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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING ______ B. WING ______	08/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE CENTER	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 An annual re-certification survey was conducted on August 2 through 11, 2010. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size included 26 residents based on a census of 167 the first day of survey, with 30 supplemental residents. Complaint #s DC00002000, DC00002001 and DC00002002 were also investigated during this survey.	F 000	Carolyn Boone Lewis Health Care Center, "CBL", is filing this Plan of Correction in accordance with the compliance requirements for federal and state regulations. This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction does not constitute admission of facts or conclusions cited. The responses to the deficiencies in the Plan of Correction will be answered in the following numerical sequence:	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 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. 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. 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. 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	F 164	1. How will the corrective actions be accomplished for those residents found to have been affected by the deficient practice? 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 3. What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not occur. 4. How do you plan to monitor your performance to make sure that solutions are sustained? **483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS** **Ftag 164** It is this facility's practice to ensure that the facility's staff maintain resident privacy/ confidentiality (records). Privacy/ Confidentiality and HIPAA is reviewed on hire with new staff and at least annually with the current staff. A notice of privacy practices and resident rights is reviewed with residents and/responsible parties on admission via the admissions agreement packet.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	LNHA	10/26/10

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 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for four (4) of 26 sampled residents, it was determined that facility staff failed to maintain resident privacy: during wound treatments and by maintaining the medication administration record in the open position while unattended. Resident #5, 6, 12 and 19. The findings include: 1. Facility staff failed to maintain privacy during a wound treatment for Resident #5. Employee #16 was observed providing wound treatment to Resident #5 ' s lower extremities on August 3, 2010 at 11:10 AM. The resident was lying in his/her bed that was positioned proximal to the entry door. The privacy curtain was drawn between the two beds that occupied the room, however, the curtain was not was not drawn to obscure visualization from the room entryway. The entry door of the room remained open. Facility staff failed to maintain privacy while performing a wound treatment. 2. The facility staff failed to ensure privacy during a wound treatment observation for Resident #6. During a wound treatment observation of Resident #6 it was determined that facility staff	F 164	Continued From page 1 **F tag 164** **#1 - Resident #5** 1. The corrective action achieved for Resident #5 was that Resident #5 has been informed by the DON on privacy and dignity measures to expect from the staff during the rendering of care. 2. All residents have the potential to be affected by this practice. As a corrective action Unit Managers/designee will complete random monthly audits to ensure that resident's privacy and confidentiality (records) is maintained during the provisions of care, which includes, however is not limited to wound care treatment. 3. The systematic change/measures taken to correct this practice have been: Staff has been educated on resident 10/25/10 privacy/confidentiality (records) by the Educator and via the distribution of a self-learning resource educational packet. and Resident and/responsible party education on privacy/confidentiality (records) via the distribution of an education packet. 4. A report of the random resident privacy and confidentiality audit(s) will be provided to the DON/designee of any corrective actions implemented and indications of the need for further education. The results of this audit will be reported by the DON/Designee to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be	10/19/10 10/19/10 10/25/10 10/28/10

Continued From page 2

presented. The CQI committee will determine the need for other interventions and the frequency of further audits.

F tag 164
#2 - Resident #6

1. The corrective action achieved for Resident #6 was that they have been informed by the Unit Manager on privacy and dignity measures to expect from the staff during the rendering of care. **10/23/10**

2. All residents have the potential to be affected by this practice. As a corrective action Unit Managers/designee will complete random monthly audits to ensure that resident's privacy and confidentiality (records) is maintained during the provisions of care, which includes, however is not limited to wound care treatment. **10/19/10**

3. The systematic change/measures taken to correct this practice have been: 10/25/10

Staff has been educated on resident 10/25/10 privacy/confidentiality (records) by the Educator and via the distribution of a self-learning resource educational packet. and Resident and/responsible party education on privacy/confidentiality (records) via the distribution of an education packet.

4. A report of the random resident privacy and confidentiality audit(s) will be provided to the DON/designee of any corrective actions implemented and indications of the need for further education. The results of this audit will be reported by the DON/Designee to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and the frequency of further audits. **10/28/10**

#3 – Resident #12

1. The facility is unable to implement corrective action(s) for Resident#12due to them no longer residing at the facility. 10/ 19/10

2. All residents have the potential to be affected by this practice. As a corrective action Unit Managers/designee will complete random monthly audits to ensure that resident's privacy and confidentiality (records) is maintained during the provisions of care, **10/19/10**

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F 164	Continued From page 2 failed to ensure privacy by leaving the door open during the wound treatment. On August 4, 2010 at approximately 9:15 AM Employee #32 had entered the room of Resident #6, (door remaining open) as he/she washed hands. Resident #6 was partially dressing from top down to the waist, legs exposed, and in a disrobing manner constantly readjusting his/her clothing periodically exposing more of his/her body. Employee #5 at this time (9:22 AM) asked to shut the door. At 9:34 AM Resident #6 brought to the attention of Employee #32 of another skin alteration on his/her right leg. Employee #32 left out of the room to retrieve additional items to assess and treat wound (left the door open), cleaned 2nd wound with solution and covered the wound. Door remained open throughout the entire cleaning and dressing of the 2nd wound. A face-to-face interview was conducted with Employee #5 after review of the process he/she acknowledged that the door should have been closed during the wound treatment. Facility staff failed to ensure privacy by not closing the door during a wound treatment observation. The observation was made on August 4, 2010 3. Facility staff failed to provide privacy and confidentiality while administering medications to Resident #12. On August 4, 2010 at approximately 9:56 AM, Employee # 32 was observed leaving the Medication Administration Book open on medication cart while administering medications to Resident #12.	F 164	**Continued From page 2 b** **F tag 164** which includes, however is not limited to wound care treatment. 3. The systematic change/measures taken to correct this practice have been: Staff has been educated on resident privacy/confidentiality (records) by the Educator and via the distribution of a self-learning resource educational packet. and Resident and/responsible party education on privacy/confidentiality (records) via the distribution of an education packet. 4. A report of the random resident privacy and confidentiality audit(s) will be provided to the DON/designee of any corrective actions implemented and indications of the need for further education. The results of this audit will be reported by the DON/Designee to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and the frequency of further audits.	10/25/10 10/28/10

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F 164	Continued From page 3 A face-to-face interview was conducted with Employee #5 on August 4, 2010 at approximately 11:00AM. He/she acknowledged that Employee #32 should have closed the Medication Administration Record before proceeding to administer Resident #12 ' s medications. 4. Resident #19 was observed in bed, during a wound care treatment to the abdominal umbilicus area on August 10, 2010 at approximately 10:55 AM. The resident ' s gown was adjusted to drape only the shoulders. At the end of the treatment, Employee #35 proceeded to do the left thigh wound care further exposing her undraped abdomen and pelvic areas. The resident ' s upper chest, abdomen, and pelvic areas were exposed throughout the treatment. A review of the resident ' s record revealed a physician ' s order dated July 20, 2010 directing " Cleanse abdominal umbilicus with Normal saline solution and apply polysporin and calcium alginate, cover with dry dressing. Clean left thigh wound with normal saline, apply silver hydrogen and cover with dry dressing. " Facility staff failed to prevent unnecessary exposure of body parts during the provision of wound care treatment to Resident #19. A face-to-face interview was conducted with Employee #5 on August 10, 2010 at approximately 1:00 PM. He/she acknowledged that the resident should have not been exposed while Employee #35 was " doing wound care and the area receiving the treatment needed to be exposed. " The record was reviewed on August 10, 2010.	F 164	Continued From page 3 **F tag 164** **#4 - Resident #19** 1. The corrective action achieved for Resident #19 was that they have been informed by the Unit Manager on 10/23/10 privacy and dignity measures to expect from the staff during the rendering of care.	10/23/10
			2. All residents have the potential to be affected by this practice. As a corrective action Unit Managers/designee will complete random monthly audits to ensure that resident's privacy and confidentiality (records) is maintained during the provisions of care, which includes, however is not limited to wound care treatment.	10/19/10
			3. The systematic change/measures taken to correct this practice have been: Staff has been educated on resident privacy/confidentiality (records) by the Educator and via the distribution of a self-learning resource educational packet. and resident and/responsible party education on privacy/confidentiality (records) via the distribution of an education packet.	10/25/10
			4. A report of the random resident privacy and confidentiality audit(s) will be provided to the DON/designee of any corrective actions implemented and indications of the need for further education. The results of this audit will be reported by the DON/Designee to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be presented.	10/28/10

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F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, family interview and staff interview, it was determined that the facility failed to logged a grievance for a complaint of misappropriation of funds and availability of oxygen for an outpatient appointment for Resident #16. The findings include: On August 4, 2010 at 9:40 AM, a family interview was conducted with Resident #16 ' s [family member]. Stated, " [Resident #16] enjoys Bingo, however when money is left, someone takes the money from his drawer. Also, [he/she] had to return from a scheduled appointment because the oxygen tank had not been turned on, and the young lady that accompanied him/her had no key to turn it on. " On August 6, 2010 at approximately 2:00 PM, and August 9, 2010 at approximately 3:00 PM, a face-to-face interview was conducted with Employee #5. He/she stated " the incident with the oxygen was investigated; we were surprised the oxygen was not working, because it was working before he left. A concerns and comments form was completed by Employee #3, which included the facility ' s intervention and response. "	F 166	Continued From page 4 The CQI committee will determine the need for other interventions and the frequency of further audits. **483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES** **Ftag 166** It is the policy of this facility to have a problem resolution process that promptly addresses the grievance(s) of residents/responsible parties/ visitors/staff. 1. The corrective actions accomplished for this practice with Resident #16 is that the Director of Social Services has communicated with the family member of Resident #16 in regard to the misappropriation of funds and availability of oxygen. Staff education was conducted by the nursing department at the time of Resident#16's return to the facility on the management/ operation of the oxygen tank. The grievance log has been updated by Administration to reflect the concern of oxygen availability and misappropriation of funds in follow-up to the concern made by Resident #16's family member. 2. All residents utilizing oxygen have the potential to be affected by this practice. An assessment of the key (wrench) availability for oxygen tank management was completed by the Central Supply Coordinator and corrective actions implemented entailed providing additional keys to make available	10/25/10 10/19/10

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for staff managing oxygen tanks.
A review of the grievance log has been conducted to:

ensure that all documented grievances received reflect on the Grievance Log. Residents/ Responsible parties/Staff have been educated on the documentation of grievances and how to request a copy for confirmation.

3. The measures taken to correct this practice are: 10/19/10
Education for the licensed and unlicensed nursing staff on the operation/management of oxygen tanks by the Director of Education during the facility's Competency Skills Fair.
and
A review of the Grievance Policy and Procedures; the Concerns and Comments form was conducted on 09/09/10 and revisions have been made. Education was provided on the revised policy on 09/10/10 to residents in attendance at the Resident Council Meeting and on 09/30/10 to responsible parties/family members present during the Family Council Meeting. In addition policy to was distributed to residents and/family members/staff. The Grievance policy and procedure has been posted on each residential level at the facility.

4. Random audits of residents receiving oxygen going on appointments will be conducted by the Unit Managers/Designee monthly. A report of problems identified and corrective actions implemented will be presented to the CQI committee The grievance log will be reviewed on a monthly basis by the Director of Social Services /Designee to ensure that all concerns/grievances have been addressed in accordance with the facility's policy. Corrections that can be made upon discovery will be made. A report of the findings of this review and problems identified along with ; along with corrective actions will be presented to the CQI committee on a monthly basis for the next three months. Quarterly reporting will be made to the CQI committee thereafter. 10/28/10

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F 166	Continued From page 5 On August 5, 2010 at approximately 10:15 AM, a face-to-face interview was conducted with Employee #22. He/she stated, " When [Resident #16] was first admitted, he/she was in and out of the hospital frequently. I had not heard about money being left for him to play Bingo. I will call [the family] and discuss this with her. Moving forward, the family can give him/her the money and he/she will make sure [Resident #16] will attend Bingo. " Observation made on August 10, 2010 at approximately 2:00 PM, Resident #16 was in the activity room playing Bingo with other residents. According to the facility's policy titled "Grievance Policy and Procedure, Policy & Procedure No. 112, Revised 08/3/07, pp129", revealed "each grievance will be logged in an administrative record kept by the Administrator and maintained for at least three (3) years after the date of filing and shall be available to the Director of Human Services." Although, Employees #5 and #22 pointed out that there was an investigation on the availability of oxygen and of misappropriation of funds for Resident #16, there was no formal grievance logged in the book. The record was reviewed August 6, 2010.	F 166	Continued From page 5b	
F 221 SS=G	483.13(a) RIGHT TO BE FREE FROM 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	**483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS.** **Ftag 221, #1** 1. A corrective action was unable to be achieved with Resident CBL2 due to this resident no longer residing at the facility.	10/19/10

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F 221	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined that facility staff failed to ensure freedom from restraints for one (1) resident who sustained an injury while restrained and failed to identify full bilateral siderails as a restraint for eight (8) residents. Residents CBL2, #13, #21, CBL22, CBL23, CBL24, CBL25, CBL26, and CBL27 The findings include: 1. Facility staff failed to protect Resident CBL2 from physical abuse. The resident sustained a right hand fracture while restrained. A review of the March 12, 2009 admission Minimum Data Set (MDS) contained in the clinical record revealed that the 97 year old female was admitted to the facility with diagnoses which included Alzheimer ' s Disease, Dementia, Glaucoma, Hypertension and Renal Failure. The June 10, 2009 MDS was coded in Sections B2a and B2b (cognitive decision making) with long and short term memory problems. A score of zero (0) in Sections E1 and E4 (Mood/Behavior and Psychosocial Symptoms) indicated that the resident had no problems in these areas. A copy of an investigative report regarding an allegation of Suspected Abuse and Neglect of Resident CBL2 was given to the survey team by the facility. The report indicated that the resident sustained an injury of unknown origin (fracture of the distal 3rd of the 5th metacarpal of the right hand.)	F 221	Continued From page 6 2. All residents have the potential to be affected. An audit was conducted of residents using restraints for the appropriateness of the restraint. Corrective actions were implemented as needed. 3. The Restraint Authorization and the Resident Abuse, Neglect, Misappropriation of Property policies have been re-evaluated and updated. Staff has been in-serviced on the policies, the overall process of restraint use, and what constitutes abuse. 4. A Restraint audit will be completed monthly by the Unit manager/designee. A report will be provided to the Director of Nursing/designee of problems identified. The results of the above audit will be reported to the CQI committee monthly by the Director of Nursing/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. Corrective actions will be reviewed by the Administrator and corrective action plans will be implemented.	 10/19/10 10/19/10 10/28/10

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F 221	Continued From page 7 A review of the "Conclusion of Incident Report" which was completed by Employee #2 and submitted to the State Agency revealed the following information. According to the supervisor who was on duty on September 19, 2009 [the day of the alleged incident] the resident was very agitated and walking up and down the hallway with an unsteady gait. The supervisor continued " Someone said " Tie her up and they did." The report continued, "The supervisor asked a Certified Nursing Assistant to get a recliner chair. He/she [the CNA] got the chair and placed a sheet around the resident and tied it to the back of the chair." The exact time of the incident was not documented but according to the documentation of the incident as reported by the facility, the incident occurred on the evening shift September 19, 2010. The report as documented by Employee #2 at approximately 1:30PM on September 20, 2009 stated, "The CNA who was monitoring the day room, reported to the charge nurse that the resident was, complaining of discomfort, was tied with a sheet and had not received any ADL [Activities of Daily Living] assistance or care." As documented on Sunday September 20, 2009, " the day staff and the nursing supervisor were informed that the resident had been agitated all night, but no mention was made of the resident being tied down. However, at approximately 1:30PM the resident who was still in the recliner chair in the day room complained of discomfort and the CNA monitoring the residents noticed the tied sheet and informed the charge nurse. At this time it was also noted that the resident had not received any ADL assistance or care." The report further revealed that, "on Monday September 21, 2009 the day shift noticed that the	F 221	**483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS** **Ftag 221, #2 a-h** 2. A screen has been completed by the rehabilitation department on the residents #13, #21, CBL22, CBL23, CBL 24, CBL25, CBL26 and CBL 27. Siderails have been removed as appropriate and/ physician orders have been obtained as needed.The MDS's for the residents identified above have been reviewed and corrected to ensure proper coding. 2. An audit of current residents with siderails have been completed by the night shift supervisor and the MDS's of these residents have been reviewed for MDS coding corrections. 3. The Restraint Authorization policy has been re-evaluated and updated. Staff has been in-serviced on the Use of Restraint policies. Staff has also been educated on the coding of the MDS in reference to restraints. 4. A restraint and MDS audit will be completed monthly by the Unit Manager/ Designee. A report will be provided to the DON/Designee of problems identified. The results of the Restraint and MDS audit will be reported to the CQI committee monthly by the Director of Nursing/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10 10/19/10 10/19/10 10/28/10

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resident's right hand was discolored and swollen." The report concluded with an x-ray report of the right hand that revealed a fracture of the distal 3rd of the 5th metacarpal.

Per the facility's report, "the staff tied the resident to the recliner chair with a sheet [during the evening shift on September 19, 2009], allowed him/her to sleep through the night in the recliner chair; and as a result the resident suffered an injury " [fracture of the distal 3rd of the 5th metacarpal]. The report also documented that the resident "did not receive adequate care." Per the documentation the staff failed to provide ADL care to the resident from evening shift September 19, 2010 until 1:30PM on September 20, 2009.

Based on the evidence in the documents reviewed and staff interview, it has been determined that facility staff physically abused the resident when they tied him/her to a recliner chair with a sheet. The evidence also revealed that the resident was allowed to sleep in the chair while restrained during the night and subsequently suffered a fracture of the distal 3rd of the 5th metacarpal of the right hand while he/she was in the chair and received no ADL care or assistance until 1:30PM on Sunday September 20, 2009.

A face-to-face interview was conducted with Employee#2 at approximately 4:00PM on August 10, 2010. He/she acknowledged that employees of the facility tied the resident to a chair with a sheet to prevent him/her from walking and that the resident sustained a fracture of the distal 3rd of the 5th metacarpal of the right hand while restrained. The record was reviewed on August 9, 2010.

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2. During the initial tour of the facility on August 2, 2010, it was determined that facility staff failed to identify full bilateral siderails as a restraint, identify them as the least restrictive device and follow a systematic process of evaluation and care planning prior to their implementation for the following eight (8) residents:

a.) A review of the clinical record for Resident #13 revealed facility staff failed to identify side rails that extended the full length of both sides of the bed as a restraint and follow a systematic process of care planning and evaluation by the interdisciplinary team for the least restrictive device prior to its implementation.

Resident #13 ' s diagnoses included hypertensive cardiovascular disease, diabetes mellitus, dementia congestive heart failure, chronic obstructive pulmonary disease, emphysema, and arteriosclerotic cardiovascular disease.

The coding for Section G, Physical Functioning, of the annual Minimum Data Set (MDS) completed May 31, 2010 revealed the resident required extensive assistance for transfer and was independent for locomotion on the unit via wheelchair. Section J, Accidents revealed the resident sustained a fall in the past 30-days. Section P, Devices and Restraints was coded as "not used."

Physician's orders dated July 2, 2010 directed "Restraint: bed alarm activated when in bed at all times as part of falls management to alert staff."

The resident was observed lying in bed on August 2, 2010 at approximately 9:00 AM. Full side rails

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F 221	Continued From page 10 were observed on each side of the bed in an upright position. The clinical record lacked evidence that facility staff identified the side rails a restraint. There was no evidence that the interdisciplinary team convened to determine the side rails were the least restrictive device. There was no evidence that the resident and/or responsible party had been counseled regarding the risks/benefits of the use of the side rails. (b). Facility staff failed to identify use of siderails as a restraint and initiate a systematic process of evaluation and care planning prior to using siderails as a restraint. Resident #21. Resident #21 was observed during the initial tour of the facility on August 2, 2010 at approximately 10:30 AM. He/she was in bed with the two full siderails up. Upon interview, Resident #21 said, for a very long time, they always have the two siderails up while I am in bed so that I do not fall. This statement was made in the presence of Employee #5. Employee #5 added I will take note of this and care plan accordingly. According to an annual Minimum Data Set assessment that was completed on June 26, 2010, the resident's diagnosis included arthritis, osteoporosis, and seizure disorder. The coding for Section G, Physical Functioning, of a quarterly Minimum Data Set (MDS) completed June 28, 2010 revealed the resident required extensive assistance for bed mobility and transfer. He/she was not coded for Devices and Restraints in Section P4.	F 221		

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F 221	Continued From page 11 He/she was observed wheeling self around the unit. However, the Resident #21's clinical record lacked documented evidence that facility staff: identified use of siderails as a restraint and initiated a systematic process of evaluation and care planning prior to using siderails as a restraint. A face-to-face interview was conducted with Employee #5 on August 6, 2010 at approximately 2:30 PM. After a review of the resident ' s clinical record, he/she acknowledged the aforementioned findings and added I will take care of it right away. The record was reviewed August 6, 2010. c.) A review of the clinical record for Resident #CBL22 revealed facility staff failed to identify side rails that extended the full length of both sides of the bed as a restraint and follow a systematic process of care planning and evaluation by the interdisciplinary team for the least restrictive device prior to its implementation. Resident #CBL22 ' s diagnoses included pulmonary embolism/infarct, sepsis, dehydration, anemia, atrial fibrillation and transmission based precautions for infection. The coding for Section G, Physical Functioning, of the admission Minimum Data Set (MDS) completed July 21, 2010 revealed the resident required extensive assistance for transfer and limited assistance for bed mobility. Bed rails were coded for use as bed mobility/transfer. Section P, Devices and Restraints was coded as " not used. "	F 221		

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F 221	Continued From page 12 The resident was observed lying in bed on August 2, 2010 at approximately 9:00 AM. Full side rails were observed on each side of the bed in an upright position. The clinical record lacked evidence that facility staff identified the side rails a restraint. There was no evidence that the interdisciplinary team convened to determine the side rails were the least restrictive device. There was no evidence that the resident and/or responsible party had been counseled regarding the risks/benefits of the use of the full side rails. d.) A review of the clinical record for Resident #CBL23 revealed facility staff failed to identify side rails that extended the full length of both sides of the bed as a restraint and follow a systematic process of care planning and evaluation by the interdisciplinary team for the least restrictive device prior to its implementation. Resident #CBL23 ' s diagnoses included atrial fibrillation, schizophrenia, cerebrovascular accident, dementia with behaviors, and gastrostomy. The coding for Section G, Physical Functioning, of the quarterly Minimum Data Set (MDS) completed June 5, 2010 revealed the resident was totally dependent for transfer and required extensive assistance for bed mobility. Section P, Devices and Restraints was coded as " not used. " Physician ' s orders dated July 21, 2010 directed " Siderails up for turning and repositioning every shift. "	F 221		

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F 221	Continued From page 13 The resident was observed lying in bed on August 2, 2010 at approximately 9:05 AM. Full side rails were observed on each side of the bed in an upright position. The clinical record lacked evidence that facility staff identified the side rails a restraint. There was no evidence that the interdisciplinary team convened to determine the side rails were the least restrictive device. There was no evidence that the resident and/or responsible party had been counseled regarding the risks/benefits of the use of the full side rails. e.) A review of the clinical record for Resident #CBL24 revealed facility staff failed to identify side rails that extended the full length of both sides of the bed as a restraint and follow a systematic process of care planning and evaluation by the interdisciplinary team for the least restrictive device prior to its implementation. Resident #CBL24's diagnoses included anemia, hypothyroidism, hypoglycemia, hypokalemia and arteriosclerotic cardiovascular disease. The coding for Section G, Physical Functioning, of the admission Minimum Data Set (MDS) completed June 14, 2010 revealed the resident was totally dependent for bed mobility and required extensive assistance for transfer. Section P, Devices and Restraints was coded as "not used." The resident was observed lying in bed on August 2, 2010 at approximately 9:10 AM. Full side rails were observed on each side of the bed in an upright position.	F 221		

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F 221	Continued From page 14 The clinical record lacked evidence that facility staff identified the side rails a restraint. There was no evidence that the interdisciplinary team convened to determine the side rails were the least restrictive device. There was no evidence that the resident and/or responsible party had been counseled regarding the risks/benefits of the use of the full side rails. f.) A review of the clinical record for Resident #CBL25 revealed facility staff failed to identify side rails that extended the full length of both sides of the bed as a restraint and follow a systematic process of care planning and evaluation by the interdisciplinary team for the least restrictive device prior to its implementation. Resident #CBL25's diagnoses included Hypertension, degenerative joint disease, feeding dysfunction, gastrostomy and electrolyte imbalance. The coding for Section G of the quarterly Minimum Data Set (MDS) completed May 19, 2010 revealed the resident was totally dependent for transfer and mobilization. Bed rails were coded for use as bed mobility/transfer. Section P, Devices and Restraints was coded as "not used." Physician's orders dated July 21, 2010 directed "Restraint: Siderails up to aid in turning and positioning in bed every shift." The resident was observed lying in bed on August 2, 2010 at approximately 9:15 AM. Full side rails were observed on each side of the bed in an upright position. The clinical record lacked evidence that facility	F 221		

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staff identified the side rails a restraint. There was no evidence that the interdisciplinary team convened to determine the side rails were the least restrictive device. There was no evidence that the resident and/or responsible party had been counseled regarding the risks/benefits of the use of the full side rails.

g.) A review of the clinical record for Resident #CBL26 revealed facility staff failed to identify side rails that extended the full length of both sides of the bed as a restraint and follow a systematic process of care planning and evaluation by the interdisciplinary team for the least restrictive device prior to its implementation.

Resident #CBL26's diagnoses included Hypotension, urinary tract infection, dehydration and cardiovascular disease.

The coding for Section G of the quarterly Minimum Data Set (MDS) completed August 2, 2010 revealed the resident was totally dependent for transfer and mobilization. Bed rails were coded for use as bed mobility/transfer. Section P, Devices and Restraints was coded as " not used. "

Physician ' s orders dated July 2, 2010 directed " Restraint: Siderails up while in bed for safety and turning every shift."

The resident was observed lying in bed on August 2, 2010 at approximately 9:20 AM. Full side rails were observed on each side of the bed in an upright position.

The clinical record lacked evidence that facility staff identified the side rails a restraint. There was

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F 221	Continued From page 16 no evidence that the interdisciplinary team convened to determine the side rails were the least restrictive device. There was no evidence that the resident and/or responsible party had been counseled regarding the risks/benefits of the use of the full side rails. h.) A review of the clinical record for Resident #CBL27 revealed facility staff failed to identify side rails that extended the full length of both sides of the bed as a restraint and follow a systematic process of care planning and evaluation by the interdisciplinary team for the least restrictive device prior to its implementation. Resident #CBL27 ' s diagnoses included cerebrovascular accident, diabetes mellitus, hypertension, anemia, edema, psychotic behavior and hypercholesterolemia. The coding for Section G, Physical Functioning, of the admission Minimum Data Set (MDS) completed May 26, 2010 revealed the resident required extensive assistance for transfer and bed mobility. Section P, Devices and Restraints was coded as " not used. " Physician ' s orders dated July 2, 2010 directed " Siderails up for turning and positioning. " The resident was observed lying in bed on August 2, 2010 at approximately 9:25 AM. Full side rails were observed on each side of the bed in an upright position. The clinical record lacked evidence that facility staff identified the side rails a restraint. There was no evidence that the interdisciplinary team convened to determine the side rails were the	F 221		

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F 221	Continued From page 17 least restrictive device. There was no evidence that the resident and/or responsible party had been counseled regarding the risks/benefits of the use of the full side rails. The observations for Residents # CBL 22, 23, 24, 25, 26, 27 and Resident #13 were made in the presence of Employee #7 who acknowledged the full siderails restricted freedom of movement. S/he stated the siderails should have been applied only partially and only on one side of the bed ... " I must re-educate my staff. "	F 221		
F 223 SS=G	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 26 sampled residents and one (1) of 30 supplemental residents, it was determined that facility staff failed to protect one (1) resident from physical abuse and one (1) resident from verbal abuse. Residents: CBL2 and #23 . The findings include: 1. Facility staff failed to protect Resident CBL2 from physical abuse.	F 223	**83.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION** **Ftag 223 #1** 1. Resident CBL2 no longer resides at the facility. All staff involved in this incident were remediated and corrective actions were taken at the time of the incident. 2. All residents have the potential to be affected by the deficient practice. A review of incidents have been completed to ensure that corrective actions have been implemented as needed. 3. The Restraint Authorization and the Resident Abuse, Neglect and Misappropriation policy have been re-evaluated and updated. Staff has been in-serviced on: the policies, the inappropriate use of resident property to restrain residents, the overall process of restraint initiation, what constitutes abuse,legalities of documentation to stress the importance of timing notes and on the process of shift change report.	10/19/10 10/19/10 10/19/10

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F 223	Continued From page 18 A review of the March 12, 2009 admission Minimum Data Set (MDS) contained in the clinical record revealed that the 97 year old female was admitted to the facility with diagnoses which included Alzheimer ' s Disease, Dementia, Glaucoma, Hypertension and Renal Failure. The June 10, 2009 MDS was coded in Sections B2a and B2b (cognitive decision making) with long and short term memory problems. A score of zero (0) in Sections E1 and E4 (Mood/Behavior and Psychosocial Symptoms) indicated that the resident had no problems in these areas. A copy of an investigative report regarding an allegation of Suspected Abuse and Neglect of Resident CBL2 was given to the survey team by the facility. The report indicated that the resident sustained an injury of unknown origin (fracture of the distal 3rd of the 5th metacarpal of the right hand.) A review of the " Conclusion of Incident Report " which was completed by Employee #2 and submitted to the State Agency revealed the following information. According to the supervisor who was on duty on September 19, 2009 [the day of the alleged incident] the resident was very agitated and walking up and down the hallway with an unsteady gait. The supervisor continued " Someone said "Tie her up and they did. " The report continued, "The supervisor asked a Certified Nursing Assistant to get a recliner chair. He/she [the CNA] got the chair and placed a sheet around the resident and tied it to the back of the chair. " The exact time of the incident was not documented but according to the documentation of the incident as reported by the facility, the incident occurred on the evening shift on September 19, 2009. According to the report	F 223	4. A documentation audit will be completed monthly by the Medical Records Clerk. A Restraint audit will be completed monthly by the unit manager/designee. The Unit Manager/ MDS Coordinator will conduct a random weekly audit of the shift change report process. A report will be provided to the Director of Nursing/ designee on all audits of problems identified and corrective actions implemented. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly by the DON/ Designee. A report of problems identified and corrective actions implemented with be presented. The CQI committee will determine the need for other interventions and the and need and frequency of further audits.	10/28/10

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F 223	Continued From page 19 as documented by Employee #2, at approximately 1:30PM on September 20, 2009 the CNA who was monitoring the day room, reported to the charge nurse that the resident was, complaining of discomfort, was tied with a sheet and had not received any ADL [Activities of Daily Living assistance or care]. As documented on Sunday September 20, 2009, "the day staff and the nursing supervisor were informed that the resident had been agitated all night, but no mention was made of the resident being tied down. However, at approximately 1:30PM the resident who was still in the recliner chair in the day room complained of discomfort and the CNA monitoring noticed the tied sheet and informed the charge nurse. At this time it was also noted that the resident had not received any ADL assistance or care. "The report further revealed that, "on Monday September 21, 2009 the day shift noticed that the resident's right hand was discolored and swollen." The report of an x-ray of the right hand revealed a fracture of the distal 3rd of the 5th metacarpal. Per the facility's report, "the staff tied the resident to the recliner chair with a sheet, allowed him/her to sleep through the night in the recliner chair; and as a result the resident suffered an injury" [fracture of the distal 3rd of the 5th metacarpal]. The report also documented that the resident "did not receive adequate care." Per the documentation facility staff failed to provide ADL care to the resident from evening shift on September 19, 2010 until 1:30PM on September 20, 2009. Based on the evidence in the documents reviewed and staff interview, it has been	F 223		

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F 223	Continued From page 20 determined that facility staff physically abused the resident when they tied him/her to a recliner chair with a sheet. The evidence also revealed that the resident was allowed to sleep in the chair while restrained during the night and subsequently suffered a fracture of the distal 3rd of the 5th metacarpal of the right hand while he/she was in the chair and received no ADL care from the time of the incident until 1:30PM on Sunday September 20, 2009. A face-to-face interview was conducted with Employee#2 at approximately 4:00PM on August 10, 2010. He/she acknowledged that employees of the facility tied the resident to a chair with a sheet to prevent him/her from walking. That the resident suffered a fracture of the distal 3rd of the 5th metacarpal of the right hand and that the staff failed to provide ADL care to the resident as of 1:30PM on September 20, 2009. The record was reviewed on August 9, 2010. 2. Facility staff failed to protect Resident #23 from verbal abuse. A face-to-face interview was conducted with Resident #23 at approximately 11:00 AM on August 6, 2010. During the interview the resident informed this investigator that a Certified Nursing Assistant (CNA) had spoken to him/her in what he/she described as "Rudely". The resident who is blind in his/her right eye stated, "This man/woman came up beside me and started talking to me. He/she was on my right side and I am blind in my right eye. I told him/her I was blind and could not see to [he/she should] come over to the other side. He/she ignored me then said, I don't have time man/woman."	F 223	**483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION** **Ftag 223 #2** 1.Corrective actions were implemented for the employee identified in this incident. 2. An audit has been completed on visually impaired residents to ensure that their rights have not been violated. 3. The Abuse, Neglect and Misappropriation of Property policy has been reevaluated and updated. Staff has been in-serviced on the policies, use of restraints. Staff has also been educated on the legalities of documentation to stress the importance of timing notes. A shit change report process has been implemented and staff has been educated. 4. A documentation audit will be completed monthly by the Medical Records Coordinator. A Restraint audit will be completed monthly by the Unit Manager/MDS Coordinator. The Unit manager/designee will conduct a random weekly audit of the shift change report process. A report will be provided to the Director of Nursing/designee on all audits of problems identified and corrective actions implemented. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly by the Director of Nursing/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10 10/19/10 10/19/10 10/28/10

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F 223	Continued From page 21 A face-to-face interview was conducted with Employee #2 at approximately 2:30 PM on August 10, 2010. He/she acknowledged that the incident occurred. He/she stated, " The social worker and I spoke to the resident regarding the incident and assured him/her that the CNA would not be returning to the facility. He/she [the CNA] was employed through an agency. We immediately called the agency and terminated his/her contract. The record was reviewed on August 10, 2010.	F 223	Continued From page 21 **483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS /INDIVIDUALS.** **Ftag 225** 1. A written report was provided to the DOH on verbal report for Resident #23.	10/27/10
			2. All residents have the potential to be affected by this practice current abuse investigations have been reviewed to ensure that proper notification of state and other reporting agencies have been completed.	10/19/10
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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	3. The Abuse, Neglect and Misappropriation of Property policy has been re-evaluated and updated with the addition of an abuse notification checklist. Staff has been in-serviced on the policy and what constitutes abuse with the emphasis on verbal abuse. Staff education has also been completed by the educator on reportable incidents and the timeliness of reporting incidents. Training for nursing supervisory staff has been conducted by the DOH on the electronic reporting and documenting of incidents.	10/19/10
	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		4. The DON/designee will conduct random monthly audits of abuse investigations and incident reports to assure completion, documentation, and appropriate reporting. A report will be provided to the Administrator of problems identified and corrective actions implemented. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly by the Director of Nursing/designee.	10/28/10

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F 225	Continued From page 22	F 225	Continued From page 22	

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 interview for one (1) of 26 sampled residents, it was determined that facility staff failed to report an incident of alleged verbal abuse to the state agency. Resident #23.

The findings include:

A face-to-face interview was conducted with Resident #23 at approximately 11:00 AM on August 6, 2010. During the interview the resident informed this investigator that a Certified Nursing Assistant (CNA) had spoken to him/her in what he/she described as " Rudely". The resident who is blind in his/her right eye stated, "This man/woman came up beside me and started talking to me. He/she was on my right side and I am blind in my right eye. I told him/her I was blind and could not see to come over to the other side. He/she ignored me then said, I don't have time man/woman."

A review of the resident's clinical record failed to reveal any documentation of the incident.

Provider's Plan of Correction (F 225):

A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

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F 225	Continued From page 23 A face-to-face interview was conducted with Employee #2 at approximately 2:30 PM on August 10, 2010. He/she acknowledged that the incident occurred, however there was no notification of the allegation of verbal abuse sent to the state agency. The record was reviewed on August 10, 2010.	F 225	**483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES** **F tag 226**	
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on a review of the facility ' s abuse policy, it was determined that facility staff failed to develop and operationalize procedures for " Prevention " of Resident Abuse . The findings include: The census on the first day of survey (August 2, 2010) was 167 residents. A review of the Policy "Resident Abuse, Neglect and Misappropriation of Property: Policy and Procedure No: 117, Revised Date: 08/11/08, stipulated, " Practice Guidelines: Component I: Screening, Component II: Training, Component III: Identification, Component IV: Investigation, Component V: Protection, Component VI: Reporting/Response " . The policy lacked documented evidence that the facility developed and operationalize procedures	F 226	1. Resident Abuse and Neglect, Misappropriation of Property Policy has been updated to reflect the component on Prevention. 2. All residents have the potential to be affected by this practice. Resident Abuse and Neglect, Misappropriation of Property Policy has been re-evaluated and updated to reflect a component on prevention. 3. The Resident Abuse, Neglect and Misappropriation of Property Policy has reevaluated and updated to reflect prevention. Staff has been in-serviced on the policy and what constitutes abuse and the seven components of the abuse policy. The DON/ designee will conduct random monthly audits of staff regarding the components of the abuse policy. A report will be provided to the Administrator of problems identified and corrective actions implemented. 4. The results of the above audit will be reported to the CQI committee quarterly by the Director of Nursing/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other	10/19/10 10/19/10 10/19/10 10/28/10

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

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F 226	Continued From page 24 for "Prevention". A face-to-face interview was conducted with Employees #1 and 3 on July 29, 2010 at approximately 10:50 PM. The employees reviewed all aspects of the " Resident Abuse, Neglect and Misappropriation of Property " policy and acknowledged that procedures for " Prevention " were not included in the policy.	F 226	interventions and need and frequency of further audits.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 observations during the tray line observation it was determined that sufficient chinaware and silverware was not available for all residents' trays that were served in one (1) of one (1) observation. These observations were observed in the presence of Employee # 13. The findings include: During tray line observation it was determined that sufficient quantity of chinaware and silverware was not available to serve the last 38 residents during the lunch meal in one (1) of one (1) observation at 12:54 PM on August 5, 2010. Based on observation, record review and staff interview, it was determined that facility staff	F 241	**483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY** **F tag 241** 1. Food Services Director ordered 5 cases of china (total 48 plates) and 12 dozen pieces of silverware to ensure a sufficient quantity of china are available to serve all of the residents' meals on at all times.	8/11/10
			2. The director of the department will maintain weekly inventory of china and silverware to make sure there is sufficient supply for all resident's meals.	10/19/10
			3. A physical inventory will be conducted on a weekly basis to ensure that china and silverware levels are sufficient to serve all residents meal. The par level of 3 cases of plates, 8 dozen silverware pieces will be in stock.	10/19/10
			4. A monthly food safety audit will include the auditing of china and silverware inventory, which will be reported to the CQI committee for three months then quarterly, thereafter.	10/28/10

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F 241	Continued From page 25 failed to promote dignity during dining for one (1) of 30 supplemental residents. Resident CBL #18. The findings include: Facility staff failed to promote dignity during dining for Resident #CBL 18. On August 3, 2010 at approximately 12:45PM, Employee #19 was assisting Resident CBL #18 to eat the lunch meal. Employee #19 stood over the resident while assisting the resident. Facility staff failed to promote dignity as evidence by employee standing over resident during the lunch meal while assisting him/her to eat	F 241	**Continued From page 25** **F tag 241** **Resident CBL#18** 1. The staff was remediated at the time of survey and corrective actions were implemented.	8/11/10
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations during the initial tour of the facility, it was determined that facility staff failed to ensure that call bells were within reach and/or operational in three (3) resident rooms. The findings include: On August 2, 2010 at approximately 9:30 AM during the initial tour of the facility, it was	F 246	2. All residents have the potential to be affected by this deficient practice. An audit of meal services were completed and corrective actions implemented as needed.	10/19/10
			3. The Educators have in-serviced staff on maintaining resident dignity while feeding.	10/19/10
			4. Unit Managers will conduct random audits to ensure that meal dignity is maintained. A report will be provided to the DON/designee of corrective actions implemented and the need for further education. The results of the above audit will be reported to the CQI committee for three months, then quarterly by the Director of Nursing/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further actions.	10/28/10

Continued from page 26

483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES
F tag 246

1. Call bells in rooms 318A, 314P, and 328A where placed in reach and repaired or replaced during survey. 8/10/10

2. All residents have the potential to be affected by this practice. Call bells have been audited by the Maintenance staff for operability and safety. 10/19/10

3. The Educator has in-serviced the staff on the accommodation of resident needs in the regards to placement of call bells within resident's reach. The Unit Managers via his/her daily rounds will assess compliance with this process. 10/19/10

4. The Unit secretaries will complete random audits of call bells bi-weekly. A report will be provided to the DON/designee of problems identified and corrective actions implemented and indications of need for further education. 10/28/10

The results of the above audit will be reported to the CQI committee quarterly by the DON/ designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

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F 246	Continued From page 26 observed that a call bell was on the floor and not accessible to the resident who occupied room 328A. The call bell was not present for the resident who occupied room 314P and the call bell wires were frayed for the resident who resided in room 318A. The findings were observed and confirmed in the presence of Employee #7.	F 246		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	**F-250 #1** **Resident#3** 1. The medical record of Resident #3 was reviewed and documented by the Director of Social Services to reflect the resident's elopement risk and facility's "Elopement Policy", which was reviewed to ensure compliance with elopement risk residents.	10/19/10
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 26 sampled residents, it was determined that the social worker failed to address resident's elopement and initiate discharge planning for one (1) resident and initiate discharge planning for one (1) resident who wanted to live somewhere other than a nursing facility. Residents #3 and 23.		2 Review of new and current admission discharge plans has been completed by the Social Workers. Corrective actions have been implemented as needed.	10/19/10
	The findings include: 1. The social worker failed to address Resident #3 ' s attempted elopement.		3. A Weekly Discharge Planning meeting has been initiated to address the new and current resident needs, concerns, and to identify residents that are eligible for discharge and their discharge plan. The Administrator/designee will audit this process monthly problems identified and corrective actions implemented and indications of the need for further education will be reported to the CQI Committee.	10/19/10
	A review of resident #3 ' s clinical record revealed the following: An admission Minimum Data Set (MDS)		4. The results of the above audit will be reported to the CQI committee quarterly by	10/28/10

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F 250	Continued From page 27 completed November 2, 2009 coded in Section AB 1 Demographic Information: Date of entry as October 23, 2009. A nursing note dated January 28, 2010 at 3:00 PM noted: " Resident left facility [without medical advice [AMA]. Release form of responsibility signed. All personal belongings sent [with] resident and ...medication [for] seven (7) days sent [with] instructions also sent. " A nursing note of March 10, 2010 at 2:00 PM noted: " Admission note ...Resident admitted to room ...from ...via ambulance. Resident admitted with diagnosis of altered mental status secondary to hypothermia ... " A social progress note dated March 17, 2010 noted " Initial care plan meeting was held today by IDT [Interdisciplinary care committee] ...Goal is to provide counseling and assist in stabilizing living arrangement for resident ... " A nursing note dated July 24, 2010 at 2:50 PM noted " ...Resident elopement attempt at 2:50 PM ...staff was able to intervene and escort resident in via W/C [wheelchair]. A face-to-face interview was conducted with Resident #3 on August 2, 2010 at approximately 2:00 PM. He/she said " My right is being denied. I was retired from the air force. I used to go out but not anymore. I can see if I am mentally ill, I am not. I worked at Saint Elizabeth for 24years as a mental health specialist. I am not going to be here for the rest of my life. I am not going to be like this for long. If I leave again, I will not come back. If someone attempts to stop me, I'll hurt the person. This is like a jail ... " This social worker	F 250	Continued From page 27 the Administrator/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	

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has not done anything for me. It is like talking to brick. This is a nursing home and should be treated like one. I used to live with my girlfriend but we lost the lease. I need my own housing."

A further review of the social worker notes dated March 17, 2010, April 6, 2010, May 12, 2010 and July 29, 2010 lacked documented evidence that the resident's above concerns were addressed.

A face-to-face interview was conducted with Employees #2 and 8 on August 6, 2010 at approximately 9:30 AM. After reviewing the resident's clinical record he/she acknowledged that the resident's clinical record lacked documented evidence that the resident's concerns and attempted elopement were addressed. He/she acknowledged that he resident left the facility AMA sometime in January 2010 and attempted to elope from the facility. He/she added further that he/she will start looking into the resident's concerns including housing in the community. It was emphasized to Employees # 2 and 8 that the resident verbalized the intention of leaving the facility if he/she feels his/her rights continued to be denied and that he/she threatens to hurt whosoever attempts to stop him/her. The record was reviewed August 6, 2010.

2. Facility staff failed to initiate discharge planning for Resident #23 who wanted to live somewhere other than a nursing facility.

A face-to-face interview was conducted with Resident #23 at approximately 11:00AM on August 6, 2010. During the interview the resident stated that he/she has been approved for public housing and, "right now I am trying to find an apartment that is wheel chair accessible. The

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F 250	Continued From page 29 resident added, "The social worker has agreed to assist me in finding an apartment." A review of the clinical record failed to reveal any documentation about the resident's housing status and/or pending discharge status. A face-to-face interview was conducted with Employee #21 at approximately 2:00PM on August 6, 2010. He/she acknowledged being aware that the resident's application for congregate housing has been approved. The employee further acknowledged that he/she had failed to document any information regarding the resident's housing status and/or his/her pending discharge and added, "I will write a note today." The record was reviewed on August 6, 2010.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 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 is maintained in a safe and sanitary as evidenced by: soiled wheelchairs in one (1) of one (1) observation, The spoken frame surfaces of residents non mobilize wheelchairs in the first floor lounge were observed to be soiled with dust and debris in three (3) of seven (7) observation worn and damaged wheelchairs, the armrests and seat surfaces of residents' wheelchairs were observed to be worn and	F 253		

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F 253	Continued From page 30 damaged in the first floor lounge in four (4) of seven (7) observations, the back and seat surfaces of sofas and chairs in the first and second floor dayrooms were damaged and worn in two (2) of two (2) observations soiled baseboard heaters, worn and soiled sofas and chairs, soiled window sills floor in two (2) of two (2) observations, soiled floor surfaces at the entrance to the facility in one (1) of one (1) observation, marred hand rails at the entrance to the building in one (1) of one (1) observation, . Heating Ventilation and Air Conditioning [HVAC] louvers were soiled with accumulated dust in the ante-area outside of facility ' s lobby in one (1) of one (1) observation soiled cabinets in the Utility Room in one (1) of one (1) observation, the interior areas of the sink in the housekeeping closet were soiled and rusty in one (1) of one (1) observation, soiled bedside rails in thirteen (13) of 20 observations, door jams were marred and scarred in four (4) of twenty (20) observations, the interior areas of the sink in the housekeeping closet were soiled and rusty in one (1) of one (1) observation interior and exterior surfaces of exhaust vents were soiled with dust239 in eight (8) of 20 observations, the frontal surfaces of elevator doors were soiled and marred in the basement , 1st, 2nd, and 3rd floors, in addition, elevator tracks were soiled with accumulated debris between in six (6) of six (6) observations, horizontal surfaces of bed frames soiled with dust 13 of 20 observations, soiled and marred elevator doors in six (6) of six (6) observations, soiled ceiling tiles in resident ' s rooms in four(4) of 20 observations, personal clothing observed on floor surfaces in four (4) of 25 observations, missing threshold to entrance of resident ' s bathroom in one (1) of one (1) observation, and damaged wall surfaces in resident ' s rooms in three (3) of 20	F 253	**483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES.** **Ftag 253#1 The corrective actions taken are:** 1.Mobile wheelchair identified was disposed of. 2.Residents on the 1st floor wheelchairs were cleaned. 3.Armrests and seat surfaces of first floor residents' wheelchairs were repaired and replaced. Two wheelchairs were ordered. 4.Base board heater surfaces have been cleaned and were repaired. 5.Sofas and chairs in the first and second floor day rooms will be replaced. Sofas and chairs have been ordered as of 10/12/10. Allow 8 weeks for receipt. 6.First floor day room window sill surfaces have been cleaned. 7.Entrance floor tile surfaces will be cleaned and replaced. Replacement tiles were installed. 8.Hand rails outside the entrance were painted. 9.Heating Ventilation and Air Conditioning louvers have been cleaned. 10. Floor surfaces and exhaust vents in the medication and treatment room have been cleaned. 11. The interior area of the cabinet under the sink in the soiled utility room has been cleaned. 12. The interior areas of the sink in the housekeeping closet has been cleaned. 13.The horizontal and vertical surfaces of bedside rails and bed frames in rooms 112, 120, 127, 128, 146, 208, 210, 220, 230, 236, 313, 318 and 340 were cleaned. 14. Resident's entrance door jams for rooms 112, 140, 214, 340 and the second floor Activity room were repaired and painted.	10/15/10 10/19/10 10/19/10 10/19/10 10/19/10 10/19/10 10/19/10 10/19/10

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F 253 (summary statement):

observations, clothes hamper covers were missing or damaged in rooms 135,239, 321, 324 and 336 in five (5) of 20 observations the frontal surfaces of furnishings in residents were observed to be marred and damaged in rooms 221, 236, 308, and 321 in four (4) of 20 observations. These observations were made in the presence of the Maintenance Director employees # 13 and 31.

The findings include:

1. A mobile wheelchair observed in the first floor resident ' s lounge was soiled with dust in one (1) of one (1) observation at 3:15 PM on August 2, 2010.
2. The spoken frame surfaces of residents non-mobilize wheelchairs in the first floor lounge were observed to be soiled with dust and debris in three (3) of seven (7) observations at 3:20 PM on August 2, 2010.
3. The armrests and seat surfaces of residents wheelchairs were observed to be worn and damaged in the first floor lounge in four (4) of seven (7) observations at 3:20 PM on August 2, 2010.
4. The top and frontal surfaces of baseboard heaters were soiled and damaged in two (2) of two (2) observations at 3:25 PM on August 2, 2010.
5. The back and seat surfaces of sofas and chairs in the first and second floor dayrooms were damaged and worn in two (2) of two (2) observations at 3:45 PM on August 2, 2010 and 11:00 AM on August 3, 2010.
6. The window sill surfaces were soiled with dust in dayroom and lounge on the first floor in two (2) of two (2) observations at 3:45 PM on August 2, 2010.
7. Floor tile surfaces were observed to be soiled, marred, and tiles were not secured at the

F 253 (provider's plan of correction):

Corrective action	Completion date
15. Interior and exterior surfaces of exhaust vents were cleaned in resident's bathrooms and common areas in first floor shower room, medication room, third floor shower room, and residents' rooms 130, 143, and 239.	10/19/10
16. Elevator doors and elevator tracks were cleaned on all floors.	10/19/10
17. Ceiling tile in resident rooms 208;308 and in the laundry room have been repaired and/ replaced.	10/19/10
18. Excessive personal belongings for resident rooms 140, 143, 308 and 309 have been reorganized and/ removed.	10/19/10
19.Threshold was replaced under entrance door and bathroom door of room 135.	8/12/10
20. Wall surfaces in resident rooms 218, 239, 344 and the activity room have been repaired and painted.	8/12/10
21. Clothes hamper covers for rooms 135, 239, 321, 324 and 336 have been replaced.	10/19/10
22.The facility will replace the marred and damaged furnishings that are facility owned in rooms 221, 236, 308 and 321. Furnishings that are resident owned will remain as is for sentimental value/a sense of home purposes. Furnishings have been ordered. Delivery is expected in 8 weeks.	10/19/10

Ftag 253

All residents have the potential to be affected by this practice. The following corrective actions have been implemented:

Corrective action	Completion date
1. An audit of all in-house wheelchairs was conducted to determine the repair needs of all in-house wheelchairs.	10/12/10
2. A monthly cleaning schedule has been implemented to ensure that all wheelchairs	10/19/10

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(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 253	Continued From page 32 entrance to the facility in one (1) of one (1) observation at 3:20 PM on August 2, 2010. 8. Handrails were observed to be marred and needed repainting outside of facility ' s entrance in one (1) of one (1) observation at 3:20 PM on August 2, 2010. 9. Heating Ventilation and Air Conditioning [HVAC] louvers were soiled with accumulated dust in the ante-area outside of facility ' s lobby in one (1) of one (1) observation at 3:25 PM on August 2, 2010. 10. Floor surfaces and exhaust vents were soiled in the medication and treatment room in one (1) of one (1) observation at 3:30 PM on August 2, 2010. 11. The interior area of the cabinet under the sink in the soiled utility room was soiled in one (1) of one (1) observation at 3:45 PM on August 2, 2010. 12. The interior areas of the sink in the housekeeping closet were soiled and rusty in one (1) of one (1) observation at 4:05 PM on August 2, 2010. 13. The horizontal and vertical surfaces of bedside rails and bed frames were soiled with dust and spillages in rooms 112, 120, 127, 128, 146, 208, 210, 220, 230 236, 313, 318 and 340 in thirteen (13) of 20 observations between 3:15 PM on August 2, 2010 and 12:00 PM on August 4, 2010. 14. The frontal surfaces of resident ' s entrance doors and door jams were marred and scarred in rooms 112, 140, 214, 340 and second floor activity room in four (4) of twenty (20) observations between 3:15 PM on August 2, 2010 and 3:30 PM on August 4, 2010. 15. The interior and exterior surfaces of exhaust vents were soiled with accumulated dust and debris in resident ' s bathrooms and common	F 253	Continued From page 32 are cleaned on a routine basis. Wheelchairs that are identified or discovered to require more than monthly cleaning will be cleaned as required to ensure that the residents' wheelchairs are maintained in a clean sanitary manner. Wheelchairs are spot cleaned at the end of each day by nursing staff. A wheelchair committee has been formed as of 10/4/10. Meeting will be conducted on a quarterly basis.	
			3. The initial wheelchair repair clinic has been scheduled to start on 10/12/10 and end on 10/15/10.	10/19/10
			4.All baseboard heaters were assessed for cleanliness. Baseboard heaters identified to be in need of cleaning were cleaned upon discovery.	10/4/10
			5.Day room furnishings for all common areas have been ordered as of 10/19/10. An 8 week delivery time is required.	10/19/10
			6. Window sill inspections and cleaning has been conducted throughout the facility.	10/19/10
			7. Other areas have been inspected for loose tile repair and replacement. Maintenance staff will perform monthly inspections to ensure compliance. Findings will be reported to CQI committee.	10/19/10
			8. No other areas have the potential to be affected by this deficient practice. Maintenance staff will conduct monthly audits to ensure compliance. Findings will be report to CQI committee.	10/19/10

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F 253	Continued From page 33 areas in the first floor shower room, medication room, third floor shower room, and resident ' s rooms 130, 143, 239 in eight (8) of 20 observations between 3:40 PM on 3:15 PM on August 2, 2010 and 3:30 M on August 4, 2010. 16. The frontal surfaces of elevator doors were soiled and marred in the basement , 1st, 2nd, and 3rd floors, in addition, elevator tracks were soiled with accumulated debris between 3:15 PM on August 2, 2010 and 3:30 PM on August 4, 2010 in six (6) of six (6) observations. 17. Ceiling tiles in resident ' s rooms and common areas were soiled and stained in rooms 208, 308, third floor housekeeping closet, and the main laundry room in four(4) of 20 observations between 3:15 PM on August 2, 2010 and 3:30 PM on August 4, 2010. 18. Excessive personal belongings were observed on the floors and beside the resident ' s beds, impeding access around resident ' s bed in rooms 140, 143, 308, and 309 in four (4) of 25 observations between 3:15 PM on August 2, 2010 and 3;30 PM on August 4, 2010. 19. Thresholds were missing under the entrance door and bathroom in room 135 in one (1) of one (1) observation at 10:10 AM on August 3, 2010. 20. Wall surfaces in resident ' s rooms and common areas were observed to be marred and damaged in rooms 218, 239, 344, and activity room in three (3) of 20 observations between 3:15 PM on August 2, 2010 and 11:50 AM on August 4, 2010. 21. Clothes hamper covers were missing or damaged in rooms 135,239, 321, 324 and 336 in five (5) of 20 observations between 3:15 PM on August 2, 2010 and 12:40 PM on August 4, 2010. 22. The frontal surfaces of furnishings in residents were observed to be marred and damaged in rooms 221, 236, 308, and 321 in four	F 253	9. Heating Ventilation and Air Conditioning louvers have been cleaned facility wide.	10/19/10
			10. Floor surfaces and exhaust vents in the medication and treatment rooms have been cleaned facility wide.	10/19/10
			11. The interior area of the cabinet under the sink in the soiled utility rooms has been cleaned.	10/19/10
			12. The interior areas of the sinks in the housekeeping closets have been cleaned.	10/19/10
			13. The horizontal and vertical surfaces of bedside rails and bed frames in rooms 112, 120, 127, 128, 146, 208, 210, 220, 230, 236, 313, 318 and 340 were cleaned.	10/19/10
			14. Other entrance door jams were inspected for marring and damage; painted when identified as needed. Findings will be reported to CQI committee.	10/19/10
			15. Interior and exterior surfaces of exhaust vents were cleaned in resident's bathrooms and common areas in first floor shower room, medication room, third floor shower room, and residents' rooms 130, 143, and 239.	10/19/10
			16. Elevator doors and elevator tracks were cleaned on all floors.	10/19/10
			17.A ceiling tile audit was conducted facility wide and those in need of replacement were replaced.	10/15/10
			18. A review/inspection of all resident rooms was conducted to ensure that excessive belongings have been reorganized and neatly stored. Family was contacted in regard to removal of some belongs requested to be removed.	10/19/10
			19. Facility wide entrance and bathroom thresholds were audited. Areas identified in need of replacement and/ repair were completed.	10/19/10
			20. Wall surfaces in resident's rooms and common areas were audited for marring and damage. Corrective actions identified were implemented and completed.	10/19/10

Continued from page 34

21. Clothes hampers were ordered for all resident rooms. 10/19/10
22. Replacements have been ordered for facility owned furnishings in resident's rooms which were observed to be marred and damaged. 10/19/10

Ftag 253

#3. Measures/systematic changes are as follows:

Environmental Services
Environmental Services staff have been in-serviced to identify and correct any deficiencies in cleaning at the time of discovery if possible. A daily task cleaning checklist for each staff member was developed for completion on their assigned shift. 10/19/10

#4. Monitoring to assure that solutions are sustained:
Monthly rounds are conducted by the Department Director to assure compliance with standards. A secondary check is conducted by the EMS Contractor's corporate office for 3 months, then on a quarterly basis. The Environmental Services Director will report findings to the CQI committee on a monthly basis. 10/19/10

#3. Measures/systematic changes are as follows:
Maintenance Staff
Maintenance staff was in-services on the need to identify and correct any deficiency at the time of the discovery as possible. If immediate correction is not possible, staff has been educated on necessary steps to address the area of concern. 10/19/10

Monthly rounds are conducted by Maintenance staff at the beginning and end of the month. Items identified as requiring correction are immediately corrected or arrangements are made. The check at the end of the month identifying those items still requiring attention.

#4. Monitoring to assure that solutions are sustained:
Maintenance staff will perform monthly audits. Findings will be reported to the CQI committee on a monthly basis by the Maintenance Director/designee. 1019/10

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F 253	Continued From page 34	F 253		
	(4) of 20 observations between 3:15 PM on August 2, 2010 and 12:40 PM on August 4, 2010.			
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS	F 272		

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview for 10

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F 272

Continued From page 35

of 26 sampled residents and one (1) of 30 supplemental residents, it was determined that facility staff failed to complete the Resident Assessment Protocol (RAP) summaries. Residents # 3, 4, 7,11, 15,16, 17, 21, 24, 25 and CBL5.

The findings include:

Facility staff failed to complete RAP summaries for Residents # 3, 4, 7,11, 15, 16, 17, 21, 24, 25 and CBL5.

"According to MDS 2.0 pages 3-237-238" The MDS alone does not provide a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident problems, strengths, and preferences. The RAPs are problem-oriented frameworks for additional assessment based on problem identification items (triggered condition). They form a critical link to decisions about care planning. The RAP Guidelines provide guidance on how to synthesize assessment information within a comprehensive assessment.

The RAPs in the RAI cover the majority of areas that are addressed in a typical nursing facility resident's care plan. Following completion of the MDS and review of the triggered RAPs, a decision is made by the interdisciplinary team to proceed to care planning for each of the triggered RAPs.

The RAPS provide further assessment of the triggered areas; they help staff to look for casual or confounding factors (some of which may be reversible). Use the RAPs to chart your assessment findings and then chart your thinking.

F 272

Continued From page 35

483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS

Ftag 272

1. Care Area Assessments (CAA) were completed as a part of the Comprehensive Assessment. Resident # 4, 7 RAP summaries were located on the medical record. Resident # 3, 11,15,16,17,21,24,25, and CBL 5 have been printed and filed on the resident records. — 10/19/10

2. A random audit of resident records will be completed to ensure RAP summaries are present for all comprehensive assessments. — 10/19/10

A new MDS Coordinator has been identified, who has attended the 10/18/10 2010 three day AANAC training. Also, one additional 1.0 FTE has been approve to support the completion of the facility-wide MDS's.

3. A review of the CAA process has been conducted with all disciplines involved in the MDS process. Policies and procedures will be initiated identifying discipline responsibilities toward CAA completion. — 10/19/10

4. Results of the random monthly audit will be submitted to the CQI committee monthly for the next six months and quarterly thereafter by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. — 10/28/10

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F 272	Continued From page 36 The RAP Summary documents the decisions from the interdisciplinary team on which of the triggered condition will be addressed in the care plan. A review of the clinical record for Residents # 3, 4, 7,11, 15, 16,17, 21, 24, 25 and CBL5 lacked documented evidence that facility staff completed the required RAP summaries when the residents' comprehensive Minimum Data Set (MDS) assessments was completed. A face-to-face interview was completed with Employee #4 on August 9, 2010 at approximately 11:45 AM after reviewing the residents' clinical records; he/she acknowledged that RAP summaries had not been completed for the aforementioned residents. The records were reviewed August 9, 2010.	F 272		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews for one (1) of 26 sampled residents, it was determined that facility staff failed to complete a comprehensive assessment. # 3.	F 273		

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F 273	Continued From page 37 The findings include: Facility staff failed to complete a comprehensive assessment one resident who left the facility against advice and was admitted to the facility after Intensive care hospitalization. Resident # 3. A review of resident #3 ' s clinical record revealed the following: An admission Minimum Data Set (MDS) completed November 2, 2009 coded in Section AB 1 Demographic Information: Date of entry as October 23, 2009. A nursing note dated January 28, 2010 at 3:00 PM noted: " Resident left facility [without medical advice. Release form of responsibility signed. All personal belongings sent [with] resident and ...medication [for] seven (7) days sent [with] instructions also sent. " Against Medical Advice Policy #906 effective 09/19/2000 [September 9, 2000], revised 08/03/2007[August 3, 2007], 7/20/2010 [July 29,2010 states: "...If the resident is does not return to the facility within 24 hours, he/she is considered discharged. The Resident/ responsible party will be issued a notice of discharge." A nursing note of March 10, 2010 at 2:00 PM noted: " Admission note ...Resident admitted to room ...from ...via ambulance. Resident admitted with diagnosis of altered mental status secondary to hypothermia ... " A further review of the resident ' s clinical record lacked documented evidence that an admission	F 273	**483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT** **Ftag 273** 1. Resident #3 is no longer a resident in the facility 2. A random audit of residents discharged over the past ninety days will be completed to ascertain the completion of the admission assessment. Any records lacking documented evidence will be completed. 3. Comprehensive assessments will be completed timely according to the mandated MDS schedule identified in the CAA process. Documentation of the completion of the comprehensive assessments will be submitted to the DON/designee on a monthly basis by the MDS Coordinator 4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee monthly for the next six months and quarterly thereafter by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	 10/19/10 10/19/10 10/19/10

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F 273	Continued From page 38 MDS assessment was completed 14 days after the resident ' s admission to the facility. on March 10, 2010. A face-to-face interview was conducted with Employee #4 on `August 6, 2010 at approximately 10:30 AM. After reviewing the resident ' s clinical record he/she acknowledged the above findings. The record was reviewed August 6, 2010.	F 273		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 26 sampled residents it was determined that facility staff failed to perform a significant change reassessment for one (1) resident with weight loss and activities of daily living. Resident #14. The findings include:	F 274	**483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE** **Ftag 274** 1. A comprehensive assessment will be completed no later than October 19.2010 on Resident #14 to determine the accuracy of a significant change, which includes a evaluation by members of the interdisciplinary team. If a significant change is identified, a Significant Change assessment will be completed. 2. An interdisciplinary team review will be conducted by the MDS consultant on all resident assessments completed within the last ninety days. The review will determine if the correct assessments have been completed. Any resident assessment not deemed appropriate by the team members was be re-assessed and the appropriate assessment were completed.	10/19/10 10/19/10

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F 274	Continued From page 39 1. Facility staff failed to code a " significant change " reassessment for a resident that had a decline in two (2) or more areas. Resident #14. According to the Revised Long-Term Care Facility Resident Assessment Instrument User ' s Manual Version 2.0 A " significant change " is a decline or improvement in a resident ' s status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not " self-limiting " 2. Impacts more than one area of the resident ' s health status 3. Requires interdisciplinary review and /or revision of the care plan. A review of the Nutrition Note dated May 18, 2010 no time indicated revealed that in May 2010 the resident weighed 204 pounds, weight gain 5.6% x (times) 30 days, decrease 8.5% x 90 days. A review of the Quarterly MDS completed June 9, 2010 showed that the resident had change in two or more areas in Section G Physical Functioning and Structural Problems; (a) Bed mobility went from Limited Assistance (2) to Extensive Assistance (3); (g) Dressing went from Limited Assistance (2) to Extensive Assistance (3); (h) Eating went from Independent (0) with one (1) setup help only to Extensive Assistance (3) with 2 one person physical assist; (i) Toilet use went from Limited Assistance (2) to Extensive Assistance (3) and (j) Personal Hygiene went from Limited Assistance (2) to Extensive Assistance(3). A face-to-face interview was conducted with Employee #6. After review of the aforementioned findings he/she acknowledged the findings. The	F 274	**Continued From page 39** 3. During daily stand-up meetings, resident changes were discussed. Residents experiencing a decline or improvement in status will be reviewed to determine if a significant change has occurred and assessments were conducted according RAI guidelines. The MDS Coordinator, as part of the team, will receive information for each resident identified from the appropriate team member within 48-72 hours and determine if a significant change has occurred and implement a Significant Change Assessment. Documentation of Significant change assessments have been submitted to the DON/designee monthly. 4. Documentation of residents experiencing a decline or improvement of status will be reviewed to determine if there is a permanent change. If a change is supported, the MDS Coordinator will schedule and complete a SCSA within 14 days of determining this change is permanent. Results of the comparative review will be submitted to the CQI committee monthly for the next six months and quarterly thereafter. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10 11/19/10

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F 274	Continued From page 40 record was reviewed on August 5, 2010.	F 274	**Continued From page 40**	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 30 supplemental residents, it was determined that facility staff failed to complete a quarterly Minimum Data Set [MDS] assessment for Resident #CBL14. The findings include: According to the " MDS User ' s Manual " page 2-1, " The OBRA regulations have defined a schedule of assessments that will be performed for a nursing facility resident at admission, quarterly, annually, whenever the resident experiences a significant change in status, and whenever the facility identifies a significant error in a prior assessment. These are known as " OBRA assessments. " A review of the clinical record for Resident CBL #14 revealed that the resident had an annual assessment September 9, 2009, quarterly assessment in December 2009 and March 2010. There were no additional MDS assessments in the clinical record. The clinical record lacked evidence that a quarterly assessment for June 2010	F 276	**483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS** **Ftag 276** 1. A completed locked quarterly assessment for Resident #CBL14 was located in AccuCare, the facilities computerized system. A copy of this assessment has been placed in the clinical record. 2. A random audit of resident's clinical records was completed by 10/19/10 evaluating for the presence of the appropriate assessments. Any assessments not located was retrieved and placed on the clinical record. 3. The OBRA defined scheduled assessments was placed on the clinical record following completion identified by the MDS Coordinator. The MDS Coordinator is responsible for filing of the MDS assessment once deemed completed. Each month a list of scheduled assessments will be provided to the DON/Designee for compliance monitoring. A random review of the clinical record evaluating the presence of completed assessments was completed. 4. Reports of the random audits will be presented to the CQI committee monthly for the next six months and quarterly thereafter by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10 10/19/10 10/19/10 10/28/10

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F 276	Continued From page 41 .was completed. A face-to-face interview was conducted with Employee #4 on August 9, 2010 at approximately 2:00 PM. He/she acknowledged that the quarterly assessment was not completed for June 2010. The record was reviewed August 9, 2010.	F 276		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

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F 278	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for 11 of 26 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to accurately code: one (1) resident ' s sleep pattern (#2), two (2) residents for restraints (#4 & 21), three (3) residents for falls (# 6, 8, 20), one (1) resident for behavior, (#7), one (1) resident for foley and for swallowing (#9) , one (1) resident for incontinent (#24), one (1) resident for pressure ulcer (#12), one resident for MRSA in urine (#19) and one (1) resident for pneumonia, C.diff and hepatitis C (# CBL13). Residents #2, 4, 6, 7, 8, 9, 12, 19, 20, 21, 24, and CBL 13. The findings include: 1. The Social Worker failed to accurately code Section E1(k) Insomnia/change in usual sleep pattern, (ARD) Assessment Reference Date June 11, 2010. Resident #2 According to the Nursing Progress Notes dated and signed June 4, 2010 at 7:00 AM Resident #2 " ...awake and OOB (out of bed) @ (at) 2:30 AM in w/c (wheelchair). Resident wheeling herself up and down hallway. Did not go back to bed. Noted moving furniture around in room at 3:00 AM ...Several attempts were made to get resident to go back to bed, she refused. " Nursing Progress Note dated and signed June 6, 2010 10:40 PM " Resident alert oriented, order for Ambien 10mg ... " Nursing Progress Note dated and signed June 11, 2010 at 8:15 AM " Resident alert and	F 278	**Continued From page 42** **483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED Ftag 278 #1** 1. The assessments addressed in this section were opened assessments and not requiring a correction request. Section E1 (k) for Resident #2 has been corrected in annual MDS assessment with ARD 09/01/10 to accurately reflect the presence of insomnia exhibited. 2. A random audit of resident's assessments over the past ninety days was completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status has been corrected. 3. A review of the importance of accuracy in assessments was completed on 10/19/10 with the interdisciplinary team. Each team member responsible for an assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date in section AA8 and section Z on MDS 3. 4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency	10/19/10 10/19/10 10/19/10

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F 278	Continued From page 43 responsive slept in long naps. Up and about in the wheelchair. " A face-to-face interview was conducted with Employee #8 on August 3rd, 2010 at 12:11 PM. After review of the MDS and Nursing Progress Notes, he/she acknowledged that the quarterly MDS was not accurately coded in Section E1 (k). The record was reviewed on August 3, 2010. 2. Facility staff failed to code Resident #4 ' s quarterly MDS for restraints. According to the quarterly Minimum Data Set (MDS) assessment completed May 19, 2010, the resident was coded in Section P4 (a) -- (Devices and Restraints) as " 0" for full bed rails on all open sides of bed. Indicating the resident had not used full bed rails at any time during the day or night over the last seven days. A review of the Physician ' s Order Form signed and dated May 11, 2010, directed the following: "Restraints ... Side rails utilized to assist resident with turning and positioning D-E-N [day, evening, and night], side rails X4, only in bed due to mobility. " A face-to-face interview was conducted with Employee #4 on August 3, 2010 at approximately 9:15 AM. He/she acknowledged that the quarterly MDS was not coded for restraints. The record was reviewed on August 3, 2010. 3a. Facility staff failed to accurately code Section J4 (a) and (b) Accidents for falls on two Quarterly MDS assessments. Resident #6	F 278	**Continued From page 43** of further audits. **F tag 278 #2** 1. The assessments addressed in this section were opened assessments and not requiring a correction request. Section P4(a) for Resident #4 has been corrected in the subsequent quarterly assessment dated 8/10 as used daily. An assessment of the resident has been completed to reflect usage of side rails. 2. A 100% audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status will be corrected. 3. A review of the importance of accuracy in assessments was completed on 10/19/10 with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date in section AA8 and section Z on MDS 3.0. 4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other	10/19/10 10/19/10 10/19/10 10/28/10

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According to the quarterly MDS assessment completed on March 30, 2010 with an ARD (Assessment Reference Date) of March 24, 2010 Section J4 (a) lacked coding for a fall occurring in the past 30 days.

According to the Nursing Progress Note dated and signed March 23, 2010 3:00 PM revealed the following: " Resident alert and verbal. s/p (status/post) fall, no changes in mental status noted ... "

According to the Nursing Progress Note dated and signed March 3, 2010 at 8:00 AM,
" Resident was observed sitting on floor in dayroom and stated, I just fell ... "

3b. According to the next quarterly MDS assessment completed on June 30, 2010 with an ARD of June 24, 2010 Section J4 (b) lacked coding for a fall that occurred in the past 31-180 days.
Resident #6

A face-to-face interview was conducted on August 5, 2010 with Employee #6 at approximately 8:50 AM. After review of the two quarterly MDS he/she acknowledged that Section J4 (a) and (b) lacked coding for fall in the past 30 days and in the past 31-180 days. The record was reviewed on August 5, 2010.

4. Facility staff failed to accurately coded Resident #7 for indicators of depression, anxiety, sad mood, mood persistence, and behavioral symptoms.

F 278 — Continued from page 44

interventions and need and frequency of further audits.

F tag 278 #3a & 3b Resident #6

1. The assessments addressed in this section were opened assessments and not requiring a correction request. An annual assessment with ARD of 9/4/10, sections J4 (a) and (b) has been completed to reflect a fall in the past 31-180 days, for Resident #6 — 10/19/10

2. A 100% audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status has been corrected. — 10/19/10

3. A review of the importance of accuracy in assessments was completed on 10/19/10 with the interdisciplinary team Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordinator will verify section completion. Each team member completing an assessment will list sections completed with a signature and date in section AA8 and section Z on MDS 3.0 — 10/19/10

4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. — 10/28/10

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F 278	Continued From page 45	F 278	Continued From page 45	

Summary statement of deficiencies (F 278):

A review of Resident #7 ' s quarterly MDS completed on July 23, 2010 with an Assessment Reference Date [ARD] (last date for observations) of July 16, 2010 revealed varied indicators depression, anxiety, sad mood, mood persistence, and behavioral symptoms in last 7 days prior to the ARD. Section E 1, 2 and 4. [He/she was coded as exhibiting one or more indicators of making: expressions of what appear to be unrealistic fears, repetitive health complaints, sad pained worried facial expressions, repetitive physical movements and presentations with ' not easily altered ' persistent mood, physically abusive behavior and care resistance.]

A further review of Resident #7 ' s Clinical record including the " Nurses' notes " for June and July 2010 lacked documented evidence of the aforementioned behaviors.

A face-to-face interview was conducted with Employees #7 on August 4, 2010 at approximately 9:20 AM. After a review of Resident #7 ' s clinical record he/she acknowledged that the resident ' s clinical record lacked documented evidence for indicators of depression, anxiety, sad mood, mood persistence and behavioral symptoms. The record was reviewed August 4, 2010.

5. Facility staff failed to accurately code Resident #8 for a fall on the quarterly MDS.

A review of the clinical record for Resident #8 revealed the resident sustained a fall on March 4, 2010 and March 23, 2010 with no injury according to nurse ' s progress notes dated March 4, 2010.

Provider's plan of correction (F 278):

F tag 278 #4 Resident 7

Plan of correction	Completion date
1. The assessments addressed in this section were opened assessments and not requiring a correction request. A quarterly assessment with ARD of 10/14/10 will include updated information regarding the behavioral status of Resident #7. A SW note of 10/13/10 will support the clarified information.	10/19/10
2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status will be corrected.	10/19/10
3. A review of the importance of accuracy in assessments was completed with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date.	10/19/10
4. A monthly audit of MDS completion compliance have been completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10

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F tag 278 #5 Resident #8

1. The assessments addressed in this section were opened assessments and not requiring a correction request. Section J4 has been corrected on a subsequent Annual Assessment with ARD of 9/12/10 to reflect a fall within the last 31-180 days for Resident #8.	**10/19/10**
2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status will be corrected.	**10/19/10**
3. A review of the importance of accuracy in assessments was completed on with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date	**10/19/10**
4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	**10/28/10**

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F 278	Continued From page 46	F 278	**F tag 278 #6 Resident #9**	
	A review of the quarterly Minimum Data Set (MDS) completed March 29, 2010 revealed Section J4 (accidents) - " 0 " indicating no falls in the past 30-180 days. A face-to-face interview was conducted with Employee #4 on August 5, 2010 at approximately 11:30 AM, who acknowledged that the quarterly MDS did not reflect the resident's falls in the month of March. The record was reviewed August 5, 2010		1. The assessments addressed in this section were opened assessments and not requiring a correction request. A subsequent quarterly assessment with ARD was corrected for Resident #9 to indicate continence in the presence of a Foley catheter and swallowing difficulty in the presence of a gastrostomy tube.	10/19/10
	6. Resident #9 ' s clinical record revealed facility staff failed to accurately code the Admission Minimum Data Set [MDS] and Quarterly MDS completed March 1, and June 8, 2010 respectively.		2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status will be corrected.	10/19/10
	Section H, Continence and Section K, Oral/Nutritional Status was inaccurately coded on the admission and quarterly MDS assessments. According to the nursing admission assessment dated February 17, 2010, Resident #9 was admitted with an indwelling urinary catheter in place. The record revealed the indwelling catheter had been managed during the entirety of his/her stay and there was no evidence of catheter malfunction.		3. A review of the importance of accuracy in assessments was completed on with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date.	10/19/10
	Additionally, the initial Speech and Language Pathologist [SLP] assessment dated February 22, 2010, revealed Resident #9 had " profound dysphagia characterized by pocketing and poor oral clearance. " A subsequent SLP progress note dated February 26, 2010 revealed a gastrostomy tube was placed on February 26, 2010 for the administration of nutrition and		4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10

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F 278	Continued From page 47 hydration enterally. The annual and quarterly MDS ' were not coded to include the indwelling urinary catheter and continence in Section H; and failed include swallowing problem in section K. The record was reviewed August 4, 2010. 7. Facility staff failed to accurately code Resident # 12 ' s quarterly MDS for Section M, (Pressure Ulcer.) A review of the quarterly MDS completed May 3, 2010 with an Assessment Reference Date of April 22, 2010, revealed that the resident was coded for zero (0) pressure ulcer (s) in Section M1 and M2. A review of the weekly " Pressure Area Documentation Form " revealed that on April 23, and April 20, 2010 a right heel ulcer was documented as being assessed weekly. A face-to-face interview was conducted with Employee # 4 on August 5, 2010 at approximately 2:25 PM. The employee acknowledged the aforementioned findings. The record was reviewed on August 5, 2010. 8. Facility staff failed to accurately code the July quarterly MDS assessment for infections for Resident #19. A review of the quarterly MDS assessment completed April 16, 2010 coded Resident #19 for having an antibiotic resistant infection [e.g., [Methicillin-Resistant Staphylococcus Aureus] in Section I2 [Infections]. A review of the quarterly MDS assessment completed July 20, 2010, coded Resident #19 for	F 278	**F tag 278 # 7 Resident #12** 1. Residents' #12, 24, and CBL13 have been discharged and no further corrections can be made. 2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status will be corrected. 3. A review of the importance of accuracy in assessments was completed on with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date. 4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. **F tag 278 # 8 Resident #19** 1. The assessments addressed in this section were opened assessments and not	 10/19/10 10/19/10 10/28/10

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Resident #19 on a subsequent quarterly assessment has been updated to include the presence of MRSA. 10/19/10

2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status will be corrected. **10/19/10**

3. A review of the importance of accuracy in assessments was completed on with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date. 10/19/10

4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. 10/28/10

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F 278	Continued From page 48 having no infections in Section I2 [Infections]. A review of the physician' s orders dated and signed July 2, 2010, initiated March 22, 2010 directed, " Isolation Precautions every shift - MRSA [Methicillin -Resistant Staphylococcus Aureus]/ Urine. A face-to-face interview was conducted on August 6, 2010 at approximately 4:15 PM with Employee #4. He/she acknowledged that the MDS was inaccurately coded for Infections. The record was reviewed August 6, 2010. 9. Facility staff failed to accurately code Section J4 (b) Accidents for occurring in past 31-180 days on the Quarterly MDS assessments. Resident #20 According to the quarterly MDS assessment completed on July 23, 2010 with an ARD (Assessment Reference Date) of July 16, 201 Section J4 (b) lacked coding for a fall occurring in the past 31-180 days. According to the Nursing Progress Notes dated and signed May 14, 2010 at 8:30 PM " C.N.A. (Certified Nursing Assistant) assigned to resident stated " while she was putting pt (patient) in bed from his/her wk (work), slid to the ground. Fall was " witnessed C.N.A. stated patient did not hit her head that she fell on her buttocks. " A face-to-face interview was conducted on August 5, 2010 with Employee #6 at approximately 3:50 PM. After review of the quarterly MDS he/she acknowledged that	F 278	**F tag 278 #9 Resident #20** 1. The assessments addressed in this section were opened assessments and not requiring a correction request. A subsequent quarterly assessment with ARD of 10/16/10 for Resident #20 has been accurately coded to reflect a fall within the last 31-180 days.	10/19/10
			2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status will be corrected.	10/19/10
			3. A review of the importance of accuracy in assessments was completed on with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date.	10/19/10
			4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10

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F 278	Continued From page 49 Section J4 (b) lacked coding for fall in the past 31-180 days. The record was reviewed on August 5, 2010. 10. Facility staff failed to code for use of side rails as a restraint for Resident #21. Resident #21 was observed during the initial tour of the facility on August 2, 2010 at approximately 10:30 AM. He/she was in bed with the two side rails up. Upon interview, he/she said, they always have the two side rails up while I am in bed so that I do not fall. This statement was made in the presence of Employee #5. Employee #5 added I will take note of this and care plan accordingly. A further review of the resident ' s annual Minimum Data Set assessments completed on April 5, 2010 and a quarterly assessment completed on June 28, 2010 revealed that the resident was not coded for use of side rails as a restraint to prevent falls A face-to-face interview was conducted with Employees 4 and 5 on August 6, 2010 at approximately 10:30 AM. After a review of the resident ' s clinical record, Employee #4 acknowledged that the resident was not coded for use of side rails as a restraint and that he/she was not aware of the practice. Employee #4 concluded that he/she will follow-up with an appropriate assessment of the resident ' s use of side rails. The record was reviewed August 6, 2010. 11. Facility staff failed to accurately code Resident #24 for incontinence of bladder in	F 278	**F tag 278 # 10 Resident #21** 1.The assessments addressed in this section were opened assessments and not requiring a correction request. A functional assessment to determine the need for side rails will be completed and documentation of such will be included to accurately code the open assessment for Resident #21. 2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status will be corrected. 3. A review of the importance of accuracy in assessments was completed on with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date. 4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10 10/19/10 10/19/10 10/28/10

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F 278	Continued From page 50 Section H1b of the quarterly MDS. A face-to-face interview was conducted on August 6, 2010 at approximately 11:45 AM with Employee #28. He/she stated, " He/she was incontinent of bowel and bladder we had to change him/her. " A review of the quarterly MDS completed May 5, 2010, Section H1b [Bladder Continence] was coded as " 0 " indicating that the resident is in complete control of bladder. A face-to-face interview was conducted on August 6, 2010 at approximate 12:15 PM with Employee #4. He/she acknowledged that the admission MDS was coded incorrectly. The record was reviewed on August 6, 2010. 12. Facility staff failed to accurately code Resident CBL 13's for pneumonia, Clostridium difficile (C. Diff.) and Hepatitis C virus. The Resident was admitted to the facility on June 22, 2009. A review of the resident ' s clinical record revealed the followings: Nursing note March 17, 2010 at 3:00 PM: " Alert and responsive CXR (Chest X-ray) done [Related to] coughing." A nursing note dated March 17, 2010 at 3:00 PM: "...Rt [Right] upper lung field pneumonia infiltrate. PMD [Primary doctor] ordered the resident to be sent to the nearest ER. [Emergency Room] The ambulance came and took the resident to the hospital. "	F 278	**F tag 278 # 11 Resident #24** 1. Residents' #12, 24, and CBL13 have been discharged and no further corrections can be made. 2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status will be corrected. 3. A review of the importance of accuracy in assessments was completed on with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date. 4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	 10/19/10 10/19/10 10/28/10

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F 278	Continued From page 51	F 278	**F tag 278 # 12 Resident #CBL 13**	
	March 17, 2010 "Transfer Summary Form": "Past history: ...Hepatitis C virus ... "		1. Residents' #12, 24, and CBL13 have been discharged and no further corrections can be made.	
	"Medications: Thiamine 100mg P. O. [By mouth] daily, Levaquin 500mg P.O. daily for the next 7 days ... " "Diagnostic impression: Right pneumonia, hepatitis C virus ..."		2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of assessment. Any assessment that does not accurately reflect the resident status will be corrected.	10/19/10
	A nursing note dated March 30, 2010 at 3:30 PM stated: "Readmitted to this facility ..."		3. A review of the importance of accuracy in assessments was completed on with the interdisciplinary team. Each team member responsible for assessment is held accountable for accuracy in section completion. The RN Coordination will verify section completion. Each team member completing an assessment will list sections completed with a signature and date.	10/19/10
	A telephone interim order dated March 30, 2010 at 11:20 PM that directed "Zithromax 250mg I tablet P.O. QD [Daily] x10days for pneumonia."		4. A monthly audit of MDS completion compliance will be completed and the results of the audit will be submitted to the CQI committee quarterly DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/28/10
	An untimed telephone order dated April 15, 2010 that directed "Stool specimen for C-Diff and oval parasite"			
	An telephone interim order dated April 15, 2010 at 2:00 PM that directed " Follow-up CT scan of chest: Dx [Diagnosis] Pneumonia."			
	An telephone interim order dated April 16, 2010 at 2:00 PM that directed "Resident on contact isolation for C. Diff. in stool, Flagyl 250 mg TID [Three times daily] x10 PO days Dx. C. Diff, Transfer resident to room ...for contact isolation."			
	A nursing note dated April 15, 2010 at 8:00 AM "...Resident had a large slimy jelly stool [with] no odor at this time. Stool specimen [obtained] for C. Diff.-ova parasite to be ruled out. "			

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F 278	Continued From page 52 "...Resident's stool culture was positive for C. Diff ...MD] made aware. New orders given for resident to be place on isolation. Resident to start Flagyl 250 mg TID [Three times daily] x 10days ..." A further review of the resident's clinical record revealed that a quarterly MDS completed on April 16, 2010 failed to code the resident in Section I2 "Infections" for C. diff., Pneumonia, and viral hepatitis. A face-to-face interview was conducted with Employee # 4 on August 10, 2010 at approximately 12:00 PM. After reviewing the resident's clinical record, he/she acknowledged the above findings. The record was reviewed August 10, 2010. Facility staff failed to accurately code Resident CBL 13's quarterly MDS of April 16, 2010 for pneumonia, C. Diff. and Hepatitis C virus. A face-to-face interview was conducted with Employee #4 on August 9, 2010 at approximately 12:15 PM. After reviewing the resident's clinical record, he/she acknowledged the above findings. The record was reviewed August 9, 2010.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		

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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 interview for 12 of 26 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to initiate care plans for right eye irritation for one (1) resident, allergies for one (1) resident, altered skin integrity for two (2) residents, multiple medications for one (1) resident, falls and incontinence for one (1) resident, Plavix for one (1) resident, diagnoses for five (5) residents, utilization of side rails for one (1) resident and discharge planning for one (1) resident. Residents # 2, 4, 5, 6, 7, 12, 15, 16, 19, 21, 23 and CBL13.

The findings include:

1. Facility staff failed to initiate a care plan for right eye irritation for Resident #2.

According to a Nursing Progress Note dated and time April 10, 2010 at 2:00 PM Resident #2 " Right eye redness noted in lower inner corner of the eye. No drainage, discomfort or itching in eye

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483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

Ftag 279 #1 Resident #2

1. An assessment note reflecting the absence of infection for Resident #2 is completed on 10/18/10. A care plan to address this concern is not needed — 10/19/10

2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's status will be corrected. — 10/19/10

3. Care Area Triggers identified through completion of the comprehensive assessments will be care planned within seven days. The MDS Coordinator will ensure supporting documentation is available to support care planning decisions. The date and location of the supporting documentation will be entered on the CAT summary and signed by the MDS Coordinator indicating completion. Care plans will be reviewed and revised according to an established timetable that meets the objectives and approaches set forth in each individualized triggered area. — 10/19/10

4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results — 10/28/10

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F 279	Continued From page 54 at 11:15 AM. Physician notified to just monitor eye and have NP (Nurse Practitioner see on Monday ... " April 11, 2010 at 11:00 PM " Right eye sclera redness clearing ... " April 13, 2010 at 8:30 AM " ...ABT (Antibiotic) Gentamycin to both eyes in progress ... " Review of all care plans initiated since April 2010 lacked evidence of a care plan initiated for right eye redness. A face-to-face interview was conducted with Employee #6 on August 5, 2010 at approximately 3:40 PM after review of the care plans he/she acknowledged the above findings. The record was reviewed on August 5, 2010. 2. Facility staff failed to develop a care plan for falls and incontinence for Resident #4. According to the resident ' s admission Minimum Data Set (MDS) assessment completed November 25, 2009, and the quarterly Minimum Data set (MDS) assessments completed February 24, 2010 and May 19, 2010, the resident was coded in Section H as incontinent of bowel and bladder function. Physician ' s orders dated and signed June 2, 2010 directed, " Treatments ... Fall Precautions. " A review of the nursing notes dated June 9, 2010 revealed; Resident #4 sustained a fall without injury on June 9, 2010. A review of the resident ' s care plans lacked evidence that facility staff initiated a care plan with	F 279	Continued From page 54 of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. **F tag 279 #2 Resident #4** 1. A care plan addressing fall precaution addressing precautions for bowel and bladder incontinence for Resident #4 was completed on 10/18/10. 2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's status will be corrected. 3. Care Area Triggers identified through completion of the comprehensive assessments will be care planned within seven days. The MDS Coordinator will ensure supporting documentation is available to support care planning decisions. The date and location of the supporting documentation will be entered on the CAT summary and	 10/18/10 10/19/10 10/19/10

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signed by the MDS Coordinator indicating completion. Care plans will be reviewed and revised according to an established timetable that meets the objectives and approaches set forth in each individualized assisting the residents to attain and maintain revised according to an established timetable that meets the objectives and approaches set forth in each individualized triggered area.

4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. 10/28/10

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F 279	Continued From page 55 appropriate goals and approaches for bowel and bladder incontinence and fall. A face-to-face interview was conducted on August 3, 2010 at approximately 2:30 PM with Employee #5. He/she reviewed the resident ' s clinical record and acknowledged that the resident ' s record lacked evidence that a care plan was initiated for incontinence and falls. He/she said, " I will initiate the care plan right away. " The record was reviewed on August 3, 2010. 3. Facility staff failed to develop a care plan for potential drug interactions for the use of nine (9) or more medications for Resident #5. Section O, Medications, of the quarterly Minimum Data Set (MDS) completed June 4, 2010 revealed that Resident #5 ' s medication regimen included thirteen (13) different medications. Physician ' s orders dated July 7, 2010 revealed the following medications for prescribed for the resident: Norvasc, Aricept, Vitamin C, Fentanyl, Ferrous Sulfate, Lasix, Hydralazine, Megace, Multivitamins, Percocet, Ammonium lactate and Polysporin powder. The care plan most recently updated June 3, 2010 lacked problem identification, goals and approaches to address the potential interactions associated with the use of multiple medications. The record was reviewed August 2, 2010. 4. The facility staff failed to initiate a care plan for skin alteration with appropriate goals and approaches for Resident #6.	F 279	Continued From page 55 **F tag 279 #3 Resident #5** 1. The care plans for Resident's #5 & 12 have been updated to reflect the potential for adverse reactions associated with multiple medication usage on 10/18/10. Residents have been assessed and no associated reactions are noted. 2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's status will be corrected. 3. Care Area Triggers identified through completion of the comprehensive assessments will be care planned within seven days. The MDS Coordinator will ensure supporting documentation is available to support care planning decisions. The date and location of the supporting documentation will be entered on the CAT summary and signed by the MDS Coordinator indicating completion. Care plans will be reviewed and revised according to an established timetable that meets the objectives and approaches set forth in each individualized assisting the residents to attain and maintain revised according to an established timetable that meets the objectives and approaches set forth in each individualized triggered area. 4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical,	 10/19/10 10/19/10 10/28/10

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mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

F tag 279 # 4 Resident #6

1. The plan of care for Resident #6 is updated to reflect appropriate goals and approached for skin alterations on 10/18/10. Resident #6 skin alterations are now resolved. 10/19/10

2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's status will be corrected. 10/19/10

3. Care Area Triggers identified through completion of the comprehensive assessments will be care planned within seven days. The MDS Coordinator will ensure supporting documentation is available to support care planning decisions. The date and location of the supporting documentation will be entered on the CAT summary and signed by the MDS Coordinator indicating completion. Care plans will be reviewed and revised according to an established timetable that meets the objectives and approaches set forth in each individualized triggered area. 10/19/10

4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. 10/28/10

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F 279	Continued From page 56 Review of the treatment record for the month of July, signed June 25 revealed " Right Leg - cleanse w/NS (with Normal Saline) apply Neosporin every shift and leave open to air until healed. " According to the Non-Pressure area Documentation Form first initiated June 19, 2010 and last updated July 30, 2010 revealed that Resident #6 has a right leg shin wound no type and staging identified. Review of the care plans last updated June 22, 2010 lacked evidence of a care plan initiated for a right leg shin wound. A face-to-face interview was conducted with Employee #5 on August 5, 2010 at approximately 8:5 0 AM after review of the care plans he/she acknowledged that the record lacked evidence of a care plan with appropriate goals and approaches for a right leg skin alteration. The record was reviewed on August 5, 2010. 5. Facility staff failed to develop a care plan hypertension, and communication for Resident #7. An annual Minimum Data Set (MDS) assessment completed on April 16, 2010 revealed that the resident presented with impaired communication in Section C (Communication/Hearing Patterns). His/her diseases included hypertension Section I (Disease Diagnoses). A further review of the resident ' s clinical record revealed that his/her quarterly care plan was last updated on July 20, 2010 and lacked documented evidence that facility staff initiated care plans with	F 279	Continued From page 56 **F tag 279 # 5 Resident #7** 1. Care plans for Resident #7 has been updated to reflect goals and approaches for impaired communication on 10/18/10. Resident #7 does not have a diagnosis of hypertension. Resident #7 uses body language understood by staff to indicate her wishes/needs. 2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's status was corrected. 3. Care Area Triggers identified through completion of the comprehensive assessments will be care planned within seven days. The MDS Coordinator will ensure supporting documentation is available to support care planning decisions. The date and location of the supporting documentation will be entered on the CAT summary and signed by the MDS Coordinator indicating completion. Care plans will be reviewed and revised according to an	10/19/10 10/19/10 10/19/10

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F 280	Continued From page 64	F 280		
	A face-to-face interview was conducted with Employee #7 on August 3, 2010 at 3:00 PM. S/he stated that the physician ' s plan of care did not include pulse oximetry testing and that the intervention would be removed from the nursing plan of care. The record was reviewed August 3, 2010.		**F tag 280 #2 Resident #5**	
	2. Facility staff failed to update Resident #5 ' s nutritional risk and diabetes care plan.		1. The plan of care for Resident #5 has been updated to reflect the physician's order for no added salt and no concentrated sweets. The nutritional risk and diabetes care plans have been specifically addressed to reflect these items. Resident # 5 has been assessed by the dietician and these items remain necessary for continued care.	10/19/10
	a.) The nutritional risk care plan was last updated March 4, 2010. The interdisciplinary care team convened and updated the resident ' s plan of care on June 3, 2010; however, the nutritional risk care plan was not updated.			
	b.) The Diabetes care plan was updated June 2, 2010 and included a prescribed diet of 1800 calories with no concentrated sweets.		2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's current status have been corrected.	10/19/10
	According to physician ' s orders, Resident #5 ' s diet was liberalized to " no added salt no concentrated sweets " on February 4, 2010.			
	Facility staff failed to amend the diabetes care plan to include the current dietary regimen of the resident. The record was reviewed August 2, 2010.		3. Care Area Triggers identified through completion of the comprehensive assessments will be care planned within seven days. The MDS Coordinator will ensure supporting documentation is available to support care planning decisions. The date and location of the supporting documentation will be entered on the CAT summary and signed by the MDS Coordinator indicating completion. Care plans will be reviewed and revised according to an established timetable that meets the objectives and approaches set forth in each individualized triggered area.	10/19/10
	3. The facility staff failed to review and revise a care plan for multiple falls with appropriate goals and approaches for Resident #6.			
	A review of the care plans last updated June 22, 2010 revealed that the care plan lacked evidenced of revision with appropriate goals and			

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4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.

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F 280	Continued From page 65 approaches for a fall occurring March 3, 2010, March 23, 2010 and July 16, 2010. According to the Nursing Progress Notes dated and signed March 3, 2010 at 8:00 AM, " Resident was observed sitting on floor in dayroom and stated, I just fell ... " Nursing Progress Notes dated and signed March 23, 2010 3:00 PM revealed the following: " Resident alert and verbal. s/p (status/post) fall, no changes in mental status noted ... " Nursing Progress Notes dated and signed July 16, 2010 at 9:00 PM revealed " resident was observed sitting on the floor in her room, stated " I did not fall, like to sit on the floor." A face-to-face interview was conducted on August 5, 2010 with Employee #6 at approximately 8:50 AM. After review of the care plans he/she acknowledged that form lacked evidenced of revision with appropriate goals and approaches for multiple falls. The record was reviewed on August 5, 2010. 4. A review of the clinical record for Resident #9 revealed facility staff failed to amend the Fall Prevention Care Plan to include approaches and interventions for transfer and ambulation. Documented in the " approaches and interventions " section of the " Falls " care plan was " assist with transfers and ambulation as follows: " The section of the plan allotted for interventions remained blank. The plan lacked evidence of approaches and	F 280	**F tag 280 #3 Resident #6** 1. The care plan for Resident #6 has been updated to incorporate goals and approaches regarding multiple falls. 2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's current status have been corrected. 3. Care planning is an on-going process. Each member of the interdisciplinary team will introduce topics for care planning. The MDS coordinator will coordinate the completion of care plans utilizing the comprehensive assessment and any subsequent changes in the resident's condition. 4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. **F tag 280 #4 Resident #9**	10/19/10 10/19/10 10/19/10 11/19/10

Continued from page 66.

1. The Fall Prevention Care plan has been reviewed and revised to include approaches and interventions to guide staff in measures to assist Resident #9 in transfer and ambulation. 10/19/10

2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's current status have been corrected. 10/19/10

3. Care planning is an on-going process. Each member of the interdisciplinary team will introduce topics for care planning. The MDS coordinator will coordinate the completion of care plans utilizing the comprehensive assessment and any subsequent changes in the resident's condition. 10/19/10

4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. 11/19/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING ____ B. WING ____	08/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 66 interventions that staff were to follow to assist the resident with transfer and ambulation. The findings were reviewed and confirmed during a face-to-face interview with Employee #5 on August 9, 2010 at 4:30 PM. 5. Facility staff failed to review and revise a care plan with appropriate goals and approaches for removal of pressure tape post dialysis for Resident #10. During an observation on August 3, 2010 at approximately 2:00 PM, Resident #10 was observed in his/her wheelchair with a pressure dressing noticed on the left upper arm covering the AV site. According to the Physician Order Form signed and dated July 2, 2010 directed " Dialysis on M-W-F (Monday-Wednesday-Friday) at ...10:00 AM, Assess AV Shunt every shift, Remove pressure tape from AV (arterial venous) site at 11:00 PM on dialysis days. " Review of the Nursing Progress Note Identified that the resident returned from dialysis on August 2, 2010 at approximately 2:00 PM. Review of the care plans last updated July 13, 2010 lacked evidenced of revisions to include " Remove pressure tape from AV site at 11:00 PM on dialysis days " A face-to-face interview was conducted with Employee #7 on August 3, 2010 at approximately 2:10 PM after review of the care plans and the resident ' s left upper arm, he/she acknowledged that the tape was still on from the	F 280	**F tag 280 # 5 Resident #10** 1.The care plan for Resident #10 has been updated to include removal of a pressure dressing from the graft site post dialysis. The resident has been assessed and no complications have been identified. Documentation of pressure dressing removal is noted on the Treatment Record. 2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's current status have been corrected. 3. Care planning is an on-going process. Each member of the interdisciplinary team will introduce topics for care planning. The MDS coordinator will coordinate the completion of care plans utilizing the comprehensive assessment and any subsequent changes in the resident's condition. 4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10 10/19/10 10/19/10 11/19/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 67 previous dialysis day and that it should have been removed last night August 2, 2010. He/she also acknowledged that the care plan lacked evidence of revisions to include removal of pressure tape post dialysis. The record was reviewed on August 3, 2010. 6. Facility staff failed to review and revise a care plan for falls with identified goals and approaches for Resident #20. According to the Nursing Progress Notes dated and signed May 14, 2010 at 8:30 PM " C.N.A. (Certified Nursing Assistant) assigned to resident stated " while she was putting pt (patient) in bed from her wk (work), slid to the ground. Fall was witnessed C.N.A. stated patient did not hit her head, that she fell on her buttocks. " Review of the care plans last up dated May 5, 2010 lacked evidence of identification of the fall with appropriate goals and approaches. A face-to-face interview was conducted on August 5, 2010 with Employee #6 at approximately 3:50 PM. After review of the care plans he/she acknowledged the above. The record was reviewed on August 5, 2010. 7. A review of the clinical record for Resident #CBL3 revealed facility staff failed to review and revise the Smoking Care Plan to include approaches and interventions to address concerns related to Resident #CBL3's role in resident-to-resident altercations centered around smoking.	F 280	**F tag 280 #6 Resident #20** 1. The care plan for Resident #20 has been reviewed and revised to include approaches and interventions for fall safety. The fall of May 14, 2010 has been documented on the Fall Assessment Record. 2. A random audit of resident's assessments over the past ninety days will be completed to ascertain the accuracies of the care plan assessment. Any care plan lacking evidence of the resident's current status have been corrected. 3. Care planning is an on-going process. Each member of the interdisciplinary team will introduce topics for care planning. The MDS coordinator will coordinate the completion of care plans utilizing the comprehensive assessment and any subsequent changes in the resident's condition. 4. A random review of the care plans will be completed monthly evaluating the inclusion of goals and approaches associated with assisting the residents to attain and maintain the resident's highest practical physical, mental, and psychosocial well-being. Results of the audit will be submitted to the CQI committee monthly. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits.	10/19/10 10/19/10 10/19/10 11/19/10