewed monthly, most recently February 2, 2009.</p> <p>According to the annual Minimum Data Set assessment completed August 24, 2008, the resident was not coded in Section E (Mood and Behavior Patterns) for any behavior problems and in Section I, (Disease Diagnoses) for psychosis.</p>	F 386	<p>#2</p> <p>1. A review of Resident #16's medication has been completed by the psychiatrist and changes made as indicated. The MDS for Resident #16 has been corrected.</p> <p>2. An audit of residents receiving psychotropic medications will be completed by the Social Worker and discussion held with the psychiatrist to determine need for dose Reduction.</p> <p>3. Quarterly review of residents on antipsychotic medication will be completed by Social Worker.</p> <p>4. A report will be provided to the CQI Committee quarterly by the Social Worker.</p>	<p>4/07/09</p> <p>4/07/09</p> <p>On-going</p> <p>On-going</p>

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F 386	Continued From page 31 The attending physician saw the resident on June 29, July 30, August 16, September 19, October 31, November 30 and December 27, 2008 and February 17, 2009. There was no evidence in the physician's notes that the use of Haldol was reviewed or a dose reduction attempted or documentation to indicate that a dose reduction was clinically contraindicated.  The resident was observed sitting calmly in a wheelchair on February 19, 2009 at 11:00 AM in the day room. The resident was alert and responsive to name when called.  A face-to-face interview was conducted with Employee #3 on February 19, 2009 at 11:30 AM. He/she acknowledged the above findings. The record was reviewed February 19, 2009.	F 386			
F 425 SS=E	483.60(a), (b) PHARMACY SERVICES  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425			

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NAME OF PROVIDER OR SUPPLIER  <b>CAROLYN BOONE LEWIS HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1380 SOUTHERN AVE SE WASHINGTON, DC 20032</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 32  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interview for 10 of 28 residents receiving controlled substances, it was determined that facility staff failed to consistently sign the Controlled Medication Utilization Record and the Medication Administration Record (MAR) when administering controlled substances to residents and unlabeled and/or expired medications were present in two (2) of three (3) medication refrigerators. Residents #2, 7, 18, 20, S2, S3, S4, S5, S8, and S13.  The findings include:  A. The following residents' Medication Administration Records (MAR) and Control Medication Utilization Records were reviewed on February 18, 2009 from 10:30 AM until 12:30 PM and on February 19, 2009 from 8:15 AM until 8:45 AM.  1. A review of Resident #2's record revealed a physician's order dated January 14, 2009 that directed, "Percocet two tabs via G-tube every 4 hours as needed for pain."  Oxycodone w/APAP (Percocet), 5 mg/325 mg, two tablets, was signed on the Controlled Medication Utilization Record for February 3, 2009 at 6:00 AM as being removed from the narcotics drawer.  According to the February 2009 MAR, there were no nurses' initials in the area designated for	F 425	<b>A. #1 Resident #2</b> 1. A medication error report completed and the physician was notified.  2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time.  3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances.  4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly.	3/18/09  2-28-09  3-31-09  3-19-09 Ongoing

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F 425	<p>Continued From page 33</p> <p>February 3, 2009 indicating that the medication was administered to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered" documenting the administration of medication or the effectiveness of the medication for the above cited date and time.</p> <p>There was no evidence in the nurses' notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #4 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>2. A review of Resident #7's record revealed a physician's order dated February 4, 2009 directed, "Lorazepam 1 mg by mouth every 8 hours as needed for agitation."</p> <p>Lorazepam 1 mg was signed on the Controlled Medication Utilization Record for February 7, 2009 at 2:00 AM as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were no nurse's initials in the area designated for February 7, 2009 indicating that the medication was administered to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered" documenting the administration of medication or the effectiveness of the medication for the above cited date and time.</p> <p>There was no evidence in the nurses' notes that</p>	F 425	<p><b>#2 Resident #7</b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</li> </ol>	

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F 425	<p>Continued From page 34</p> <p>documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #6 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>3. A review of Resident #18's record revealed a physician's order dated February 6, 2009 directed, "Morphine Sulfate (Roxanol) 5 mg every 4 hours for pain."</p> <p>Morphine Sulfate 5 mg was signed on the Controlled Medication Utilization Record for February 9, 2009 at 11:30 PM as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were no nurse's initials in the area designated for February 9, 2009 indicating that the medication was administered to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered" documenting the administration of medication or the effectiveness of the medication for the above cited date and time.</p> <p>There was no evidence in the nurses' notes that documented that the medication was administered to the resident on the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #5 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p>	F 425	<p><b>#3 Resident #18</b></p> <p>1. A medication error report completed and the physician was notified.</p> <p>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time.</p> <p>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances.</p> <p>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly.</p>	<p>3/18/09</p> <p>2-28-09</p> <p>3-31-09</p> <p>3-19-09 Ongoing</p>

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F 425	<p>Continued From page 35</p> <p>4. A review of Resident #20 ' s record revealed a physician ' s order dated February 2, 2009, directed, " Tylenol #3 1 tab by mouth every 6 hours as needed for severe pain ... "</p> <p>Acetaminophen w/Codeine #3 (Tylenol #3) was signed on the Controlled Medication Utilization Record for January 8, 2009 at 2:00 PM as being removed from the narcotics drawer.</p> <p>According to the January 2009 MAR, there were no nurses' initials in the area designated for January 8, 2009 indicating that the medication was administered to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and time.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #6 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>5. A review of Resident S2's record revealed a physician ' s order dated January 28, 2009 directed, " Percocet 1 tab by mouth every 6 hours as needed for pain. "</p> <p>Oxycodone w/APAP (Percocet) was signed on the Controlled Medication Utilization Record for January 8, 2009 at 2:00 PM as being removed from the narcotics drawer.</p>	F 425	<p><b><u>#4 Resident #20</u></b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</li> </ol> <p><b><u>#5 Resident S2</u></b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</li> </ol>	

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F 425	Continued From page 36  According to the January 2009 MAR, there were no nurses' initials in the area designated for January 8, 2009 indicating that the medication was administrated to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and time at the time of the observation.  There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time.  A face-to-face interview was conducted with Employee #6 at the time of the findings. He/she acknowledged the above findings at the time of the observation.  6. A review of Resident S3's record revealed a physician ' s order dated January 6, 2009 directed, " Klonopin 1 tab by mouth every day. " The medication was scheduled for 9:00 AM.  According to the February 2009 MAR, there were nurses' initials in the area designated for February 13 and 16, 2009 indicating that the medication was administrated to the resident.  Klonopin was not signed on the Controlled Medication Utilization Record for February 13 and 16, 2009 as being removed from the narcotics drawer. However, the number of tablets on the medication card equaled the number of tablets on the Controlled Medication Utilization Record.  A face-to-face interview was conducted with	F 425	<b>#6 Resident S3</b>  1. A medication error report completed and the physician was notified.  2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time.  3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances.  4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly.	3/18/09  2-28-09  3-31-09  3-19-09 Ongoing

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F 425	<p>Continued From page 37</p> <p>Employee #4 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>7. A review of Resident S4's record revealed physician ' s orders dated January 30, 2009, directing, " Tylenol #3 two tabs every 8 hours via G-tube PRN (as needed) for severe pain. Lorazepam 2 mg 1 tab via G-tube every day PRN anxiety. "</p> <p>Acetaminophen w/codeine #3 was signed on the Controlled Medication Utilization Record for February 10, 2009 at 6:00 AM as being removed from the narcotics drawer.</p> <p>Lorazepam 2 mg was signed on the Controlled Medication Utilization Record for February 13, 2009 at 10:30 AM as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were no nurses' initials in the area designated for February 10, 2009 or February 13, 2009 indicating that the medication was administrated to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and times.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #5 at the time of the findings. He/she</p>	F 425	<p><b>#7 Resident S4</b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified.</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time.</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances.</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly.</li> </ol>	<p>3/18/09</p> <p>2-28-09</p> <p>3-31-09</p> <p>3-19-09 Ongoing</p>

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F 425	Continued From page 38. acknowledged the above findings at the time of the observation.  8. A review of Resident S5's record revealed a physician ' s order dated January 19, 2009 directed, " Percocet 2 tabs by mouth every 6 hours as needed for pain. "  Oxycodone w/APAP (Percocet) 2 tabs, was signed on the Controlled Medication Utilization Record for February 16, 2009 at 2:00 PM and 9:00 PM as being removed from the narcotics drawer.  According to the February 2009 MAR, there were no nurses' initials in the area designated for February 16, 2009, 2:00 PM and 9:00 PM, indicating that the medication was administrated to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and times.  There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time at the time of the observation.  A face-to-face interview was conducted with Employee #4 at the time of the findings. He/she acknowledged the above findings.  9. A review of Resident S8's record revealed a physician ' s order initiated December 26, 2009 directed, " Percocet 2 tab s po 45 min prior to wound care every other day. " The facility designated January 1, 3, 5, 7, 9, 11, 13, 15, and	F 425	<b>#8 Resident S5</b> 1. A medication error report completed and the physician was notified.  2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time.  3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances.  4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly.  <b>#9 Resident S8</b> 1. A medication error report completed and the physician was notified.  2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time.  3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances.  4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly.	3/18/09  2-28-09  3-31-09  3-19-09 Ongoing  3/18/09  2-28-09  3-31-09  3-19-09

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F 425	<p>Continued From page 39 17, 2009.</p> <p>Oxycodone w/APAP (Percocet) 2 tabs, was signed on the Controlled Medication Utilization Record for February 12 and 16, 2009 as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were no nurses' initials in the area designated for February 12 and 16, 2009, indicating that the medication was administered to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered" documenting the administration of medication or the effectiveness of the medication for the above cited date and times.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #6 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>10. A review of Resident S13 's record revealed a physician ' s order dated January 23, 2009 directed, " Tylenol #3 1 tab by mouth every 6 hours as needed for severe pain ... "</p> <p>Acetaminophen w/Codeine #3 (Tylenol #3) was signed on the Controlled Medication Utilization Record for February 2, 1:00 PM and 6:00 PM, February 8, and February 11, 2009 as being removed from the narcotics drawer.</p> <p>According to the February 2009 MAR, there were</p>	F 425	<p><b>#10 Resident S13</b></p> <ol style="list-style-type: none"> <li>1. A medication error report completed and the physician was notified. 3/18/09</li> <li>2. Medication and narcotic records have been audited by the Unit Managers and corrective actions implemented as needed. Training completed at this time. 2-28-09</li> <li>3. Licensed staff will receive training from the Administrator, DON, and ADON on Documentation of PRN medication with emphasis on Controlled Substances. 3-31-09</li> <li>4. Unit Manager will audit the Controlled Substances sheets monthly to ensure that the appropriate documentation has occurred. Findings of the audit will be submitted to CQI Committee monthly x3 then quarterly. 3-19-09 Ongoing</li> </ol>	

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F 425	<p>Continued From page 40</p> <p>no nurses' initials in the area designated for February 6 (two times) 8, and 16, 2009 indicating that the medication was administrated to the resident. There was no documentation on the back of the MAR under "PRN, State and Medications Not administered "documenting the administration of medication or the effectiveness of the medication for the above cited date and time.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above cited date and time.</p> <p>A face-to-face interview was conducted with Employee #4 at the time of the findings. He/she acknowledged the above findings at the time of the observation.</p> <p>B. Facility staff failed to date vials when opened and/or remove expired medications from the current stock. These findings were observed on February 17, 2009 in the presence of Employees #10, 14 and 15. Employees #10, 14 and 15 acknowledged these findings at the time of the observations.</p> <p>1. The following items were observed in two (2) of three (3) medication refrigerators as undated when opened and /or expired:</p> <p>February 17, 2009 at 1:00 PM 1st Floor: One (1) of two (2) 10 ml vials of Ativan undated when opened. One (1) of 10 vials of PPD opened November 3, 2008 and January 17, 2009 and expired December 4, 2008.</p>	F 425	<p><u>B.</u> <u>#1</u></p> <p>1. Opened, undated medications were discarded.</p> <p>2. Refrigerators and Medication rooms were checked by the Unit Managers and corrections were made as needed.</p> <p>3. The DON/ADON will educate the Unit Managers and Clinical Supervisors of the "Medication: Expired/Undated Audit Sheet." An audit of refrigerators and Medication rooms will be completed by Unit Managers and supervisors weekly.</p> <p>4. Findings of the "Medication: Expired /Undated audit tool will be submitted to CQI Committee monthly.</p>	<p>3/15/09</p> <p>3-15-09</p> <p>3-15-09</p> <p>3-19-09 Ongoing</p>

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F 425	<p>Continued From page 41</p> <p>2nd floor February 17, 2009 at 12:25 PM One (1) of two (2) vials of Tuberculin Purified Protein Derivative (PPD) undated when opened.</p> <p>Two (2) of three (3) vials of Novolin 70/30 insulin opened January 14, 2009 and expired February 14, 2009.</p> <p>One (1) of three (3) vials of Novolog insulin opened January 14, 2009 and expired February 14, 2009.</p> <p>Two (2) of eight (8) vials of Lantus insulin opened January 14, 2009 and expired February 14, 2009.</p> <p>One (1) of three (3) vial of Novolin 70/30 insulin undated when opened.</p> <p>One (1) of three (3) vials of Novolog insulin undated when opened.</p> <p>One (1) of eight (8) vials of Lantus insulin undated when opened.</p>	F 425		
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 428		

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F 428	<p>Continued From page 42</p> <p>Based on record review and staff interview for one (1) of 24 sampled residents, it was determined that the pharmacist failed to recommend a dose reduction for Resident #16, who was receiving a psychotropic medication.</p> <p>The findings include:</p> <p>A review of Resident #16 's record revealed that he/she was initially prescribed the following by the psychiatrist, " Haldol 1 mg by mouth daily for psychosis " on December 19, 2006.</p> <p>On January 23, 2007 and August 21, 2007, the psychiatrist wrote, "Med Review done today." There was no evidence in the record that the psychiatrist saw the resident after August 21, 2007. An order signed by the attending physician dated November 20, 2007 directed, "Haldol 0.5 mg by mouth daily." There was no evidence in the record that the use of Haldol was assessed by the psychiatrist or the attending physician after the November 20, 2007 order.</p> <p>The resident was hospitalized from June 20 through until June 25, 2008. Re-admission orders signed by the attending physician on June 29, 2008 directed "Haldol 0.5 mg by mouth every day for psychosis." The order was renewed monthly, most recently February 2, 2009.</p> <p>According to the annual Minimum Data Set assessment completed August 24, 2008, the resident was not coded in Section E (Mood and Behavior Patterns) for any behavior problems and in Section I, (Disease Diagnoses) for psychosis.</p> <p>The pharmacist reviewed the resident's drug</p>	F 428	<ol style="list-style-type: none"> <li>1. On 3/13/09 the pharmacist reviewed the resident's medication regime and recommendation were made. 3/13/09</li> <li>2. The pharmacist will review other residents on psychotropic medication and recommendation made as needed. 4/30/09</li> <li>3. The pharmacist will audit psychotropic medications monthly. 3/11/09</li> <li>4. A report will be provided to the CQI Committee quarterly of results of those Audits. On-going</li> </ol>	

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F 428	Continued From page 43 regimen on February 2, March 26, April 25, May 22, June 23, July 18, August 27, September 29, October 24, November 26, December 17, 2008 and January 29 and February 21, 2009. There was no evidence that the pharmacist recommended a dose reduction for Haldol.  The resident was observed sitting calmly in a wheelchair on February 19, 2009 at 11:00 AM in the day room. The resident was alert and responsive to name when called.  A face-to-face interview was conducted with Employee #3 on February 19, 2009 at 11:30 AM. He/she acknowledged the above findings. The record was reviewed February 19, 2009.	F 428		
F 442 SS=D	483.65(b) (1) PREVENTING SPREAD OF INFECTION  When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.  This REQUIREMENT is not met as evidenced by:  Based on an observation of one (1) of five (5) dressing changes, facility staff failed to maintain isolation techniques to prevent the spread of infection from a resident on Contact Isolation.  The findings include:  On February 19, 2009 at approximately 12:45 PM Employee # 17 removed the following items: Three (3) unopened 4 x 4 (Gauze pads). One (1) partially used tube of Bacitracin	F 442	1. (A) Employee #17 has received training on "Maintaining Isolation Techniques", "Proper Storage of Items used for a Resident In Isolation". (B) Medication cart and Room were Disinfected opened items discarded.  2. Other units were checked and corrections made as needed.  3. Staff has been educated on maintaining isolation technique a proper storage of items used in an Isolation Room.  4. Random audits of Isolation Technique and Storage of items will be conducted by the Unit Managers monthly and reported to the CQI Committee quarterly.	3/15/09  3-15-09  3-15-09  3/19/09 On-going

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F 442	Continued From page 44 ointment. One (1) partially used small bottle of Normal Saline Solution (120 ml bottle) from the room of a resident who was on Contact Isolation Precautions. Employee #17 removed the aforementioned items from the resident's room and then placed them on a Medication Cart. Employee # 17 later removed the items from the medication cart and placed them into a drawer in the Medication Room.  A face-to-face interview was conducted with Employee # 17 at approximately 1:00 PM on February 19, 2009. The employee acknowledged the observation but did not offer an explanation.	F 442		
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 observations, staff interview and review of 11 newly hired employee records, it was determined that facility staff failed to: complete a criminal background check for one (1) new employee, and administer a tuberculosis test for three (3) new employees; Food temperatures at the point of service were below 140 degrees Fahrenheit (F) for hot foods and above 45 F for cold foods for one (1) sample test tray; and that the facility failed to maintain a three (3) supply of non-perishable staples for emergency use.	F 492		

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F 492	<p>Continued From page 45</p> <p>The findings include:</p> <p>1. Facility staff failed to complete a criminal background check for one (1) new employee.</p> <p>According to 47DCMR 4701.2, " Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. "</p> <p>A review of personnel records revealed, Employee #24 was hired on December 29, 2008.</p> <p>On February 20, 2009 at approximately 11:00 AM a copy of Employee #24 ' s background report was presented which revealed, " ... Request Date: February 19, 2009 and Returned: February 20, 2009 ... No court records found in the jurisdictions searched. "</p> <p>The facility lacked evidence the criminal background check was conducted prior to hire.</p> <p>A face-to-face interview was conducted with Employee #23 on February 20, 2009 at 11:00 AM. He/she acknowledged that the criminal background was not conducted prior to hire.</p> <p>2. Facility staff failed to administer a tuberculosis test for three (3) new employees.</p> <p>According to 22 DCMR 3202.2, "Each facility shall develop and maintain personnel policies which shall include methods used to document the presence or absence of communicable disease."</p>	F 492	<p>1. Active and current employees will have TB Test administered and results within 48 hours.</p> <p>2. An audit of all new hires as of November 3 2008 was conducted. See attached I.</p> <p>3. Human Resources staff will meet weekly to review pending applications to determine if all requirements are met prior to extending an offer of employment and scheduling an orientation date. See attached II. Human Resources new hire checklist will be used during recruitment and hiring process. Process will be monitored by the Human Resources Manager.</p> <p>4. Report of all new hires for the previous quarter will be reported at the monthly CQI meeting.</p>	<p>3/18/09</p> <p>3/09/09</p> <p>3/04/09 On-going</p> <p>On-going</p>

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F 492	<p>Continued From page 46</p> <p>A review of the " CBL Recruitment Checklist "[no date of initiation] revealed," ...PPD [purified protein derivative]/Nursing [indicating the a PPD is to be conducted]</p> <p>Employee # 24 was hired on December 29, 2008 Employee # 26 was hired on December 8, 2008 Employee # 25 was hired on January 26, 2009</p> <p>There was no evidence in the record that the above cited employees received a PPD test prior to the date of hire.</p> <p>A face-to-face interview was conducted with Employee #22 on February 19, 2009 at 3:30 PM. He/she acknowledged that the PPD were not administered prior to hire.</p> <p>3. Facility staff failed to ensure that food temperatures at the point of delivery to the resident were above 140 degrees Fahrenheit (F) for hot foods and did not exceed 45 F for cold foods. This observation was made in the presence of Employee #7 who acknowledged the findings at the time of the observations.</p> <p>A test tray was conducted on February 20, 2009 at the lunch meal. The test tray was placed on the delivery cart at 12:29 PM. The elevator arrived at 12:31 PM and was filled with residents. There was no room on the elevator for the delivery cart. The delivery cart was placed on the elevator at 12:40 PM and arrived on the unit at 12:44 PM. There were 13 resident trays on the delivery cart. The first tray was passed at 12:46 PM and the test tray temperatures were taken at 1:00 PM, after all trays had been passed and all residents were eating.</p>	F 492		

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F 492	<p>Continued From page 47</p> <p>Food temperatures were as follows: Hot water 130 F Coffee 130 F Zucchini 128 F Chicken Patty 130 F Chopped Chicken 132 F Tapioca Pudding 60 F</p> <p>4. Based on observations and staff interview during the tour of the main kitchen, it was determined that facility staff failed to maintain a three (3) day supply of non-perishable staples for emergency use. This observation was made in the presence of Employee #7 on February 17, 2009 from 8:45 AM through 10:30 AM. Employee #7 acknowledged these findings at the time of the observations.</p> <p>According to 22DCMR 3222.3, "A three (3) day supply non-perishable staples shall be maintained on the premises."</p> <p>Employee #7 presented a three (3) day "Cold Food" menu that was developed for use by the facility for emergencies. The following non-perishable items were included on the menu:</p> <p>Day One: cottage cheese and fruit plate for lunch and turkey and cheese sandwiches for dinner.</p> <p>Day Two: Cold Cut sandwich for dinner.</p> <p>Additionally, items on the menu and not stocked at the facility included potato chips, soda and dry milk.</p> <p>A face-to-face interview was conducted at the time of the observations. Employee #7 stated, "If the electricity goes out, we have about 4 to 6</p>	F 492	<p>F 492</p> <p>1. Emergency food items have been increased to meet regulations. 3/17/09</p> <p>2. Emergency menus have been changed to reflect the foods needed in case of power outage. 3/17/09</p> <p>3. The emergency food shelf will be monitored for rotation and needed items by the Food Services Supervisor. 3/17/09</p> <p>4. The results will be reported to the CQI CQI Committee meetings. Ongoing</p>	



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F 514	<p>Continued From page 49</p> <p>order included treatments and the following three (3) routine medications:</p> <p>"Acetaminophen w/codeine #3 300mg-30mg Tablet"</p> <p>"Fentanyl 25 mcg/hr patch TD72 (WF: Duragesic)"</p> <p>"Tab-A-Vite Tablet (WF: Multi-vitamin)"</p> <p>The resident was hospitalized from January 16 through January 23, 2009. A review of the readmission orders signed January 26, 2009 included an additional 15 medications the above cited medications.</p> <p>A review of the resident's record revealed a February 2009 Medication Administration Record (MAR) listed the 15 additional medications that appeared on the January 26, 2009 POS. The resident received all 18 medications as prescribed by the physician on the January 26, 2009 readmission orders from January 26 through February 17, 2009.</p> <p>There was no evidence in the physician's progress notes or orders to indicate that the 15 medications on the January 26, 2009 orders were discontinued.</p> <p>The record lacked evidence that Resident #5's February 2009 Physician's Order Form was complete and accurately documented.</p> <p>A face-to-face interview was conducted with Employee #1 on February 17, 2009 at approximately 3:00 PM. He/she acknowledged that facility staff failed to ensure that Resident #5's February 2009 Physician Order Form was complete and accurately documented. The record</p>	F 514		

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F 514	<p>Continued From page 50 was reviewed February 17, 2009.</p> <p>2. The physician failed to follow up with his/her plan of care to monitor HGA1C [Glycated Hemoglobin] laboratory values every three (3) months for Resident # 8.</p> <p>A review of the resident's clinical record revealed Physician's Order Forms signed by the nurse practitioner on December 3, 2008, January 9 and February 4, 2009 that directed "HGBA1C every 3 months Mar/Jun/Sep/Dec ..."</p> <p>The physician visited on January 7, 2009. There was no evidence in the physician's progress note dated January 7, 2009 that the resident's HGBA1C was addressed.</p> <p>A review of the resident's clinical record lacked evidence the physician followed up with his/her order to monitor the resident's HBGA1C. The resident's record lacked evidence that the aforementioned laboratory test was done for December 2008.</p> <p>A face-to-face interview was conducted with Employee #2 on February 17, 2009 at approximately 3:00 PM. He/She acknowledged the aforementioned findings. He/she received a fax from the laboratory showing that the blood work was done on January 27, 2009. Employee #16 reviewed, signed and dated the laboratory result on February 18, 2009. The record was reviewed on February 18, 2009.</p>	F 514	<p><b>#2 Resident #8</b></p> <p>1. The physician reviewed the laboratory results and orders obtained as needed.</p> <p>2. An audit of residents with routine scheduled labs will be completed and corrections made as needed.</p> <p>3. A uniform time period has been identified for collection of routine scheduled labs. Staff will be educated on this process.</p> <p>4. A quarterly review of labs will be conducted by the Unit Managers. The results of these audits will be reported to the CQI Committee quarterly.</p>	<p>4/07/09</p> <p>4/07/07</p> <p>4/07/09</p> <p>On-going</p>
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