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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		R 05/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A federal follow up survey to the January 28, 2010 Recertification survey was conducted from May 3, 2020 through May 5, 2010. The following deficiencies were based on observation, record review, staff and resident interviews. The sample included 13 residents and 4 supplemental residents.	{F 000}		
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview for one (1) of 13 sampled residents, it was determined that facility staff failed to inform resident of radiology test results. Resident # 12. The findings include: In a face-to-face interview with Resident #12 on May 3, 2010 at approximately 9:00 AM the resident stated that he/she had a chest x-ray done but still was not able to obtain the results from facility staff. The resident stated that the x-ray had been done at the end of December, 2009 and he/she still had the pain in his/her chest and needed to know what was going on.	F 154	F154 1. Resident #12 was notified of the X-ray results on 05/04/10. The residents primary care physician discussed mammogram results with the resident on 05/30/10. Medication for pain management was ordered and is being administered per order. 2. Nursing management is utilizing a daily audit tool to identify residents with changes in medical status. Nursing management will ensure notification of resident and/or responsible parties regarding any changes in care or treatment that may affect the resident's well being. 3. Nursing staff will be educated as to their responsibilities regarding notification of resident and/or responsible parties of any changes in care or treatment that affects the residents well being. 4. The DON is responsible for maintaining compliance through review of the 24 hour report and the supervisory audit tools. The DON will implement additional action plans and/or disciplinary action as warranted per review. The DON will report audit results to QA committee to determine any additional actions are required.	7/01/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/1/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 154	Continued From page 1 The facility was unable to provide evidence that Resident #12 was notified of the chest x-ray that was completed December 28, 2009. A face-to-face interview was conducted on May 5, 2010 at approximately 3:30 PM with the Employees #2 and #3. They acknowledged that the resident had not been notified of the chest x-ray from December 28, 2009 through May 5, 2010. The record was reviewed on May 5, 2010.	F 154		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview for one (1) of 13 sampled residents, it was determined that facility staff failed to obtain a physician's order to allow Resident #10 to keep and administer medication(s) at his/her bedside. The findings include: On May 3, 2010 at approximately 10:00 AM, two (2) bottles of Anbesol were observed on Resident #10's beside table. Bottle #1 was unopened and contained 12mls (milliliters) of Anbesol and Bottle #2 was opened and contained approximately four (4) mls of Anbesol. The observation was made in the presence of another surveyor and Employee #6.	F 176	1. Resident #10 has been assessed for self administration of medication and orders have been obtained from the physician. Resident #10 and their responsible party have been educated to the facility's self administration of medication policy. 2. There are no other resident's currently self administering medications without appropriate assessment and orders. The DON has educated residents to the self administration of medication policy and process at the bi- weekly coffee hour with residents, an education letter regarding self administration of medication policy will be sent to all current residents and there responsible parties. . Nursing staff and supervisors conduct walking rounds at the start and end of each shift and will check for any noncompliant areas. 3. The nursing staff will be educated to the self administration of medication policy and procedure. This will be inclusive of reporting any medications noted at the bedside to nursing management for immediate corrective action.	

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F 176	Continued From page 2 A review of the record lacked evidence of a physician's order allowing the resident to keep medication(s) at his/her bedside. The clinical record also lacked evidence that the Interdisciplinary Team had determined that it was safe for the resident to self-administer medications. A face-to-face interview was conducted with Employee #6 immediately after the observation. He/she stated, " I know he/she is having problems with a tooth and he/she is probably using the Anbesol for the pain. I had no idea that he/she had it but I will remove it. " Both bottles of Anbesol were observed at the bedside of Resident #10 from May 3 thru 5, 2010. The record was reviewed on May 5, 2010.	F 176	4. The Resident Care Coordinator and Nursing Supervisors are responsible for maintaining compliance through review of the 24 hour report, completion of daily rounds and use of daily audit tools. All findings and corrective actions implemented will be reported to the DON and the QA committee to determine if any additional action is required.	7/01/10
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that for one (1) of 13 sampled residents facility staff failed to identify that the placement of the bed against the wall served as a restraint device and failed to implement restraint policy and procedures. Subsequently the resident developed pressure ulcers on the left great toe and 2nd [second] toe related to friction from rubbing the left foot against the wall. Resident #7	F 221	1. Resident # 7 bed was removed from the wall on May 5, 2010 . The residents wounds are being treated by the Wound Care Nurse and are healing. 2. Environmental rounds were completed by the DON and nursing management team . There were no other residents identified with an unassisted or nonordered restraints. 3. The Nursing staff will be educated to the restraint policy inclusive of appropriate bed/ equipment placement. The nursing management team will make walking round every shift to visually check for bed placement or equipment used that would be defined as a restraint. Any identified areas of non- compliance will be corrected immediately and reported to the DON.	

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F 221	Continued From page 3 The findings include: (Facility) Policy # NS04-060 Titled: RESTRAINTS effective 12/01/08 [December 01, 2008] " USE OF RESTRAINTS The residents have the right to be free from any physical restraint imposed for the purposes of discipline or convenience and not required to treat the resident ' s medical symptoms. POLICY It is the policy of (facility) to use mechanical restraints only upon the order of a licensed physician. Standing orders for restraint are no allowed: PRN [As Needed] Restraint orders are not permissible. Restraints are used for resident safety and never for purposes of convenience or discipline. Restraints will be used with care to avoid any injury to the resident and to minimize discomfort .... DEFINITION RESTRAINTS: Use of physical, mechanical or chemical involuntary restraints restrict the movement of the whole or a portion of resident ' s body as a means of controlling physical activities in order to protect him/her or others from injury. " During the initial tour of the 7th floor unit on May 3, 2010 between 9:00 AM and 10:45 AM the following was observed from the foot of the bed: Resident #7 was noted in bed lying partially on his/her right side with knees and feet facing toward the wall. Bed was in low position with quarter side rails at head of bed and left side of	F 221	4. The DON is responsible for maintaining compliance through review of the 24 hour report and the supervisor daily audit tools . The DON will implement additional action plans and/or disciplinary action as warranted per review. The DON will report audit results to the QA committee to determine if any additional action is required.	7/01/10

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F 221	Continued From page 4 bed was placed flush against the wall. A mat was positioned on the floor to the right side of the bed. This observation was made in the presence of Employee # 4. Resident #7 was admitted to the facility on September 10, 2009 and was 85 years old. A review of the resident ' s annual MDS [Minimum Data Set] assessment dated September 18, 2009 revealed that the resident was coded for Diagnoses of Insulin Dependent Diabetes Mellitus (IDDM), Hypertension, Dementia, Anemia and severely impaired vision. The quarterly MDS, dated March 12, 2010, revealed: Section B was coded -Cognitive skills moderately impaired; Section C was coded - Resident able to make self understood, has clear speech and the ability to understand others; Section G was coded - Bed mobility-total dependent; Transfer-total dependent; Leg and foot -Limitation on one side -partial loss; Bed rails used for bed mobility or transfer. A review of the clinical record revealed that the resident was observed on the floor on April 18, 2010. A care plan for falls dated 04/18/10 [April 18, 2010] indicated use of a fall mat, low positioning of bed, a referral for PT [Physical Therapy] / OT [Occupational Therapy] and neuro [neurological] checks. The care plan did not address the placement of the bed against the wall. A face to face interview was also held on May 5, 2010 with Employee #2 who acknowledged that placement of the bed against the wall for resident #7 was done to keep him/her from getting out of	F 221		

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F 221	Continued From page 6 queried regarding abuse training. Employee #30 stated that training on abuse was provided during orientation when he/she started employment but had received no additional training. Employee #30 was asked why resident #7's bed was positioned against the wall and responded " probably for safety ". When asked if placement of the bed against the wall was considered use of a restraint, he/she responded: " in a way I think they are a restraint, sometimes. It was done without thinking of it as a restraint. [Resident #7] is blind and sometimes is found hanging out of the bed."	F 221		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview for 1 (one) of (13) thirteen sampled residents, it was determined that facility staff failed to implement an ongoing program of activities to meet the Resident ' s individual interest. Resident #2. The findings include: Facility staff failed to provide activities as care planned for Resident #2. During survey, Resident #2 was observed in her room on three different dates during which time no individual activities were offered: May 4, 2010-	F 248	F248 1. Resident #2 is receiving daily music and is also being read to two times per week by the activities Department. This resident's care plan has been updated to include current interventions. 2. The Activities Department has reviewed all residents to ensure activity plans have been developed and implemented to meet each residents needs. 3. Activities staff have been reeducated to the resident activity care plans inclusive of implementation and documentation of services received. 4. The Activity Director will monitor compliance through review of daily activity participation forms. The Activity Director will conduct and document two random audits per week to validate compliance. The Activity Director will implement additional action plans and/or disciplinary action as warranted per review and audits. The Activity Director will report audit results to the QA committee and determine if any additional action is required.	7/01/10

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F 248	Continued From page 7 11AM-4:00PM, May 5, 2010 - 11AM-4PM and May 6, 2010- 11AM-2PM. The Resident was observed in bed, alert and responsive without evidence of any structured activities. According to Resident #2 ' s comprehensive plan of care, revised December 13, 2009 (Problem #18) for Activities, revealed the resident required in room activities. Passively participates in structured activities: approach...provide soothing spiritual music. A face to face interview was conducted with Employee #13 on May 5, 2010 at approximately 11:00AM. He/she acknowledged that the resident was not provided soothing spiritual music or structured activities as ordered.	F 248	F253 1. The water temperatures that were cited as low as 66 degrees in 10 of 16 rooms were corrected during the survey period. • The water temperatures that were cited to have barely met the met minimum requirement of 95 degrees F and took longer than five minutes in 6 of 16 resident's rooms will be corrected to heat up in a more timely fashion by May 6, 2010.. The privacy curtains that were cited as damaged or missing hooks during the survey period were replaced.	
{F 253} SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during environmental tours of the facility on May 3-5, 2010, it was determined that the facility failed to provide effective maintenance services in residents rooms including low water temperatures in 10 of 16 resident rooms, damaged privacy curtains in three (3) of 16 resident ' s rooms, a television set and a slow to flush toilet in one (1) of 16 resident ' s rooms, dusty bed frames in six (6) of 16 resident ' s rooms, and 11 damaged tiles in one (1) of 16 resident ' s rooms.	{F 253}	The television that was cited as not functioning as intended, in 638 will be corrected by July 1, 2010. The toilet that flushed slowly in room 638 was corrected on May 6, 2010. The bottom rails of bed frames that were cited as dusty is six of sixteen rooms have been cleaned as of 05/05/10. The eleven tiles that were cited as damaged in room number 627 were repaired as of June 1, 2010. 2. All other mixing valves, privacy curtains, TV, Toilets, tiles and bed frames were checked to ensure proper compliance. No other issues were found.	

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F 221	Continued From page 5 the bed but not thought of as a restraint. A review of the Wound Care Nurse's notes dated April 27, 2010 at [time not legible] reveals ... " #1 Left great toe wound 0.7 x1.5 x0.3 cm in size...#2 is on resident's left 2nd [second] toe 1x 1.3 x 0.3 cm in size Wound care for this resident was observed on May 4, 2010 at approximately 11:00 AM being provided by Employee #29. The left great toe and left 2nd were observed with scabbing and drainage. Employee #29 stated: "Medical Director observed areas on toes and thinks they are the result of the resident rubbing toes against the wall". The weekly wound rounds report dated 5/5/2010 [May 5, 2010] identified the left great toe as a Stage II pressure ulcer with a measurement of [.7 x 1.5 x .3 cm] comments indicate a " Dry Stable Scab " . The left 2nd toe is identified as a stage III pressure ulcer with a measurement of [1.5 x 1.8 x .3 cm] with moderate drainage. Lab results for a culture and sensitivity of Left second toe drainage [dated Final May 1, 2010] indicates " Staphylococcus Aureus (MRSA) " . A review of the clinical record lacked evidence that the positioning of the bed against the wall was identified as a restraint and that protocols were observed related to restraint use. Resident #7 subsequently developed the above pressure ulcers from friction contact with the wall. A face to face interview was conducted with Employee #30, a night supervisor, at 9:15 AM the morning of May 5, 2010. The employee was	F 221		

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{F 253}	Continued From page 8 The findings include: 1. Water temperatures were as low as 66 degrees Fahrenheit (F) in 10 of 16 resident 's rooms:#727, 724 718, 716, 706, 701, 603, 618, 616, 619. 2. Water temperatures barely met the minimum requirement of 95 degrees F and took longer than five minutes in six (6) of 16 resident's rooms (rooms 722, 719, 718, 721, 624, 627) to reach that minimum. 3. Privacy curtains were damaged or missing hooks in three (3) of 16 residents rooms. 4. The television set did not function as intended and the toilet flushed slowly in room # 638. 5. The bottom rails of bed frames were dusty in six of sixteen resident ' s rooms. 6. Eleven tiles were damaged in room # 627. These observations were made in the presence of employee # 23 and #24 who acknowledged these findings during the survey.	{F 253}	3. The Director of Environmental Services (EVS) has developed individual cleaning schedules to monitor cited deficiencies and ensure compliance. All environmental services staff have been in-serviced on the 10-step cleaning process. Environmental rounds will also be used to maintain compliance. 4. Findings will be monitored monthly for three months, then quarterly by the Director of Environmental Services or designee and presented to the in QA committee starting July 1, 2010.	07/01/10
{F 281}	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 observations during the medication pass conducted on May 3, 2010 at 10:30 AM, it was determined that facility staff failed to use correct placement of blood pressure cuff to measure one (1) resident ' s blood pressure. Resident M3. The findings include:	{F 281}	1. Resident M3's blood pressure readings are being completed with the correct placement of the blood pressure cuff. The employee Identified was reeducated to the correct application of the blood pressure cuff. 2. No other resident was found to be affected by this deficient practice. 3. The nursing staff will be educated on the correct placement of a blood pressure cuff. The education will include assessment of the competency of the staff by completion of a demonstration of the proper placement and use of the B.P. cuff. Competency results will be documented on the nursing management daily audit tool.	

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{F 281}	Continued From page 9 Facility staff failed to obtain blood pressures in accordance with professional standards of measuring blood pressure. During the medication pass observation conducted on May 3, 2010 at 10:30 AM on 7TH floor, the facility staff wrapped a regular adult blood pressure cuff around the resident ' s left upper arm. The range for use was identified on the cuff with white markings and arrow for placement at the ante-cubital space. The cuff wrapped around Resident M3's upper left arm was secured and inaccurately placed as per the manufacturer's identified range for use. The cuff was wrapped around Resident M3' s upper left arm and was secured approximately 1 " (one inch) past the white arrow markings, labeled on the blood pressure cuff to identified the placement of the cuff; the arrow markings were pointed away from the ante-cubital space. A face-to-face interview was conducted with Employee #4 at the time of the observation. He/she acknowledged that the blood pressure cuff was not in the correct position on the resident's arm and was placed over the resident clothing. The record was reviewed on May 3, 2010	{F 281}	4. Resident care coordinators and the nursing supervisors will continue to conduct two audits per week to visually verify the proper placement of the BP cuff by the staff for the next three months. Immediate corrective action will be instituted for any noted non – compliance and reported to the DON. The DON will implement any additional action plans and /or disciplinary action as warranted per findings. The RCC will report audit results to the QA committee to determine if any additional action is required.	7/01/10
{F 309} SS=D	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.	{F 309}		

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{F 309}	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on an observation, record review and staff interview for two (2) of 13 sampled residents and two (2) of four (4) supplemental residents, it was determined that facility staff failed to sign and date the Duragesic Patch that was applied to the right chest wall for one (1) resident; failed to make sure administered medication was completely taken by one (1) resident; and failed to follow manufacture recommendation for crushing a gel cap and other medications at the same time /together for one (1) resident. Residents #10, 12, M2, and M3. The findings include: 1. Facility staff failed to date and sign Duragesic patch that was applied to Resident #10's chest wall. On May 5, 2010 at approximately 10:00 AM the resident was observed with a patch partially applied to his/her right chest wall. A piece of tape (approximately three to four inches in length) was partially secured across the patch. The surveyor asked the resident when was the patch applied and he/she responded, " A few days ago. I think it is going to be changed today. " A review of the physician's order dated March 8, 2010 which directed, " Duragesic patch 50mcg 1 externally to chest wall every 3 days for pain". Review of the Medication Administration Order [MAR] sheet revealed the following, " Fentanyl/Duragesic Patch 50mcg/hr. Apply 1	{F 309}	1. Resident #10 had no negative outcome related to this deficiency. The duragesic patches are being dated and initiated with application. Resident # 12 has been assessed by the physician and is receiving treatment for pain management. Resident #M2 had no negative outcome related to this deficiency and is receiving medications in the appropriate dosage form. Resident # M3 had no negative outcome related to this deficiency and is receiving complete dosage of medications as ordered. 2. The facility realizes that all residents may be impacted by this deficiency. Nursing Management is completing rounds daily utilizing an audit form and will be visually checking that there are no medications at bedside, all patches are labeled, dated and initialed and residents are receiving entire medication. Medication pass competencies are being completed to validate the sttaff knowledge of administering medications in the appropriate dosage form, use of DO NOT CRUSH lists and the drug handbook. Nursing management will review the 24 hour report daily to ensure appropriate assessment and treatment of residents identified with pain. The nursing management team will implement immediate corrective action per findings on rounds and review of the 24 hour report. Findings will be reported to the DON.	7/01/10

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	095039		R 05/05/2010

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{F 309}	Continued From page 11 patch externally to rotating sites every 72 hours for pain". The time of administration was listed as 10:00AM and the dates for administration were identified with a box. According to the documentation on the MAR the patch was last administered on May 2, 2010. A face-to-face interview was conducted with Employee #31 at approximately 10:15 AM on May 5, 2010. He/she acknowledged that he/she had neglected to sign and date the patch before placing it on the resident's chest on May 2, 2010. The record was reviewed on May 5, 2010. 2. Facility staff failed to accurately assess resident ' s complaint of pain and to address his /her concerns about changes in body image for three (3) months for Resident #12. The 53 year old resident was admitted to the Facility on November 10, 2009. The resident is alert and oriented x 3 and independent in activities of daily living. In a face-to-face interview with Resident #12 on May 3, 2010 at approximately 9:00 AM the resident stated that he/she had a chest x-ray done but still was not able to obtain the results from facility staff. The resident stated that the x-ray had been done at the end of December, 2009 and he/she still had the pain in his/her chest and needed to know what was going on. When queried about the type and location of the pain the resident stated that the pain was actually in his/her breasts not chest. An observation and assessment was made of the resident ' s chest area by Employee # 3 with the resident ' s permission. Areas of swelling were noted on the	{F 309}	3. The licensed staff will be educated on procedure and documentation for the following: comprehensive pain assessments, medication administration policies inclusive of dating and initialing of medication patches , ensuring residents receives entire medication dosage and not leaving medications at the bedside and utilization of the Do Not Crush list and the nursing drug hand book to ensure medications are administered in there proper form. Medication pass competencies will be completed with the licensed staff. 4. The Resident Care Coordinators and the Nursing Supervisors will monitor compliance through use of daily audit tools and rounds. Findings will be reported to the DON who will implement additional action plans and /or disciplinary action as warranted. Audit result will be reported the QA committee on going.	7/01/10

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{F 309}	Continued From page 12 resident ' s chest the left being greater than the right. A small lump was palpable under the resident ' s left arm pit. The resident was asked if he/she had told facility staff about the pain and swelling in his/her chest and responded yes. The resident stated that he told his Primary Medical Doctor, Employee #27 and Employee #28. Nurse ' Note dated and signed 12/26/09 at 1:00 AM reveals: ' c/o pain [Left] side of [his/her] nipple at 12:40 AM. [Name] Nurse Practioner called and ordered to continue Percocet. ' Admission History and Physical dated and signed by Primary Medical Doctor on November 11, 2010 and Physician ' s notes dated and signed November 26, 2009, December 28, 2009, January 27, 2009, February 15, 2010 and March 31, 2010 lacked evidence that swelling in the resident ' s chest area had been noted. Employee #3 informed Medical Director about resident ' s lack of documented assessment of swelling in breasts and the Medical director assessed the resident on May 5, 2010. New orders were received and a Bilateral Mammogram was performed on May 5, 2010. The results are on the clinical record. A face-to-face interview was conducted on May 5, 2010 at approximately 3:30 PM with the Employee #2 and #3. He/she acknowledged that the resident had not been assessed or evaluated for treatment of bilateral swelling of the breast from December 26, 2009 through May 5, 2010. The record was reviewed on May 5, 2010.	{F 309}		

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{F 309}	Continued From page 13 3. Facility staff failed to make sure administered medication is completely taken by Resident M2. On May 3, 2010 at 10:15AM during med pass resident was observed to have cough medicine sitting in medication cup at the bedside. Facility staff verified that the medication was administered on the earlier shift and discarded it. A face-to-face interview was conducted with Employee #15 on May 3, 2010 at10:20 AM. He/she acknowledged that Resident M2 ' s medication was left at his/her bedside instead of being administered by facility staff. 4. Facility staff failed to follow recommendations for not crushing gel capsules for Resident M3. The findings include: "2009 Lippincott's Nursing Drug "Appendix G [pages1255-1256] provides a listing of "Tablets and capsules that should not be cut, crushed , or chewed"...example a liquid within a capsule... On Wednesday May 5, 2010 at 9:20 AM, observations were made as the nurse administered medications to Resident M3. In the course of preparing medications for Resident M3, the nurse crushed Docusate gel cap100mg, ferrous sulfate tablet 325mg; multivitamin 1 tablet, Nifedipine tablet 30mg and Percocet tablet 5/325mg together. The medications were then administered in applesauce. The record was reviewed on May 5, 2010	{F 309}		
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	{F 323}		

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{F 323}	Continued From page 14 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations during the medication pass conducted on May 3, 2010 at 9:25AM, it was determine that facility staff failed to properly identify one (1) of nine (9) resident prior to administering medication. Facility Staff failed to check arm band of resident #M4 during medication pass. The findings include: On May 5, 2010 facility staff was observed administering medication to resident #4. He/she greeted resident and did not check for the resident arm band before giving the medication. A face-to-face interview was conducted with Employee #7 at the time of the observation. He/she acknowledged that the resident arm band was not checked.	{F 323}	1. Resident #4 had no negative outcome related to the deficiency. 2. The facility realizes that all residents may be impacted by this deficiency. Medication pass competencies will be conducted with licensed staff to ensure the checking of residents armbands prior to the administration of medications. 3. Licensed staff will be educated on properly identifying residents prior to administering the residents' medications by checking armbands and recent pictures per facility policy. 4. The Resident Care Coordinators and the Nursing Supervisors will be responsible for monitoring compliance. They will conduct random visual audits twice per shift per shift for the next month to validate the checking of resident armbands. Findings will be reported to the DON who will implement additional action plans and /or disciplinary action as warranted. Audit result will be reported the QA committee (on going)	7/01/10
{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: Injections;	{F 328}		

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{F 328}	Continued From page 15 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, record review, staff and resident interviews for four (4) of 13 sampled residents, it was determined that facility staff failed to: to date, time and initial midline catheter dressing for one (1) resident ; and to properly label tube feeding for three (3) residents. Residents #2, 7, 8 and SM1 The findings Include: 1. Facility staff failed to date, time and initial midline dressing for Resident #2. On May 3, 2010 at 4:40PM Resident #2 was observed in bed alert and responsive. The resident agreed to allow an observation of the mid line catheter of the right upper extremity. The Midline was covered with a transparent dressing without evidence of date, time and/or initials on dressing. The clinical record revealed the Midline catheter was inserted on April 29, 2010. The facility ' s m id-Line catheter protocol stipulated that the site of the midline catheter labeled with date/time and initials. The dressing must be changed within 24 [twenty-four] of insertion and then every 7 [seven] days and as needed.	{F 328}	1. Resident # 2, midline catheter was removed on 05/28/10. Residents # 7,#8,SM1, tube feedings are being labeled, dated and initialed per policy. 2. There are currently no residents receiving intravenous therapy. New orders for intravenous therapy will be monitored daily for dressing changes and kept on the 24 hour report until intravenous therapy is discontinued. A master list of residents has been developed listing residents that are receiving tube feedings. Nursing management is utilizing a daily audit tool and will visually validate labeling, dating and initialing of intravenous dressing and tube feedings every shift. 3. Licensed staff will be educated on the requirements for labeling, dating and initialing of all dressings and tube feedings. 4. The Resident Care Coordinators and the Nursing Supervisors will be responsible for monitoring compliance. They will utilize the daily audit tools to visually check intravenous dressings and tube feedings containers every shift. Findings will be reported to the DON who will implement additional action plans and /or disciplinary action as warranted. Audit result will be reported the QA committee (on going)	7/01/10

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{F 328}	Continued From page 16 There was no evidence that the resident ' s dressing had been changed and the dressing was not labeled in accordance with the facility ' s protocol. A face-to-face was conducted on May 3, 2010 at 4:40PM; he/she acknowledged that the dressing lacked evidence of dressing being changed in accordance with facility ' s protocol. The clinical record was reviewed on May 3, 2010. 2. Facility staff failed to properly label containers of tube feeding for residents #7, 8 and SM1 During the initial tour of the 7th floor unit on May 3, 2010 between 9:00 AM and 10:45 AM the following was observed and noted: A. Tube feeding was being administered via G-tube to resident #7. The container of Glucerna was not labeled with the date, time, rate of administration or initials of person hanging the feeding. A bag of water hanging parallel to the feeding was labeled B. Tube feeding was being administered to Resident # 8. The container of tube feeding was not labeled with the date, time, rate of administration and initials of person hanging the feeding. C. Tube feeding was being administered via G-tube to resident #SM1. The container of Jevity was not labeled with the date, time, and rate of administration and initials of person hanging the feeding. A bag of water hanging parallel to the feeding was labeled	{F 328}		

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{F 328}	Continued From page 17	{F 328}		
	On May 3, 2010 at approximately 4:30 PM a face to face interview was conducted with employee #4. Employee # 4 acknowledged the findings. Employee #4 later stated that the feeding were hung by a nurse from the " Float Pool" .		{F 332 1. There are no specific identified residents in this deficiency.	
{F 332} SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Facility staff failed to maintain med error rate less than 5% Based on observations during medication pass on the 6th and 7th floor nursing units and review of documents (Medication Administration Records and physicians' orders), it was determined that the facility had a medication error rate of 7.0%. Morning medication pass was observed on Tuesday, May 4, 2010 and Wednesday, May 5, 2004. Twenty-nine (29) opportunities were observed on Tuesday, May 4, 2010 and fourteen (14) opportunities were observed on Wednesday, May 5, 2010. These observations included four (4) nurses on both units. After the medication pass on Tuesday, the observed medications were reconciled with the physicians' orders. Three medication errors were observed: Facility staff failed to follow manufacture recommendation for crushing gel cap and other medications together.	{F 332}	2. The facility realizes that all residents have the potential to be affected by this deficiency. Medication pass competencies will be conducted with licensed staff . Competency will include the following: Visual verification of licensed staff completing G-tube flushes per policy, oral quiz on where to find and how to use the DO NOT CRUSH list and nursing handbooks and an oral quiz on what to do when a medication is not available inclusive of use of the Interim drug box. 3. Licensed staff will be educated Regarding the following: administration of medications in their proper form, use of the "DO NOT CRUSH" list and the nursing drug hand book, the Interim drug box, G-Tube flushing before and after medication administration and the process to follow when a medication is not available. 4. The Resident Care Coordinators and the Nursing Supervisors will be responsible for monitoring compliance. They will conduct two random medication pass audits per shift each week to ensure compliance. Findings will be reported to the DON who will implement additional action plans and/or disciplinary action as warranted. Audit result will be reported the QA committee (on going)	7/01/10

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{F 332}	Continued From page 18 Facility staff failed to flush G-tube before and after medication administration. Facility staff failed to administer a daily dose of Digoxin 0.125mg. significant errors + non-significant errors doses given + doses ordered but not given = medication error rate 3 = 3 42 + 1 43 0.0698 x 100 = 6.97674% or 7.0% medication error rate	{F 332}		
{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 by: Based on observation and review of documents (physician's order and Medication Administration Record (MAR) for one (1) of 13 sampled residents and one (1) of four (4) supplemental residents , it was determined that the facility staff did not ensure that two (2) residents were free of any significant medication errors. Resident # 8, M1 The Findings include: 1. Facility staff failed to flush G-tube before and after medication administration. Resident #8 On May 3, 2010 at 10:25 AM during the morning	{F 333}	1. Resident# 8 had no negative outcome from this deficiency and is receiving G-Tube flushes as ordered. Resident M1 is receiving digoxin as ordered. The employee who failed to administer the Digoxin dose was educated to the use of the Interim Box and process to follow if a medication is not available. 2. The facility realizes that all residents have the potential to be affected by this deficiency. Medication pass competencies will be conducted with licensed staff . Competency will include the following: Visual verification of licensed staff completing G-tube flushes per policy and an oral quiz on what to do when a medication is not available inclusive of use of the Interim drug box.	

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{F 333}	Continued From page 19 medication pass, the medication nurse was observed crushing all of the resident 8's medication that was to be administered via G-tube for the resident. The resident ' s medication included Aricept 5 mg, Aspirin 81mg and liquid Prosource 30ml. Prior to administering medication via G-tube facility staff did not flush with 30ml of water. The medication did not flow from syringe into G-tube staff had to use the syringe plunger to push medication into G-tube. After last medication was administered facility staff failed to flush with 30 ml of water before attaching G-tube to feeding pump. 2. Facility staff failed to administer a daily dose of Digoxin 0.125mg. Resident #M1 On May 4, 2010 at 9:10AM during the morning medication pass, the medication nurse was observed preparing resident M1's medication. The resident ' s medication included Metoprolol 100 mg, Spirnolactone 50mg, Digoxin 0.125mg, Beniprotein 1 pack, Juven powder 1 pack and liquid Prosource 30ml. The Digoxin was not available, facility staff stated that the medication was finished he/she was going to get in touch with pharmacy. On May 4, 2010 at 3:00PM the nurse left for the day without giving resident #M1 his/her Digoxin. On May 5, 2010 at 8:50AM resident #M1 ' s " MAR " revealed that facility staff failed to administer a daily dose of Digoxin 0.125mg for the resident on May 4, 2010. An inspection of interim box revealed that there were ten 0.125mg digoxin located in the interim box. A face-to-face interview was conducted with	{F 333}	3. Licensed staff will be educated regarding the following: the Interim drug box and the process to follow when a medication is not available, G-Tube flushing before and after medication administration . 4. The Resident Care Coordinators and the Nursing Supervisors will be responsible for monitoring compliance. They will conduct two random medication pass audits per shift each week to ensure compliance. Findings will be reported to the DON who will implement additional action plans and/or disciplinary action as warranted. Audit result will be reported the QA committee (on going)	07/01/10

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{F 333}	Continued From page 20 Employee 4 #. He/she acknowledged that there were ten 0.125mg digoxin located in interim box on May 4, 2010the day that resident #M1 did not receive his/her digoxin.	{F 333}	F371 1. The food items of rye bread, wheat bread, hot dog rolls, steak rolls, one bag of marinara sauce, one bag of chicken noodle soup, and pork gravy that were cited as expired during the survey period have been discarded.	
{F 371} SS=D	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 that were made during a tour of the dietary services on May 3-5, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by expired foods such as 15 of 15 loaves of bread, 19 of 19 packs of rolls and three (3) of three (3) 96 ounce bags of foods, inconsistent final rinse dishwashing machine temperatures that fluctuated between 176 and 192 degrees Fahrenheit (F), two (2) of two (2) fire extinguishers that were past due their inspection date; soiled equipment and food containers such as one (1) of one (1) baking oven, three (3) of three (3) food warmers, 43 of 51 spice containers and the kitchen floor; 10 of 35 jars of salad dressing that were not dated; dishwashing machine temperature logs that were not recorded for 4 months and dish washing machine temperature logs that were pre-recorded for one	{F 371}	The dishwashing machine temperatures that were cited as inconsistent, final rinse temperature gauge was sporadic and temperatures fluctuated above and below 180 degrees Fahrenheit were corrected during the survey period. The machine leaks in 3 to 4 places including the vacuum breaker will be corrected by July 1, 2010. The two fire extinguishers and the ansul fire extinguishment system that were cited as past due for their annual verification were corrected during the survey period. The spice containers, compartment warmers , and baking and kitchen floors that were cited as soiled and in need of cleaning have been cleaned. The ten one gallon jars of salad dressing that were cited as not labeled or dated during the survey period have been corrected. The temperature logs that were cited as unavailable from December 2009 through March 2010 have been corrected. by July 1, 2010.	

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{F 371}	Continued From page 21 day, 12 of 12 freezer and cooler units that were not identified and one (1) of one (1) drain line that extended too far into the drain. The findings include: 1. Food items were stored beyond their expiration date such as: Three (3) of three (3) loaves of light rye bread (April 30) 12 of 12 loaves of wheat bread (April 29) 10 of ten 10 packs of hot dog rolls (April 30) Nine (9) of nine (9) packs of steak rolls (April 26) One (1) of one (1) 96 ounce bag of marinara sauce (April 29) One (1) of one (1) 96 ounce bag of chicken noodle soup (April 28) One (1) of one (1) 96 ounce of pork gravy (April 20). 2. Dishwashing machine temperatures were inconsistent, final rinse temperature gauge was sporadic and temperatures fluctuated above and below 180 degrees Fahrenheit (F). As observed, final rinse temperature was between 176 and 192 degrees F, rinse temperature was 144 degrees F (160 degrees F) is required and wash temperature was 154 degrees F (150 F required). Machine leaks in three (3) to four (4) different places including the vacuum breaker. According to contractor and engineering, the steam solenoid valve needs to be replaced also. 3. Two (2) of two (2) fire extinguishers and the Ansul fire Extinguishment system were past due for their annual verification, Their last inspection date was April 2009.	{F 371}	The dishwasher temperature logs that were cited to have pre-recorded temperatures on May 4, 2010 at 0940 hours have been corrected to ensure deficient practice does not reoccur. The ten to twelve freezer units that were cited as not alphabetically or numerically numbered during the survey period have been corrected. The drain line from the coffee machine and the drain that was cited as not having the proper air gap will be corrected. 2. All other areas concerning these cited deficient practices were checked and no other issues were found. 3. The dietary director or designee will make weekly rounds to ensure food has not expired or begun the deterioration process to ensure compliance. Dietary staffs were in-serviced on rotating and labeling food products. This in-service was held on May 24, 2010. The dishwasher will be monitored on a monthly basis to ensure compliance, and prevent deficient practice from re-occurring. The mechanical dishwasher has been repaired, and cleaning procedures for washing, rinsing, and sanitizing pots and pans have been implemented. All dietary staff have been in-serviced on this policy. All plant operations staff will be in-serviced on proper routine maintenance policies and procedures. The Plant Operations Manager will perform the in-service by July 1, 2010.	

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{F 371}	Continued From page 22 4. The following items were soiled and in need of cleaning: Thirty-five (35) of forty-three (43) 24-ounce spice containers Eight (8) of eight (8) 5 to 7 pounds spice containers One (1) of one (1) sixteen compartments warmer Two (2) of two (2) six compartment warmers One (1) of one (1) baking and the kitchen floor. 5. 10 of 35 one gallon jars of salad dressing were not labeled or dated. 6. Dishwasher temperature logs were not available from December 2009 thru March 2010. 7. Dishwasher temperature logs received on May 4, 2010 at 0940 hours included lunch and dinner pre-recorded temperatures. 8. Approximately ten (10) to twelve (12) freezer and cooler units are not alphabetically or numerically identified and temperature logs are not specific to any one unit. 9. There was no air gap between the drain line from the coffee machine and the drain. These observations were made in the presence of employee # 25 and #26 who acknowledged these findings during the survey.	{F 371}	All dietary staff have been in-serviced on proper labeling and record keeping of kitchen equipment. This in-service was performed on May 24, 2010. A master cleaning schedule has been devised and implemented for the Dietary Department. Staff were in-serviced on February 2, 2010 by the Director of Dietary Services. Weekly audits will be conducted by the Director of Dietary to ensure compliance. The executive chef has been assigned to maintaining all facets of the storeroom, and all dietary staff have been in-serviced on rotating and labeling food products. This in-service was conducted on May 24, 2010. All dietary staff have been in-serviced on proper log-keeping practices, policies rocedures. All dietary staff have n-serviced on proper labeling and record keeping of kitchen equipment his in-service was performed on May 24, 2010. Plant Operations will make provisions to ensure that this deficient practice does not occur again. All plant operations staff have been in-serviced on proper gap clearance for all condensate lines and drain lines. The ice machine will be checked on a monthly basis on environmental rounds. 4. Findings will be monitored monthly, and then quarterly in by the management or designee of the deficient departments cited and the finding will be reported at the QA meeting monthly.	
{F 386} SS=E	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	{F 386}		07/01/10

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{F 386}	Continued From page 23 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 and resident interview for one (1) of 13 sampled residents it was determined that facility staff failed to accurately assess resident ' s complaint of pain and to address his /her concerns about changes in body image for three (3) months. Resident #12. The findings include: The 53 year old resident was admitted to the Facility on November 10, 2009. The resident is alert and oriented x 3 and independent in activities of daily living. In a face-to-face interview with Resident #12 on May 3, 2010 at approximately 9:00 AM the resident stated that he/she had a chest x-ray done but still was not able to obtain the results from facility staff. The resident stated that the x-ray had been done at the end of December, 2009 and he/she still had the pain in his/her chest and needed to know what was going on. When queried about the type and location of the pain the resident stated that the pain was actually in his/her breasts not chest. An observation and assessment was made of the resident ' s chest area by Employee # 3 with the resident ' s permission. Areas of swelling were noted on the resident ' s chest the left being greater than the	{F 386}	1. Resident #12 has been informed of test results and is receiving treatment. 2. The facility realizes that all residents may be impacted by this deficiency. The attending physician was contacted by the facility about the citied deficiency. 3. The attending physician was educated to requirement to ensure resident current status and treatment plans are addressed in progress notes. 4. The ADON is responsible to maintain compliance through review of the physicians progress notes. Any non-compliant areas will be reported to the Administrator and Medical Director for further action plans and/or disciplinary action as warranted. They will report results to QA committee to develop additional plans.	07/01/10

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{F 386}	Continued From page 24 right. A small lump was palpable under the resident ' s left arm pit. The resident was asked if he/she had told facility staff about the pain and swelling in his/her chest and responded yes. The resident stated that he told his Primary Medical Doctor, Employee #27 and Employee #28. Nurse ' Note dated and signed 12/26/09 at 1:00 AM reveals: ' c/o pain [Left] side of [his/her] nipple at 12:40 AM. [Name] Nurse Practioner called and ordered to continue Percocet. ' Admission History and Physical dated and signed by Primary Medical Doctor on November 11, 2010 and Physician ' s notes dated and signed November 26, 2009, December 28, 2009, January 27, 2009, February 15, 2010 and March 31, 2010 lacked evidence that swelling in the resident ' s chest area had been noted. Employee #3 informed Medical Director about resident ' s lack of documented assessment of swelling in breasts and the Medical director assessed the resident on May 5, 2010. New orders were received and a Bilateral Mammogram was performed on May 5, 2010. The results are on the clinical record. A face-to-face interview was conducted on May 5, 2010 at approximately 3:30 PM with the Employee #2 and #3. He/she acknowledged that the resident had not been assessed or evaluated for treatment of bilateral swelling of the breast from December 26, 2009 through May 5, 2010. The record was reviewed on May 5, 2010.	{F 386}		
{F 431}	483.60(b), (d), (e) DRUG RECORDS,	{F 431}		

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{F 431} SS=D	Continued From page 25 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and review of Controlled	{F 431}	1. There were no specific residents identified in this deficiency. 2. The facility realizes that all residents have the potential to be affected by this deficiency. Nursing Management is utilizing a daily audit tool to review appropriate count of control substances and documentation in controlled substance log. The identified employee received re-education and a written warning on 05/13/10. 3. Licensed staff will receive education regarding counting controlled substances and the documentation process. 4. The Resident Care Coordinators and the Nursing Supervisors will be responsible for monitoring compliance. They will review controlled substances documentation each shift and visually validate completion of the count two times a week on each shift. Findings will be reported to the DON who will implement additional action plans and /or disciplinary action as warranted. Audit result will be reported the QA committee (on going)	07/01/10

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{F 431}	Continued From page 26 Substances records, it was determined that facility staff failed to follow protocol for narcotic counts. The findings include. Facility staff failed to follow protocol for Controlled Substances management by counting narcotic alone. Facility staff failed to sign off on controlled substance medications record after counting narcotics. Facility staff failed to follow facility policy to count controlled substance medications by two (2) licensed health care providers.	{F 431}		
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	{F 441}	1. Staff member # 19 and #20 were immediately coached on the importance of Isolation Precautions, PPE use and the importance of hand washing hygiene. 2. The ICP will maintain a current listing of all residents requiring Isolation precautions. 3. The staff has been in-serviced on the importance of isolation precautions, PPE use and the importance of hand washing before and after resident contact. The staff has been in-serviced to the protocol to disinfect equipment after each use. 4. The Administrator and Director of Nursing will be responsible for ensuring compliance through the use of an audit tool. This tool will be completed daily by Nursing Management. Findings from this audit will be reviewed at the quality Assurance Committee meeting Monthly.	7/01/10

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{F 441}	Continued From page 27 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on an observation and staff interview it was determined that facility staff failed to follow posted guidelines for Contact Isolation and failed to handle linen in a manner to prevent the spread of infection. The findings include: 1. Facility staff failed to follow posted guidelines for Contact Isolation. At approximately 4:00PM on May 5, 2010 Employee #19 and #20 were observed in room 708 which was posted for Contact Isolation. The employees were not wearing personal protective equipment (PPE) - gloves and gowns as directed by the posted signage for Contact Isolation. Employees #19 and Employee #20 exited Room 708 [by- passing the sink located near the door] and without washing their hands. Employee #19 was rolling an automatic blood pressure machine.	{F 441}	1. Employee # 31 was immediately counseled on the fact that once linen touches the floor it is considered contaminated and has to be placed in the laundry for proper cleaning. The contaminated linen was immediately removed from the cart. Counseling was provided on handling contaminated linen. 2. Nursing Management is conducting a daily audit and documenting observation of infection control practices by staff. Observations include: proper handling of linen , use of personal protective equipment and staff hand washing. 3. The Infection control coordinator has in-serviced the staff on proper linen handling. 4. The Administrator and Director of Nursing will be responsible for ensuring compliance through the use of an audit tool. This tool will be completed daily by Nursing Management. Findings from this audit will be reviewed at the quality Assurance Committee meeting Monthly.	7/01/10

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{F 441}	Continued From page 28 Employee # 19 immediately entered room 710 rolling the automatic blood pressure machine and by-passed the sink near the entrance to the room. Employee # 20 was stopped in the hallway and Employee #19 was asked to step into the hallway for a face-to-face interview. A face-to-face interview was conducted with Employee #19 and 20 regarding infection control practices. Employee #19 acknowledged that the posted guidelines for Contact Isolation had not been observed and that he/she had failed to wash hands after providing care to a resident. Employee #20 acknowledged the same and when queried about the automatic blood pressure cuff going from room 708 to room 710 without being cleaned stated that it should have been wiped down with alcohol pads. On May 4, 2010 between at 9:50 AM and 11:30 AM face- to- face interviews were held with Employees #10 and #14 regarding staff training for infection control. A review of inservice training revealed that Employee #19 had not received additional training for infection control. Employee #20 had received additional training on March 3, 2010 2. Facility staff failed to handle linen in a manner to prevent the spread of infection. At approximately 3:10PM on May 4, 2010 Employee #31 was observed removing linen from a linen cart located in the right back hallway approximately one (1) to two (2) feet from the doorway of Room 644. The linen fell to the floor. Employee #31 bent over, retrieved the linen from the floor and replaced the items on to the cart.	{F 441}		

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{F 441}	Continued From page 29 A face-to-face interview was conducted with the employee immediately after the incident. The employee acknowledged the finding. Employee #3 was present during the interview and went with the employee to remove the linen from the cart.	{F 441}		
{F 454} SS=F	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observations made during environmental tours of the facility on May 3 through 5, 2010, it was determined that the facility failed to provide timely maintenance services for 28 of 28 fire extinguishers that were past due their yearly inspection date. The findings include: 28 of 28 fire extinguishers located on the sixth and seventh floors were past due for their annual verification; their most recent inspection date was April 2009. These observations were made in the presence of Employees # 23 and #24 who acknowledged these findings during the survey.	{F 454}	1. The twenty-eight fire extinguishers located on the sixth and seventh floors that were cited as past due for their annual verification date were corrected during the survey period. 2. All fire extinguishers have been checked and updated accordingly to ensure compliance. 3. All plant operations staff will be in-serviced on proper routine maintenance policies and procedures. The Plant Operations Manager will perform the in-service by July 1, 2010. 4. Findings will be monitored by the Plant Operations Manager and the Environment of Care Coordinator or designee in QA starting July 1, 2010.	07/01/10
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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F 465	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observations made during the environmental tour of the facility on May 4 and 5, 2010, it was determined that the facility failed to provide a safe environment for its residents as evidenced by the improper storage of six (6) of twenty-two (22)oxygen tanks in oxygen rooms. 1. Two (2) of eight (8) oxygen tanks on the sixth floor and four (4) of fourteen (14) oxygen tanks on the seventh floor were stored upright and directly on the floor in the oxygen room. These observations were made in the presence of employee # 23 and #24 who acknowledged these findings during the survey.	F 465	1. The six oxygen tanks observed during the environmental tour that were improperly stored were corrected at the time of the survey. 2. All other oxygen tanks were checked for improper storage. Nursing Management is visually checking the oxygen rooms to ensure compliance. No others were found deficient. 3. All licensed staff will be educated as to the proper storage of oxygen tanks in the oxygen room. 4. The Resident Care Coordinators and the nursing supervisor will audit the oxygen rooms for compliance. Findings will be reported to the Quality Assurance Committee Monthly times six.	7/01/10
F 502 SS=C	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 12 sampled residents it was determined that facility staff failed to demonstrate implementation of a process by which ordered labs are drawn and results are then retrieved and reported to the physician in timely manner. Residents # 7, 8 and 9 The findings include:	F 502		

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F 502	Continued From page 31 1.Facility staff failed to obtain lab results of a wound culture in a timely manner as ordered by the physician for Resident #7. A review of Resident #7 ' s interim physician ' s orders dated April 29, 2010 revealed an order to obtain wound cultures of the great toe and second toe. A review of the clinical record on May 4, 2010 lacked evidence that the results of the culture/sensitivity were on the record.. A face-to-face interview was conducted on May 4, 2010 at approximately 11:40 AM with Employee # 4. After a review of the clinical record, he/she acknowledged that the results were not in the clinical record. A telephone query was made to the lab by Employee #4 on May 4, 2010 at approximately 11:44 AM which revealed that the results were available and lab personnel was asked to fax a copy of the report to the floor at that time. The final Lab report indicates that the Cultures of the left great toe and 2nd toe were collected on April 30, 2010 at 6:00 AM; Received in the Lab at 6:50 AM and results were finalized on May 2, 2010 at 3:56 PM. The results were positive for MRSA [Methicillin Resistant Staphylococcus Aureus] in both wounds. Further query was made with Employee #4 as to how facility staff usually obtained results from the lab. Employee # 4 responded that they often had to call the lab to get the results "because we don ' t have access to get reports from the	F 502	1. Resident #7-Wound culture was obtained 5/4/10. The attending physician was notified of results and treatment was initiated per physician orders. Resident #8-Dilantin level was obtained on 5/5/10. The attending physician was notified of results. Resident #9-Sputum culture was obtained 5/7/10. The attending physician was notified of results. 2. The facility realizes that all residents may be impacted by this deficiency. The facility has developed a master list of all routine labs and has set up a system for completion of routine labs including documentation of receipt of results. Nursing Management will check records daily for any new lab orders and ensure completion of lab. The lab book now contains a form requiring signature and date by nurse who receives results. Nursing Management is utilizing a daily audit tool to review lab book daily for all required elements. 3. Licensed staff and unit secretaries will be educated to new lab forms and procedure for use. 4. The RCC and Nursing Supervisors are responsible for maintaining compliance through use of daily audit tool. They will institute immediate corrective action as needed per findings and report to DON. The DON will report results.	7/01/10

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F 502	Continued From page 32 computer". A nurse ' s note dated May 4, 2010 at 12:10 PM indicated that the Physician was notified and new orders were received. A face -to- face interview was held with Employees #33 and #34 on May 5, 2010 at approximately 11:00 AM. After an investigation of the lab process, Employee #33 stated that "the results for this lab were considered a critical value and should have been called to the unit on May 2, 2010 when the lab was finalized". Lab personnel failed to follow the protocol for notification of critical values to the unit for this result. Facility staff failed to obtain wound culture results in a timely manner for Resident #7. 2. Facility staff failed to obtain Dilantin level as ordered by the physician for Resident # 8. Facility staff failed to obtain a scheduled Dilantin level for a resident diagnosed with a seizure disorder. Resident #8. A review of Resident #8's Treatment Administration (TAR) 2010 Record and "Physician Admission Orders " signed and dated April 29, 2010 by physician revealed a lab order that directed obtain " Dilantin level every month " . A review of TAR revealed that Dilantin level schedule to be drawn on May 5, 2010 at 6:00AM was not done. A face-to-face interview was conducted with Employee #4 on May 5, 2010 at 10:45 AM.	F 502		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		R 05/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 502	Continued From page 33 He/she acknowledge that there was no lab drawn at 6:00AM for resident #M8. The record was reviewed May 5, 2010. 3. Facility staff failed to obtain a sputum culture for Resident # 9. According to a physician ' s order dated April 10, 2010 "obtain deep suction culture of sputum on 4/12/10 [April 12, 2010] @ (at) 6:00 PM R/O (rule/out) MRSA (Methicillin Resistant Staphylococcus Aureus)". A review of the clinical record on May 4, 2010 lacked evidence of results of a sputum culture for Resident #9. A-face-face interview was conducted on May 4, 2010 with Employee #10 at 2:30 PM. After review of the clinical record, he/she acknowledged that the clinical record lacked evidence of a sputum culture result for Resident #9. A query was made if the sputum culture was obtained. Employee #10 acknowledged that the culture was ordered but was not obtained. Employee #10 could not identify why the culture was not obtained. Facility staff failed to obtain a sputum culture for Resident #9. Further interviews were conducted with facility staff After review of the above findings to determine the effectiveness of the Lab Program. A face-to-face interview was conducted on May 4, 2010 at approximately 4:45 PM with Employees #10, and #33. Employee #33 indicated that lab	F 502		

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F 502	Continued From page 34 results automatically print to the unit printer via fax when the results of the lab test are finalized. If the Lab results are considered a critical value they are also called to the unit as well. On May 5 , 2010 at 10:30 AM a face- to- face interview was conducted with Employees #2 and #4. Employee #2 stated "that results should print on the unit but don ' t always". Stated a meeting was scheduled with Employee # 33 to discuss lab issues. When queried regarding how the unit ensures ordered labs are drawn , results are received and the is physician notified . Employee #4 stated that ordered labs are placed on the TAR [Treatment Administration Record] and in the "Lab Reconciliation Book". Labs are discussed at the morning stand up meeting and Employee #4 stated: "I write and circle them in my notebook for follow-up. The sheets in the Reconciliation Book capture information regarding lab draws completed by the phlebotomists but lacks evidence of lab results received and notification of the physician of the results. It was determined that facility staff failed to demonstrate implementation of a process by which ordered labs are drawn and results are then retrieved and reported to the physician in timely manner.	F 502		