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 280	Continued From page 68 A review of the resident ' s care plan most recently updated June 9, 2010 lacked evidence that the Smoking care plan was amended after the resident engaged in more than one altercation centered around smoking. According to a facility incident report dated August 1, 2010 and based on staff interview, Resident #CBL3 was engaged in more than one resident-to-resident altercations centered around smoking. A review of the clinical record on August 6, 2010 lacked evidence that the plan of care was reviewed and/or revised to include goals, objectives and interventions to address the resident and his/her role in smoking associated altercations. The findings were reviewed and confirmed during a face-to-face interview with Employee #5 on August 10, 2010 at approximately 4:00 PM. The record was reviewed August 6, 2010.	F 280	Continued From page 68 **483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **Ftag281** 1. Staff was remediated at the time of survey. 8/11/10 2. All residents have the potential to be affected by the potential practice. Wound competency has been conducted on the licensed staff; remediation has been made as needed. 10/19/10 3. Wound competencies will be completed on licensed staff during orientation and quarterly by the Educator. A report of competency results have been provided to the DON/Designee. 10/19/10 4.Results the audit will be submitted to the CQII 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 need and frequency of further audits. 10/28/10	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that facility staff failed to cleanse a resident ' s skin prior to the application of a topical cream in an isolated observation. Resident #5.	F 281		

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F 281	Continued From page 69 The findings include: Employee #16 was observed performing a wound treatment on Resident #5 on August 3, 2010 at 11:30 AM. Physician ' s orders dated July 7, 2010 directed Ammonium Lactate 12% cream " moisturize skin on both legs and feet with cream every day as directed. " Employee #16 removed Kerlix bandage from Resident #5 ' s lower extremities and applied Ammonium Lactate to the skin surrounding the site of the wound. The skin was not cleansed prior to the application of the cream. Facility staff failed to prevent the accumulation of naturally occurring wastes excreted from the skin and minimize the exposure to a potential source of infection by failing to cleanse the resident ' s skin prior to the application of a prescribed topical cream. [http://www.cdc.gov/mmwr and http://www.surgeryencyclopedia.com] The findings were reviewed with Employee #6 during a face-to-face interview on August 6, 2010 at approximately 2:30 PM. He/she acknowledged that the resident ' s skin should have been cleansed prior to the application of the cream.	F 281		
F 286 SS=D	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.	F 286	F 286 1.The Discharge tracking forms for January 27, 2010, March 11, 22010, April 17, 2010, May 5, 2010, June 16, 2010, and July 7, 2010, and Re-entry forms for April 29, 2010, May 13, 2010, and July 7, 2010 have been located and placed on the clinical record for Resident #24.	10/19/10

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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 57 goals and approaches for hypertension and communication. A face-to-face interview was conducted with Employee #7 on August 4, 2010 at approximately 4:35 PM. After a review of the care plans in the resident ' s clinical record. He/she acknowledged that the record lacked evidence that care plans were initiated hypertension, and communication. The record was reviewed on August 4, 2010. 6. Facility staff failed to develop a care plan for the potential adverse interaction for the use of nine (9) or more medications for Resident #12. A review of the clinical record for Resident #12 revealed a physician ' s order dated and signed July 2, 2010 included the following medications: Acetaminophen (Tylenol), Ascorbic Acid (vitamin C), Aspirin, Carvedilol (Coreg), Certavite-Lutein (Certagen), Docusate Sodium (Colace), Enulose, Fentanyl (Duragesic), Isosorbide Dinitrate (Isordil), Methoclopramide (Reglan), Omeprazole and Simvastatin. A review of the care plan last updated on July 28, 2010 revealed that there was no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #5 at approximately 10:00 AM on August 3, 2010. He/she acknowledged that the record lacked a care plan for the use of nine (9) or more medications. The record was reviewed on August 3, 2010. 7. Facility staff failed to develop a care plan	F 279	Continued From page 57 **F tag 279 #6 Resident #12** 1. Resident #12 is no longer a resident in the facility 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 the care plan assessment. Any care plan lacking evidence of the resident's status have been 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 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	10/19/10 10/19/10 10/19/10 10/28/10

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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 279	Continued From page 58 for Anemia for Resident #15. An admission Minimum Data Set (MDS) assessment completed on June 8, 2010 coded the resident in Section I (Disease Diagnoses) for diseases that included anemia. According to a history and physical completed on May 29, 2010, the resident ' s active problem included anemia. A further review of the resident ' s clinical record revealed that care plans initiated on June 2 and 18, 2010 for his/her active problems failed to include one for anemia. A face-to-face interview was conducted with Employee #7 on August 4, 2010 at approximately 4:45 PM. After a review of the care plans in the resident ' s clinical record. He/she acknowledged that the record lacked evidence that care plan was initiated for anemia. He/she stated, "That was an oversight. I will complete one right away." The record was reviewed on August 4, 2010. 8. Facility staff failed to develop a care plan for the potential adverse interaction for the use of nine (9) or more medications, allergy to Levaquin and left heel ulcer for Resident #16. A review of the clinical record for Resident #16 revealed physician ' s orders dated and signed July 2, 2010 that included the following medications: Aspirin, Enulose, Ferrous Sulfate, Finasteride (Proscar), Folic Acid (Folvite), Omeprazole (Prilosec), Simvastatin (Zocor), Theophylline, Vitamin B-1, Warfarin (Coumadin), and Xopenex [vial nebulization].	F 279	Continued From page 58 **F tag 279 #7 Resident #15** 1. The care plan for Resident #15 has been updated to include goals and approaches for care associated with a diagnosis of anemia. The resident has been assessed and no associated complications are evident. Resident #15 is receiving medical support for this diagnosis. 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 have been 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 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	10/19/10 10/19/10 10/28/10

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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 279 # 8 Resident #16

1. The care plans for Resident #16 has been updated to reflect goals and approaches associated with multiple medication usage and allergy to Levaquin, and right heel ulcer. The resident has been assessed and no associated contraindications or adverse reactions have been noted for multiple medication usage or allergy to Levaquin. Resident #16 is currently receiving treatment to the right heel ulcer. 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 10/28/10

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F 279	Continued From page 59 A review of the medical record revealed that Resident #16 had an allergy to Levaquin on the front of the chart. The physician order sheet and plan of care dated April 27, 2010 indicated the resident was allergic to Levaquin. The history and physical dated April 28, 2010 indicated the resident was allergic to Levaquin. A review of the facility ' s " Pressure Area Documentation Form " revealed, " July 16, 2010, acquired in house, [left] heel ulcer, length 2cm x width 2 cm, depth 0. " Nursing notes dated July 16, 2010 revealed, " wound rounds per [MD]. Left heel wound 2x2 cm in size, scab, no drainage. Tolerated procedure well." A review of care plans last updated on June 9, 2010 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications, allergies or left heel ulcer. A face-to-face interview was conducted with Employee #5 at approximately 4:00 PM on August 4, 2010. He/she acknowledged that the record lacked care plans for the potential adverse drug interaction for the use of nine (9) or more medications, allergies, and left heel ulcer. The record was reviewed August 4, 2010. 9. Facility staff failed to initiate a care plan for Plavix for Resident #19. According to the preprinted " Physician ' s Orders " signed by the physician on July 2, 2010, directed " Plavix 75mg, one tablet by mouth every day. "	F 279	Continued From page 59 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 279 #9 Resident #19 1. An updated care plan for Resident #19 is present reflecting goals and approaches for care associated with the use of an anticoagulant. The resident has been assessed and no evidence of bleeding has been identified.	10/19/10

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2. A 100% 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 60 A review of the resident ' s care plans revealed that there was no care plan initiated with appropriate goals and approaches for the use of Plavix. A face-to-face interview was conducted with Employee #5 on August 7, 2010 at approximately 3:30 PM. He/she acknowledged that there was no care plan for the use of Plavix. The record was reviewed on August 7, 2010. 10. Facility staff failed to develop a care plan for incontinence for Resident #21. A review of an annual MDS dated April 5, 2010 indicates that the resident was coded as incontinent of Bladder and bowel Sections H1a and H1b, respectively. The RAP summery triggered for an incontinence care plan and was coded yes. The Quarterly MDS completed July 28, 20110 is also coded for incontinence under sections H1a and H1b. A review of the clinical record failed to reveal documentation of a care plan with appropriate goals and approaches for incontinence. A face-to-face interview was conducted on August 5, 2010 with Employee #49, who stated " [Resident #21] is continent during the day, but uses briefs at night. He/she does not like to get up at night. The record was reviewed on August 5, 2010. 11. Facility staff failed to initiate discharge planning for Resident #23. 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	F 279	Continued From page 60 **F tag 279 # 10 Resident #21** 1. The care plans for Resident #21 is updated to include goals and approaches addressing incontinent care and brief usage. Resident #21 continues to use incontinent briefs at night. 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 have been 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 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	10/19/10 10/19/10 10/28/10

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F 279	Continued From page 61 apartment that is wheel chair accessible. The 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. No care plan with appropriate goals and approaches was identified for Discharge planning in the clinical record. 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. 12. Facility staff failed to develop care plans for Pneumonia and Hepatitis C for Resident CBL13. An admission Minimum Data Set (MDS) assessment completed on June 30, 2009 coded the resident in Section I(3) (Other current Diagnoses and ICD-9 codes) for diseases that included Hepatitis C Carrier ICD-9 code VO2.62. According to a history and physical in the resident ' s clinical record dated March 17, 2010, the resident ' s diagnostic impression included right upper lobe pneumonia, rule out tuberculosis and hepatitis C virus. According to a Social Progress Notes dated March 24, 2010, the resident ' s care plan update	F 279	Continued From page 61 implemented will be presented. The CQI committee will determine the need for other interventions and need and frequency of further audits. F tag 279 #12 Resident #CBL 13 1. Resident #CBL 13 is no longer a resident in the facility 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 the care plan assessment. Any care plan lacking evidence of the resident's status have been 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 279	Continued From page 62 was not done because he/she was hospitalized. A nursing " Progress Notes " of March 30, 2010 at 3:30 stated " Re-admitted to this facility ...was in the hospital. He/she received treatment for pneumonia ... " A further review of the resident ' s clinical record lacked documented evidence that facility staff initiated care plan with goals and approaches to address the resident ' s pneumonia and Hepatitis C. A face-to-face interview was conducted with Employee #5 on August 10, 2010 at approximately 10:30 AM. After a review of the care plans in the resident ' s clinical record, Employee #5 acknowledged that the record lacked evidence that care plan was initiated for pneumonia and Hepatitis C. After a review of the resident ' s clinical record, he/she acknowledged the aforementioned finding. The record was reviewed on August 10, 2010.	F 279	Continued From page 62 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
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		

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F 280	Continued From page 63 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for six (6) of 26 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to review and revise care plans for mode of transfer for one (1) resident, nutritional needs for one (1) resident, diabetes mellitus for one (1) resident, smoking related incidents for one (1) resident, falls for one (1) resident, altered skin integrity for one (1) resident, management of graft site for one (1) resident and management of chronic conditions for two (2) residents. Residents #1, 5, 6, 9, 10, 20 and CBL3. The findings include: 1. Facility staff failed to update the approaches and interventions of Resident #1 ' s Chronic Obstructive Pulmonary disease [COPD] and Congestive Heart Failure [CHF] care plan. The clinical record revealed that the COPD and CHF plan of care was most recently updated on June 16, 2010. Approaches and interventions for the management of these conditions included " Check pulse oximetry every shift and as needed. " A review of the Treatment Administration Record [TAR] lacked evidence of the assessment of pulse oximetry.	F 280	**483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** **Ftag 280 # 1 Resident #1** 1. The order for pulse oximetry was removed from the plan of care for Resident #1. Resident #1 has been assessed and is currently stable and do not this level of monitoring. 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 10/19/10

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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 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 CQI

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F 286	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 18 sampled residents, it was determined that facility staff failed to maintain 15 months of completed Minimum Data Set (MDS) assessments in Resident #12's active record. The findings include: A review of the clinical record for Resident #24 revealed the following discharge tracking forms were not on the active clinical record at the time of this review: January 27, 2010, March 11, 2010, April 17, 2010, May 5, 2010, June 16, 2010 and July 7, 2010. A review of the clinical record for Resident #24 revealed the following Reentry tracking forms were not on the active clinical record at the time of this review: April 29, 2010, May 13, 2010, and July 6, 2010. A face-to-face interview was conducted with Employee #4 at approximately August 9, 2010 at approximately 4:00 PM. He/she acknowledged that the discharge and reentry forms were not on the active clinical record. The record was reviewed on August 9, 2010.	F 286	2. A 100% audit of resident's discharged and returned over the past ninety days will be completed to ensure tracking forms are evident in the clinical record. Any clinical record lacking evidence of the discharge and re-entry tracking will be corrected.	10/19/10
			3. The MDS Coordinator within seven days of the Discharge and Re-entry will complete the tracking forms according to the OBRA required schedule. The Admissions Department will provide a listing each month to the Medical Records Department of residents discharged and re-admitted to the facility.	10/19/10
			4. The Medical Records Coordinator will review the clinical records monthly utilizing a listing provided by the Admissions Department of residents discharged and returned to the facility evaluating for the presence of tracking forms. A random audit will be completed monthly evaluating for the presence of 15months of Assessments present on the clinical record. 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
F 287 SS=D	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment. Annual assessment updates.	F 287		

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F 287	Continued From page 71 Significant change in status assessments. Quarterly review assessments. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, if there is no admission assessment. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment. Annual assessment. Significant change in status assessment. Significant correction of prior full assessment. Significant correction of prior quarterly assessment. Quarterly review. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.	F 287		

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F 287	Continued From page 72 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews for one (1) of 30 supplemental residents, it was determined that facility staff failed to complete the appropriate transfer, re-entry and discharge Minimum Data Sets (MDS) for Resident CBL 13. The findings include: Facility staff failed to complete appropriate transfer, re-entry and discharge MDS for Resident CBL 13. A review of the Resident CBL 13's clinical record revealed the followings: A nursing note dated March 17 2010 at 3:00PM that indicated that the resident was ordered transferred to the hospital by the physician. A nursing note dated March 30, 2010 at 3:30 PM that indicated that the resident was re-admitted to the facility. The last nursing note in the resident's clinical record dated May 17, 2010 at 4:00PM indicated that the resident was ordered transferred to the hospital by the physician. The resident has being out of the facility now for 84days, and according to Employees #2, 3, and 5 the resident's will be returned to the facility as soon as a single room becomes available. Further review of the resident's clinical record lacked documented evidence that facility staff completed appropriate transfer, re-entry and	F 287	1. Resident #CBL13 is currently discharged from the facility. A discharge tracking form for 3/17/2010 and Re-entry tracking form for 3//30/2010 for Resident# CBL 13 will be added to the clinical record 2. A 100% audit of resident's discharged and returned over the past ninety days will be completed to ensure tracking forms are evident in the clinical record. Any clinical record lacking evidence of the discharge and re-entry tracking will be corrected. 3. The MDS Coordinator within seven days of the Discharge and Re-entry will complete the tracking forms according to the OBRA required schedule. The Admissions Department will provide a listing each month to the Medical Records Department of residents discharged and re-admitted to the facility. 4. The Medical Records Coordinator will review the clinical records monthly utilizing a listing provided by the Admissions Department of residents discharged and returned to the facility evaluating for the presence of tracking forms. A random audit will be completed monthly evaluating for the presence of 15months of Assessments present on the clinical record. Results of the audit will be submitted to the CQI	10/19/10 10/19/10 10/19/10 10/19/10

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F 287	Continued From page 73 discharge MDS for the aforementioned dates. A face-to-face interview was conducted with Employee # 5 on August 9, 2010. After reviewing the resident's clinical record, he/she acknowledged the above findings. The record was reviewed August 9, 2010.	F 287	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 309 SS=H	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews for eight (8) of 26 sampled residents and six (6) supplemental residents, it was determined that facility staff failed to: manage a graft site per physician orders for one (1) resident, obtain specialty consultations for two (2) residents, administer oxygen therapy as prescribed for three (3) residents, discontinue eye drops and obtain an order for adaptive equipment for one (1) resident, clarify orders for type of isolation for one (1) resident, fully assess an eye injury sustained by one (1) resident, administer pain medications as prescribed for two (2) residents and for one (1) resident that sustained undue pain, failed to assess a sudden change in one (1) resident's respiratory condition, failed to have medication available for one (1) resident for 3 days, failed to administer psychotropic	F 309		

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F 309	Continued From page 74 medications for one (1) resident whose behaviors escalated in the absence of the medication, assess blood pressure per physician ' s orders for three (3) residents and consistently monitor a venous access device for one (1) resident. Residents #2, 4, 5, 10, 13, 16, 18, 25, CBL3, CBL8, CBL10, CBL11, and CBL14. The findings include: 1. Facility staff failed to acquire medication according to physician ' s order in a timely manner resulting in escalation of the resident's behaviors. Resident #2. A review of the MAR (Medication Administration Record) for Resident #2 indicated an order for Klonopin 0.25 1 tablet po (by mouth) q (every) 12 hours for agitated behavior, original order date July 22, 2010. Further review of the MAR revealed that the medication was not given on July 24th, 25th, 26th, as evidenced by the 6:00 AM and 6:00 PM doses being circled and that July 27th 6:00 AM dose was also circled. A review of the MAR's " medication not administered reason " section identified the following: July 24, 2010 6:00AM, not yet received by pharmacy; July 24, 6:00 PM Klonopin 0.25 mg awaiting supply not given; July 25, 2010 6:00 [no AM or PM time identified], Pharmacy called awaiting del. July 25th 6:00 PM Klonopin 0.25mg awaiting supply (delivery); not given; July 26th 6:00 AM Klonopin 0.25 mg C-2 form to be complete and faxed; July 26th 6:00 PM Klonopin 0.25mg awaiting	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING **Ftag 309** **#1 - Resident#2** 1. A review of Resident #2's current medication regimen has been completed. All medications are being administered as ordered and the resident's behaviors are under control. 2. A review of new physician orders for the past 30 days has been completed by the unit managers to assure medications have been received in a timely manner. Corrections made as needed. 3. A review of the process of the receipt of medications has been completed with the pharmacy consultant and the attending physician. Supervisors have been educated by the Director of Nursing, to check physician orders each shift, with each nurse team leader to ensure medications have been received and to implement corrective actions as needed. 4. An audit of this process will be conducted monthly by the Director of Nursing/designee. The results of the above audit will be reported 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.	10/19/10 10/19/10 10/19/10

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Pharm (Pharmacy) not given;
July 27th 8:00 PM Klonopin 0.25 mg [documented as given] anxiety c/o (complained of) shaking - effective.

According to the Nurses Progress Note:

Dated and signed July 22, 2010 at 4:00 PM, Resident #2 was " readmitted to the facility. "

Dated and signed July 23, 2010 11:00 PM, " Klonopin order faxed to MD (Medical Doctor) for Authorization. "

Nurses Progress Note dated and signed July 25, 2010 at 10:00 PM, " The resident ' s Klonopin, still awaiting delivery. "

Nurses Progress Note dated and signed July 26, 2010 at 7:00 AM Pharmacy called for Klonopin 0.25 mg (milli gram) tab. " Has not received since ordered on July 22, 2010. "

Nurses Progress Note dated and signed July 27, 2010 at 8:00 AM " ...[Resident #2] OOB (out of bed) in w/c (wheel chair) throughout the night he/she was pulling items out of the carts and infection control cart. He/She was going through trash ... "

Nurses Note dated and signed July 27, 2010 at 4:00 PM "[Resident #2] ...riding [wheelchair] up and down the hallway yelling ... "

Nurses Progress Note dated and signed July 27, 2010 Physician started new meds for Seroquel today. "

Nurses Progress Note dated and signed July 30,

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F 309	Continued From page 76 2010 9:30 PM " resident received all evening meds (medications). " A face-to-face interview was conducted with Employee #6 on August 2, 2010 at approximately 3:40 PM. He/she acknowledged the above findings of the escalating behaviors and indicated that the " Klonopin C-2 form was faxed to the MD (Medical Doctor) from the facility and that the MD faxed to pharmacy. Pharmacy did not give a cause for the delay. The medications were sent on July 27, 2010 at night. The record was reviewed on August 5, 2010. 2. Facility staff failed to follow physician ' s order for discontinuation of eye drops and obtain an order for adaptive equipment for Resident #4. a.) The physician ' s orders dated and signed July 2, 2010 directed, " Isopto Homatropine 5% drops ...instill one (1) drop in each eye every day for glaucoma. An interim telephone order dated July 21, 2010 directed, " [discontinue] isopto homatropine 5% drop. A review of the July 2010 Medication Administration Record (MAR) revealed that Isopto Homatropine 5% was initialed as being given daily at 9:00 AM on July 22-30, 2010. There was no evidence that facility staff discontinued the Isopto Homatropine eye drops on July 21, 2010. A face-to-face interview was conducted on August 4, 2010 approximately 1:00 PM with Employee #5. He/she acknowledged that the	F 309	Continued From page 76 **Ftag 309** **#2a – Resident#4** 1. The eye drops were discontinued for Resident #4 on 7/2/10. 2. An audit was completed on physician orders over the past 30 days. Corrections were implemented as needed. 3. New orders will be reviewed daily by the unit managers/supervisors to assure that they have been transcribed correctly. All medical records will have a 24-hour chart review of all orders written for the day by the night shift team leader. All new orders will be reviewed for accuracy, start/stop dates, transcription on MAR/TAR. The night shift supervisor will check with each team leader on each unit to ensure that the process is completed and orders are sent to pharmacy. 4. Problems identified in the above process will be reported to the CQI committee monthly for three months, then quarterly by the DON or 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 for frequency of further audits.	10/19/10 10/19/10 10/19/10 10/28/10

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F 309	Continued From page 77 Isopto Homatropine eye drops was not discontinued as directed by the physician on July 21, 2010. The record was reviewed on August 3, 2010. Resident #4 was observed on August 3, 2010 at approximately 12 Noon wearing a splint on left arm. A review of the resident ' s record lacked evidence that the facility staff obtained a physician ' s order to administer an arm splint to the resident. A face-to-face interview was conducted with Employee #45 and Employee #46 on August 4, 2010 at approximately 11:10 AM. After a review of the resident ' s record and an observation of the resident, he/she acknowledged that the resident ' s clinical record lacked evidence that the facility staff obtained a physician ' s order to administer an arm splint to the resident. The record was reviewed on August 4, 2010. Facility staff failed to properly manage Resident #4 ' s gastrostomy tube in accordance to facility policy as it related to patency, subsequently resident had gastrostomy tube replaced. According to physician ' s orders signed July 2, 2010 directed, " Enteral Protocol ... Check tube for proper placement prior to each feeding, flush or medication administration... Flush tube with 250ml [millimeters] of water every 4 [four] hours .... Flush tube with 30ml water before and after medication as needed and 5ml water between each medication Nurse ' s note dated July 3, 2020 at 8:00 AM	F 309	Continued From page 77 **Ftag 309 #1a** 1. The order for a splint was obtained on 8/4/10 for Resident #4. 2. Rehab staff will assure that orders for splints are obtained prior to leaving adaptive equipment at the bedside. Inter-depart communication form will be used by therapy and nursing to assure orders are in place. 3. New orders will be reviewed daily by the unit managers/supervisors to assure that they have been transcribed correctly. All medical records will have a 24-hour chart review of all orders written for the day by the night shift team leader. All new orders will be reviewed for accuracy, start/stop dates, transcription on MAR/TAR. The night shift supervisor will check with each team leader on each unit to ensure that the process is completed and orders are sent to pharmacy. 4. Quarterly Rehab will audit splints and the results of the audit will be reported to the CQI committee quarterly by the Rehab coordinator. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for other interventions and need for frequency of further audits. **Ftag 309 #1b** 1. Resident #4 was sent to the hospital at the time of the incident. 2. An audit of residents with G-tube to assure patency and flushing per facility procedure. Physician order correction have been made as needed.	8/4/10 10/19/10 10/19/10 10/28/10 10/19/10

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F 309	Continued From page 78 revealed, " GT [Gastrostomy Tube] is very short due to breakage while milking it. It is a PEG [Percutaneous Endoscopic Gastrostomy] GT and need to go out to be replaced. " According to " Taber ' s Cyclopedic Medical Dictionary " , 20th edition, copyright 2005, page 1367 defined " milking as ... removal of the contents of a tubular structure by compressing the tube with the fingers and moving them along the course of the tube and away from the origin .... This maneuver forces material out of the tube that might not otherwise be seen. " According to your " Policy & Procedure No. 1012, Tube Feeding, " Effective: 02/2005, Revised: 08/03/07 " , directed the following: " Procedures, Gravity Feeding Tube ... **#7** [seven] ... Insert 30cc of air into the feeding tube while holding the stethoscope over the epigastrium to listen for gurgling sound. (If none is heard, do not start feeding and report to supervisor or charge nurse), Pump Feeding... Flush feeding tube with prescribed bolus flush by using an eccentric or catheter tip syringe as often as prescribed. " A review of the " EGD [Esophagogastroduoenoscopy] Report " completed on July 20, 2010 revealed, " Indications: Malfunctioning GT]. Other findings: S/P [Status Post} PEG placement. GT was replaced with a #20 [number 20] replacement tube. A face-to-face interview was conducted with Employees **#4** and Employee **#5** on August 5, **2010** at 5:59 PM. Both stated " we do not milk the tubing. " The record was reviewed on August 5, 2010.	F 309	Continued From page 78 3. Staff have been educated to obtain an order for liquid medications for residents with G-tubes. A G-tube skills competency has been completed by the educator and DON.	10/19/10
			4. Random audit of medication pass with G-tubes will be completed by the Educator. The results of this audit will be reported to the CQI committee monthly for three months then quarterly by the Educator/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 for frequency of further audits.	10/28/10
			practice. An audit was conducted of residents **Resident#5** 1. Resident #5 venous access device was assessed and flushed at the time of survey. There were no redness and/or drainage observed..	8/2/10
			2. All residents with Venous Access Devices have the potential to be affected by this with Venous Access Devices.	10/19/10
			3. Systematic changes/measures implemented to correct this practice include staff education, which has been provided on assessment and documentation of venous access devices.	10/19/10
			4. Unit Managers will complete audits monthly, which will be provided to the DON/designee of problems identified and corrective actions implemented.	10/28/10

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F 309	Continued From page 79 3. Upon review of the clinical record for Resident #5, it was determined that facility staff failed to assess a venous access device [VAD], blood pressure, obtain an Ear, Nose and Throat [ENT] specialty consultation and administer medications that were labeled and dispensed for the resident. According to the History and Physical Examination dated August 23, 2009, Resident #5 ' s diagnoses included hypertension, anemia, peripheral vascular disease, degenerative joint disease, chronic venous stasis wounds and angioedema. a.) Facility staff failed to assess Resident #5 ' s Porta-cath [VAD] per physician orders. Physician ' s orders dated July 7, 2010 directed " assess Porta-cath insertion site every 3 days for redness, warmth, swelling and drainage. " A review of the monthly Treatment and Medication Administration Records [TAR/MAR] revealed that the Porta-cath assessment schedule was annotated on the TAR by a darkened box. Licensed staff initialed inside the box when an assessment was performed. The boxes remained blank on the following dates, reflecting that the assessments were not performed: May 2nd, June 10th, July 1st and 25th 2010. Licensed staff failed to consistently assess the resident ' s Porta-cath every three (3) days in accordance with physician ' s orders. The record was reviewed August 2, 2010. b.) Facility staff failed to assess Resident #5 ' s	F 309	Continued From page 80 **Resident #5b** 1. The corrective action achieved for **Resident #5** includes the review of Resident#5's blood pressure monitoring revealed that no others were missed. 2. All residents have the potential to be affected by this practice. Residents receiving hypertensive medications had a review of their MAR. 3. The systematic change/measures taken to correct this practice entails: staff education on the importance of documentation on the MAR/TAR and revised shift report, which includes the review of MARs/TARs. 4. Unit Managers will complete audits monthly and a report will be provided to the DON. The results of this 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 will be presented. The CQI committee will determine the need for other interventions and need for frequency of further audits.	10/19/10 10/19/10 10/19/10 10/28/10

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F 309	Continued From page 80 blood pressure in accordance with physician ' s orders. Resident #5 ' s medication regimen included Norvasc 5mg daily and Hydralazine 50mg three times daily by mouth for hypertension. Physician ' s orders dated July 7, 2010 [originated July 28, 2009] directed blood pressure assessments every week at 6AM, 2PM and 10PM for hypertension. A review of the monthly Treatment and Medication Administration Records [TAR/MAR] revealed that the blood pressure assessment schedule was annotated on the TAR by a darkened box. Licensed staff documented the blood pressure reading inside the box when an assessment was performed. The boxes remained blank on the following dates, reflecting that blood pressure assessments were missing: April 1st, May 6th, 20th, 27th, June 2nd, 9th, 16th, 23rd, 30th, July 7th, 14th, 21st, and 28th, 2010. Facility staff failed to consistently assess Resident #5 ' s blood pressure on three (3) occasions weekly in accordance with physician ' s orders. The record was reviewed August 2, 2010. c.) Facility staff failed to obtain an ENT specialty consultation per physician orders. Physician ' s order dated February 16, 2010 directed " ENT appt in 3 months " A review of the May 2010 TAR revealed that an ENT appointment scheduled for May 11, 2010 was cancelled. The clinical record lacked evidence of a reason for the cancellation and	F 309	Continued From page 80 **Resident#5 C** 1. The corrective action achieved for Resident #5, is that an ENT consultation was completed on 8/24/10. 2. All residents with consultation orders have the potential to be affected by this practice. An audit has been completed by the unit secretary of appointments for the past 30 days to assure completion of problems identified have been corrected. 3. Systematic changes/measures to prevent this practice from reoccurring entails: staff education has been completed by the DON regarding the process for appointment scheduling and follow-up. The unit secretaries will complete weekly audits of appointments and provide a report to the DON. 4. The results of the above audit will be reported to the CQI committee monthly for three months then quarterly by DON/ designee 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 further interventions and need and frequency of further audits. 4WTJ11	8/24/10 10/19/10 10/19/10 10/28/10

Continued From page 81

Ftag 309 #5d

1. Medications were ordered for Resident #5 and received.	8/11/10
2. Review of MARs has been completed to assure that medications have been received as ordered.	10/19/10
3. Staff has been educated by the pharmacist on the ordering and receiving of medications.	10/19/10
4. An audit of this process will be conducted monthly by the Director of Nursing/designee. The results of the above audit will be reported 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

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F 309	Continued From page 82 there was no evidence that Resident #5 had been rescheduled. 4. Facility staff failed to follow physician ' s orders for wound treatment for Resident #5. The following were observed on August 2, 2010 at approximately 4:30 PM: According to the Physician ' s Orders dated and signed by the physician on July 2, 2010 it was directed that staff label and dispense tape for Resident #5 at 11:00 PM on dialysis days. During a wound treatment observation for Resident #5 on August 3, 2010 at 10 AM, it was observed that Resident #5 had a dressing covering the left arm AV site was noted in place. Physician ' s orders dated July 7, 2010 prescribed the administration of Ammonium Lactate 12% to both legs daily and cleanse the wound on the left shin with wound cleanser, pat dry, apply Aquacel Ag and cover. Medihoney and cover. Employee #16 was interviewed on August 3, 2010 at approximately 2:00 PM after observing Resident #5's left AV site dressing. She stated that the tape should have been removed. This observation was made on August 3, 2010. A face-to-face interview was conducted with Resident #13 on August 3, 2010 at approximately 2:30 PM. He/she stated that Resident #5 ' s blood pressures were assessed by the nurses. According to the history and physical examination dated Sept 19, 2009, Resident #13 ' s diagnoses included but were not limited to: diabetes mellitus, atherosclerotic cardiovascular disease, congestive heart failure emphysema and	F 309	Continued From page 82 **#4- Resident#10** 1. The tape was removed at the time of the survey for Resident #10 and the staff was remediated. 2. A review has been completed of residents receiving dialysis by the unit manager to assure orders are being implemented as ordered by the physician. 3. The educator has provided in-service training to the staff on care of dialysis access sites. 4. Random audits of dialysis shunts will be completed weekly by the supervisor and corrective actions made as needed. **Ftag 309 #5** 1. Resident #13, we are unable to correct the cited deficiency for pain medication. Staff was remediated at the time of the survey. 2. Review of residents with scheduled pain medication and those receiving scheduled pain medication prior to wound care has been completed. 3. An in-service for staff has been completed by the educator on pain management. 4. An audit of this process will be conducted monthly by the Director of Nursing/designee. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly. A report of problems identified and corrective actions implemented will be presented. The CQI	8/3/10 10/19/10 10/19/10 10/28/10 8/4/10 10/19/10 10/19/10 10/28/10

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F 309	Continued From page 83 chronic obstructive pulmonary disorder. The resident ' s medication regimen included Lisinopril 20mg daily for hypertension. a.) Physician ' s orders dated July 2, 2010 [originated March 22, 2006] directed, " [assess] blood pressure every Tuesday. " A review of the Medication Administration Records [MAR] for June and July 2010 lacked evidence of blood pressure assessments. b.) Physician ' s orders dated July 2, 2010 [originated September 22, 2009] directed " Bengay Ultra regular strength 5% patch, apply one patch to skin of right shoulder every morning at 9AM and remove at 9PM for pain. " A review of the Medication Administration Record [MAR] for July 2010 revealed the resident ' s pain medication, Bengay was not administered July 1st thru 4th, 6th and 7th. The record lacked evidence of a reason why the medication was omitted. The findings were reviewed and confirmed during a face-to-face interview with Employee #7 on August 4, 2010 at approximately 12:30 PM. The record was reviewed August 4, 2010. 6. Facility staff failed to administer oxygen continuously to Resident #16 according to physician ' s order, subsequently resident was transferred to hospital with respiratory distress. According to the physician ' s admitting evaluation history dated April 28, 2010, revealed chief complaint of shortness of breath. Diagnosis: hypertension, chronic obstructive pulmonary disease, atrial fibrillation, coronary artery disease,	F 309	Continued From page 83 committee will determine the need for other interventions and the frequency of further audits. Ftag 309 #6 1. **Resident #16** was transferred to hospital at the time of survey. Staff was remediated at the time of survey. 2. An audit has been completed on residents receiving oxygen therapy by the unit managers. Corrective actions have been implemented as needed. 3. Staff education has been completed on respiratory assessment and the use of oxygen by the educator. 4. A monthly audit of respiratory care and services will be completed by the unit manager/ designee monthly for three months then quarterly and a report provided to the DON. 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 will be presented. The CQI committee will determine the need for other interventions and need for frequency of further audits.	8/3/10 10/19/10 10/19/10 10/28/10

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F 309	Continued From page 84 and cardiomyopathy. According to resident ' s clinical record, resident was admitted on April 27, 2010 to the facility. Resident was admitted to [hospital] on April 28, 2010 with chief complaint of worsening shortness of breath and lethargy/altered mental status. Resident was discharged back to skilled nursing facility on May 11, 2010. On May 15, 2010, resident was admitted with chief complaint of shortness of breath, cough and chest tightness and discharged back to the facility on May 26, 2010. Physician ' s order sheet and plan of care signed and dated April 27, 2010, directed [Oxygen at 2 liters via [nasal cannula] continuous for shortness of breath. Physician ' s order sheet and plan of care signed May 26, 2010, directed oxygen- 2 liters via nasal cannula every shift for shortness of breath. According to the admission Minimum data Sets [MDS] dated June 8, 2010, Section I, Disease Diagnoses included Arteriosclerotic Heart Disease, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, and Emphysema/Chronic Obstructive Lung Disease. Section P revealed the resident required oxygen therapy. According to the oxygen nursing care plan initiated April 26, 2010 and updated June 9, 2010 revealed, " resident oxygen dependent 2L [oxygen] via nasal cannula with humidity. Saturation 95% on oxygen. Continue plan of care. "	F 309		

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F 309	Continued From page 85 Physician ' s orders signed July 2, 2010 prescribed [Oxygen} at 2L/min via nasal cannula every shift. Resident observed on August 3, 2010 in the dayroom at approximately 1:20 PM sitting in wheelchair next to the window. Resident was not wearing his/her oxygen. A face-to-face interview was conducted with Employee #5 regarding resident ' s mental status. He/she stated, " he/she is alert and oriented times three, however, he/she can get confused when he/she is not on his oxygen, he can get hypoxic. " Informed Employee #5 he/she was not wearing oxygen. Employee #5 proceeded to dayroom and assisted resident back to his/her room to obtain a pulse ox. Resident ' s oxygen concentrator was in the dayroom by the door to the left. Oxygen concentrator was taken to resident ' s room. Employee #5 was unable to obtain a pulse oximetry times two when placed on index finger of both hands. Oxygen was initiated. Employee #5 obtained a reading of 70% to 78% when placed on the left great toe. Oxygen titrated from 2-4L by Employee #5. Resident ' s vital signs were: Temperature 98.2, Pulse 63, Respirations 28, and Blood Pressure130/70. Resident was transferred to the hospital at approximately 5:15 PM. Vital signs at the time of transport were, Blood Pressure 130/70-130/78, Pulse 63, Respirations 18, Pulse Ox-99% on 12 liters oxygen via rebreathing mask. Facility staff failed to administer oxygen continuously to ensure the resident ' s oxygen saturation was maintained according to physician ' s order; subsequently resident was transferred to hospital with respiratory distress. The record	F 309		

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F 309	Continued From page 86 was reviewed August 3, 2010. 7. Resident #18 ' s clinical record revealed facility staff failed to consistently assess the resident ' s blood pressure prior to the administration of an antihypertensive medication and failed to administer pre-treatment pain medication prior to performing wound care. According to the history and physical examination dated October 8, 2009, Resident #18 ' s diagnoses included psychotic disorder, diabetes mellitus, heart failure, atherosclerotic cardiovascular disease, schizophrenia and sepsis. a.) Physician ' s orders dated July 2, 2010 [originated October 5, 2009] directed, " Atenolol 25mg by mouth every day for hypertension, hold if systolic blood pressure is less than 110. " A review of the Medication Administration Records [MAR] for May and June, 2010 revealed the resident ' s blood pressure was inconsistently assessed. Parameters of administration [hold for systolic less than 110] were not followed in the absence of blood pressure assessments. b.) Physician ' s orders dated July 2, 2010 [originated October 5, 2009] directed " Tylenol 650 mg by mouth every day 30 minutes before dressing change. " A review of the Medication Administration Record [MAR] for May and June, 2010 revealed Resident #18 ' s pre-treatment pain medication, was inconsistently administered in synchronization with wound care. The record lacked evidence of reasons why the medication was omitted.	F 309	**Ftag 309 7a – Resident#18** 1. **Resident #18's** Blood pressures are being monitored as ordered.	10/19/10
			2. All residents have the potential to be affected by this practice. Residents receiving hypertension medications had a review of their MAR.	10/19/10
			3. The systematic change/measures taken to correct this practice entails: staff education on the importance of documentation on the MAR/TAR and revised shift report, which includes the review of MARs/TARs.	10/19/10
			4. Unit Managers will complete audits monthly and a report will be provided to the DON. The results of this audit will be reported to the CQI committee monthly for three months then	10/28/10
			Ftag 309 7a – Resident#18 1. Resident #18, we are unable to correct the cited deficiency for pain medication. Staff was remediated at the time of the survey.	8/6/10
			2. Review of residents with scheduled pain medication and those receiving scheduled pain medication prior to wound care has been completed.	10/19/10
			3. An in-service for staff has been completed by the educator on pain management.	10/19/10
			4. An audit of this process will be conducted monthly by the Director of Nursing/designee. The results of the above audit will be reported to the CQI committee monthly for three months, then quarterly. A report of	10/28/10

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F 309	Continued From page 87 The findings were reviewed and confirmed during a face-to-face interview with Employee #5 on August 6, 2010 at approximately 4:30 PM. The record was reviewed August 6, 2010. 8. Facility staff failed to follow up on a dental consult as per the physicians order for Resident #25. The Interim Order Form dated July 22, 2010 directed, "Dental Consult for cleaning teeth ." A review of the current clinical was conducted and there was no evidence that Resident #25 was seen by a dentist during his/her stay at the facility. A face-to-face interview was conducted with Employee #5 at approximately August 9, 2010 at approximately 4:17 PM. He/she acknowledged that the dental consult was not done as ordered/directed by the physician. The record was reviewed on August 9, 2010. 9. Facility staff failed to fully assess Resident #CBL3 after sustaining an injury to the eye. According to the history and physical examination dated May 29, 2010, the resident ' s diagnoses included schizophrenia, anemia, peripheral vascular disease and frostbite with bilateral lower extremity amputations. A review of the clinical record for Resident #CBL3 revealed the resident sustained an injury to the left eye on August 1, 2010. According to documentation accompanied with the incident report dated August 1, 2010, " [employee name]	F 309	continued from page 87 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. **Ftag 309 #8** 1. **Resident #25** no longer resides in the facility. 2. An audit of appointments and follow-up has been conducted by the unit secretaries.. Corrective actions and physician notifications have been completed as needed for the past 30 days.. 3. Staff education has been completed by the DON regarding the process for appointment scheduling and follow-up. The unit secretaries will complete weekly audits of appointments and provide a report to the DON. 4. The results of the above audit will be reported to the CQI committee monthly by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further 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 309	Continued From page 88 had a cigarette and some of the ashes got in [his/her] left eye, assessment done, no sign of injury, [he/she] denies pain but says irritation to left eye gone at this time, left eye clear no redness ... " Resident #CBL3 was observed on August 6, 2010 at approximately 5:30 PM with medical tape adhered to the left eyelid rendering it shut. The observation was made in the presence of Employee #5, who stated the resident applied the tape to his/her eye. The resident stated " my eye is irritated and my vision is blurred since [employee named] hit me in the eye with ashes from a cigarette. " A review of the clinical record on August 6, 2010, lacked evidence of an assessment of the resident ' s eye subsequent to August 1, 2010. Facility staff acknowledged observing the resident with tape applied to the left eye subsequent to the incident. He/she verbalized irritation and blurred vision of the affected eye. A subsequent interview was held with the resident on August 9, 2010 at approximately 2:30 PM. He/she stated the left eye had continued irritation and that visually, he/she couldn't ' t see as well as before the incident. " They [facility staff] told me to keep the tape off of my eye, I put it there because it made it feel better, they are going to let me see an eye doctor. " Facility staff failed to fully assess Resident #CBL3 after sustaining and injury to the eye. The resident applied tape to his/her eye subsequent to the incident and complained of eye irritation and blurred vision. There was no evidence that the medical team evaluated the resident ' s eye.	F 309	**Ftag 309 #9** 1. **CBL #3** was examined by an Opthalmologist on 8/12/10.	8/12/10
			2. A review of the Incident Report for the past 7 days has been completed to assure residents have follow-up documentation on the record Incident Reports. An audit has been completed on assessments post injury.	10/19/10
			3. Staff education has been completed by the educator on generalized assessment and documentation of post injury.	10/19/10
			4. The results of the above audit will be reported to the CQI committee monthly by the DON/designee. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further interventions and need and frequency of further audits. A random audit of Incident Reports will be completed monthly by the Medical Records Coordinator to assure that flu documentation is present and problems identified will be reported to the DON.	10/28/10

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F 309	Continued From page 89 A face-to-face interview was conducted with Employee #5 on August 10, 2010 at approximately 4:00 PM. S/he stated that the physician ordered an ophthalmology consultation on August 8, 2010 and the appointment was pending. The record was reviewed August 6, 2010. 10. Facility staff failed to assess a sudden change in one (1) resident's respiratory condition Resident #CBL8. On August 3, 2010 during med pass the CNA reported to nurse that resident was in distress. The nurse immediately went to the medication cart and checks the resident medication in Medication Administration Record. He/she poured resident morning medication, he/she knocked the resident room door, on entering the room he/she put on a mask and a pair of gloves per isolation policy. The nurse offered the resident his/her morning medication and water to drink. The resident refused his/her medication but did take his/her bronchodilator puff. Nurse continue to encourage resident to take him/her medication when resident stated he/she will try that ' s when resident reached in to the medication cup picked up two (2) small pills one brown and the other white place in his/her mouth and followed it with drinking more water. Resident was able to verbalize refusal of the rest of medication. Resident was observed to be short of breath and very fatigued as he/she communicated his/her needs to the nurse. The nurse pulled resident up in bed elevate his/her head and voiced while leaving room that he/she will try later to offer resident his/her medication. A review of MAR on August 3, 2010 revealed that	F 309	**Ftag 309 #10** 1. **CBL #8** was transferred to hospital at the time of survey. Staff was remediated at the time of survey.	8/3/10
			2. An audit has been completed on residents receiving oxygen therapy by the unit managers. Corrective measures have been implemented as needed.	10/19/10
			3. Staff education has been completed on respiratory assessment and the use of oxygen by the educator.	10/19/10
			4. A monthly audit of respiratory care and services and documentation will be completed by the unit manager and submitted to the DON/designee. The results of the above audit will be reported to the CQI committee for three months and then 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 further interventions and need and frequency of further audits	10/28/10

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F 309	Continued From page 90 resident morning medication was as followed: Ascorbic Acid 500mg twice a day for wound healing Aspirin chewable 81mg everyday for prophylaxis Calcium Carbonate 648mg tablet twice daily for supplement Digoxin 250mcg tablet every day for Congestive heart failure Diltiazem HCL 120mg every day for Chronic Hypertension Disease Furosemide 20mg tablet every day for diuretic Isosorbide Monoonitrate 30mg every day for Cardiovascular Disease Prednisone 20mg tablet twice daily for prophylaxis Ranitidine HCL 300mg tablet every day for Gastroenteritis Reflux Disease Singular 10mg tablet every day for COPD Tab-A-Vite multivitamin tablet every day for supplement Vitamin B-1 100mg On August 3, 2010 at 10:15AM another visit to resident room, the resident was observed to be in respiratory distress and the nurse was observed at the medication cart signing off medication. Review of resident clinical records revealed the following: Physician order sheet and plan of care dated July 26, 2010 reads Oxygen with 3 liters continuing every shift via Nasal cannula. Telephone order dated July 27, 2010 at 10:15AM reads Maintain pulse OX above 90 if less than 90 increase oxygen to 4 liters per nasal canula. On August 3, 2010 at 10:20AM an interview immediately with employee # 16 revealed that the only intervention offered to resident was the medications he/she refused at 9:30AM. An immediate interview with Employee #2 and Employee #6 revealed that they were not notified	F 309		

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F 309	Continued From page 91 that the Resident ' s was experiencing a change in his/her respiratory status, resident pulse Ox was 88 when taken by Employee #2. A face-to-face interview was conducted post incident with Employee #2 and Employee #3 on August 3, 2010, 10:50AM. He/she acknowledged that an assessment and description of the resident's condition and interventions should have been done. There was no explanation as to why the staff failed to assess the resident. The record was reviewed August 3, 2010. 12. The facility staff failed to have medication available for Resident CBL10 for three (3) days. A review of medication administration record was conducted on August 6, 2010 at 10:00AM revealed that the missed medication dosage was as follows: Baclofen 10mg tab give one (1) tab by mouth three (3) times daily for spasms, was missed six (6) times during the month of July 2010 Lyrica 200mg capsule give one (1) capsule by mouth three (3) times daily neuropathic pain, was missed eight(8) times during the month of April 2010 Tramadol 50mg tablet give one (1) Tablet by mouth three (3) times daily for pain, was missed 11 times during the month of July 2010 An interview was conducted with resident CBL10 on August 6, 2010 at 10:15AM and he revealed that because he/she missed those dosages of medication he/she suffered from a burning pain in his/her right arm, diarrhea, no feelings in his/her finger tips and depression. " I now take cymbalta for my depression; I do not want to go through the pain I felt when I missed those medications because the pain was so bad I could not eat. A face-to-face interviewed was conducted with Employee #7 on August 6, 2010 at 10:30AM. He/she acknowledge that the medication was	F 309	**Ftag 309 #12** 1. **CBL #8** was transferred to hospital at the time of survey. Staff was remediated at the time of survey. 2. An audit has been completed on residents receiving oxygen therapy by the unit managers. Corrective measures have been implemented as needed. 3. Staff education has been completed on respiratory assessment and the use of oxygen by the educator. 4. A monthly audit of respiratory care and services and documentation will be completed by the unit manager and submitted to the DON/designee. The results of the above audit will be reported to the CQI committee for three months and then 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 further interventions and need and frequency of further audits	8/3/10 10/19/10 10/19/10 10/28/10

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F 309	Continued From page 92 ordered and pharmacy called each of the three days the resident was without medication. The record was review August 6, 2010. 13. The facility staff failed to clarify order for type of isolation for Resident #CBL 14. Physician Order Sheet and Plan of Care dated and signed July 7, 2010 directed, " Contact Isolation for MRSA [methicillin resistant staphylococcus aureus] in sputum. " According to the July 2010 MAR [Medication Administration Record]; MRSA of sputum was included as one of the diagnoses. The clinical record lacked documented evidence that the resident had MRSA of the sputum A Nurse Practitioner progress note dated April 28, 2010 revealed, " [positive] MRSA [methicillin resistant staphylococcus aureus] of left big toe wound. Plan: Contact isolation for [positive] MRSA wound. Nurses note dated June 1, 2010 revealed, " Continue on isolation for MRSA to great toe. " According to the MDS [Minimum Data Set] completed June 4, 2010, resident was coded under Section I (12a Infections) as Antibiotic resistant infection and Section M (6b) infection of the foot. A face-to-face interview was conducted with Employees #4 and Employee #5 on August 10, 2010 at 12:45 PM. Both acknowledged that the resident " was on contact isolation for MRSA of the right big toe. "	F 309	**Ftag 309 #13** 1. **CBL #14** was seen by the physician and the isolation order was clarified on 8/23/10. 2. Review of residents requiring isolation has been conducted by the ADON. Corrective actions implemented and physician notified as needed. 3. The ADON has completed staff education on isolation implementation and discontinuation. A review of the facility policy on Isolation has been completed and corrections made as needed 4. An audit of residents on isolation will be completed monthly and a report provided to the DON. The results of the above audit will be reported to the CQI committee monthly by the ADON/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.	08/23/10 10/19/10 10/19/10 10/28/10

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F 309	Continued From page 93 Facility staff failed to clarify Physician's order for type of isolation. The record was reviewed on August 10, 2010.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 30 supplemental residents, it was determined that the facility staff failed to: accurately document the number of pressure sores and include one (1) resident on the facility's "Pressure Area Documentation" form. Resident # CBL17. The findings include: A review of the facility ' s " Pressure Area Documentation Form " [a line listing of all residents in the facility with pressure ulcers and other areas of skin impairment] was conducted with Employee #2 on August 10, 2010 at 8:45 AM. He/she confirmed that the facility had 28 residents listed on the " Pressure Area Documentation " form, of which 17 residents were identified as having pressure ulcers and 11 residents identified with non-pressure ulcers.	F 314		

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F 314	Continued From page 94 A face-to-face interview with Employee #5 was conducted on August 10, 2010 at approximately 4:30 PM. He/she reviewed the "Pressure Area Documentation " form, and acknowledged that Resident CBL17 had a pressure ulcer but was not listed on the form. When Employee #5 was queried as to the actual stage of the wound, he/she was unable to state the stage. When Employee #5 was asked to define the characteristics of a Stage II wound, he/she was unable to do so. A review of Resident CBL17 ' s " Pressure Area Documentation " form revealed that Resident CBL17 had two (2) open areas to the right outer thigh, that were first observed and documented on June 3, 2010. The facility continued to document the open areas to the right outer thigh until August 1, 2010. A review of the Treatment Administration Record for June and July 2010 revealed that the open areas to the right thigh were treated from June 4, 2010 through July 4, 2010. The facility continued to measure the resident ' s right thigh area for three (3) additional weeks after the wound treatment stopped on July 4, 2010. According to the " Pressure Area Documentation " form, the right thigh area #1 had the following characteristics from July 6 through August 1, 2010: Wound Measurements 1 x 0 x 0; wound base M (moist) ...Tx (treatment)- was left blank; Pressure Relief - was left blank... The right thigh area #2 had the following characteristics from July 6 through July 26, 2010:	F 314	Continued From page 94 1. The pressure area documentation form was corrected to reflect resident CBL#17. 2. An audit has been completed by the wound care nurse of residents with wounds to assure accuracy of documentation. 3. The wound care nurse has educated the staff on the use of the tools used for documentation of wounds. The wound care nurse will audit the wound care documentation weekly and provide a report to the director of nursing. 4. The results of the above audit will be reported to the CQI committee monthly by the wound care nurse. 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 314	Continued From page 95 Wound Measurements 1 x 0.1 x 0; wound base M (moist) ...Tx (treatment) Y (yes); Pressure Relief N (no)... There was no evidence that facility staff included Resident CBL17 on the facility's "Pressure Area Documentation" form and accurately documented the characteristics for two (2) pressure sores. A face-to-face interview with Employee #2 on August 11, 2010 at approximately 9:30 AM. He/she stated that Resident CBL17 was in the hospital, therefore the area could not be observed. Employee #2 acknowledge that the "Pressure Area Documentation" form for Resident CBL17 was inaccurate. Employee #2 also stated that Employee #5 was inserviced on June 15, 2010 on pressure ulcers. The record was reviewed August 10, 2010.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for two (2) of 26 sampled residents and 3 supplemental residents, it was determined facility staff failed to adequately supervise one (1) resident that sustained a fracture, one (1) resident that fell out of a wheelchair and two (2)	F 323		

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F 323	Continued From page 96 residents involved in altercations centered around smoking and to perform a risk assessment for one (1) resident who attempted to elope, and failed to keep environment free of accidental hazards. Residents #3, 22, CBL2, CBL3 and CBL6. The findings include: 1. Facility staff failed to failed to ensure that the resident receives adequate supervision to prevent accident. 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 [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 ... "	F 323	Continued From page 96 **483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **Ftag 323** **#1 – Resident #3** 1. Resident #3 returned to the facility and systems were put in placed to prevent further incidents of elopement. 2. A review has been completed of new admissions to assure that appropriate assessments, safety measures implemented, and referrals for evaluations by outside disciplines are completed by the unit managers. The director of social services has reviewed new admissions to assure discharge plans are addressed per residents wishes. 3. New admissions will be reviewed via the trace mythology meeting daily. The nursing new admission packet has been updated by the Director of Nursing and staff has been educated. The discharge planning process has been reviewed with the social workers. Discharge planning meetings have been implemented. A Discharge planning audit will be completed by the Director of Social Services monthly and a report provided to the administrator. 4. The results of the above audit will be reported to the CQI committee monthly by the Director of Social Services/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.	07/26/10 10/19/10 10/19/10 10/28/10

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F 323	Continued From page 97 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 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 resident's clinical record lacked documented evidence that: the resident's above concerns were addressed and that the resident receives adequate supervision to prevent his/her attempted elopement. The resident wheeled self from his/her room to the basement floor, exited the building unnoticed/unsupervised. A face-to-face interview was conducted with Employees #2, 5 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 were addressed and that the resident receives adequate supervision to prevent elopement. Employee # 5 acknowledged that he	F 323		

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F 323	Continued From page 98 resident left the facility AMA sometime in January 2010. Employee # 8 added further that he/she will start looking into the resident's concerns including housing in the community. It was emphasized to Employees # 2, 5 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 adequately supervise two residents that engaged in more than one resident to resident altercation. A review of the facility ' s incident report revealed Residents #22 and CBL3 had an altercation on August 1, 2010. The report revealed that the residents were in the designated smoking area, a verbal altercation ensued and Resident #22 attempted to strike Resident #CBL3 with a butter knife. A face-to-face interview was conducted with Employee #29 on August 9, 2010 at 3:55 PM. Telephone interviews were conducted with Employees #33 and 34 on August 10, 2010 at approximately 2:30 PM. A recapitulation of the incident was verbalized as follows: The residents were in the outdoor smoking courtyard unsupervised. Employee #33 was in the dining hall making rounds and was alerted by a staff person who observed what appeared to be an altercation in the courtyard. The employee intervened and retrieved a butter knife from Resident #22. The residents agreed to get along and Employee #50 left the area and radioed for Employee #34 to monitor the smoking area.	F 323	Continued From page 98 **#2** 1.Cameras are in place to monitor the smoking areas. A smoking monitor has been approved for the courtyard as of 10/25/10. 2. A review of incident reports of residents with accidents has been completed by the DON to assure that residents are receiving adequate supervision post incidents. A review of facility smokers has been completed by the Evening Supervisor. 3. A review of the smoking policy was completed by the administrator and changes made as needed. Staff education regarding the smoking policy and smoking safety has been completed by the educator. Staff education regarding resident safety and supervision post incidents has been completed by the educator. An audit of the changes implemented will be audited by the administrator/designee monthly. 4. The results of the above audit will be reported to the CQI committee monthly by 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.	10/7/10 10/19/10 10/19/10 10/28/10

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F 323	Continued From page 99 A short time later [approximately 10 minutes] Employee # 29 entered the unsupervised smoking courtyard looking for another resident. Residents #22 and CBL3 were observed engaged in a second altercation described as " arguing and pushing each other. " Employee #29 intervened and Employee #34 entered the courtyard and escorted Resident #22 out of the area. On August 2, 2010 at approximately 11:30 AM during general observations of the facility a member of the survey team observed Residents #22 and CBL3 unsupervised and engaged in a verbal altercation near the elevators on the level of the smoking courtyard. A review of the facility ' s Policy #120 " Smoking Policy " that stipulates, item #8 smoking is only allowed in the designated outside smoking areas and item #9 Supervised smoking is conducted in two hour intervals beginning at 9:00 AM and ending at 9:00 PM. Face-to-face interviews were conducted with Employees #1 and 2 August 9, 2010 at approximately 5:30 PM. Each confirmed that smoking is the designated courtyard must be supervised. Facility staff failed to adequately supervise Residents #22 and CBL3 who engaged in three (3) resident-to-resident altercations in a period of 48 hours. 3. Facility staff failed to maintain a safe environment and provide adequate supervision to prevent injuries for Resident CBL2 who sustained	F 323		

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F 323	Continued From page 100 a fracture of the distal 3rd of the 5th metacarpal. 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. 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. According to the information contained in the report of an investigation which was completed by the facility and sent to the State Agency on March 7, 2010 the resident " had a history of intermittent explosive episodes and agitation. During his/her stay at the facility he/she had displayed these bouts of irritability and agitation. What triggers these episodes has been undetermined; however he/she has previously prescribed Lorazepam but it has been discontinued. " The report continued. " The staff maintained that the resident was so agitated that the assistance of one (1) Licensed Practical Nurse (LPN) and two Certified Nursing Assistants (CNA) was needed. " The documentation indicated that the staff also called the nursing supervisor. According to the documentation the incident occurred on the evening of Saturday September 19, 2009. Per the supervisor the staff stated that the staff placed the resident in a recliner because they were afraid that he/she would fall and " tied him/her down loosely. " According to one CNA ' s version, " the supervisor asked a CNA to get a recliner chair. He/she (the CNA) got the chair	F 323	Continued From page 100 1. Resident CBL#2 has been discharged and no further corrections can be made for this resident at this time. 2. All residents have the potential to be affected. An audit was completed of residents using restraints for the appropriateness of the restraint by the unit managers. Corrective actions were implemented as needed. 3.The restraint and the abuse policy has been reevaluated and updated. Staff has been in-serviced on the policies, the use of sheets to restrain residents, the overall process of restraint use, and what constitutes abuse. Staff education has been completed for the line staff and supervisors regarding the change of shift process. 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. 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 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 323	Continued From page 101	F 323		

and placed a sheet around the back of the resident and tied it to the back of the chair. " The report continued, " According to everyone present, the resident fell asleep in the recliner chair for the rest of the night. "

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 concluded that the X-ray revealed a fracture of the distal 3rd of the 5th metacarpal.

Per the facility ' s report, " The staff failed to provide and maintain a safe environment for the resident, the supervisor failed to monitor and supervise proper care for the resident; and as a result the resident suffered an injury and did not receive adequate care. "

A face-to-face interview was conducted with Employee #2 at approximately 9:35AM on August 11, 2010. He/she acknowledged that the facility failed to maintain a safe environment and provide adequate supervision to prevent injuries for Resident CBL2 who sustained a fracture of the distal 3rd of the 5th metacarpal. The record was reviewed on August 9, 2009.

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F 323	Continued From page 102 4. Facility staff failed to provide safety for resident being transported by wheel chair, and subsequently resident sustained an injury after falling from chair. Resident # CBL6. A review of resident nurses note dated July 22, 2010 at 7:00AM revealed, " Resident fell from the wheel chair and hit head on floor with small amount of blood about ... noted on open laceration on forehead. Pressure has been put on forehead at the site of injury about 5 min. bleeding stop cover open laceration with dry gauze. Resident transferred to emergency room at 9:15PM." Attempted to conduct an interview on August 9, 2010 at 11:15AM with resident while she was sitting up in wheel chair in day room revealed that the resident was unable to respond that he/she fell when questioned about the healed laceration area on her forehead or say what attributed to his/her falling. A review of the "Resident Risk Assessment for Fall Sheet" completed on July 20, 2010 revealed that facility staff answered "yes" to the following questions: 1. Does the resident have alteration of safety awareness due to dementia? 2. Is the patient on any medications that would require increased safety precautions? On August 9, 2010 at 3:50 PM Employee # 23 was interviewed about the incident. He/she acknowledged that the resident fell while he/she transported resident via wheelchair back to his/her room to put him/her in bed. He/She stated, "because males certified nursing assistants could not take care of [female/male] residents, I was asked to care for Resident CBL6. The resident was not a resident I usually take care of... but on July 22, 2010 around 8:40PM, as	F 323	Continued From page 102 #4 1. Resident #CBL6 footrests have been applied to the wheelchair and the careplan has been updated to reflect the decrease in safety awareness, cognition and required safety precautions during transport. 2..An audit of residents in wheelchairs with and without footrests has been completed by the rehabilitation department. 3. Staff education during resident safety during transport and the appropriateness use of footrests has been completed by the Educator. An audit of wheelchair bound residents will be completed quarterly by the restorative aides. 4. 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 will be presented. The CQI committee will determine the need for other interventions and need and frequency of other audits.	10/19/10 10/19/10 10/19/10 10/28/10

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F 323	Continued From page 103 I pushed the wheelchair is when the resident crossed his/her legs at the ankles and took a tumble forward, and fell on floor. Resident hit forehead and was bleeding from forehead." When asked if resident's chair had a foot pedal, Employee #23 responded, "at the time of the incident, resident's chair did not have a foot pedal." According to an "occupational therapy screen" form dated July 29, 2010 at 10:30 AM revealed under "comment section," "resident require support when in wheel chair due to decrease safety awareness and decrease cognition as was identified when on caseload in February 2010." There was no evidence in clinical record that facility staff provided safety for resident identified to have decrease safety awareness, decrease cognition and was on medications that required increased safety precautions when resident was transported in wheel chair without foot rest. A face-to-face interview was conducted with Employee # 7 on August 10, 2010 at 10:00AM. He/she acknowledge that resident chair has a foot rest she did not understand why the resident chair was without it that evening. The record was reviewed August 10, 2010. 5. Facility staff failed to keep the resident environment free of accidental hazards by not removing broken equipment (transfer lift/assistive devices) from the hallway. During the initial tour of the second floor conducted on August 2nd, 2010 at approximately 8:45 AM a broken transfer lift was noticed in the hallway. Further investigation revealed that there were no signs affixed to the equipment to alert facility staff that the equipment was broken.	F 323	Continued From page 103 #5 1. The hallways were cleared equipment at the time of survey. 2. All residents have the potential to be affected by this practice. 3. Environmental safety rounds will be completed weekly by the Safety Team. Staff has been completed by the Safety Officer regarding the disposal of broken equipment. The results of the rounds will be provided to the Administrator 4. The results of the above rounds will be report to the CQI committee quarterly by the Safety Officer/designee. A report of the problems identified and the corrective actions will be presented to CQI committee will determine the need for further intervention and the frequency of further audits.	10/19/10 10/19/10 10/19/10 10/28/10

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F 323	Continued From page 104 A face-to-face interview was conducted at that time with Employee #3. After review of the equipment he/she acknowledged that the broken piece of equipment should have been removed from service and summoned a staff member to remove it. The observation was made on August 2, 2010.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for one (2) of 26 sampled residents, it was determined that facility staff failed to include a nutrition related laboratory finding in the nutrition assessment and there were no dietary assessments for a period of six (6) months and failed to perform dietary assessment according to facility policy, Resident #1 and 14. The findings include: 1. Resident #1 ' s clinical record revealed the dietician failed to include measures to address	F 325		

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F 325	Continued From page 105 the resident ' s subnormal albumin level in the nutrition assessment. According to the history and physical examination dated March 18, 2010, Resident #1 ' s diagnoses included hypertension, chronic obstructive pulmonary disease, dementia, and degenerative joint disease. The review of systems revealed the resident ' s skin was intact. The resident ' s albumin level was 3.2 [normal 3.5-5.0] on March 30, 2010. Nutrition assessments were performed on March 29, 2010 and June 21, 2010 and lacked evidence of any significant weight changes. The record lacked evidence that the dietician acknowledged and/or implemented measures to address the resident's subnormal albumin level in the June 2010 dietary assessment. In the section of the facility ' s nutrition assessment form entitled " lab values, albumin and other nutrition related lab values " the resident ' s March 30, 2010 albumin level was not included. Additionally, the record lacked evidence of dietary assessments during the period of September 2009 through March 28, 2010. Per the facility ' s Nutritional Care Policy, " all residents are assessed and documented on at a minimum of every 90 days ... " 2. Facility staff failed to conduct dietary assessments per facility policy. Resident #14 According to the " Resident Nutritional Care "	F 325	Continued From page 105 #1 Resident #1 1. Resident albumin level was drawn for resident #1 and the results were within normal limits. 2. A random chart audit of dietary assessments for the past thirty days have been completed and corrective actions implemented as needed. 3. Dietary staff has been educated by the Regional Dietician on the documentation. Quarterly audits dietary assessments will be conducted by the Regional Dietician. A result of the above audits will be reported to the CQI committee quarterly by the dietician. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further intervention and the frequency of further audits.	10/7/10 10/19/10 10/19/10 10/28/10

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F 325	Continued From page 106 Nutrition Assessment - RC -3 Policy reads " All residents will receive a comprehensive nutrition assessment by a qualified individual. Assessment and documentation of nutritional concerns is recorded in a timely manner in the medical record by a qualified person. According to the " Procedures: number five (5) All residents are assessed and documented on at a minimum of every 90 days; however, the frequency depends ultimately on the condition of the resident " A review of the " Nutrition Assessment " dated and signed November 9, 2009 revealed the weight for Resident #14 was 224 pounds, no labs were documented on the form. The next " Nutritional Assessment " that was performed was dated and signed March 2, 2010, and weight was 219 pounds, no labs since October 27, 2009. A face-to-face interview was conducted with Employee #47 on August 4, 2010 at 3:00 PM. After review of the clinical record he/she indicated that he/she was the only Nutritionist working in the building at that time. Facility staff failed to conduct dietary assessments per facility policy. The record was reviewed on perform August 5, 2010	F 325	Continued From page 106 F tag 325 #2 1. A nutritional assessment has been completed for resident #14. Lab results for this resident were placed on the medical record. 2. A random chart audit of dietary assessments for the past thirty days have been completed and corrective actions implemented as needed. 3. Dietary staff has been educated by the Regional Dietician on the documentation. Quarterly audits dietary assessments will be conducted by the Regional Dietician. A result of the above audits will be reported to the CQI committee quarterly by the dietician. A report of problems identified and corrective actions implemented will be presented. The CQI committee will determine the need for further intervention and the frequency of further audits.	8/17/10 10/19/10 10/19/10 10/28/10
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services:	F 328		

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F 328	Continued From page 107 Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. 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 post precautionary notices that oxygen therapy was in use in two (2) resident rooms. The findings include: During the initial tour of the facility on August 2, 2010, it was determined that facility staff failed to post precautionary notices to alert staff, residents and visitors that oxygen was in-use. Residents residing in rooms #327 and 329 received oxygen therapy in the absence of precautionary signage to relay to others that oxygen was in use. The facility had a designated smoking area out-of-doors; however, during a face-to-face interview with Employee #2 on August 10, 2010 at approximately 5:00 PM, he/she stated that some residents manage their own smoking supplies and incendiary devices. Precautionary signs were not posted to alert others that oxygen was in-use.	F 328	1. Precautionary signs were posted on rooms 327 and 329 at the time of survey. 2. An audit of residents utilizing oxygen was completed by the evening supervisor. Corrective actions implemented as needed. 3. Staff education has been completed by the educator on the use of oxygen and the safety precautions necessary when in oxygen is in use. Audit of Oxygen signs will be completed weekly by the unit secretaries. A report provided to the director of nursing. 4. 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.	8/11/10 10/19/10 10/19/10 10/28/10
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=E	Continued From page 108 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview for Five (5) of 26 sampled residents and 2 supplements residents, it was determined facility staff failed to monitor behaviors of nine (7) residents receiving psychotropic medication, attempt gradual dose reduction for one (1) resident on antipsychotic medication and identify indications for use for medications administered to four (4) residents. Residents #2, 4, 6, 7, 24,	F 329		

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F 329	Continued From page 109 CBL3 and CBL7. The findings include: 1. Facility staff failed to adequately monitor the use of Clonazepam, Zolpidem, Paroxetine and Seroquel for Resident #2. A review of the Resident #2 ' s Physician ' s Order Form signed and dated by the physician on July 7, 2010 directed the following: Clonazepam 0.5 mg tablet give ½ (half) tab (0.25mg) by mouth twice daily for behavior (agitated); Zolpidem 10 mg tablet 1 tab by mouth at bedtime as needed for insomnia; Paroxetine HCL 10 mg tablet 1 tab by mouth every day for depression. According to the last Psychiatry report dated and signed July 27, 2010: continue with medications as ordered hold meds if falls, increased sedation (illegible writing on last recommendation). A review of the resident's record revealed that the " Behavior Monitoring Flow Record " for July 2010 failed to identify the medication side effects and lacked consistent monitoring of targeted behaviors from July 1st to July 5th for Clonazepam, Zolpidem, Paroxetine HCL and no monitoring from July 6th-through July 22nd, 2010. Seroquel was consistently monitored until July 5, 2010, and no further monitoring from July 6th through July 22, 2010. A face-to-face interview was conducted with Employee #6 on August 3rd, 2010 at approximately 3:40 PM. After review of the Behavior Monitoring Flow Sheets, he/she acknowledged that there were blank from July 6th through July 22, 2010. The record was reviewed	F 329	1. The behavior monitoring sheet for Residen#2 has been updated to reflect the behaviors and side effects to be monitored as outlined by the physician. 2. An audit of residents receiving psychotropic medications has been completed by the unit managers. Corrective actions have been implemented as needed. 3. Staff education has been completed by the educator on the use of psychotropic medications in the elderly, documentation of monitored side effects for resident specific behaviors and the importance of following up with the PMD and psychiatrist in reference to documentation of dose reductions. Audits of psychotropic medications and dose reductions will be completed by the social worker monthly. The results of these audits will be reported to the Administrator. Audit of behaviors and side effect monitoring will be completed by the unit managers monthly. The results of these audits will be reported of the director of nursing. 4. The results of the above audit will be reported to the CQI committee monthly x3 and quarterly thereafter by the Director of Social Services/Designee and 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. Feb, May, Aug., Nov.	10/25/10 10/19/10 10/19/10 10/28/10

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F 329	Continued From page 110 on August 3rd, 2010. 2. Facility staff failed to attempt a gradual dose reduction for the use of a psychotropic medication for Resident #4. On December 15, 2009, the psychiatrist documented the following on a " Report of Consultation " under the heading of " Report. " " Patient has been weaned off lorazepam recently because she has done well which was not the case recently. " Under the heading of " Recommendations " the psychiatrist wrote the following: " Resume Ativan 0.5mg po [by mouth] BID (twice daily) for agitation. Hold it if B/P [blood pressure] less than 90/60, falls [and] increased sedation and call this writer. See resident in 90 [ninety] days or [as needed]. According to the Pharmacist Consultation Report dated February 17, 2010, under the heading of " Recommendations " the pharmacist wrote the following: " Please consider a gradual dose reduction, perhaps decreasing to 0.5mg q [every] pm while concurrently monitoring for re-emergence of target and/or withdrawal symptoms. Of therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated. " According to physician ' s orders signed April 2, May 5, and June 2, 2010, the resident ' s medication regimen included Lorazepam 0.5mg.. 1 [one] table by mouth twice daily for agitation. Further review of the record failed to reveal any other documentation from the psychiatrist.	F 329	1.The physician was notified of the dose reduction for resident #4 and orders obtained. 2. An audit of residents receiving psychotropic medications has been completed by the unit managers. Corrective actions have been implemented as needed. 3.Staff education has been completed by the educator on the use of psychotropic medications in the elderly, documentation of monitored side effects for resident specific behaviors and the importance of following up with the PMD and psychiatrist in reference to documentation of dose reductions. Audits of psychotropic medications and dose reductions will be completed by the social worker monthly. The results of these audits will be reported to the Administrator. Audit of behaviors and side effect monitoring will be completed by the unit managers monthly. The results of these audits will be reported to the director of nursing. 4. The results of the above audit will be reported to the CQI committee monthly x3 and quarterly thereafter by the Director of Social Services/Designee and 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. Feb, May, Aug., Nov.	10/25/10 10/19/10 10/19/10 10/28/10

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F 329	Continued From page 111 The attending physician saw the resident on March 17, April 9, June 8, and July 3, 2010. There was no evidence in the physician ' s notes that the use of Ativan was reviewed or a dose reduction attempted or documentation present to indicate that a dose reduction was clinically contraindicated. A face-to-face interview was conducted with Employee #5 on August 4, 2010 at approximately 1:00 PM. He/she acknowledged the above findings. The record was reviewed August 4, 2010. 3. Facility staff failed to adequately monitor the use of Lorazepam and Fluphenazine HCL for Resident #6. A review of the Resident #6 ' s Physician ' s Order Form signed and dated by the physician on July 2, 2010 directed the following: Lorazepam 1 mg tablet by mouth twice daily for agitation; Fluphenazine HCL 2mg by mouth twice daily for psychosis. According to the last Psychiatry report dated and signed March 9, 2010: continue with medications as ordered hold meds if falls, increased sedation. A review of the resident's record revealed that the " Behavior Monitoring Flow Record " for July 2010 failed to identify the medication side effects and lacked consistent monitoring of targeted behaviors on July 1, 2, 3, 4, 13, 21, 24, and 28 for Lorazepam and Fluphenazine. A face-to-face interview was conducted with Employee #6 on August 5th, 2010 at	F 329	1.The behavior monitoring sheet for Resident #6 has been updated to reflect the behaviors and side effects to be monitored as outlined by the physician. 2. An audit of residents receiving psychotropic medications has been completed by the unit managers. Corrective actions have been implemented as needed. 3. Staff education has been completed by the educator on the use of psychotropic medications in the elderly, documentation of monitored side effects for resident specific behaviors and the importance of following up with the PMD and psychiatrist in reference to documentation of dose reductions. Audits of psychotropic medications and dose reductions will be completed by the social worker monthly. The results of these audits will be reported to the Administrator. Audit of behaviors and side effect monitoring will be completed by the unit managers monthly. The results of these audits will be reported to the director of nursing. 4. The results of the above audit will be reported to the CQI committee monthly x3 and quarterly thereafter by the Director of Social Services/Designee and 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. Feb, May, Aug., Nov.	10/25/10 10/19/10 10/19/10 10/28/10

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F 329	Continued From page 112 approximately 8:50 PM. After review of the Behavior Monitoring Flow Sheets, he/she acknowledged that there was inconsistent monitoring on the above mentioned days. The record was reviewed on August 5th, 2010. 4. Facility staff failed to adequately monitor the use of Seroquel for agitation for Resident #7. A review of the Resident #2 ' s Physician ' s Order Form signed and dated by the physician on July 2, 2010 directed medications including Seroquel 25 mg tablet 1 tab by mouth twice daily for agitation. A review of the resident ' s Medication Administration Record [MAR] in the resident ' s clinical record for the months of April through July 13, 2010 revealed the resident was administered Seroquel 25mg one (1) tablet by mouth at 9:00 AM and 5:00 PM daily as evidenced by the initials across the entries for Seroquel 25mg I tablet by mouth. A further review of the resident ' s clinical record revealed " Behavior Monitoring Flow Record " [BMFR] for the months of April through July 31, 2010 that consistently monitored for " #11; Resist, and #13 Persistent pacing " . The resident ' s clinical record including the BMFR lacked documented evidence that he/she was monitored for agitation while he/she was receiving Seroquel for agitation. A face-to-face interview was conducted with Employee #7 on August 4, 2010 at approximately 9: 20 AM. After a review of the resident's clinical record including the " Behavior Monitoring Flow	F 329	1. The behavior monitoring sheet for Resident #7 has been updated to reflect the behaviors to be monitored as outlined by the physician. 2. An audit of residents receiving psychotropic medications has been completed by the unit managers. Corrective actions have been implemented as needed. 3. Staff education has been completed by the educator on the use of psychotropic medications in the elderly, documentation of monitored side effects for resident specific behaviors and the importance of following up with the PMD and psychiatrist in reference to documentation of dose reductions. Audits of psychotropic medications and dose reductions will be completed by the social worker monthly. The results of these audits will be reported to the Administrator. Audit of behaviors and side effect monitoring will be completed by the unit managers monthly. The results of these audits will be reported to the director of nursing. 4. The results of the above audit will be reported to the CQI committee monthly x3 and quarterly thereafter by the Director of Social Services/Designee and 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. Feb, May, Aug., Nov.	10/25/10 10/19/10 10/19/10 10/28/10

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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 329	Continued From page 113 Record " he/she acknowledged that the aforementioned findings. The record was reviewed August 4, 2010. 5. Facility staff failed to monitor behaviors for Resident #24 receiving Ambien. According to the physician order sheet dated July 1, 2010 and signed by the physician on July 5, 2010 directed, " Ambien 5 mg one (1) tab po (by mouth) at bedtime for insomnia " The nursing notes and the Medication Administration Records lacked document of behaviors being monitored for the use of Ambien. A face-to-face interview was conducted on August 9, 2010 at approximately 3:00 PM with Employee #6. He/she acknowledged that the behavioral monitoring for the use of Ambien was not documented. The record was reviewed on August 9, 2010. 6. A review of the clinical record for Resident #CBL3 revealed that the resident ' s medication regimen included psychotropic medications for the management of behavioral symptoms. Facility staff failed to implement measures to monitor the efficacy of the psychotropic medications. Physician ' s orders dated June 30, 2010 directed Risperdal 1mg twice daily for psychosis and Ativan 2mg every 8 hours as needed for agitation. The clinical record lacked evidence that facility staff initiated measures to monitor the effectiveness of the medications used to address behavioral symptoms	F 329	1.Resident #24 no longer resides in the facility. 2. An audit of residents receiving psychotropic medications has been completed by the unit managers. Corrective actions have been implemented as needed. 3. Staff education has been completed by the educator on the use of psychotropic medications in the elderly, documentation of monitored side effects for resident specific behaviors and the importance of following up with the PMD and psychiatrist in reference to documentation of dose reductions. Audits of psychotropic medications and dose reductions will be completed by the social worker monthly. The results of these audits will be reported to the Administrator. Audit of behaviors and side effect monitoring will be completed by the unit managers monthly. The results of these audits will be reported to the director of nursing. 4. The results of the above audit will be reported to the CQI committee monthly x3 and quarterly thereafter by the Director of Social Services/Designee and 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. Feb, May, Aug., Nov.	10/19/10 10/19/10 10/28/10

Continued from page 114.

1. The behavior monitoring sheet for Resident #CBL3 has been updated to reflect monitoring for the efficacy of the medications as outlined by the physician. 10/25/10

2. An audit of residents receiving psychotropic medications has been completed by the unit managers. Corrective actions have been implemented as needed. 10/19/10

3. Staff education has been completed by the educator on the use of psychotropic medications in the elderly, documentation of monitored side effects for resident specific behaviors and the importance of following up with the PMD and psychiatrist in reference to documentation of dose reductions. Audits of psychotropic medications and dose reductions will be completed by the social worker monthly. The results of these audits will be reported to the Administrator. Audit of behaviors and side effect monitoring will be completed by the unit managers monthly. The results of these audits will be reported to the director of nursing. 10/19/10

4. The results of the above audit will be reported to the CQI committee monthly x3 and quarterly thereafter by the Director of Social Services/Designee and 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. Feb, May, Aug., Nov. 10/28/10

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	095015	A. BUILDING _____ B. WING _____	08/11/2010

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F 329	Continued From page 114 The findings were reviewed and confirmed during a face-to-face interview with Employee #5 on August 10, 2010 at approximately 4:00 PM. 7. Facility staff failed to adequately monitor Resident #CB7, who was receiving Zoloft. A review of Resident #CB7 ' s record revealed a physician's order dated July 2, 2010, initiated February 23, 2010 directed, " Sertraline HCL 50 mg tablet [Zoloft], 1 tablet by mouth every day for depression. " According to the June 2010, "Behavior Monitoring Flow Record" there was no evidence that any behavior was monitored. A review of the April, May, June, and July 2010 "Behavior Monitoring Flow Record " indicated, " Drug: Sertraline HCL, Strength: 50mg " , revealed that the resident ' s behavior was not consistently monitored for depression. A face-to-face interview was conducted with Employee #7 on August 9, 2010 at approximately 3:30 PM. He/she acknowledged that the resident's behavior was not consistently monitored for depression. The record was reviewed August 9, 2010.	F 329	1.The behavior monitoring sheet for Resident #CBL7 has been updated to reflect the behaviors to be monitored as outlined by the physician. 2. An audit of residents receiving psychotropic medications has been completed by the unit managers. Corrective actions have been implemented as needed. 3. Staff education has been completed by the educator on the use of psychotropic medications in the elderly, documentation of monitored side effects for resident specific behaviors and the importance of following up with the PMD and psychiatrist in reference to documentation of dose reductions. Audits of psychotropic medications and dose reductions will be completed by the social worker monthly. The results of these audits will be reported to the Administrator. Audit of behaviors and side effect monitoring will be completed by the unit managers monthly. The results of these audits will be reported to the director of nursing. 4. The results of the above audit will be reported to the CQI committee monthly x3 and quarterly thereafter by the Director of Social Services/Designee and 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. Feb, May, Aug., Nov.	10/25/10 10/19/10 10/19/10 10/25/10
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 333		

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F 333	Continued From page 115 by: Based on an observation during the medication pass, it was determined that facility staff failed to ensure that one (1) resident was free of significant medication errors. Resident # CBL I9. The findings include: Facility staff failed to administer Klor Con per manufacturer standards On August 2, 2010 at 10:15AM during the morning medication pass, the medication nurse was observed crushing two of the resident ' s medication and administered it with applesauce. The resident ' s medication included Klor Con 20 meq tablet. According to the manufacturer, Klor Con tablet should not be chewed or crushed. A face-to-face interview was conducted with employee # 16 on August 2, 2010. He/she acknowledge that resident had no problem swallowing the smaller pills. The record was review August 2, 2010.	F 333	1.The physician was notified of the medication error. New orders were obtained for liquid medication. 2. All residents have the potential to be affected by this practice. A Do Not Crush list has been placed on all MARs. 3. Staff education was completed by the educator regarding medications on the do not crush list. It was requested that pharmacy send liquid medications for resident with orders to crush meds and gastrostomy tubes. Nurses will be audited monthly during med pass observation by the educator. A report of these audit will be provided to the director of nursing. 4. 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.	08/31/10 10/19/10 10/19/10 10/28/10
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations during the survey period it was determined that dietary services were not adequate to ensure that foods are prepared and	F 371		

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F 371	Continued From page 116 served in a safe and sanitary manner as evidenced by: the ice cream freezer doors failed to close and seal properly in one(1) of one (1) observation, Salisbury steak was observed unthawing on top of a box of pork loin and juices from the Salisbury steak were dripping onto a box of pork loin in one (1) of one (1) observation, six cartons of half and half were stored in the walk in refrigerator past the expiration date in six (6) of six (6) observations, the outer surfaces of the water filter adjacent to the ice machine was soiled in one (1) of one (1) observations, frozen chicken was observed unthawing above 70 degrees Fahrenheit in three (3) of three (3) observations, open drains under sink were soiled with debris in two (2) of two (2) observations, chemicals cleansers were stored under the sink in two (2) of two (2) observations, the gear surfaces on the manual can opener was soiled with rust in one (1) of one (1) observation, facility staff were observed in the main kitchen without a hair net in two (2) of two (2) observations, the shelf surface of the pot and pan track was soiled with accumulated debris of grease and water residue, cutting boards were observed to be worn with grooves in board surfaces in two (2) of two (2) observations, condiment jars located in the cook ' s preparation area lacked an open date in 22 of 22 observations, and cold foods were served above 41 degrees during a test tray observation in four (4) of six (6) observations. The findings include: 1. The ice cream freezer doors failed to close and seal properly allowing cold air to escape from the freezer compartment in one(1) of one (1) observation at 9:05 AM on August 2, 2010. 2. A box of Salisbury steak was observed unthawing on top of a box of pork loin, liquids	F 371	Continued From page 116 **#1. The corrective actions taken are:** 1. A new refrigerator has been ordered for the storing of dairy products and has been received as of 10/14/10. 2. The Salisbury steak was removed and immediately cooked at the appropriate temperature. 3. The half and half was removed from the walk in and disposed of in the garbage disposal at the time of the survey finding. 4. The water filter was cleaned at the time of the survey finding. 5. The chicken being thawed during the time of this deficiency was immediately discarded. 6. The drains were cleaned during the survey process and placed in the locked closet. The drains have been repainted for a fresher look. 7. A new can opener was purchased and installed to replace the old unit on 8/11/10. The item was delivered on 8/10/10. 8. The cooks and utility staff will date spices and seasonings as new ones are opened for usage. 9. The administrative staff was informed to place a hairnet on his head while in the kitchen during the survey process, which was completed. 10. The pot and pan rack was cleaned when indicated as being deficient during the survey process. 11. The cutting boards were replaced with new cutting boards at the time of the survey process. 12. Test trays are conducted bi-weekly by the Director of Food Services Department, which is conducted from the time that the test tray is assembled until the time of delivery to the resident.	10/14/10 8/11/10 8/11/10 8/11/10 8/11/10 8/11/10 8/11/10 8/11/10 8/11/10 8/11/10 8/11/10

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#2. The following corrective actions have been implemented for areas that have the potential to be affected by this practice:

1. The new refrigerator will replace the ice cream cooler. It will be maintained with a temperature log and refrigerator thermometer. It will be placed on a weekly cleaning schedule. 10/14/10

2. The staff was in-serviced on August 16th about the placement of food on the shelves and competency was given to the staff. The staff have been instructed on the requirement and reason for the requirement of appropriate storage of refrigerated food items on the correct shelf, which entailed instruction on the top shelf contains ready to eat food, second is seafood, third is whole roast, fourth is ground beef and the last shelf is raw chicken. 8/16/10

3. The utility staff and cooks were in-service on August 31st to check all dates on all perishable items. 8/31/10

4. The water filter was cleaned at the time of the survey finding. 8/11/10

5. Fresh chicken does not require defrosting will be utilized, until the water temperature control is resolved. 8 /31/10

6. The floor drains have been placed on weekly cleaning list. The drains will be checked by the weekend supervisor after cleaning. 8/11/10

7. A new can opener was purchased and installed to replace the old unit on August 11, 2010. 8/11/10

8. The cooks and the utility staff were in-serviced on the dating of spices and seasonings; on the dating of new spices and seasonings as they are opened. 8/11/10

Continued From Page 117B

9. Hairnet stations will be placed at each of the door areas entering into the main kitchen. 10/19/10

10. The pot and pan rack was placed on a weekly cleaning schedule. 8/11/10

11. Back-up cutting boards will be maintained in the department at all times. The boards will be checked bi-weekly for marring and scarring and replaced immediately. 8/11/10

12. Test trays are conducted bi-weekly by the Director of Food Services department, which is conducted from the time that the test tray is assembled till the time of delivery to the resident. 8/11/10

#3. **Measures/systematic changes are as follows:**

1. The temperature of the refrigerator will be recorded daily and the results will be reported the to the CQI committee quarterly. 10/14/10

2. The staff was in-serviced on August 16, 2010 about the placement of food on the shelves and a competency was given to the staff. The staff have been instructed on the requirement and reason for the requirement of appropriate storage of refrigerated food items on the correct shelf, which entailed instruction on the top shelf contains ready to eat food, second is seafood, third is whole roast, fourth is ground beef and the last shelf is raw chicken. 8/16/10

3. The staff was in-serviced on August 16, 2010about the placement of food on the shelves and a competency was given to the staff. 8 /31/10

4. The outer surfaces of the water filter were placed on a weekly cleaning schedule. 8/31/10

5. The cooks have been in-serviced on the proper thawing of foods, which included chicken. 10/13/10

Continued From Page 117C

6. The utility aides and the cooks were in-serviced to place all chemicals in the closet. The floor drains have been placed on the weekly cleaning list. The drains will be checked by the weekend supervisor after cleaning. 10/13/10

7. An alternative can opener will be available in the kitchen as a spare/back-up at all times. 8/23/10

8. A monthly audit which checks to ensure that all spices and seasonings will be conducted by the Food Services Director/designee. Hairnet stations will placed at each of the door areas entering into the main kitchen. 9/30/10

9. Hairnet stations will placed at each of the door areas entering into the main kitchen. 10/19/10

10. A pot and pan rack was placed on a weekly cleaning schedule, which will be audited on a monthly basis by the Director of Food Services/Designee utilizing the Food Sanitation tool. 10/19/10

11. Back-up cutting board will be maintained in the department at all times. The cutting boards will be checked weekly for marring and scarring and replacement will be completed upon discovery. 8/11/10

12. Test tray temperatures will be monitored on a biweekly basis and will be reviewed by the Director of Food Services/Designee on a monthly basis as part of the Food Safety audit. A senior dining program was introduced on September 30, 2010 on all three floors and in the main dining room to provide the residents with a quality dining experience, which entails ensuring that meals are served at the required food temperatures. 8/30/10

Continued From Page 117D
#4. Monitoring to assure that solutions are sustained entail:

1. The temperature of the refrigerator will be recorded daily and the results will be reported the to the CQI committee quarterly. 10/28/10

2. The food items will be monitored each morning by the supervisor and the results will be reported to the CQI committee meeting quarterly. 10/28/10

3. All food items will be monitored each morning by the opening supervisor and the results reported to the CQI committee quarterly.

4. The sanitation of water filters will be checked via the opening supervisor each morning and results will be reported to the CQI committee on a quarterly basis.

5. The temperature log will be completed for all pulled food items on a daily basis. Findings and corrective actions implemented upon discovery will be reported to the CQI committee monthly.

6. The daily opening and closing list will be reviewed by the utility aides and the cooks were in-serviced to place all chemicals in the closet. The Director of Food Services. District Manager will conduct monthly food sanitation audits and these audits will be reported to the CQI committee quarterly until the committee determines that this area of concern has been resolved.

7. An alternative can opener will be available in the kitchen as a spare/back-up at all times.

8. A monthly audit which checks to ensure that all spices and seasonings will be conducted by the Food Services Director/designee and reported to the CQI committee quarterly.

9. All food service staff will monitor all persons walking into the department to make sure hairnets are being worn and are available at each hair net station. Signs have been posted at the entrance doors to the kitchen.

If continuation sheet Page 117E of 212

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10. Pot and pan rack cleaning compliance will be monitored via the opening/closing checklist. The results will be reported by the Director of Food Services/Designee to the CQI committee quarterly.

11. Compliance will be monitored weekly via the weekly walk through check list. It will be reported by the Director of Food Services/Designee to the CQI committee quarterly.

12. Test tray temperatures will be monitored on a biweekly basis and will be reviewed by the Director of Food Services/Designee on a monthly basis as part of the Food Safety audit. The results of the audit and corrections implemented is applicable will be reported to the CQI committee monthly for three months, then quarterly.

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F 371	Continued From page 117 from the Salisbury steak was observed dripping onto the box of pork loin in one (1) of one (1) observation at 9:15 AM on August 2, 2010. 3. Six cartons of half and half was observed in the walk in refrigerator and was held beyond the expiration date of July 31, 2010 in six (6) of six (6) observations at 9:20 AM on August 2, 2010. 4. The outer surface of the ice machine water filter was soiled with accumulated mineral deposits in one (1) of one (1) observations at 9:25 AM on August 2, 2010. 5. Frozen chicken (legs, thighs, and breasts) was observed unthawing under submerged water in the food preparation sink at a temperature of 80 degrees F, which is above the recommended temperature of 70 degrees F in three (3) of three (3) observations at 9:30 AM on August 2, 2010. 6. Open drains under the cold food preparation and pot wash sinks were soiled with accumulated food and debris in two (2) of two (2) observations at 9:35 AM on August 2, 2010. In addition, chemicals cleansers were stored under the sink in two (2) of two (2) observations on 9:35 AM on August 2, 2010. 7. The gear and cutting surfaces of the manual can opener was soiled with rust deposits in one (1) of one (1) observation at 9:40 AM on August 2, 2010. 8. Condiment jars located in the cook ' s preparation area lacked an open date in 22 of twenty-two (22) observed at 9:40 AM on August 2, 2010. 9. Administrative staff were observed in the main kitchen without a hair net while lunch meal were being prepared in two (2) of two (2) observations at 10:00 AM on August 2, 2010. 10. The shelf surfaces of the pot and pans rack was soiled with accumulated grease and water in four (4) of four (4) rack observations at 10:05 AM	F 371		

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F 371	Continued From page 118 on August 2, 2010. 11. White cutting boards were stored on a rack in the post and pan wash area were observed to have deep grooves in the board surfaces in two (2) of two (2) observations at 10:10 AM on August 2, 2010. 12. During a test tray observation, it was determined that cold foods were served above 41 degrees F as evidenced by the temperature of the vanilla pudding (66 degrees F), juice (46 degrees F), and tapioca pudding(60 degrees F) in four (4) of six (6) observations at 12:49 PM on August 5, 2010. These observations were made in the presence of the Food Service Director Employee #13.	F 371		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 26 sampled records, it was determined the physician failed to review the total plan of care for Resident #3 The findings include: 1. The physician failed to address Resident #3 ' s	F 386		

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F 386	Continued From page 119 attempted elopement. A review of resident #3 ' s clinical record revealed the following: A nursing note dated October 23, 2009 at 10:00 PM noted " New admission notes: A ...new admission ...transferred at 8:00 PM from ...via stretcher ...with diagnosis ... " 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 [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 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 24 years as a	F 386	1. The physician is unable to make correction at this time. 2. All residents have the potential to be affected by this practice. 3. Physicians were educated by the medical director regarding the requirements of physician documentation. A physician's communication log has been implemented. The medical director will complete random audits of physician documentation. 4. The results of the above audit will be reported to the CQI committee quarterly by the Medical Director/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 386	Continued From page 120 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 ... " A further review of the resident ' s clinical record revealed physician notes dated March 11, April 30, May 20 and June 30, 2010 that lacked evidence that the physician addressed the resident ' s elopement attempt. A face-to-face interview was conducted with Employees #5 on August 6, 2010 at approximately 12:45 AM. After reviewing the resident ' s clinical record he/she acknowledged that the physician ' s progress notes lacked evidence that the resident ' s concerns and attempted elopement were addressed by the physician. He/she acknowledged that the resident left the facility AMA sometime in January 2010 and attempted to elope from the facility on July 24, 2010 . He/she added further that he/she will discuss the resident ' s concerns including housing in the community with the physician. It was emphasized to Employees # 2, 5 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.	F 386		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.	F 387		