

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

PRINTED: 08/19/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2008
NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	
(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 000	INITIAL COMMENTS A recertification and licensure survey was conducted July 21 through 25, 2008. The following deficiencies were based on record review, observations, and interviews with the facility staff and residents. The sample included 25 residents based on a census of 163 residents on the first day of survey and four (4) supplemental residents.	F 000	Disclaimer Preparation or execution of this Plan of Correction ("POC") does not constitute an admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forth in the Statement of Deficiencies ("SOD"). The POC is prepared and executed solely because it is required under the law. Be this response, Carolyn Boone Lewis Health Care Center acknowledges receipt of the SOD and alleges that it is in compliance. Accordingly, this POC is submitted as written allegation of compliance effective September 8, 2008.	
F 154 SS-D	483.10(b) (3), 483.10(d) (2) NOTICE OF RIGHTS AND SERVICES The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 25 sampled residents, it was determined that facility staff failed to fully communicate with Resident #20 in a language he/she can understand or that allowed him/her to fully participate in his plan of care and provide information to the staff regarding unexplained injuries sustained by him/her. The findings include: According to the resident's record, he/she spoke a language other than English. According to an Unusual Incident Reporting form prepared by the	F 154	Resident #20 1. A list of the most common ADL care needs words were interpreted into resident #20 native language and place on communication care plan 8/25/08 and placed on a communication card for everyday use by staff. 2. All other residents identified with communication/language barrier clinical records were reviewed and care plan was updated as needed. 3. All staff inserviced on 8/25/08 by the Unit managers on Communicating with Residents with Communication/language barrier. 4. All new admissions will be assessed for communication/language barrier and a care plan initiated as needed monitoring of communication care plans will be done by Unit manager and report in Quarterly CQI.	09/08/08

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

Calantha Green

TITLE

Administrator

(X6) DATE

9-3-08

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 comments 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 154	<p>Continued From page 1</p> <p>facility, and dated May 5, 2008, Employee #4 wrote that on April 28, 2008 the resident was observed "to have what appeared to be an old, discolored bruise beneath the right eye on the right cheek bone. Resident was unable to state what happened due to a language barrier."</p> <p>Documentation on the Incident Report form regarding the same April 28, 2008 incident included "Cannot speak English or express [himself/herself]."</p> <p>Another incident report documented a fall with injury dated May 12, 2008 and lacked information from the resident. In the area designated for the resident's statement the following information was documented: "Resident was agitated and confused very combative."</p> <p>A face-to-face interview was conducted with Employee #4 at approximately 3:00 PM on July 24, 2008 regarding the methods used to communicate with the resident, and whether the Language Bank was ever contacted for an interpreter.</p> <p>Employee #4 stated "[He/she] does not speak English. The staff has worked with [him/her] for a long time and they understand [him/her]. [The resident] also uses hand gestures. We recently found out that one of the employees speaks [his/her] language. We use [him/her] whenever [he/she] works."</p> <p>The employee identified as speaking the same language as Resident #20 routinely worked the evening shift (3:00 PM through 11:30 PM).</p> <p>The record and the interview lacked evidence that</p>	F 154			

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F 154	Continued From page 2 the facility had provided for adequate communication with the resident to provide information regarding the total health status in a language he/she can understand. The record was reviewed on July 24, 2008.	F 154		
F 160 SS=D	<p>483.10(c) (6) CONVEYANCE UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on a review of the Resident Fund Management Service Trial Balance dated July 21, 2008 it was determined that facility staff failed to convey the personal funds of one (1) of six (6) deceased resident within 30 days of expiration. Resident #23.</p> <p>The findings include:</p> <p>A review of Resident #23's medical record revealed that he/she expired on May 14, 2008.</p> <p>A review of Resident Fund Management Service Trial Balance dated July 21, 2008 indicated a balance of \$70.00 in Resident #23's account, 66 days after the resident expired.</p> <p>A face-to-face interview was conducted on July 21, 2008 at 2:30 PM with Employee #20. He/she acknowledged that the money in Resident #23's account should have cleared by June 2008.</p>	F 160	<ol style="list-style-type: none"> 1. Resident Funds Management was called and an inquiry was made on why names still appear on the Trial Balance after Status Change forms had been sent to close accounts. We were informed to resend forms on all residents affected by the deficiency. Corrected forms were sent on August 14, 2008. Resident #23 account was closed on 8/14/08 and funds were sent back to Social Security. 2. All other residents who were discharged/ expired accounts were verified to ensure they were closed out timely and Status Change Forms were faxed to Resident Funds Management as needed to close Accounts. 3. Business Office Manager will monitor all expired and discharged resident's accounts monthly are closed and all monies disbursed accordingly. 4. RFM resident's accounts will be monitored weekly to ensure compliance of discharged and/or expired residents. Findings will be reported in Quarterly CQI. 	09/08/08
F 164	483.10(e), 483.75(l)(4) PRIVACY AND	F 164		

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F 164 SS=E	<p>Continued From page 3</p> <p>CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview for one (1) of 25 sampled residents, facility staff failed to promote Resident #5's dignity during a skin observation; and during the environmental tour it was observed that 18 of 27 privacy curtains in residents' rooms failed to provide complete visual</p>	F 164		

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F 164

Continued From page 4
privacy. These observations were made in the presence of Employees #3, 4, 5, 6, 15, and 16.

The findings include:

A. On July 25, 2008 at approximately 10:45 AM, facility staff failed to pull the privacy curtain completely around Resident #5's bed [bed B] located near the window, to provide complete visual privacy during a skin observation.

His/her roommate was seated in a chair between A and B beds at this time of the observation. Resident #5's lower body was completely exposed.

A face-to-face interview was conducted with Employee #18 immediately after the procedure. Employee #18 stated, "The curtain is short and if I pulled it all the way it would have been open at the other end and the roommate would have been able to see everything from where [he/she] was sitting." He/she acknowledged that the curtain was not pulled completely around the resident's bed during the procedure.

B. During the environmental tour conducted on July 22, 2008 from 9:00 AM through 11:52 AM, privacy curtains in the following rooms were observed to be too short in width to provide complete visual privacy for residents during personal care:

110 A and B beds, 111 A and B beds, 138 A and B beds, 144 A bed, 121 A bed, 211 A and B beds, 212 B bed, 213 A bed, 218 B bed, 242 B bed, 244 A bed, 310 A bed, 318 B bed and 338 B bed in 18 of 27 rooms observed.

F 164

#A.

Resident #5

1. Unit manager called housekeeping on 7/22/08 to get wider privacy curtain for resident #5. Curtain was exchanged on 7/28/08.
2. All other resident's rooms were checked and privacy curtains were ordered. Privacy curtains were replaced on 9/08/08.
3. All staff was inserviced on 7/28/08 concerning Privacy and Dignity for All Residents by unit managers.
4. Unit rounds by Unit Managers and Housekeeping staff will be conducted bi-weekly to ensure proper fitting of privacy curtains and reported in Quarterly CQI.

#B.

1. Privacy curtains have been ordered for the room numbers 110A and B, 111A and B, 138A and B, 144A, 121A, 211A and B, 212B, 213A, 218B, 242B, 244A, 310A, 318B, and 338B that were identified during the survey.
2. All resident rooms have been checked for proper fitting Privacy curtains and replacement curtains were installed on 9/08/08.
3. The Environmental Service Manager and/or Supervisor will conduct environmental rounds/audit on a bi-weekly basis to ensure Privacy curtains are in compliance.
4. Findings of environmental rounds will be reported in the Quarterly CQI meeting.

09/08/08

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F 164	Continued From page 5 The findings were acknowledged at the time of the observations.	F 164		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 25 sampled residents, it was determined that the clinical record lacked evidence that a pillow paw protector [hand mitten] was the least restrictive device for Resident #10. The findings include: On July 23, 2008 at approximately 11:40 AM, Resident #10 was observed lying in bed in his/her room with the pillow paw protector on the night stand next to the resident's bed. A face-to-face interview with Employee #17 was conducted on July 23, 2008 at 9:58 AM. He/she stated, "I don't apply the hand mitts, the nurses do. But [Resident #10] wears them every day." According to the "Restraint Use" policy and procedure No. 908, effective 09/19/00, "Orders for restraints will read as follows: Apply (type of restraint) for (reason) while (under what condition) for 90 days. Check for proper placement of restraint and condition of resident every 30 minutes. Release every two hours for at least ten minutes. Re-evaluate and document need for restraints every ninety (90) days."	F 221	Resident #10 1. Unit manager called physician on 7/24/08 for clarification of the pillow-paw order for resident #10 and the order was discontinued. 2. All other residents identified prone to scratching themselves orders/MARS/care plan were reviewed and updated as needed or discontinued. 3. All licensed staff was informed that pillow-paws are a form of restraints and inserviced on the Restraint Policy and Procedure on 7/24/08. 4. Residents with restraints are to be placed on the Unit manager's monthly audit form and reported in quarterly CQI.	09/08/08

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F 221	<p>Continued From page 6</p> <p>A telephone order dated May 2, 2008 and signed by the physician May 7, 2008, directed the following: "Pillow paw protectors to hands to prevent self-inflicted scratches."</p> <p>The order was renewed on the July 2008 physician's orders signed July 2, 2008.</p> <p>There was no evidence that the physician addressed the following in the May 7 or July 2, 2008 orders regarding the pillow paw protectors: under what conditions, checking for proper placement of restraint, condition of resident every 30 minutes, and release (of restrained limb) every two hours for at least ten minutes</p> <p>A review of the July 2008 Treatment Administration Record [MAR] revealed that the physician's order for pillow paw protectors was documented as " FYI" (for your information) and not signed by the nurse to indicate that the pillow paw protectors were applied to the resident's hands.</p> <p>According to the "Restraint Authorization" policy and procedure No. 906, effective 09/19/00, " I give permission ... physically restrained due to ... I understand that the reevaluation of the need for this restraint will be done every ... to determine if continued restraint is necessary ... resident or the legal representative signature and date ..."</p> <p>The record lacked evidence that the "Restraint Authorization" was completed for the use of the pillow paw protector.</p> <p>The record lacked evidence of the following: there was no Interdisciplinary team [IDT]</p>	F 221			

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F 221	Continued From page 7 assessment for the resident's use of the pillow paw protector that the resident was unable to release/remove; there was no care plan developed with goals and approaches to address the use of the pillow paw proctor; there were no other devices and/or interventions that were tried prior to obtaining an order for a pillow paw protector to determine if the device was the least restrictive and no on-going attempts to reduce the restraint. On July 23, 2008 at approximately 11:04 AM, a face-to-face interview was conducted with Employee #4. He/She acknowledged that an IDT assessment was not done, the order was not clarified to include under what conditions the restraint was to be used, checking for proper placement of restraint and condition of resident every 30 minutes, release every two hours for at least ten minutes, re-evaluation and documentation need for restraints every ninety (90) days, no authorization from the legal representative, and no care plan to address the use of the pillow paw protector. The record was reviewed on July 23, 2008.	F 221			
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225			

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F 225

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The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff and resident interviews for five (5) of 25 sampled residents, it was determined that facility staff failed to: identify, investigate and report to the State Agency injuries of unknown origin, potential abuse violations. Residents #1, 2, 6, 19 and 22.

The findings include:

1. Facility staff failed to investigate injuries of unknown origin and to report them to the State Agency for Resident #1.

F 225

Residents #1, #2, #6, #19 and #22

1. Resident #1 Incident Report was faxed on 6/4/08. Resident #2 Incident Report was faxed 7/25/08. Resident #6 Incident Report was faxed 7/22/08. Resident #19 Incident Report was faxed on 9/09 /08 and resident #22 Incident Report was faxed on 9/09/08. Staff involved in these incidents were inserviced on these specific residents on 8/6/08.
2. All other residents identified with reported injuries of unknown origin, compliant of inappropriate verbal exchange or violation of resident's rights will be investigated and reported in the designated time frame to the Department of Health.
3. All staff was inserviced by the Inservice Coordinator on Investigation and Reporting Incidents of Alleged Abuse and Injuries of Unknown Origin on 8/6/08, 8/7/08, 8/8/09 and 8/9/08.
4. Review Incident Reports and complaints as they occur and investigate in a timely manner and report to Department of Health and other agencies as required and report in Quarterly CQI.

09/08/08

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F 225	<p>Continued From page 9</p> <p>A review of Resident #1's clinical record revealed the following:</p> <p>Review of the nurses' progress notes:</p> <p>May 11, 2008 at 6:00 PM: "...Resident noted with superficial scratches on the (RT) [right] forearm and hematoma on (RT) [right] hand ..."</p> <p>May 17, 2008, no time noted: "...Residents showing S/S [signs and symptoms] of pain about 5:00 PM. Resident's son was the one that reported Tylenol 160 mg/ml was given as per order for pain. MD [Medical Doctor] made aware. Order received for X-ray to (L) site of ribs."</p> <p>May 19, 2008 at 3:00 PM: "Radiology [name] called and reported X-ray revealed FX [fracture of (L) [left] 7th Rib."</p> <p>June 3, 2008 at 9:30 PM: " ... writer was called by CNA observe an old bruise under the @ eye of the resident ..."</p> <p>A physician's order dated May 19, 2008 at 3:00 PM directed "... Bone density test ...R/O [rule out] Osteoporosis." The bone density test was completed May 27, 2008 with results documented as "Within Normal Limits."</p> <p>According to a Nurse Practitioner's progress note dated June 4, 2008 at 12:00 Noon, "...asked to evaluate resident with newly developed bruise under @ [right] eye ... R [right] eye secondary? X-ray of @ orbital bone; Hold Plavix X 5 days; CBC, PT (prothrombin time)/INR (international normalized ratio) in am; Ice Pack Q Shift for 5 minutes X 5 Days."</p>	F 225			

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F 225	<p>Continued From page 10</p> <p>June 5, 2008 PT result was 10.8 [range 9.6-12.7 secs] and the INR result was 1.0 [range .8-1.1].</p> <p>Resident observed lying in bed on July 24,2008 at 11:00 AM. Resident and bedding were clean. Resident was not responsive to verbal communication. The resident was restless and flayed his/her hands when touched by staff attempting to replace his/her arm band.</p> <p>Face-to-face interview with Employee #17 was conducted on July 24, 2008 at 11:10 AM. Employee #17 stated, "The resident does not move in bed. [The resident] is a fighter and does not like to be touched. [Resident #1] will kick and fight." When asked if staff had received training on handling difficult residents, Employee # 17 responded: "When a resident is combative at least 2 people are to provide care."</p> <p>A face-to-face interview was conducted on July 24, 2008 at 3:07 PM with Employees #4. Employee #4 stated, "I talked to the staff regarding the above incidents but did not document the investigation. I was concerned about the number of injuries so I started to give all the staff inservices on abuse." Employee #4 could not confirm that reports of the above incidents were sent to the State Agency either by facsimile, electronic mail or letter mail. The record was reviewed on July 24, 2008.</p> <p>2. Facility staff failed to report an injury of unknown origin for Resident #2 to the State Agency.</p> <p>A review of Resident #2's clinical record revealed the following:</p>	F 225		

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F 225	<p>Continued From page 11</p> <p>A nurse's note dated April 25, 2008 at 4:45 PM documented " ...CNA [Certified Nursing Assistant] assisted resident with ADLs [Activities of Daily Living] observed Left thumb to be swollen [with] redness and painful. No skin breaks to the thumb or surrounding areas. Hand warm to touch. Placed call to PMD [Primary Medical Doctor]. Orders given Motrin PRN, X-rays. Place call to RP [Responsible Party] ..."</p> <p>April 25, 2008 at 5:00 PM, "X-ray results...fracture of the left thumb. MD was called ..."</p> <p>An incident investigation completed by Employee #3 on April 29, 2008, and was reviewed. The report was addressed to the attention of the State Agency. There was no evidence in the record that the above cited injury was reported to the State Agency.</p> <p>An interview was conducted on July 25, 2008 at approximately 10:00 AM with Employees #1, 2, and 3. These employees could not confirm the report was sent to the State Agency either by facsimile, electronic mail or letter mail. The record was reviewed on July 25, 2008.</p> <p>3. Facility staff failed to report an injury of unknown origin to Resident #6 to the State Agency.</p> <p>A review of Resident #6's clinical record revealed the following:</p> <p>A nurse's note dated July 21, 2008 at 10:30 AM documented " Res. noted with bruising (L) knee and (R) thigh with dark appearance. No opening/drainage noted. PMD [Private Medical</p>	F 225		

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F 225	<p>Continued From page 12</p> <p>Doctor] notified, labs ordered - family notified."</p> <p>A face-to-face interview was conducted with Employee # 2 at approximately 2:00 PM on July 23, 2008. He/she acknowledged that the report was not sent to the State Agency. The record was reviewed on July 23, 2008</p> <p>4. Facility staff failed to identify and investigate Resident # 19's right swollen hand (from wrist to finger) as an injury of unknown origin and report the injury to the State Agency.</p> <p>A review of Resident #19's clinical record revealed the following nurses' notes:</p> <p>May 31, 2008 at 7:00 PM:"...Resident noted with right swollen hand from wrist to finger ...no redness noted, verbalized no pain at this time. ROM WNL [Range of Motion Within Normal Limit]....order received for X-ray to be done."</p> <p>June 1, 2008 at 10:30 PM:"...Stable and verbally responsive. X-ray result read negative for fracture. Resident denied pain."</p> <p>A review of the facility's incident/ unusual occurrence reports failed to reveal that the resident's swollen right hand and fingers were documented or investigated.</p> <p>A face-to-face interview was conducted with Employee #3 on July 23, 2008 at approximately 2:30 PM. He/she stated," I did not consider this as an unusual incident/occurrence."</p> <p>5. Facility staff failed to identify, report and investigate potential verbal abuse towards Resident #22.</p>	F 225			

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F 225	<p>Continued From page 13</p> <p>The following face-to-face interview was conducted on July 21, 2008 at 2:00 PM with Resident #22:</p> <p>He/she stated that staff didn't always talk to [him/her] in the proper way. "They [staff] try to get back at me because I speak up" The resident then presented a letter that had been written to the facility Administrator by his/her attorney and legal guardian on June 22, 2008.</p> <p>The letter referenced the reporting of a formal complaint to the facility Administrator, Director of Nursing and the Social Worker regarding an incident that occurred on Saturday, June 21, 2008 involving the resident, the guardian and a certified nursing assistant (CNA). The letter referenced the following:</p> <p>" ...On Saturday, June 22, 2008, I was visiting [Resident #22] in his/her room [#]. During my visit, I asked that [he/she] be cleaned due to a strong odor that was emanating from [him/her] as well as [his/her] roommate. The odors appeared to be Human Waste that had been on the patients for some time during the day. The nurse was contacted and in response, [Employee #16] was sent in reply. ...I indicated to [Employee #16] that [Resident #22's] Diaper needed to be changed before he/she could eat dinner. [Employee #16] indicated to me, in so many words that the odor was not human waste but [Resident #22's-] mouth, meaning bad breath, and body odor and that [his/her] diaper did not need changing and [he/she] did not need cleaning. When I insisted that [Resident #22] be cleaned, [Employee #16] refused ...After waiting more than 15 minutes [Employee #13] did respond and handle the</p>	F 225		

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F 225	<p>Continued From page 14 situation ..."</p> <p>A face-to-face interview was conducted on July 23, 2008 at 5:05 PM with Employees #1, #2 and #3. When queried regarding the above stated incident, it was determined that the facility did not investigate this incident as potential alleged abuse and did not report this incident to the State agency.</p> <p>Employee #1 stated, "I saw this as disrespect to the resident's attorney." Additionally, Employee #1 stated that Employee #16 left his/her assignment on June 22, 2008 and the facility when he/she found out about the letter from the resident's attorney and was later terminated for desertion.</p> <p>Employee #2 responded that it was investigated by HR [Human Resources] as inappropriate behavior of the CNA toward the attorney. He/she stated, "I did not view this incident as abuse."</p> <p>Employee #3 stated: "I feel that it was a confrontation between the CNA and the attorney and I did not do a written investigation. It was given to Human Resources for follow-up."</p> <p>A face-to-face interview was conducted on July 25, 2008 at 2:10 PM with Employee #13. He/she stated, " I told [Employee #16] that the customer is always right and we have to say we are sorry, even if we don't think we are wrong. [Employee #16] didn't want to say [he/she] was sorry. Employee #16 always felt that [he/she] was being disrespected. [Employee #16] finally came around cleaned the resident and shook hands with the attorney."</p> <p>When Employee #13 was queried regarding the</p>	F 225		

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F 225	<p>Continued From page 15</p> <p>above incident as representative of verbal abuse, his/her response was, "The way it came to me ... I didn't view it as an abuse situation. I thought it was a communication problem. When [Employee #13] was queried as to what constitutes abuse, he/she stated, "Abuse can be verbal or physical. I didn't detect any in this situation."</p> <p>When asked about abuse training, Employee #13 responded, "I'm not aware that we had it." When asked about writing an incident report, Employee #13 stated, "I didn't write an incident report because I thought it was over."</p> <p>When asked about Employee #16's comment regarding the resident's mouth, Employee #13 replied, "I had heard that before ...it wasn't the first time I'd heard about [his/her] breath."</p> <p>Employee #13 was asked if the resident heard these comments. He/she replied, " Yes, these comments were made in the presence of the resident."</p> <p>A face-to-face interview was conducted on July 25, 2008 at 1:25 PM with Employee #15. He/she stated, "On hire, we do a background and reference check and we validate that the employee has a license or certificate. In orientation, we train the new employees on abuse and residents rights. Abuse training is done annually around the employee's anniversary date."</p> <p>Employee #15 was asked how many of the current staff had received abuse training. Employee #15 referenced the document, "Summation of the Completion of the Mandatory Inservice Training for February - June 2008."</p>	F 225			

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F 225	<p>Continued From page 16</p> <p>According to this document, 63 employees were identified as eligible for training by their hire date. 37 employees had completed abuse training. 26 employees were beyond their annual hire date and had not attended an abuse training class at this time of this review.</p> <p>Employee #15 presented the policy and educational hand -outs that were used to train staff. Absent from the educational handouts was a definition of verbal abuse.</p> <p>Employees #1, 2, and 3 failed to recognize potential resident abuse in this reported incident and to investigate as potential abuse and to report this incident to the State</p>	F 225		
F 226 SS=E	<p>483.13(c) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff and resident interviews, it was determined that the facility failed to operationalize policies and procedures for identification, investigation and reporting of abuse, neglect, mistreatment and misappropriation of funds as evidenced by failing to: include verbal as a type of abuse in its policy and procedures, investigate injuries of unknown origin and report incidents of alleged abuse to the State Agency.</p> <p>The findings include:</p>	F 226	<ol style="list-style-type: none"> 1. Corrective actions for residents #2, #19 and #22 could not be implemented due to the lapsed of time. 2. The facility has implemented the procedure of reporting any unusual occurrence that suggests any type alleged abuse. 3. The facility has implemented the use of an investigative tool that will be used on any type of alleged abuse. Supervisory staff will be trained on the proper use of the "Investigation Form". 4. The Quality Improvement Coordinator will maintain a log of all suspected abuse and unusual occurrences. Audit of logs will be reviewed for trends, types, etc. and a report will be submitted to the Quarterly CQI. 	09/08/08

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F 226	<p>Continued From page 17</p> <p>A review of the facility's abuse training program was conducted on July 25, 2008 at 1:25 PM with Employee #15.</p> <p>Employee #15 stated, "On hire, we do a background and reference check and we validate that the employee has a license or certificate. In orientation, we train the new employees on abuse and residents rights. Abuse training is done annually around the employee's anniversary date."</p> <p>Employee #15 referenced the document, "Summation of the Completion of the Mandatory Inservice Training for February - June 2008." According to this document, 63 employees were identified as eligible for training by their hire date. 37 employees had completed abuse training. 26 employees were beyond their annual hire date and had not attended an abuse training class at this time of this review.</p> <p>Employee #15 presented the following documents: " Resident Abuse, Neglect and Misappropriation of Property, Policy & Procedure No.117, 3/3/06 ", a " Resident Abuse " packet given to each employee during training, " Seven Steps to Preventing Abuse ", " Abuse Definitions " and a packet titled " Resident Abuse " including definitions and preventive actions.</p> <p>Types of abuse as defined in the above cited facility 's policy included physical, psychological, sexual, financial, active neglect and passive neglect in section " IV -Identification. "</p> <p>Psychological abuse was defined as "The threat of injury, unreasonable confinement and punishment or verbal intimidation humiliation</p>	F 226			

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F 226	<p>Continued From page 18</p> <p>that may result in mental anguish such as anxiety or depression. Example- yelling, screaming or using demeaning language or ridicule. " There was no other type of abuse in the definitions that included an explanation of verbal abuse.</p> <p>There was no evidence in the above cited documents that indicated that verbal abuse was included as a type of abuse.</p> <p>In section " IV -Identification, physical abuse includes unexplained injuries or explanation inconsistent with medical findings, such as: fractures ... "</p> <p>There was no evidence that Resident #2's fracture of unknown origin, (reference CFR 483.13, F225 of this report) was investigated by the facility.</p> <p>According to section " VII: Reporting/Response 1. All alleged violations concerning abuse, neglect or misappropriation of property are reported immediately to the Administrator/Designee and other enforcement agencies, according to state law including the State Survey and Certification Agency (nurse aide registry or licensing authorities). "</p> <p>The above cited incidents for Residents #2, 19, and 22 were not reported to the State Agency.</p> <p>The facility failed to include verbal as a type of abuse in section " IV Identification " of the abuse policy and procedures, and in all additional documents that included definitions of types of abuse.</p> <p>The facility failed to investigate an injury of</p>	F 226			

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F 226	Continued From page 19 unknown origin and report incidents of alleged abuse to the State Agency.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled kitchen appliances; damaged and/or marred/scarred baseboards, walls, shower room tiles and odors detected in resident areas. A tour of the kitchen was conducted on July 21, 2008 from 8:45 AM to 11:45 AM in the presence of Employee #8 and the findings were acknowledged at the time of the observations. The environmental tour was conducted on July 22, 2008 from 9:00 AM through 11:52 AM in the presence of Employees #3, 4, 5, 6, 15, and 16. The findings were acknowledged at the time of the observations. The findings include: 1. The following appliances were observed soiled in the main kitchen: A. Gas stove in one (1) of one (1) stove observed; B. Ovens in two (2) of two (2) ovens observed; C. Deep fryer in one (1) of one (1) deep fryer	F 253	#1 1. All areas (ABCD) have been cleaned: the ice machine has been replaced and was installed on July 25, 2008. 2. Because other areas have the potential to be affected therefore other equipment items were inspected to ensure cleanliness and corrected as needed. 3. Cleaning scheduled were instituted for the kitchen equipment Inservice was done on 8/26/08 by Dietary supervisor on cleaning of appliances and ice machine. A. Gas stove top and tray will be cleaned after each meal and the supervisor will checked daily before closing. B. Ovens will be cleaned weekly. C. Deep fat fryer will be cleaned after each use and checked daily by the supervisor. D. Streamer will be cleaned daily and checked by the supervisor. E. Ice machine will be cleaned/inspected. 4. Cleaning schedules have been instituted to monitor equipment/areas. An audit of the system checks will be maintained by the Food Service Manager to ensure equipment/areas are in compliance. results of the findings of the audits will be reported in the Quarterly CQI.	09/06/08

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F 253	Continued From page 20 observed; D. Steamer in one (1) of one (1) steamer observed; 2. The following items/areas were observed marred/scarred: A. The first floor day room walls in one (1) of three (3) day rooms observed. B. Arm chairs in the first floor day room in seven (7) of seven (7) chairs observed. C. Entry doors to the first floor day room in two (2) of two (2) entry doors observed. 3. The following items/areas were observed damaged: A. Walls in the 2nd floor day room in one (1) of three (3) day rooms observed. B. Baseboards in the 2nd floor day room in one (1) of three (3) day rooms observed. C. Floor tiles were damaged in the 1st floor and 3rd floor shower room in two (2) of three (3) shower rooms observed. 4. Urine odors were detected on the first floor near the nurses' station on July 21, 2008 at 11:50 AM.	F 253	#2, #3 and #4 1. The areas identified below as marred and scarred, damaged floor tiles on 1 st and 3 rd floor shower room were corrected on 8/29/08. Urine odors that was detected on 1 st floor near Nursing Station was disinfected by Environmental Services same day as survey. A. Walls have been repaired/painted. B. Chairs have been replaced. C. Entry doors have been repaired/painted. D. Floor tiles in the 1 st and 3 rd floor shower Rooms have been repaired. E. Baseboards in the 2 nd floor dayrooms have been replaced. F. Area around the Nurses Station was cleaned and disinfected. 2. The Environmental Service and Maintenance staff has conducted a facility wide check to ensure that the walls, floors, baseboards, and equipment are in good/functional and that facility is odor free. Repairs and sanitizing were done as needed. 3. Maintenance staff will conduct random monthly Preventative Maintenance audits on equipment and repair as needed. The Environmental Service Manager/Supervisor will conduct monthly audits on the various areas to ensure cleanliness. 4. The findings of the audits will be submitted to the Quarterly CQI.		
F 257 SS=E	483.15(h)(6) ENVIRONMENT- TEMPERATURE The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observations during the survey period,	F 257		09/08/08	

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F 257	<p>Continued From page 21</p> <p>it was determined that the facility failed to maintain comfortable and safe temperature levels in the range of 71 degrees Fahrenheit (F) and 81 F.</p> <p>The findings include:</p> <p>Facility temperatures were observed as follows:</p> <p>July 24, 2008 at 12:30 PM the temperature was 85.6 F in the 3rd floor lounge. July 24, 2008 at 12:45 PM the temperature was 85.8 F in the 3rd floor dining room two (2) residents were eating in the dining room at the time of the observation. July 25, 2008 at 10:55 AM, the temperature was 85.2 F in the 3rd floor dining room at the time of this observation three (3) residents and two (2) facility staff members were present in the dining room. July 25, 2008 at 11:02 AM, the temperature was 85.1 F in the 2nd floor dining room.</p> <p>These observations were made in the presence of Employee #15 who acknowledged these findings at the time of the observations.</p> <p>A face-to-face interview was conducted with Employee #1 on July 25, 2008 at approximately 1:00 PM. He/she acknowledged that the temperatures in the 2nd and 3rd floor lounge and dining areas were high. Employee #1 stated, "We [the facility] are installing new units on the roof. The units [staff on the units] were instructed not to place residents in the dayrooms."</p>	F 257	<p>F 257</p> <ol style="list-style-type: none"> 1. New Air Conditioning units were installed by the Maintenance staff on the 2nd floor and 3rd floor dayrooms August 27-28, 2008. 2. All other day rooms were checked by Maintenance staff to ensure compliance and corrected as needed. 3. Maintenance staff will conduct monthly rounds to ensure compliance for air temperature quality. 4. Findings will be reported in the Quarterly CQI. 	09/08/08
F 278 SS=D	<p>483.20(g) - (j) RESIDENT ASSESSMENT</p> <p>The assessment must accurately reflect the resident's status.</p>	F 278		

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NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	
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F 278	<p>Continued From page 22</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review for one (1) of 25 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) assessment for one (1) resident for diabetes and one (1) resident with swallowing problems. Resident's #9 and JH1.</p> <p>The findings include:</p>	F 278		

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F 278	<p>Continued From page 23</p> <p>1. Facility staff failed to accurately code Resident #9 for diabetes.</p> <p>The review of the clinical record for Resident #9 revealed :</p> <p>A physician's order dated and signed April 14, and July 14, 2008 that included the following : "Novolin regular Insulin 2 units subcutaneous everyday if blood sugar 200-300. Fingertstick daily at 6:00 AM. HGBAIC [Hemoglobin A1C] every three months..."</p> <p>A Laboratory Cumulative Report for March 27, and June 23, 2008 stating the results for HGBAIC..."</p> <p>A "Care Plan" evaluated April 22, 2008 for "Therapeutic Diet related to DM [Diabetes] ..."</p> <p>A "Nursing Care Plan Notes" dated April 24, 2008 that included "... [Resident] has experienced ...no glycemic episodes ..."</p> <p>A "Diabetes Care Plan" dated January 22, 2008 and evaluated on April 24, 2008 and July 23, 2008.</p> <p>The resident was observed in bed on July 22, 2008 at approximately 8: 53 AM.</p> <p>A review of the resident's quarterly MDS in Section I1 "Diseases" completed April 21, 2008, failed to code the resident for diabetes.</p> <p>A face-to-face interview was conducted with Employee #2 on July 25, 2008 at approximately 11:45 AM. Employee #2 acknowledged that He / she failed to accurately code the resident was for</p>	F 278	<p>Residents #9 and JH1</p> <p>#1 and #2</p> <p>1. DON corrected resident #9 April 2008 MDS on 7/23/08 to reflect the diagnosis of diabetes and dietician corrected resident JH1 June 2008 MDS to reflect swallowing difficulties on 7/23/08.</p> <p>2. All other residents identified with diagnosis diabetes and swallowing difficulties MDS were reviewed for correct coding and corrected as indicated.</p> <p>3. MDS Manual reviewed by DON on 7/24/08 and Dietician was inserviced on accurate MDS coding by DON on 7/28/08.</p> <p>4. Random MDS auditing by MDS Coordinator and DON for accurate coding and report in Quarterly CQI.</p>	09/08/08

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F 278	<p>Continued From page 24</p> <p>diabetes on the quarterly MDS completed on April 21, 2008. The record was reviewed July 25, 2008.</p> <p>2. The quarterly MDS was not accurately coded for swallowing for Resident JH1.</p> <p>On July 21, 2008, at approximately 9:15 AM, during the medication pass, Resident JH1 was observed sucking on tablets of medication that were administered. The medications included KCL 10 mEq capsule, Multivitamin tablet, Ferrous Sulfate 325 mg tablet, Furosemide 20 mg tablet and Lisinopril 40 mg tablet.</p> <p>An initial contact note dated April 8, 2008 from speech therapy documented "... SLP [speech language pathologist] revealed, "oral leakage, pocketing with mechanical soft textures, poor oral /pharyngeal clearance, decrease lip closure and decreased chewing ..."</p> <p>The care plan entitled, "Impaired Swallowing" was initiated on May 8, 2008. The evaluation documented, "SLP has evaluated resident and noted difficulty swallowing. SLP recommends nectar consistency liquids resident. Will monitor prn."</p> <p>A physician's order dated May 6, 2008 directed, "Start nectar thick liquid."</p> <p>A review of the quarterly MDS completed June 23, 2008 revealed that Section K1(b) [Oral Problems] was not coded for swallowing.</p> <p>On July 24, 2008, at approximately 10:00 AM, an interview was conducted with Employee #19. He/she acknowledged that Resident JH1 had a swallowing problem and the MDS was not coded</p>	F 278		

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F 278	Continued From page 25 for swallowing. The record was reviewed on July 21, 2008.	F 278		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</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 staff interviews and record review for four (4) of 25 sampled residents, it was determined that facility staff failed to initiate care plans with appropriate goals and approaches for: three (3) residents for the potential for adverse drug reactions for the use of nine (9) or more medications, one (1) resident with skin impairment, and one (1) resident for psychotropic medications and behaviors. Residents #4, 10, 11, and 15.</p>	F 279		

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F 279	<p>Continued From page 26</p> <p>The findings include:</p> <p>1. Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #4.</p> <p>A review of the clinical record for Resident #4 revealed physician orders dated and signed May 5, June 4, and July 2, 2008 that included the following medications:</p> <p>"Acetaminophen, Ascorbic Acid, Docusate liquid, Ferrous Sulfate, Furosemide, Hydralazine, Metoprolol Tartrate, Multivitamin Liquid, Ranitidine Hydrochloride, Simvastatin, and Insulin Novolin."</p> <p>There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications.</p> <p>On July 23, 2008 at approximately 3:55 PM, a face-to-face interview was conducted with Employee #3. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. He/she said, "I must have missed that." The record was reviewed on July 23, 2008.</p> <p>2. Facility staff failed to initiate care plans for Resident #10 for skin impairment and potential adverse drug reactions for the use of nine (9) or more medications.</p> <p>A. Facility staff failed to initiate a care plan for impaired skin integrity for Resident #10.</p>	F 279	<p>Resident #4, #10, and #11</p> <p>#1. #2B and #3</p> <p>1. Unit manager initiated an adverse drug reaction care plan for nine or more medications on resident #4, #10 and #11 on 7/23/08.</p> <p>2. All other residents identified on nine or more medications clinical records were reviewed for nine or more medications and care plan initiated as indicated.</p> <p>3. Unit managers were inservice on initiating care plans for adverse drug reaction of nine or more medication by DON on 8/25/08.</p> <p>4. Monthly review of POSs and MARs by the charge nujrse during MAR check/ changeover and report in quarterly CQI.</p> <p>Resident #10</p> <p>#2A</p> <p>1. Retrospectively unable to correct this error for resident #10. Unit manager inserviced on 7/25/08 by DON on initiating skin impairment care plan as indicated.</p> <p>2. All other residents identified with potential for skin impairment clinical records were reviewed and an impaired skin integrity care plan was initiated as indicated.</p>	09/08/08

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F 279	<p>Continued From page 27</p> <p>Review of Resident #10's record revealed a "Nursing Admission Assessment Form" dated April 21, 2008. Under "Skin Assessment" a Stage II open blister was identified on the right forearm. A treatment order was obtained on April 21, 2008 and according to the April and May 2008 Treatment Assessment Record (TAR), the treatment was applied daily until May 5, 2008. On May 5, 2008 it was documented on the TAR that the wound was healed.</p> <p>According to the admission Minimum Data Set completed May 5, 2008, Section M [Skin Condition] was coded for one (1) stage 2, indicating that the resident had one (1) stage 2 ulcer.</p> <p>There was no evidence that a care plan for impaired skin integrity with appropriate goals and approaches was initiated on April 21, 2008. The skin assessment dated April 21, 2008 was incomplete.</p> <p>On July 23, 2008 at 11:04 AM, a face-to-face interview was conducted with Employee #4. He/she acknowledged that a care plan for skin integrity should have been initiated. The record was reviewed on July 23, 2008.</p> <p>B. Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications.</p> <p>A review of Resident #10's record revealed physician's 30 day orders dated July 2, 2008 to include the following medications: Ascorbic Acid, Aspirin, Diovan, Lipitor, Lisinopril, Lovenox, Metoprolol, multivitamin and Prevacid.</p>	F 279	<p>#2A cont.</p> <p>3. Unit managers were inserviced on initiating skin impairment care plans on 8/26/08 by DON.</p> <p>4. Random chart audits by Unit managers and MDS Coordinator for impaired skin integrity care plan report in quarterly CQI.</p>	09/08/08

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F 279	<p>Continued From page 28</p> <p>There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications.</p> <p>On July 23, 2008 at 11:04 AM, a face-to-face interview was conducted with Employee #4. He/she acknowledged that a care plan for a potential adverse drug reaction for the use of nine (9) or more medications should have been initiated. The record was reviewed on July 23, 2008.</p> <p>3. Facility staff failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #11.</p> <p>A review of the clinical record for Resident #11 revealed physician orders dated and signed May 11, June 14, and July 12, 2008 that included the following medications:</p> <p>"Amlodipine Besylate, Antacid, Ascorbic Acid, Aspirin, Caduet, Clonazepam, Folic acid, Lisinopril, Metoclopramide, Multivitamin plus iron, Pantoprazole, Zinc Sulfate, and Selenium sulfide"</p> <p>There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications.</p> <p>On July 23, 2008 at approximately 3:55 PM, a face-to-face interview was conducted with Employee #3. He/she acknowledged that the record lacked a care plan for potential adverse</p>	F 279		

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F 279	Continued From page 29 drugs reactions for the use of nine (9) or more medications. He/she said, "I must have missed that." The record was reviewed on July 23, 2008. 4. Facility staff failed to initiate a care plan with goals and approaches for Resident #15, who was receiving a psychotropic medication. Signed and dated "Physician's Order Forms" revealed the following: May 5, 2008 - "Seroquel 25 mg 1 tablet by mouth every day for agitation behavior." June 4, 2008 - "Seroquel 25 mg 1 tablet by mouth every day for agitated behavior." July 2, 2008 - "Seroquel 25 mg po [By Mouth] 4 x weekly X 6 weeks than... Seroquel 25 mg 2 x weekly x 4 weeks start July 31, 2008 then D/C [discontinue after] 4 weeks." A review of the May, June, and July 2008 Medication Administration Record revealed that Seroquel 25 mg was initialed by the nurse [indicating that the medication was administered to the resident] as ordered. A review of the record lacked evidence that a care plan was developed with goals and approaches for Resident #15's use of a psychotropic medication. A face-to-face interview was conducted with Employee #3 on July 23 2008 at approximately 4:05 PM. He/she acknowledged that a care plan was not developed for the use of a psychotropic medication. The record was reviewed July 23, 2008.	F 279	#4 Resident #15 1. Unit manager updated the psychotropic medication care plan for resident #15 on 7/23/08. 2. All other residents identified on psychotropic medications clinical records were reviewed and psychotropic medication care plan was updated as indicated. 3. Unit managers were inserviced on 8/26/08 by DON on updating care plan for residents with psychotropic medication. 4. Random chart audits by unit managers and MDS Coordinator for psychotropic medication care plan update and report in quarterly CQI.	09/08/08
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS	F 280		

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F 280	<p>Continued From page 30</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for four (4) of 25 sampled residents, it was determined that facility staff failed to update one (1) resident's care plan for behavior, one (1) resident's care plan for communication, one (1) resident's care plan for dialysis and one (1) resident's care plan for hospice care. Residents #2, 15, 18, 20 and 21.</p> <p>The findings include:</p> <p>1. Facility staff failed to update Resident # 2's care plan with appropriate goals and approaches for behavior.</p>	F 280	<p>#1</p> <p>Resident #2</p> <p>1. Unit manager updated resident #2 behavior care plan with the appropriate goals and approaches on 7/25/08.</p> <p>2. All other residents identified with behavior care plans clinical records were reviewed and updated as indicated.</p> <p>3. Unit managers were inserviced by DON on 8/25/08 on Updating Behavior Care Plans after each unusual occurrence and monthly.</p> <p>4. Random care plan audits by unit managers and MDS Coordinator and report in quarterly CQI.</p>	09/08/08

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F 280	<p>Continued From page 31</p> <p>A review of the resident's clinical record revealed the followings:</p> <p>A "Nursing Care Plan Notes" dated May 14, 2008, "...Had [two] 2 episodes of inappropriate behavior toward [two] 2 residents..."</p> <p>A "Social Progress Notes" dated May 14, 2008, "Care Plan Progress Note:...Resident has had incidents during this assessment period where she scratched another resident in the face and another resident on the left breast. Resident has episodes of agitation and other behavioral concerns that require [Psychiatric evaluation] ..."</p> <p>A review of "Resistive Behavior Care Plan " dated May 8, 2008 lacked evidence that additional goals and approaches were initiated after aforementioned episodes of agitation and inappropriate behavior.</p> <p>A face to-face interview was conducted with employee # 3 on July 23, 2008 at approximately 2:30 PM. He/she acknowledged that the clinical record lacked evidence that the resident ' s care plan was updated with additional goals and approaches after the aforementioned episodes of agitation and inappropriate behavior. The record was reviewed on July 23, 2008.</p> <p>2. Nursing staff failed to update care plan for an emergency dialysis plan for Resident #18.</p> <p>Physician's orders signed July 2, 2008, directed, "Dialysis on Tue, Thurs, Sat"</p> <p>On July 23, 2008, at approximately 3:45 PM, the resident was observed sitting at beside in a wheelchair. There were no emergency devices in</p>	F 280	<p>#2</p> <p>Resident #18</p> <p>1. Unit manager updated Resident #18 dialysis care plan on 7/23/08 and placed an emergency dialysis kit at resident's bedside on 7/23/08.</p>	

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F 280	<p>Continued From page 33</p> <p>encourage initiation of conversation by: Nonverbal gestures.</p> <p>4. Validate meaning of nonverbal communication, examples: [No examples were given.]</p> <p>5. Increase resident's opportunities for communication with others by: encouraging group participation."</p> <p>Approach #6 was added on March 25, 2008: "Utilize any/all staff (if avail) who speak same dialect." [No employee was identified on the care plan who spoke the same dialect.]</p> <p>The evaluation of the goals was first documented on March 25, 2008, "Resident's needs are being met...Sometimes understanding poses a challenge - Continue care plan."</p> <p>The evaluation of the goals on June 25, 2008 documented, "Needs continue to be met despite no oral communication. Understands gestures and cues. Continue care plan. "</p> <p>A face-to-face interview was conducted with Employee #4 at approximately 3:00 PM on July 24, 2008. He/she acknowledged that the "Alteration in Communication" care plan lacked goals and interventions to determine whether the resident understood and/or was able to participate in planning his care or meeting his needs. The record was reviewed on July 24, 2008.</p> <p>4. A review of Resident #21's record revealed that the resident was admitted to the facility on June 10, 2008. The Physician Order Sheet and Plan of Care dated June 11, 2008 indicated "Do Not Resuscitate" under diagnosis and "Hospice Care" under discharge plan.</p>	F 280	<p>Resident #21 #4</p> <p>1. Unit manager updated resident #21 with the appropriate goals and approaches for Hospice care on 7/24/08.</p> <p>2. All other residents identified on hospice care, care plans were updated as indicated.</p>	

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F 280	Continued From page 34 A "Death with Dignity, Comfort and Support Care Plan" was initiated on June 10, 2008". A telephone order dated June 23, 2008 indicated "Patient admitted to [...Hospice...]. A physician's progress note of June 24, 2008 stated, "Continue with Hospice care". There was no evidence in the record that the care plan was updated with additional approaches and interventions indicated on the signed admission order. A face-to-face interview was conducted with Employee #3 on July 24, 2008 at approximately 3:30 PM. He/she acknowledged that additional goals and approaches were not initiated after the resident was admitted to hospice care. The record was reviewed on July 24, 2008.	F 280	#4 cont. 3. All staff was inserviced on hospice care and care plans 8/20/08 by the Community Hospice Coordinator. 4. Unit managers and DON will review all resident's clinical records placed on hospice care to ensure hospice has provided a care plan within 72 hours of placement on hospice and report Quarterly CQI.	09/08/08
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 record review and staff interview for two (2) of 25 sampled residents, it was determined that facility staff failed to maintain 15 months of Minimum Data Set (MDS) assessments on the resident's active record. Residents #1 and 25. The findings include: 1. A review of Resident #1's medical record on	F 286	Residents #1 and #25 #1 and #2 1. DON placed resident #1 April 2008 Quarterly MDS and resident #25 March 2008 Annual MDS on the chart on 7/23/08. 2. All other residents identified as having MDSs done March and April 2008, clinical records for MDS presence and corrected as indicated. 3. Administrator met with DON in regards to placing MDSs on charts in a timely manner on 7/28/08. 4. Random chart audits for MDS presence by MDS Coordinator and Unit Secretaries and report in Quarterly CQI.	09/08/08

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F 286	<p>Continued From page 35</p> <p>July 23, 2008 revealed the following MDS assessments were present on the record: July 7, 2007 (quarterly); October 8, 2007 (annual), December 31, 2007 (quarterly), and July 9, 2007 (quarterly).</p> <p>The quarterly April 7, 2008 MDS assessment was not present on the resident's record.</p> <p>A face-to-face interview was held with Employee #2 on July 23, 2008 approximately 2:00 PM who acknowledge that the April 7, 2008 MDS was not on the record. Employee #2 stated that a stack of completed MDS assessments were in his/her office and should have been filed in the residents' records. The record was reviewed on July 23, 2008.</p> <p>2. A review of Resident #25's closed medical record on July 23, 2008 revealed the following MDS assessments were present on the record: April 2, 2007 (annual), July 2, 2007 (quarterly), October 1, 2007 (quarterly), and December 31, 2007 (quarterly).</p> <p>The annual MDS assessment completed March 31, 2008 was not included in the closed record. The resident expired on April 30, 2008</p> <p>A face-to-face interview was held with Employee #2 on July 23, 2008 approximately 2:00 PM who acknowledge that the MDS assessment completed March 31, 2008 was not included in the closed record. Employee #2 stated that a stack of reports were in his/her office and should have been filed in the residents' records. The record was reviewed on July 23, 2008.</p>	F 286			
F 309 SS=D	483.25 QUALITY OF CARE	F 309			

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F 309	<p>Continued From page 36</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and record review for four (4) of 25 sampled residents, it was determined that facility staff failed to: schedule a pacemaker check for one (1) resident, provide nectar thickened liquids for one (1) resident, and administer medication as per physician's order for two (2) residents. Residents #1, JH1, JH2 and JH3.</p> <p>The findings include:</p> <p>1. The facility staff failed to follow physician's order for pacemaker checks for Resident #1.</p> <p>A review of Resident #4's record revealed a physician's order dated July 7, 2007 for "Pacemaker Check every six (6) months Jun and Jan by [name of company]."</p> <p>There was no evidence in the record that a pacemaker check had been performed since January, 2008.</p> <p>During a face-to-face interview with Employee #4 was conducted on July 23, 2008 at 3:07 PM. He/she acknowledged that the pacemaker check had not been done in June of 2008. The record was reviewed July 23, 2008.</p>	F 309	<p>#1</p> <p>Resident #1</p> <p>1. Unit manager ensured that resident #1's pacemaker was checked on 7/25/08.</p> <p>2. All other residents identified with pacemakers clinical records were reviewed for pacemaker check compliance and corrected as indicated.</p> <p>3. Licensed staff and unit secretaries were inserviced on 7/23/08 by Unit manager on pacemaker check schedule and compliance.</p> <p>4. Pacemaker resident names are to be listed on Unit manager's monthly audit form and report in quarterly CQI.</p>	09/08/08

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F 309	<p>Continued From page 37</p> <p>2. Facility staff failed to provide nectar thick liquids in accordance with the physician's order for Resident JH2.</p> <p>On July 21, 2008, at approximately 9:20 AM, during the medication pass, the nurse was observed administering medications which included KCI 10 mEq capsule, Multivitamin tablet, Ferrous Sulfate tablet, Furosemide tablet and Lisinopril 40 mg tablet to Resident JH2, along with a cup of plain water.</p> <p>On July 21, 2008, at approximately 2:00 PM, during the reconciliation of the medication pass, a physician's order signed July 2, 2008 directed, "Start nectar thick liquid."</p> <p>A face-to-face interview was conducted with Employee #20 on July 25, 2008 at approximately 12:00 PM. He/she acknowledged that the medication was not given with nectar thickened liquids. The record was reviewed on July 21, 2008.</p> <p>3. The facility staff failed to follow physician's orders for the administration of Lovenox injection for Resident JH3.</p> <p>On July 21, 2008, at approximately 10:00 AM, during the medication pass, the nurse was observed administering Lovenox injection to Resident JH2.</p> <p>Employee #21 was observed giving the entire amount of medication in the Lovenox syringe to the resident. During the reconciliation of the medication pass, it was discovered that the amounts of Lovenox injection given to resident</p>	F 309	<p>#2 Resident #JH2</p> <ol style="list-style-type: none"> Charge nurse provided resident #JH2 medication draw with nectar/thickened liquid supplement for the next medication pass on 7/21/08. Charge nurse was inserviced 7/21/08 on following physician's orders and the physician was made aware the resident did not receive the nectar/thickened liquid no adverse reaction to the resident. Nectar thicken liquid was stocked on Medication Cart for all other residents with orders for thickner. All licensed staff was inserviced on 7/22/08 by the Unit manager on following the physician's orders on nectar/thickened liquids. Random medication cart check for the presence of nectar/thickened liquids and report in quarterly CQI. <p>#3. Resident #JH3</p> <ol style="list-style-type: none"> DON and Unit manager call pharmacy on 7/21 and 7/22, 2008 to clarify the correct dosage of Lovenox for resident #JH3. Charge nurse was inserviced on 7/21/08 on following the physician's orders and the physician was made aware of medication error on 7/21/08 and that there was no adverse reaction to the resident. All other residents identified on Lovenox MARs were reviewed for the correct dosage and clarified as indicated. 	09/08/08
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F 309	<p>Continued From page 38</p> <p>JH2 was incorrect.</p> <p>The July 2008 physician's order form, signed June 28, 2008 directed "Lovenox 60 mg/0.6 syringe, Inject 0.5 ml (50 mg) sub-q every 12 hours for Deep Vein Thrombosis."</p> <p>A face-to-face interview was conducted on July 21, 2008, at approximately 3:10 PM with Employee #21. After reviewing the resident's Medication Administration Record (MAR), Employee #21 stated that the physician ordered 60 mg/0.6 ml and the wrong amount of Levonx was administered to the resident. The chart was reviewed on July 21, 2008.</p> <p>4. The nursing staff failed to follow a physician's order for the administration of Senna-Gen (Senokot) tablets for Resident JH1.</p> <p>On July 22, 2008, at approximately 9:50 AM, during the medication pass, the nurse was observed administering one (1) Senna-Gen tablet to Resident JH1.</p> <p>On July 22, 2008, at approximately 2:20 PM, during the reconciliation of the medication pass, it was discovered that the incorrect medication was given.</p> <p>The physician's order form signed July 21, 2008 directed, "Senna w/Docusate (Pericolace) 8.6 mg / 50 mg, 1 tab by mouth every day for bowel regimen."</p> <p>A face-to-face interview was conducted with Employee #22 on July 22, 2008, at approximately 2:30 PM. He/she acknowledged that the incorrect medication was given to the resident. The record</p>	F 309	<p>#3 cont.</p> <p>3. Licensed staff was inserviced by the Unit manager on 7/21 and 7/22,2008 on the correct medication dosage administration. Licensed staff was observed during a medication pass for the correct dosage administration of Lovenox on 7/28/08 by DON, Unit manager and Inservice Coordinator.</p> <p>4. Random medication pass observation by the Inservice Coordinator and report in quarterly CQI.</p> <p>#4 Resident #JH1</p> <p>1 Charge nurse was inserviced on 7/22/08 on following the physician's order for resident #JH1 and the physician was made aware of medication error on 7/22/08 and that there was no adverse reaction to the resident.</p> <p>2. All other residents identified on Senekot medication draw were reviewed for the presence of the correct medication in the medication cart and pharmacy called as needed.</p> <p>3. Licensed staff was inserviced by the Unit manager on 7/22,2008 on administrating the correct medication. Licensed staff was observed during a medication pass for the correct medication administration of Senekot and other medications on 7/28/08 by DON, Unit manager and Inservice Coordinator.</p> <p>4. Random medication pass observation by the Inservice Coordinator and report in Quarterly CQI.</p>	<p>09/08/08</p> <p>09/08/08</p>
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F 309	Continued From page 39 was review on July 22, 2008. 4. The facility staff failed to follow physician's order for pacemaker checks for Resident #1. A review of Resident #4's record revealed a physician's order dated July 7, 2007 for "Pacemaker Check every six (6) months Jun and Jan by [name of company]." There was no evidence in the record that a pacemaker check had been performed since January, 2008. During a face-to-face interview with Employee #4 was conducted on July 23, 2008 at 3:07 PM. He/she acknowledged that the pacemaker check had not been done in June of 2008. The record was reviewed July 23, 2008.	F 309	#5 Resident #1 1. Unit manager ensured that resident #1's pacemaker was checked on 7/25/08. 2. All other residents identified with pacemakers clinical records were reviewed for pacemaker check compliance and corrected as indicated. 3. Licensed staff and unit secretaries were inserviced on 7/23/08 by Unit manager on pacemaker check schedule and compliance. 4. Pacemaker resident names are to be listed on Unit manager's monthly audit form and report in quarterly CQI.	09/08/08
F 362 SS=E	483.35(b) DIETARY SERVICES - SUFFICIENT STAFF The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that the facility failed to ensure sufficient certified food handlers were present in the dietary department during the hours of operations These observations were made in the presence of Employee #8 on July 21, 2008 at 9:30 AM. The findings include:	F 362	1. Dietary staff attended a Food Handler's Class on July 25, 2008. A schedule has been initiated to ensure there is adequate Certified handlers during meal preparation. 2. All other staff records were reviewed to ensure compliance and classes have been scheduled as needed. 3. The Food Service manager will establish system that will identify when each employee is eligible for the renewal of certification. 4. The Food Service Manager will audit personnel files monthly to ensure compliance. Findings of the audit will be reported in the monthly CQI.	09/08/08

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F 362	Continued From page 40 Upon review of the dietary staff records and daily schedule, it was determined that there were insufficient certified food handlers to ensure that proper sanitary techniques were being utilized on each shift. The food service schedule was reviewed from July 1 to July 21, 2008. Certified food service handlers were no scheduled for the following days and times: July 1, 2008 from 4:00 PM to 7:30 PM July 5, 2008 from 6:00 AM to 7:30 PM July 6, 2008 from 3:00 PM to 7:30 PM July 14, 2008 from 4:30 PM to 7:30 PM July 15, 2008 from 4:00 PM to 7:30 PM July 19, 2008 from 2:30 PM to 7:30 PM July 20, 2008 from 2:30 PM to 7:30 PM A face-to-face interview was conducted with Employee #8 at 9:30 AM on July 21, 2008. At the time of this review, he/she stated, "We don't have enough certified food handlers for weekends and one evening during the week. I have three employees scheduled to attend training on July 23, 2008. "	F 362		
F 412 SS=D	483.55(b) DENTAL SERVICES - NF The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	F 412		

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F 412	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 25 sampled residents, it was determined that a dental screen was not completed annually. Residents #6 and 25. The findings include: 1. A review of Resident #6's record revealed the last dental screen was completed May 7, 2007. There was no evidence that a dental screen was completed after May 7, 2007. A face-to-face interview was conducted with Employee #3 on July 23, 2008 at 10:00 AM. He/she acknowledged that a dental screen should have been completed in May 2008. The record was reviewed July 22, 2008. 2. A review of Resident #25's record revealed the last dental screen was completed January 25, 2007. There was no evidence that a dental screen was completed after January 25, 2007. The resident expired on April 30, 2008. The record was reviewed July 23, 2008.	F 412	Residents #6 and #25 1. Dentist was called by Unit Secretary on 8/29/08 to complete resident #6 dental assessment and will be done on 9/4/08. Unable to correct resident #25 dental assessment resident expired April 2008. 2. All other residents identified clinical records were reviewed for past due dental assessment and dentist was called for assessment compliance. 3. Unit Secretaries were inserviced by DON on Consultant Due Dates on 7/28/08 and a tickler sheet was provided to each unit to remind the Unit Secretaries of due dates. 4. Unit Secretaries to complete monthly chart audit and tickler sheet on Consultant's visits and report in Quarterly CQI.	09/08/08	
F 456 SS=F	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations during the inspection of the main kitchen, it was determined that the	F 456			

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F 456	Continued From page 42 facility failed to maintain the ice machine in a safe operating condition. The findings include: On July 21, 2008 at 9:00 AM, the ice machine in the main kitchen was observed with rust build-up on the tray and chute. This ice machine provided ice for the entire facility for residents' consumption. This observation was made in the presence of Employee #8, who acknowledged the findings at the time of the observation.	F 456	1. The ice machine in the main kitchen was replaced 7/25/08. 2. Director of Food Services has initiated a cleaning schedule for the ice machine. 3. Inservice was given by Director of Food Service to Dietary staff on 8/27/08 on Properly cleaning of the ice machine. 4. Monitoring of ice machine will be conducted monthly and findings reported to Quarterly CQI.	09/08/08
F 469 SS=E	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview during the survey period, it was determined that the facility failed to maintain a pest free environment. The findings include: Pests were observed in the following areas: July 21, 2008 at 8:45 AM, gnats in the main kitchen July 21, 2008 at 9:00 AM, gnats in room 238. July 22, 2008 at 9:45 AM, gnats in room 144. July 22, 2008 at 10:46 AM, gnats in the 1st floor hallway near the dining room. July 22, 2008 at 11:59 AM, gnats in room 129. July 22, 2008 at 4:00 PM, gnats in room 318.	F 469	1. The areas identified during the survey: kitchen, Rooms 238, 144, 129,318, 242, 1 st floor hallway and Nursing Station were cleaned and trash removed. The Pest Control Contractor visited during the survey for extermination purposes. 2. The Environmental Service Manager has checked other resident rooms for insect and trash removal and/or extermination. Trash cans are cleaned weekly and as Needed to prevent further occurrences. 3. The Environmental Service Manager inserviced the EMS staff 8/27/08 on trash removal, cleaning of the trash containers and proper cleaning techniques in resident rooms and other common areas. 4. Weekly rounds/audits will be conducted by Director of Environmental Services. Findings of the rounds/audits will be Reported in the quarterly CQI meeting.	09/08/08

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2008
NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(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 469	Continued From page 43 July 23, 2008 at 10:25 AM, fly in room 242. July 24, 2008 at 11:24 AM, gnats on the 1st floor near the nurse ' s station. A face-to-face interview was conducted with Employee #16 on July 22, 2008 at 10:50 AM. He/she stated, "[A pest control company] comes to spray every week. We still have some problems with flying insects." These observations were made in the presence of Employees #3, 4, 5, 8 and 16 who acknowledged the findings at the time of the observations. This is a repeat deficiency from the re-certification and licensure survey December 6, 2007.	F 469			
F 520 SS=E	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520			

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F 520	<p>Continued From page 44</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interviews, it was determined that the facility's Quality Assurance committee failed to develop and implement appropriate plans of action to identify, investigate and report falls and injuries and bruises of unknown origin as potential abuse.</p> <p>The findings include:</p> <p>On July 25, 2008 at approximately 1:00 PM, a face-to-face interview was conducted with Employees #1, 2, 7 and 15, regarding the Quality Assurance (QA) program.</p> <p>Based on concerns identified during the survey, the Employee #15 was asked if the committee monitored injuries of an unknown origin and falls in the facility. Employee#15 explained that he/she did not monitor injuries or falls in the facility. Employee# 1 stated that Employee #2 monitored the falls and Employee #7 monitored abuse allegations.</p> <p>Employee #2 stated that their investigative process was by word of mouth and that there was no documentation of the investigation. The supervisors did an incident report. Incident reports were discussed in the morning meeting for administrative staff and managers followed up. "We do not track or trend injuries of unknown origin." When asked for documentation of incidents investigated over the last three (3)</p>	F 520	<p>#1 and #2</p> <ol style="list-style-type: none"> 1. The facility has identified the CQI/Educator as the person responsible for the follow-up and review of the investigations of alleged abuse, falls, injuries of unknown origin, and unusual occurrences. 2. Residents who have: alleged abuse, falls, injuries of unknown origin and had unusual occurrences will be investigated by the Nursing Management using the "Investigation Form". The CQI/Educator will review/follow-up on all claims. 3. The facility has reviewed its present "Resident Abuse and Prevention" policy and will implement the use of the "Investigation Form". Staff have been inserviced on "Elder Abuse and Neglect" August 6th -9th, 2008. Nursing Management will be inserviced on the use and implementation of the "Investigation Form". 4. The CQI/Education will review and log in: falls, alleged abuse, injuries of unknown origin, and unusual occurrences. Findings will be reviewed for: trends and patterns as well as the development of plans of correction to prevent the reoccurrence will be reported in Quarterly CQI. 	09/08/08
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F 520	<p>Continued From page 45</p> <p>months, only one (1) investigative report, a fall with injury, dated April 29, 2008 was provided. When asked for documentation of action plans related to the investigation of the fall, none were provided.</p> <p>Employee #7 stated that he/she did not monitor abuse but tracked grievance reports.</p> <p>Employee #1 failed to identify a facility employee who was responsible for tracking abuse.</p> <p>According to the facility's policy entitled, "Resident Abuse, Neglect and Misappropriation of Property, " No.117, March 3, 2008, under "V - Investigation" was the following:</p> <p>"1. the resident, family, visitor and/or staff shall notify the Director of Nursing, Clinical Coordinator or Administrator of the complaint of resident abuse...</p> <p>2. [The facility] conducts an internal investigation..."</p> <p>No employee was identified in the facility's abuse policy to be responsible for the investigation of an alleged abuse complaint.</p> <p>On July 25, 2008, after the exit conference, Employee # 2 presented an Incident Report Log that documented 39 incidents for the month of June 2008. 23 of the 39 incidents were falls and none had an action plan. 4 of 39 incidents described resident injuries of unknown origin but were identified as "other" on the Incident Report Log and contained no action plans.</p> <p>There was no evidence that the QA committee</p>	F 520		

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F 520	Continued From page 46 identified and investigated residents with injuries of unknown origin and developed and implemented appropriate plans of action for residents with falls.	F 520		
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